RISE
Rapid-Improvement Support and Exchange

Understanding need, demand and supply to enable primary care expansion

16 October 2025

McMaster University | HEALTH FORUM

NOSM UNIVERSITY | UNIVERSITÉ EMNO

Trillium Health Partners | INSTITUTE FOR BETTER HEALTH

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Land acknowledgement

"As we meet here today, we are in solidarity with Indigenous Peoples of Turtle Island and would like to begin by acknowledging that the land on which we gather is part of the Treaty Lands and Territory of the Mississaugas of the Credit, and before, the traditional territory of the Haudenosaunee, Huron and Wendat. We also acknowledge the many First Nations, Inuit, and Métis Peoples who call this area their home. We are grateful for the opportunity to be working on this land".

We invite you to visit the link provided, to learn more about treaties.

https://www.ontario.ca/page/treaties

Objectives for Today

RISE
Rapid-Improvement Support and Exchange

Building on the June (Peer profile: Primary Care Access and Attachment) and July sessions (PC AA deep-dive) this session aims to help OHTs to:

1. learn approaches to understanding your attributed population's needs, including the needs of those unattached to primary care
2. explore strategies to assess and understand the supply of and demand for primary-care providers and how this affects PC-AA approaches
3. exchange learnings with peer OHTs/PCNs about how they're understanding (measuring) demand, supply and need and using this understanding to inform the mix of PC-AA approaches to leverage as they design their interprofessional primary care team models.

Today's session will support OHTs/PCNs in achieving their PC-AA TPA deliverables

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Possible approaches	TPA deliverables
❑ The RISE peer profile on primary care access and attachment (PC-AA) describes nine possible approaches ❑ Implement approaches to **primary-care access and attachment** (PC-AA) → Mix and match 'solutions'	✓ Develop and implement a plan for PC-AA and specifically for clearing the Health Care Connect (HCC) waitlist (as it stood on 1 January 2025) by spring 2026 ✓ Lead/coordinate submissions for new or expanded interprofessional primary-care team (IPCT) investment ✓ Implement collaborative initiatives to provide clinical services to unattached patients

Recall OHT Transformation: Integrated Local Care Systems

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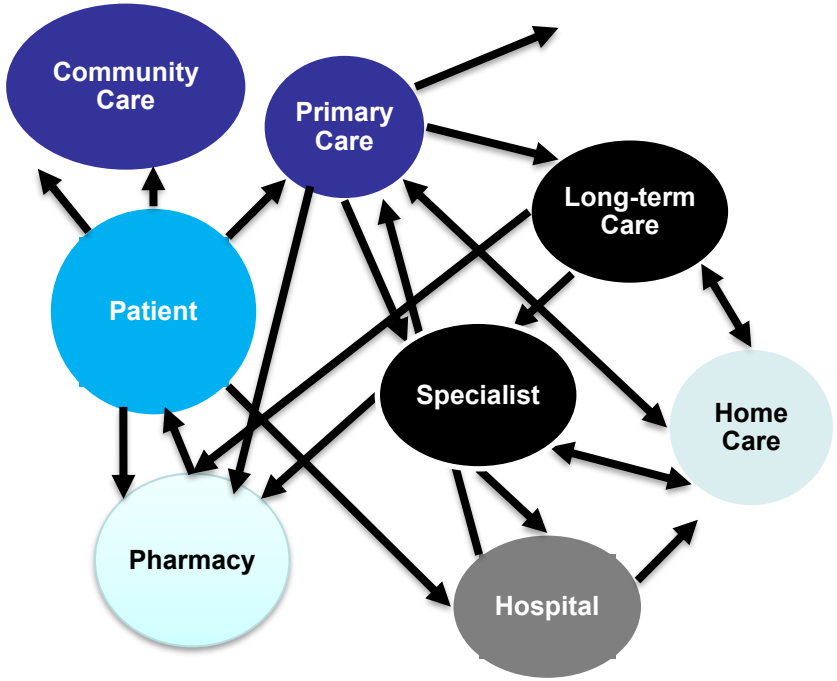
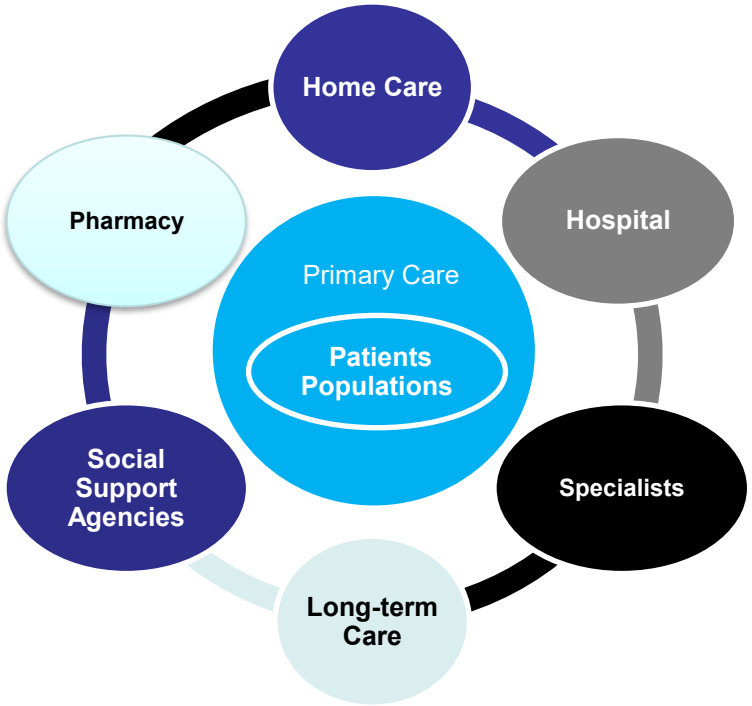


Whole Person Equitable Care



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Integrated Care Systems: The Imperative

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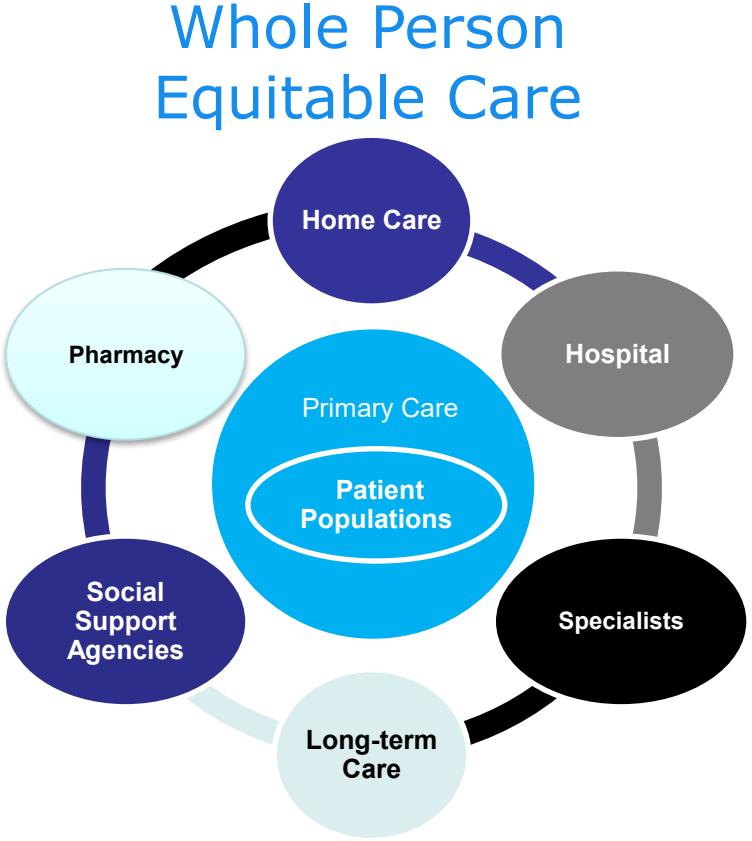
High performing primary care is at the heart of integration.

Population Health Management *is a critical process and outcome for a fully integrated system.*



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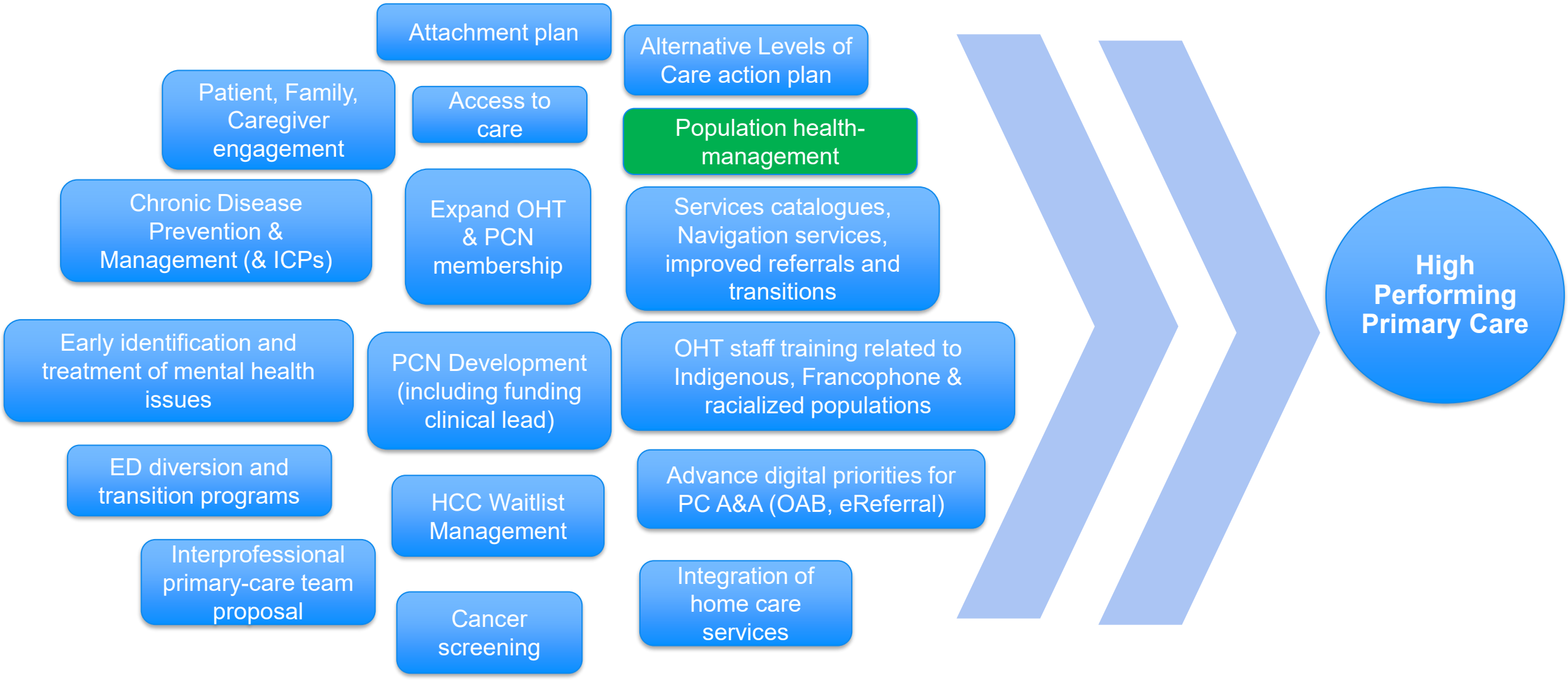
What OHTs are doing to move towards high performing primary care.



