HSPN Health System Performance Network

Local Innovation in Population Health: Lessons from the LDPHM Initiative

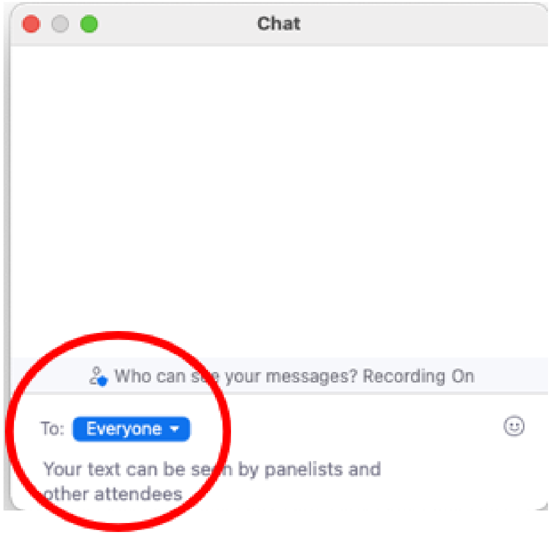
HSPN Monthly Webinar

July 22, 2025

Welcome & thank you for joining us!

Please let us know who you are by introducing yourself (name & OHT or other org)

- Open Chat



- Set response to everyone in the chat box

Land Acknowledgement

We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

Poll 1

Webinar poll | 1 question | 69 of 93 (74%) participated

1. Have you joined us for an HSPN webinar previously? (Single choice)

69/69 (100%) answered

Yes. I have participated previously (41/69) 59%

No. This is my first event (28/69) 41%

HSPN Health System Performance Network

Today's event:

Local Innovation in Population Health: Lessons from the LDPHM Initiative

Co-Host

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Co-Lead
Leading Project Evaluation HSPN

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Presenters

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Director of Development and Clinical Care

Neethan Shan
Carefirst Seniors & CommunityServices

Carefirst Seniors & Community Services

Amanda Bonacci
Director of Community and Social Services

Fatima Andad
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Rana Taher
Resident Leader

South-East Ottawa CHC

Sophie Ikura
Executive Director
Health Commons Solutions Lab

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Poll 2

1. To what extent are community members involved in designing health initiatives in your setting? (Single choice)

56/56 (100%) answered

Answer	Responses
They lead or co-lead program design	(7/56) 13%
They are regularly consulted during development	(33/56) 59%
They provide input occasionally	(11/56) 20%
We inform them, but don't typically involve them in design	(2/56) 4%
Not involved at all	(3/56) 5%

Agenda and Overview

1. Introductions
2. What are the Locally Driven Population Health Models?
3. Learning from Community Agencies
   - Flemingdon CHC
   - Carefirst Seniors & Community Services
   - South-East Ottawa CHC
4. Learnings from the Health Commons Solutions Lab
5. Panel Discussion

What are the Locally Driven Population Health Models?

Locally Driven Population Health Models

- partnerships with health and social service organizations
- locally informed, culturally responsive programs to improve access to healthcare services
- addresses community and population health needs

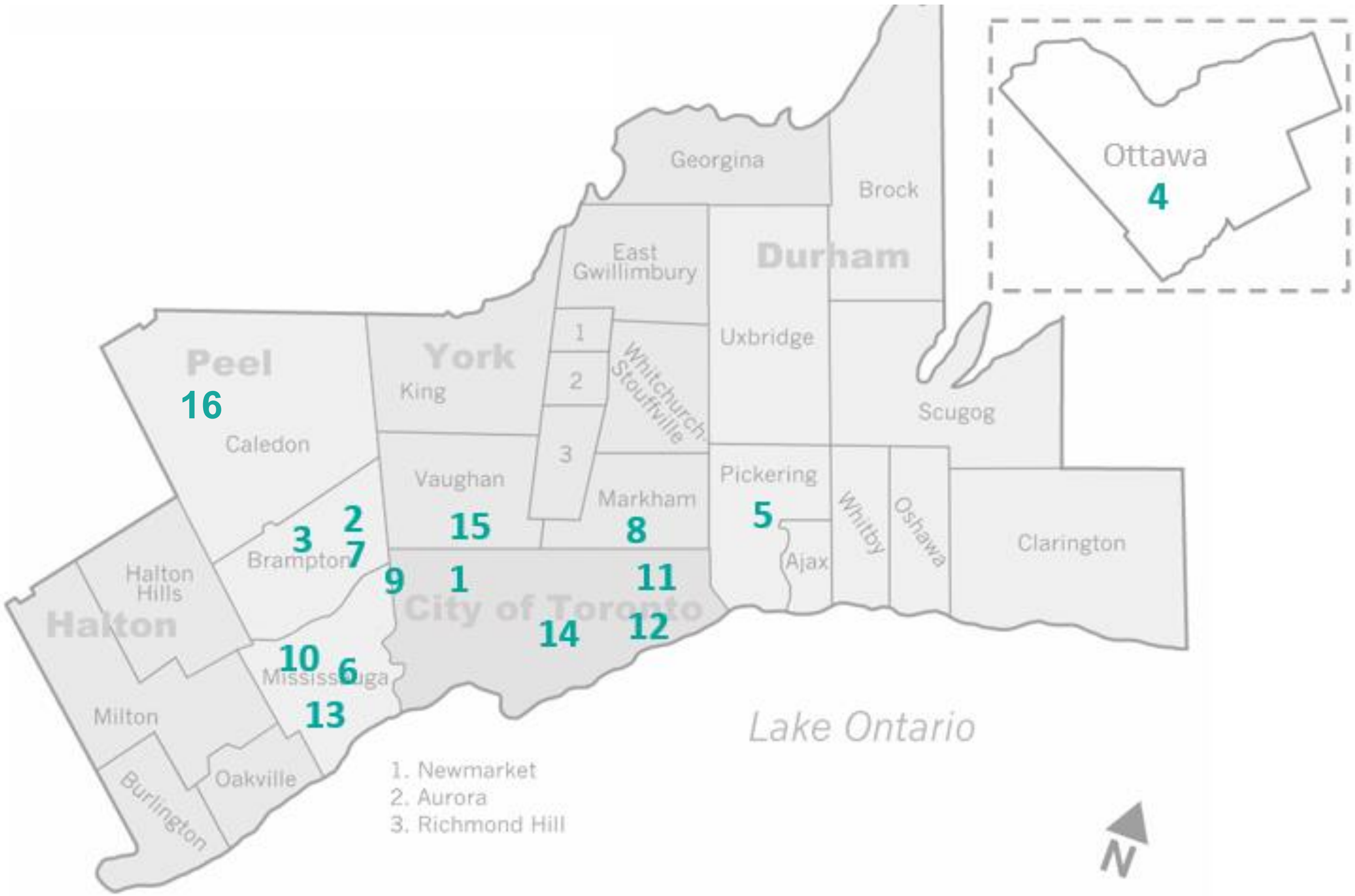
- Initially focused on ***pandemic response supports in at risk communities*** (as part of the High Priority Communities Strategies)

