RISE
Rapid-Improvement Support and Exchange

Peer profile

RISE brief 37: Improving primary-care access and attachment

Context

RISE co-designed with OHTs a process to create a peer profile for OHT priorities, The first wave of peer profiles is provided in Box 1.

A peer profile describes the experiences and lessons learned from the Initial 12 (I-12) and other OHTs who have particularly rich insights to share about a given priority, while providing all OHTs with an opportunity to learn from peers and collaborate in efforts to advance a useful resource that can be used by all teams.

This peer profile is focused on improving primary-care access and attachment (or PC-AA). It is complemented by: 1) a recording of the peer sharing and learning session where the slides on which the peer profile is based were presented by the OHTs and RISE and discussed with participants (see Box 2); 2) the slides in PDF format; and 3) the slides developed specifically by RISE available in editable PowerPoint format. Readers are encouraged to listen to the recording or relevant 'chapters' in it and to adapt and use the PowerPoint if helpful.

Profiled OHTs were selected based on: 1) a strong Primary Care Network (PCN) and demonstrated PC-AA results; 2) mix of OHTs, regions and North / South; and 3) alignment with success-story criteria. The seven profiled OHTs are:

- All Nations Health Partners OHT (AN OHT)
- Eastern York Region North Durham OHT (EYRND OHT)
- Frontenac, Lennox and Addington OHT (FLA OHT)
- Greater Hamilton Health Network (GHHN)
- Hastings Prince Edward OHT (HPE OHT)
- Mid-West Toronto OHT (MWT OHT)
- Nipissing Wellness OHT (NW OHT).

Additional details about each OHT – its region, attributed population size, and contributors to this peer profile – are provided in Exhibit 1.

Exhibit 1: Profiled OHTs

Box 1: Coverage of OHT priorities

This RISE brief addresses a primary-care enablement priority – improving primary-care access and attachment – and is part of a series of peer profiles. The first two peer profiles addressed 'implementing two or more integrated clinical pathways (ICPs) using a population-health management approach' and 'establishing a Primary Care Network (PCN).'

Box 2: Accompanying recording

This RISE brief is accompanied by a recording of a peer sharing and learning session in which the seven profiled OHTs shared their 'story so far.' These OHT stories are bracketed by a RISE presentation of the key frameworks and concepts used in this peer profile and a RISE presentation about the cross-cutting experiences and lessons learned: 1) with the journey; 2) in relation to approaches for improving primary-care access and attachment; 3) in relation to OHT building blocks; 4) in relation to barriers and facilitators; and 5) from a Northern perspective. The recording concludes with: 1) some reactions from session participants; and 2) an overview of available resources and next steps. We encourage you to listen to some or all of the recording.

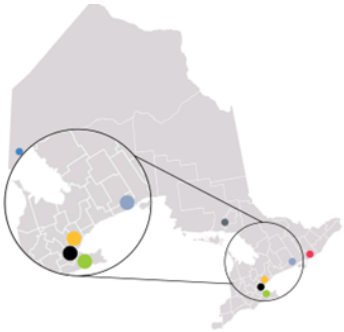
'Chapter' in recording	Minute mark	Direct link
Context for session	0:00	Context
'Story so far' from profiled OHTs	14:55	Story so far
• All Nations Health Partners OHT	• 14:55	• AN OHT
• Eastern York Region North Durham OHT	• 21:18	• EYRND OHT
• Frontenac, Lennox & Addington OHT	• 28:48	• FLA OHT
• Greater Hamilton Health Network	• 35:23	• GHHN
• Hastings Prince Edward OHT	• 41:41	• HPE OHT
• Mid-West Toronto OHT	• 49:46	• MWT OHT
• Nipissing Wellness OHT	• 57:15	• NW OHT
Reactions from participants	1:06:51	Participants
Wrap up with resources & next steps	1:27:11	Wrap up

Note that the recording mentions the sequence and timing of future peer sharing and learning sessions, however, some of these have changed since the date of the recording.

All Nations Health Partners OHT*
(NW Region, 26,273)
- Colleen Neil

Eastern York Region North Durham OHT
(Central Region; 317,790)
- Cheryl Osborne
- Mandy Lau
- Munira Thayani

Frontenac, Lennox & Addington (FLA) OHT*
(East Region; 210,113)
- Anna Chavlovski
- Liz Garfin
- Kim Morrison
- Suzanne Pashley



Greater Hamilton Health Network*
(West Region; 602,483)
- Marijke Ljogar
- Melissa McCallum

Hastings Prince Edward OHT* **
(East Region; 147,412)
- Dr. Robert Pincock
- Dr. Carolyn Brown
- Sheila Braidek
- Karen Clayton-Babb
- Barinder Gill

Mid-West Toronto OHT
(Toronto Region; 558,936)
- Justine Humphries
- Cliff Ledwos
- Edward Aust
- Faye Goldman
- Michelle Naimer
- Melanie Yang

Nipissing Wellness OHT* **
(NE Region; 92,746)
- Wendy Smith
- Jaymie Lynn Blanchard

Three transfer-payment agreement (TPA) deliverables and three OHT measurement and evaluation priorities pertain directly to improving PC-AA (see row 1 in Exhibit 2), while other TPA deliverables and measurement priorities pertain to complementary domains (see rows 2-4 in Exhibit 2).

