Alliance for Healthier Communities
Alliance pour des communautés en santé

500-970 Lawrence Ave. W.
Toronto, ON M6A 3B6
416-236-2539
www.AllianceON.org

Regional Attachment for Primary Care

Executive Summary

Ontario's goal of improving primary care attachment cannot be achieved sustainably through uniform panel size assumptions alone. Patients differ substantially in their levels of medical and social complexity, and these differences shape the real workload required to provide timely, comprehensive, team-based care. This paper suggests that **Ontario should adopt a regional, complexity-adjusted, population-based framework for attachment planning, funding, and accountability, while simultaneously achieving the goal of 100% attachment**.

The province already has relevant tools, including the Standardized ACG Morbidity Index (SAMI) and the OMA acuity modifier, that demonstrate the feasibility of incorporating case mix into policy design. In a model that accounts for complexity, **OHT/PCN would be assigned responsibility for regional accountability** with regional targets that would be set based on attachment goals. A regionally-based **centralized intake** process would be used to assess clinical and social complexity and people would be matched with the best provider. This would be done by load balancing across all physicians and nurse practitioners in the region based on their practice model, type and capacity. Targets would be adjusted regularly depending on population need with the goal of 100% attachment across the population. This would require the use of a complexity modifier and **collaboration between all primary care providers and teams** which the OH region would help convene and ensure equitable involvement. This approach would better align resources with need, reduce disincentives to serve high-need populations, support health equity, and create a sound path toward universal attachment in Ontario after two years of initial investment. This approach does not require primary care funding reform – it balances expected panels on the characteristics of the patients and some primary care models may want to exceed these expectations if they see healthier people and have higher income expectations. The time is right to implement this strategy because of the investments and progress made during these first two years.

Introduction

In Ontario, primary care policy and decision makers are increasingly being asked to solve two problems at once: improve attachment and access for people without a regular primary care provider, and do so in a way that is equitable, sustainable, and realistic for clinicians and teams. These goals cannot be achieved through a headcount approach to panel size or attachment targets. Patients do not require the same level of care. Complexity in primary care is shaped not only by multimorbidity, frailty, and mental health conditions, but also by social determinants of health such as poverty, housing instability, language barriers, trauma, and isolation. As a result, two practices with the same number of attached patients may face very different workloads, resource requirements, and capacity constraints.

Ontario's current policy direction on attachment and new primary care investments tends to rely on uniform expectations about how many patients can be attached to a clinician or team. That approach may be administratively helpful, but it is not neutral. It disadvantages providers serving populations with greater multimorbidity, frailty, mental health needs, and social complexity. It may also create unrealistic expectations in communities where the work of attachment is more intensive, where patients require team-based support once attached, or where primary care is already carrying a disproportionate burden of unmet need. If Ontario pursues universal attachment without complexity adjustment, the system may expand nominal access while underestimating the workforce, team capacity, and funding required to provide meaningful and quality care.

The policy implication is straightforward: if Ontario expects all providers or teams to meet identical attachment expectations regardless of case mix, it risks embedding inequity into the design of the system. Providers serving populations with higher medical and social complexity will have less practical capacity to take on additional patients, even when they are working efficiently and intensively. A fair policy framework must recognize complexity as a core input into attachment planning and accountability.

Centralized intake, regional accountability and risk adjustment offers a practical solution for addressing this challenge – especially given many regions are working this way already. There are regions that have adopted a neighbourhood home model that includes a hub (existing team based primary care organization) and spoke (primary care clinicians or priority population team-based care organization), centralized intake, link workers and collaborations with all primary care clinicians to attach 100% of their population to primary care.

What Ontario Already Knows About Complexity

Patients with complex needs in primary care often experience **multimorbidity**, with multiple chronic conditions becoming increasingly common as populations age. More Ontarians than ever are living with **two or more chronic conditions**, with **complexity increasing over time**, such that more people are experiencing major chronic diseases and an increasing number living with **eight or more conditions**. Simultaneously, **resource intensity is rising**, meaning these patients require more complex, coordinated, and sustained care across the health system. This is further challenged with increasing mental health challenges such as depression and anxiety. All of this is compounded by **social determinants of health** - including housing instability, food insecurity, and limited social support—often which act as pivotal drivers of poor outcomes.

In primary care, risk adjustment is used to account for differences in the health status and social needs of patient populations when comparing performance, allocating resources, or designing payment models. Its purpose is not simply technical. It helps ensure that clinicians and organizations are not discouraged to serve people with more complex needs, and it reduces incentives to avoid patients who require more time, coordination, and interdisciplinary support.

