

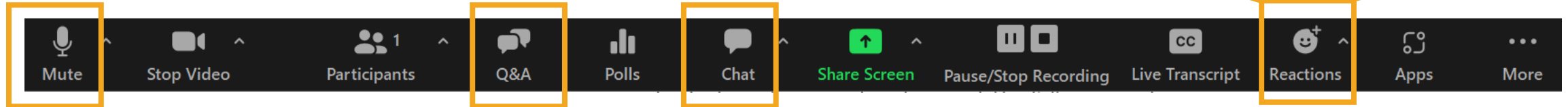
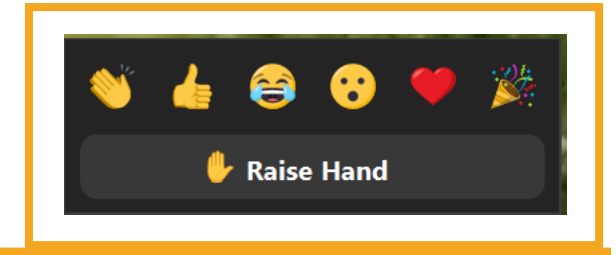
Connected Health Neighbourhoods: A Vision for Health System Transformation

April 4, 2025



Alliance for Healthier Communities
Alliance pour des communautés en santé

Housekeeping



- Audience **microphones are muted** and will remain muted throughout.
- Please submit questions using the **Q&A panel**.
 - Questions may be answered **in writing within the Q&A panel, verbally during the Q&A period, or in a follow-up email** after the webinar
 - You can also upvote or comment on others' questions.
- The webinar is being **recorded**. A link to the recording and slide deck will be shared by email next week.
- Simultaneous **French-language interpretation** is being provided. To access it, please click on the **globe icon at the bottom of your screen** and select "French." You can switch back to English the same way.

Acknowledgement of Traditional Indigenous Territories

We recognize that the work of the Alliance for Healthier Communities and Alliance members takes place across what is now called Ontario on traditional territories of the Indigenous people who have lived here since time immemorial and have deep connections to these lands. We further acknowledge that Ontario is covered by 46 treaties, agreements and land purchases, as well as unceded territories. We are grateful for the opportunity to live, meet and work on this territory.

Ontario continues to be home to vibrant, diverse Indigenous communities who have distinct and specific histories, needs, and assets, as well as constitutionally protected and treaty rights. We honour this diversity and respect the knowledge, leadership and governance frameworks within Indigenous communities. In recognition of this, we commit to building allyship relationships with First Nation, Inuit and Métis peoples in order to enhance our knowledge and appreciation of the many histories and voices within Ontario. We also commit to sharing and upholding responsibilities to all who now live on these lands, the land itself and the resources that make our lives possible.

Presenters



Sarah Hobbs

Chief Executive Officer, Alliance for Healthier Communities



Jennifer Rayner, PhD

Director of Research & Policy, Alliance for Healthier Communities

Objectives for Today

Introduction	Review common definitions and the Primary Care Action Team and Today's Primary Care Context
Review	Neighbourhood Health Home Model and components of the Health Home
Actions	Steps toward realizing the Health Home Model
Discussion	Discussion and Questions

Definitions & Developing a Shared Understanding



Primary Care vs Primary Health Care

Primary Care

- Narrower concept of primary care provider type (typically family doctor) services delivered to individuals
- Care provided at the individual level
- Often first contact of care
- Includes amongst other things: comprehensiveness, continuity, care coordination that are longitudinal in nature

Primary Health Care

- Broader term which derives from core principles articulated by the WHO
- Approach to health policy and service provision that includes both services delivered to individuals and at population level
- Often team-based and focused on determinants of health and health equity

Health Equity



- Equality and equity are not the same
- Everyone has the opportunity to attain their full potential for health and well-being, regardless of their social position or other factors

Community Governance

- Community governance is a powerful mechanism for public and community engagement
- Community governance is a governance model that involves an organization being overseen by a board of directors whose voting directors are community members that **equitably represent the community(ies)** served, as defined by the organization, and not employees of the organization or people that benefit financially from the organization
- **Complies with conflict of interest guidelines of the not-for-profit act (reference)**
- Meaningful community governance **centres the voice of the community within the decision-making across the organization**
- Reflective of the **people who face the most barriers in the community**