Exhibit 2: TPA deliverables for fiscal year 2025-26 and OHT measurement and evaluation priorities

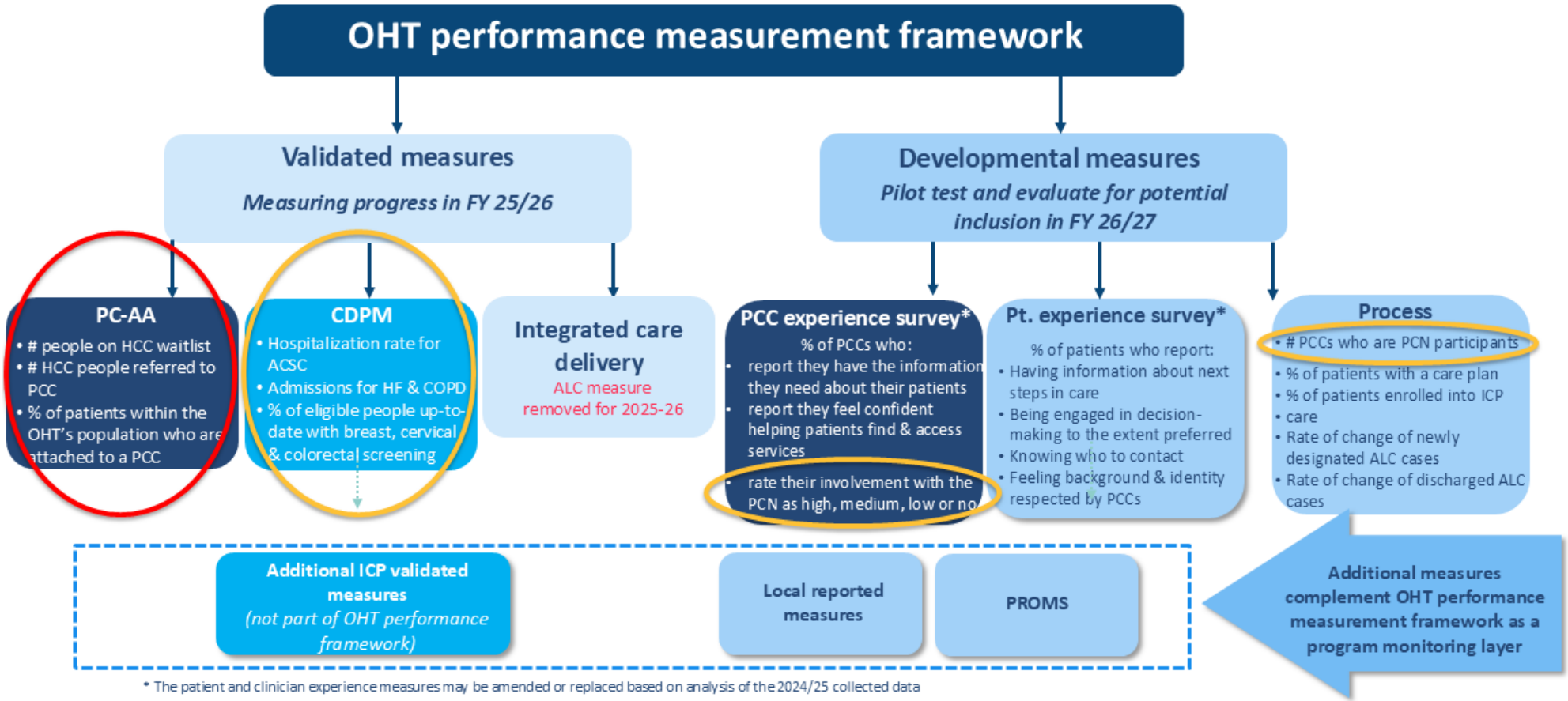
Possible approaches	TPA deliverables	Measurement & evaluation in FY 25/26
Implement approaches to **primary-care access and attachment** (PC-AA) → Mix and match 'solutions' – the RISE peer profile and rapid-evidence synthesis describe nine approaches – based on local contexts and on learning and improvement cycles → Then we can move on to identifying patterns and proposing a small number of contextually appropriate models	• Develop and implement a plan to facilitate matching and attachment of patients on the Health Care Connect (HCC) waitlist (as of 1 January 2025) by spring 2026 • Develop an initial plan to support 100% attachment of local population by 2029 • Lead/coordinate submissions for new or expanded primary-care team (IPCT) investment • Implement collaborative initiatives to provide clinical services to unattached patients	• # people on HCC waitlist • # HCC people referred to a primary-care clinician (PCC) • % of attributed population who are attached to a PCC

