RISE
Rapid-Improvement Support and Exchange

Improving the primary care system in your local community

18 June 2026

https://youtu.be/wvkYjLST4eQ

McMaster University | HEALTH FORUM
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Trillium Health Partners
INSTITUTE FOR BETTER HEALTH

RISE facilitated primary care shared space

RISE
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Staying 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

Objectives for Today

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This session is meant to help OHTs and PCNs and those working in PC to achieve their TPA deliverables and priorities (including advancing local primary care access and attachment) aligned with Ontario's Primary Care Action Plan.

- ✓ understand key drivers to improving the primary-care system that enables attachment and building IPCTs
- ✓ learn through real-life examples of PC system development
- ✓ obtain a shared understanding of key terms
- ✓ learn about 2026/2027 RISE supports for OHTs/PCNs and RISE's collaboration with the Association of Family Health Teams of Ontario (AFHTO) and the Ontario College of Family Physicians (OCFP).

RISE Coaching Preparations for 2026-27

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What we did

- Emailed OHT/PCN leads in the 58 OHTs inviting them to inform RISE supports for 2026-27
- 34 responded and interviews were conducted during April and May with leads and frontline providers

What we heard from OHTs/PCNs

In addition to themes (like leadership) which we have heard from other sources, below is a list from OHTs/PCNs:

- Interest in primary care system change but with more “how to” support: practical, replicable examples
- Building and sustaining primary care teams and “teamness”
- How to engage primary care
- Attachment and access within primary care operations
- Data for PHM and equity across the various primary care models
- Governance and relationship building
- Digital enablement and scalability
- RISE sessions to be more interactive, breakouts by similar geography/models, some sessions with peers only and “not over lunch!”

Redesigning RISE program of supports for 2026-27

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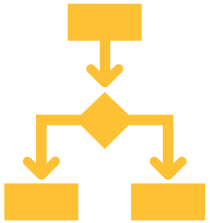
Monthly peer sharing and learning sessions

- **When:** Monthly (3rd Thursday, 11am-12pm)
- **Who**: Open to all
- **What:**
  - Didactic overview of core concepts & principles
  - Illustrative examples of “how to” from peers
  - Facilitated discussions with participants



Peer Problem-solving sessions

- **When:** Monthly (4th Thursday, 11am-12pm)
- **Who**: Session just for PC working group members (including those leading PC clinics)
- **What:** Interactive session driven by OHTs/PCNs focused on solving specific problems related to the peer sharing & learning session topic

Working group coaching

- **When:** as needed/identified by OHT/PCN
- **Who:** Individual or groups ofl OHT/PCN primary care related working groups (e.g., PC attachment, PC development of CDPM etc.)
- **What:** Supports are customized to the team. Examples could include:
  - Providing support and guidance at monthly OHT/PCN PC working group meetings
  - Pre-meets with co-leads to support planning and progression of work
  - Providing quality improvement supports
  - Sustainable scale and spread/implementation guidance
  - Connecting to other resources and OHTs/PCNs

Online shared spaces: for resource sharing & posting questions between sessions.

Translating your feedback into a series of sessions

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Peer sharing and learning session topics

Today!
- Orientation to improving your local PC system

July
- 'Staging the work' for improving your local PC system

August
- Break

September
Placeholder: Engaging PC (TBC)

October
Placeholder: Planning local staffing models (TBC)

Potential topics for subsequent months
- Improving access
- Integration of PC with community and specialty care (e.g., COPD/HF etc.)
- Building trust to enable sustainable spread and scale

Each peer sharing & learning session topic will be followed by a peer problem solving session which will work through the specific details of topic

We will continue to adjust and adapt based on your feedback!

Orientation to improving primary care at your local OHT and PCN

DON'T' GET CONFUSED BY THE ARRAY OF LABELS USED IN ONTARIO

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6 objectives from the Primary Care Act

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The Government of Ontario shall have the following objectives in its design, implementation and maintenance of the publicly funded primary care system within Ontario:

1. **Province-wide:** Insured persons across the Province should have the opportunity to have a documented and ongoing relationship with a primary care clinician or team.

2. **Connected:** Insured persons should have the opportunity to receive primary care services that are co-ordinated with existing health and social services.