Foundational Elements

Health Equity Charter

Health equity: Bold, strategic, relentless
 Anti-racism
 Determinants of health
 INCLUSION
 Digital equity
 Indigenous Health in Indigenous Hands

Partnership
 ACCESS
 Health

Wellbeing
 Health care
 Systemic inequities
 Anti-oppression
 COMMUNITY

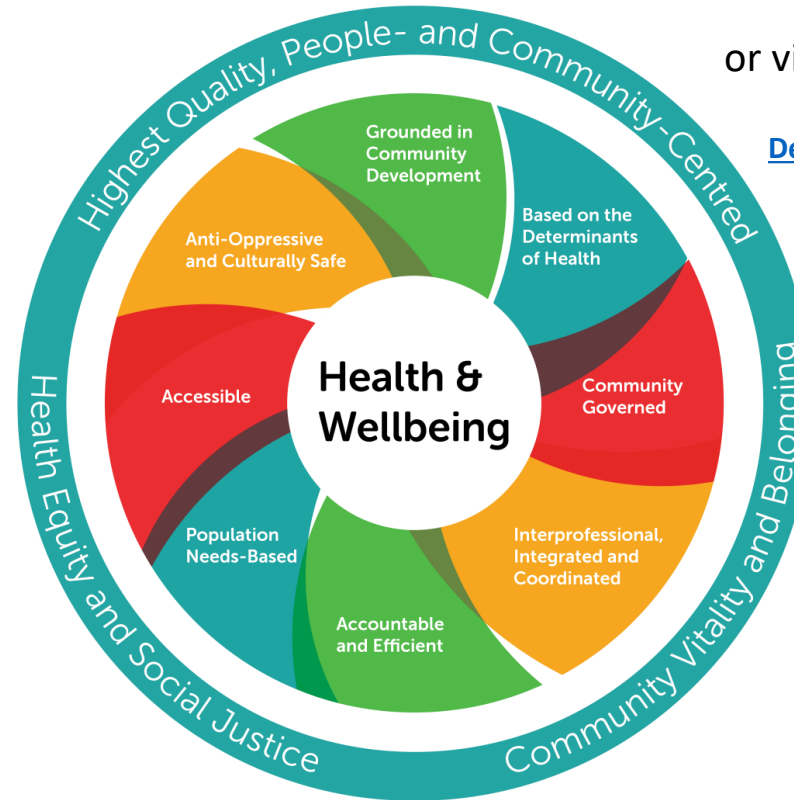
Humility
 Human rights
 Social justice
 ACTION
 Intersectionality

WHAT IS THE HEALTH EQUITY CHARTER?
 It is a commitment to action by the Alliance for Healthier Communities and Alliance member organizations to recognize and confront barriers to equitable health. We commit to be bold, strategic and relentless in challenging these barriers and addressing the needs of the people and communities we serve to achieve our vision of the best possible health and wellbeing for everyone living in Ontario.

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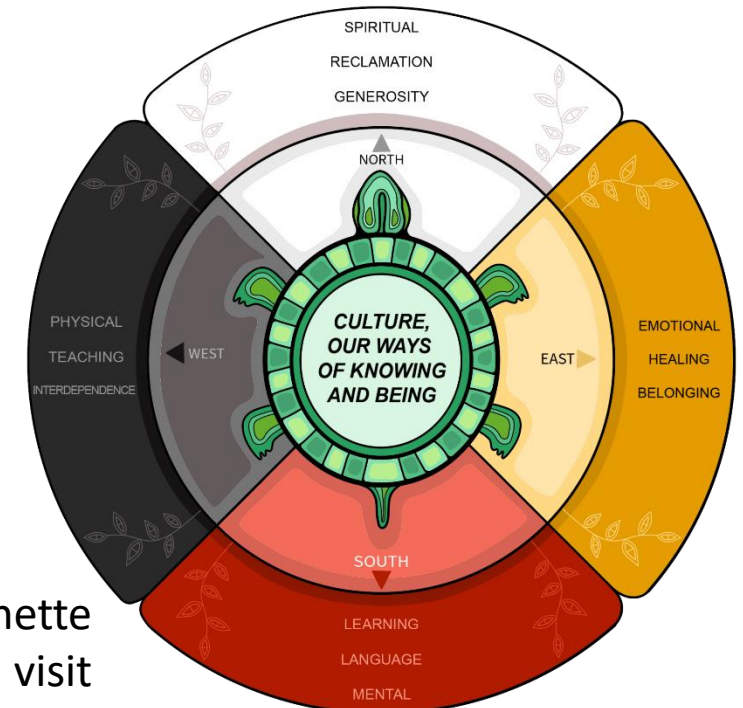
Transitive Change
 Accountability
 Solidarity