Take other steps that get us closer to what Ontarians should expect of primary care regardless of the practice or funding model and location [a RISE peer rapid-evidence synthesis is being prepared]	• Develop a community-based plan for chronic disease prevention and management (CDPM), as well as an ALC action plan
	• Increase participation in cancer screening
		• CDPM
		  ○ Hospitalization rate for ACSC
		  ○ Admissions for HF & COPD
		• Cancer screening

Possible approaches	TPA deliverables	Measurement & evaluation in FY 25/26
	• Expand access to online appointment bookings • Facilitate adoption and report on progress with eReferral solutions • Curate information about local services	○ % of eligible people up-to-date with breast, cervical & colorectal screening • Additional clinician and patient experiences (see next slide)
Strengthen, and focus the work of, **Primary Care Networks** (PCNs) so they can help with the above [see the RISE peer profile and rapid-evidence profile]	• Continue to advance a PCN • Continue to fund PCN clinical lead(s) to advance the PCN	• % of PCCs who rate their involvement with the PCN as high, medium, low or no • # PCCs who are PCN participants
Align **OHT building blocks** (BBs) – including BB #6 (leadership, accountability & governance) and BB #7 (funding and incentive structure) – to help with the above	• Continue to expand OHT and PCN membership (Building block 6: Leadership, accountability and governance) • Continue to advance patient, family and caregiver engagement (BB #3: Patient partnership & community engagement) • Ensure OHT staff have completed relevant training related to Indigenous, Francophone and racialized populations (BB #1: Defined patient population and equity-deserving groups)	

These PC-AA measures can also be shown in the context of the broader OHT performance measurement framework. These measures are circled in red in Exhibit 3.

Exhibit 3: OHT measurement and evaluation overview [Source: Ontario Health]



Legend for abbreviations

- ALC = alternative level of care
- ACSC = ambulatory care-sensitive conditions
- CDPM = chronic disease prevention & management
- COPD = chronic obstructive pulmonary disease
- HCC = Health Care Connect
- HF = heart failure
- PC-AA = primary-care access & attachment
- PCN = Primary Care Network
- PCC = primary-care clinician

Legend for colours

- Red is a primary focus here
- Yellow is a secondary focus

RISE identified nine approaches for improving PC-AA and many examples of these approaches, as shown in Exhibit 4.

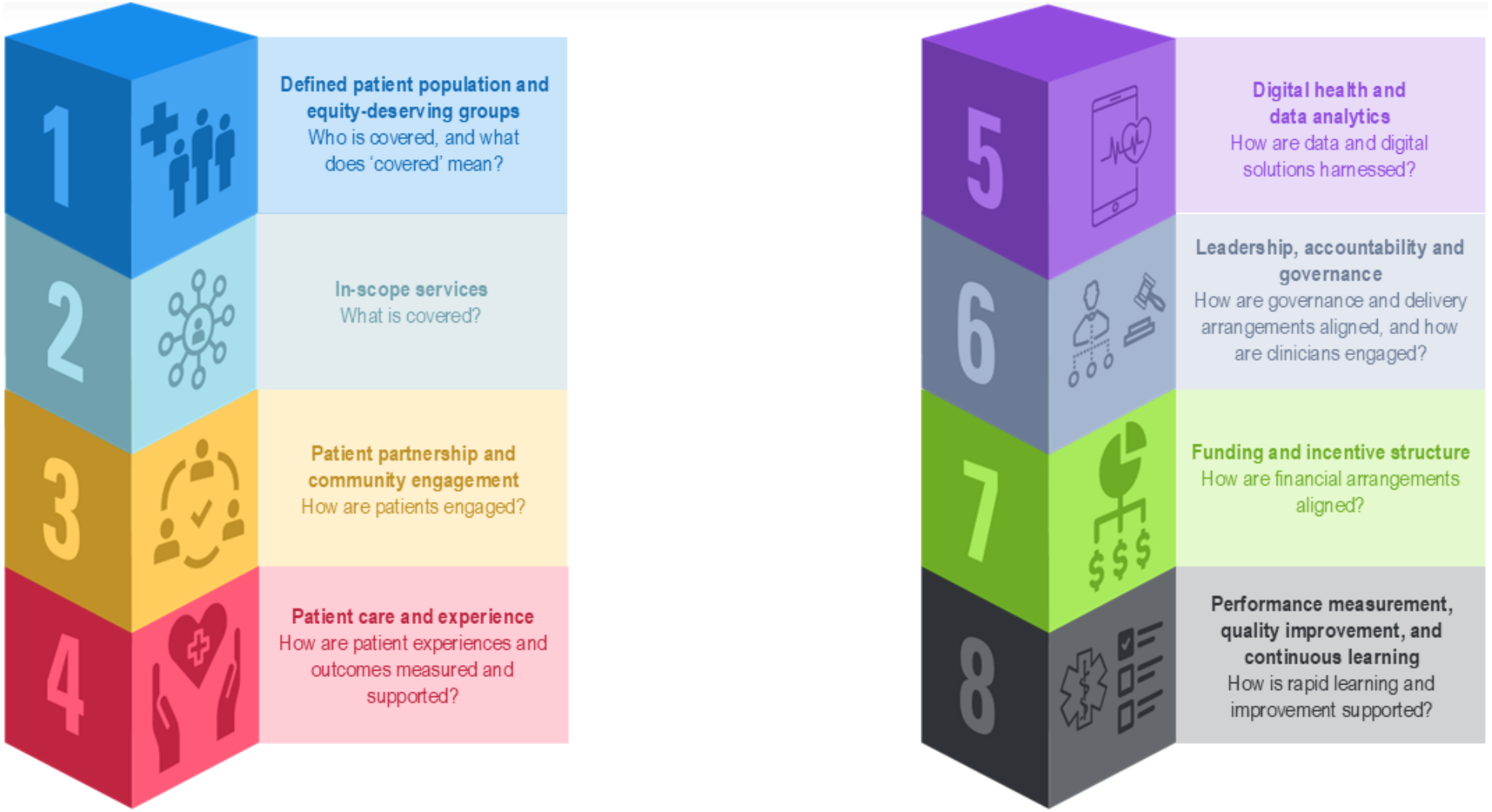
Exhibit 4: Approaches for improving PC-AA (an enlargeable version can be found in slides 7 and 8)