3. **Convenient:** Insured persons should have access to timely primary care services.

4. **Inclusive**: Insured persons should have the opportunity to receive primary care services that are free from barriers and free from discrimination prohibited by the Human Rights Code or the Canadian Charter of Rights and Freedoms.

5. **Empowered:** Insured persons should have the opportunity to access their personal health information through a digitally-integrated primary care system that connects insured persons to clinicians involved in their care.

6. **Responsive:** The primary care system should respond to the needs of the communities it serves, and insured persons should have access to information about how the system is performing and adapting.

Source: Primary Care Act, 2025, S.O. 2025, c. 8 - Bill 13 | ontario.ca

Improving Primary Care Systems: Principles & Drivers

Principles
What are we trying to accomplish?

Improving Primary Care to ensure it is:

- continuous
- collaborative
- accessible
- comprehensive & coordinated
- equitable & culturally safe
- connected digitally
- accountable
- learning & improving

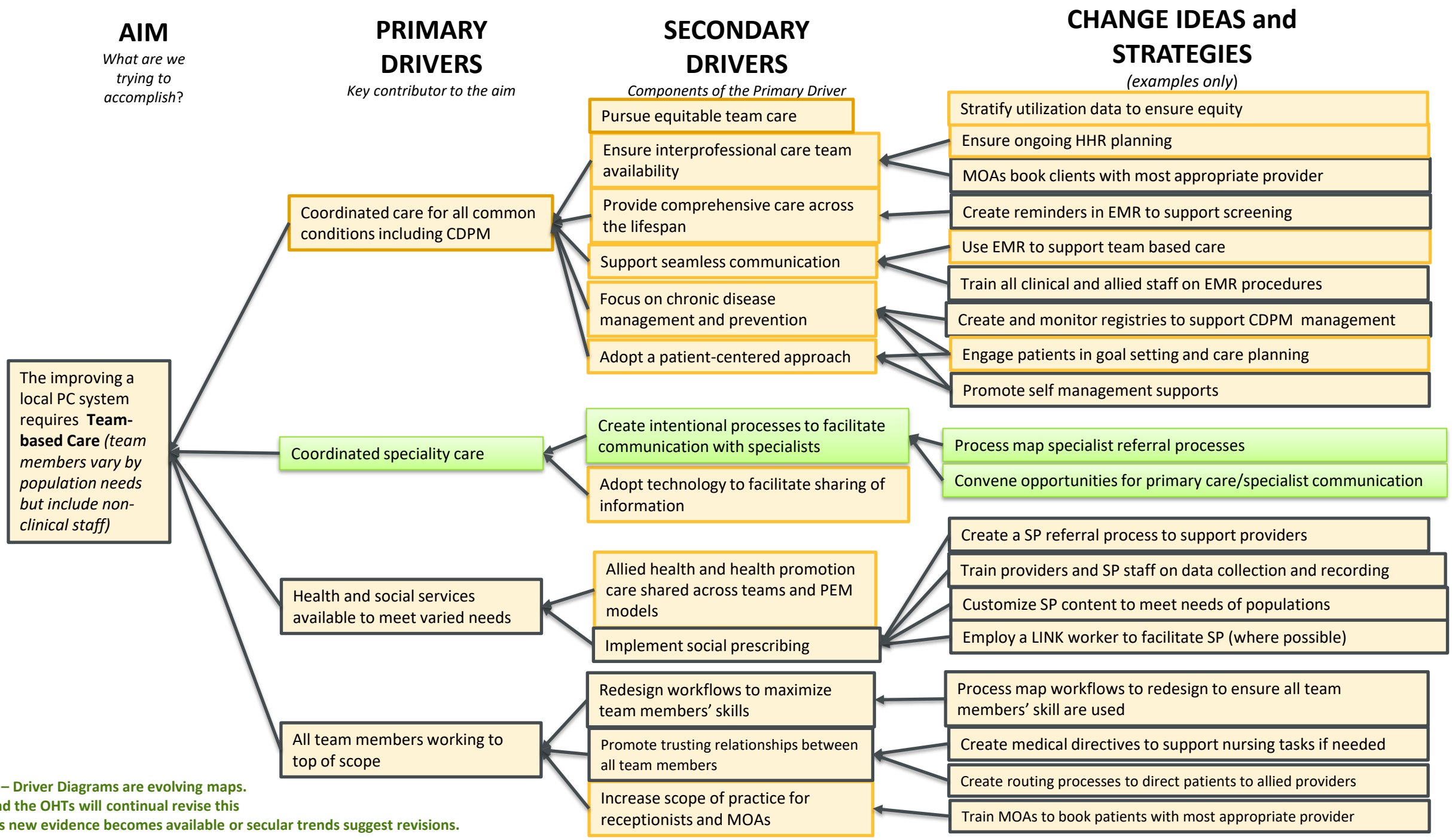
Drivers
Key contributor to principles

Interprofessional Team-based care	Relational continuity (including attachment)
Timely Access to Care	Population Health Management Approach
Patient partnership and community engagement (BB3)*	Performance measurement, QI & continuous learning (BB8)*
Leadership, accountability & governance (BB6)*	Digital health & data analytics (BB5)*

DRAFT

Adapted from the Ontario Primary Care Act, FLA Health Home and other OHT models, Starfield, OCFP and AHC models and Bodenheimer 10 building blocks of PC

* Reference to RISE Building Blocks for integrated care: https://www.mcmasterforum.org/rise/access-resources/resources-by-oht-building-block



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.

Your TPA Deliverables are tied together through Improving the Primary Care System

OHT/PCN TPA deliverables 2026/27
(examples only)

Your past and current work on leading/ coordinating submissions for interprofessional primary care teams (IPCTs)

Interprofessional Team-based care

Advance CDPM activities in primary/community care settings to strengthen proactive management and improve patient outcomes and access to care.

Timely Access to Care

Continue patient inclusion in working groups and expand specialty and tertiary care in IPCT development

Patient partnership and community engagement

Advance a PCN that organizes the local primary care sector and engages interprofessional primary care providers in quality improvement

Leadership, accountability & governance