Since April 2022:

Chronic disease prevention	Mental health and addictions supports
Primary care attachment	Wrap-around supports

Lead Agencies involved in LDPHM

1. Black Creek (Black Creek CHC)
2. Bramalea (Wellfort Community Health Services)
3. Brampton(Punjabi Community Health Services
4. Central Ottawa (South East CHC)
5. Durham West (Carea)
6. East Mississauga (Dixie Bloor Neighbourhood) Services)
7. Malton (Wellfort Community Health Services)
8. Markham (Carefirst)
9. North Etobicoke (Rexdale CHC)
10. North West Mississauga (Indus Community Services)
11. Scarborough North (TAIBU CHC)
12. Scarborough South (Scarborough Centre for Health Communities
13. South West Mississauga (Dufferin-Peel Canadian Mental Health Association)
14. Thorncliffe Park (Flemingdon CHC)
15. Vaughan (Vaughan CHC)
16. Roots Community Services (providing service to Peel Region)



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What do the LDPHMs do?

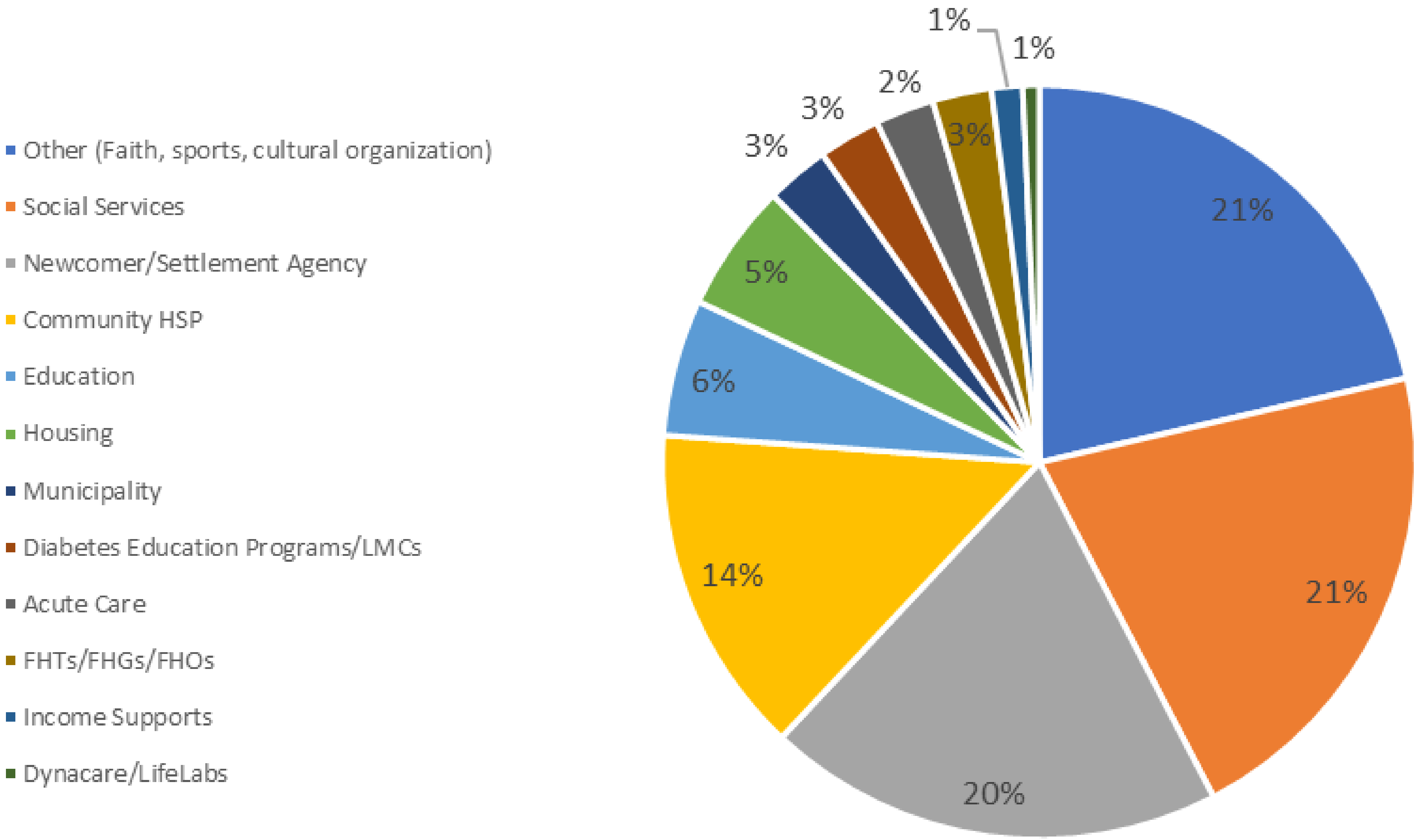
- Bringing Services to the Community
- Partnering with Primary Care
- Education and Communication
- Wraparound Supports
- Community Ambassadors
- Coordinating Referrals
- Expanding Partnerships