Nine broad approaches (and many specific approaches)

1. **Facilitate the entry of people onto patient lists (or panels, registries or rosters)**
   - having dedicated staff (or a hub) create a comprehensive EMR record for unattached people (to ease onboarding by new clinicians)
   - engaging community paramedicine and community health nurses, or a chronic-disease clinic, to stabilize people prior to initiating attachment
   - accepting people into a practice before a most-responsible clinician has been designated
2. **Establish additional 'entry points' for PC-AA**
   - providing a dedicated role for community health centres (CHCs) and interprofessional primary-care centres
   - exploring partnerships with pharmacies, paramedicine, urgent care clinics in hospitals, emergency rooms, and local public-health agencies
3. **Leverage solutions that enable primary-care clinicians to enroll more people on their patient list**
   - leveraging **digital solutions**, such as AI scribes to 'free up' time, EMRs to support NPs in providing longitudinal care, & virtual care to promote efficiency
   - reducing **administrative burden** and/or providing administrative support to 'free up' time for patient care
   - supporting **self-management** & substituting **group** (vs individual) **sessions** (e.g., for diabetes nutrition counselling) to promote efficiency
   - implementing **advanced access scheduling** to promote efficiency
   - improving **referrals** to promote efficiency
   - adjusting **payment mechanisms** within the control of an OHT or PCN
4. **Coordinate the expansion of interprofessional primary-care teams**
   - making the most of interprofessional primary-care team (IPCT) expansion funding
5. **Better match less intensive care models to preferences and needs**
   - designing a not-for-profit virtual-care model for younger and healthier people that, when needed, allows for patient data to be shared with in-person clinics
6. **Take a 'whole OHT' approach to increasing PC-AA**
   - establishing a shared vision among primary-care clinicians and partners to support attachment for all and greater access to team-based care for all people regardless of practice type
   - improving data access about unattached people (through Health Care Connect) and about successfully attached people
   - consolidating primary-care waiting lists held by local practices (and providing administrative support to assist with 'cleaning up' these lists)
   - resource sharing across practice models to increase primary-care clinician capacity and thereby enable increases to attachment
   - set, and ensure that contract requirements are aligned with, attachment targets appropriate to the local context
7. **Establish transitional solutions – including those sometimes called 'navigation' and 'facilitating access to interim services' – to facilitate access as attachment efforts ramp up**
   - providing high-value services to unattached people (e.g., screening, immunizations)
   - enabling paramedicine to organize themselves locally to act as a main primary-care point of contact for unattached people
   - building relationships with walk-in clinics that support those with fewer or more time-limited needs (or in their absence, have a local clinic add a walk-in service)
8. **Establish hybrid attachment models that respond to seasonal shifts**
   - allowing college and university students living away from home to have a secondary attachment to a local clinician
   - allowing those who spend seasonal periods in smaller communities to have a secondary attachment to a local clinician
9. **Improve the supply and distribution of primary-care clinicians**
   - undertaking local HHR planning, including developing recruitment, retention and succession plans in primary care
   - undertaking research to understand local and regional HHR inventory
   - identifying local people who could be prioritized for education and training opportunities
   - offering flexible/part-time work options to retain pre-retirees and attract retirees

The OHT building blocks provide the broader context within which OHTs select, implement and continually improve their approaches to improving PC-AA. The building blocks are shown in Exhibit 5.

