

# Integrated Health Service Plan

## ***Integration Priority & Action Plans:***

### ***Strengthening Primary Health Care***

Mississauga Halton Local Health Integration Network

Appendix G.2

Appendix  
G.2

# Strengthening Primary Health Care

## Description

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There is an abundance of compelling evidence which supports that a strong primary care infrastructure can lead to improved population health status and reduced health system costs.<sup>1</sup>

The World Health Organization defines Primary Health Care as “the first level of contact of individuals, the family and the community with the health care system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.”<sup>2</sup> Primary Health Care addresses the main health concerns in a community, providing health promotion, preventative, curative, rehabilitative and supportive services. It is designed to focus on meeting population health needs.<sup>3</sup> Health Canada suggests that primary health care services often include:

- prevention and treatment of common diseases and injuries;
- basic emergency services;
- referrals to/coordination with other levels of care (such as hospitals and specialist care);
- primary mental health care;
- palliative and end-of-life care;
- health promotion;
- healthy child development;
- primary maternity care; and
- rehabilitation services.<sup>4</sup>

At present, primary care services in Canada are delivered chiefly by family physicians and general medical practitioners who focus on the diagnosis and treatment of illness and injury. Further developments seek to build on this foundation.<sup>5</sup> In recent years, the ways in which primary health care services are organized and delivered have been the focus of much debate (see, for example, the Romanow Report and Health Council of Canada Report). Concerns include:

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<sup>1</sup> Starfield, B. and Shi, L., “Policy Relevant Determinants of Health: An International Perspective,” **Health Policy**, 2002, 60: 201-18.

<sup>2</sup> World Health Organization Website

<sup>3</sup> *ibid*

<sup>4</sup> Health Canada Website – Primary Health Care

<sup>5</sup> Health Canada website: [http://www.hc-sc.gc.ca/hcs-sss/prim/about-apropos/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/prim/about-apropos/index_e.html)

- the relative lack of emphasis on health promotion and disease prevention, which has been linked to high rates of preventable illness;
- lack of continuity, with various providers and institutions often appearing to work in isolation from one another;
- problems with access, particularly in rural and remote areas, but also in urban centres where the lack of after-hours services often results in the use of emergency rooms for non-urgent care; and
- providers' concerns regarding their working conditions, including long hours and impacts on their own health and family life.<sup>6</sup>

The importance of having a strong primary health care system and the overwhelming of support for this priority in the community demands a concerted effort to:

- Improve and promote inter-disciplinary practice and inter-provider collaboration; and
- Focus efforts to improve the continuum of services for specific populations including moms and babies and children and youth.

To promote greater collaboration across providers within the Mississauga Halton LHIN, this priority sets forth a vision for the future with the goal of:

To ensure all patients get the level of primary health care service that is needed, the scope of practice of each primary care health professional will be maximized in order for family physicians to have more time for practicing medicine.

***Improving and promoting inter-disciplinary practice and inter-provider collaboration:***

Building mechanisms that support an integrated and comprehensive primary care system must include physicians who work in inter-disciplinary practices as well as those who work independently or in small group practices. Figure 1 illustrates a more integrated approach to primary care for those physicians who practice independently or in small group practices. In this model providers are not co-located and the family physician or another health professional plays a case coordination role by providing linkages to other health care providers. Access to an electronic inventory of services (ideally web-based) including access methods and referral forms improves the efficiency of this model.

Figure 2 depicts primary care inter-disciplinary practices where services are co-located to provide integrated and comprehensive care to patients. Co-

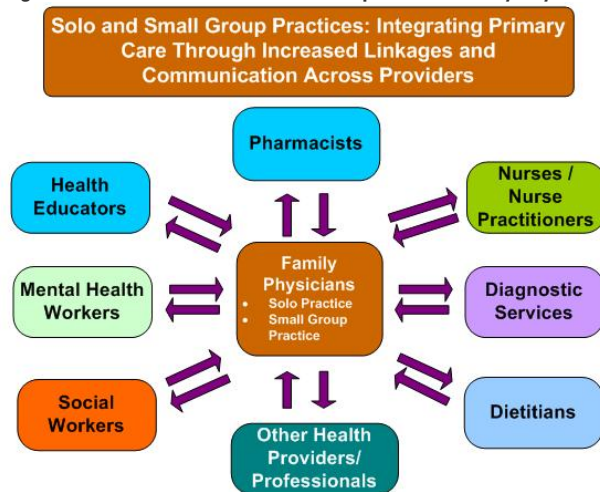
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<sup>6</sup> ibid

