RISE
Rapid-Improvement Support and Exchange

An introduction to optimizing team-based primary care

20 November 2025

Recording: https://youtu.be/FBPmTY3g8mk

NEW!

RISE facilitated primary care shared space

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Stay connected!

You can also post questions, share resources and watch previous sessions in the OHT/PCN shared space.

Joining is easy

1. Visit the OHT shared space platform and click the "Sign Up" button.

2. Join the RISE facilitated primary care shared space by clicking on the "Join Group" button

3. Click "**Subscribe to Updates**" to stay up to date on events and resources

For any questions, please feel free to reach out to your coach or Leslie McGeoch (Leslie.McGeoch@outlook.com)

BENEFITS

- ✓ **Group** for those leading OHTs/PCNs and responsible for PC TPA deliverables (e.g. PC AA)
- ✓ Receive email **notifications on sessions**
- ✓ Access **resources and templates**
- ✓ **Watch recordings** of previous sessions and discussions
- ✓ **Post questions** to other OHTs, PCNs and experts on the board

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

Today's agenda

RISE
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1. **An introduction to high-performing PC and team-based PC**

   Gain an initial understanding of primary drivers for high-performing PC followed by a specific focus on one of these drivers (optimizing team-based care)

   12:05-12:20

2. **Social prescribing**

   Understand how the process of social prescribing can improve team-based care

   12:20-12:50

3. **Mural board activity**

   Participants to co-create a list of change ideas which they can take back to their teams to progress team-based care

   12:50 – 1:25

Objectives for Today

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- ✓ Learn about the characteristics of creating high performing primary care
- ✓ Understand how primary care practices can achieve better outcomes and quality of care through team-based care (e.g., ensuring additional health and social services to meet needs)
- ✓ Contribute towards a list of change ideas to test within your own context to optimize team-based care
- ✓ Continue to learn from peer OHTs/PCNs on how they're approaching this work

Recall OHT Transformation: Integrated Local Care Systems

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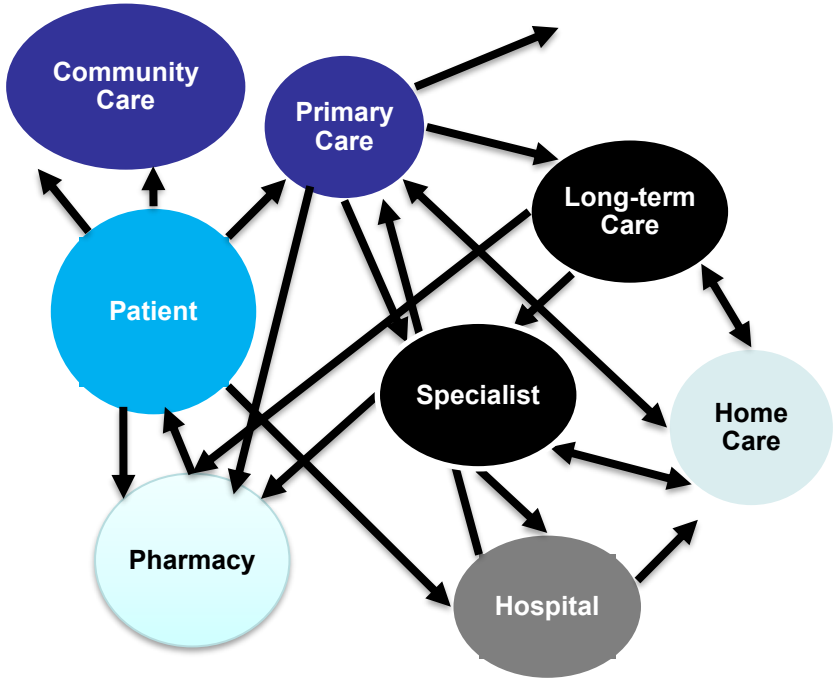
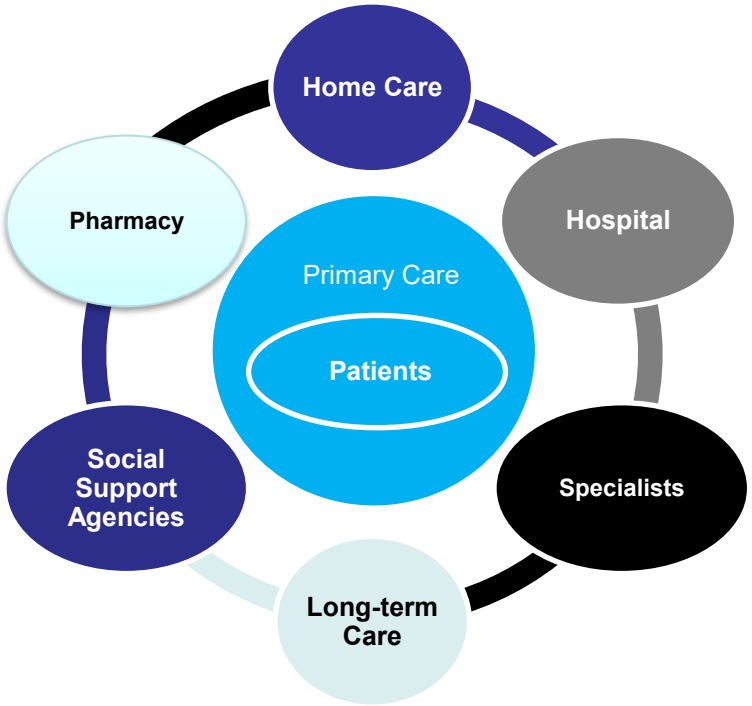


Whole Person Equitable Care



The Primary Care Imperative

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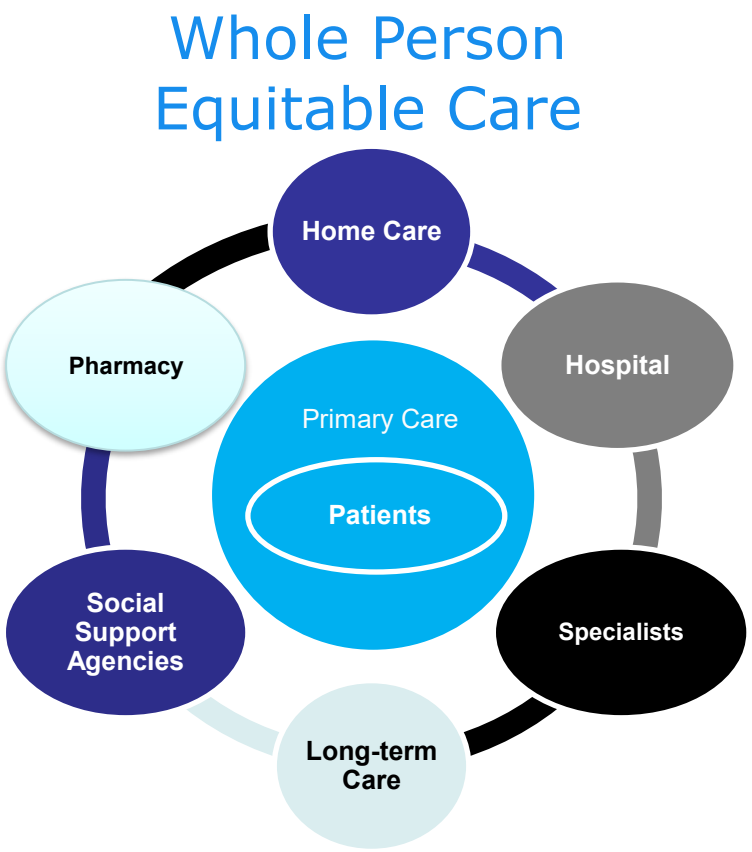
High performing primary care is at the heart of integration.

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



Your Journey: 2019-to date

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The Long and Winding Road

The Destination

High Performing Primary Care

So, what next? How does this help your work?

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Create a – local and provincial – **high-performing primary-care sector**
(regardless of the practice or funding model and location)

Your Associated TPA Requirements

- Develop a community-based plan for chronic disease prevention and management (CDPM), as well as an ALC action plan
- Increase participation in cancer screening
- Expand access to online appointment bookings
- Facilitate adoption and report on progress with eReferral solutions
- Curate information about local services

Corresponding Measurement Requirements

- CDPM
  - Hospitalization rate for ACSC
  - Admissions for HF & COPD
- Cancer screening
  - % of eligible people up-to-date with breast, cervical & colorectal screening
- Additional provider and patient experiences

What is high performing primary care?

