**South West LHIN Primary Engagement Sessions – November/December 2015**
**Summary of Emerging Themes**

## Key messages of advice for those planning changes in primary care in the South West

### Build on Strengths and Overcome Challenges

- Enhance existing relationships and the spirit of collaboration
- Seek out untapped resources at the clinical and administrative levels
- Build on the high functioning team-based care where improved patient outcomes are being realized
- Leverage technology for communication between providers and strive for 'real time' sharing
- Ensure improved linkages between specialists and primary care as well as home care and primary care
- Work towards appropriate capacity of primary care providers, inclusive of allied health
- Take into consideration specialist resources when assessing capacity in the system
- Determine adequate funding levels for complex and special populations such as those with mental health and addictions challenges/low socioeconomic status
- Implement health literacy education for patients so they can become partners in care
- Advocate for change in barriers outside our control (e.g. scope of practice, managed entry)

### Work to Align Resources for Effective and Efficient Care

- Reallocate funding to support clinical and coordination work
- Improve coordination of care at the point of care; in primary care, at discharge from hospital
- Support improved care for those with mental health and addictions challenges, including children and adolescents
- Leverage all resources, inclusive of human resources and technology, to support patients with high care needs
- Integrate care coordination currently with CCAC into primary care
- Review, understand and improve the processes of care, inclusive of information sharing
- Utilize community resources to enhance public health education

### Engage Leaders that have meet such evidenced-based criteria as:

- Lived experience as a clinician and/or administrator in order to know how all of the pieces work together
- An understanding of both the primary care system and local needs
- Courage to stand up and challenge norms and current thinking
- Ability to use both qualitative and quantitative data to inform decisions
- Utilize local needs to drive system change, and vice versa

**Ensure Access to Primary Care for the most Vulnerable Populations**

Those who are most vulnerable are:

- Living in poverty with low literacy/language barriers
- Seniors with both physical and mental health challenges, who often are living alone
- People of all ages with mental health and addictions challenges
- Requiring a holistic approach to care
- Lacking social support and are isolated

Improved Access could look like:

- Team approaches where people are enabled to practice to their full scope of practice, including physician assistants, NPs, etc.
- Flexible care delivery models built for the population they serve, meaning they could be geographic specific
- Consumer - friendly tech options that incorporate wait times, primary care business hours and after hours availability
- Triage role to ensure patients see the right kind of practitioner
- Improved provider communication/integration
- More primary care providers using advanced access methodology

**Overall themes by question***
(Each theme received a minimum of 5 votes and themes are listed in descending order in each section)

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| Strengths | • Communication –informal, EMR, formal strategy, real time (HP)<br>• Untapped resources (eg. speciality GPs) and the need to partner, network and better exploit those resources (LM)<br>• Interdisciplinary care (LM)<br>• Spirit of collaboration (Oxford)<br>• Good resources in Specialist and other resources within our geography (LM)<br>• Proximity of providers (GB)<br>• Good EMR. Able to access records (GB)<br>• Comprehensive care by all family practitioners leads to a functional team of physicians (HP)<br>• Size, relationships and civic connections allow for strong primary care community (Elgin)<br>• Continuity of care for patient leads to decreased medical errors and increased outcomes (HP) |
| Challenges | • Future challenges – resources spread too thin if bringing other doctors under team (HP)<br>• Accountability of specialists to primary care (Elgin)<br>• Funding and resources often not enough to meet the needs of complex and special populations (mental health, social determinants) (LM)<br>• Patient expectations (LM)<br>• Increasing complexity of patients on roster (Grey Bruce)<br>• Managed entry process – limits entry (LM)<br>• Access to specialists (e.g. ortho, rheum, physiatry), Access to diagnostics (CT, MRI) (LM)<br>• Being able to address the social determinants of health (literacy, housing, poverty, education) (LM)<br>• Barriers between sectors (Elgin)<br>• Coordination with all partners (HP)<br>• Scope of practice (NP) (Elgin)<br>• Link between primary care and home care (Elgin)<br>• Administrative tasks (Elgin)<br>• Access to family physicians (LM) |
| Resources that could be better aligned | • Reallocation of funding – more to front lines and less to planning/admin (LM)<br>• Better coordination of hospital discharge planning (LM)<br>• Better care for children/adolescents with mental illness (Elgin)<br>• Need for better coordination of all services in the area (Oxford)<br>• Mental Health community resources (LM)<br>• Integrating CCAC into primary care practices (HP)<br>• Better use of IT solutions for integrating communication (HP)<br>• Reallocating resources from other sectors into primary care, especially care coordination (GB)<br>• Reexamine process of care and communication (Elgin)<br>• Better alignment with CCAC (HP)<br>• Direct patient care by leveraging all of the resources in the system (allied health resources, public health, community resources) (LM)<br>• Better integration of community resourcing to improve public health education (HP) |

