Alliance for Healthier Communities
Advancing Health Equity in Ontario

Vision for a Health Home

Introduction

For over 50 years, community health centres (CHCs) in Ontario have delivered comprehensive primary health care according to the shared principles described in our Model of Health and Wellbeing (MHWB). Like a neighbourhood home, our member organizations reach beyond their doors to improve the lives of people in their communities. Although it began with CHCs, this approach is now embodied by organizations from multiple primary health care models[1], who together form the Alliance for Healthier Communities.

This document elaborates on a vision of primary health care based on the MHWB, bred in our bones. If implemented, it will improve the health and wellbeing of people across Ontario.

Our Vision: A Neighbourhood Health Home

The Alliance for Healthier Communities (Alliance) strongly supports the vision of Health Homes nestled within neighbourhoods. The Health Homes we envision will serve people from geographical areas or priority populations, such as Francophone, Indigenous, Black, 2SLGBTQ+, or rural, remote, and northern people and communities. In our vision, every person will have barrier-free access to an interprofessional primary care team.

We envision that communities will be entrusted with governance and decision-making for their Health Homes. Community members will not only lead the organizations' boards, but they will also be meaningfully engaged in co-design to ensure that services are tailored and accountable to those who receive them.

In our vision, primary health care will be supportive and collaborative. It will advance population health and be grounded in health equity. The entire community will be included in this neighbourhood home – not just the patients who walk through the clinic doors. By building on existing team-based models – and establishing new ones where necessary – we can enable

[1] The Alliance is a network of 109 members, which include CHCs, community family health teams (CFHTs), nurse practitioner–led clinics (NPLCs), and Indigenous primary health care organizations (IPHCOs). IPHCOs deliver care according to the Model of Wholistic Health and Wellbeing.

interprofessional teams to collaborate deeply, with each provider working to their full scope of practice. This will help ensure that people receive seamlessly linked to care when they need it.

Primary Care Networks (PCNs) will be essential to the co-design and oversight of Health Homes. By participating in this process, primary care providers can help develop a tailored approach that supports the needs of their clients. We are confident that this will lead to strengthened comprehensive primary health care – a solid foundation for our health system.

Pillars of the Health Home

We are proposing a neighbourhood model that ensures everyone has a Health Home. Each Health Home will consist of a Hub (team-based primary health care organization) and Spokes (primary care providers and groups who are not directly part of a team, but who have access to it). In this collaborative hub-and-spoke model, primary care providers and interprofessional teams will collaborate to meet local needs. Each Hub organization will work with the PCN in their region to design services that meet physician and community needs.

The Health Home will be built on the following pillars:

1. Interprofessional, collaborative primary health care

If possible, each Hub will be an existing interprofessional primary health care organization. It will provide, in addition to primary care, a suite of interprofessional, team-based health care services. The Hub will consist of physicians and nurse practitioners who focus on serving the most socially and medically complex community members, along with interprofessional team members who support these patients and those of other primary care providers in the community. All primary care providers in the community will have access to the interprofessional team at the Hub, ensuring that care is coordinated and seamless.

Utilizing existing CHCs and CHC-like, team-based organizations as Hubs will enable Health Homes to build on an existing strong model with autonomous and accountable leadership, community governance structures, and back-office support. Alliance member organizations have a rich history of forging partnerships, collaborating, and obtaining funding to support their communities population-health-supporting programs, such as health promotion and disease prevention, which are not typically provided in other primary care settings.

The Spokes will be the primary care providers within the Primary Care Network (PCN). Every primary care provider should feel that they are part of a team – regardless of location. Seamless communication and care coordination will be built upon innovation that has already been demonstrated by numerous Alliance members through projects such as TeamCare and Neighbourhood Primary Care Networks (see Figure 1).

Ideally, each PCN will include a CHC (or a similar equity-focused organization) and an Indigenous Primary Health Care Organization (IPHCO) which would provide ongoing primary care as well as social and community-based supports tailored to the needs of people who experience barriers to care. These organizations would be the lead agencies for health promotion and preventive care in the network, as well as social and community supports, such as social prescribing, thus enabling a Health Neighbourhood.

In addition to nurse practitioners and family physicians, the Hub team will include nurses, pharmacists, dietitians, social workers, system navigators/link workers, health promoters and community health workers/community ambassadors. Hub teams will coordinate care and provide administrative support. It is important to recognize that the specific composition of teams will vary according to community needs. In some cases, additional staff will be required to ensure appropriate service delivery and care.