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High Performing Primary Care

is

- **Equitable**
- **Culturally safe**
- **Collaborative**
- **Continuous**
- **Comprehensive/ Holistic**
- **Connected (digitally also)**
- **Accessible**
- **Accountable**
- **Coordinated**
- **Improving and Learning**

Driver Diagram for a High Performing Primary Care System

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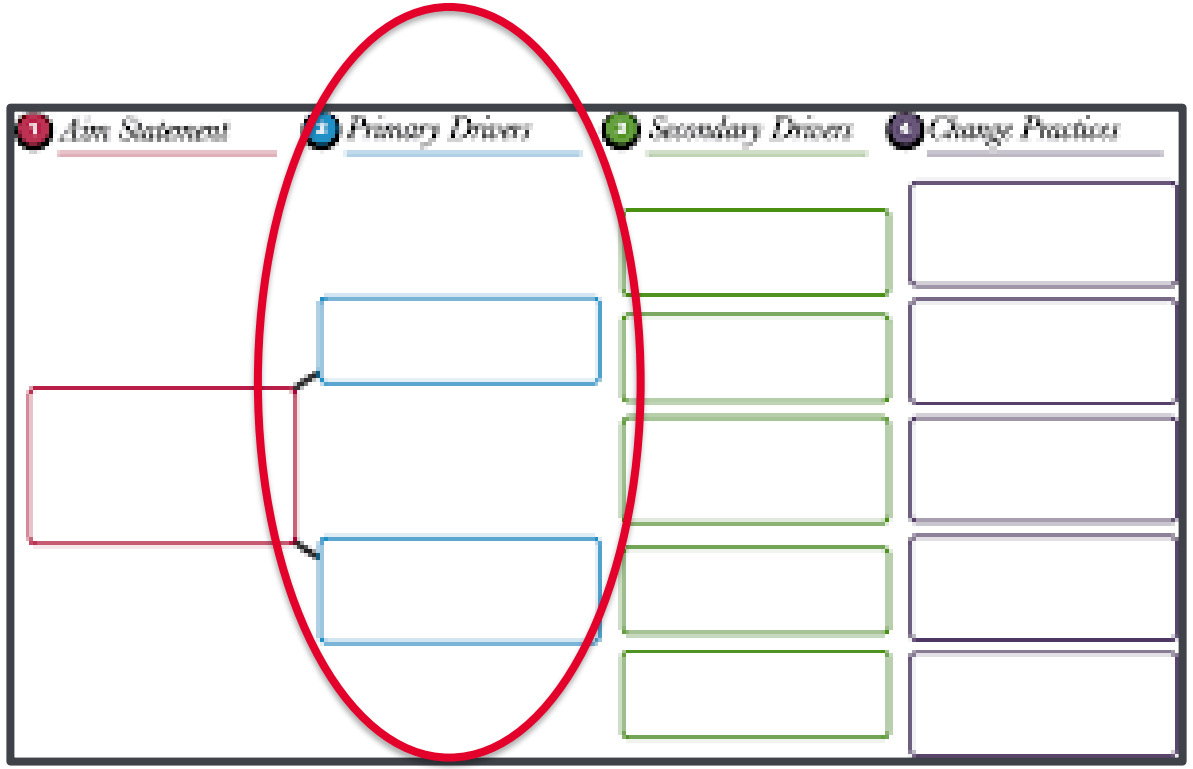
Others (Starfield, Bodenheimer, FLA OHT) have developed and described principles for a high performing primary care system.

In the following slides, we describe a **Theory of Change** – a map of specific actions that will lead to a high performing primary care system

To ultimately create a high performing primary care system, all primary drivers will need to be addressed



Driver Diagrams

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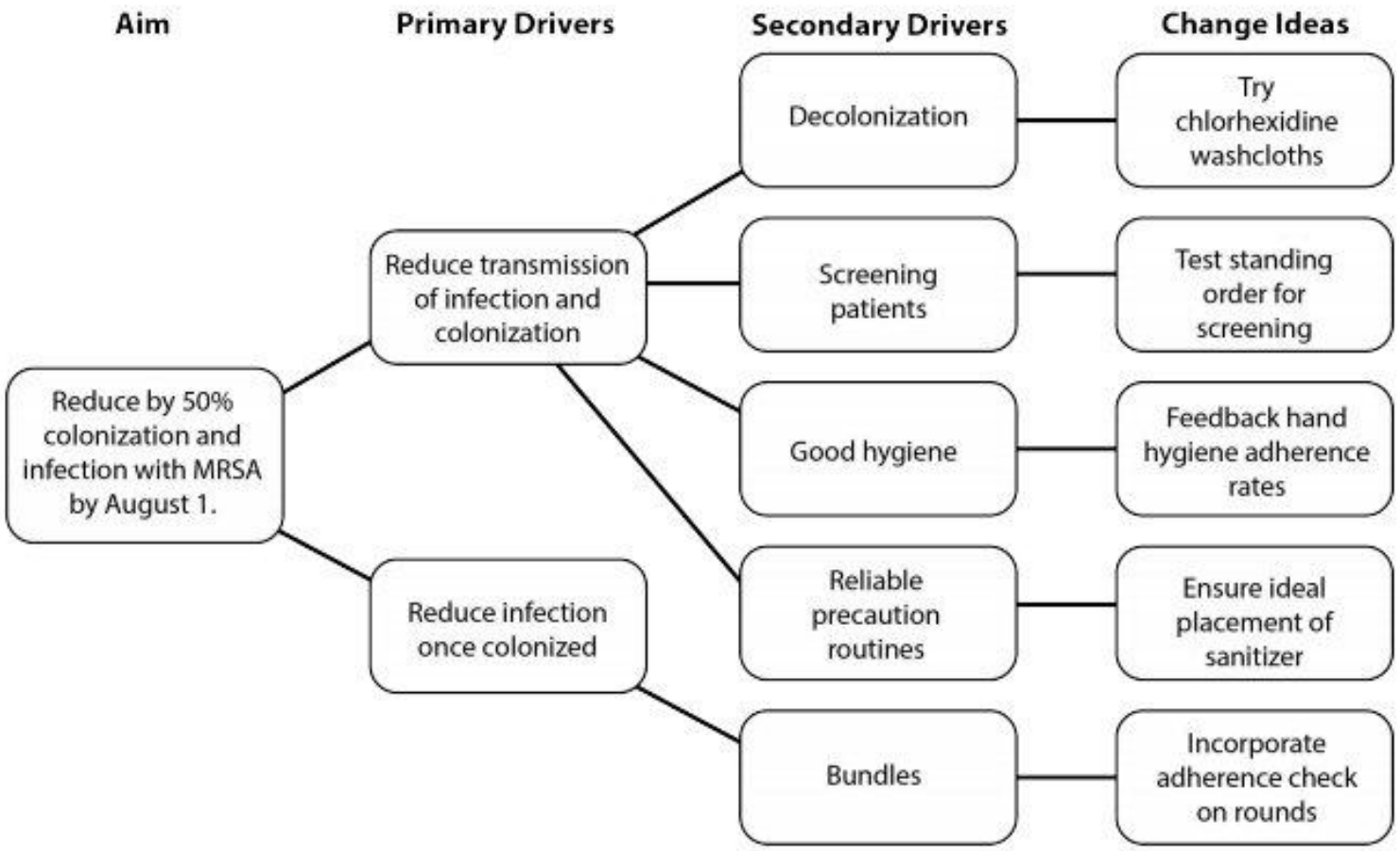
Example: Driver Diagram



AIM
What are we trying accomplish?

We aim to create an

- Equitable
- Culturally safe
- Collaborative
- Continuous
- Comprehensive/ Holistic
- Connected (digitally)
- Accessible
- Accountable
- Coordinated
- Continually learning and improving

Primary Care System

PRIMARY DRIVERS
Key contributor to aim

- Relational Continuity *(ongoing therapeutic relationship between a single healthcare provider (or a small team) and a patient)*
- Team-based Care *(team members vary by population needs but are inclusive of non-clinical staff)*
- Population Health Management Approach and Policies
- Timely Access to Care (i.e. prompt access to care when people need it)
- Efficient, effective skills-based governance (BB6)
- Learning Health System

SECONDARY DRIVERS *Components of the Primary Driver*

- Processes to support equitable relational continuity
- Reliable attachment processes (to FP/NP/ IP PC team)
- All clinicians, allied providers and staff value and pursue relational continuity
- Patients/clients understand and value continuity
- Provide coordinated care for all common conditions including CDPM
- Provide coordinated specialtyy care
- Health and social services available to meet varied needs
- All team members working to full scope of practice
- Identify populations to serve and understand their needs
- Segment for Needs, Risk and Barriers (including SDOS)
- Co-design person-centered care models and service mix (including preventive care
- Consider reach into vulnerable at-risk populations and a phased approach to spread/scale
- Use an equity-centered quadruple aim approach
- Understand needs, supply and demand of appointments
- Reduce demand for appointments
- Increase supply of appointments
- Increase efficiency of non-clinical work (i.e. referral processes
- Provide care close to home or via equitable virtual options
- System supported by trusting relationships
- Patient partnerships
- Ongoing community engagement
- Decisions made with system partners including clinicians

CHANGE IDEAS and STRATEGIES *(examples)*

Given the complexity of building a High Performing Primary Care Sector, all changes cannot be captured in one driver diagram.