LDPHM Impact

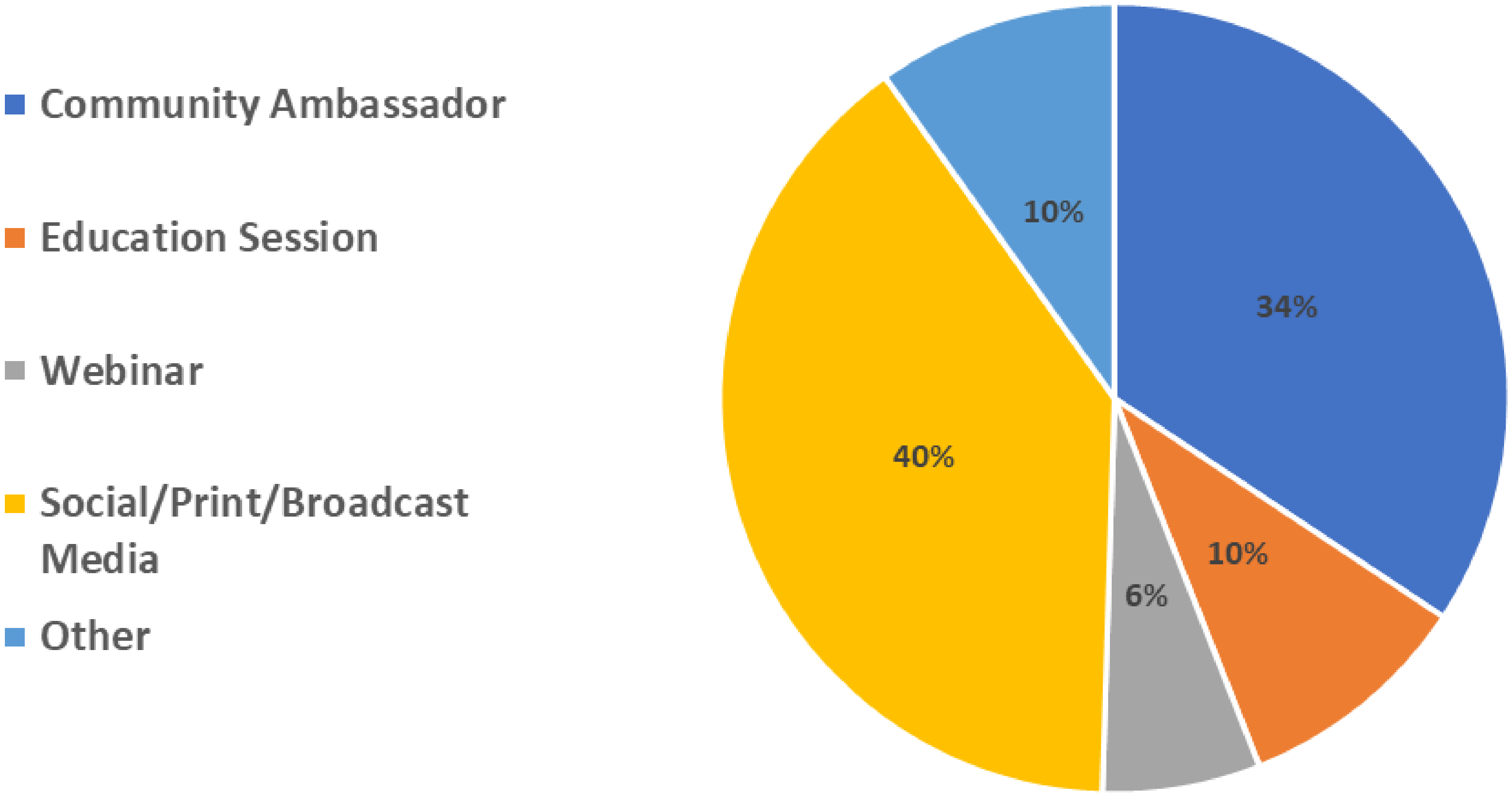
In Q4 2023/24:

- 2,252 **new partnerships formed across 10 sectors**
- 291,000+ **community engagement interactions**
- 57,300+ individuals were **referred**, while 29,400+ directly received **wraparound supports**
- 9,700+ individuals **referred to primary care** and 2,105 **successfully attached**
- 17,000+ referrals for **cancer screening**
- 17,000+ individuals referred to **mental health or addiction (MHA) supports**, while 9,900+ individuals received MHA supports directly from Lead Agencies
- 1,300+ **Naloxone kits distributed**

Partnerships with Health and Social Organizations (Q3, 2023/24)



Community Engagement Interactions



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Flemingdon Community Health Center

East Effort

A Community-Based Network of Ambassadors solving Health System Inequities in Toronto

Evolution of East Effort

- The pandemic underscored the need for culturally relevant, community-rooted responses.
  - Organizations onboarded neighbourhood-embedded leaders as CHAs to increase vaccine uptake, provide wraparound support, and reduce isolation barriers.

- The role of CHAs evolved with each wave, becoming essential in addressing health inequities.
  - FHC advocated for program sustainability, securing baseline funding in 2024/25

- The East Effort Steering Committee prioritized CHA sustainability and skill and knowledge capacity.
  - In response, FHC expanded training offerings, focusing on chronic disease management (CHF, COPD) aligned with OHT Integrated Care Pathways.

- Today, CHAs are better equipped to guide communities onto care pathways, fostering long-term health and resilience.

East Effort Background

What is the East Effort Project?

ENABLERS

Provide guidance and support. Ontario Health provides funding under the High Priority Communities Strategy. FHC is the lead agency supporting all levels of the East Effort Project.

DECISION MAKERS

Members of the steering committee along with FHC, are responsible for the planning and development of the infrastructure to support East Effort (EE).
(represents organizations that were engaged during all 4 phases and not exhaustive list)

PARTNERS

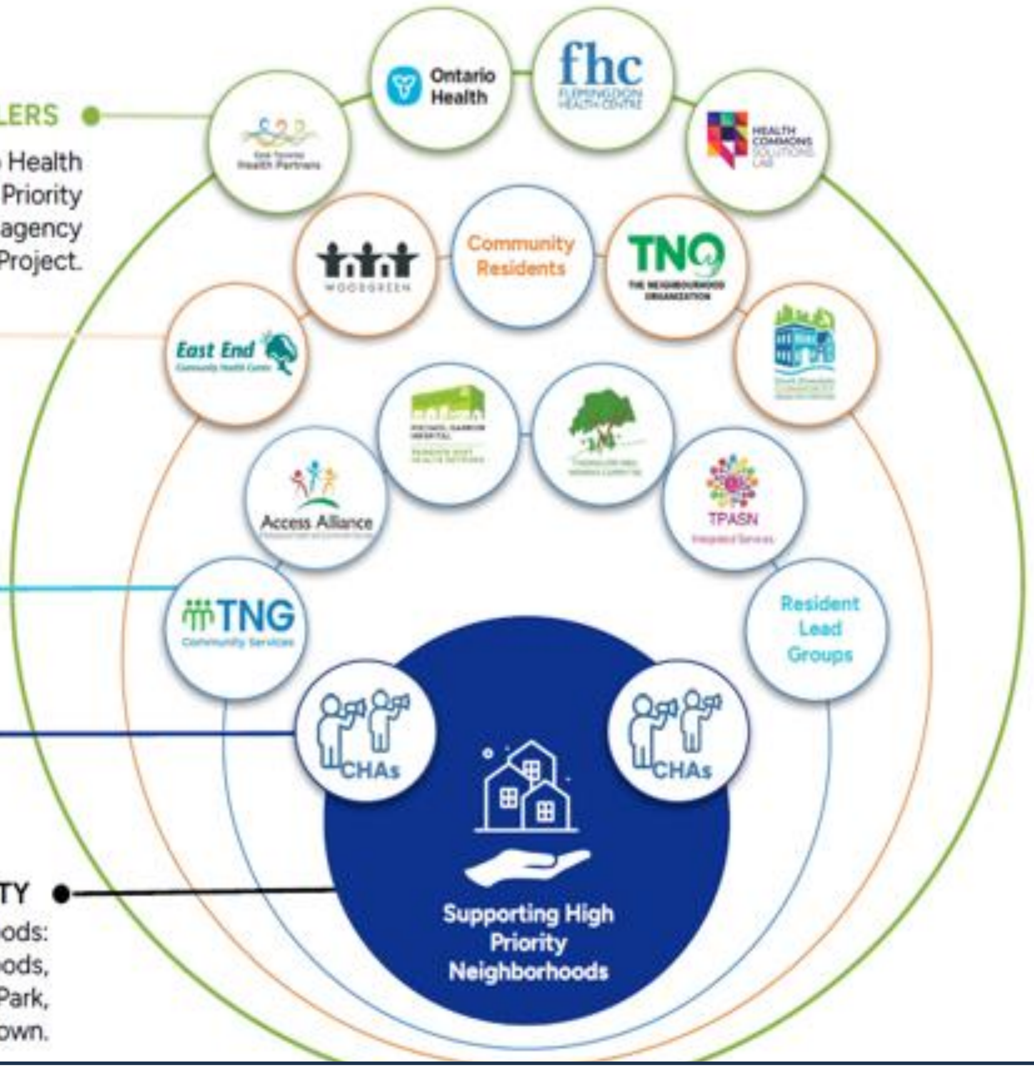
Responsible for delivery of services in the community, addressing health inequity.
(represents organizations that were engaged during all 4 phases and not exhaustive list)