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Recall from RISE June & July sessions: A taxonomy of nine possible approaches to improving primary-care attachment and access

1. Facilitate the entry of patients onto rosters
2. Establish additional 'entry points' for PC-AA
3. Leverage solutions that enable primary-care providers to enroll more patients on their roster
4. Coordinate the expansion of primary-care teams
5. Better match less intensive care models to preferences and needs
6. Take a 'whole OHT' approach to increasing attachment
7. Establish transitional solutions to facilitate access as attachment efforts ramp up
8. Establish hybrid attachment models that respond to seasonal shifts
9. Improve the supply and distribution of primary-care providers

OHT experiences related to today's session

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Possible approaches	OHT experiences
1. Facilitate the entry of people onto rosters • engaging community paramedicine and community nurses, or a chronic-disease clinic, to stabilize people prior to initiating attachment • accepting people into a practice before a most-responsible provider has been designated	• Health Care Connect collaboration (FLA) • Central intake coordinator (MTW)
2. Establish additional 'entry points' for PC-AA • 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)
6. Take a 'whole OHT' approach to increasing PC-AA • **establishing a shared vision among primary-care providers and partners to support attachment for all and greater access to team-based care for all people regardless of practice type** • **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 provider capacity and thereby enable increases to attachment**	• **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)**

OHT experiences related to today's session (cont'd)

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Possible approaches	OHT experiences
7. Establish transitional solutions – including those sometimes called 'navigation' and 'facilitating access to interim services' – to facilitate access as attachment efforts ramp up • 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)
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 provider • allowing those who spend seasonal periods in smaller communities to have a secondary attachment to a local provider	• Seasons residents & plan for students (FLA's Sharbot Lake FHT)
9. Improve the supply and distribution of primary-care providers • undertaking local HHR planning, including developing recruitment, retention and succession plans in primary care	• Partnerships with MD and NP training programs (EYRND) • Bringing local recruiter in-house (GHHN)

Some definitions to begin …

RISE
Rapid-Improvement Support and Exchange

Need is the capacity for an individual's health to benefit from the consumption of a specific good or service in a given situation

Example: someone living with diabetes needs to receive chronic disease management or diabetes education

Want is a desire to consume a specific good or service

Example: patients want a primary care provider close to home without waiting

Demand is want backed up by the willingness and ability to actually access (use) a specific good or service

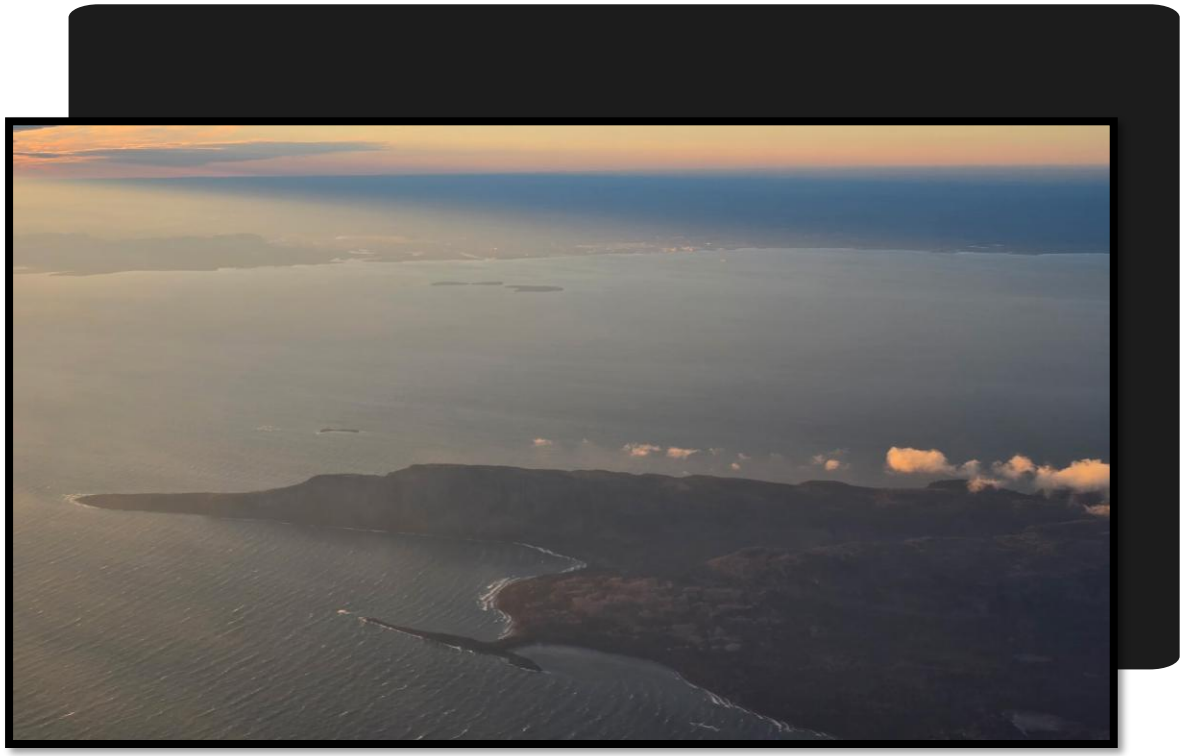
Example: the number of primary care appointments accessed/used in a year/week/month,

Supply is the amount of a commodity or service that is available

Example: Number of appointments in a primary care clinician's schedule, number of primary care providers

October RISE Peer Sharing and Learning

Geographically-based primary health care capacity assessment in Northwestern Ontario



Sleeping Giant, photo credit: Jeff Brendish

Brianne Wood (bwood@nosm.ca)

Mannila Sandhu, Jinfan Qiang, Jennifer Bertoni, Jennifer Lawrance, Jessica Logozzo, Colleen Neil, Jackie Park, Wesley Willick, Eliot Frymire, Hannah Willms, Michael E Green

What is the “Northern Ontario” context?

11 OHTs

Range in size of patient population, partners, priorities.

Primary care

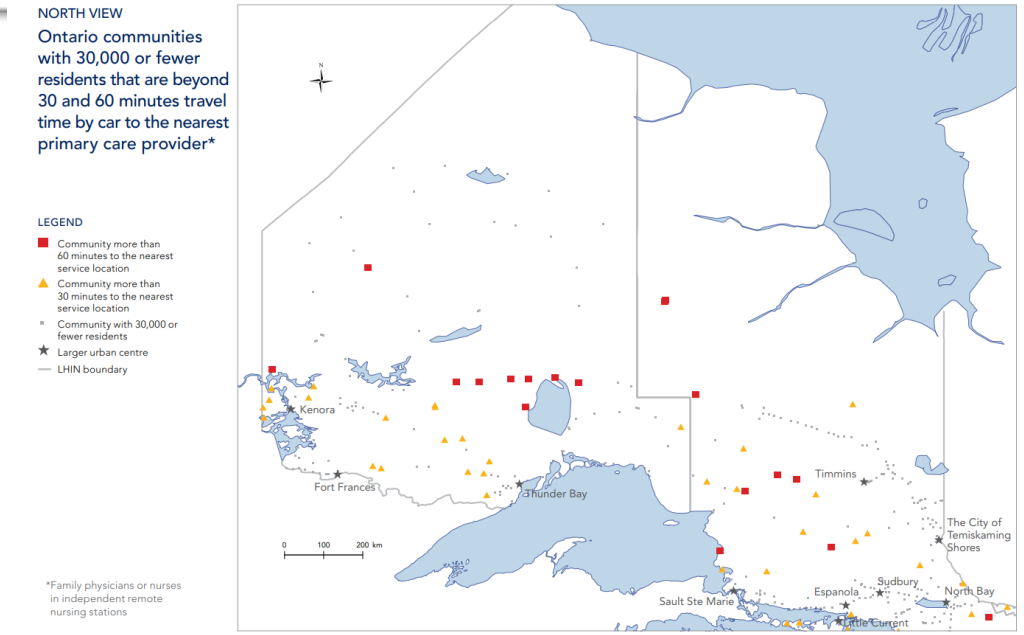
Is sometimes the only local care, and it might be delivered in unexpected places

We collaborate

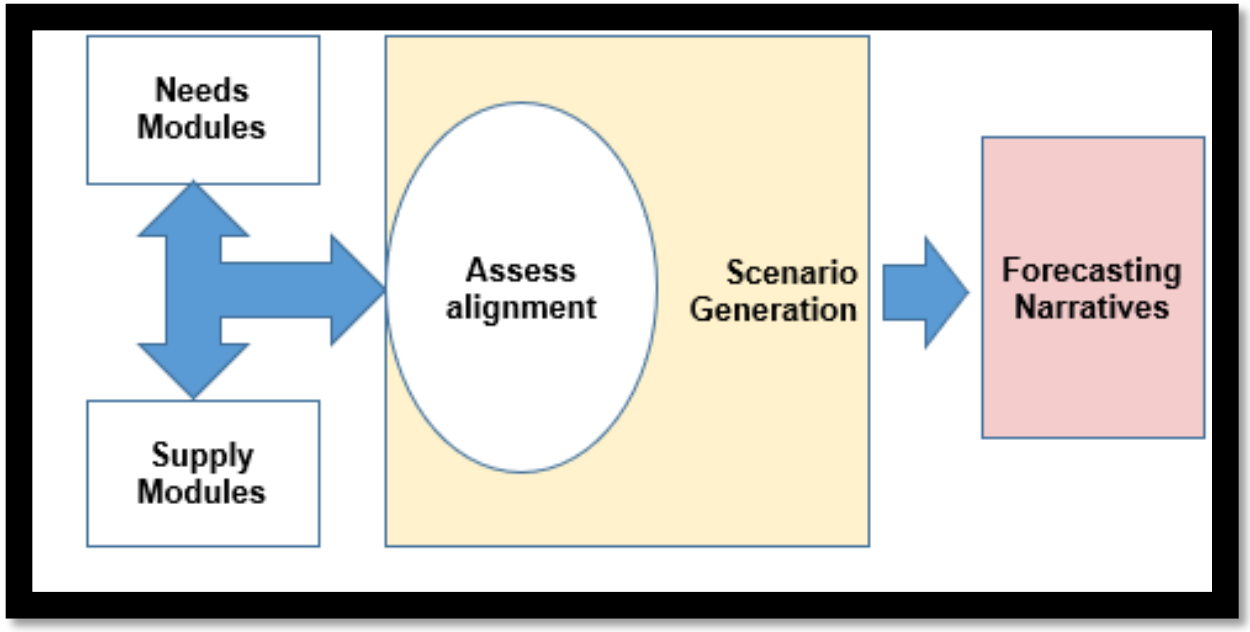
Because we need to, and we always have.

Diverse

Often painted as “the North”, we are not a singular population. We are also often “Othered” because of this.



Approach



Adapted from Simkin et al, 2021. https://doi.org/10.1186/s12960-021-00595-y. Published in Erin Cameron, Diana Urajnik, Brianne Wood, John Hogenbirk. Working models for human capital planning in Northern Ontario: A model for the primary healthcare workforce. Ontario Ministry of Labour, Training, and Skills Development; 2021 Mar.

- **1. Confirm geographic segmentation approach with health system decision-makers and their community partners**
- 2a) Determine indicators for **needs** and **supply** modules and populate with existing data – Jinfan Qiang
- 2b) Collect qualitative insights to improve and add richness to existing modules (thinking beyond workforce planning and into transforming to primary care systems) – Mannila Sandhu
- 2c) Collaborate with INSPIRE-PHC to acquire commonly reported **needs** and **supply** descriptives using our geographic segmentation (and prior attachment algorithm)
- **3a) Assess alignment between needs and supply modules**
- **3b) Compare assessment approaches and identify strengths and limitations**

Project Methodology – Reporting Items

Population Health
Needs

OHT-level (geographic population)
Age, Sex, Mother Tongue, Priority Populations, Chronic Conditions (particularly ICP relevant & Mental Health), Ambulatory Care sensitive conditions.