OHT/PCN TPA deliverables 2026/27
(examples only)

Relational continuity (including attachment)

Continue to implement supported attachment

Population Health Management Approach

Increase participation in cancer screening, including supports for unattached participants accessing screening

Digital health & data analytics

Engage with primary care providers to advance provincial priorities, including eReferral, Central Intake

Performance measurement, QI & continuous learning

On-going monitoring and evaluation of OHT/PCN TPA reporting indicators/ OHT Performance & Improvement Framework

Drivers do not operate independently rather, they're part of an eco system

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Example:

Driver

Population Health Management Approach

A system of chronic illness care meeting the needs for all patients

Drivers

Interprofessional Team-based care

Community engagement & patient partnership

Teams with a range of skillsets which efficiently provide comprehensive and holistic care

Increased access **AND** ability to attach more patients

Examples only:

Creating a system of care for complex older adults

- **Geriatric medicine embedded in the team**
- **Bi-weekly round tables**
- **Shared care approach across team members**

Strong connection with community resources (e.g., Alzheimer's society)

Approach resulted in:

- **PC capacity building**
- **Person-centered flexible approach**
- **Improved access to needed care**

Example source: KW4 OHT IPCT approach for older adults and West-Region-Heckman-and-Mensink-.pdf
Additional examples can be found here: Models and Examples of Primary Care Integrated Geriatric Teams: Presentations and Resources - Provincial Geriatrics Leadership Ontario

Chatterfall: What work do you believe needs to be done to make this happen?

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HURON PERTH & AREA
ONTARIO HEALTH TEAM

Building an Integrated Primary Care System in Huron Perth & Area

The Neighbourhood Health Home Model

Robin Spence-Haffner, Listowel Wingham Family Health Team and Joëlle Lamport Lewis, Director HPA-OHT

PRIMARY CARE IN HURON PERTH & AREA

PRACTICE MODELS

8 Family Health Teams (FHT)/Family Health Networks (FHN)

- Listowel Wingham
- Maitland Valley
- Bluewater Area
- Clinton
- Huron Community
- STAR
- Stratford
- Happy Valley

1 Community Health Centre (CHC)

- Grand Bend

2 Family Health Organizations (FHO)

- Exeter
- Mitchell

PRIMARY CARE PROVIDERS

29 Primary Care Nurse Practitioners

- 18 full-time
- 11 part-time

111 Primary Care Physicians

10/11 FHOs /CHC work in hospital or practice commitments outside of primary care.

