Access & Attachment to Primary Care

Co-Design Summary Report

Executive Summary

On April 24, 2025, the Middlesex London Ontario Health Team (MLOHT) and Middlesex London Primary Care Network (MLPCN) hosted a co-design session focused on expanding access to team-based primary care and what can be learned from the Neighbourhood Health Home model. This session brought together diverse stakeholders—including Family Physicians, Nurse Practitioners and other providers, administrators, community organizations, patients, and caregivers (Appendix A) —to develop a shared vision and define actionable components for building inclusive, responsive, and sustainable care models across Middlesex London.

Participants envisioned Neighbourhood Health Homes as integrated, community-rooted hubs that provide accessible, culturally safe, and comprehensive care tailored to local needs. Core themes included expanding interdisciplinary teams, reducing administrative burden, and embedding services within familiar community spaces. Emphasis was placed on equitable access, proactive outreach, and supporting patients across the continuum of health and social care. Teams identified a range of critical roles—from family physicians and nurse practitioners to social workers and system navigators—needed to operationalize this model.

Infrastructure priorities included shared Electronic Medical Records (EMRs), centralized intake, and population health data systems. Flexible design principles, including hybrid Community Health Centre - Family Health Team (CHC-FHT)models and place-based governance structures, were recommended to support adaptation across diverse geographies. Finally, robust quality improvement strategies were highlighted, focusing on shared metrics, equity-informed analytics, and community-driven evaluation.

This co-design session laid the groundwork for a coordinated, equity-centered transformation of primary care that meets the evolving needs of neighbourhood populations.

Introduction and Context

The MLOHT and MLPCN Access and Attachment to Primary Care initiative aims to reimagine primary care delivery to ensure all Ontarians have access to comprehensive, team-based, and community-rooted healthcare. The MLOHT/MLPCN hosted a Co-Design session on April 24, 2025, focusing on "Expanding Primary Care Team-Based Services Across Middlesex London" and what we can learn from the Health Home Model. This report synthesizes findings from table discussions and post-event surveys.

Facilitated table discussions focused on Health Equity; Services and Roles; Health Home Models and Enabling Infrastructure; and Evaluation and Quality Improvement. Participants were provided with a brief literature summary of each topic to prepare for the session (Appendix B). Key takeaways from table discussions were shared with the broader group and participants were asked to prioritize those findings (Appendix D).

Themed Results

The following is a summary of the themes that came out of the session. For more detailed information on these themes, please refer to Appendix C.

1. Vision for Neighbourhood Health Homes

Sub-Themes

- Integrated, accessible, culturally safe, community-based primary care hubs
- Comprehensive, continuous, and coordinated care tailored to the needs of the local population

Insight - ***Flexibility in implementation is essential.***

2. Service Models and Interdisciplinary Team Roles

Sub-Themes

- Clinical Staff
- Allied Health Professionals

- Social Supports
- Infrastructure and Navigation
- Community roles

Insight – ***Health Homes should have a centralized intake system and triage staff who act as a first point of contact to direct patients to the appropriate team member.***

3. Integration with community Supports

Sub-Themes

- Community Co-location and Embedded Services
- Formal Partnerships
- Community Development and Governance
- Health Promotion and Education
- Data Sharing and Referral Networks

Insight – ***Integrated models ensure that care is not just clinically effective but also socially responsive and community driven.***

4. Health Equity approaches

Sub-Themes

- Culturally appropriate care
- Representation and hiring
- Inclusive feedback systems
- Socio-demographic data collection
- System navigation
- Centralized triage and matching
- Place-based outreach strategies
- Health promotion and upstream prevention
- Governance and community voice

Insight – ***Health equity is more than a guiding value – it is an operation imperative that demands system-wide attention and action.***

5. Health Home Model Options and Enabling Infrastructure

Sub-Themes

- Hybrid Models
- Co-Location and Integrated Services
- Team-Based and Population Health Approaches

- Use of Extenders
- Neighbourhood-Based Design
- Flexible Attachment Models
- Enabling Infrastructure – Digital and Data Systems
- Human Resource Infrastructure
- Workforce Stability

Insight – ***Considerations reflecting the diverse needs and geographies of Ontario communities, and reinforce that flexibility, integration, and system coordination, will be the key to success.***

6. Measurement Evaluation and Quality Improvement

Sub-Themes

- Shared Roles and Resources
- Common Data Standards and Evaluation Measures
- Data Infrastructure
- Holistic Measurement
- Equity-Informed Analytics
- Panel Evaluation and Complexity
- Use of Existing Population Data
- Evaluating the Unattached
- Feedback from Community and Providers
- Governance and Accountability
- Pragmatic and Relevant Metrics

Insight - ***Evaluation should not only assess outcomes but guide action continuously, refine service delivery, and ensure Neighbourhood Health Homes meet the evolving needs of the people they serve.***

Together, these insights reflect a shared commitment to building evaluation and improvement processes that are data-informed, equity-sensitive, and community-accountable. Evaluation should not only assess outcomes but guide action, continuously refine service delivery, and ensure Neighbourhood Health Homes meet the evolving needs of the people they serve.

