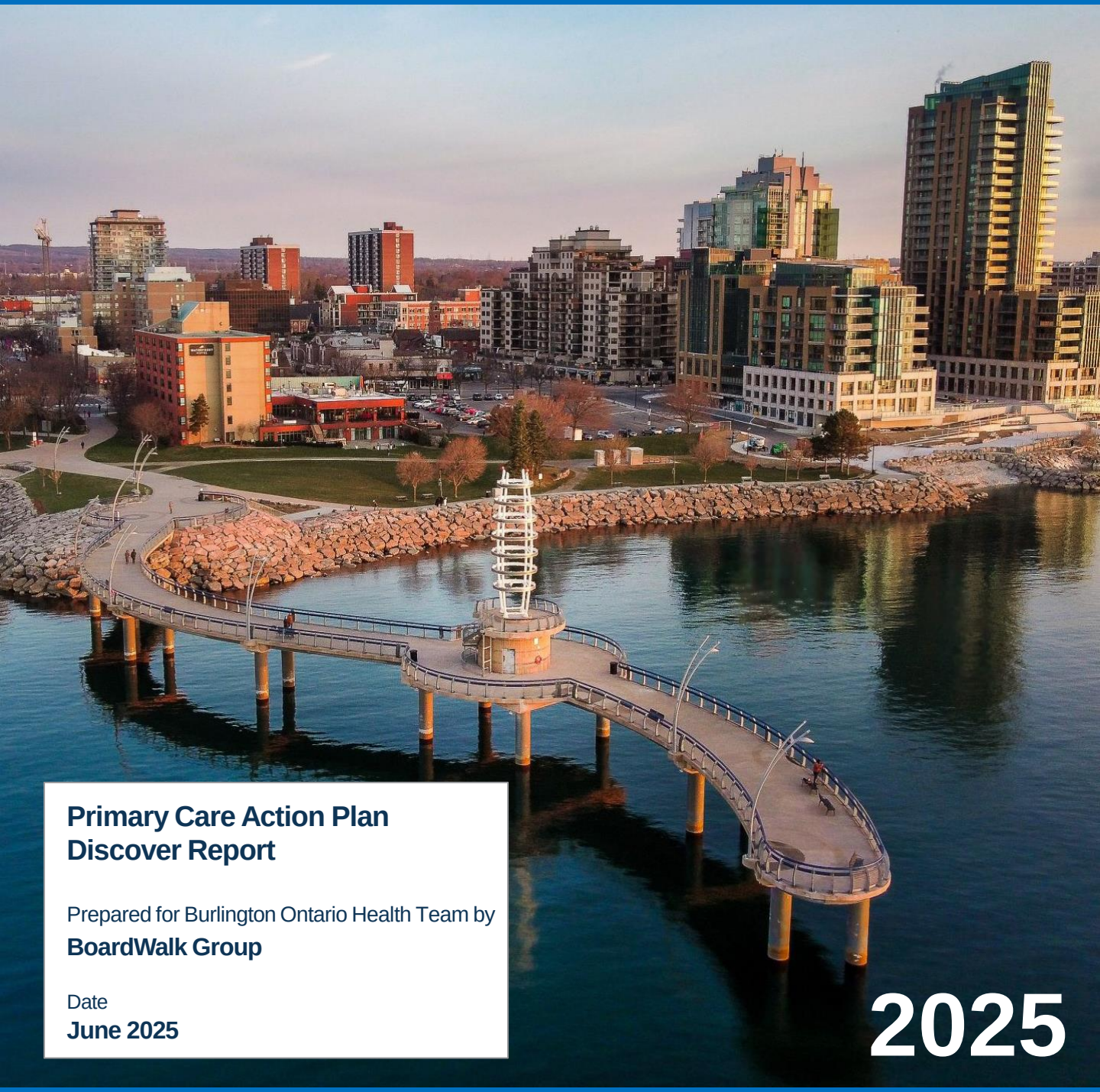
BURLINGTON
ONTARIO HEALTH TEAM

DISCOVER REPORT



Primary Care Action Plan Discover Report

Prepared for Burlington Ontario Health Team by

BoardWalk Group

Date

June 2025

2025

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ACKNOWLEDGEMENTS

The development of this work was informed by the contributions of a diverse group of knowledge holders representing clinical, operational, academic, and community perspectives. Their input has supported the identification of key issues and opportunities related to access and attachment in primary care. Together, these voices have shaped the broader dialogue and direction of this work, and we recognize the cumulative value of their ongoing insights, expertise, and commitment throughout the process.