ATTACHMENT RATE

93%

Attachment in Huron Perth & Area

Team-based care is present across all Forward Sortation Areas (FSAs)

PRIMARY CARE PROGRAMS

126 Total number of Primary Care Programs

Examples include:

AFTER HOURS CLINICS

Offered in

- Grand Bend
- Stratford

UNATTACHED CARE CLINICS

6000+ unique patients

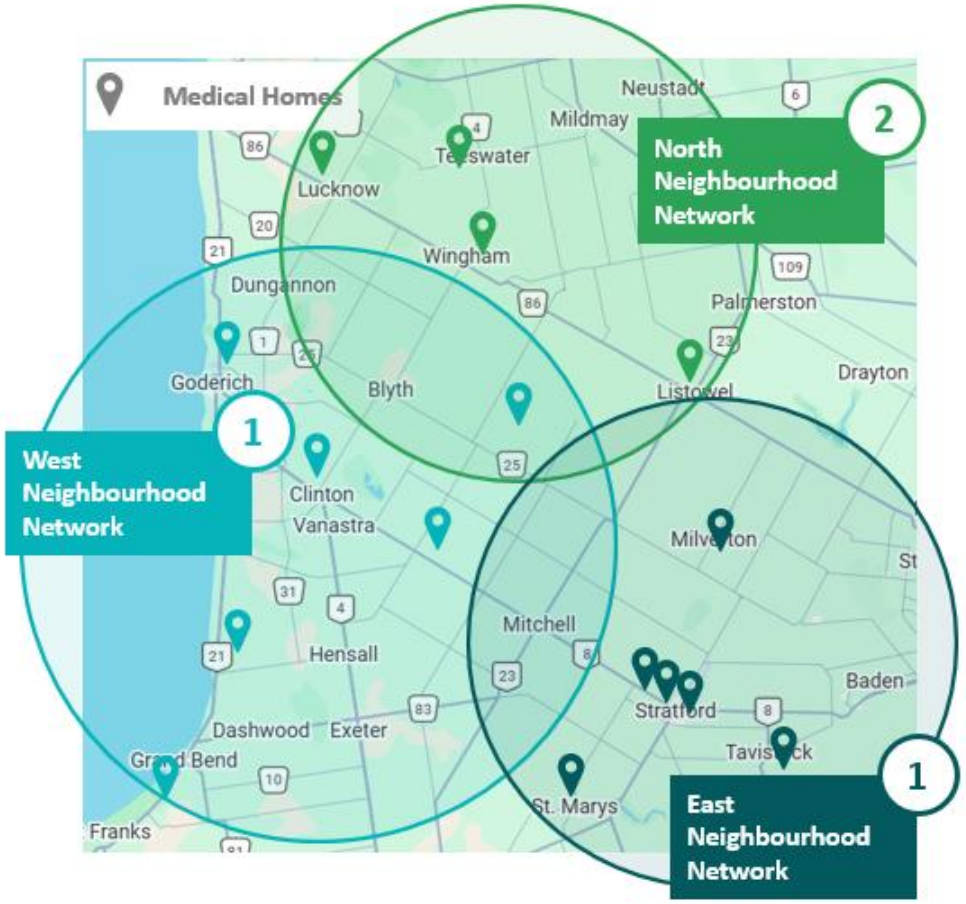
7300+ total visits

~21 months

HURON PERTH & AREA
ONTARIO HEALTH TEAM

OUR NEIGHBOURHOOD MODEL

- **Neighbourhood Networks:** Services are planned and delivered in a coordinated manner across each neighbourhood
- **Medical Homes (Primary Care):** The primary clinical home for patients in their local community. These homes will continue to deliver team-based primary care services
- **Community Care:** Optimize community-based services to streamline patient pathways (i.e., individual providers, pharmacies, community-based organizations, community paramedicine). This extends care and supports into neighbourhoods and connect through shared pathways and referral relationships
- **Acute Care:** Optimize neighbourhoods by defining care pathways to/from acute care.