Unmet Needs
Needs

OHT-level (attributed population)
Rostered & Attached populations.
Users of primary care. Marginalization.
Average number of visits.
Health Care Experience Survey.

Spatial Patterns of Utilization
Demand

OHT-level (geographic population)
Primary care visits by PEM or location.
ED visits best managed elsewhere.
ED visits related to substance use.

- **<u>What we need from OHTs</u>:**
- Does the presented information seem right? ("face validity")

Do you have additional data or knowledge that you'd like to supplement these data?

Are there other data fields that you want captured in these domains? (feasible + wish list)

Would you like the information presented differently? If so, how?

Project Methodology – Reporting Items

Workforce Profile & Service Capacity (Physicians)
Supply

OHT-level, Community Hub & Within Practice
Counts and FTEs, Vacancies.
Practice Models/PEM types.

Workforce Profile & Service Capacity (Team-Based Care & Interdisciplinary)
Supply

OHT-level, Community Hub and Within Practice
Types, Counts and FTEs, Vacancies.

- **What we need from OHTs**:
- Does the presented information seem right? ("face validity")

Do you have additional data or knowledge that you'd like to supplement these data?

Are there other data fields that you want captured in these domains? (feasible + wish list)

Would you like the information presented differently? If so, how?

Output 1:Heat Map

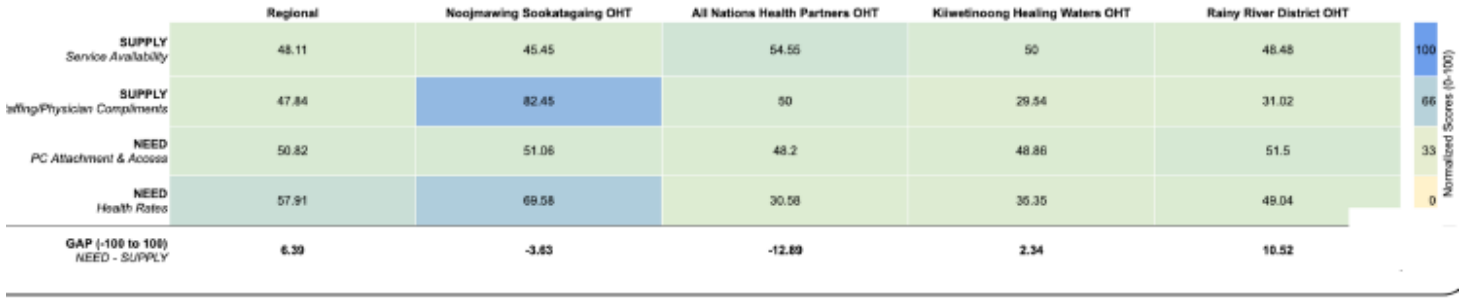
(Jinfan Qiang, Mannila Sandhu, et al.
2025. Data Driven Workforce Planning to
Address Primary Care Gaps in Northwestern Ontario. Presentation
for Trillium Primary Health Care
Research Day)

Results

Domain Components with Examples

Needs		Supply	
PC attachment & utilization	Health Conditions	Service Availability	Staffing/Physician Complements
• Attachment Gaps (e.g. Unattached) • PC Utilization (e.g. PC visits, Virtual visits) • Acute Utilization (e.g. ED visits) • Post-Acute Continuity (e.g. 7-day readmission)	Population grouper • Palliative • Major Mental Health • Moderate Chronic • Healthy Newborn	Service Type • Acute/Episodic Care • Diabetes Care • Mental Health Care • Maternal Newborn and Pediatric Care	• Staff Type (e.g. NPs, Administrations) • Physician Type (e.g. Family Medicine, Emergency Medicine)

Gap Heatmap Across NorthWest Ontario Health Teams

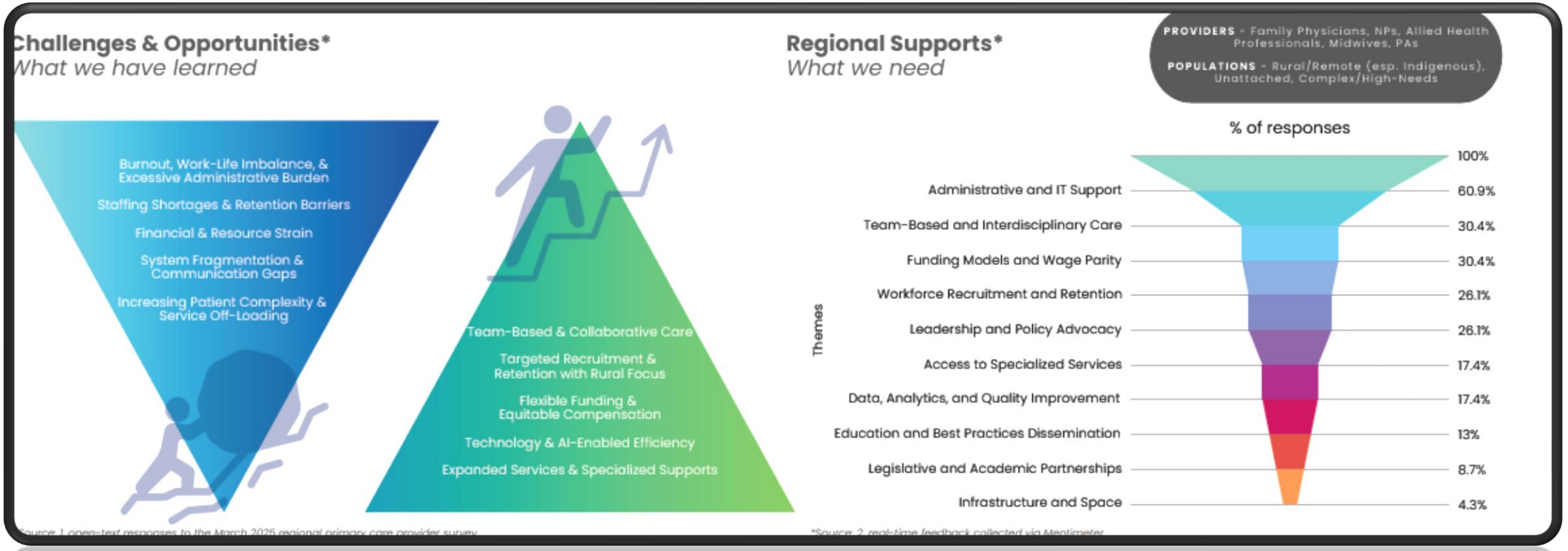


Implication & Future Steps

- Data-driven workforce planning helps identify service gaps and guide alignment of population needs with provider capacity across Northern Ontario.
- Findings have been shared with OHT leads and Ontario Health, with tailored sessions offered to support local interpretation and planning.
- Next steps include validation, integration of new data, and continued engagement to strengthen regional decision-making and equitable access to primary care.

Output 2:Thematic Analysis

(Mannila Sandhu, Jinfan Qiang et al. 2025. Voices from the North: Provider-Identified Challenges and Supports
to Strengthen Primary Care in Northwestern Ontario. Presentation for Trillium Primary Health Care Research Day)



Output 3: INSPIRE-PHC - primary care utilization

Table 2: Primary care utilization, October 1, 2023 - October 1, 2024

Value													
Supply/Need (Office)	0.49	0.30	0.39	0.38	0.34	0.24	0.33	0.53	0.27	0.31	0.47	0.38	0.44	0.39
Supply/Need (Any)	0.89	0.96	0.99	1.04	0.73	0.79	0.80	1.05	0.54	0.73	0.80	1.00	0.87	0.92
Office Visits/Any Visits	0.55	0.31	0.40	0.36	0.46	0.31	0.42	0.51	0.50	0.42	0.58	0.38	0.50	0.43

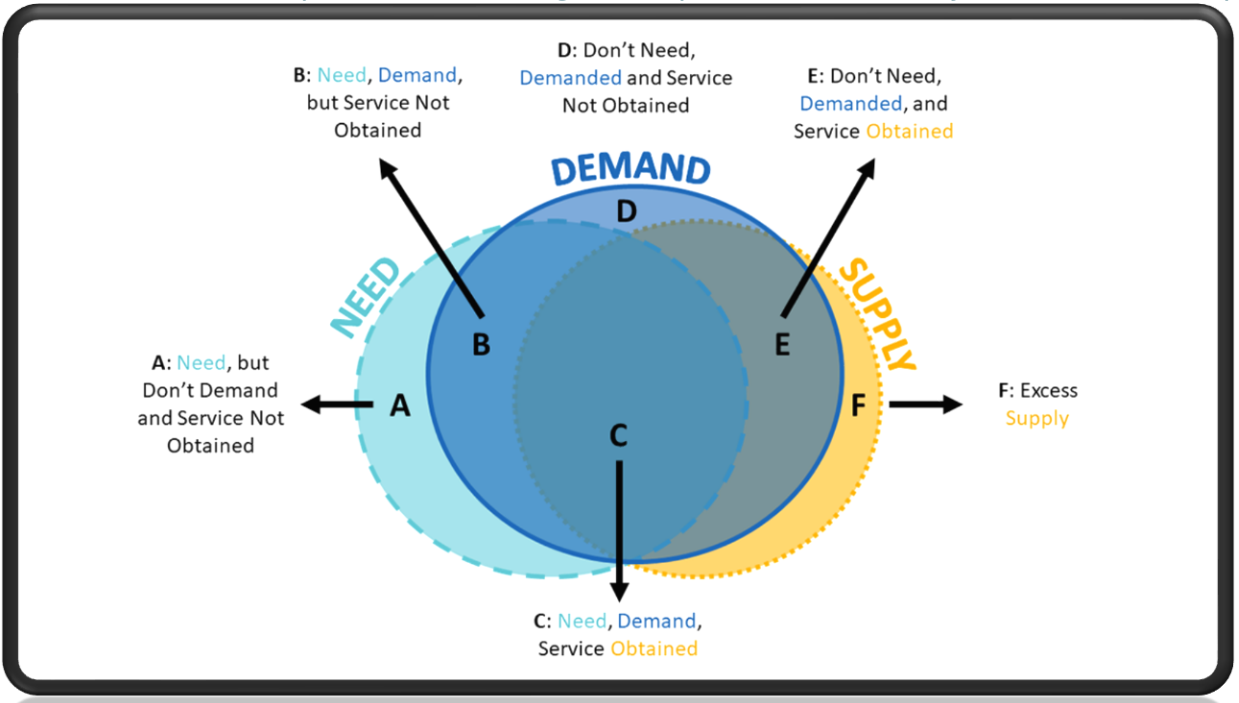
This analysis indicates that ALL local health hubs have greater primary care need (“expected visits”) than primary care supply, in 2023-2024. The health hubs in red in the first row have the greatest difference between primary care need and supply.

In the second row, the health hubs with green cells have their number of primary care visits supplied were almost equal to the number expected, although most of these visits were not in an office setting (e.g., in hospital, emergency room, etc).

For most local health hubs, fewer than 50% of their core primary care visits were completed in an office setting.

These data indicate that we need MORE CLINICAL CAPACITY in every local health hub, particularly to deliver PC in the optimal setting when possible. *Note – this only reflects physician billing.

Source: Adapted from Figure 2 in Safarishahrbijari A. Workforce forecasting models: a systematic review. J Forecast. 37(7):739–753. https://doi.org/10.1002/for.2541. Accessed from https://www.aamc.org/data-reports/workforce/why-health-workforce-projections-are-worth-doing on Oct 15, 2025



Local data and knowledge is critical to interpret and synthesize routinely-reported data AND drive equitable decision-making in Northern Ontario primary health care.