CHAs

Community Health Ambassadors (CHAs) are connectors to the community, leading outreach and engagement. They are employed by various Partner organizations.

COMMUNITY

East Effort (EE) focuses on supporting these neighborhoods: Oakridge, Warden Woods, Flemingdon Park, Thorncliffe Park, Taylor Massey & Crescent Town.



Identifying & Addressing the Needs based on Data available

East Toronto's population is more than 50% immigrants (Source: Canada Census 2021)

East Toronto's average colorectal screening rate is 57% (Source: Ontario Health 21/22)

Vulnerable neighborhoods at 10% lower rates than higher socio-economic neighborhoods (Source: Ontario Community Health Profiles Partnership).

Understanding the needs of the community has enabled solution design around the community.

Community Health Ambassadors got **trained to offer cancer screening education,** knowledge translation, language support and culturally adapted messaging.

Flemingdon Health Center implemented a robotic process **automation (RPA), named "Poppy Bot"** on their electronic health record that will identify eligible clients and ensure the client receives a screen.

Collaborative Quality Improvement Plan

To Bring Eligible patients up-to-date with Papanicolaou tests, mammograms, and colorectal screening.

01 Problem

1. The pandemic has demonstrated a backlog in care.
1. Inequitable screening rates (race & income)

02 Indicator: Current → Targets

- Eligible patients up-to-date with Papanicolaou (Pap) tests:
  2022/23: **49.10 %** → 2023/24 **50.10%** 1.0
- Eligible patients up-to-date with a mammogram:
  2022/23: **54.90 %** → 2023/24 **56.00%** 1.1
- Eligible patients up-to-date with colorectal screening:
  2022/23: **58.00 %** → 2023/24 **59.5%** 1.5

03 Change Concept

1. **Test of Change: Poppy Implementation**
2. Strengthen and build upon partnerships
3. Geoanalytics- Mammogram Use Case
4. **Engagement in priority neighbourhoods with Community Health Ambassadors**
5. East Toronto Community Health Centers creation and implementation of Cancer Screening Dashboard