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For more, watch MHWB 101 ([English](#) | [French](#)) or visit <http://www.allianceon.org/model-health-and-wellbeing>

Study: [Delivering primary health care as envisioned: A model of health and well-being guiding community-governed primary care organizations](#)



To learn more, watch Health Equity Charter 101 ([English](#) / [French](#)) or visit: <http://www.allianceon.org/Health-Equity-Charter>

Credit: Hawlii Pichette
 For more, visit www.iphcc.ca

Today's Primary Care Context



Reality Today

- By 2026, 1 in 4 Ontarians are predicted to be without a family physician or Nurse Practitioner (NP).
- Retirements, burnout, fewer family physicians to fill these voids.
- Unequal access to interprofessional team-based care and people most at risk more likely to be without a family physician or NP.
- Future must maximize access to team-based care.
- Dr. Jane Philpott, chair and lead of the Primary Care Action Team, established in late fall 2024.



Primary Care Action Team

- Mandate and Vision → within next 5 years, 100% of people in Ontario are attached to a family physician or NP in a publically funded interdisciplinary system, where they receive ongoing, comprehensive, and convenient care that is:
 - 1) Universal
 - 2) Team-Based
 - 3) Convenient
 - 4) Equitable
 - 5) Digitally-Enabled

Big Questions we are grappling with...

How do we collectively build a primary care system that not only meets the needs of individuals but goes beyond basic primary care resulting in true health and wellbeing for people in Ontario?

How do we serve communities and support 100% attachment and ensure access to the services individuals require to achieve the best possible health and wellbeing?

How do we reduce health disparities in our communities? How do we work collaboratively with existing and new resources?





Model that may help teams and providers with their planning.

Model built from evidence and research into what works for people, especially for people that have traditionally faced barriers in the health system.

We believe that the re-design must have an equity lens and must be grounded in community.