Takeaways

Northern and rural communities have planned and delivered (primary health) care geographically for a long time

Tensions between attachment-only provincial focus and actual challenges in Northern Ontario primary health care

Still many questions and unknowns (i.e., locums, resource-sharing across huge geography, community's perceptions of access and attachment). How do we leverage our strengths?

Thank you!

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SOCIAL MEDIA

@Brianne Wood

North Toronto Primary Care Network
making practice easier

NORTH TORONTO
Ontario Health Team

North Toronto's Approach to Primary Care Expansion

October 16th, 2025

Baycrest
Caregivers / Patients (People)
LOFT
Ontario
Primary Care Providers
Health
SPRINT Senior Care
Sunnybrook HEALTH SCIENCES CENTRE
Unison Health & Community Services
VHA Home HealthCare Creating More Independence
Vibrant Community Health

Our Challenge: Many people in North Toronto do not have a primary care home

~ 150%
population growth in select North Toronto areas

+

30,000
residents without a Primary Care Provider

+

1 in 5
patients visiting Sunnybrook's ED without a Primary Care Provider

Data used to help quantify the magnitude of our problem (supply and demand):

- Toronto Region Primary Care Workforce Planning Toolkit
- OHT Data Dashboard: Primary Care Action Team Data Package
- Hospital ED data on patients without a primary care provider

Step 1: Understand Community Characteristics

What are the characteristics of the population?

RCPS Réseau canadien des personnels de santé | CHWN Canadian Health Workforce Network

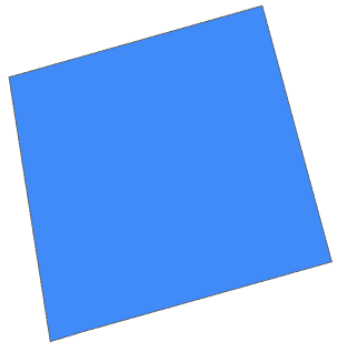
Ontario Health Toronto

Sub-Region

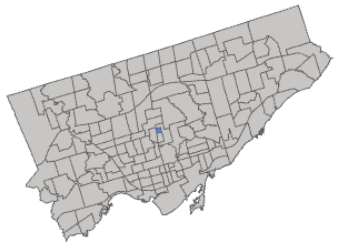
North Toronto

Neighbourhood

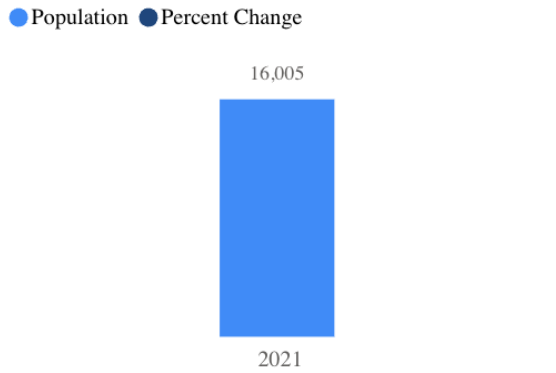
North Toronto



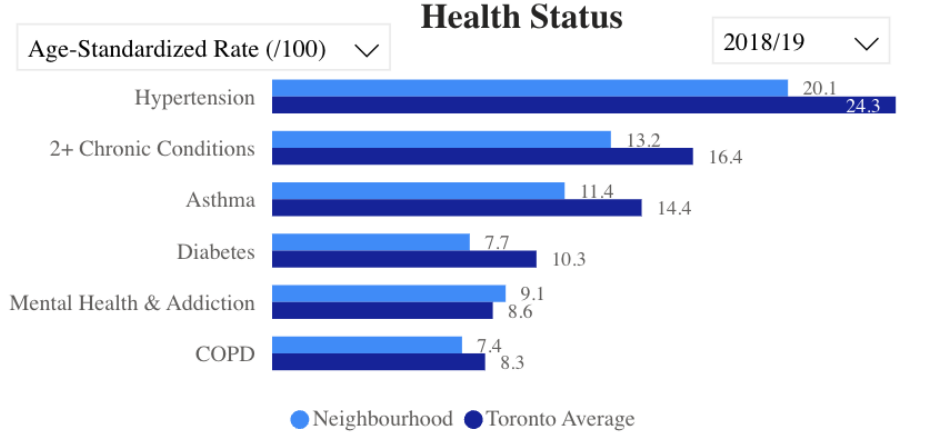
North Toronto



Population Size



Health Status



Summary

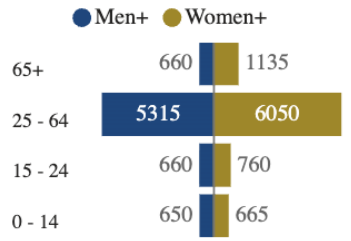
- In 2021 there were 16,005 residents in North Toronto
- Seniors made up 11% of the population
- Amongst the selected chronic conditions, the three most prevalent health conditions are: Hypertension (20.1%), 2+ Chronic Conditions (13.2%), and Asthma (11.4%)
- Marginalisation Summary: North Toronto ranked in the 1st quintile for Age & Labour Force, the 1st quintile for Material Resources, the 4th quintile for Racialized & Newcomer Populations, and the 5th quintile for Households & Dwellings
- In 2021, 75% of patients were attached to a primary care provider
- In 2021, patients from

Estimated Population Growth (2021-2031)

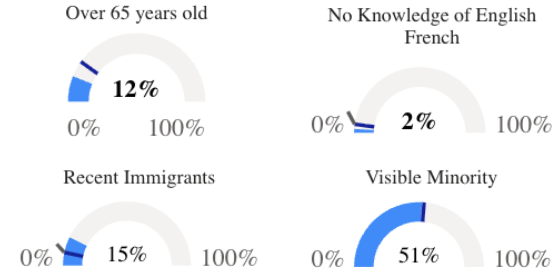
151.4%

Attachment (2021)

Age Structure (2021)

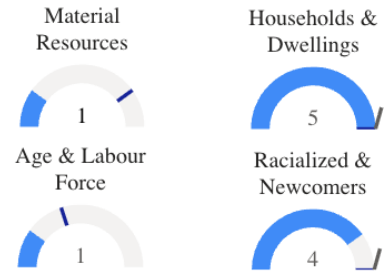


Other Community Characteristics



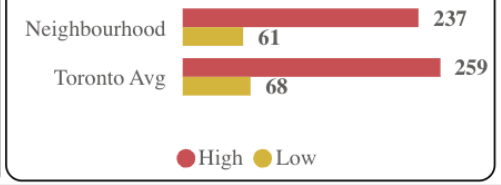
Ontario Marginalization Index (ON-Marg) Quintile 2021

with Toronto benchmark



Emergency Department

Age Adjusted Visit Rate by Urgency /1000 population (2018-2020)



Hospitalizations

Ambulatory Care Sensitive Conditions /100,000 (2021 - 2023)

Quick Tips | Technical Notes

Step 2: Understand Service Requirements

How many primary care visits are needed?

RCPS Réseau canadien des personnels de santé | CHWN Canadian Health Workforce Network

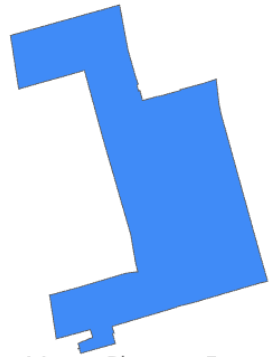
Ontario Health Toronto

Sub-Region

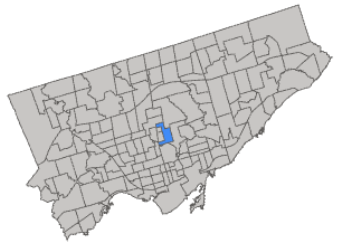
North Toronto

Neighbourhood

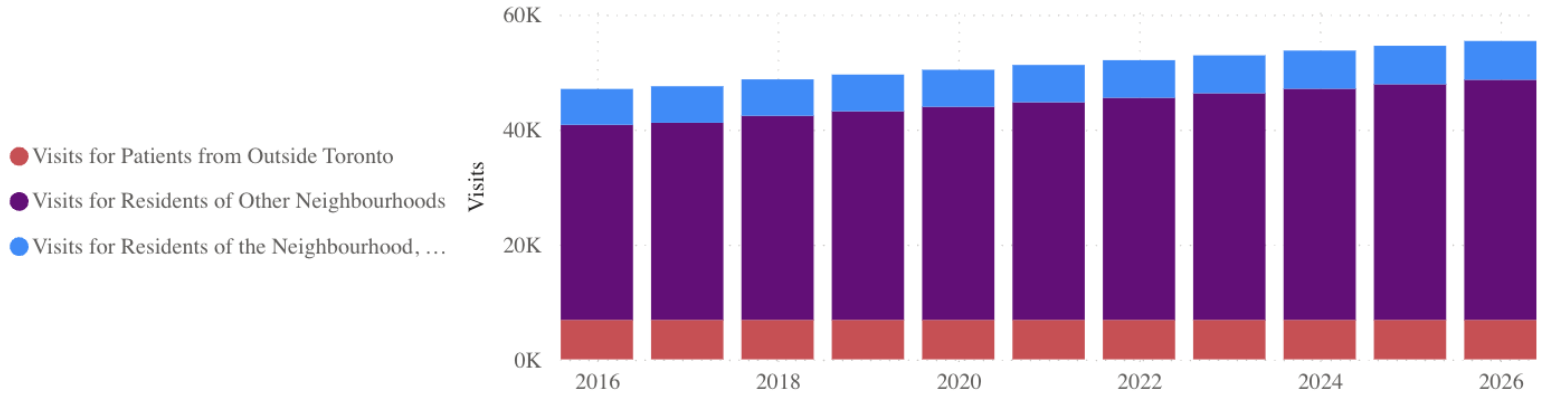
Mount Pleasant East



Mount Pleasant East



Physician Service Requirements



Physician Service Requirements

Service Requirement	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Number of Residents	16893	17031	17168	17306	17443	17581	17718	17856	17993	18131	18268
Visits for Residents of the Neighbourhood	57754	58224	58694	59164	59634	60104	60574	61044	61514	61984	62454
% of Care Accessed in Home Neighbourhood						11					
Visits for Residents of the Neighbourhood, Adjusted for Patient Mobility	6237	6356	6339	6390	6440	6491	6542	6593	6644	6694	6745
Visits for Patients from Outside Toronto						6871					
Visits for Residents of Other Neighbourhoods	33945	34295	35512	36296	37080	37864	38648	39432	40216	41000	41784
Total Service Requirements	47053	47522	48722	49557	50392	51226	52061	52896	53730	54565	55400

Summary

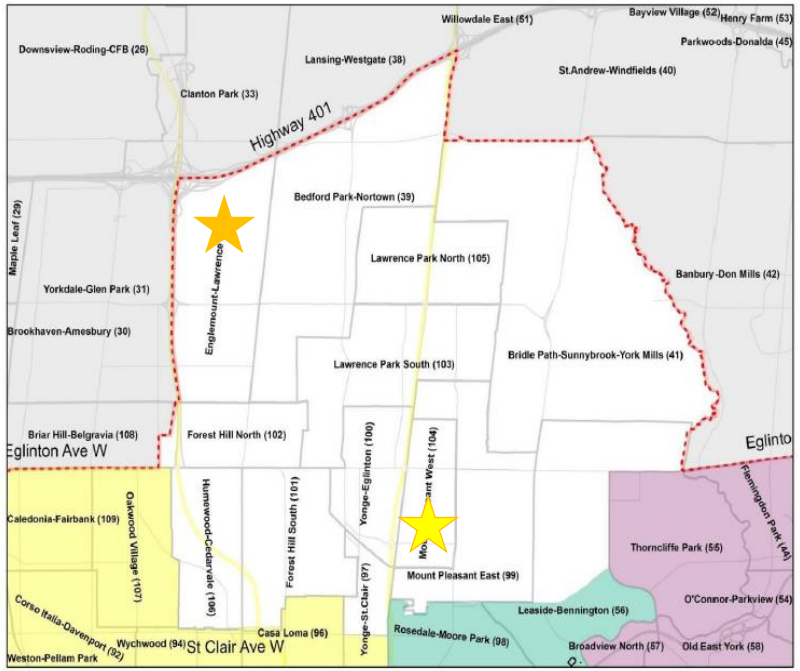
- In 2016, 47,053 primary care visits were required in total: 6,237 for residents, 33,945 for patients from other neighbourhoods, and 6,871 for patients from outside the city
- In 2021, 51,226 primary care visits were required in total: 6,491 for residents, 37,864 for patients from other neighbourhoods, and 6,871 for patients from outside the city
- In 2026, 55,400 primary care visits will be required in total: 6,745 for residents, 41,784 for patients from other neighbourhoods, and 6,871 for patients from outside the city
- Service requirements are expected to increase to 55,400 in 2026

Quick Tips | Technical Notes

A closer look at our geography

Compared to the city/province, North Toronto has:

- Higher Education
- Fewer Inpatient & ED visits
- Fewer Chronic Illnesses
- More Affluent



However, not all neighbourhoods are equal. The NT OHT must strive to improve health outcomes of our most vulnerable communities in Mount Pleasant West and Englemount Lawrence.