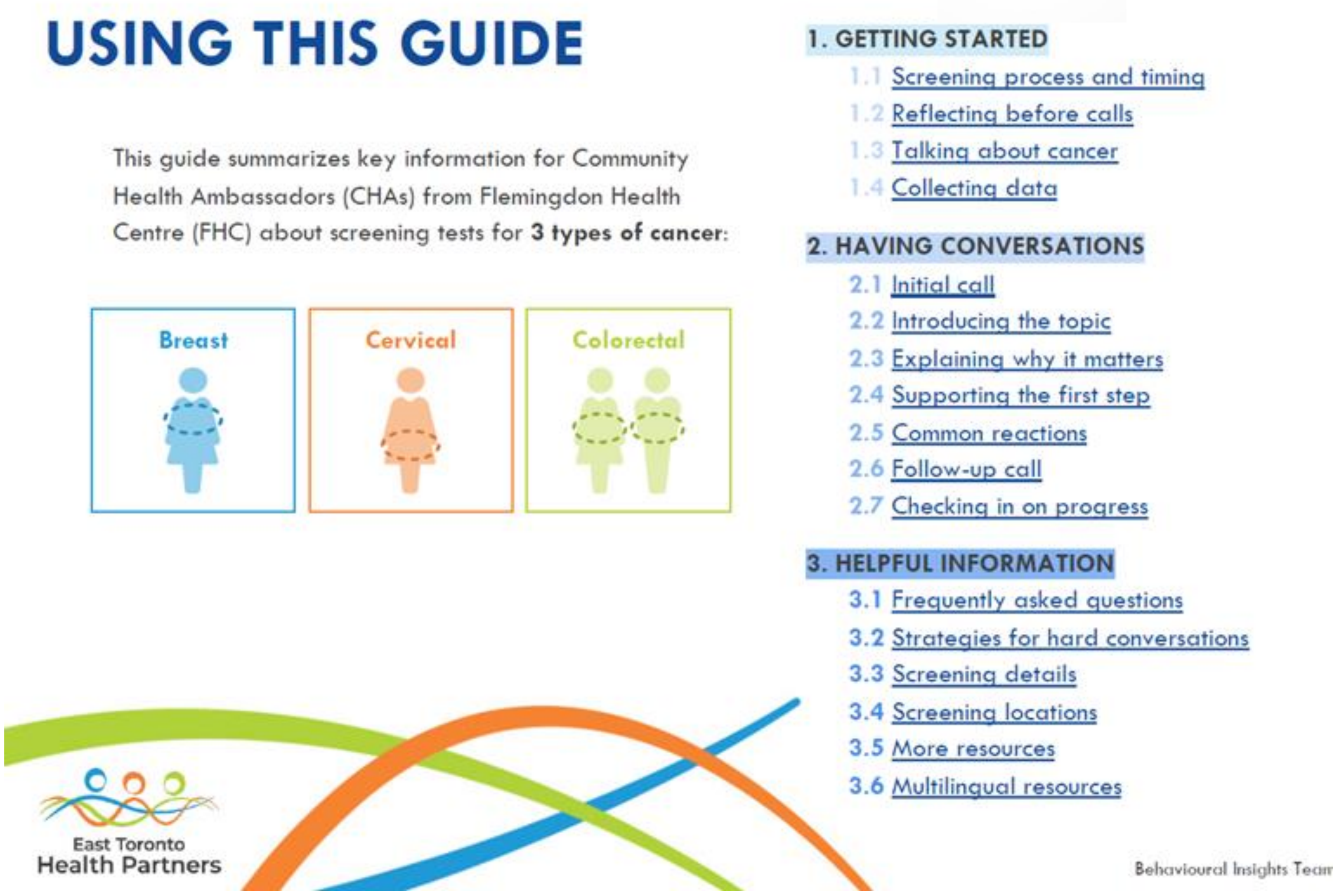
CHA Impact in Cancer screening

- ETHP, FHC, Health Commons and the Behavioural Insight Team along with our CHAs developed a one of a kind framework for culturally informed cancer screening awareness
- CHAs supported colorectal, cervical, and breast cancer screening through:
  - Language-specific outreach (Pashto, Urdu, Bengali, Dari, Arabic, Slovak.)
  - One-on-one client support (booking, navigation, education)
  - Onsite and mobile screening events (e.g. health fairs, mobile buses)
  - Use of culturally appropriate communications:
    - Co-designed flyers and outreach materials
    - Avoided stigmatizing terms (e.g. “cancer” where culturally sensitive)
- Motivated 1000+ previously reluctant residents to undergo screening.

50 YEARS OF IMPACT fhc FLEMINGDON HEALTH CENTRE

East Toronto Health Partners

Cancer Screening Awareness Blueprint



USING THIS GUIDE

This guide summarizes key information for Community Health Ambassadors (CHAs) from Flemingdon Health Centre (FHC) about screening tests for **3 types of cancer**:

Breast

Cervical

Colorectal

East Toronto Health Partners

Behavioural Insights Team

Impact of Community Health Ambassadors

Community Testimonials for Cancer Screening:

"Yes it was very helpful to have someone reminding me that I needed the testing. I understand that it was a great effort and time-consuming for the people who called me, but really appreciated being able to ask questions about the testing, and being reminded that I needed to do it this year. Overall a great effort by my doctor and team."

"Yes it was helpful. It was helpful to be reminded of the fact that I was due for screening. They talked to me about the specific test I needed and answered my questions. Usually other doctors' offices don't even call you or tell you that you are due, so I appreciated it"

"It was good someone called me about this. They told me I needed to get it done. I did not know much about the test and they explained to me that I needed to get it done regularly after the age of 50. It is so helpful to have someone call about this."

Nimble response to emerging crisis in the community:

- Partnered with IPCT to address student suspensions caused by missing vaccination records
- Delivered language-specific support to families from diverse backgrounds.
- Helped parents understand requirements and accurately upload immunization records
- Prevented school interruptions through building bridges between parents, students, the school and community health partners.
- Our response helped drop the number of suspensions at Marc Garneau C.I. from 114 to 37.

Current CHA Outreach Activities

"NEW" Flemingdon Park & Thorncliffe Park Access Clinic

Flemingdon Park:
10 Gateway Boulevard
Hours: Mon, Wed 4pm to 8pm,
every other Sat 9am to 2pm

Thorncliffe Park:
45 Overlea Boulevard, 2nd Floor
Hours: Tue, Thu 4pm to 8pm,
every other Sat 9am to 2pm

What the Access Clinics are Offering:

- Interim care from a primary care provider
- Help in finding ongoing support with a permanent family doctor
- Cancer Screening
- Vaccination
- Service Navigation (Settlement, Housing, Food Security, Employment, Dental, Optometry, and more)
- Referrals to other health and social services for equity focused neighborhoods in East Toronto (including: Thorncliffe Park, Flemingdon Park and Taylor Massey)

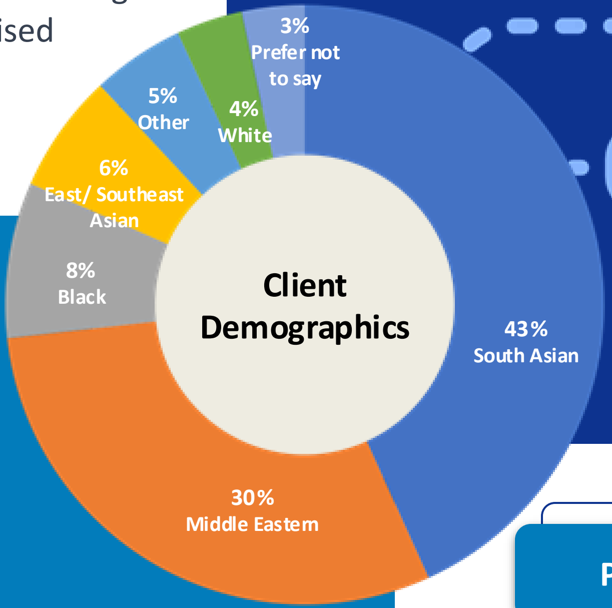
Supporting Interprofessional Primary Care Teams

- CHAs are actively engaging communities to raise awareness about available primary care services in high priority neighborhoods.
- "Meeting people where they are" remains a guiding principle, with outreach embedded in culturally relevant settings and during religious holidays i.e Eid and Holi .

East Effort In Action 2023-2025

Population served:

Low-income equity deserving populations including: seniors, single mothers, immunocompromised people, families with disabilities, newcomers and racialized communities.



Community Engagement, Education & Information Sharing

35 CHAs deployed in their local communities

67,983
Community Interactions

9555
1:1 interactions

2978
Educational Session Attendees

meeting the community where they are…

- CHAs are local residents
- Door-to-door outreach
- Wellness check-ins
- Local whatsapp groups
- Resident tabling sessions
- Wellness fairs & community events
- Flyer distribution

Cultural Sensitivity & Language Diversity

English, Dari, Urdu, Slovak, Bengali, Arabic, Pashto, Amharic, Tamil, Hindi

Service Navigation & Wraparound Support

81 referrals to community assessment centres/prescribers

Service Navigation

6,140 Referrals

Wraparound Supports

4,110 Direct Support

Wraparound Supports include: Housing, Food Security, Income Support, Social Services, Reminder Calls, Settlement Services, Transportation, etc).