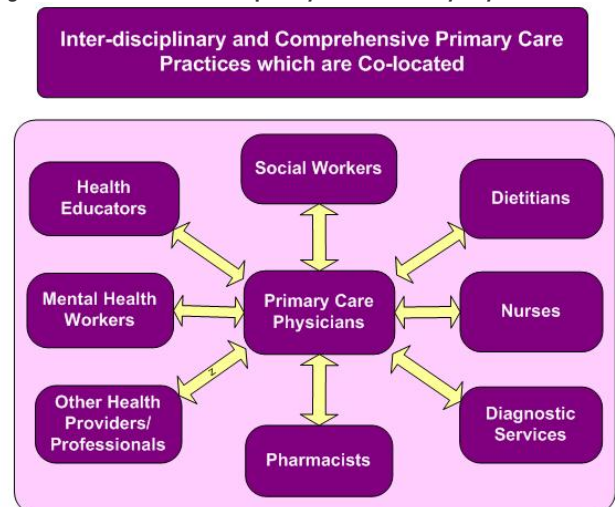
location facilitates ongoing two-way communication and more immediate problem solving. Maximizing the scope of practice of each health professional is critical in both models to ensure optimal efficiencies are achieved.

It is recognized that primary health care is the foundation for the health system within the Mississauga Halton LHIN and considerable interdependence across the other priorities exists. Therefore, primary care delivery models contemplated here must connect and integrate as effortlessly as possible with the delivery tools and techniques of the other priorities. The design of the other priorities will need to focus on supporting the maximization of time with patients/clients within primary care service delivery.

**Figure 1. Model for Solo and Small Group Practice Family Physicians**



**Figure 2. Model for Inter-Disciplinary Practice Family Physicians**



The Family Medicine Teaching Unit, part of the Department of Family and Community Medicine, University of Toronto, will be established at Credit Valley Hospital and is being considered by the Trillium Health Centre. The future graduates of this program will gain inter-disciplinary experience from working in an academic Family Health Team environment. Thus the vision of the team based model will be further supported through educational and training experience.

***Focus efforts to improve the continuum of services for specific populations – mothers and babies and children and youth:***

The need to focus on mother, babies, children and youth within primary care is critical to the population within the Mississauga Halton LHIN. Most children receive the bulk of their health care services from primary health care providers and partners. Public Health have the lead responsibility for the postpartum component they will work with hospitals, midwives, community care access centres, physicians and other community partners across the health and social services sectors to implement the postpartum and early identification component of Healthy Babies, Healthy Children. It is important

that a strong infrastructure is available to those who cannot always advocate for themselves.

## Rationale

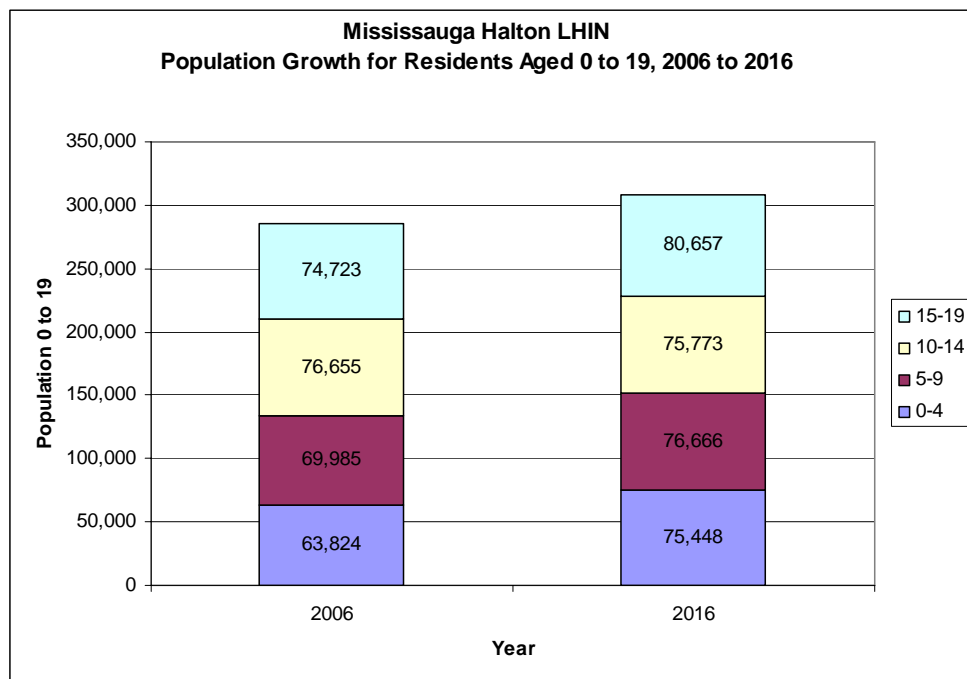
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### Environmental Scan:

Key messages extracted from the full environmental scan and pertinent to this priority include:

- In comparison to the Ontario average, Mississauga Halton hospitals are discharging a greater proportion of their patients without any support services (e.g., home care).
- Residents of Peel Municipality may have a greater need for post-acute discharge support, based on ALC separations, days and average length of stay.
- Approximately 40 per cent of emergency visits are classified as “less urgent” or “non-urgent”. This suggests that there is some opportunity to offer other means of non-urgent or emergent treatment (service areas or treatments) in other ways.
- There are currently no operational community health centres serving clients with “barriers to access”.
- Mississauga Halton LHIN has been among the lowest of the LHINs per capita expenditure in community services. This has significant implications in providing any form of integrated service delivery to residents that are seeking non-acute support services within their community.
- As of 2004, there were 732 family physicians in the Mississauga Halton LHIN. This translates to approximately 1 physician per 1,422 people. However, the ratio is lower in Halton Hills and Milton and they have been designated as “under-serviced areas” for family physicians.
- The Canadian Community Health Survey (CCHS, 2003) estimates 6.6 per cent of Mississauga Halton LHIN residents do not have a regular medical doctor.
- For Mississauga Halton LHIN, 74.8 per cent of patients visited a primary care physician within their own LHIN. For specialists it drops to 55.9 per cent, one of the lowest among the LHINs. However, 72.9 per cent of the patients visiting a primary care physician came from within the physician’s LHIN and for specialists it was 67.1 per cent. This means that residents from Mississauga Halton receive services outside the LHIN, while residents from other LHINs receive services in Mississauga Halton.
- The population of residents in Mississauga Halton LHIN aged 0 to 19 in 2006 is estimated to be 285,186. This represents approximately 26.3% of the total population, and is slightly higher than the provincial average of 24.5%.

- The southern portions of the LHIN fall below the provincial average of 26.3% while the northern portions exceed this rate. Furthermore, Northwestern Mississauga has a significantly higher rate (31.6%).
- The Mississauga Halton LHIN rated poorly in the percentage of the population receiving an influenza vaccination.
- There are clear “pockets” of residents with potential barriers to access as indicated by
  - Larger concentration of seniors, renters, low income earners and recent immigrants and fewer participants in the workforce are evident in some parts of the Mississauga Halton LHIN; and
  - Concentration of recent immigrants and visible minorities in Mississauga.
- The population growth for the 0 to 19 age group over the next decade is projected to be 49,478 or approximately 17.3% which is significantly higher than the province overall.



Source: Unpublished Draft Projections (2005 Base), 2006-2016, for Local Health Integration Networks

**Community Engagement:**

Phase 1 Engagement:

Participants in the public and provider forums suggested the need to:

- Develop inter-disciplinary team approaches for primary care
- Expand the role of the multidisciplinary team members
- Improve communication/linkages among providers
- Provide more home support (e.g., postpartum follow-up for new mothers and newborns)

- Improve public and provider knowledge about local health services
- Create linkages between LHINs and Family Health Teams to identify further integration opportunities.
- Increase community primary care resources – local and available longer hours.

#### Phase 2 Engagement:

This phase has included dialogue with physicians, numerous forums with the public, expert panels made up of providers and partners from the LHIN and the provider conference. From these conversations it has been suggested that:

- Children and youth need a higher profile within the IHSP priorities.
- Many diagnostic services have wait times associated with them – and thus the practice of wait time tracking should be expanded to other diagnostic services (beyond MRI and CT).
- There is limited access to diagnostics services for children who are demonstrating developmental delays.
- There be a review of how better services might be provided in the community to handle acute episodes for children.
- A shared care model for primary care be developed in order to get family physicians and specialists working together more closely.
- More alternatives to the emergency department are needed to access non-urgent care.
- The goals outlined are worthwhile.
- To achieve these goals there are a number of challenges.
- Sharing information across providers will be important to success.
- An inventory of services should be developed for physicians and all health care professionals to access (i.e. web based ideally).
- It is critically important that pharmacists and other professionals be utilized differently in service delivery.