Key Recommendations and Next Steps

1. **Build Flexible, Community-Driven Models:** Design Health Homes to reflect the specific needs of neighbourhoods through flexible models—such as mobile units,

virtual access, co-located services, and embedded teams—to improve reach, especially in rural and underserved areas.

2. **Embed Equity at Every Level:** Ensure equity is foundational to all aspects of the Health Home model. This includes hiring staff reflective of community demographics, collecting race-based and socio-demographic data, using risk-adjusted rostering, and involving communities in governance and service design.
3. **Invest in Infrastructure and Staffing:** Secure stable, long-term funding for clinical and non-clinical roles, including system navigators, administrative support, and data/QI specialists. Address provider burnout and strengthen recruitment for team-based primary care.
4. **Develop Standardized but Adaptable Metrics:** Create a core set of shared indicators across health homes, complemented by locally relevant measures. Metrics should span clinical care, patient experience, health equity, and social determinants.
5. **Promote Interoperability and Automation:** Prioritize investments in shared EMRs, centralized intake, and referral systems. Ensure systems are interoperable, minimize administrative burden, and improve coordination between care providers.
6. **Foster a Culture of Learning and Improvement:** Embed evaluation into daily practice through dedicated QI roles, shared learning opportunities, and real-time use of performance data. Support reflection and improvement at both clinical and system levels.
7. **Enhance Community Partnerships:** Strengthen relationships with organizations such as CMHA, Ontario Works, public libraries, Indigenous and newcomer services. Shared locations and formal MOUs should support holistic, wraparound services.
8. **Ensure Patient Voice and Choice:** Incorporate patient and caregiver feedback through multiple mechanisms (e.g., town halls, surveys, advisory councils). Respect individual preferences in attachment and ensure culturally safe, responsive care.

This report reflects the collective wisdom from table discussions and surveys. It underscores the potential of Neighbourhood Health Homes to transform care delivery by centering equity, community voice, and team-based, data-informed models of care. It offers a strong foundation for the next steps in planning and implementation.

Appendices

Appendix A - Participating Stakeholder Representatives (Event and/or Survey)

- Patients and caregivers (PCCPC)
- Equity deserving community members
- Family Physicians
- Nurse Practitioners
- Social Workers
- Mental Health and Addictions Cluster
- Occupational Therapists
- Registered Practical Nurses
- Family Health Teams
- Community Health Center (LIHC)
- Western University
- First Nations Representatives
- Home and Community Care
- Primary Care Recruitment, Retention and Transition Lead
- Cross Culture Learning Center
- MLOHT Operations Team Members
- MLOHT Access and Attachment Steering Committee and Project Team Members
- 2023 Team Based Primary Care Expansion EOI Participants
- Providers interested in 2025 Integrated Primary Care Team Expansion Proposal
- Huron Perth OHT Lead
- Sarnia Lambton OHT Lead
- Elgin OHT Lead

Additional stakeholder representatives were invited but unable to attend

Appendix B - Pre-Read Literature Summary of Each Topic

- Co-Design Topic A_Health Equity.pdf
- Co-Design Topic B_Services and Roles.pdf
- Co-Design Topic C_Health Home Models & Enabling Infrastructure.pdf
- Co-Design Topic D_Evaluation and Quality Improvement.pdf

Appendix C - Detailed Notes for Themed Results

Vision for Neighbourhood Health Homes

Neighbourhood Health Homes are envisioned as integrated, accessible, culturally safe, community-based primary care hubs that provide comprehensive, continuous, and coordinated care tailored to the needs of local populations. The model aspires to:

- Increase equitable access to care.
- Enhance team-based service delivery.
- Address social determinants of health (SDOH).
- Embrace a population health approach, including health promotion, prevention, and chronic disease management.
- Include clear governance structures that reflect community leadership and foster trust and accountability.
- Embed continuous quality improvement and evaluation mechanisms

Flexibility in implementation is essential. For example, rural areas may require mobile units or virtual clinics to address transportation barriers. Urban models might embed clinical and support services within existing community hubs. A hybrid model combining elements of CHCs and FHTs was also recommended to serve both complex and general populations effectively.