Recently the OMA has recognized the importance of understanding patient complexity and implemented an **Acuity Modifier**. This is a payment adjustment to Ontario's capitation model that compensates family physicians (primarily in FHN and FHO models) for managing highly complex patients. This is similar to the UK (NHS) where patient and visit complexity is managed through a weighted capitation formula. This works for physician focused capitation models however with the focus on population health and team-based care additional considerations must be made.

Ontario does not need to start from scratch to address complexity, while attaching 100% of its population to primary care. The province already uses established case-mix methodologies to understand expected resource need in primary care populations. The Standardized ACG Morbidity Index (SAMI), derived from the Johns Hopkins Adjusted Clinical Groups system, provides a practice-level indication of expected health care need relative to the Ontario average. Every practice (except NPLCs) can receive a SAMI score in their MyPractice report or their Practice Profile. With standardized data entry, NPLCs could also receive this information. This information is available now and provides a comparable method to look at complexity across

practices and regions. The CIHI 'pop grouper' is also widely available, however does not have an easy-to-understand standardized measure.

The SAMI score offers a practical, interpretable measure for understanding whether a practice population is less complex, average, or substantially more complex than the provincial norm and the expected resources required to care for this population. The **average SAMI score in Ontario is 1.0**, and scores above or below this reflect proportional differences in expected primary-care workload. A team with a SAMI of 1.4, for example, is caring for a population expected to require **40% more primary-care resources** than the provincial average.

There is considerable variation in Ontario and recognizing that all clinicians have medically complex patients many have SAMI scores less than 1 or slightly above 1 – some organizations that serve older populations or populations with significant mental health/addictions, comorbidities that are compounded by determinants of health have SAMI scores predicting extensive primary care utilization (e.g. a recent project indicated SAMI scores between .78-2.2). Using the SAMI score and SDOH data, existing attachment goals could still be met however practices with a lower-than-average SAMI score can take more patients compared to practices with a higher-than-average SAMI score. A hypothetical scenario is provided below.

Hypothetical Scenario (physicians only however NPs could/should be included with standardized data entry)

A mid-size regional area has a total of 195,000 people and 83,000 of them are unattached to primary care. To improve access, a Neighbourhood Health Home approach has been introduced that uses centralized intake and data-driven matching to connect patients with the most appropriate provider.

Primary care physicians have unadjusted targets of 1,400 patients per physician. However, analysis of SAMI (Standardized ACG Morbidity Index) scores indicate that patient complexity varies significantly across practices. Some physicians care for less complex populations and may want and be able to manage larger panels, while others care for more complex populations and may require smaller panels. To ensure fairness and sustainability, the OHT/PCN would adjust attachment targets based on complexity and available team supports.

Hypothetical SAMI distribution

- **40 physicians** have a SAMI score of **0.80**, meaning their patient populations are **20% less complex** than the provincial average.
- **75 physicians** have a SAMI score of **1.0**, meaning their patient populations are of **average complexity**.
- **20 physicians** have a SAMI score of **1.4**, meaning their patient populations are **40% more complex** than average.

Complexity-adjusted attachment targets

- Physicians with a **SAMI of 0.80** can reasonably take on larger panels:
    - Adjusted target = 1400 ÷ 0.80 = **1750 additional patients per physician**
    - Across 40 physicians = **70,000 patients attached**
- Physicians with a **SAMI of 1.0** require no adjustment:
    - Adjusted Target = **1400 patients per physician** (no adjustment, SAMI = 1)
    - Across 75 physicians = **105,000 additional patients attached**
- Physicians with a **SAMI of 1.4** require smaller adjusted panels due to higher complexity:
    - Adjusted target = 1400 ÷ 1.4 = **1000 patients per physician**
    - Across 20 physicians = **20,000 patients attached**

Total impact

Together, these adjusted targets would support the regional attachment of approximately **195,000 patients**, meeting the regional area's overall attachment goal while better reflecting differences in patient complexity across practices.

Patient complexity and physician panel composition would be reviewed annually, with attachment targets adjusted over time as needed.