Mount Pleasant West

271 per **1,000** average annual ED visits compared to 208 in Bridle Path	**30%** unattached to primary care	**21%** below low income measure
34% Identify as a visible minority	**102.7%** population growth from 2017 to 2026	**55%** of seniors living alone

Englemount-Lawrence

290 per **1,000** average annual ED visits compared to 208 in Bridle Path	**37%** unattached to primary care	**21%** below low income measure
41% Identify as a visible minority	**17%** do not have suitable accommodation	**15%** have more than 4 Chronic Conditions

Sunnybrook HEALTH SCIENCES CENTRE

Understanding the Supply and Demand for Primary Care in the community

- **PCN engagement and PC Census 2025**
  - Few doctors are publicly accepting patients
  - More doctors in focused practice
  - Few new doctors are arriving to the community
  - Many older doctors are retiring or leaving due to high rents

- **Hospital Data**
  - 20% of ED patients are without primary care

- **Community Engagement Events**
  - Schools, Community centres, seniors centres, libraries

- **Other Data**
  - Who are the unattached? Many are men 25 to 45 yrs, and others?
  - Access to team-based care is 7 % in North Toronto vs > 20% across the province

North Toronto OHT Approach to Primary Care Attachment

- Our approach addresses **retention and attachment** at the same time:
  - Following primary care co-design, PCN engagement and through Round 1 PCAT funding, we are building a **HUB & AFFILIATE MODEL**:
  - OHT and Hospital support partners have been invaluable in this work, targeting 10,000 attachments in the coming year.
  - Hubs (one CHC and one FHT) are expanding their allied teams, based on need, to enable increased attachment at the hubs.
  - Hubs are also employing allied health staff, to work in 5 affiliated community practices, to increase attachments.
  - Choice of professional type is up to the practice, based on their needs and preferences: PAs , NPs, and SW have been chosen in Round 1.

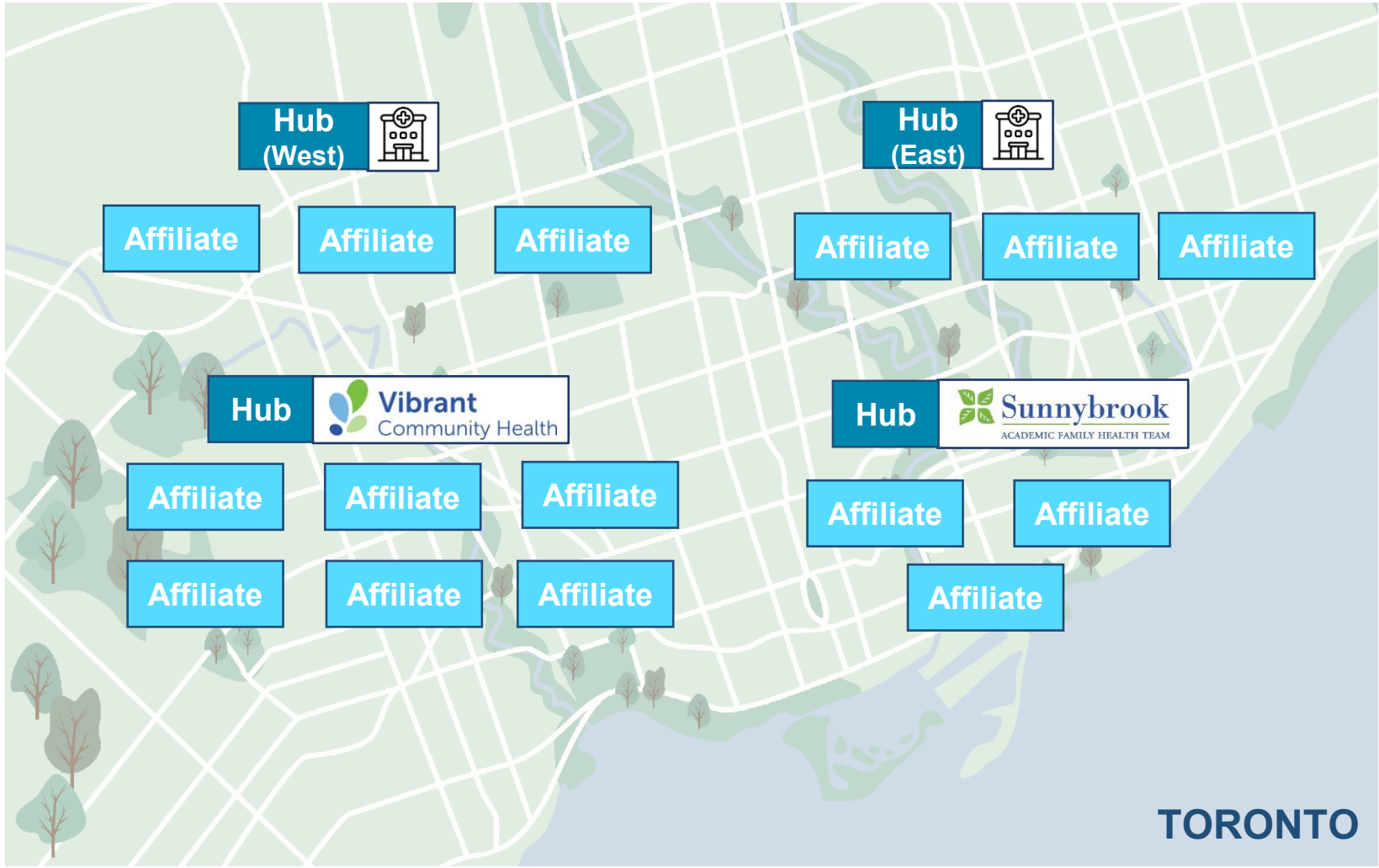
North Toronto Primary Care Hub and Affiliate Model

Access to team-based care regardless of Patient Enrolment Model (PEM)

Affiliated Clinics ···▶

Hubs ···▶

Our Goal: 30,000 Unattached North Toronto Residents connected to Team-Based Primary Care in 4 years



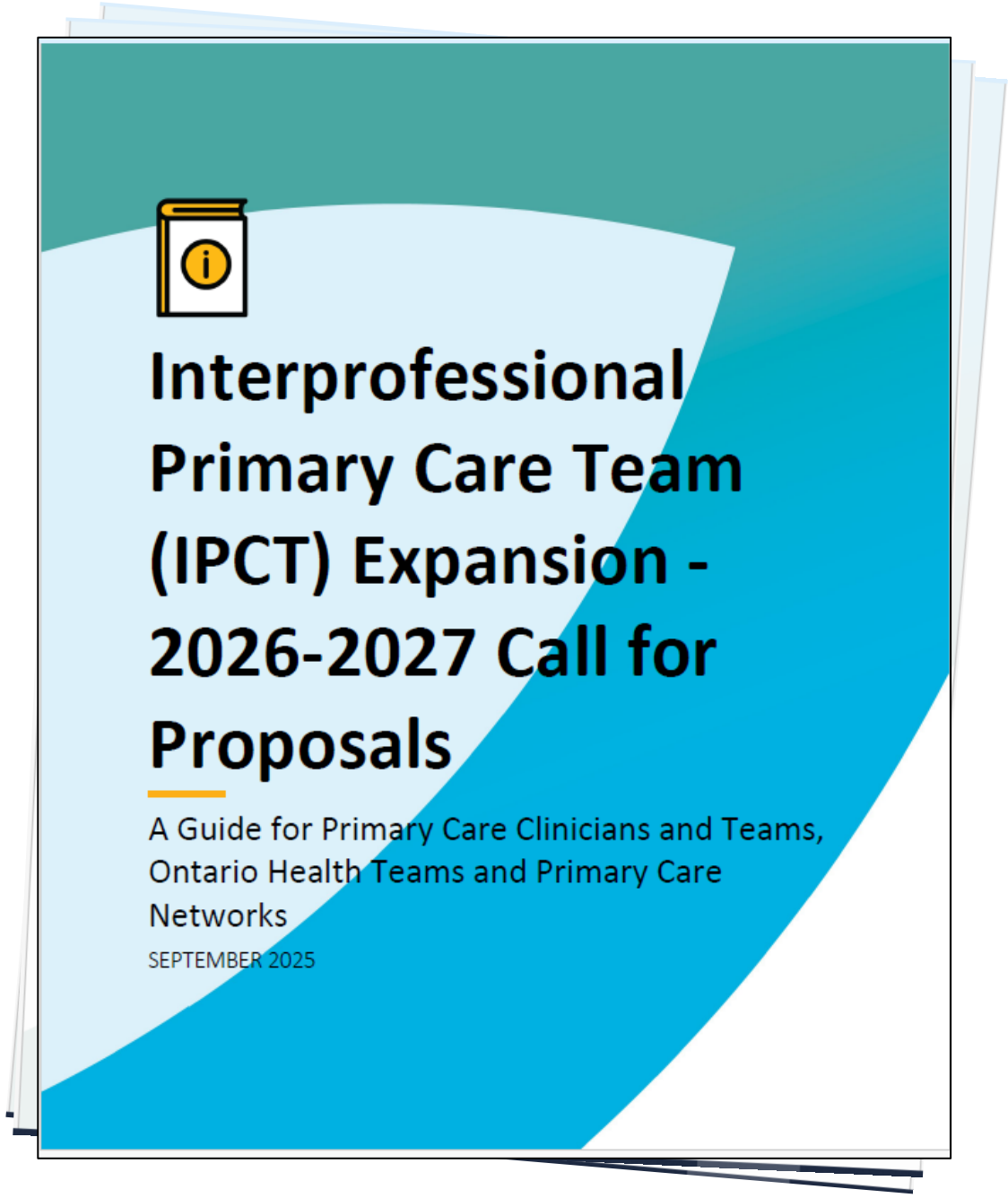
Next Steps: PCAT Round 2

Ontario

NEWS RELEASE

Ontario Connecting 500,000 More People to a Family Doctor and Primary Care Team

Next call for proposals open as part of plan to connect every person in the province to convenient primary care by 2029