Service Models and Interdisciplinary Team Roles

The effectiveness of a Health Home depends on the integration of a broad range of interdisciplinary roles tailored to community needs. Roles consistently emphasized include:

- **Clinical staff**: Physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), nurses.
- **Allied health professionals:** Physiotherapists, occupational therapists, dieticians, mental health professionals, respiratory therapists, diabetes educators, pharmacists, psychologists.
- **Social supports**: Social workers, addictions counsellors, case managers, community health workers.
- **Infrastructure and navigation**: Clinical navigators, system navigators, administrative staff, data/QI analysts.
- **Community roles:** Health promoters, social prescribing link workers, outreach workers, community development workers.

To support care navigation, every Health Home should have a centralized intake system and clinical navigators who act as a first point of contact to direct patients to the appropriate team members. Several survey responses emphasized that this

model reduces delays and enhances access, especially for underserved populations. These navigators should also maintain current community resource maps to effectively refer patients to local support services.

Participants strongly advocated for a model where team members work to full scope, which includes redefining roles and addressing scope creep, professional overlap, and system inefficiencies. There were calls for salary-based compensation models, particularly for physicians serving high-needs populations, and for administrative relief through funded MOA and EMR scribe support.

Integration with Community Supports

The integration of Health Homes with community-based organizations is fundamental to their success. The co-design event and survey responses emphasized the following strategies and examples of integration:

- **Community Co-location and Embedded Services**: Health Homes should be located in accessible, familiar community spaces such as libraries, community centres, and YMCAs. These locations reduce stigma and encourage engagement. Embedding services within known spaces fosters continuity and normalization of care-seeking behavior.
- **Formal Partnerships:** Health Homes should establish MOUs and collaborative working relationships with CMHA, Ontario Works, Autism Ontario, Indigenous organizations, public health units, and local settlement agencies. These partnerships ensure that care is culturally competent, socially inclusive, and coordinated across the social and healthcare continuum.
- **Community Development and Governance:** Health Homes must embed community development workers and promote the creation of Neighbourhood Councils—distinct from patient advisory councils—to guide care design based on population needs. This ensures community representation and oversight.
- **Health Promotion and Education:** Dedicated health promoters within the team can run upstream initiatives such as wellness workshops, chronic disease self-management groups, and youth education programs. By acting within community venues and schools, these roles promote preventive health and strengthen community relationships.
- **Data Sharing and Referral Networks:** Integration must extend to shared digital tools and interoperable systems that connect primary care to community partners. Centralized intake and referral pathways, including

those for social services and specialty medical care, were strongly recommended.

Together, these integrated models ensure that care is not just clinically effective but also socially responsive and community driven.

Health Equity Approaches

Equity is a foundational principle for Neighbourhood Health Homes. Health equity is more than a guiding value—it is an operational imperative that demands system-wide attention and action. Key strategies to support equity include:

- **Culturally appropriate care:** Employ Indigenous representatives, multilingual staff, and community leaders; provide signage, forms, and educational materials in multiple languages; offer on-demand interpretation throughout the clinic, starting at reception.
- **Representation and hiring**: Ensure staff reflect the demographic and linguistic diversity of the community.
- **Inclusive feedback systems:** Host town halls, establish Neighbourhood Councils, and support anonymous and in-person feedback tools.
- **Socio-demographic data collection:** Regularly collect race-based, income, housing, and postal code data.
- **System navigation:** Assign system navigators to support people who face barriers in accessing care.
- **Centralized triage and matching:** Implement a unified intake model and introduce risk-adjusted rostering.
- **Place-based outreach strategies:** Meet people where they are—through mobile services, libraries, or food security organizations.
- **Health promotion and upstream prevention**: Assign dedicated health promoters to address social isolation, food insecurity, and preventive screening.
- **Governance and community voice:** Involve community leaders in decision-making structures and resident-led planning.

Together, these actions help to ensure that Health Homes serves not only the patients who walk through the door, but the broader population—especially those who are traditionally excluded or underserved.

Health Home Model Options and Enabling Infrastructure

Participants highlighted several model options and infrastructure supports essential to realizing the vision for Neighbourhood Health Homes. These include both

structural designs for delivering care and enabling systems that support scale, sustainability, and effectiveness.