To capture more detail, individual driver diagrams have been created for each primary driver in this system level driver diagram. Please see the following pages for the detailed primary drivers.

- Analytics and population insights
- Evidence synthesis
- Patient caregiver provider community co-design
- Evaluation Feedback and Adaptation
- Culture of Learning and Improvement

DRAFT – Driver Diagrams are evolving maps.
RISE and the OHTs will continual revise this work
as new evidence becomes available or secular trends suggest revisions.

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Primary Care System

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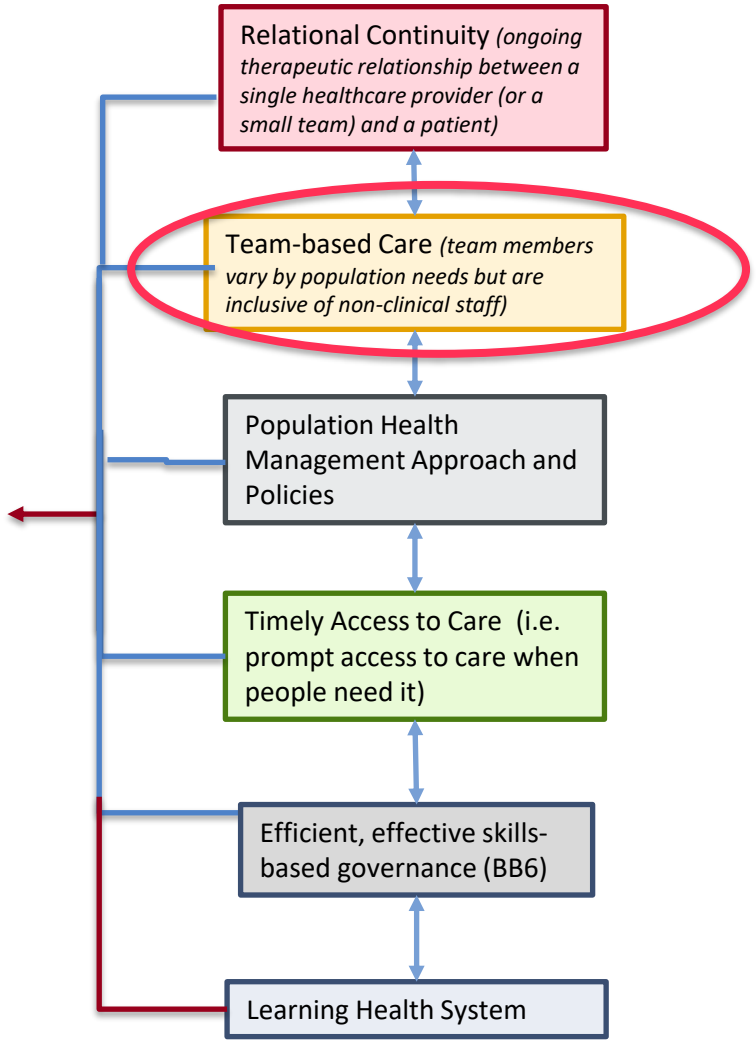
Key contributor to aim

SECONDARY DRIVERS

Components of the Primary Driver



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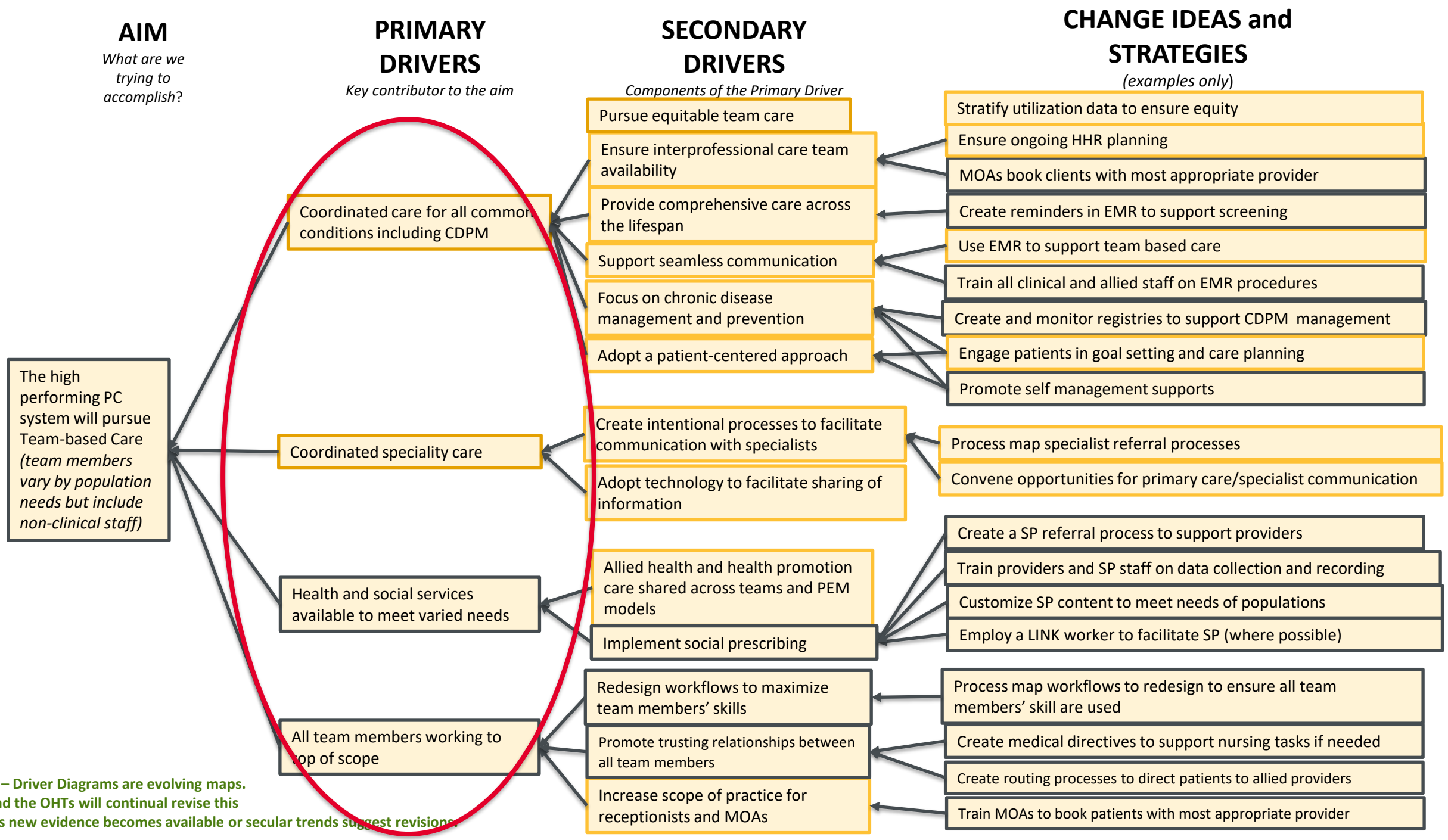