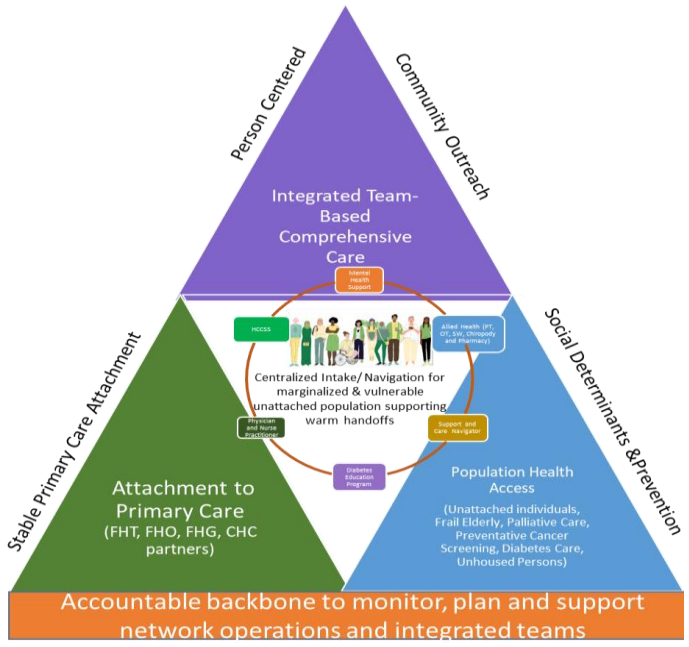

Figure 1. The Neighbourhood Primary Care Network model has been successfully implemented by Wellfort CHC. This model exemplifies our vision for Health Homes. To-date results are positive and strong. See Appendix for more details (case study pending).

All teams will have access to administrative and data resources as well as a quality improvement (QI) coach or practice facilitator to ensure ongoing improvement and implementation support.

2. Community governance and engagement

Each Hub organization will be community governed (see Alliance Community Governance paper). This will ensure that the community has an explicit voice in decision-making and accountability. Meaningful community governance goes beyond having a board comprised of community members; the voice of the community must be centred in decision-making across the organization. It is through effective community engagement and governance that organizations orient and tailor services to meet ongoing and changing population health needs.

3. Population-based approach

Health Homes will embrace a population-based approach. They will be the centre of care for people throughout their life course. Individual sociodemographic and race-based data, as well as community-level data, will be continually collected and utilized to support tailored service delivery and program planning as well as allowing for stratified outcome measurement and enabling continuous improvement.

This approach will ensure that comprehensive primary health care is accessible to all and grounded in health equity. Care will have a strong focus on illness prevention and health

promotion, supporting multiple determinants of health. This approach will be operationalized through intersectoral action and partnerships. Community outreach and engagement will ensure that local needs and solutions are deeply understood.

4. A strong data foundation

Health Homes will be supported by robust data infrastructure that includes data collection from all interprofessional teams and providers. Sociodemographic and race-based data will be collected for all patients, as will encounter-level details for every provider/staff interaction recorded in an electronic medical record (EMR). This will all be linked to system administrative data and used for accountability, improvement, and planning. The Alliance has a strong framework to enable this work, which should be utilized for all teams.

All systems should be interoperable and allow any health care provider to access information about their patients' care, regardless of where that care was provided. A subset of the EMR data should be extracted and available to Ontario Health, ICES, the Canadian Institute for Health Information, and the Ministry of Health to support system planning.

This strong data foundation will support a culture of learning and improvement, operationalized through dashboards, benchmarking reports, and other tailored reports that inform responsive action. All providers and teams will be enabled to participate in this culture. Patient-reported experience and outcome measures will be collected and used to improve care and to support program planning. Data will be equity-stratified to identify health disparities, so services can be tailored to address them. Practice facilitation and QI support will be available across the board.

Neighbourhood-level data and community engagement will inform program and service planning. Population segmentation will help ensure a proactive approach to service delivery in the community that includes health promotion and illness prevention.

5. A focus on equity and the determinants of health

We believe that the Hub, and the Health Home generally, should play a crucial role in promoting health equity by addressing the social and structural determinants of health. Comprehensive primary health care addresses the many issues that significantly impact a person's health, such as income, education, housing, racism, and access to quality healthcare. Health Hubs will focus on reaching populations that might otherwise face barriers to care due to their social circumstances, seamlessly integrating social and community services alongside clinical care. This will involve link workers, health promoters, community health workers, and others. Services will be planned in partnership with community members and tailored to local needs. Social prescribing will be available to every person in Ontario, and every Hub will provide access to a link worker or system navigator.

Social justice will be embedded in each Hub's mandate. They will be committed to providing equitable access to quality health care for all individuals, regardless of their socioeconomic status, race, ethnicity, gender, or other social factors, and they will actively address the underlying causes of health inequities.

Foundational training for equity will be provided to all primary care organizations and teams within a Health Home through the Hub. This training will build capacity for Indigenous cultural safety, addressing anti-Black racism, supporting 2SLGBTQ+ health, and providing trauma-informed care.

6. Accountability and efficiency

Hubs will provide accountability metrics to funders and communities. Mechanisms for accountability will include benchmarking reports and performance measures, which will be publicly shared. These will support transparency, oversight, and meaningful comparisons with peer organizations to inform improvement.

Mandatory accreditation will help ensure the organization is meeting standards for high quality, safe, patient-centered care. This will include assessments of community engagement, governance, and improvement activities, and it will highlight innovation. Currently, most Alliance members receive accreditation from the Canadian Centre for Accreditation (CCA). Like other accreditation bodies, CCA reviews standards, best practices, safety, and policies. Additionally, it includes modules on community governance, health equity, and innovation.