Data-Informed Primary Care Expansion Planning

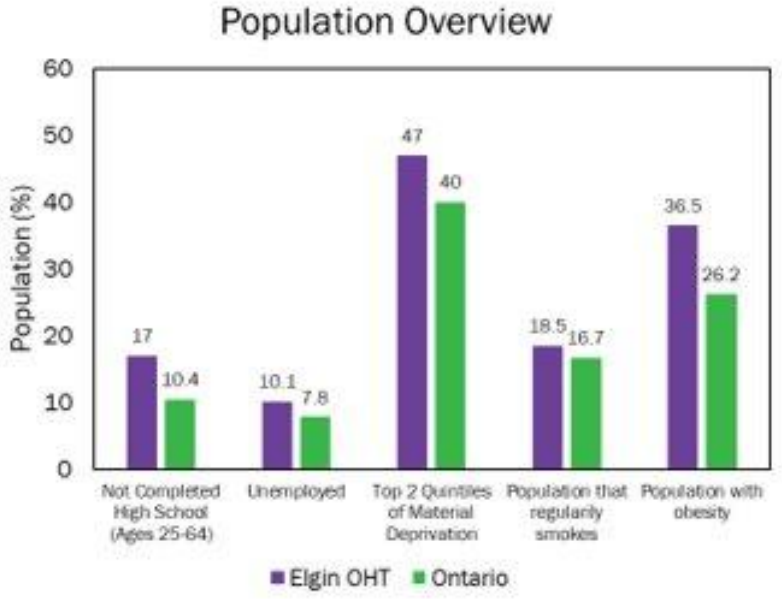
Deanna Huggett, Executive Director, Elgin OHT

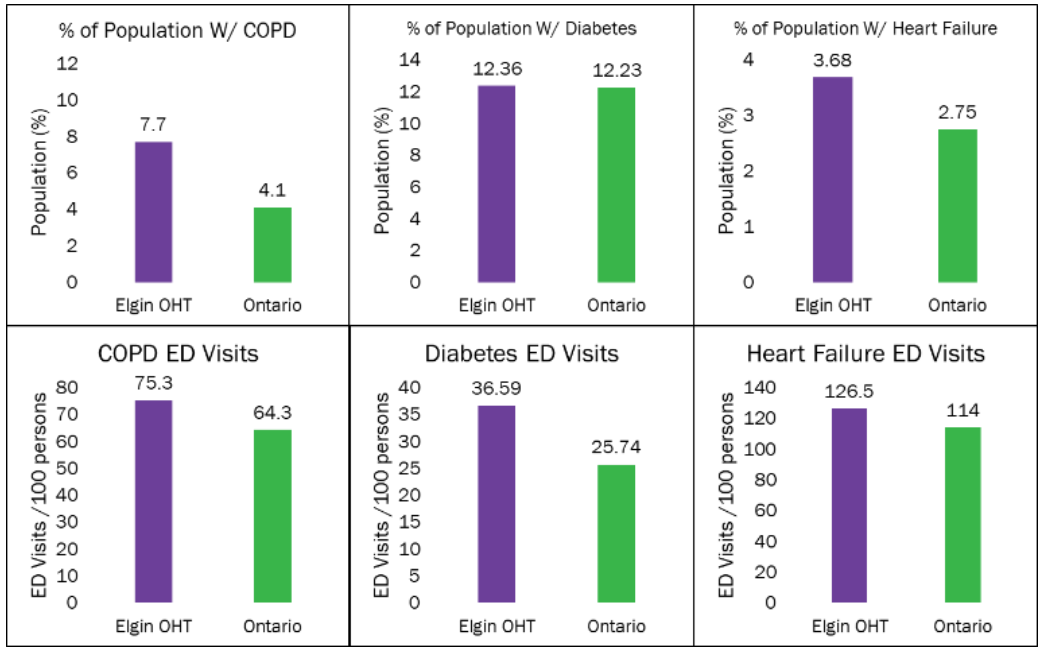
Deanna.Huggett@elginoht.ca

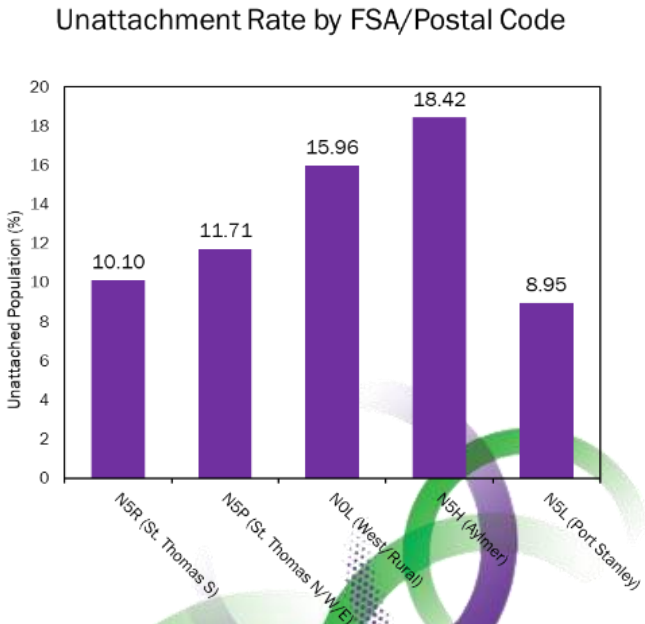
October 16, 2025

Understanding Population Needs

- **Who? (resources):** OHT members, RISE coaches, students, small decision-support contract
- **What? (quantitative sources):** Census, OHT data dashboard, INSPIRE PHC, HSPN
- **What? (qualitative sources):** community engagement, interviews with OHT members and partners serving equity-deserving populations





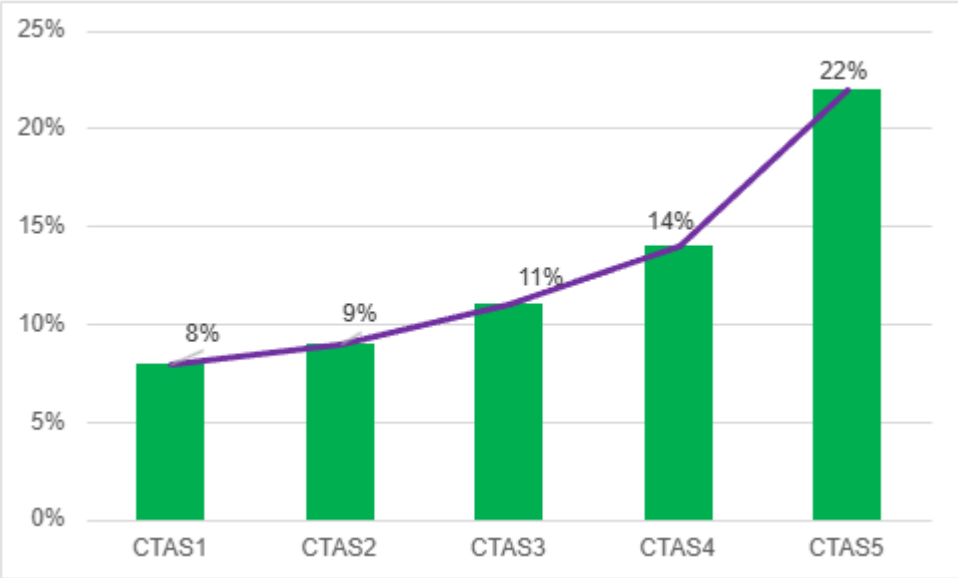


Understanding Primary Care Demand

- **Data sources:** emergency department, walk-in clinic, unattached clinic, community paramedicine
- **Primary care data:** team survey, MD and NP engagement through PCN + template
- Patient/Client Volume, Capacity, and Waitlist Status
- Geographic Distribution of People Served
- Appointment Access & Patient/Client Attachment Changes
- Visit Types & Care Patterns
- Provider Staffing & Clinical Capacity
- Population growth

Unattached Clinic: Top Visit Reasons

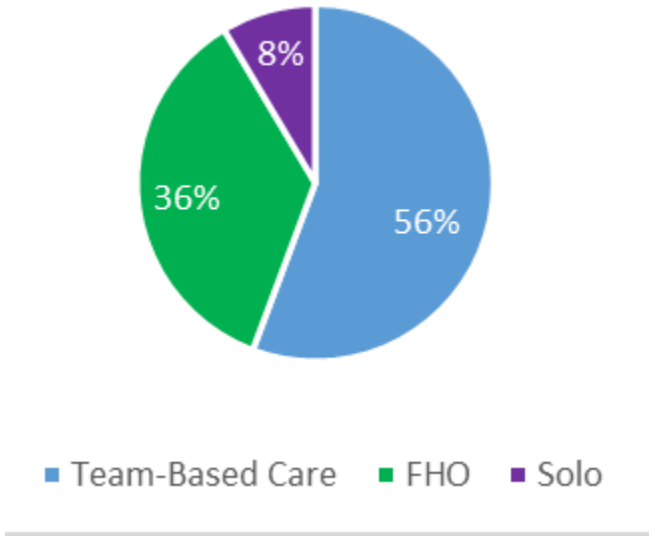
Reason for Visit	YTD Count (Visits)
Patient Education	904
Lab Results	512
Preventative Health	321
Prescription Renewal	143
Medication Review	203



Percentage of ED visits for people without a physician increases with lower-acuity CTAS classes.

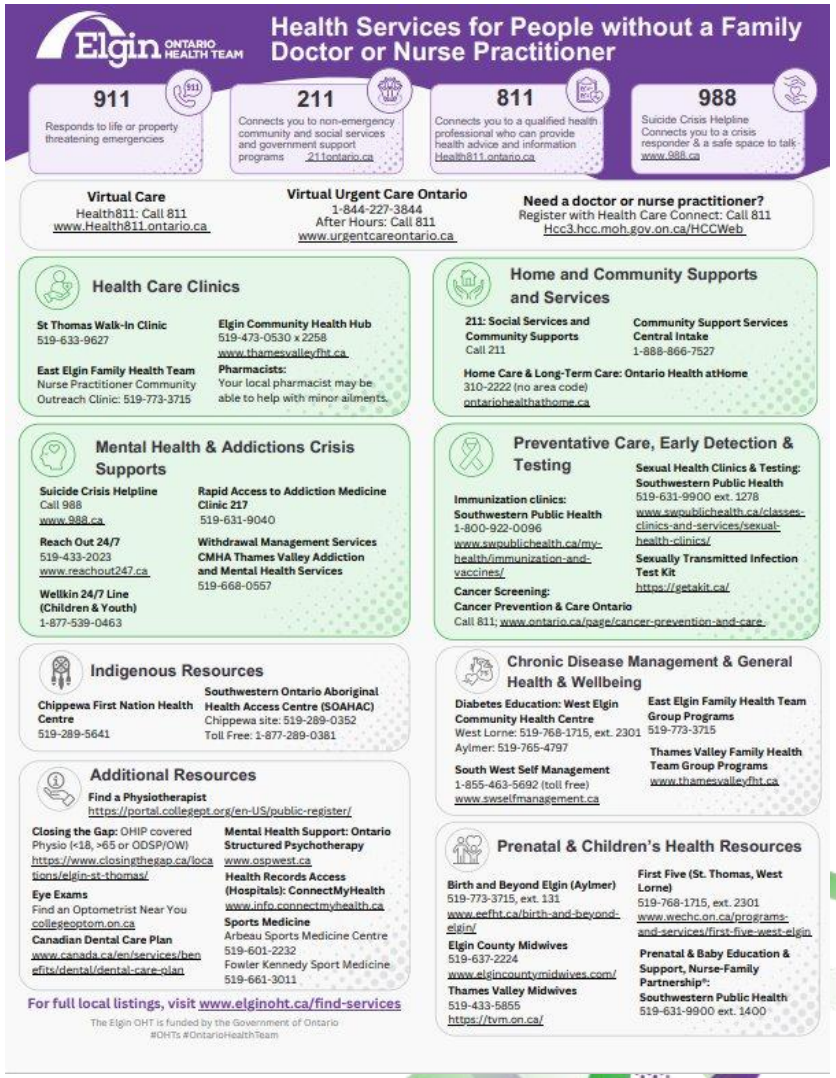
Understanding Primary Care Supply

- What services exist?
- Who can access them?
- Who provides them?
- Waiting lists?
- Community strengths and successes?