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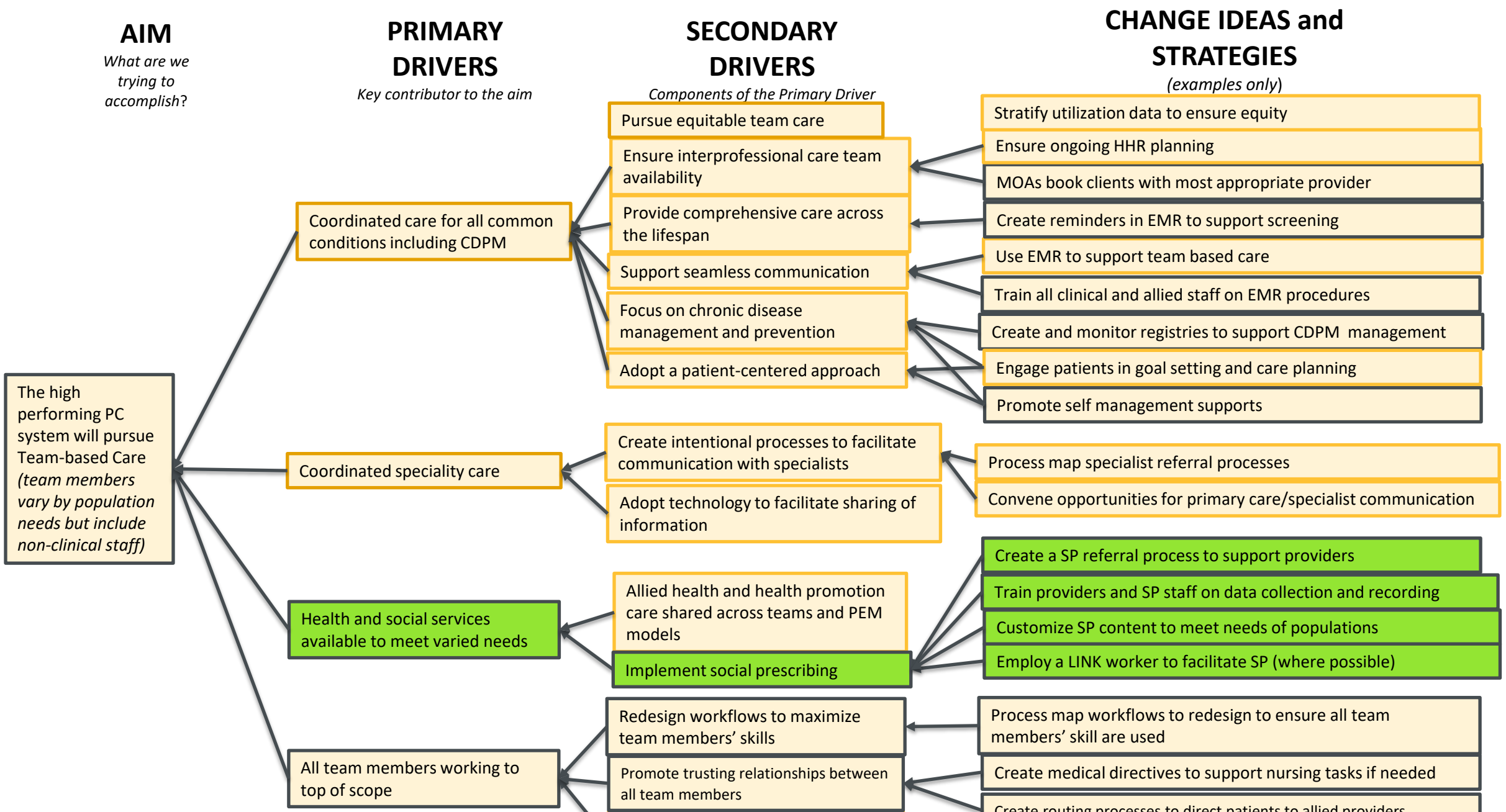

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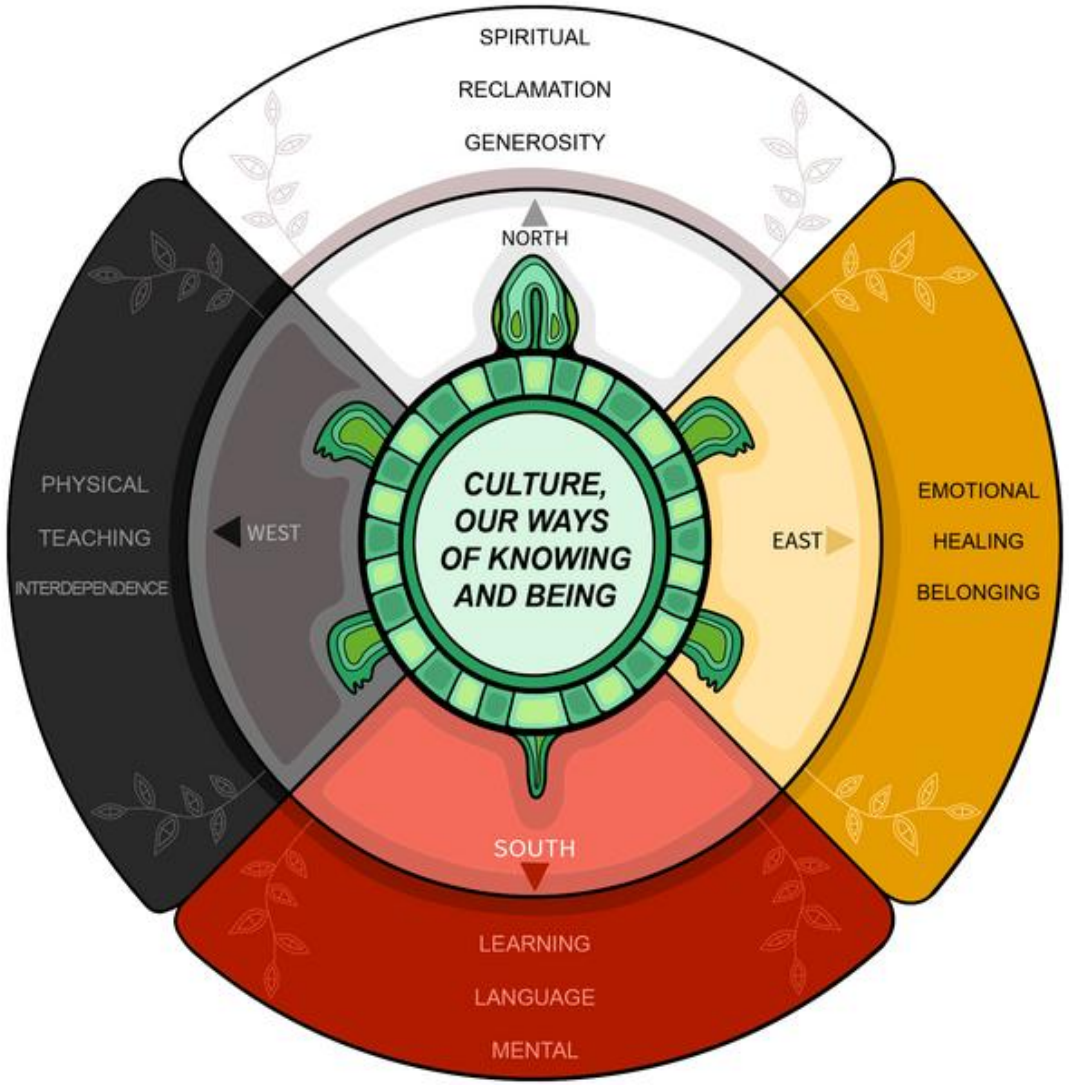
Health Equity Focused Social Prescribing

Natasha Beaudin (she/her/elle) --Je parle français--
Social Prescribing Project Lead| Responsable pour le projet de la prescription sociale
Alliance for Healthier Communities | Alliance pour des communautés en santé
Natasha.Beaudin@allianceON.org

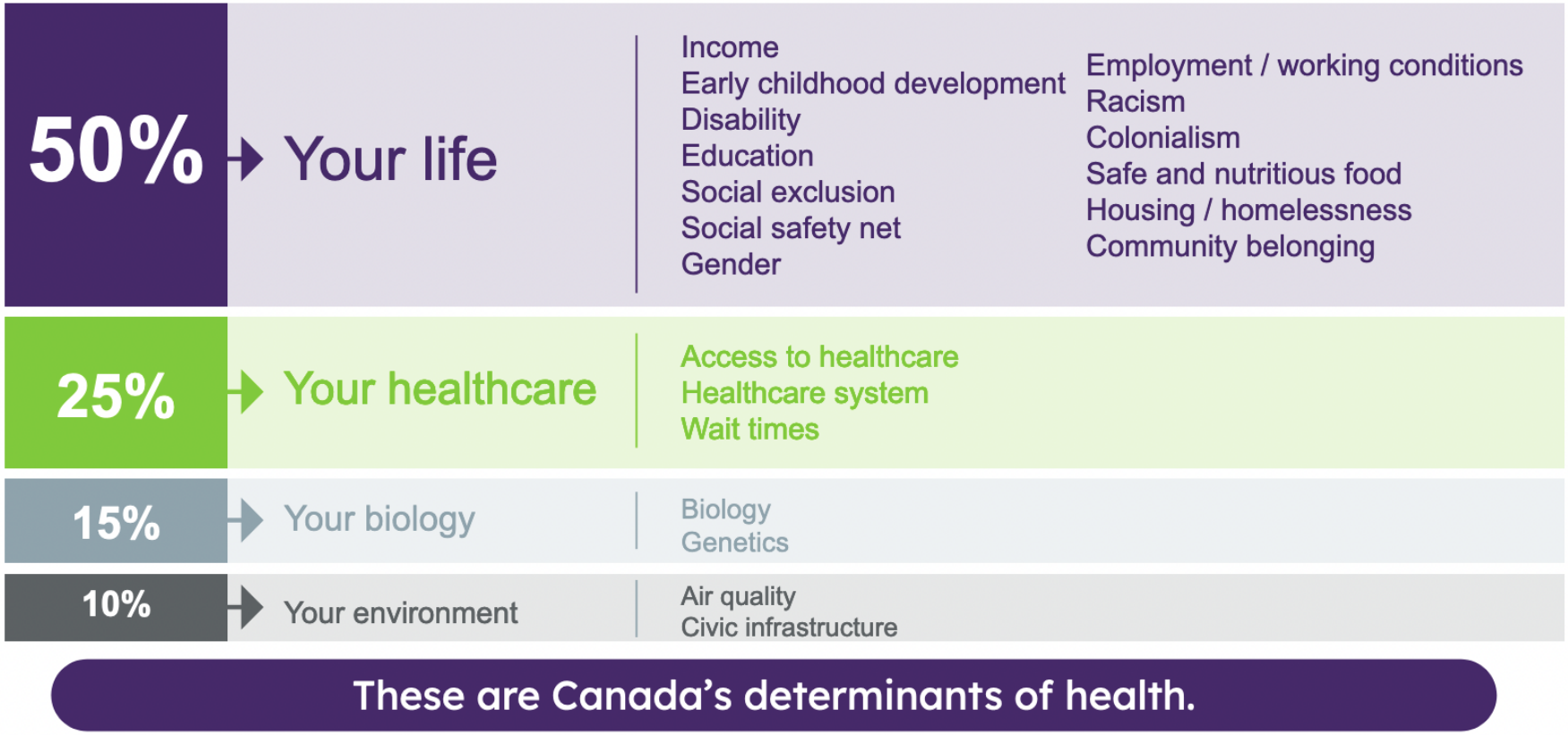
Alliance for Healthier Communities
Alliance pour des communautés en santé