- **Hybrid Models:** Many participants supported blended models that leverage the strengths of both Community Health Centres (CHCs) and Family Health Teams (FHTs). CHCs were seen as particularly effective for marginalized populations due to salaried physician models and embedded social supports, while FHTs could serve moderate-complexity patients within rostered teams.
- **Co-Location and Integrated Services:** Successful models often co-locate services (e.g., primary care, mental health, addictions, housing supports) within a shared space to provide "one stop" care. Integration with community partners like CMHA, social assistance programs, libraries, and newcomer supports was emphasized to enhance holistic service delivery.
- **Team-Based and Population Health Approaches:** The health home model should shift from a physician-centered approach to one that prioritizes a broad interdisciplinary team and population health management. Risk stratification and segmentation can help target resources appropriately based on community health profiles.
- **Use of Extenders:** Physician Assistants (PAs) and other extenders can be used to expand access and support attachment of unattached patients. There was broad agreement that PAs can reduce physician burden and serve lower-complexity patients under appropriate supervision.
- **Neighbourhood-Based Design**: Health Homes should be accountable to geographic populations. This includes an emphasis on place-based planning, embedded community governance, and outreach to individuals who are not formally attached to care but live within the service area.
- **Flexible Attachment Models:** Stakeholders acknowledged the tension between attachment to providers versus attachment to location. While continuity of care is important, Health Homes must be flexible enough to accommodate patient preferences, mobility, and therapeutic relationships.
- **Enabling Infrastructure – Digital and Data Systems:**
  - ✓ Investment in digital infrastructure (shared EMRs, referral systems, centralized intake platforms) was seen as foundational.
  - ✓ A common digital interface across providers can reduce duplication, improve referral feedback loops, and ensure real-time access to care histories.
  - ✓ EMR funding and interoperability challenges were frequently cited as barriers that must be addressed to support team-based care.

- **Human Resource Infrastructure:** Stable funding for non-clinical roles such as administrative support, quality improvement staff, and data analysts is essential. These roles help ensure that clinical teams can focus on direct care delivery, and service planning can be data informed.
- **Workforce Stability:** Sustainability of any health home model depends on addressing provider burnout, retention, and the disparities in compensation between acute and community-based care. Suggested solutions included blending salary-based roles, recognizing the unique needs of providers nearing retirement, and improving the recruitment pipeline for community-focused clinicians.

These model and infrastructure considerations reflect the diverse needs and geographies of Ontario communities and reinforce that flexibility, integration, and system coordination will be key to success.

Measurement, Evaluation, and Quality Improvement (QI)

Evaluation and quality improvement (QI) are essential to ensure that Neighbourhood Health Homes are effective, equitable, and responsive to both community and system needs. Based on the notes and survey responses, several consistent themes emerged:

- **Shared Roles and Resources**: Shared QI specialists and data analysts (as seen in NPLC models) can support multiple clinics effectively with the right governance.
- **Common Data Standards and Evaluation Measures:** Teams emphasized the need for shared indicators, definitions, and metrics across all health homes to allow for comparison, benchmarking, and collective learning—even across different EMR platforms. These should include not only clinical metrics but also measures related to social determinants of health and patient experience.
- **Data Infrastructure:** A centralized data warehouse and standardized indicators are essential. There is a need for interoperability across EMRs, automated reporting, and regionally consistent metrics.
- **Holistic Measurement:** Evaluation should include clinical outcomes, patient-reported outcomes, and experiences (PREMs and PROMs), ER use, quality of life, social determinants, and subjective community feedback.
- **Equity-Informed Analytics:** Several participants stressed the importance of collecting socio-demographic data, including race, language, housing status, and income. Stratifying all QI measures by equity indicators helps to identify

gaps in care, reach marginalized populations, and monitor systemic disparities.

- **Panel Evaluation and Complexity**: Stakeholders raised concerns about "cream skimming" and highlighted the importance of evaluating panel complexity. Tracking complexity modifiers and population health profiles can ensure fair distribution of workload, funding, and service expectations.
- **Use of Existing Population Data:** Collaborating with Ontario Health and Public Health was seen to incorporate population-level data (e.g., census, regional deprivation indices) to understand who is not being served and where targeted interventions are needed.
- **Evaluating the Unattached:** Traditional evaluation frameworks often exclude individuals not rostered to a provider. Participants emphasized the need to assess service access and unmet needs across the full neighbourhood population, not just those formally attached to the Health Home.
- **Feedback from Community and Providers:** Community engagement was seen as a key component of quality evaluation. Participants recommended gathering qualitative insights from patients and caregivers through surveys, outreach, and open forums. Additionally, measuring provider experience—including burnout, role clarity, and administrative burden—was recognized as critical to system sustainability.
- **Governance and Accountability:** Data collection must be ethical, relevant, and sufficiently powered to inform actionable change. Governance structures must support accountability for reaching and serving priority populations.
- **Pragmatic and Relevant Metrics**: Metrics should be meaningful, practical to collect, and directly tied to patient and provider priorities. This includes tracking transitions in care (e.g., hospital to home), home care coordination, and access to interdisciplinary services like mental health and addiction support.