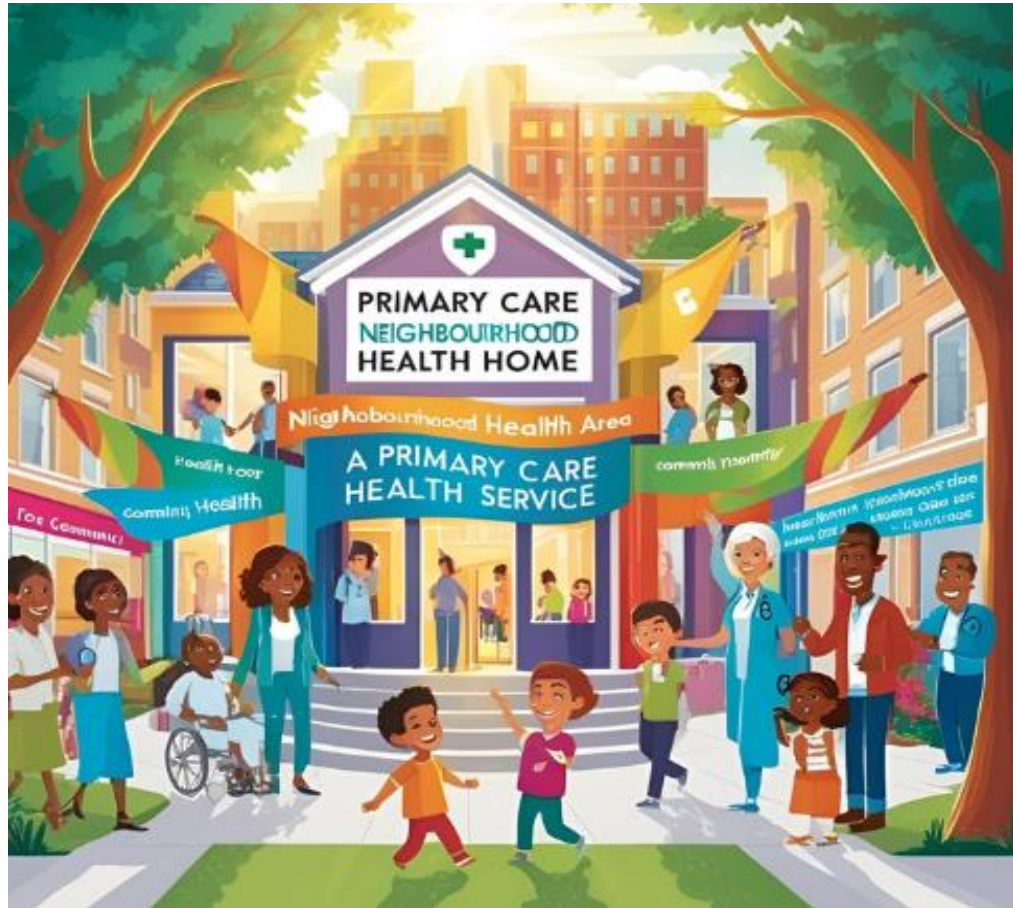
The model is robust, and built on six pillars, including: Interprofessional, collaborative primary health care; Community governance and engagement; Population-based approach; A strong data