Exhibit 5: OHT building blocks



‘Story so far’ from profiled OHTs

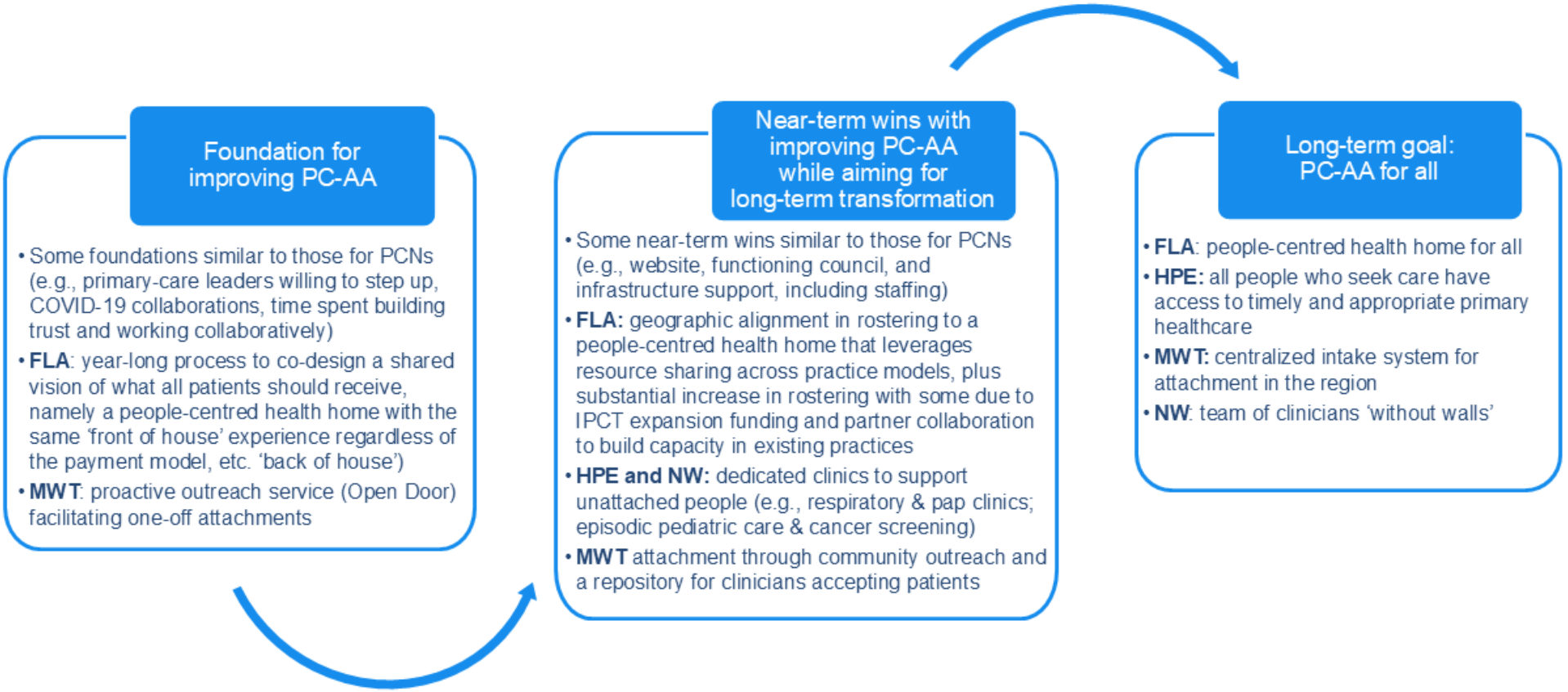
RISE asked each OHT to tell the ‘story so far’ in their efforts to improve PC-AA. You can listen to the recordings of each of these ‘stories’ by clicking on a link in Box 2, as well as access the slides in PDF format. We encourage you to listen to these OHTs’ stories in their own words.

RISE summarized the highlights from these stories based both on each team’s presentation at the peer sharing and learning session and on our original interviews with each OHT prior to the session. These highlights can be found in slides 38-44.

Experiences and lessons learned from RISE’s perspective

RISE also summarized particular highlights from the OHT stories as they pertained to: 1) the journey; 2) experiences and evidence in relation to PC-AA approaches; 3) experiences in relation to OHT building blocks, and 4) experiences in relation to barriers and facilitators. These highlights can be found in Exhibits 6-10.

Exhibit 6: Experiences with the journey



To capture as much information as possible in a single exhibit, we combined in Exhibit 7 the examples of each approach (column 1), which approaches were being used by which profiled OHTs (column 2), and which approaches were discussed in the research literature (column 3), described in a domestic jurisdictional scan (column 4), and described in an international jurisdictional scan (column 5). The findings captured in columns 3-5 are drawn from a complementary rapid evidence synthesis. The approaches being used by each profiled OHT can be found in slides 50-53.

Exhibit 7: Experiences and evidence in relation to PC-AA (an enlargeable version can be found in slides 47-49)

Possible approaches	OHT experiences	Evidence for impacts on PC-AA & relevant experiences		
		Evidence documents	Canadian P/Ts	Other countries
1. Facilitate the entry of people onto patient lists • having dedicated staff (or a hub) create a comprehensive EMR record for unattached people (to ease onboarding by new clinicians) • engaging community paramedicine and community health nurses, or a chronic-disease clinic, to stabilize people prior to initiating attachment • accepting people into a practice before a most-responsible clinician has been designated	• Health Care Connect collaboration (FLA) • Central intake coordinator (MTW)	• Telephone outreach to ease onboarding		
2. Establish additional 'entry points' for PC-AA • providing a dedicated role for community health centres (CHCs) and interprofessional primary-care centres • exploring partnerships with pharmacies, paramedicine, urgent care clinics in hospitals, emergency rooms, and local public-health agencies	• Clinics or hubs (EYRND, GHHN, HPE, NW) • Referrals from key programs (FLA) • 'Open door' policy & service (MWT)	• Clinics or hubs • Community health services programs and transitional care clinics for people living in underserved communities and/or people with no established primary- care clinician • Partnerships between public health and local emergency medical services for older adults at risk of falls	• Nurse practitioner-led clinics partnering with local emergency services and other primary-care clinicians in ON	• Clinics or hubs (SI) • Community pharmacies (ES, FI, FR, GB) • Integrated community care (NL)