Increasing Access to Care

Primary Care

572 Primary Care Referrals

194 Newly Attached Patients

Preventative Care

174 HBA1C Screening Referrals

HBA1C Tests Completed

149

Retinal Screening Referrals

139 Retinal Screenings Completed

117 Mammogram, FIT & PAP Referrals

400

Mental Health & Addictions

151 Addiction Referrals

Mental Health Referrals

704

Mental Health Services Provided

815

Lessons Learned

1. Early identification of Challenges
2. Community consultations
3. Transparency and Community Engagement
4. Community Capacity Building
5. Inclusive Decision Making
6. Cultural Competency
7. Regular Communication
8. Leverage Relationships

CHA Program Outcomes

- CHA program data collected on:
  - Pre/post comfort with accessing care
  - Pre/post knowledge of cancer screening
  - # of individuals contacted during community engagement + # of primary care attachments.
  - Health Equity and access to OH services data collection

- Lessons learned now informing future projects. Such as CDM work.

- Recognized by:
  - North America Conference of Integrated Care 2024 and International Conference on Integrated Care 2025
  - Published case study: “How can we reach non-English speakers for cancer screening?”

Some of the faces behind the East Effort Community Health Ambassador Model

Carefirst Seniors & Community Services

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HPCS/LDPHM Community-based Lead Agency: Carefirst
Adopting a Life Model and Integrated Care Approach

Carefirst One Stop Multi Services Centre

Carefirst Campus of Care (In development)

Comprehensive continuum of coordinated, person-centered health and social supports for older persons and care partners with ongoing care needs at home, in local community hubs, and in residential settings

- PREVENTIVE CARE INTERGENERATIONAL WELLNESS
- ADULT DAY PROGRAM
- PRIMARY CARE
- CHRONIC DISEASE MANAGEMENT
- COMMUNITY SUPPORT SERVICES
- HOME CARE
- ASSISTED LIVING
- TRANSITIONAL CARE
- LONG-TERM CARE

BASED ON PACE (PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY)

INTERPROFESSIONAL & INTEGRATED PRIMARY AND SOCIAL CARE

Carefirst

Carefirst partners with local community centres to engage isolated seniors in exercise and falls prevention program with transportation support.

Carefirst co-hosts annual Celebrate Health Fairs with EYRNDOHT and YMCA.

Carefirst's Community Ambassadors developed and performed drama to raise awareness around early identification of mental health challenges within intergenerational immigrant households.

Carefirst, WYROHT, March of Dimes Canada, and Reena came together for ground-breaking efforts to provide tailored cervical cancer education and onsite HPV screening clinic to individuals with intellectual and developmental disabilities on Carefirst's Mobile Health Unit.

Healthcare - Including Mental health and addictions and Ontario Health Teams (OHTs)

Since 2021,
- Addictions Services Central Ontario
- Canadian Mental Health Association York & South Simcoe
- Carefirst Family Health Team (FHT)
- Dynacare
- Eastern York Region North Durham OHT
- Health-For-All FHT
- Hong Fook Mental Health Association
- Oak Valley Health
- Regional Cancer Programs (Central, Central East)
- Regional Municipality of York (E.g. Community and Health Services – Public Health)
- Scarborough Centre for Healthy Communities
- Scarborough Health Network
- Scarborough OHT

Since 2023,
- The Canadian Centre for Refugee & Immigrant HealthCare
- Western York Region OHT
- Sinai Health, Community Mental Health Program

Carefirst collaborates with an evolving network of local partners to tackle complex health challenges addressing the determinants of health

1. Integration across systems over time to listen/advance changing local needs

2. Meeting needs through equitable access and hyper-local innovations

3. Building shared capacities

Social Care and Community Support Services

Since 2021,
- 105 Gibson Centre
- 360° Kids
- Centre for Immigrant & Community Services
- Community & Home Assistance to Seniors
- Social Services Network
- The Cross-Cultural Community Services Association
- Welcome Centre Immigrant Services
- YMCA of Greater Toronto (Markham YMCA)

Since 2022,
- Across U-Hub
- Island Breeze Seniors Day Program
- Markham Public Library
- York Hills Centre for Children, Youth and Families
- Your Support Services Network

Since 2023,
- COSTI Immigrant Services
- EarlyON Child and Family Centres Markham
- ESS Support Services
- March of Dimes Canada
- Markham Food Bank
- Reena
- Women's Support Network of York Region
- York Region Centre for Community Safety

Faith-based, Ethnocultural, and Grassroot Organizations

Since 2021,
- Ebenezer United Church
- Islamic Society of Markham
- Markham Chinese Presbyterian Church
- Markham Wesley Centre
- **South Asian Health Alliance**
- **Tamil Canadian Centre for Civic Action**

Since Dec/2022,
- Council of Agencies Serving South Asians
- Federation of Tamil Canadians
- Sanatan Mandir Cultural Centre

Since 2023,
- Afghan Women's Organization Refugee and Immigrant Services
- Refugee Women’s Network

Other sectors – Including Government, service networks, housing, academia, private sectors and more

Since 2021,
- Councillors, City of Markham
- Health Commons Solutions Lab
- Media partners (ethnic media)

Since 2022,
- Housing York Inc.
- Seneca College
- Shopping centres
- South Markham Community Action Tables (SMCAT)
- Toronto Metropolitan University
- University of Toronto

Since 2023,
- *York Region District School Board*

Partnership in Action: The need, elements, and growth

Carefirst co-hosted with Health Commons Solutions Lab, *The Gathering 2024*, bringing together a network of activated Community Ambassadors and system leaders in Ontario Health.

Carefirst and partners brought mobile health screening and wellness clinics across local settings – bringing care closer to home.

Key Enablers,

1. Enabling policy framework and mentorship for local innovations
2. Community-based Lead Agency model
3. <u>Dynamic Partnership</u>
4. Focus: EIDA-R and Wellness

The HPCS/LDPHM Impact
A Made-in-Ontario Model of Care
on:

- Health and wellness
- People, communities and assets
- Integrating care
- Shared capacity building: Partners
- "What matters to you?" and <u>*You matter!*</u>

Carefirst co-hosted with EYRNDOHT a series of community engagement in the collective journey to advance local Black health priorities.

Community Partners Visioning sessions on health equity.

Carefirst's Prevention Specialists engaged with working individuals in chronic conditions prevention during weekend outreach.

South-East Ottawa Community Health Center

Community Development Framework
Cadre de Développement Communautaire

South-East Ottawa Community Health Centre
Centre de santé communautaire du sud-est d'Ottawa

Community Ambassadors

A Strengths-Based & Culturally Adapted Gateway to Community

Presenters:

Rana Taher, Resident Leader/Community Ambassador

Amanda Bonnaci, Director of Community and Social Services

Fatima Andad, Mental Wellbeing Coordinator CDF

Who we are

The Community Development Framework (CDF) started in South-East Ottawa Community Health Centre's (SEOCHC) Banff neighbourhood and now supports 56 priority communities across Ottawa facing inequities

The CDF is an initiative of SEOCHC and helps create lasting improvements in Ottawa's health and well-being of priority communities.