foundation; A focus on equity and the determinants of health; Accountability and efficiency.



Neighbourhood Health Home Model



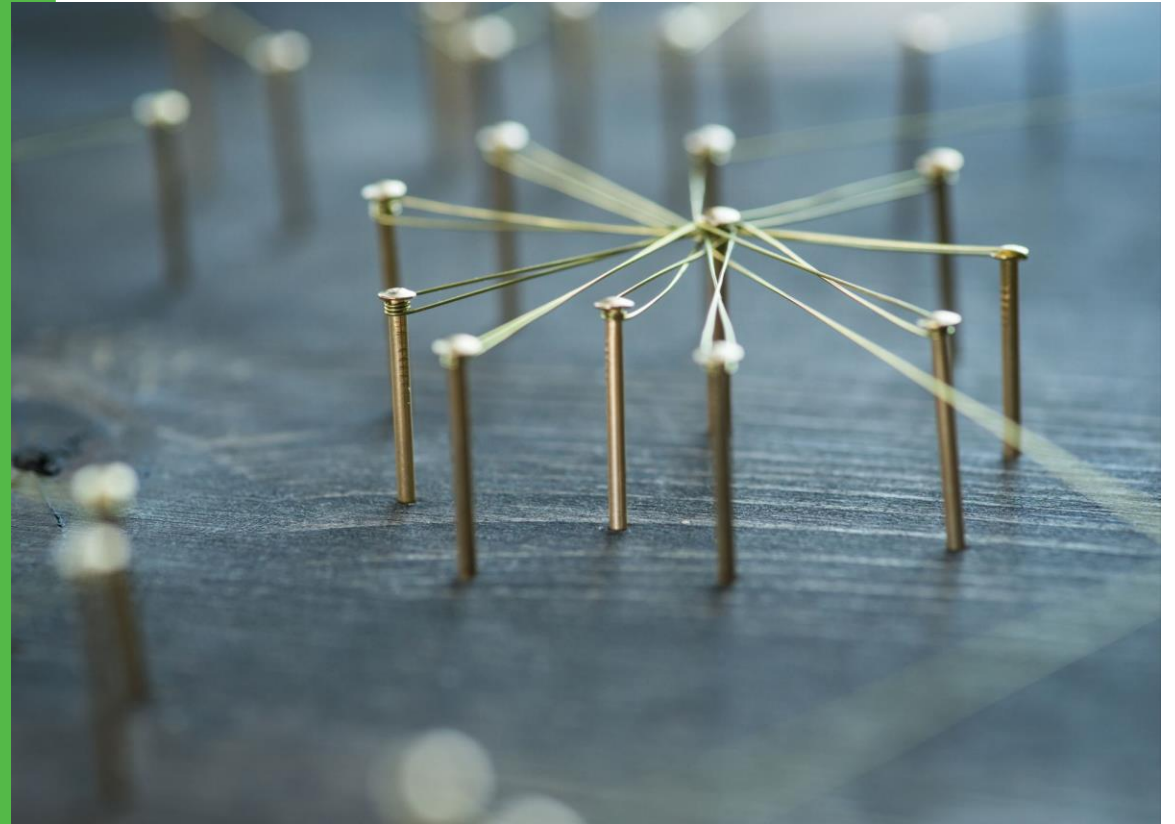
Vision: Neighbourhood Health Home that Centres Equity at the Core