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| | • CCAC Care Coordinator on site in primary care practice (LM)<br>• Technology, and navigators to follow patients through the system (LM) |
| Criteria for Leaders | • Evidence-based criteria (LM)<br>• Combination of clinician and admin – LEAN process empowerment (Elgin)<br>• Good understanding of primary care system and local needs (GB)<br>• Courage to stand up and challenge the norms and current thinking (LM)<br>• Accessing qualitative and quantitative data to inform decisions (Oxford)<br>• Experienced clinician leading sub-LHIN level (Elgin)<br>• Operational understanding and how all pieces work together (Oxford)<br>• Understand how local needs drive system change, and vice versa (LM) |
| Populations most Vulnerable | • living in poverty with low literacy/language barriers (LM)<br>• combination of seniors with physical and mental health challenges (LM)<br>• Mental health and addictions (GB)<br>• Children & youth with severe mental health (no services) (Elgin)<br>• Mental health challenges (HP)<br>• Vulnerable, isolated senior in own home (Elgin)<br>• Low socioeconomic status (Oxford)<br>• Those with co-morbidities requiring a holistic approach to care (LM)<br>• Mental health challenges, increase access to social workers/psychologists (LM)<br>• Those with low socio-economic status, navigation and health literacy (LM)<br>• Frail elderly (GB)<br>• Those with lack of social support/social isolation in all populations (Elgin) |
| How to improve access to Primary care | • Team approaches where people are enabled to practice to their full scope of practice (HP)<br>• Better communication of “business hours” to see physician and keep it up to date for holiday hours, etc. (Elgin)<br>• Flexible model (variety of maximized roles and physician models) (GB)<br>• Geographic specific solutions (what works in London won’t work here) (HP)<br>• Consumer - friendly tech options that incorporate wait times (Elgin)<br>• Triage – a role to ensure patients see the right kind of practitioner (GB)<br>• Creative advanced access using technology, education (LM)<br>• Improve provider integration (Oxford)<br>• Patient/provider education on advanced access (LM)<br>• Use of physician assistants, NPs, and RNs to increase right care, right time, so people can see the right kind of care providers to meet their needs (HP) |

*results may be skewed by higher numbers of participants in London/Middlesex

**Key Themes by Geography**

| Geography | Strengths | Challenges | Resources that could be better aligned | Criteria for Leaders | Populations most Vulnerable | How to improve access to Primary Care |
|---|---|---|---|---|---|---|
| Huron/ Perth | Communication – informal, EMR, formal strategy, real time | Future challenges – resources spread too thin if bringing other doctors under team | Integrating CCAC into primary care practices | Background and understanding of primary care | mental health challenges - 12 | Team approaches where people are enabled to practice to their full scope of practice |
| | Comprehensive care by all family practitioners leads to a functional team of physicians | Coordination with all partners | | | | |
| | | Mental health – 2.5-3 month wait times to see allied health | Better use of IT solutions for integrating communication | | | |
| | | Equitable care for all patients | | | | Geographic specific solutions (what works in London won't work here) |
| | | Competing demands on their time | Better alignment with CCAC | Good data that you can apply and do something with | socioeconomic status | |
| | Continuity of care for patient leads to decreased medical errors and increased | Access to mental health services | | | | |
| | | Access | Better integration of | | | Use of physician |

| Geography | Strengths | Challenges | Resources that could be better aligned | Criteria for Leaders | Populations most Vulnerable | How to improve access to Primary Care |
|---|---|---|---|---|---|---|
| | outcomes | Differences in care settings – urban/rural have same access expectations | community resourcing to improve public health education | | | assistants, NPs, and RNs to increase right care, right time, so people can see the right kind of care providers to meet their needs |
| | | capacity | CCAC Care Coordinators embedded within FHTs, seamless transitions from hospital to home | Leaders need to have an open mind | unattached patients | |
| | | Capacity with Stretched resources | | | | Remove caps for number of family docs in family health teams |
| | | System coordination | Public Health needs to be realigned | | | |
| | | Equal valuing of allied and physician resources | | | | |
| Grey Bruce | Proximity of providers | Increasing complexity of patients on roster | Reallocating resources from other sectors into primary care, especially care coordination | Good understanding of primary care system and local needs | Mental health and addictions | Flexible model (variety of maximized roles and physician models) |
| | Good EMR. Able to access records | Rural primary care providers torn in many different directions | Home care and primary care working collaboratively | Inspiring and brings out others ideas (think outside the box) | Frail elderly | Triage – a role to ensure patients see the right kind of practitioner |