SOCIAL PRESCRIBING AND THE MODEL OF HEALTH & WELLBEING



What is something that is non-clinical that supports your wellbeing?

What makes Canadians sick?



Canadian Medical Association (2013). *Health care in Canada: What makes us sick?: Canadian Medical Association Town Hall Report.*

WHAT IS SOCIAL PRESCRIBING

Guelph CHC Soup & Symphony event

- An intentional, structured way of connecting people with a range of local, non-clinical services, to address the determinants of health and wellbeing for people accessing primary care.
- Social prescribing can look different for each community depending on resources and supports.
- Health equity is a cornerstone of effective social prescribing. Successfully implementing a social prescribing program means removing the barriers clients experience.

Instead of asking "What is the matter with you?" let's start asking
What matters to you?"

5 KEY COMPONENTS OF THE PATHWAY

Client

Individual with social and medical needs, interests, and gifts.

Data tracking

Track client journey, follow-up, and improve through a Learning Health System.

Prescriber

Healthcare provider identifies non-medical issues and makes a social presription referral

Navigator/Connector

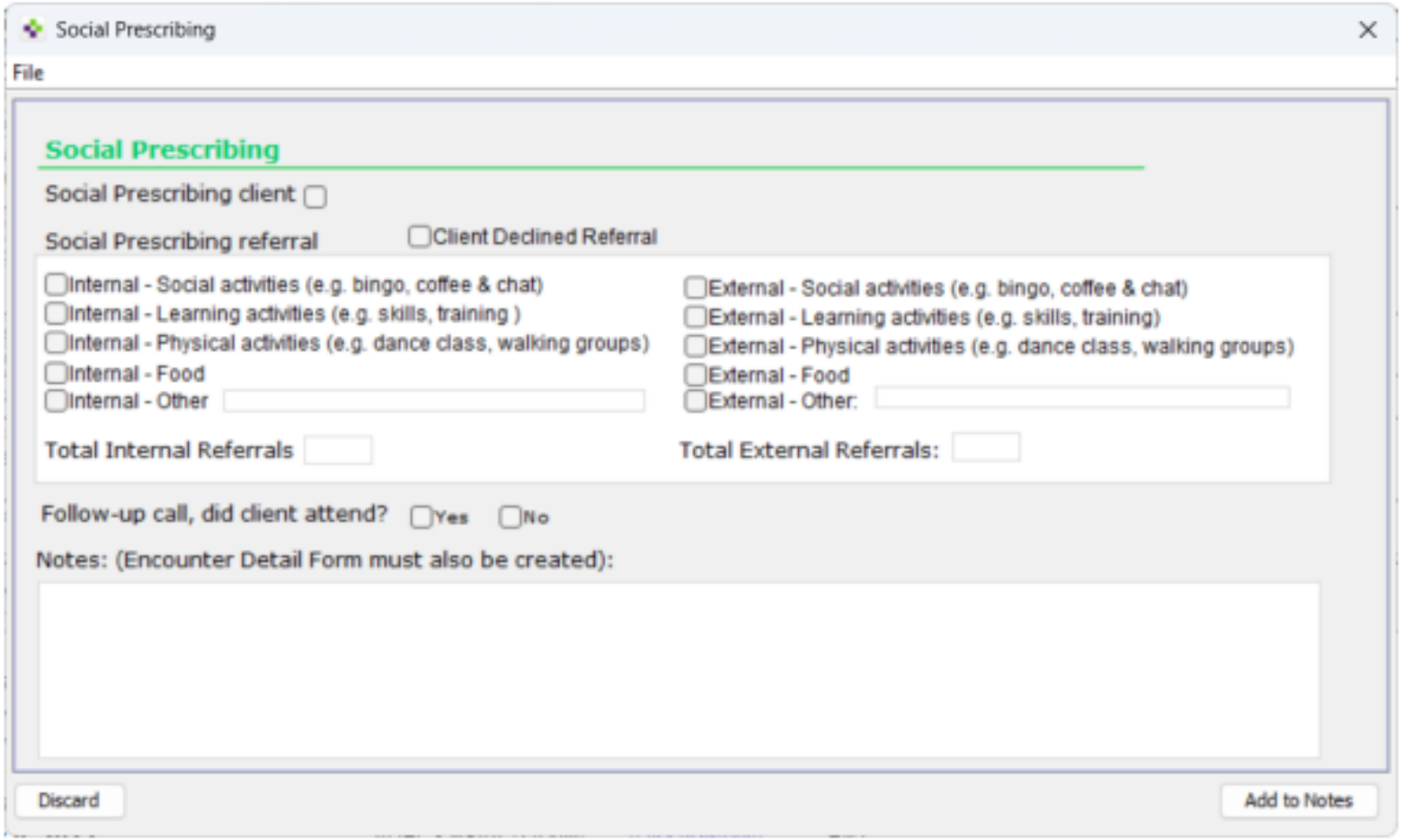
Connects individual to appropriate resources based on self-identified interests and needs, and supports their journey to wellbeing.

Social Prescription

Individual connected to social and community supports with invitation to engage, co-create and give back.

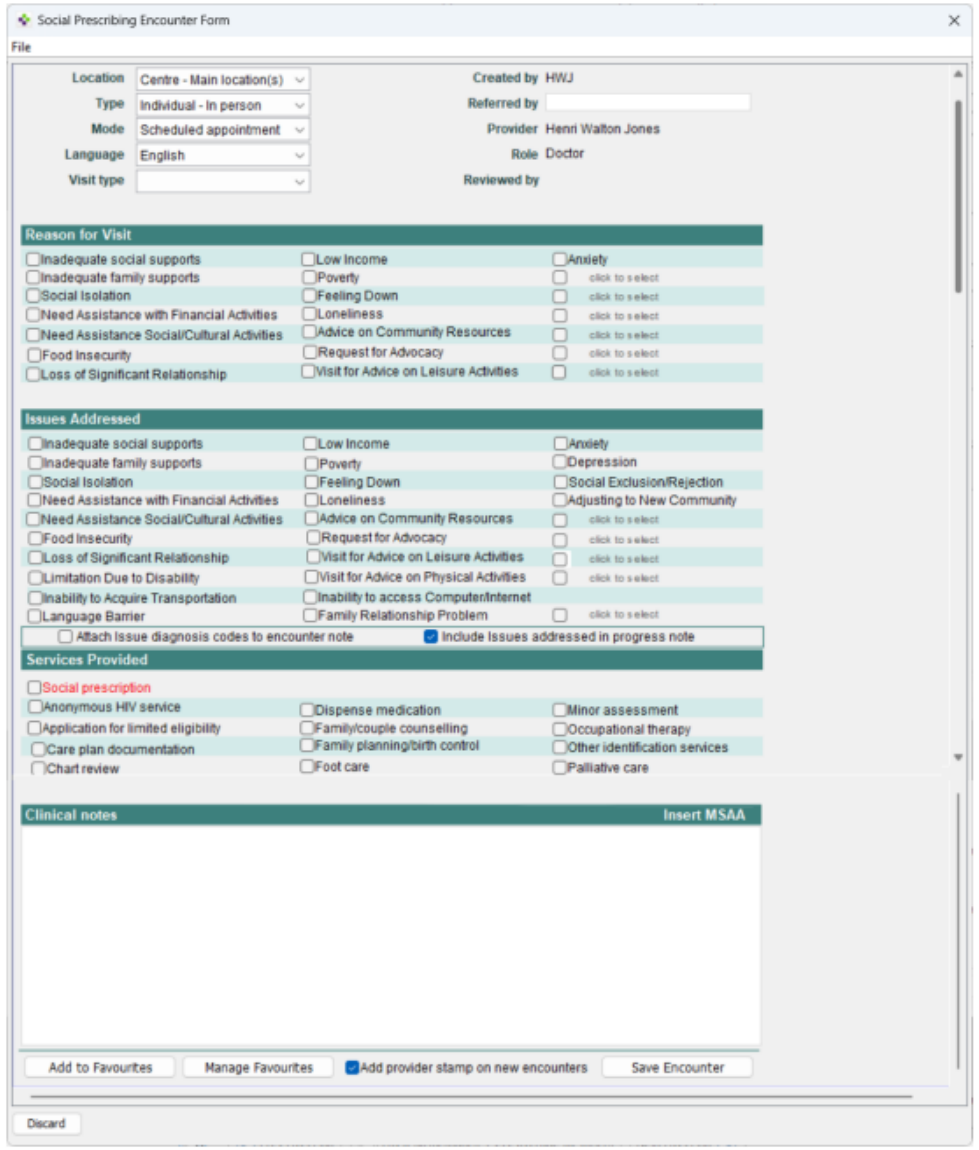
SP ENCOUNTER FORM IN EMR

Figure 2: Screenshot of Social Prescribing Form in PSS.