Appendix D - Prioritization of Key Takeaways

Each table reported key takeaways to the larger group. All participants were invited to review and rank/prioritize the key takeaways using a SLIDO application.

Topic A: Health Equity

1. Person-centered and person-led equity is necessary.
2. Community needs to be involved in the health home: volunteers, community liaisons, and must be on the board of governors.
3. Front-end staff must have access to on-demand interpretation. No wrong door.

4. It is important for the health home to be multicultural, multilingual, multi-accessible, and multi-sensitive.
5. Regular forums for community feedback.
6. Effective communication systems are needed to update and receive information.
7. Navigator role – social prescribing.
8. Ask the community what they need and provide that service/person as needed.
9. Health Home leadership should be interconnected across homes.
10. Health equity must be a component of navigation.
11. Allied health/inter-professional care team – including dieticians, physiotherapists, psychotherapists.
12. Leverage community leaders to build trust.
13. Use AI systems appropriately.
14. Shared roles to support equity efforts.
15. Ensure a truly welcoming space.
16. Governance should be community-led.
17. Signage available in multiple languages, utilizing technology.

Topic B: Roles & Services

1. Patients should be able to book services directly from any team member or via system navigators without PCP bottleneck.
2. Holistic team approach: medical services, community services, social prescribing, dementia support, trauma-informed care.
3. Population-based services tailored to each community.
4. Communication and resource sharing across hubs.
5. Case managers for complex needs with a shared system.
6. Navigation support for community services.
7. Comprehensive services all in one place (part-time as needed).
8. Maximize the scope of practice for all staff.
9. Clear communication to avoid fragmented care.
10. Clarity of roles within teams, removing hierarchy.
11. Social service workers to address social determinants of health (e.g., ODSP).
12. Funding for digital enablers.
13. Centralized information hubs and digital communications.
14. Recruitment and retention strategies for MDs/NPs.
15. Include non-clinical roles (panel management, QI, QIDS).
16. Support managing and tracking referrals.
17. Interpretation services from reception onward.
18. Stronger links to Community Paramedicine and home support.
19. Flexibility to adjust teams post-launch.

20. No wrong door model (e.g., food banks).

Topic C: Health Home Models and Enablers

1. Understand population needs (socio-demographic, equity needs).
2. Clinical navigators to assist with patient journeys.
3. Design health homes around unique community needs.
4. Embed Ontario Health at Home within health homes.
5. Collect data to inform health home development.
6. Partner with external service organizations.
7. Build infrastructure that supports socio-demographic data collection.
8. Allow patients to transfer health homes upon relocation.
9. Use mobile units and digital enablers in low-density areas.
10. Continuity and consistency of team access for patients.
11. Supportive team culture for providers and patients.

Topic D: Evaluation and Quality Improvement

1. Funded expertise for qualitative and quantitative data use.
2. Equity focused evaluations by geography and demographics.
3. Strategy should guide what data is collected, and data must inform care improvement.
4. Community needs assessments must be tailored to compatibility.
5. Share Quality Improvement Specialists across multiple clinics.
6. Streamline and automate quality improvement processes.
7. Accountability to act on collected data.
8. Integrated care lens for data strategy.
9. Focus on patient outcomes, avoiding political motivations.
10. Collect standardized, comparable data across regions.
11. Recognize different attachment preferences in populations.
12. Standardization of data strategy is achievable.
13. Provide holistic health assessments per neighborhood.
14. Transparently measure and report outcomes. -2.91
15. Clinics should have opportunities for unique, meaningful metrics. -2.82
16. Shared roles for navigators and data analysts. -2.27
17. Standardized data and data integrity across disciplines. -2.24
18. Support from QI and data specialists. -2.12
19. Clinic-specific important metric collection. -1.53
20. Use EMR toolbars effectively without overwhelming users.
21. Oversight mechanisms must track quality across hubs.
22. Address hesitations in interdisciplinary questioning.
23. Future readiness for change with 100% attachment goals.

24. Survey vulnerable populations that are not accessing services.