We coordinate, provide guidance, build resident's and organization's capabilities and connect people through a proven framework and strong network — making it easier to tackle the issues that matter most to each community.

Since 2012, the CDF has trained 350 resident leaders to build stronger, more inclusive communities

Rana’s Story

- How I got involved and became a Resident Leader
- How my role made a difference and the value I could bring
- The support I received, which transformed into co-learning

Value of Community Ambassadors

Some key Initiatives

- Door-to-door outreach
- Conversation circles
- Communities of practice
- Networks: WhatsApp groups etc.

All these initiatives

- **Bringing the door to community**
- **Culturally appropriate:** reflects communit**y**, can identify with, culture, language, religion, shared experience
- **Trust:** Inherit with local neighbours and friends
- Understanding of **lived experience and neighbourhood strengths**
- Improved **ability to reach isolated / reluctant residents**

Impact

- **Trained over 350** resident leaders
- More residents lead, volunteer and participate
- Facilitated delivery over **6,000 vaccinations to underserved populations**
- **Reached over 255k residents**
  - Distributed over **5,500 rapid test kits in the Heatherington / Cedarwood area**
- Community members **reported better health, mental well-being, access to food supports**
- **More activities / spaces to connect** with neighbours / partners, access services, and have a say in decisions:
  - ***WhatsApp, Communities of Practice, Community Events***

CDF Resident Leaders COVID 19 Outreach with Rideau Rockcliffe Community Resource Centre and Ottawa Community Housing Community Developers and Ottawa Public Health

Question:

Are there any ideas that you've heard about today, that you would be interested in implementing in your own communities?

Comment in the chat box

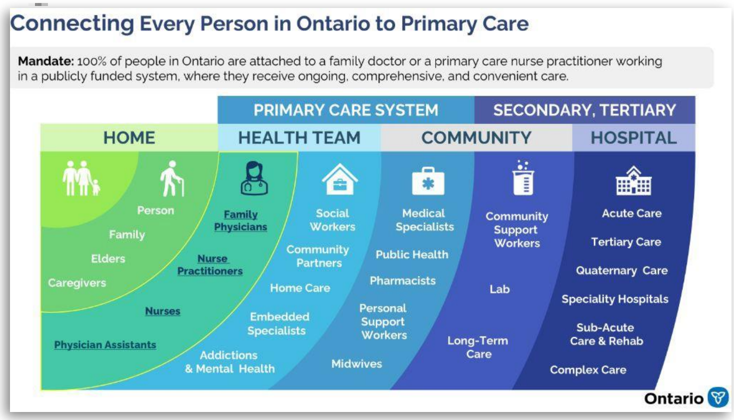
Health Commons Solutions Lab

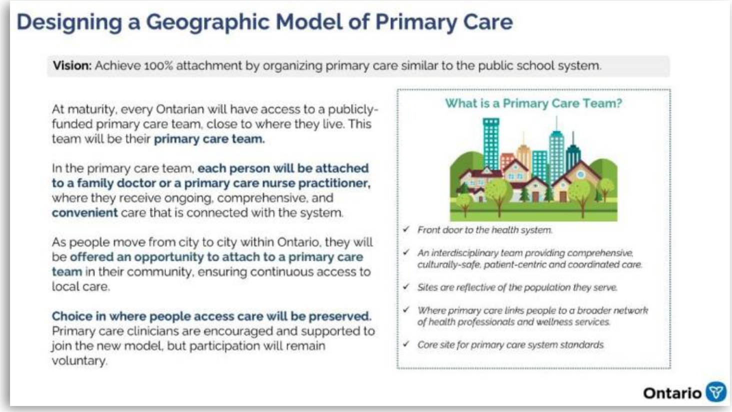
Locally Driven Population Health Management Strategy

An Engine for Connection, Access and Attachment for Ontario's Highest Need Patients

HEALTH COMMONS SOLUTIONS LAB

The **Primary Care Strategy** is an ambitious, geographically based population health model that has the potential to transform health outcomes for Ontarians





To achieve this transformation it will take…

Tangible models and new roles to tackle the geography

Proven tactics for outreach; and new roles and a plan for successful integration

High touch interactions for high need patients

LDPHM is **not** an attachment strategy for all 2.5M - it focuses on who need primary care the most because their health is shaped by both lack of access and by the SDOH

Tight accountabilities with local flexibility

Accountability for outcomes, while leaning into the local experts and ecosystem of health and social partnerships

Scaling what is already working and designed for this purpose

What are the conditions to identify and rapidly scale learning?

What does equity look like in the context of the Primary Care Strategy?

The LDPHM Strategy has demonstrated impact with a small, specific and critical population of Ontarians

5%

of Ontario's Population

Impacted by Social Determinants + Poor Access to Care = Poor Outcomes and System Pressures

Areas where there are low rates of primary care workers

Care not designed for access needs of the population - hours of operation, location and cultural barriers

$35.9B/yr

Total health annual expenditures *(**excluding** catastrophic care such as Cancer, Reproductive and Obstetrical, Motor Vehicle)**

* *Details of evidence and calculations here*

What are some key opportunities to address both individual and system outcomes?

What the evidence says about potential cost savings from improved primary care management of high needs/risk users

Improved primary care management for complex patients

- Reduces hospital admissions by **15–30%**; reduces ED visits by **20–40%**

Case Management for Chronic Disease

- **Diabetes primary care management;** reduces per-patient health system costs by **$5,000–$8,000/yr**
- **Heart failure outpatient management:** reduces admissions by **up to 35%**, savings of **$9,000–$15,000 per patient/yr**

	Savings from improved management of this population
5% System savings on $35.9B	**$1.8B/yr**
10% System savings on $35.9B	**$3.6B/yr**

Locally Driven Population Health Model Strategy is made up of three integrated efforts

*The LDPHM strategy is a three legged stool. **All three elements are key to the success***

CULTURALLY APPROPRIATE OUTREACH & MOBILE CARE

COMMUNITY AMBASSADORS/ COMMUNITY HEALTH WORKERS who bridge access, service navigation and offer effective outreach

Mobile strategies to reach into underserved populations

Mobile Teams, Well Clinics, Screening Strategies

LOCAL LEADERSHIP

- Lead Agency

LEAD ORGANIZATION that is well connected locally and can coordinate primary care, referral networks and employ outreach teams

Typically Primary Care Entity

WRAP AROUND CARE via NETWORK OF PARTNERS

Health & Social Care

Broader ecosystem of health and social care partners for referrals and wrap around supports

Partners whose expertise is to address the broader social determinants

What it looks like on the ground in these communities

ADDRESSING Gaps in Access for High Needs Communities

What's working?