Practical Application

We are proposing that Ontario should adopt a complexity-adjusted, population-based framework for primary care attachment and capacity planning. At a minimum, this means moving away from the assumption that every clinician should be expected to attach the same number of patients regardless of panel complexity. We already have a reasonable starting point that would be used to define a baseline attachment (1400) for an average-risk panel and then adjust practical targets upward or downward based on an established complexity measure such as SAMI, with room to incorporate social complexity measures where available. This would create an equitable basis for planning, especially in communities serving populations with substantial material deprivation, housing instability, comorbidity, and barriers to accessing care.

This approach should be paired with regional accountability for **attachment at the aggregate level**. Ontario Health Teams (OHTs) and Primary Care Networks (PCNs) would be responsible for regional area targets with Ontario Health managing these targets. Within a neighbourhood health home model, team and back-office supports would be available for the primary care clinicians to support these attachment goals. Funding models are not required to be changed – just the targets and expectations. Physicians who want to attach more (based on their patient complexity and income) can. Otherwise, all primary care clinicians will have targets based on complexity.

OHTs and PCNs would be responsible for convening all primary care clinicians and teams to ensure a collaborative shared approach to attachment through a neighbourhood home approach. Complexity measures will be transparent. Centralized intake is required to assess individual clinical and social complexity and ensure that every person is attached to the right provider and team. Link workers (preferably housed at a large team-based organization) would be employed to support the region and ensure people had access to the social and community services that are required and have shown to increase the capacity for primary care clinicians to increase attachment.

The OHT/PCN would be responsible for supporting primary care clinicians and organizations to meet overall regional area attachment goals and OH would be responsible for target negotiations. Local provider- and team-level expectations will be adjusted to actual patient need. In practice, this would allow providers serving more complex populations to carry smaller panels,

while providers or teams serving lower-complexity populations could appropriately carry larger ones. It would also support a more honest conversation about where interprofessional team investments are most needed, since complexity affects not only physician/nurse practitioner workload but also demand for nursing, social work, mental health, care coordination, and community outreach.

Recommendations

1. Establish regional accountability for overall population attachment while allowing flexibility in provider- and team-level expectations based on the complexity of the populations served. This will be supported by OHT/PCN with target negotiations resting with OH.
2. Adopt a complexity-adjusted framework for primary care attachment planning that sets a baseline expectation for an average-risk patient panel and adjusts practical attachment targets using established case-mix measures such as SAMI. Complexity scores will be transparent and available to ensure appropriate targets can be set and accounted for.
3. Incorporate social complexity into planning over time by combining clinical case-mix measures with area-based deprivation indicators and standardized social determinants of health data where available.
4. Implement centralized intake to assess clinical and social complexities and ensure people are attached to the right clinician and have access to a link worker that will provide support for social complexities. This could be enabled using lead organizations that are currently housed in larger team-based organizations.
5. OHT/PCN will act as a convenor and bring together all primary care clinicians and teams to ensure a collaborative approach to attachment.
6. Clear guidance should be provided that outlines a structure (e.g. neighbourhood health home) that will support regional attachment. Regions could leverage the IPCT Community of Practice and learn from regions who have adopted this approach.
7. Additional flexibility may be necessary in rural, remote and northern areas that have additional complexities (such as distance between primary care organizations).

Implementation Considerations

A practical implementation strategy should begin with measures Ontario already has. SAMI can serve as an initial proxy for expected clinical resource need, while complementary measures of social complexity can be added using existing area-based deprivation indicators (and future standardized data collection with NPLCs and interprofessional team members). This is especially important for models such as Nurse Practitioner-Led Clinics and community-governed interprofessional teams, where social complexity may be especially pronounced but not always well captured in physician billing-based approaches.

Centralized intake and coordinated regional planning could further support fair distribution of attachment across providers and teams, but only if these mechanisms are linked to transparent complexity-adjusted expectations. In the absence of such adjustment, centralized attachment systems may simply shift inequity from one part of the system to another. Complexity adjustment must therefore be paired with OH holding regions accountable for overall attachment while allowing flexibility in how providers and teams contribute – all negotiated with OHTs and PCNs to ensure a collaborative approach.

Conclusion

Ontario has both a policy opportunity and a policy obligation to align primary care attachment strategies with patient complexity. The evidence is clear that medical and social complexity increases workload, requires more interdisciplinary support, and influences the real capacity of clinicians and teams. The province already recognizes this principle in parts of its payment and case-mix infrastructure. The next step is to apply the same logic to attachment planning and accountability. A complexity-adjusted, population-based approach would better reflect reality, support health equity, reduce disincentives to serve high-need populations, and create a more credible path toward universal attachment.