#### **Other Relevant Information:**

Since the 1970's, Ontario has launched primary care renewal by undertaking several initiatives to create a variety of primary care "groups". These groups incorporate multi-disciplinary teams and payment approaches that blend traditional fee-for-service with capitation and salary options. In Mississauga Halton LHIN there are currently:

- 4 Family Health Networks<sup>7</sup>;
- 27 Family Health Groups<sup>8</sup>,

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<sup>7</sup> Family Health Network (FHN) – established in 2001, this model contains at least 3 physicians providing care to a population of enrolled patients and commit to provide care to each other's patients through after-hours clinics and telephone health advisory service (THAS). Payment is a blend of global capitation plus fee-for-service plus incentives. The blended payment allows the option to include allied health professionals.

- 32 Comprehensive Care Model physicians<sup>9</sup>;
- 1 satellite site Community Health Centre<sup>10</sup> – East Mississauga CHC which is a branch of LAMP (will be located at the southeast corner of Dixie and Dundas); and
- 3 Nurse Practitioner Programs<sup>11</sup>.

As of October 1, 2006, more than 450 local physicians are part of either a FHN or FHG, or have become a CCM physician. These physicians provide care to over 480,000 residents. Most recently, of the 150 Family Health Teams announced by the Ontario government, Mississauga Halton LHIN is home to six, one in each sub-LHIN area:

- Credit Valley FHT (Mississauga);
- Etobicoke Medical Centre FHT (Etobicoke);
- Halton Hills Family Physicians FHT (Georgetown);
- Prime Care FHT (Milton);
- Dorval Medical Associates FHT (Oakville);
- South Mississauga & South West Etobicoke FHT (Mississauga / Etobicoke)

Family Health Teams can include doctors, nurses, nurse practitioners, pharmacists, dietitians, physician specialists, social workers, health educators, mental health workers and other health care providers. They are the first point of contact in the health care system to provide better access to 24-hour care. Family Health Teams offer a range of health care services from assessing physical and mental conditions to diagnosing, treating and preventing diseases, disorders or dysfunctions. They are designed to improve health care coordination by better linking patients to other parts of the health care system, such as hospitals, long-term care homes, public health, mental health and community programs and services, and will enable health care providers to share and access test results and other important patient information. When fully operational, the Family Health Teams in the Mississauga Halton LHIN will serve over 32,000 patients. It is expected that physicians working in an interdisciplinary group practice could see up to 50 per cent more patients than those working in a solo practice.

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<sup>8</sup> Family Health Group (FHG) – created in 2003, is a blend of group practice family medicine and Family Health Networks. Like FHNs, at least 3 physicians come together and provide coverage for each other's patients through after-hours clinics and THAS. Physicians remain on fee for service and receive premiums for providing comprehensive care.

<sup>9</sup> Comprehensive Care Model (CCM) – available to any family physician licensed to practice in Ontario, physicians agree to provide comprehensive care to their enrolled patients and are paid through a combination of fee-for-services plus monthly capitation rates, special premiums and incentives.

<sup>10</sup> Community Health Centre (CHC) – is a non-profit organization made up of teams that include physicians, nurse practitioners, nurses, counselors, community workers and dietitians. They provide care for those who have difficulty accessing primary health care due to barriers such as language, culture, physical disabilities, homelessness, poverty or geographic isolation. CHCs also care for those with a higher risk of developing health problems than the general population, and provide programs and services to address factors such as education, employment, income, social support, and housing.

<sup>11</sup> Nurse Practitioner Program (NP) – developed in 2002 to expand the roll of nurse practitioners in clinical settings, particularly for small, rural and underserved areas.

## Overview of Action Plans

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The implementation plan will include three action plans:

- 1) Strengthen inter-disciplinary collaboration across providers by improving communication and linkages among physicians and primary health care providers and partners.