Councils and Committees

We wish to formally thank the BOHT councils and committees, whose members have offered thoughtful guidance and expert perspectives throughout this process that were instrumental in shaping the direction and priorities of this work. These include the BOHT Community Wellness Council, the Burlington Primary Care Network Leadership Council, and the BOHT Mental Health & Addictions Integrated Care Committee. Alongside these contributions, we also extend our thanks to the BOHT Chronic Disease Integrated Care Committee for their work in developing the Chronic Disease Prevention and Management Model Blueprint, which played an important role in informing and guiding this report.

Patients and Partners

We are grateful for the voices of patients, caregivers, and system partners who generously shared insights and reflections with our team during community engagement events and focus groups. Thank you to our system partners and organizations, their leadership, and representatives for ensuring our efforts remained grounded in the realities of service delivery and responsive to the diverse needs of the communities we serve, including Acclaim Health, Alzheimer's Society (Haldimand, Norfolk, Hamilton, Burlington), Carpenter Hospice, Community Development Halton, Grandmother's Voice, Halton Equity Diversity Roundtable, Halton Multicultural Council, Our Kids Network, and Thrive Group.

01. EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

"We should see attachment as access to a system of care—not just a doctor." – *BOHT engagement participant*

The Burlington Ontario Health Team (BOHT) Discover Report 2025 reflects BOHT's commitment to aligning with provincial priorities while driving locally tailored solutions that meet the unique needs of the Burlington community. Developed through community engagement, best practice review, and asset mapping, the report informs the BOHT Primary Care Action Plan by capturing local perspectives and identifying actionable opportunities across three interconnected priorities: **Attachment, Access, and Comprehensive Care**.

This report emphasizes that while Burlington benefits from strong attachment rates and an established Primary Care Network, knowledge holders identified opportunities to improve equity gaps, system fragmentation, and emerging population needs, underscoring the importance of coordinated local action and planning.

BUILDING ON STRONG FOUNDATIONS

Burlington is a growing, diverse, and evolving community. It is characterized by strong overall socioeconomic conditions, but also by an aging population, increasing cultural diversity, and complex health and social needs. Seniors represent a growing share of residents, many of whom live in high-density urban neighbourhoods or Naturally Occurring Retirement Communities (NORCs). At the same time, Burlington's population is projected to grow significantly over the coming decades, with many new households in higher-density housing.

BOHT is well-positioned to lead this work. The team has demonstrated system readiness and organizational maturity, with a history of strong local collaboration and inclusive engagement processes. The Burlington Primary Care Network (PCN) is well-established, with high levels of clinician engagement. BOHT's strong foundation includes successful initiatives like Community Wellness Hubs, HealthPathways, a Mobile Primary Health Team, and digital innovations such as AI Scribe, Online Appointment Booking and ConnectMyHealth—all of which underscore the capacity to deliver integrated, patient-centred care.

KNOWLEDGE HOLDER INSIGHTS & OPPORTUNITIES

Knowledge holders, including patients, primary care providers, system partners, and community organizations, offered deep, grounded insights into the realities of attachment, access, and comprehensive care in Burlington. Their perspectives illuminated not just the barriers people face, but also the practical, locally informed opportunities to create more equitable, connected, and patient-centred primary care.

ATTACHMENT

Attachment is more than simply being rostered to a provider. It means having an ongoing, trusting relationship with a primary care provider that understands and responds to health needs over time.