SP ENCOUNTER FORM IN EMR

Figure 1: Screenshot of Social Prescribing Encounter Form in PSS.



Social Prescribing for Better Mental Health

Link Workers Work!

Their work:

- **Strengthens Community Resilience**
- **Reduces Health inequalities**
- **addressing wider determinants of health**
- **Increases involvement in local communities**
- **Focuses on gradual & holistic change**
- **Increases primary care capacity & decreases repeat client visits, as well as ER visits**

Link Workers Work

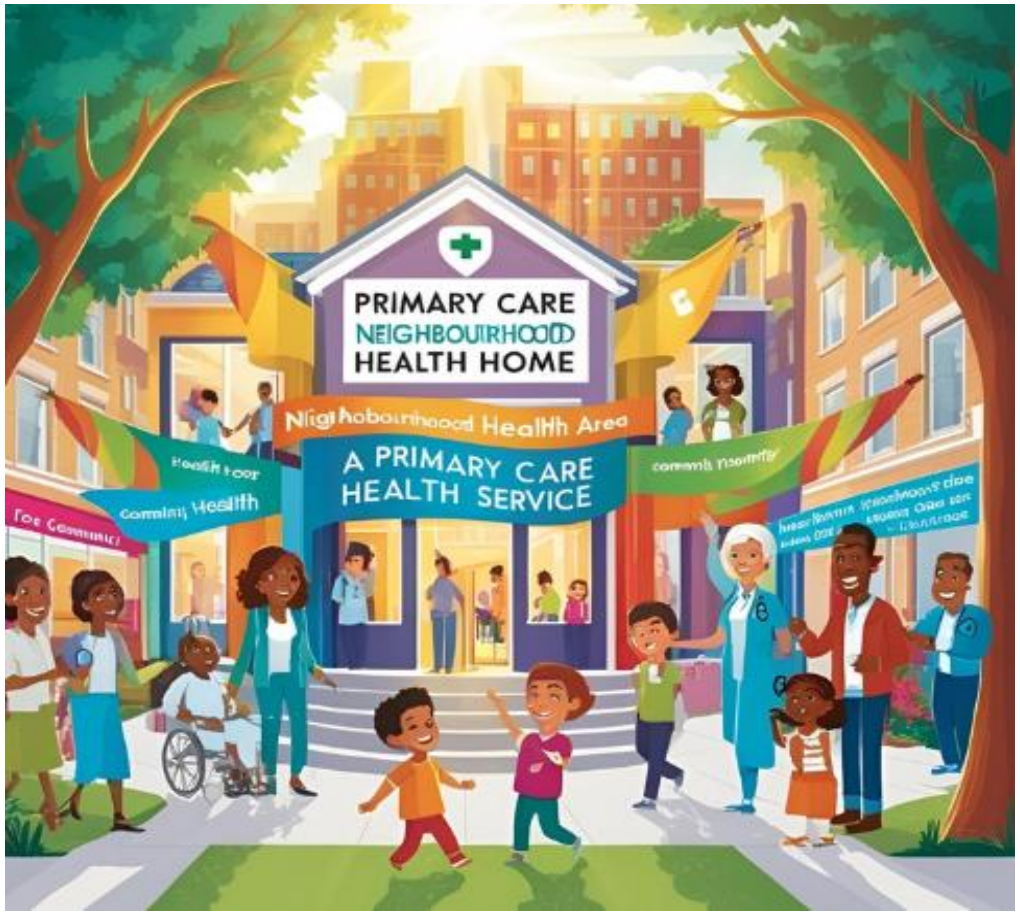
In the Alliance's Rx: Community SP Pilot Study, 42% of providers reported that they observed a decrease in the number of repeat visits among their clients who participated in a Social Prescribing Program

According to a recent survey, 59% of family doctors stated they think that social prescribing can help reduce work load.

Survey results from CHCs participating in our SP for BMH project shows that:

- **96% of health providers strongly agreed or agreed that collaborating with SP staff is helpful for supporting their clients**
- **96% of clients felt that a link worker heard their needs and interests very well or somewhat well when they were first connected to programs**

Vision: Neighbourhood Health Home that Centres Equity at the Core



- Health Homes nestled within neighbourhoods serving people from geographical areas or priority populations
- Every person will have barrier-free access to an interprofessional team, health promotion and community supports
- Community members involved with governance, decision-making and co-design
- Build on existing team-based primary care models (and establishing new ones where necessary) – hub and spoke model
- Primary Care Networks – essential to co-design and oversight

Social Prescription and the Community Connector Role

	Social Rx	Not Social Rx
Nature and urgency of need	• Social rx are proactive and upstream • Social rx are non-crisis, non-medical	• Social rx are not reactive responses to crisis and do not address immediate complex, health or social needs
Social needs	• Social rx focus on reducing social isolation • A key focus of the Community Connector role is to link clients with community resources and programs that create opportunities for them to build social connections, participate in activities that bring them joy and foster their sense of purpose and belonging	• Social rx do not address complex social needs (eg. working with F&CS, housing, ODSP, OW)
Encountering	• Social rx requires tracking of referrals in EMR • Social rx can be made in PSS by selecting Internal Referral → Social Prescribing	• No formal tracking in EMR
Co-creation	• Social rx requires co-creation to design solutions with the client	• Solutions determine by staff
Examples	• Social rx can be made for things like: connecting client to internal or external community programs/services (eg. social, art, cooking, physical activity, personal development, volunteering, nature) with a special focus on reducing social isolation, attending programs with client for warm introduction, filling out forms (eg. FAIR, mobility bus, Pet protect), check in calls, provide resources for technology supports and non-urgent food supports, etc.	• Social rx should not be made for tasks like trips to medical appointments, wellness calls, obtaining basic needs(other than non-urgent food supports), fixing of technology, etc.

Note: Medical and complex social determinant of health supports provided by primary care providers and allied health staff

Social Prescribing

What is Social Prescribing?

A healthcare tool that matches individuals with community resources based on their interests and goals to support overall health and wellbeing.

How Does it Work?

First, schedule an appointment with our community navigator. Together, you will explore local opportunities that best suit your interests, hobbies, goals and needs.

Social Prescribing Offers Support Beyond Medication

- Learn a new skill
- Participate in a new activity
- Improve your mental and physical health
- Meet new people
- Increase self-confidence and self-esteem
- Expand your community connections and belonging

HOW TO ACCESS THE SOCIAL PRESCRIBING PROGRAM:

Grand Bend Area Community Health Centre

Ask your provider to refer you today!
Contact our Community Navigator at
519-262-3140 ext. 202 or
gbonnett@gbchc.com.

Examples of Social Prescriptions:

Health & Wellbeing

- Access to groups and activities for physical activity
- Connections to community groups and service clubs

Careers & Employment

- Connections to employment counselling and support
- Education resources and job skill training

Seniors & Care Providers

- Grocery and meal programs
- Transportation
- Home supports
- Social opportunities
- Access to programs e.g., falls prevention, bone health, caregiver support
- Referrals to adult-day programs

Food & Nutrition

- Local food bank access
- Dietitian referrals
- Connection to the Hensall community fridge and community kitchen programs

Social Support

- Services and resources for mental health support
- Grief support
- Cultural programs

System Support

- Transportation
- Housing
- Financial support navigation

Volunteering

- Assistance in providing and finding volunteer opportunities
- Support with skills and required training

Asset mapping

Every community has assets: resources, programs, people or places

An asset map is a list of resources clients could be connected to, organised by categories such as location, language of services, and any other relevant criteria.