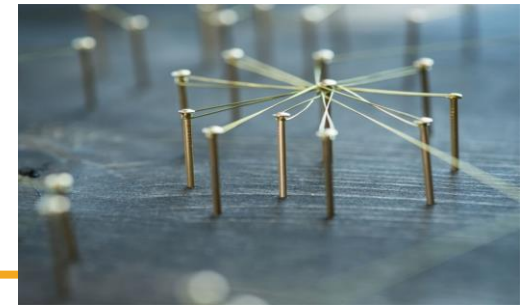
- Health Homes nestled within neighbourhoods serving people from geographical areas or priority populations
- Every person will have barrier-free access to an interprofessional team
- Community members involved with governance, decision-making and co-design
- Build on existing team-based primary care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

Hub and Spoke Model

- All primary care providers in the Neighbourhood Health Home will have access to the team, in hub and spoke model
- Primary care providers and teams will collaborate to meet local needs
- Each Neighbourhood Health Home will work with the PCN to meet physician, NP, and community needs



Hub and Spoke Model

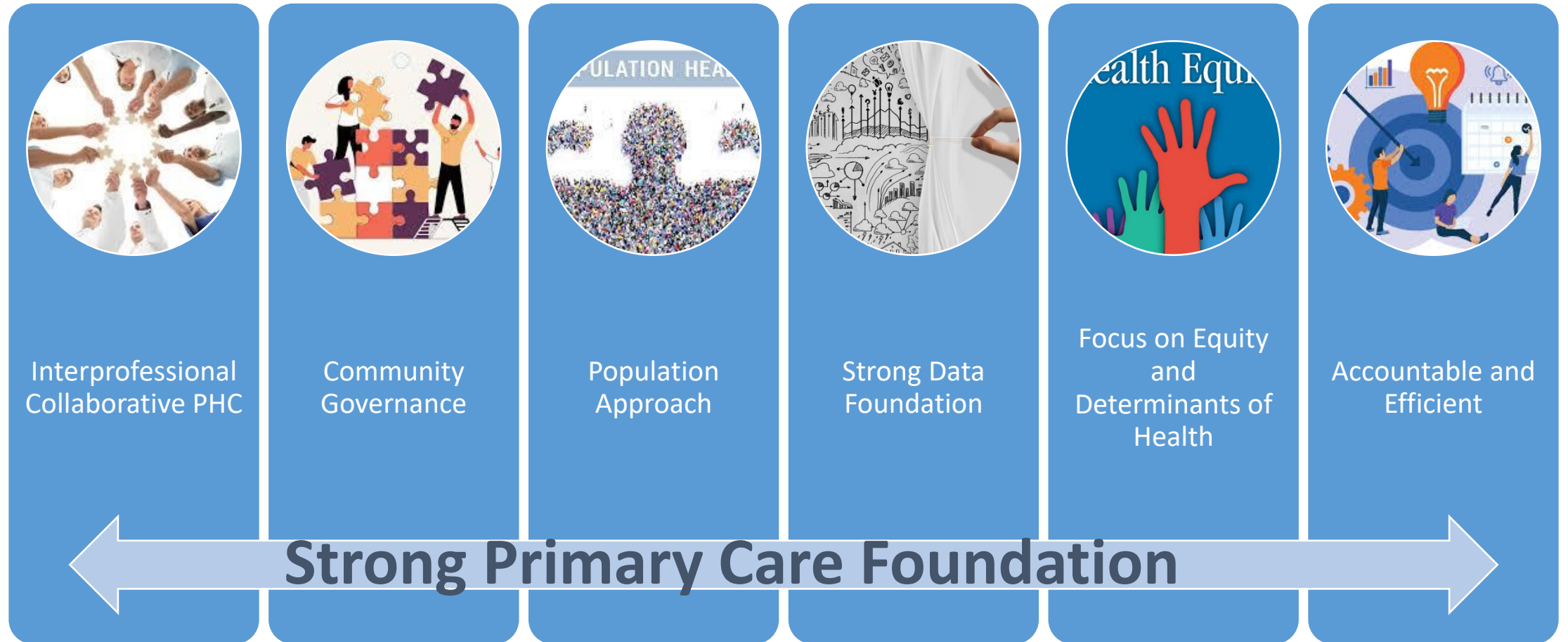


- Ideally, the HUB will be an existing interprofessional team-based primary care organization → several benefits such as existing accountable leadership, community governance, equity focussed and back-office support (including data, learning, quality improvement, etc)
- SPOKES will include all primary care providers within the Primary Care Network
- GOAL will be to ensure that every primary care provider is part of a team – regardless of location. Communication and care coordination will be seamless
- Similar models have been developed with strong results

Components of the Neighbourhood Health Home



Pillars of a Neighbourhood Health Home



Interprofessional Collaborative Primary Health Care

- The Hub will work with the Primary Care Network in each region to plan and ensure services are designed to meet physician and community needs
- All people within the community would have access to interprofessional team-based care including health promotion, prevention, social and community
- Link workers and system navigators built into each Hub to enable social prescribing



Community Governance

- Community engagement method that ensures involvement & empowerment of local community representatives in the planning, direction setting & monitoring of organizations to meet the health needs and priorities of the populations within neighbourhood communities
- Ensures voting directors are not employed by the organization
- Ensures equitable representation of the communities served
- Vision is that the Hub will be community governed



<https://www.ontario.ca/page/guide-not-profit-corporations-act-2010>

Population Approach

- Longitudinal comprehensive care for people in the community
- Tailored service delivery and population segmentation
- Ensures that care is provided across the continuum and includes strong focus on prevention, health promotion and addresses multiple determinants of health