Provider/System factors:
Approachability, acceptability, funding models, practice changes, cultural safety.

Patient factors:
Health literacy, trust, social determinants, ability to seek care, autonomy, personal values.

INSIGHTS

- Equity-deserving populations, such as newcomers, Indigenous residents, and unhoused people, face persistent attachment gaps.
- Provider retirements and practice changes disrupt continuity.
- Patients often bypass existing attachment (walk-ins, ED) when perceived access barriers arise.
- System partners call for redefining attachment to include quality, safety, and culturally safe care.

OPPORTUNITIES

- Reconsider how attachment and access are defined from an equity-centred lens
- Strengthen patient-provider matching, planning for retirements and prioritizing fit.
- Develop targeted strategies for underserved groups with local data.
- Expand flexible, assertive outreach models (mobile, embedded, drop-in).
- Increase public awareness, health literacy, and navigation support.

ACCESS

Access means more than having a clinic to go to. It requires the ability to obtain timely, equitable, and appropriate care when needed.

Provider/System factors:
Availability (hours, staff), booking systems, funding models, technology supports.

Patient factors:
Transportation, mobility, digital literacy, language, trust, living environment.

INSIGHTS

- Variable, fragmented appointment systems create barriers, particularly for seniors, newcomers, and low-income residents.
- Patients face complex, poorly navigable systems with limited centralized guidance.
- Digital-first systems risk excluding those without devices or literacy.
- Providers note fragmented incentives and funding rules (negation penalties) that discourage collaboration.

OPPORTUNITIES

- Reduce variability in appointment booking while maintaining accessible non-digital options.
- Enhance equity with multilingual, plain-language resources and in-person/phone support.
- Advocate for policy changes to enable shared after-hours coverage and seamless referrals.
- Implement community-based navigation supports to guide and assist patients..

COMPREHENSIVE CARE

Comprehensive care addresses the full range of patient needs over time, including prevention, chronic disease management, mental health, and social supports.

Provider/System factors:
Funding models, geographic access, virtual care, language supports, allied health availability.

Patient factors:
Ability to pay (travel costs, uninsured services), ability to engage (health literacy, cultural values, complexity of need), continuity of information.

INSIGHTS

- Fragmented systems and poor communication weaken continuity of care.
- Administrative burden and funding incentives discourage team-based, holistic care.
- Access to allied health and mental health services is limited and uneven.
- Patients want time for comprehensive discussions, not rushed single-issue visits.
- System partners highlight overlooked caregiver roles, cultural safety gaps, and the need for wraparound supports in familiar community settings.

OPPORTUNITIES

- Expand access to integrated comprehensive care, including co-located services, and longer-visit, relationship-based care models.
- Promote trauma-informed, culturally responsive care through training and frameworks like the Urban Indigenous Action Plan.
- Expand access to peer support and lived experience roles.
- Integrate mental health, addictions, and primary care through shared governance.
- Improve provider communication with shared digital platforms and standardized referral protocols.
- Strengthen navigation and language supports tailored to Burlington's diverse communities.

02

BACKGROUND & APPROACH

ONTARIO'S PRIMARY CARE ACTION PLAN

Ontario, like much of Canada, is facing a growing primary care crisis. Over 2.2 million residents currently lack access to a family doctor or primary care team. This number is expected to grow due to:

- An aging population with increasingly complex medical needs.
- Population growth is driven by immigration and urban expansion.
- Post-pandemic health system strain, which has exacerbated backlogs and disconnected care. .[1]

These trends are creating pressure on walk-in clinics, emergency departments, and hospitals — all of which are less equipped to manage chronic care, preventative screenings, and long-term health needs.

In January 2025, Ontario announced the Primary Care Action Plan. Led by Dr. Jane Philpott, the plan involves a historic investment.[1]

The comprehensive strategy prioritizes timely attachment, integrated service delivery, and system sustainability by expanding interprofessional teams, adopting digital tools, and deploying neighbourhood-based care models.