HURON PERTH & AREA
ONTARIO HEALTH TEAM

SERVICE DISTRIBUTION

Neighbourhood Network
North/West/East

Each will have the following processes in place to support a networked way of working

- Operationalization
- Centralized Access and Navigation
- Integrated Care Navigation
- Equity-focus
- Centralized Intake

Medical Home
FHT/CHC/FHO

Primary care will be delivered in the Medical Home with services planned across Neighbourhoods to optimize resource allocation.

- Primary Chronic Disease Management
- General Mental Health
- Lifestyle & Nutrition
- Family & Child Health
- Community Wellness
- Advanced Chronic Disease Management
- Preventative Care
- Specialized Mental Health
- Memory & Cognitive Care
- Cancer Screening & Diagnostics
- Birthing Suite
- Complex Pain & Musculoskeletal
- Specialized Women's Health

Community-Based Services
Pharmacy, Paramedicine

Low complexity programs that are highly accessible will be delivered by individual providers or community organizations.

- Foot care by local providers
- Smoking cessation groups
- Community fridges, food security programs
- Local pharmacies
- Social support & outreach programs
- Community Paramedicine

Acute Care Services

Acute services provided through neighbourhoods to support seamless continuity of care.

- Clinical Services - emergency, inpatient, ambulatory, outpatient specialist care, diagnostic services
- Integrated care navigation

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ONTARIO HEALTH TEAM

WHAT'S WORKING WELL: STRONG FOUNDATIONS TO BUILD ON

- Strong base of team-based primary care
- Existing collaboration across sectors
- Proven Hub and Spoke models (e.g., heart function, COPD, cardiac rehabilitation)
- Clear regional vision for integration
- Alignment with Provincial Direction (Primary Care Action Plan)

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ONTARIO HEALTH TEAM

KEY CHALLENGES & ADDRESSING THEM

- Fragmented workflows
- Inequitable rural access
- Rising mental health needs
- Administrative burden limiting provider capacity
- Variation in services and coordination

- Coordinating through neighbourhood networks
- Implementing centralized intake and navigation
- Define standardized care pathways
- Leveraging technology and digital tools
- Strengthening chronic disease management and preventative care

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ONTARIO HEALTH TEAM

HOW WE GOT HERE: METHODOLOGY & PHASED APPROACH TO IMPLEMENTATION

How we got started:

Collaborative, evidence-infomed planning process

Strong engagement across providers and partners

Data analysis, service mapping, and provider input

Methodology:

- Discovery
- Design
- Implementation
- Deployment
- Consolidation & Transformation

Phased Implementation:

- Phase 0: Current State & Readiness
- Phase 1: Foundations
- Phase 2: Centralize & Integrate
- Phase 3: Scale & Empower

HURON PERTH & AREA
ONTARIO HEALTH TEAM

HURON PERTH & AREA
ONTARIO HEALTH TEAM

Thank You!

hpaoht.ca

REFERENCES

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Huron Perth & Area Ontario Health Team, Primary Care Data Discovery (June 2025)

Huron Perth & Area Ontario Health Team. Primary Care Summit presentation, November 6, 2024.

Huron Perth & Area Ontario Health Team, Unattached Care Clinic Utilization Data

Stratford Family Health Team. (n.d.). After-hours clinics. https://starfht.ca/clinics_offices/after-hours/

HURON PERTH & AREA
ONTARIO HEALTH TEAM

What's next?

We are currently working with AFHTO and OCFP (among many other PC support partners) to discuss how we can collaborate and streamline our supports. Please stay tuned for details!

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'Staging the work' to improve your local primary care system

Two-part miniseries on 'staging the work'

Session 1 (peer sharing & learning session): July 16, 11am-12pm

- ✓ understand evidence informed approaches for determining how to 'stage the work'/get started/where to go next in improving your local primary care system
- ✓ learn through real-life examples from peer teams

Audience: open to all (no registration required – Zoom join link is here)

Session 2 (peer problem solving session): July 23, 11am-12pm

- ✓ 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
- ✓ Continue to adjust your workplan to improve your local primary care system

Audience: Session just for those leading PC/PC working group members/those leading PC clinics (registration required here)

Participants can attend one or both sessions. For those attending session 2, it is highly recommended to attend/watch the recording of session 1.
For questions or feedback on these sessions, please contact Leslie.McGeoch@outlook.com or your RISE coach.

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Thank you