Possible approaches	OHT experiences	Evidence for impacts on PC-AA & relevant experiences		
		Evidence documents	Canadian P/Ts	Other countries
3. Leverage solutions that enable primary-care clinicians to enroll more people on their patient list • leveraging **digital solutions**, such as AI scribes to 'free up' time, EMRs to support NPs in providing longitudinal care, & virtual care to promote efficiency • reducing **administrative burden** and/or providing administrative support to 'free up' time for patient care • supporting **self-management** & substituting **group** (vs individual) **sessions** (e.g., for diabetes nutrition counselling) to promote efficiency • implementing **advanced access scheduling** to promote efficiency • improving **referrals** to promote efficiency • adjusting **payment mechanisms** within the control of an OHT or PCN	• AI scribe (HPE) • Virtual care (NW) • Self-management supports (MWT) • Referrals & system navigation (HPE) • As many 'carrots' as possible (GHHN)	• Advanced access scheduling • Centralized EMRs • AI scribes for freeing up time (as described in a supplementary evidence source) • Virtual care, including telemedicine	• Virtual care	• Payment / remuneration (NL, NO, NZ) • Digital solutions (DK, DE, FR, GB, NZ, US) • Advanced access scheduling (DK, DE, ES, IT, NO)
4. Coordinate the expansion of interprofessional primary-care teams • making the most of interprofessional primary-care team (IPCT) expansion funding	• IPCT expansion (FLA) • Five IPCTs attaching unattached people (GHHN) • Access to IPCT resources (MWT)	• Adding nurse practitioners • New clinics, including teams targeting specific populations	• Additional teams in BC, AB, SK, MB, ON, NB, NS, PEI, NL, YK, NT	• Payment changes to secure physician buy-in and compensate non-physicians in (EE, ES, IT, NO, SI)
5. Better match less intensive care models to preferences and needs • designing a not-for-profit virtual-care model for younger and healthier people that, when needed, allows for patient data to be shared with in-person clinics			• Virtual care in the Maritimes, including VirtualCareNS, Virtual Health Care (Maple) for Islanders without a Family Doctor in PE, Teledoc and Medcuro in NL	• Virtual care (NO)

Possible approaches	OHT experiences	Evidence for impacts on PC-AA & relevant experiences		
		Evidence documents	Canadian P/Ts	Other countries
6. Take a 'whole OHT' approach to increasing PC-AA • establishing a shared vision among primary-care clinicians and partners to support attachment for all and greater access to team-based care for all people regardless of practice type • improving data access about unattached people (through Health Care Connect) and about successfully attached people • consolidating primary-care waiting lists held by local practices (and providing administrative support to assist with 'cleaning up' these lists) • resource sharing across practice models to increase primary-care clinician capacity and thereby enable increases to attachment • set, and ensure that contract requirements are aligned with, attachment targets appropriate to the local context	• Shared vision (FLA with 'health home;' HPE with PC-AA) • Resource sharing (AN with people; EYRND with people, virtual-care clinic & other supports; FLA; GHHN with people & group programs; MWT with SCOPE program & RN; NW with Best Care program & people) • Compensation model for rural generalists (AN)	• Consolidated primary-care waiting lists • Manageable panel size (i.e., attachment targets)	• Consolidated primary-care waiting lists in BC, AB, MB, ON, QC, NS, PE, NL, YK • Data about unattached people in ON • Resource sharing in MB • Set and ensure contract requirements are aligned with attachment targets in ON (as described in a supplementary jurisdictional scan)	• Consolidating primary-care waiting lists (FR, NO) • Data about unattached people (NL) • Sharing of resources (NO) • Set and ensure contract requirements are aligned with attachment targets (EE, IT, NZ)
7. Establish transitional solutions – including those sometimes called 'navigation' and 'facilitating access to interim services' – to facilitate access as attachment efforts ramp up • providing high-value services to unattached people (e.g., screening, immunizations) • enabling paramedicine to organize themselves locally to act as a main primary-care point of contact for unattached people • building relationships with walk-in clinics that support those with fewer or more time-limited needs (or in their absence, have a local clinic add a walk-in service)	• CDPM services for rural, unattached people (FLA) • Low-barrier drop-ins & co-locations (GHHN) • Walk-in clinic-like models (MWT)		• Navigators in BC, ON and QC	