Led by Ontario Health Teams (OHTs) and Primary Care Networks (PCNs), strategies are being developed to close attachment gaps and ensure that all patients have a primary care provider. The approach includes the integration of digital solutions, expansion of interprofessional care teams, and implementation of neighbourhood-based care models to enhance accessibility and efficiency.

This transformation is crucial not only to meet the needs of patients but also to strengthen the sustainability of the province's healthcare system, as comprehensive, coordinated care has been shown to improve health outcomes and reduce reliance on more costly emergency and hospital services.

*The goal of Ontario's Primary Care Action Plan is to build a primary care system that is **comprehensive**, **convenient**, and **connected** for every single person in Ontario.* [1]

1) https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025

PRIORITIZING PRIMARY CARE

THE ROLE OF ONTARIO HEALTH TEAMS

Ontario Health Teams (OHTs) are undergoing a strategic recalibration under the province's 2025–2026 Primary Care Action Plan, driven by the Ministry of Health and Ontario Health. This includes a prioritization and focus on Primary Care over the next year, with particular attention on increasing attachment.

ATTACHMENT FIRST MANDATE

- **Prioritize Primary Care Attachment**
  Working with Ontario Health and PCNs to connect patients—especially those on the Health Care Connect waitlist—with local clinicians.
- **Strengthen Primary Care Networks (PCNs)**
  These networks are now central to delivering interprofessional care and coordinating physician engagement.
- **Proposal Submissions for New/Expanded IPCTs**
  OHTs are expected to help local clinicians apply for Interprofessional Primary Care Teams (IPCTs), focused on areas of greatest need.

WHAT THIS MEANS FOR BURLINGTON

- **High Attachment**
  Burlington's high primary care attachment rates position the community as a leader in the province.
- **Strong Primary Care Networks (PCN)**
  The Burlington Primary Care Network (PCN) is already well-established and collaborative, with strong clinician engagement.
- **System Readiness & Maturity**
  Burlington OHT has demonstrated organizational maturity and innovation readiness, including inclusive community engagement processes.

1) https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025

BURLINGTON ONTARIO HEALTH TEAM

Leading the way in integrated care, improving health and well-being for all

The Burlington Ontario Health Team (BOHT) is a Not-For-Profit Incorporation. The BOHT promotes health and well-being for the benefit of the general public by delivering care through an integrated healthcare delivery system in Burlington and surrounding communities.

As one of the first Ontario Health Teams announced by the Government of Ontario in 2019, the BOHT's goal is to improve timely access to care, integrate service delivery with a focus on disease prevention and early identification, and ensure clients have seamless transitions among healthcare and social service providers.

In September 2023, the BOHT was selected as one of 12 OHTs in Ontario by the Ministry of Health to advance rapidly toward maturity. This recognition demonstrates BOHT's trusted working relationships with their community members and collaborating partners.

The Burlington Primary Care Network (PCN), is a key partner within the BOHT. They play a vital role in enabling, supporting and strengthening the primary care landscape in Burlington.

BOHT and the PCN are working together to build a locally tailored plan to improve attachment and access as the essential first steps in aligning with and advancing the Primary Care Action Plan mandate.

The high attachment in the region supports the ability to lead the way on integrated, comprehensive Primary Care models while meeting provincial benchmarks. Burlington OHT has demonstrated organizational maturity and innovation readiness. With a well-established team culture, commitment to health equity, and strong alignment with provincial priorities, the team exemplifies how local health systems can lead transformation in Ontario's primary care landscape.