Create Detailed Planning and Action (DPA) teams to focus on specific aspects of information sharing and partnership including the following:

- Build on the success of the National Home Care and Primary Health Care Partnership Project by expanding case manager services available to family physicians, hospitals and other health service providers.
- Improve access to patient information including:
  - creating a traveling patient record accessible to all health professionals;
  - ensuring physicians have access to patient records in all hospitals within the Mississauga Halton LHIN (and in neighbouring LHINs if possible); and
  - Improving communication across hospitals and physicians, and community sector organizations at the point of discharge
- Create improved coordination and communication between specialists and family physicians.
- Improve equitable access to rapid diagnostics and results.
- Improve the knowledge and understanding (by patients and health service providers) of services available in the Mississauga Halton LHIN.

- 2) Improve and strengthen support programs available for expectant mothers, new mothers and newborns.

Create a Detailed Planning and Action team and by using existing networks comprised of Public Health, Hospital leaders, Primary Care Physicians and other relevant leaders to:

- Develop an inventory of the current scope of services and activity.
- Determine unmet needs through consultations with new mothers.
- Develop and implement recommendations and plan of action to better meet the needs of this population (e.g., additional home visiting, clinics, and printed materials).

- 3) Enhance inter-disciplinary service delivery and service availability to children and youth to better meet the needs of this population throughout the LHIN.

Create a Detailed Planning and Action and by using existing networks comprised of Public Health, Hospital leaders, Primary Care Physicians and other relevant leaders to:

- Develop an inventory of the current scope of services and activity.
- Determine the unmet needs through community engagement.
- Identify the appropriate basket of services for all levels of service.
- Develop and implement recommendations and plan of action to better meet the needs of this population.

### **Challenges that Could Impact Successful Implementation**

Phase 2 Community Engagement consisted of dialogue with physicians, numerous forums with the public, expert panels made up of providers and partners from across the LHIN and the provider conference. From these conversations the following challenges have been suggested:

- The systemic bias or stigma associated with mental health is largely ignored and the focus is on physical health, particularly in the elderly.
- Key health partnerships are not aligned with the LHIN boundaries.
- After hour and weekend availability for non-urgent services – i.e.: diagnostic services.
- Many children's services are provided through other health partners which are not within the LHIN's mandate (e.g., Community and Social Services; Education; Public Health; Health Promotion).

### **Networks and Current Initiatives Identified to Support Success**

The following networks responded to the call for input on the integration priorities:

- Mississauga Halton - Mental Health and Addiction Leaders
- Halton Long Term Care Administrators Group
- Halton Peel Regional Diabetes Network
- Halton Peel Palliative Care Network
- Halton Peel Emergency Services Network (HPESN)

The following initiatives or opportunities were identified through the Phase 2 Community Engagement with the providers as strengths that the Detailed Planning and Action Teams could use as a basis for further development:

- Family Medicine Teaching Unit, Credit Valley Hospital
- West Cluster Child Health Network
- Medical Academy, University of Toronto, Mississauga campus
- Community Health Centre After-School Programs
- National Home Care and Primary Health Care Partnership Project

## **Action Plan #1**

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### **Strengthen inter-disciplinary collaboration across providers through improving communication and linkages among physicians and primary health care providers and partners.**

#### **Description**

To successfully improve inter-disciplinary practice, regardless of the physician practice model, through improving the communication and linkages between physicians, their patients, specialists, and other health care providers across sectors. This will require a concerted effort and significant leadership and the action plans have included many of the factors necessary for successful transformation.

#### **Deliverables – Years One to Three**

##### **Year 1 Deliverables:**

##### **Create a Detailed Planning and Action Team for enhancing access to primary health care and information**

- Ensure diverse representation that is inter-disciplinary (including non-professionals, e.g., volunteers) and covers the continuum of care.
- Look for opportunities and identify early wins to implement which will improve access to patient information and build partnerships.
- Look at shared-care model opportunities that can be expanded into additional health care settings and among a greater number of health care providers.
- Research traveling patient records and identify a population or small subset of which to trial one before wider expansion.
- Determine mechanisms to share test results in a timely manner and achieve improved coordination.
- Improve the discharge process which will allow more efficient and timely transfer of patient information from hospitals to physicians, specialists and other health services organizations.
- Investigate the potential role of volunteers within the primary health care setting.
- Develop mechanisms or pathways to ensure appropriate referral for diagnostic testing and to improve access to rapid diagnostics and test results.
- Conduct appropriate community engagement on specific issues to ensure robust data collection.