Conclusion

The Alliance strongly believes in comprehensive primary health care embedded within communities. We are excited to imagine this Health Home model which will strive for attachment and access to care for everyone who lives in Ontario. By embracing a team-based hub-and-spoke model, we will improve health and wellbeing by providing access to quality care for everyone – care that is focused on the whole person, addressing physical, mental, and social health.

This is an audacious vision, but we know that Alliance members are ready for the challenge. There is robust evidence demonstrating their capacity to provide high-quality, community-governed comprehensive primary health care that advances health equity and improves population health.

Appendix: The Primary Care Neighbourhood Network

Introduction

Neighbourhood models of team-based primary care have been implemented in many CHCs throughout Ontario. Over 25 organizations have successfully implemented TeamCare, which has built collaborative relationships with primary care providers who did not previously have access to teams. This overwhelmingly successful approach is exemplified in a Primary Care Neighbourhood Network that recently opened its doors thanks to new Interprofessional Primary Care Team (IPCT) expansion funding.

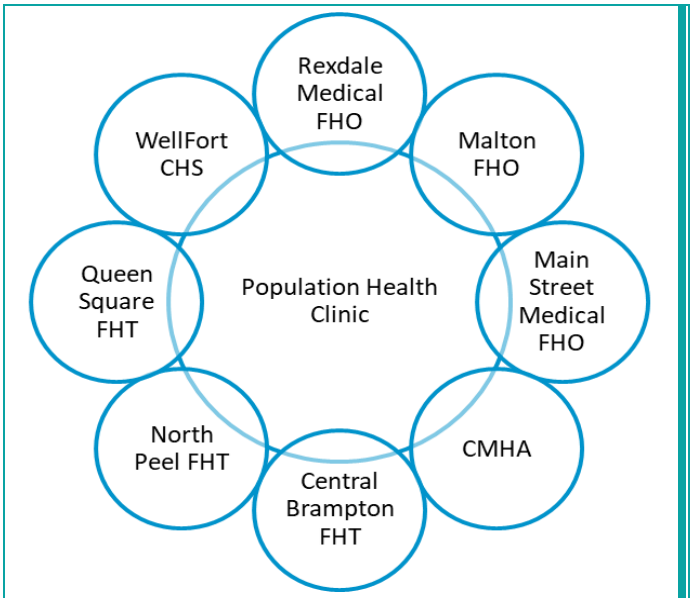

Figure 2. Primary Care Neighbourhood Network

The Primary Care Neighbourhood Network (Figure 2) is a hub-and-spoke model in which Wellfort CHC acts as the Hub. In a short time, Wellfort has built partnerships with several family health teams (FHTs) and family health organizations (FHOs) to expand primary care capacity and increase access to interprofessional teams. They are delivering person-centred care for people in Brampton and Mississauga through a population health approach that ensures all people receive the care they need, when they need it. Through additional partnerships and collaborations, they are leveraging their shared experience and resources to optimize patient outcomes and experience.

The Primary Care Neighborhood Network includes the CHC, FHTs, FHOs, and organizations providing care for mental health and addictions. The Population Health Clinic houses newly funded interprofessional team members: nurse practitioners, chiropodists, physiotherapists, dietitians, nurses, health promotion, counsellors and an intake coordinator. Primary care organizations are sharing some interprofessional team members within this model at their prospective sites.

Patients accessing care at the Population Health Clinic are assigned to primary care providers through a triage process according to social and clinical complexity, provider focus (priority population), patient preferences (gender, language), equitable distribution of patients across providers, and availability.

Model Overview

1. Increased interprofessional shared system resources
    - Increase capacity of system to attach patients to primary care (within the Hub/CHC or partner organizations) through partnerships and access to interprofessional care.
    - Resources and program expertise shared across practices.
2. New Population Health Clinic for unattached populations
    - Clinic embedded in the community focusing on population health programming and access to interprofessional resources.
3. Set up centralized intake and navigation function
    - System-wide resource to create ease of access to primary care resources for unattached, marginalized and complex patients.
    - Includes single point of contact, initial assessment, personalized care planning and navigation to primary care.
    - Social prescribing.
    - Population health-based assessment to identify care needs for unattached population in the neighbourhood network.
4. Increased backbone support to enable the model and serve the most complex patients
    - Infrastructure investment to build Wellfort (CHC) as a central coordinating entity for administration, human resources, finance, performance management, information technology, data management, and quality improvement.

Preliminary Outcomes

This model was developed in the fall of 2024. In a few short months, the Population Health Clinic has become operational, and primary care providers are working together. Interprofessional team members continue to be hired and onboarded across the network. All FHO physicians have fully embraced this model.

In three months, over 3600 patients have been attached and have increased access to interprofessional team members. Trust has been built across the network, and resources are being pooled. Care pathways are being developed, and further partnerships are being created (including the local Primary Care Network, Health Care Connect, Urgent Care, emergency departments, and the local Ontario Health Team).

This model and other TeamCare models throughout Ontario exemplify our vision of the Health Home. Alliance members are well situated to scale and spread this neighborhood model of the Health Home.