2024/2025 OHT & System Partner Accomplishments

- **43 new HealthPathways** to improve care coordination
- **7 Community Wellness Hubs** addressing social needs
- **Gender Affirming Care Clinic** serving 350+ patients
- **Mobile Primary Health Team** for unhoused and vulnerable residents
- **Strengthened governance** with **PCN Leadership Council**
- **173 PCN members** engaged
- Digital innovations: **AI Scribe Pilot, Online Appointment Booking,** and **ConnectMyHealth**
- Established **community-based aging well clinic** and **memory care clinic**
- **NP-led pathways** for unattached patients with abnormal **cancer screening results**

PROJECT SCOPE & OUTPUTS

The purpose of this project is to support the development of the BOHT Primary Care Action Plan through engagement, asset mapping, and the creation of a Primary Care Atlas to identify local resources, gaps, and opportunities for improving access and attachment.

DISCOVER REPORT

The Discover Report summarizes findings from knowledge holder engagement sessions, best practice and literature review.

The Discover Report captures the qualitative backbone of the project—what was learned through deep engagement with local knowledge holders and a thorough review of best practices.

This report synthesizes voices from across the BOHT landscape, including primary care clinicians, mental health and community providers, patients and caregivers, and system leaders.

PRIMARY CARE ATLAS

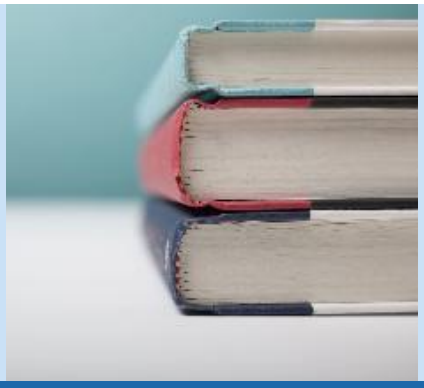
The Primary Care Atlas is a data tool that can be used to support planning and delivery of primary care across regions.

The Primary Care Atlas is a foundational output of this project, designed to visually and analytically represent the current state of primary care in the Burlington Ontario Health Team (BOHT) region.

It is a dynamic planning tool that integrates multiple data layers to support system planning, decision-making, resource allocation, and service design

APPROACH & METHODOLOGY

This project was designed to create the foundational infrastructure for a fully connected, sustainable, and patient-centred primary care system in Burlington. Recognizing that meaningful transformation must be locally informed and evidence-driven, our approach combined in-depth data analysis, cross-sectoral engagement, and best practice research to build a model that reflects both the realities of today and the needs of the future.



ASSET MAPPING

We created a detailed picture of primary care services, community supports, and population health needs in Burlington.

- Mapped all primary care practices and models (e.g., FHTs, FHGs, FHOs)
- Identified community-based services like mental health, housing, and social care
- Analyzed population health trends, including chronic disease, frailty, and deprivation
- Produced a visual, data-rich Primary Care Atlas to guide planning

ENGAGEMENT

We listened to local voices—clinicians, community providers, patients, and caregivers—to understand real-world challenges and ideas for improving care.

- Hosted sessions, interviews, and roundtables
- Highlighted gaps in access, equity, and integration
- Strengthened relationships across sectors
- Built shared priorities for improving attachment and coordination

BEST PRACTICE REVIEW

We reviewed proven models and strategies to inform what's next for Burlington's primary care system.

- Studied team-based care, outreach models, and governance structures
- Assessed innovations in digital tools, shared care, and funding approaches
- Aligned findings with BOHT's priorities for access, equity, and sustainability

03. BACKGROUND & APPROACH

BURLINGTON, ONTARIO

Burlington, Ontario, is a picturesque city nestled between Lake Ontario and the Niagara Escarpment, located within the Halton Region and forming part of the Greater Toronto and Hamilton Area. With a reputation for high livability, scenic beauty, and strong community values, Burlington is a desirable place to live, work, and invest. As of the 2021 Census, Burlington had a population of 186,948, reflecting a modest 2.0% growth since 2016. The city's population density stands at 1,004.4 people per square kilometer, highlighting its balance between urban development and green space.

To proactively manage its growth and evolving demographic needs, Burlington has adopted a forward-looking strategic vision. Its "Vision to Focus" and “Vision 2040” plans serve as blueprints for long-term development, emphasizing complete communities, economic resilience, environmental stewardship, and enhanced mobility.