| Geography | Strengths | Challenges | Resources that could be better aligned | Criteria for Leaders | Populations most Vulnerable | How to improve access to Primary Care |
|---|---|---|---|---|---|---|
| | Comprehensiveness of care | Difficult to provide equitable access, particularly Amish, Mennonite people with mental health and addictions challenges | Hospital delivered primary care realigned into primary care | Able to implement strategies for sustainability | Aboriginal and Mennonite<br>Terminally ill patients | Health literacy – leverage to teach patients when to appropriately access primary care |
| Elgin | Size, relationships and civic connections allow for strong primary care community | Accountability of specialists to primary care<br>Barriers between sectors<br>Scope of practice (NP)<br>Link between primary care and home care | Better care for children/ adolescents with mental illness | Combination of clinician and admin – LEAN process empowerment | Children & youth with severe mental health (no services)<br>Vulnerable, isolated senior in own home | Better communication of 'business hours' and keep it up to date re: holidays etc. |

| Geography | Strengths | Challenges | Resources that could be better aligned | Criteria for Leaders | Populations most Vulnerable | How to improve access to Primary Care |
|---|---|---|---|---|---|---|
| | Strong physician relationships and longevity | Administrative tasks | Reexamine process of care and communication | Experienced clinician leading sub-LHIN level | Those with lack of social support/social isolation in all populations | Consumer - friendly tech options that incorporate wait times |
| Oxford | Spirit of collaboration – especially in Ingersoll | | Need for better coordination of all services in the area | Accessing qualitative and quantitative data to inform decisions | Low socioeconomic status | Improve provider integration |
| | | | Need for better access to mental health care that is comprehensive | Operational understanding and how all pieces work together | | |
| | | | Communication and navigation in current layer | Ability to see trees and forest / system as whole & details | people with mental health and addictions issues | IT solutions |
| | Individual pockets of interesting resources that could be spread | | Technology alignment and user friendly | | | |
| London/ Middlesex | Untapped resources throughout the London Region (e.g. specialty GPs) and need to partner, network and better exploit these resources | Funding and resources not enough to meet the needs of complex and special needs populations (mental health, social determinants) | Reallocation of funding – more to front lines and less to planning/admin | Evidence-based criteria | living in poverty with low literacy/language barriers | Creative advanced access using technology, education |
| | Interdisciplinary care | Patient expectations | Better coordination of hospital discharge planning | Courage to stand up and challenge the norms and current thinking | combination of seniors with physical and mental health challenges | Patient/provide r education on advanced access |

| Geography | Strengths | Challenges | Resources that could be better aligned | Criteria for Leaders | Populations most Vulnerable | How to improve access to Primary Care |
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| | | | | | | |
| | Good resources in Specialist and other resources within our geography (Challenge – bit of a complex web to refer to specialist – don't know resources exist) | Managed entry process – limits entry | Mental Health community resources | Understand how local needs drive system change, and vice versa | Those with co-morbidities requiring a holistic approach to care | Creative solutions for after-hours care – using various billing models |
| | Partnerships between providers; provider engagement | Access to specialists (e.g. ortho, rheum, physiatry), Access to diagnostics (CT, MRI) | Direct patient care by leveraging all of the resources in the system (allied health resources, public health, community resources) | Ability to deal with uncertainty and to model leadership in that environment | Mental health challenges, increase access to social workers/psychologists | Access can be challenging with transportation and complex clients who choose to come or not come |
| | Integration/ centralization of CMHA | Being able to address the social determinants of health (literacy, housing, poverty, education | CCAC Care Coordinator on site in primary care practice | Someone with lived experience | Those with low socio-economic status, navigation and health literacy | Need for navigator to place complex needs clients |
| | Momentum of IT enablers; more tech savy | Access to family physicians | Technology, and navigators to follow patients through the system | Ability to listen (not just hear) and to show appreciation/recognition | Individuals with chronic pain/narcotic needs | |
| | Opportunity to utilize students from the university for primary care engagement | Find physical space to co-locate and integrate services e.g. mental health and psychotherapy services | Better access to resources to support primary care ie. specialists, DI | Communication (dialogue perspective) transparency, knowledge level | Frail elderly who have multiple chronic diseases and many barriers to care | |
| | | Communication between providers | Aligning resources around population | There is no one size fits all approach | Aboriginal population with barriers to | |

| Geography | Strengths | Challenges | Resources that could be better aligned | Criteria for Leaders | Populations most Vulnerable | How to improve access to Primary Care |
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| | Should we bring specialties to the primary care location? | | need (e.g. mental health, refugees) | | accessing services on and off the reserve | |
| | | | Duplication of services ie. OT in FHT and OT at CCAC | | | |

= 5 dots or more