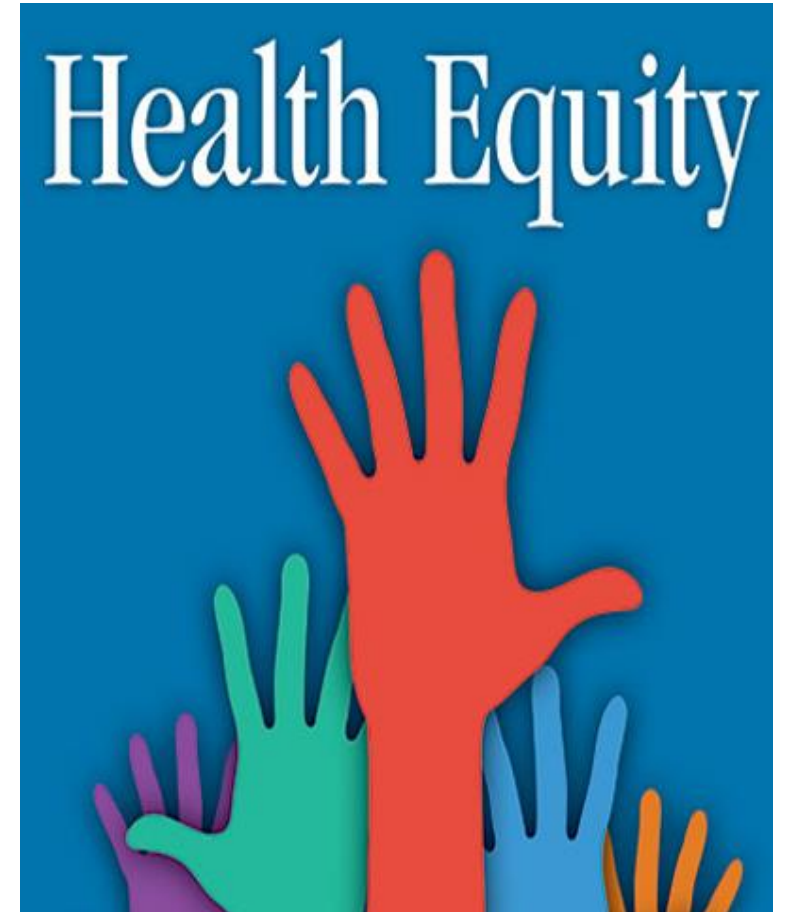
Strong Data Foundation

- Visit level data for all interprofessional team members
- Data systems inter-operable
- Support culture of learning and improvement
- Focus on patient reported experience & outcome measures
- Neighbourhood level data and community engagement will inform program and service planning.
- Population segmentation will be embraced that ensures a proactive approach to service delivery that includes health promotion and prevention within the community.



Focus on Equity and Determinants of Health

- Play a crucial role in promoting health equity by addressing SDOH
 - Focus on factors that impact a person's health such as income, education, housing, racism and access to quality healthcare
- Integrate social and community services alongside clinical care (e.g. social prescribing and link workers)
- Ensure that training is provided including Indigenous Cultural Safety, Anti-black racism, 2SLGBTQ+ and trauma-informed care



Accountable and Efficient

- Accountable to funders and community
 - Include performance measures, outcomes and contextual measures
- Equity stratified to ensure health disparities can be identified
- Mandatory accreditation to assess activities such as community engagement, governance, high quality care, improvement and highlight innovation



Steps towards realizing the neighborhood vision



Immediate Next Steps & Questions to Consider

- All models/practices in a region are required to achieve the vision
 - Are you connected to the primary care organizations and all the practices?
 - Are you exploring what kinds of populations/patients are served? What teams are in your region? What services do they provide? Inventory of mandates & expertise
 - Are there primary care organizations or providers that are providing culturally safe care to equity denied populations? Are you engaged with them? Can they act as the hub for your health home to ensure that the folks facing the most barriers and the poorest health outcomes are having their needs addressed?
 - What are the gaps?
 - What would it take to fill the gaps?
 - Can you develop MOUs to work together?

Immediate Next Steps & Questions to Consider

- Attachment is the driver, are your strategies inclusive of those that face the most barriers or are you inadvertently leaving people behind? How will you know?
- What data do you use to make decisions? Who is not included? Who isn't?
- Do you have measurable goals around equity? If not, how might you incorporate them?
- What can you do immediately to take steps towards the vision and what can you do longer term?
- Acknowledge power dynamics and protectionism – how can we proactively move forward to a place of collaboration vs competition
- Can we work together to establish shared principles to develop trust and relationships that will break these 'turf' issues behind

Immediate Next Steps & Questions to Consider

- [Indigenous Health in Indigenous Hands](#), while ensuring culturally safe care is offered in every primary care setting
- Have you engaged with Francophone, Black, 2SLGBTQ+ primary care leaders?
- If you have a rural/urban region, are you considering the unique needs of people living in rural areas?
- Are your boards talking to each other?
- If you work in an OHT are you acting as a convenor for your primary care in your area. Are you working with your PCN?
- Have you determined what would be required to meet the needs of your entire population (FTEs, programs, services, interpretation, non-insured funding, health promotion supports, interprofessional team resources, etc)

Co-Designing with Providers and Patients

- Reflect geographical areas and/or priority populations AND ensure that every member of the community has an interprofessional primary care team
- Recognize a one size fits all approach will not work
- Focus on community centeredness and co-design



Massive opportunity to make a shift
in the PHC landscape

Innovation, strategic leadership,
primary care and community
engagement is key to ensure that
we can design systems to meet the
need of our communities

Need to commit to
interprofessional team-based data
collection, ongoing improvement
and facilitation/coaching to enable
organizations to work differently





Questions/Discussion



Thank You | Merci | Miigwetch

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