Demographically, Burlington has an aging population, with a median age higher than the provincial average. Seniors aged 65 and older make up a growing share of residents, shaping the city’s housing and service planning. By 2051, Burlington is projected to add approximately 35,400 new households. Much of this growth will be in high-density housing such as condominiums, apartments, and townhomes—options better suited to smaller households, downsizing seniors, and younger residents seeking affordability.

Population growth will be focused in specific areas, with about 70% of new residents accommodated within Burlington’s existing built-up areas. The remainder will move into designated greenfield communities, with only 1% expected in rural areas.

Burlington’s population is growing in both size and complexity. Planning efforts aim to ensure the city remains livable, accessible, and responsive to the needs of all current and future residents.

*Burlington’s **rapid population growth** projections highlight the urgent need to **expand and adapt** health and social services to meet the **community’s evolving needs.***

3) https://www.burlington.ca/en/council-and-city-administration/resources/Plans-Reports-and-Studies/Strategic-Plan-2015-2040.pdf

POPULATION OVERVIEW

Burlington is a vibrant and evolving community with unique demographic trends that shape its future. The city has an aging population, with seniors representing a growing share of residents and influencing planning for housing, services, and care. The city's population is also becoming more diverse, adding to the richness and complexity of its community needs.

Looking ahead to 2051, Burlington expects to welcome approximately 35,400 new households. Much of this growth will be met through high-density housing—condos, apartments, and townhomes—designed to support smaller households, downsizing seniors, and younger residents seeking affordable, accessible options.

Attributed Population:
- 227,465 residents (FY 2023/24)

Average Age:
- 42 years (slightly older than the provincial average of 41)

Racial Demographics:
- 19% of BOHT residents identify as racialized, significantly lower than the Ontario average of 32%

Income & Employment:
- The average household income is $107,000, just below the Ontario average of $116,000
- Unemployment 11% vs 7.9% in Ontario and a low-income rate 4%

Material Deprivation:
- 50% of residents are in the least deprived quintile
- Only 4% fall into the most deprived quintile—indicating strong overall socioeconomic conditions

Naturally Occurring Retirement Communities (NORCs):
- 71 residential buildings in Burlington qualify, with over 7,700 older adults
- Many buildings housing 70%+ seniors, mostly clustered in downtown Burlington

4) Burlington Ontario Health Team Population Health and Evaluation Team. (2024, June). *Descriptive characteristics of the Burlington Ontario Health Team attributed population and primary care context*. https://wordpressuploads.blob.core.windows.net/uploads/2024/08/BOHT_Data-Package.pdf

POPULATION HEALTH

Burlington is committed to aligning with provincial health system priorities while focusing on local planning to meet the unique needs of our community. By working collaboratively with partners, we are building tailored, sustainable solutions that improve access, integration, and quality of care for our population.

PROVINCIAL PRIORITIES

COPD

- **Prevalence**: 11,510 individuals (809 per 10,000) – slightly lower than the Ontario average
- **Primary Care Visit**: 96% of COPD patients had ≥1 visit per year
- **Hospitalization Readmission**: 17% (lower than Ontario's 20%)
- **Specialist Access**: 48% had seen a respirologist—substantially higher than the provincial average of 32%

Heart Failure

- **Higher Prevalence in 80+ age group**: 26% vs. 23% Ontario average
- **Hospital Admissions**: BOHT shows consistently lower HF hospitalizations and ED visits over 4 years than Ontario averages

Diabetes

- **Prevalence**: 22,846 (101.1 per 1,000)
- **Hospitalization Rate**: 10.1% of diabetics had at least one hospital stay; 13.6% 30-day readmission
- **Retinal** Screening (40+ years): 64%
- **Statin Use (65+):** 75.6% of diabetics