You can consult provincial or regional database resources (e.g. Ontario 211 or the Ontario Caregiver Organization Hotline)

Potential Partners

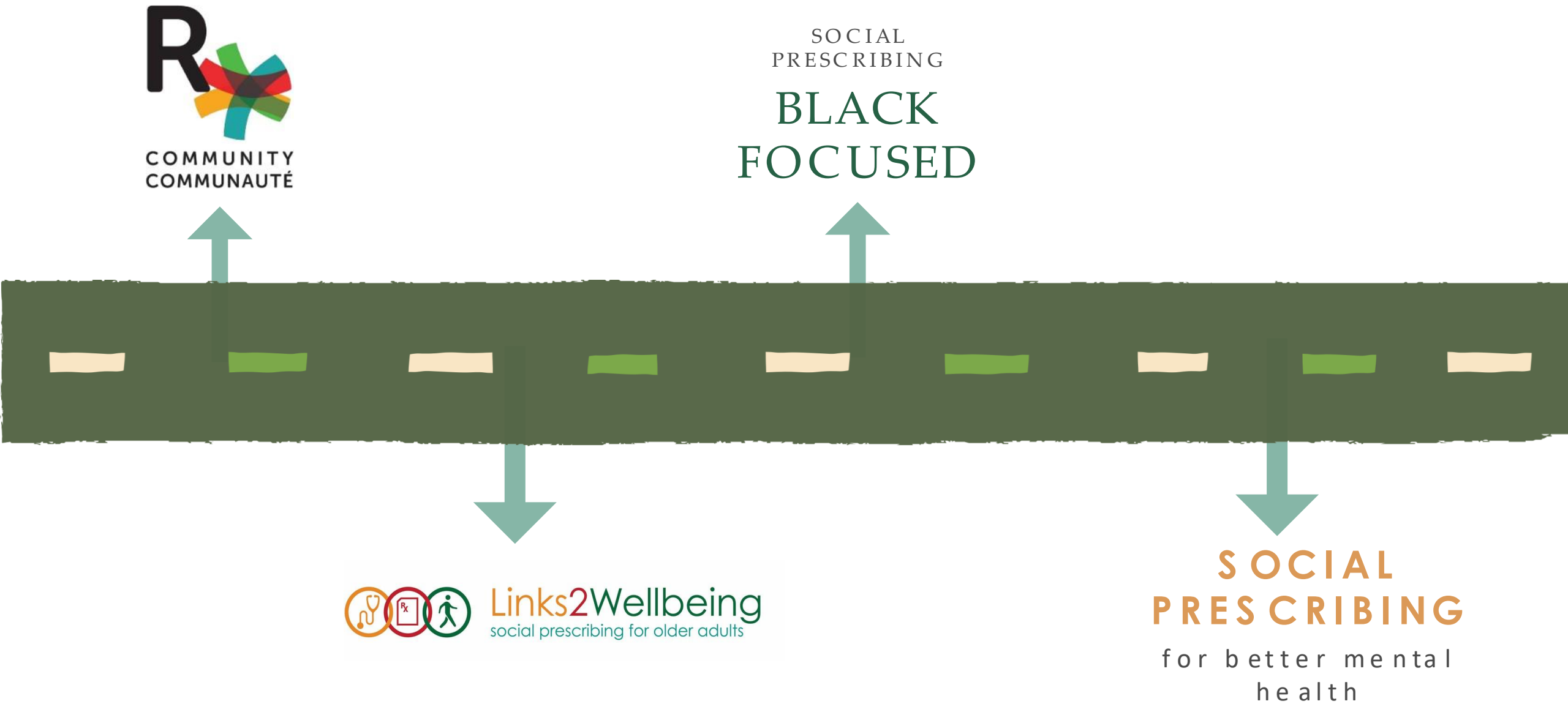
211

Older Adult Centres' Association of Ontario
Association des centres pour aînés de l'Ontario
OACAO
The Voice of Older Adult Centres
La voix des centres pour aînés
celebrating 50 1973 – 2023

Find an Older Adult Centre

THE ONTARIO caregiver ORGANIZATION

THE SOCIAL PRESCRIBING JOURNEY AT THE ALLIANCE



Black Focused Social Prescribing

BFSP is a 2.5-year pilot initiative that aims to augment social prescribing practices by developing and applying a culturally affirming model of care, specifically designed to address the unique health inequities faced by ACB communities.

The pilot was implemented by The Alliance for Healthier Communities ("Alliance"), in collaboration with four Community Health Centres (CHCs) in Ontario: Black Creek, Somerset West, TAIBU, and Rexdale.

Through BFSP, dedicated staff called Link Navigators connect clients to programs and services. These Navigators work with both clinical and non-clinical Providers to help clients access the care and resources they need. The program is supported by CHC managers who ensure it runs smoothly, while the Alliance provides overall project management and support to participating CHCs.

4,000+

Clients attended cultural programs and community events during the BFSP pilot.

1,600+

Clients received social prescriptions, linking them to essential community resources such as mental health support, cultural activities, and food security initiatives.

Guided by the Seven Principles of Kwanzaa, BFSP reflects the cultural perspectives, values, and lived experiences of ACB communities to meaningfully and effectively support their wellbeing and access to healthcare.

Umoja
Unity

Kujichagulia
Self-Determination

Ujima
Collective Work and Responsibility

Ujamaa
Cooperative Economics

Nia
Purpose

Kuumba
Creativity

Imani
Faith

Black Focused Social Prescribing: Results

89%
of participants reported feeling a stronger sense of belonging with their community

90%
of participants reported that their trust in service-providers had increased

87%
felt their health and wellbeing had improved

40%
participated in culturally affirming wellness activities

30%
engaged in mental health services

CENTRE DE SANTÉ COMMUNAUTAIRE
BLACK CREEK
COMMUNITY HEALTH CENTRE

Other examples of SP in Ontario…

Chatham Kent OHT starting to integrate referrals to 211 navigators into hospital EMR

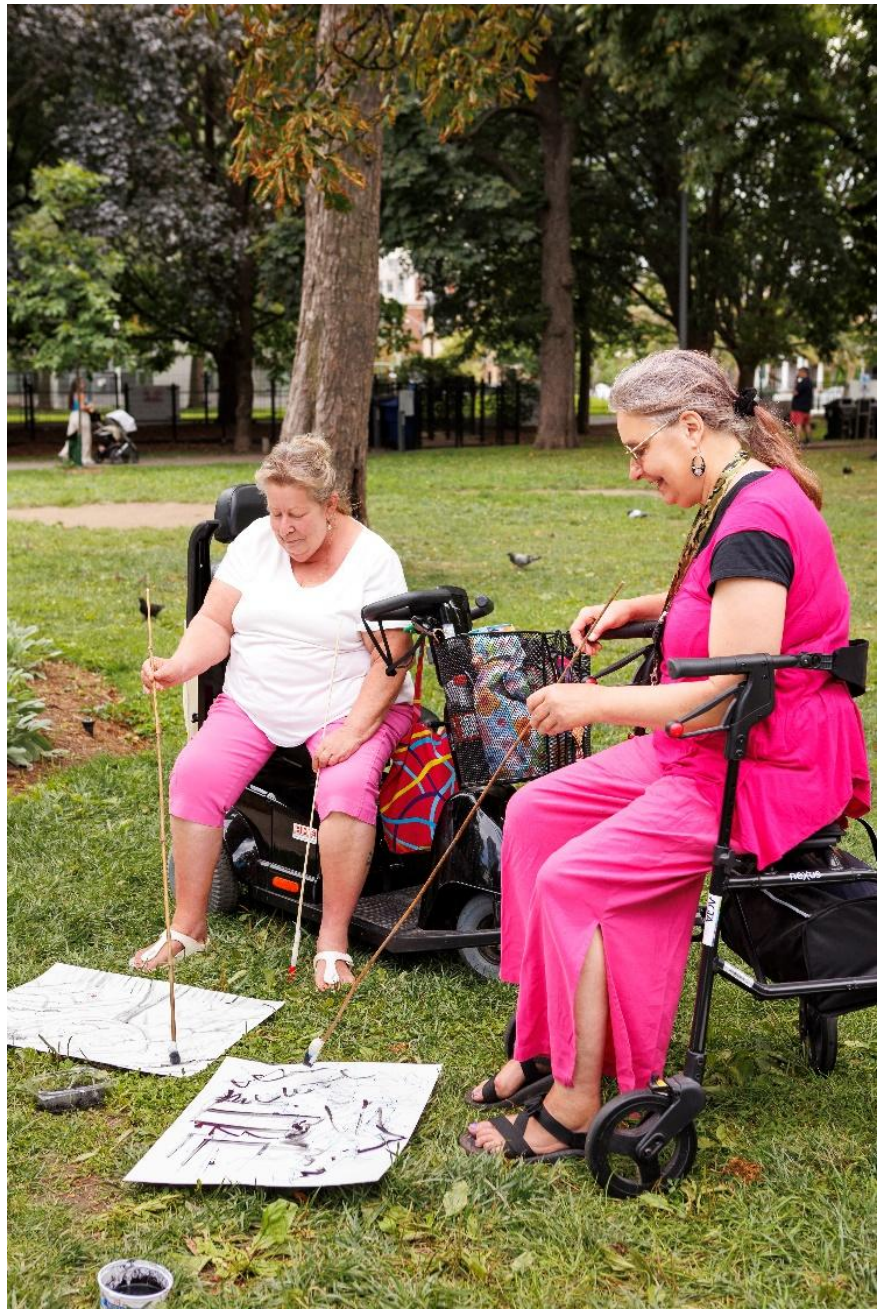
McMaster Childrens hospital building SP as part of Pediatric Complex Care Unit