- Geographic, hyper-local model
- Establish multiple low-barrier points for registration (mobile, health fairs, wellness clinics, etc.)
- Providing supports for people who are waiting for attachment

DESIGNING Care Around Population-Specific Needs

What's working?

- Data-informed priority population selection
- Services that match with what people need and want - location, hours, language and cultural understanding of health
- Cultural adaptation of programs and services

BUILDING Trust Between Communities and Providers

What's working?

- Local leadership with established presence in the community
- Proactive outreach to the 'hard to reach' communities
- Community Ambassadors as trusted advisors, service navigators, and knowledge disseminators

WRAPPING Care Around Complex Patients

What's working?

- Holistic view of person's health needs and priorities
- Tapping into network of integrated health and social care partners
- Partnerships with Ontario Health Teams

How Lead Agencies Support Primary Care Attachment and Provider Retention

- Lead Agencies are well-positioned to support Ontario Health Teams (OHTs) in ensuring immediate access and long-term primary care e populations.
  - **Connecting with Unattached Individuals**: Mobile Teams and Community Health Workers/Ambassadors initiate contact, build relatio needs.
  - **Addressing Immediate Needs**: Provide medication management, chronic disease screening, mental health support, and vaccinatio benefits of primary care attachment.
  - **Integrating Primary Care into Social Services**: Offer access to primary care through existing programs, such as adult day programs.
  - **Collaborating with Primary Care Networks**: Identify new rostered spaces as they become available.
  - **Facilitating Warm Handoffs**: Transition individuals smoothly to primary care providers, ensuring ongoing support for social service
  - **Promoting Culturally Relevant Care**: Encourage attachment to culturally appropriate primary care providers, where available.
  - **Training Community Ambassadors**: Educate individuals about the value of primary care and being rostered.
  - **Reducing Primary Care Burden**: Support navigation to broader social services and help patients become 'practice ready' through H

What specific investments for access and attachment are emerging from Lead Agencies?

ATTACHMENT

- Mobile care teams that:
- Provide episodic primary care in remote or underserved neighborhoods or buildings
- Support complete history, medication reconciliation and stabilization of social care needs
- Community Ambassadors to identify individuals in need of service; navigation to social and health providers
- Allied Health Professionals Regional Resource Team - support the complex patient population for newly rostered patients

ACCESS

- Additional primary care provider capacity at the lead agency to flex up access episodic care while people are waiting to be attached
- Specific 'campaigns' pushed through partners for increasing awareness to health and wellness screening
- Health fairs and wellness clinics
- Episodic care for people while they are waiting for care including prevention (linkage to Preventative Care Program)
- Training for Community Health Workers/Ambassadors in chronic diseases self management (linkage to OHT Priorities)

Appendix and Resources

High-Cost Health System Users in Ontario (Adults) – 2023 Data Update

Prevalence of High Users vs. General Population

- **Small Percent of High Users:** Only about **5% of Ontario's adult population** are considered "high users" of health care (typically defined as the top 5% of patients by annual health care spending)
canada.ca. In absolute terms this equates to only a few hundred thousand individuals in a province of over 14 million. These are the patients with the greatest health service utilization and costs.

- **Disproportionate Share of Costs:** This small cohort accounts for a **majority of health care expenditures**. Recent analyses show that roughly **60–65% of all Ontario health care spending** is concentrated in that top 5% of users pmc.ncbi.nlm.nih.gov canada.ca. In other words, a very small fraction of (mostly adult) patients drive nearly two-thirds of total health system costs in the province. By comparison, the *top 1%* of users alone consume about one-third of all health spending pmc.ncbi.nlm.nih.gov. Most of these high-cost patients are older adults or those with multiple chronic conditions.

- **Adjusted Share Excluding Catastrophic Cases:** If we **exclude "catastrophic" care cases** – i.e. extremely costly one-time events such as major trauma injuries, advanced cancer treatments, or complex surgeries – the spending concentration among high users is slightly less extreme (but still very high). Many high-cost patients have expenses driven by chronic or long-term care rather than acute emergencies (indeed, about 40% of top-cost patients in one Ontario study had *no* acute hospitalizations in the year) pmc.ncbi.nlm.nih.gov. **Removing these catastrophic episodes, the top 5% of patients still account for roughly ~50% of total health expenditures** (approximately half of all spending, instead of about two-thirds) pmc.ncbi.nlm.nih.gov. This adjusted figure reflects the substantial ongoing costs of high users with complex chronic needs, even when one-off acute events are set aside.

Sources: Ontario health administrative data and research studies (ICES/University of Toronto and Ontario Ministry of Health analyses) were used for these statistics. The figures are province-wide and focused on **adults**, as children represent a small portion of high-cost users. The exclusion of catastrophic care is an estimate based on removing acute one-time events from the cost data, illustrating how persistent high-need patients still consume about half of health resources even when rare expensive crises are excluded pmc.ncbi.nlm.nih.gov. All data are from recent government or academic sources (circa 2012–2023) and provide the latest insight into health system use in Ontario.

WHAT OTHER BENEFITS of STRATEGIC ATTACHMENT

- **Cost Efficiency:**

  •Research consistently shows that top users without catastrophic conditions account for a disproportionate share of health expenditures due to repeat hospital visits, ambulance calls, and avoidable admissions. Targeted interventions (such as proactive attachment to primary care, outreach, and case management) significantly reduce these costs.

- **Health System Relief:**

  •Prioritizing these populations reduces avoidable emergency visits and hospital strain, freeing up resources for acute care needs and reducing hallway medicine.

- **Improved Outcomes and Equity:**
  People most impacted by SDOH (low income, homelessness, mental health issues, language barriers) experience worse outcomes in fragmented care systems. Proactive interventions improve medication adherence, chronic disease management, and access to preventive care. This leads to better health outcomes and reduces future high-cost events.

- **Targeted, Measurable ROI:**
  Investments in navigation, outreach, and low-barrier primary care models for this population have been shown to reduce health care system costs within 12–24 months by reducing hospital readmissions and ED visits.

Question:

Are there any ideas that you've heard about today, that you would be interested in implementing in your own communities?

Comment in the chat box

Panel Discussion

Up Next

- HSPN webinar series
  - August 2025: Summer break
  - September 23rd, 2025: ***Leadership and Governance: Results from the Ontario Health Teams Leadership Survey***

THANK YOU!

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