Frail Elderly

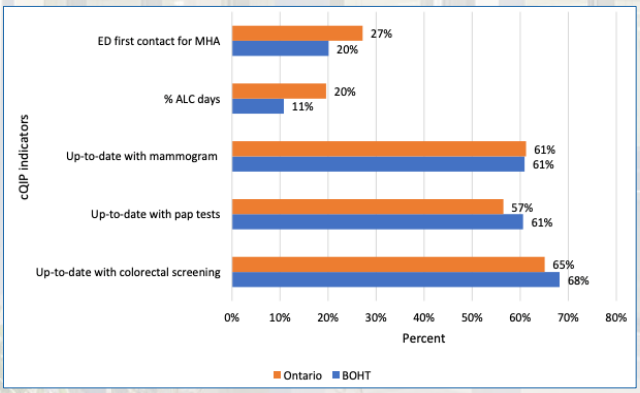
- **Prevalence**: 15,056 (321.34 per 1,000)
- **Hospitalization Rate**: 3.5% experienced hospitalization due to falls or ambulatory care sensitive conditions.

PREVENTATIVE CARE

Cancer Screening and Preventive Care (cQIP Metrics)

- **Mammogram Adherence**: 62% (matches Ontario)
- **Pap Test Adherence**: 60% (above Ontario at 57%)
- **Colorectal Screening**: 70% (above Ontario at 65%)
- **ALC Days (Hospital Efficiency):** 11% vs. 20% Ontario
- **ED as First MHA Contact:** 20% vs. 27% Ontario —suggesting better community access to mental health/addictions care

Priority cQIP indicators for Burlington OHT compared to Ontario average (2024/25)