HEC SP Paramedic program – Community paramedics referring to linkworker at CHC

Western Ottawa CRC partnering with Richmond Medical Clinic to provide linkworker & mental health services to clinic patients

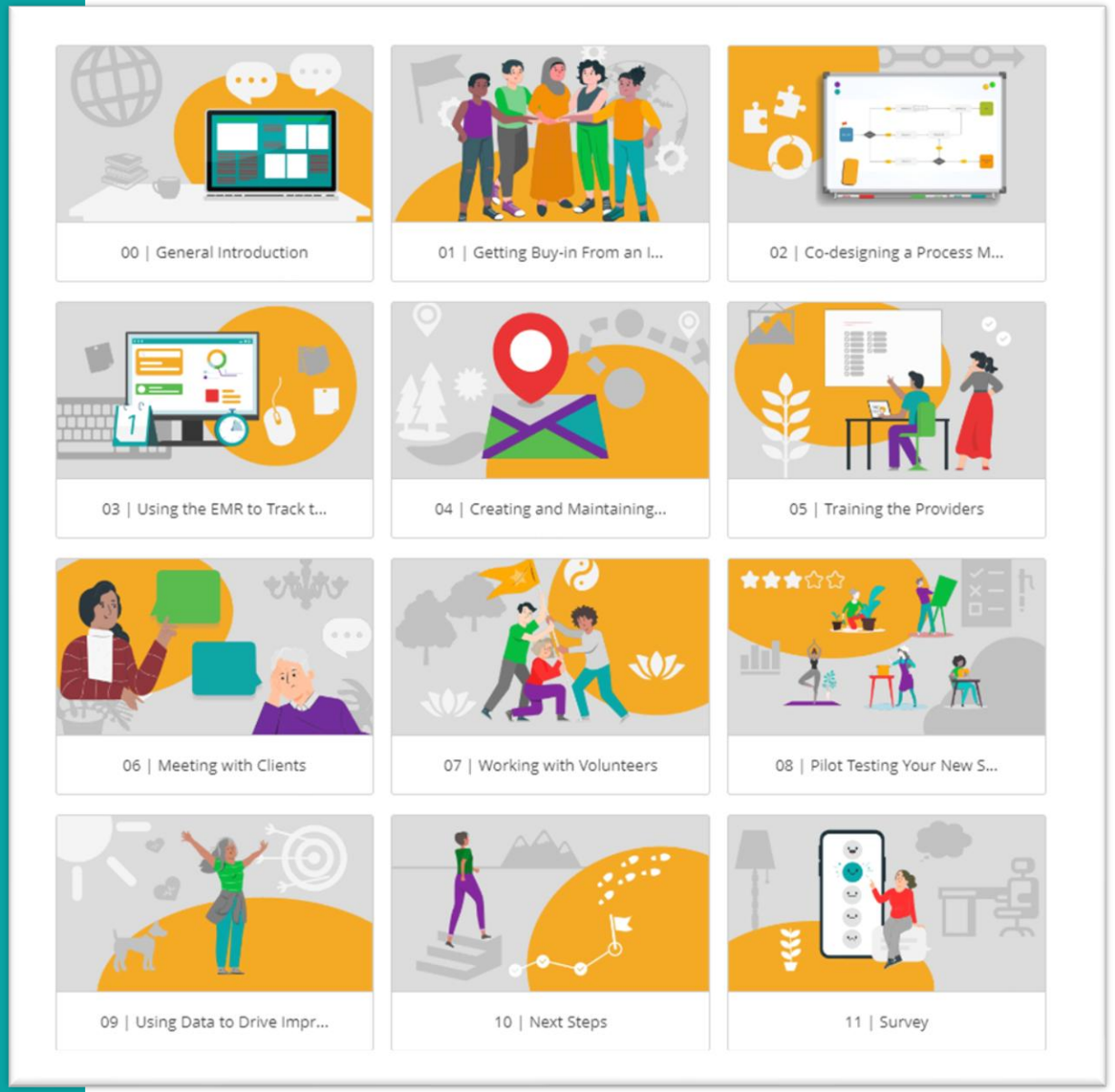
- https://tools.cep.health/tool/social-prescribing/

- **Five** project profile videos, available online on our Social Prescribing YouTube channel



HOW TO GET INVOLVED

- Ontario Social Prescribing Community of Practice
- Canadian Social Prescribing Community of Practice
- Online Learning Modules
- **www.allianceon.org/Social-Prescribing**



Social Prescribing Online Course

- **Now available in English and French!**
- **Build a social prescribing pathway that advances health equity**
- **Modules designed for health care teams**
- **Clinicians module eligible for .5 CERT/Mainpro+ credits**

Alliance for Healthier Communities
Alliance pour des communautés en santé

FINAL REPORTS

- Links2Wellbeing Final Report
- Social Prescribing for Better Mental Health Final Report
- LinkWorkers Work Document
- The Black-Focused
- Social Prescribing Program
- **www.allianceon.org/Social-Prescribing #keyresources**

Call to Action!

- Ensure that Social Prescribing and Linkworkers are included in plans to create Primary Care Attachment for people in Ontario
- Provide all interested health providers with access to linkworkers & health promoters
- to support their clients
- Advocate for Neighbourhood Health Home, a model that provides barrier-free access to an interprofessional team, health promotion and community supports

Questions?

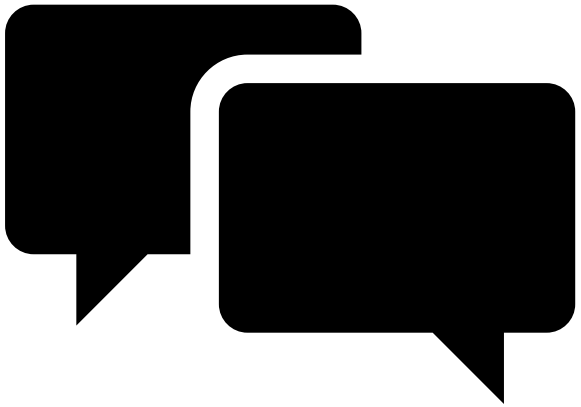
Natasha.Beaudin@AllianceON.org

www.allianceon.org/Social-Prescribing

Merci / Thank you/ Meegwetch

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



Identifying team-based primary care change ideas

30 minutes

1. **Please stay in the Zoom meeting**
2. **There will be three options for participating in the discussion**
   - **Option 1:** Click on the link to Mural provided in the chat box and post on the board (you do not need a Mural account to access)
   - Option 2: Unmute your mic (a RISE rep will add your comments to the board)
   - Option 3: Leverage the Zoom chat box (a RISE rep will add your comments to the board)
3. **RISE will share the Mural board on-screen and provide a demo of Mural**
4. **RISE coaches will provide an overview of the activity**

We are currently offering three types of RISE supports for OHTs/PCNs

RISE
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RISE peer sharing and learning sessions

Monthly sessions which provide evidence-based core concepts and principles on PC-related topics connected to OHT/PCN deliverables and building a high-performing PC sector

Coaching

Customized 1:1 or group supports based on OHT/PCN need

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)

Audience / participants

Those from OHTs/PCNs who are leading PC work and those participating in OHT/PCN PC working groups

Deep dive: Process of attachment

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RISE facilitated a two-session series for those leading PC work in OHTs and PCNs to 'dive deeper' into the process of attachment

Objectives of this series include:

- ✓ Understand what elements of the attachment processes are required to be successful and which can be customized
- ✓ Discussions with peer OHTs/PCNs at similar stages to share learnings on what worked well and to solve problems

Due to OHT and PCN feedback, these sessions will now be extended and open to more teams.

If you're interested in joining, please reach out to leslie.mcgeoch@outlook.com to register by Nov 28th

Please note, for new teams joining 'catch-up' work will be required (20 min recording).

NEW!

RISE facilitated primary care shared space

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Rapid-Improvement Support and Exchange

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RISE
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January 15, 2025 (12-1:30pm)

Next RISE OHT peer sharing & learning session will continue to focus on creating high performing primary care

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

RISE
Rapid-Improvement Support and Exchange

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Thank you