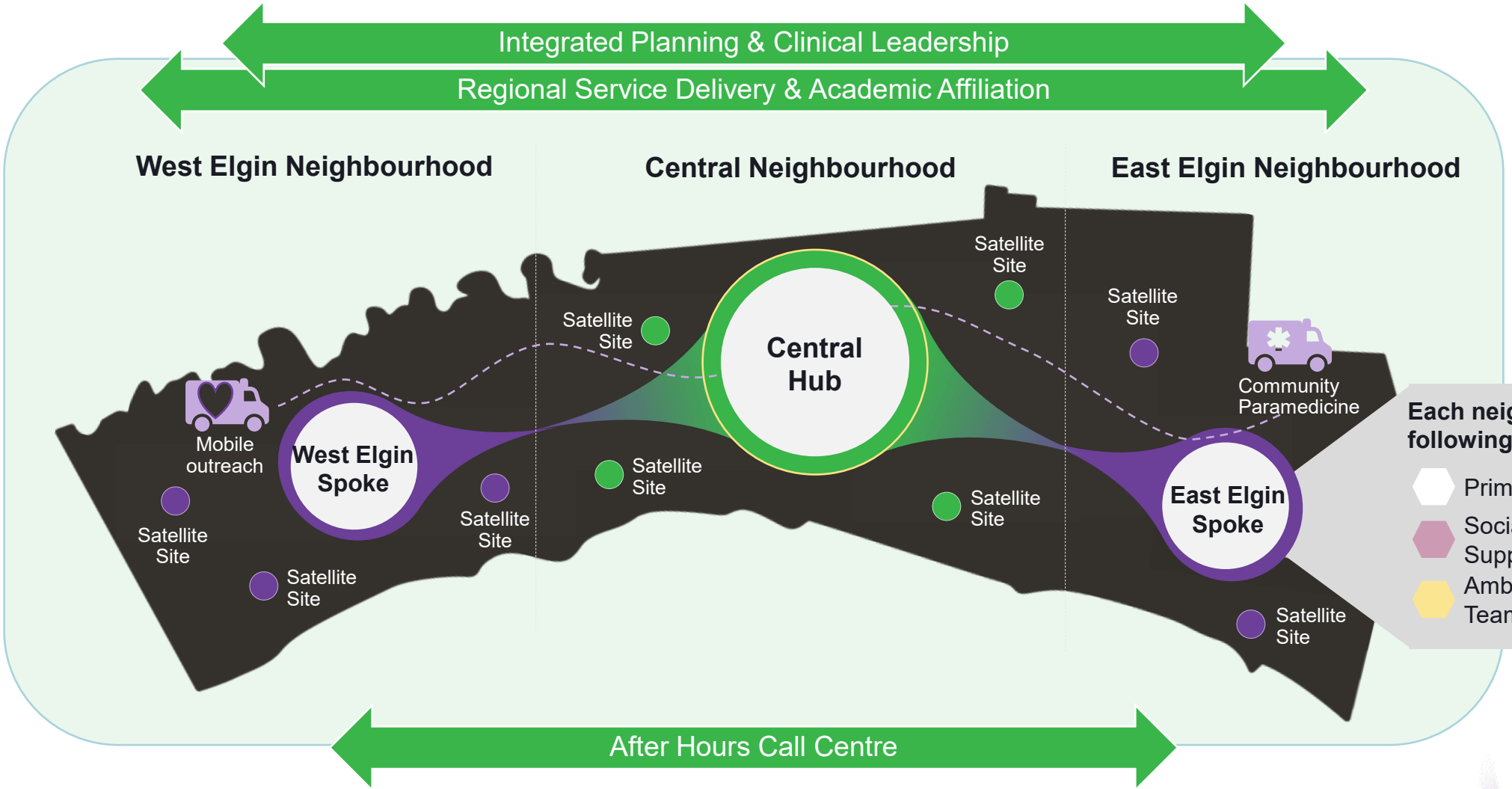


Distribution of Elgin Family Physicians by Years Since Graduation (CPSO, July 2025)

	% of Family Physicians
Pending retirement (>30)	11%
Late Career (25-30y)	16%
Mid-Career (10-24y)	58%
Early Career (<10y)	15%
	100%



Elgin Neighbourhood Health Home Model



Each neighbourhood provides the following services:

- Primary Care
- Social Care & Community Supports
- Ambulatory Care / Specialist Teams

Overview of Proposed Future Model

- The aim of a neighbourhood health home model is to ensure everyone living within the neighbourhood has access to team-based primary care.
- To achieve this in Elgin, we are proposing a hub and spoke model with a central hub in St. Thomas, a spoke in East Elgin and another spoke in West Elgin.
- There may also be satellite sites and mobile outreach to increase access to team-based services.
- The model will also provide a centralized waiting list, supported intake, referral/navigation support, and coordinated after-hours care.
- The model also seeks to develop an academic site in Elgin.

What's Next?

- Prioritizing components of the Neighbourhood Health Home Model
  - Phased implementation
  - Resource requirements
- MD, NP and team input and attachment commitments for funding proposal aligned to model
- Implementation of components leveraging existing resources

What questions do you have? What else would you like to know?

Please raise your hand and come off mute/place your comments in the chat box

Why are supply and demand important?

RISE
Rapid-Improvement Support and Exchange

When the supply of appointments and the demand for appointments are in balance: **Timely Access to Care**

Demand
want backed up by the willingness and ability to actually access (use) a specific good or service

Supply
is the amount of a commodity or service that is available

CC BY NC

Supply and Demand at the practice level

We have methods to help understand the supply of appointments and demand for appointments **at the practice level**

1. Calculate the total supply of appointments (# of appointments per week X number of weeks worked annually)

2. Calculate the total demand for appointments (panel/roster X visit rate)

If you are out of balance, you can increase the supply of appointments or decrease the demand for appointments

BY NC
McMaster University HEALTH FORUM
NOSM UNIVERSITY UNIVERSITÉ EMNO
Trillium Health Partners
INSTITUTE FOR BETTER HEALTH

Supply and demand at the OHT/PCN level

- How can we take these methods from the practice level and apply them to the OHT/PCN level?
- How can we apply visit rates from existing patients to be able to predict the supply of clinicians/teams required to ensure timely access to care for attributed populations?
- By understanding the needs of the population how can we build supply to better serve those needs?
- How can we provide care differently in a "new" high performing PC system to influence supply, demand and the need for providers?

We will be offering an opportunity to dive deeper into these questions together:

Deep Dive on Needs, Supply and Demand

BY NC

What we heard from you...

RISE
Rapid-Improvement Support and Exchange

RISE Peer Sharing and Learning Sessions

Coaching supports

NEW!

Deeper-dives

Between peer sharing and learning sessions, ‘deeper dives' into PC concepts (e.g., zooming into the ‘how-to', collaborative problem solving with peers at similar stages)

We will honour and continue relationships and are looking for innovative approaches to support the work

RISE deeper dives:

At the September peer sharing and learning session, the majority of attendees identified an interest in participating in a new form of support – deeper dives.

RISE
Rapid-Improvement Support and Exchange

What are they?

Interactive improvement sessions to apply learnings of a specific PC concept (e.g., understanding need, demand and supply to facilitate PC expansion)

How are they different from a peer sharing session?

- Zoom into the ‘how-tos' and participants would work with peers at similar stages.
- Work between meetings to accelerate progress in the specific focus area
- Specific outcomes

What is the time commitment?

- Depends on the complexity of the topic (e.g., 1+ sessions with varying length)
- Between session work will vary (your pace is up to you).

When would deeper dives occur?

Between peer sharing and learning sessions.

Who should participate? Those leading PC work at OHTs/PCNs

Poll:
Would you be interested in a 'deep-dive' on **understanding need, demand and supply to facilitate PC expansion**?

- ❑ Yes
- ❑ No
- ❑ Other (please place in chat box)

Deep-dive: The process of primary care attachment

At the September 2025 peer sharing and learning session, a deep-dive on the process of attachment was the #1 topic requested

RISE
Rapid-Improvement Support and Exchange

Outcomes from participating:

- ✓ Next steps in your workplan to build a reliable attachment process
- ✓ An improved attachment process which you can begin testing

This deep-dive will help OHTs progress their work towards the TPA deliverable: Develop and implement a plan for PC-AA and specifically for clearing the Health Care Connect (HCC) waitlist (as it stood on 1 January 2025) by spring 2026

Session 1 objectives: Oct 29, 11am-12pm

- Learn key approaches to help you progress this work
- Understand what elements of the attachment processes are required to be successful and which can be customized
- Build on your access and attachment plans submitted in summer 2025 to develop next steps in creating a reliable attachment process in your OHT/PCN

Interested?
Please indicate your interest **here**.

Session 2 objectives: Nov 18, 10am-11am

- Discussions with peer OHTs/PCNs at similar stages to share learnings on what worked well
- Problem solve with RISE coaches and peer OHTs/PCNs on challenges

RISE
Rapid-Improvement Support and Exchange

November 20 (12-1:30pm)

Next RISE OHT peer sharing & learning session will continue to focus on PC

Please reach out to leslie.mcgeoch@outlook.com , if you do not see the invite in your calendar

RISE
Rapid-Improvement Support and Exchange

Miigwech
Merci
Thank you

Appendix

Appendix 1: Deep-dive: The process of primary care attachment FAQs
Appendix 2: Appendix to Dr. Brianne Wood's presentation

Appendix 1:
Deep-dive on the process of primary care attachment FAQs

RISE
Rapid-Improvement Support and Exchange

Who should participate in the deep-dive?

- Those in OHTs/PCNs leading primary access and attachment work. Optional to bring additional PC working group members.

Will there be pre-work?

- A short questionnaire (5-10 questions)/10 min chat with a coach to understand where you are in your attachment journey
- Review of RISE Sept peer sharing and learning session on the process of attachment

Do I need to come to both the Oct 29th and Nov 18th sessions?