Possible approaches	OHT experiences	Evidence for impacts on PC-AA & relevant experiences		
		Evidence documents	Canadian P/Ts	Other countries
8. Establish hybrid attachment models that respond to seasonal shifts • allowing college and university students living away from home to have a secondary attachment to a local clinician • allowing those who spend seasonal periods in smaller communities to have a secondary attachment to a local clinician	• Seasons residents & plan for students (FLA's Sharbot Lake FHT)		• Models for students and seasonal residents	
9. Improve the supply and distribution of primary-care clinicians • undertaking local HHR planning, including developing recruitment, retention and succession plans in primary care • undertaking research to understand local and regional HHR inventory • identifying local people who could be prioritized for education and training opportunities • offering flexible/part-time work options to retain pre-retirees and attract retirees	• Partnerships with MD and NP training programs (EYRND) • Bringing local recruiter in-house (GHHN)		• Recruitment and retention initiatives	• Recruitment and retention initiatives, training programs and incentives (most jurisdictions)

RISE also summarized experiences with prioritizing, reaching and/or supporting people for attachment within a given geography (i.e., within a postal code), as shown in Exhibit 8. These approaches have now been complemented by guidance on 'supported attachment.'

Exhibit 8: Possible approaches for prioritizing, reaching and/or supporting people for attachment

Solutions to consider for prioritizing, reaching and/or supporting people when opening or expanding a patient list	Examples
First come first serve (from local waiting lists if applicable)	e.g., defacto system now in place
People in a subset of the Health Care Connect list	
People with greater (or fewer) needs	e.g., Quebec's proposal e.g., FLA's focus on pregnant women, newborns, people with a new cancer diagnosis, etc.
People from equity-deserving groups	
People who were identified as wanting attachment (through a proactive outreach service)	e.g., MWT OHT's Open Door service
People who already have EMR data entered	
People with complex conditions who have already been stabilized	e.g., NW's chronic-disease clinic and then attachment to a nurse practitioner-led clinic

Notes:
1) recent developments with Health Care Connect are likely to mean that these approaches are relevant primarily to support ongoing learning and improvement in a more coordinated approach
2) the College of Physicians and Surgeons of Ontario has a policy and related advice about accepting new patients
3) we are assuming that existing patients will not be mandated to switch to another patient list (or panel, registry or roster) that may objectively appear to be a more optimal solution for them (i.e., personal choice will continue to guide changes in attachment)

OHTs' experiences in relation to how OHT building blocks helped or were leveraged to improve PC-AA are summarized in Exhibit 9.

Exhibit 9: Experiences in relation to OHT building blocks

Building block	Experiences
1) Defined patient population and equity-deserving groups	• **FLA:** Working with public health to understand health-equity indicators for local populations • **HPE**: Exploring primary-care neighbourhood concepts through mapping and data • **MWT**: Working with partners that serve equity-deserving groups (newcomers, refugees, indigenous, racialized, French language speaking, people living with disabilities, seniors, Black community, LGBTQ+)
2) In-scope services	
3) Patient partnership & community engagement	• **FLA, NW**: Strong PFaC (or community council) engagement, including working through what can be done to help unattached people
4) Patient care & experience	
5) Digital health and data analytics	• **EYRND**: Strong OHT backbone support on population-health management (PHM) planning and data analytics, which included navigating through PHIPA and other relevant policy regarding health information custodian • **FLA**: Working to centralize data repositories that support trending of data and sharing with primary-care leaders and PCN
6) Leadership, accountability and governance	• **Many OHTs**: Strong PCN with members of all types, recruitment and tracking of PCN members, and robust communications
7) Funding and incentive structure	• **AN:** Designed a wholly new physician-compensation model • **EYRND:** Developed memoranda of understanding share IPCT funding across multiple sites/organizations
8) Performance measurement, QI & continuous learning	• **FLA**: Leveraged local universities and colleges to develop standardized health/wellness reporting tools to measure progress; shared anonymous results with OHT partners to encourage communities of practice and aid in co-designing QI interventions

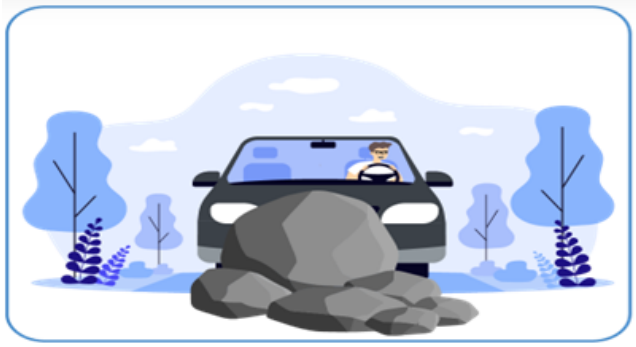
Their experiences in relation to barriers and facilitators can be found in Exhibit 10.