**Engage the existing “Central West-Mississauga Halton Community Family Medicine / Public Health Network”<sup>12</sup> and add additional representation if required**

- This network of community physicians, Chiefs of Family Medicine and Medical Officers of Health has been functioning for the past couple of years. They are currently working on an initiative of enabling affiliated physicians (from the five hospitals that are located within Mississauga Halton and Central West LHINs) to obtain “information access only” to their patients health records at each hospital.
- Expand on the work that this network has done with the National Home Care and Primary Health Care Partnership Project. They have invited the CCACs to use this network as a vehicle to reach out to other physician groups.
- Conduct appropriate community engagement on specific issues to ensure robust data collection.

**Early Wins**

- **Early Win #1:** The National Home Care and Primary Health Care Partnership Project has been underway for two years with involvement by providers in Mississauga Halton. The valuable lessons garnered from this successful project could be extended to other providers in the LHIN. Currently, case management is being expanded into all Family Health Teams in the Mississauga Halton LHIN.
- **Early Win #2:** Work with the Mississauga Halton-Central West Community Family Medicine / Public Health Network and physician leaders, to implement the process for information sharing for affiliated physicians to allow access to specific patient records. Work in conjunction with members of the e-Health Steering Committee to ensure that this is a local priority.

**Year 2 Deliverables****The second phase for the Detailed Planning and Action Team will include the following:**

- Creating mechanisms to improve the knowledge and understanding by physicians of what services are available in the Mississauga Halton LHIN for their patients. For example via information technology.
- Creating mechanisms to improve the knowledge and understanding by patients and the public of what services are available in the Mississauga Halton LHIN for themselves and their families.
- Implement the traveling patient record across the Mississauga Halton LHIN and ensure that it is consistent with other integrated models in the

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<sup>12</sup> The Detailed Planning and Action team could be an expansion of the Central West-Mississauga Halton Community Family Medicine / Public Health Network, or could have representation from this network. Also, prior work and existing relationships in this area exist due to the previous position of Primary Health Care Community Development Consultant, MOHLTC, being co-located in the Mississauga Halton LHIN office.

LHIN (i.e. the integrated service delivery model for seniors and the integrated chronic disease prevention and management model).

- Implement methods determined for improving access to rapid diagnostics and test results.
- Expand shared care models.
- Conduct appropriate community engagement on specific issues to ensure robust data collection.

#### **Engage the existing Physician Network to:**

- Recommend a process for expanding the access to patient information to unaffiliated physicians.
- Look at options for cross-credentialing across the Mississauga Halton LHIN for all physicians and specialists (physicians would be credentialed at one hospital and would be able to access information and visit their patients at other hospitals if necessary).
- Conduct appropriate community engagement on specific issues to ensure robust data collection.

#### **Year 3 Deliverables**

- Evaluation of the implementation of the traveling patient record.
- Home Care and Primary Health Care Partnership Project: The project principles will be extended to widely to other primary care providers.
- Access to Rapid Diagnostics and Results: Criteria to assess urgency for diagnostic services will be applied throughout the LHIN and parameters for obtaining/receiving results will be defined.
- Cross-credentialing recommendations will be made and implemented.
- Improved methods for information sharing between physicians and specialists and for the discharge process will be implemented.
- Inventory of available services in the Mississauga Halton LHIN will be available for patients and providers.
- Conduct appropriate community engagement on specific issues to ensure robust data collection.

#### **Outcomes**

- Quality:
  - Health issues addressed in a more timely manner
  - Higher patient and family satisfaction levels
  - Higher provider satisfaction levels
  - Greater access to patient information and more efficient care delivered
- Access:
  - Equitable access to urgently needed rapid diagnostics and results
  - Overall reduced wait times for diagnostics and results

- Evidence based data used to enhance efficient use of available services
- Efficiency:
  - Patient shares information once
  - Increased number of patients who have traveling records
- System/Process:
  - Improved coordination among primary care providers
  - Improved communication between physicians and specialists

**Performance Indicators**

- CIHI Primary Care Indicators (In progress)
- Wait Times for primary care
- Emergency Department Utilization
- Others as appropriate to be determined by Detailed Planning and Action Team