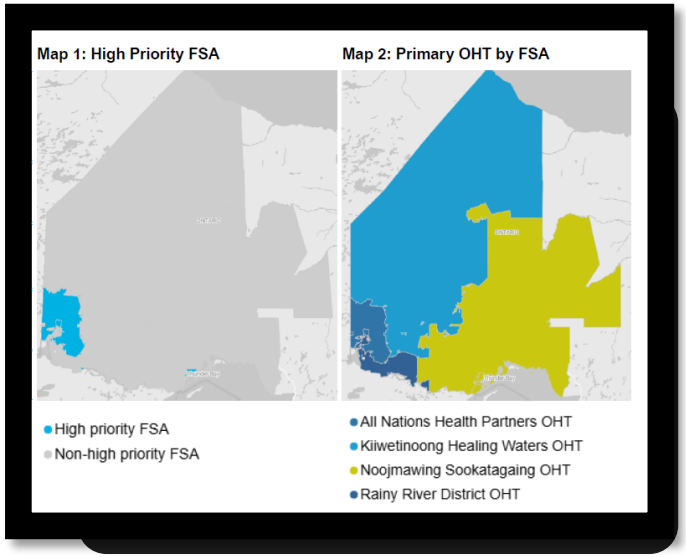
- As the sessions will build on one another, you do need to attend both sessions

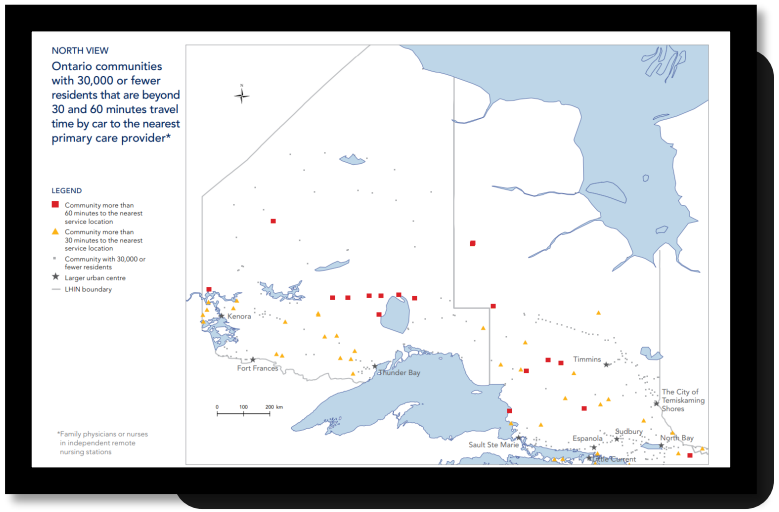
How much time should I allocate between sessions to do prework?

- Between session work will depend on where you currently are in developing an attachment process and how much time you have available (your pace is up to you). For example, a pre-existing 1 hour working group meeting could be leveraged for this work or you may want 1-2 coaching sessions to plan the work ahead. We will meet you where you are in the work.

Interested?
Please indicate your interest **here**.

Appendix 2:





DATA SOURCES

- Census data systematically undercounts Indigenous populations, urban and on-reserve
- OHIP billing can't capture rural generalism
- Nurse practitioners, traditional healers, paramedicine

SEGMENTATION

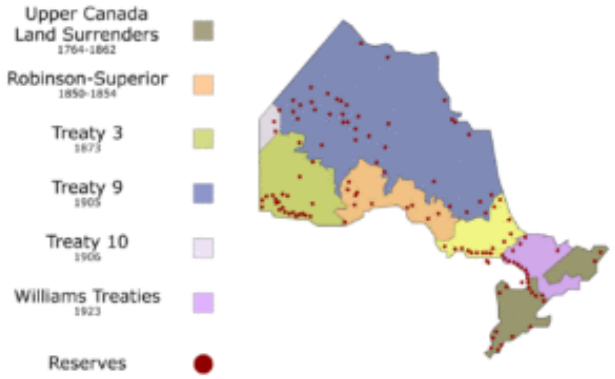
- FSAs do not have useful sub-analyses; postal codes can identify First Nations reserves; ADAs and CSDs are similar in Northern Ontario
- Small area analysis challenges!

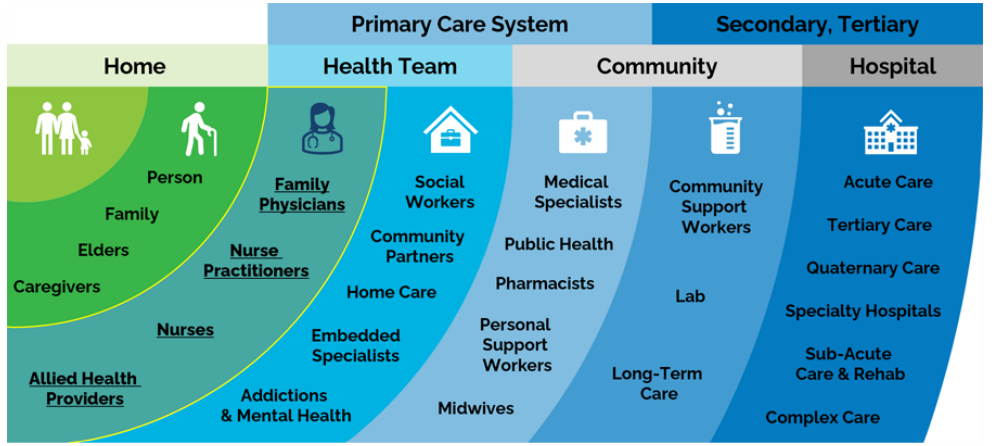
COMMON INDICATORS

- Attachment: Rural and northern physician group agreements ALREADY ENROL GEOGRAPHICALLY
- Number, proportion of clinicians does not capture FTEs, locums, or in community practicing

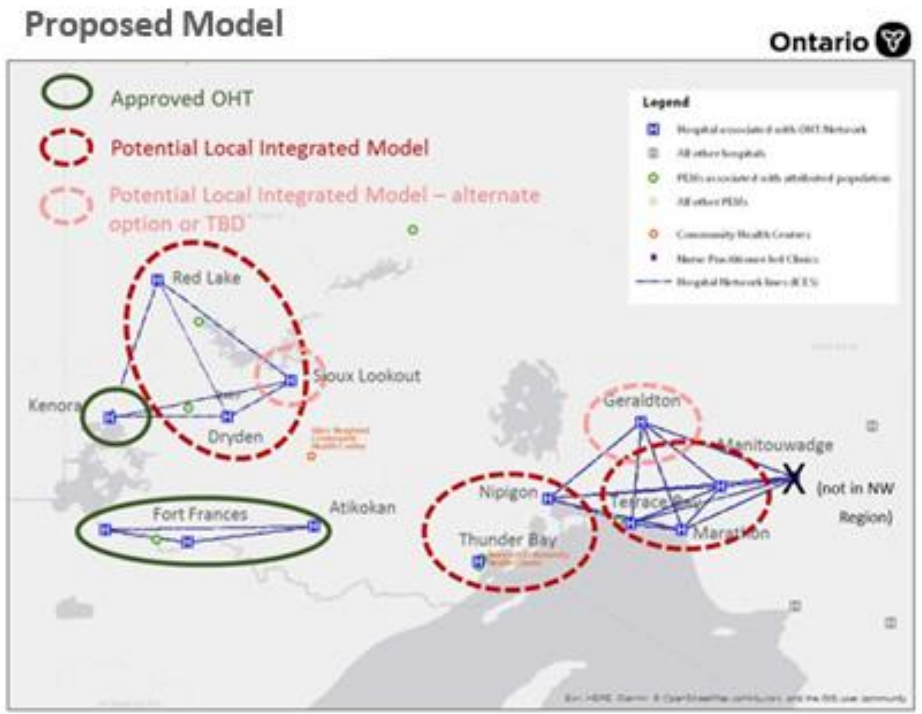
Primary Care Action in Northern Ontario

Geographic segmentation?





- **Natural patterns and ways of working**
  - North West LHIN Blueprint -> Sub-regions -> OHTs
  - Where are people getting primary care and when? Stability over time?
  - Where are people accessing community services, hospital services?
  - How do organizations work together?
- **Existing structures or expectations that need to be reflected**
  - Physical landscape (e.g., provincial parks), infrastructure (roads), social services, health services
- **Learning from others**
  - Public health units
  - Specialty networks/pathways of care
- **Face validity – accessible & useable, understandable, and meaningful**



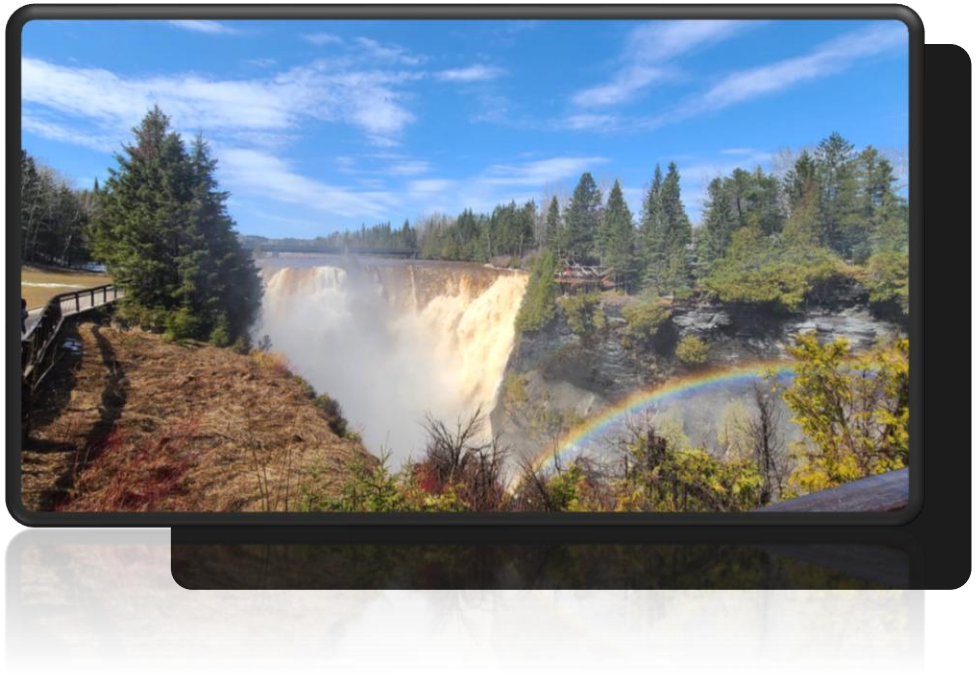
/https://nwoic.ca/wp-content/uploads/2021/05/North-West-RIC-WG-Engagement-Document-Feb-19-2021-FINAL.pdf

99	Sioux Lookout	3560	Kenora	3560085	Wunnumin 1	Kiiwetinoong Healing Waters
100	Terrace Bay	3558	Thunder Bay	3558063	Pays Plat 51	Noojmawing Sookatagaing
101	Terrace Bay	3558	Thunder Bay	3558051	Schreiber	Noojmawing Sookatagaing
102	Terrace Bay	3558	Thunder Bay	3558054	Terrace Bay	Noojmawing Sookatagaing
103	Thunder Bay	3558	Thunder Bay	3558004	City of Thunder Bay	Noojmawing Sookatagaing
104	Thunder Bay	3558	Thunder Bay	3558019	Conmee	Noojmawing Sookatagaing
105	Thunder Bay	3558	Thunder Bay	3558003	Fort William 52	Noojmawing Sookatagaing
106	Thunder Bay	3558	Thunder Bay	3558012	Gillies	Noojmawing Sookatagaing
107	Thunder Bay	3558	Thunder Bay	3558065	Gull River 55	Noojmawing Sookatagaing
108	Thunder Bay	3558	Thunder Bay	3558100	Lac des Mille Lacs 22A1	Noojmawing Sookatagaing
109	Thunder Bay	3558	Thunder Bay	3558001	Neebing	Noojmawing Sookatagaing
110	Thunder Bay	3558	Thunder Bay	3558016	O'Connor	Noojmawing Sookatagaing
111	Thunder Bay	3558	Thunder Bay	3558011	Oliver Paipoonge	Noojmawing Sookatagaing
112	Thunder Bay					Noojmawing Sookatagaing

What does this mean?

- We aggregated and mapped CSDs to **Local Health Hubs** – with validation from local health system leaders
- CSDs often represent entire “communities” (including First Nations reserves) and are easily understandable from a primary care context perspective.
- Aggregating CSDs **does not** address Indigenous data sovereignty, but allows us to be inclusive without identification

Northern Ontario primary care transformation must focus on improving access to team-based care in a way that considers the unique population needs and contexts



What's next?

Determine and measure primary health care access in a meaningful way for Northern, rural, and Indigenous populations

Work across the Northern regions to align on primary health care visions, determine change ideas locally

Strengthen and contextualize primary health care learning systems - engaging populations, evaluating changes, etc - at multiple scales including local, regional, provincial, national