Exhibit 10: Experiences in relation to barriers (red) and facilitators (green)

	System-level realities • Difficulty connecting with 'unaffiliated' PCCs (e.g., walk-in clinics) • Having people leave NP-led clinics when new interprofessional primary-care teams open or expand lists
	Data sharing • Not being able to find 'unattached' people or efficiently leverage Health Care Connect data (although this is now being addressed through improvements in Health Care Connect data) • Not being able to track and report on people formally attached to a nurse practitioner (and having these people considered' 'unattached' in the system) • Not being able to access easily already 'uploaded' data • Not being able to access remotely EMR data and not having related data-sharing agreements in place (e.g., to enable central-intake coordinators in MWT to streamline and support attachment) • Having to focus on Health Care Connect list when many local lists that are actively used (e.g., NW)
	Funding • Insufficient funding for new interprofessional primary-care clinicians (now being resolved with expansion funding) • Funding pilots ending • Focus on 'stipends' for each category of tasks in some Northern communities (e.g., NW) • Federal government funding of parallel services that can lead to having no 'most responsible clinician'
	Clinicians trust that the OHT and PCN are 'there for them,' such as addressing their top pain points (e.g., administrative burden, digital interoperability)
	Strong Primary Care Network (PCN) with members of all types, recruitment and tracking, and communications, as well as strong physician leadership more generally Long history of collaborations that continued with good success planning (e.g., MWT OHT, HPE OHT)
	New funding for interprofessional primary-care clinicians (and roadmap for the future that responding to this opportunity provided) – e.g., FLA, GHHN
	Fewer local complexities, such as no local walk-in clinics and a single EMR used by local primary-care clinicians (e.g., NW), and/or agile approach (e.g., hiring permanent people on temporary funding) to address complexity (e.g., EYRND)
	External supports to complement local capacity • e.g., FLA with local data analytics and implementation science support, as well as human factors group • e.g., HPE with evaluation of nurse practitioner-led clinic

OHTs' experiences with improving PC-AA in the North can be found in Exhibit 11.

Exhibit 11: Experiences from a Northern perspective



Roadblocks

- Chronic, extreme shortages in health workforce resources – challenging to recruit new clinicians, and retain existing ones
- Band-aid solutions, including agency staff and locums, are necessary, but they shift investments away from Northern and rural communities, deterring health professionals from taking on roles in these communities (i.e., promotes competition, not collaboration)

Challenges

- Shortages in primary care lead to demanding 'asks' on other parts of the system (e.g., pharmacy and public health) that are similarly under-resourced (e.g., sexual health clinics, vaccines)
- Prioritizing attachment over access – rural physician funding models require that the entire community population is 'attached' to the model, whether or not an individual sees the physician/team

Facilitators

- Existing ways of working together (e.g., regionally) builds upon strong relationships
- Rural generalism – physicians and primary care professionals work to a broad scope of practice, enhancing integrated care experiences among patients
- Northern medical school encourages placements in northern, rural, and First Nations communities, which supports recruitment and retention

Resources and next steps

The profiled OHTs, the Ministry of Health, Ontario Health and OHT support partners have made available resources to support efforts to improve PC-AA. These resources are listed in Exhibits 12-14.

Exhibit 12: Resources from the profiled OHTs

OHT	Resources	Description or consideration
All Nations Health Partners OHT	• Kenora Miner article about the Rural Generalist Care (RGCC) model	• Example of taking a 'whole OHT' approach to increasing PC-AA (approach 6) by designing a wholly new physician-compensation model
Eastern York Region North Durham OHT	• Landing page for clinical services associated with the Integrated Care Hub • Article with a patient's story, illustrating impact	• Example of establishing an additional 'entry point' for PC-AA (approach 2)
Frontenac, Lennox & Addington (FLA) OHT	• FLA OHT blogposts about people-centred health homes, community engagement that informed their approach, and the journey mapping that was used in this community engagement • Globe & Mail article about the FLA OHT approach: https://globe2go.pressreader.com/article/281655375607043 • FLA OHT roadmap to health homes • FLA OHT-commissioned report about co-designing the future vision of people-centred health homes	• Example of taking a 'whole OHT' approach to increasing PC-AA (approach 6)
Mid-West Toronto OHT	• Self-management toolkit	• Example of leveraging solutions (in this case self-management) that enable primary-care clinicians to enroll more people on their roster (approach 3)

Exhibit 13: Resources from the Ministry of Health and Ontario Health

Type	Resources	Description or consideration
PC-AA	• Guidance on supported attachment	• Guidance from Ontario Health about how to approach 'supported attachment
Data analytics	• OHT data dashboard	• OHT-specific information available to each OHT
Communities of practice	• OHT Shared Space, especially the Primary Care QI Hub	• Opportunities for shared dialogue on PC-AA • Collection of resources

Exhibit 14: Resources from OHT support partners

Developer	Resources	Description or consideration
RISE	Rapid evidence synthesis on PC-AA	• Summary of the available research literature about improving PC-AA and a jurisdictional scan of Canadian provinces and territories' initiatives and key comparison countries' initiatives to improve PC-AA
	RISE peer profile on PCNs • Rapid evidence profile in PCNs	• Summary of experiences and evidence about PCNs

RISE welcomes feedback on this peer profile, as well as additional resources to share, and will update it as new resources come online. Please send feedback and resources to rise@mcmaster.ca.
Nipissing

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