## **Action Plan #2**

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### **Improve and strengthen support programs available for expectant mothers, new mothers and newborns.**

#### **Description**

Community engagement forums revealed that there is a perception that unmet needs exist for postpartum follow-up visits with new mothers and babies. There were 11,950 newborns in Mississauga Halton hospitals in 2004-2005. Birth rates between 1997 and 2003 have remained relatively steady for Mississauga Halton women and match provincial rates. However, actions in the short-term will enable a baseline and inventory of current services to be developed with options for addressing the needs and gaps. Opportunities exist for improving the supports and education materials for new mothers and newborns and leveraging successful efforts from local sites of larger networks (e.g., West Cluster Child Health Care Network).

#### **Deliverables – Years one to three**

##### **Year 1 Deliverables**

###### **Create a Detailed Planning and Action Team**

- A team will be established to lead the planning and implementation. It should be comprised of hospital, public health leaders, consumers and others as required.
- Complete an analysis that will include
  - The inventory of the current scope of services and activity
  - Unmet needs
  - Options for addressing the needs
- Conduct appropriate community engagement on specific issues to ensure robust data collection.
- Apply learnings from CCAC pilot project to pre-natal - post-partum continuum.

##### **Early Win**

- Link two risk assessments to physician charts to improve services for prenatal (e-Larson tool) and post delivery (e-Parkyn tool).

##### **Year 2 Deliverables**

###### **Once the priority elements have been developed, specific implementation planning will occur**

##### **Year 3 Deliverables**

###### **Determine innovative ways to address service gaps and unmet needs**

- This could include additional home visiting, clinics, printed materials, etc. as determined in the previous steps.

- Conduct appropriate community engagement on specific issues to ensure robust data collection.

### **Outcomes**

- Quality:
  - Improved knowledge by and support of new mothers
  - Improved patient satisfaction
- Access:
  - Increased number of
  - Home visits post discharge
  - Handouts for education support
- System/Process:
  - Improved partnerships between Public Health and hospitals

### **Performance Indicators**

- CIHI Primary Care Indicators (In progress)
- Number of new mothers that access services
- Others as appropriate to be determined by Detailed Planning and Action Team

## **Action Plan #3**

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### **Enhance inter-disciplinary service delivery and service availability to children and youth to better meet the needs of this population throughout the LHIN.**

#### **Description**

Currently children and youth represent approximately just over 26% of the population. Community engagement forums revealed that there are significant challenges in accessing services, if the services exist at all. Actions in the short-term will focus on developing a baseline inventory of current services, an understanding this population's needs in detail at the sub-LHIN level and then the identification of gaps. Opportunities for early wins will be identified as the year one activities are completed.

#### **Deliverables – Years one to three**

##### **Year 1 Deliverables**

#### **Create a Detailed Planning and Action Team (working with Public Health and other Health Care Partners) that will:**

- Include appropriate multidisciplinary and cross-sectoral representation.
- Review existing services and based on detailed planning make recommendations on the core basket of services required to meet population needs in geographic areas.
- Conduct detailed community engagement with providers and the public to ensure robust data collection.
- Make recommendations on local services and the integration needed across providers to impact positively on outcomes.

##### **Year 2 Deliverables**

#### **Once the priority elements have been developed, specific implementation planning will occur**

- Implement Year 1 recommendations.

##### **Year 3 Deliverables**

#### **Determine innovative ways to address service gaps and unmet needs**

- Conduct appropriate community engagement on specific issues to ensure robust data collection.
- Continue work in those areas requiring development.
- Continue implementation of recommendations as appropriate.

#### **Outcomes**

- Quality:
  - Health issues addressed in a timely and comprehensive manner
  - Improved access to geographically based multidisciplinary teams for defined care processes

- Improved access to number of family physicians and specialists
- Improved health status for barriers to access populations
- Access:
  - Maintain number of emergency visits/1,000 residents
  - Increased number of physicians, especially in under-served areas
  - More patients accessing multidisciplinary teams
  - Smaller percentage of patients without a primary care physician
- System/Process:
  - Improved interdisciplinary care
  - Improved coordination of services
  - Higher percentage of family physicians in FHTs and lower number operating independently

**Performance Indicators**

- CIHI Primary Care Indicators as appropriate (In progress)
- Age of diagnosis for developmentally delayed children
- Others as appropriate to be determined by Detailed Planning and Action Team