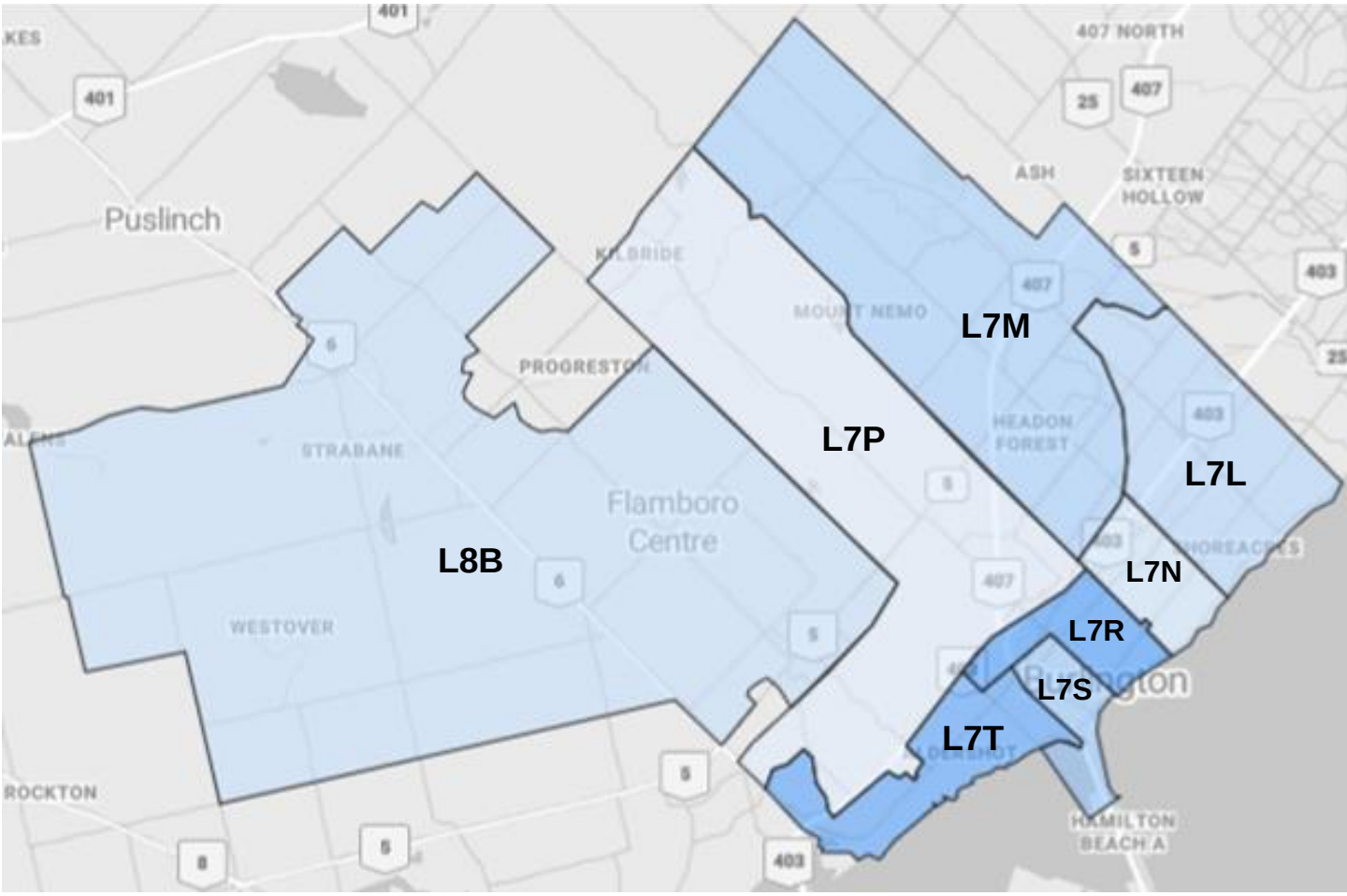


4) Burlington Ontario Health Team Population Health and Evaluation Team. (2024, June). *Descriptive characteristics of the Burlington Ontario Health Team attributed population and primary care context*. https://wordpressuploads.blob.core.windows.net/uploads/2024/08/BOHT_Data-Package.pdf

BURLINGTON COMMUNITIES (FSA)

The Forward Sortation Area (FSA) is the first three characters of a Canadian postal code, used to designate a geographic region. FSAs help identify specific areas within provinces or cities, supporting efficient postal service and often serving as a useful unit for demographic analysis, planning, and service delivery.

Burlington FSA's	
L7L	Burlington Northeast
L7M	Bulrington North
L7N	Burlington East
L7P	Burlington West
L7R	Burlington Southeast
L7S	Burlington South
L7T	Burlington Southwest
L8B	Hamilton (Waterdown)



PRIORITY COMMUNITIES (FSA)

To identify opportunities for strengthening primary care attachment and access, we conducted a focused analysis across seven FSAs within Burlington.

The analysis considered a range of indicators across four domains:

1. **Attachment:** percentage of residents not attached to a primary care provider
2. **Equity:** income, marginalization, and population diversity measures
3. **Health service utilization**: emergency department visits (particularly for mental health and addictions), including acuity and first-contact patterns
4. **Preventive care:** screening uptake for mammograms, Pap tests, and colorectal cancer

ATTACHMENT RATES: Across the eight Burlington FSAs, there are approximately an average unattachment rate of 6.6% for the attributed population. The Ontario average is 13.1%. (4)

PRIORITY FSAs: An analysis of population need, access data, and equity indicators reveals five FSAs in Burlington where there may be emerging opportunities to strengthen primary care attachment. These areas exhibit patterns that suggest strategic value in targeted engagement or future intervention.

Our Kids Network Primary Care Access Data Report

An FSA-level analysis conducted by OKN supports and reinforces the findings from BOHT, which highlights key barriers to accessing Primary Care for children and families in Burlington. These included:

- Low-income, racialized, newcomer, and Indigenous populations face disproportionate barriers to care.
- Highlighted areas based on ON-Marg and Social Risk Index scores include FSAs in South Central Burlington and Aldershot (L7S, L7T).

Theme	Key Insight	FSA
Above-Average Unattachment Rates	• Higher-than-average unattached rates indicate localized access issues	L7R, L7S, L7T
Equity and Vulnerability	• Lowest median income, social vulnerability, highest ON-Marg scores (D10), high % racialized and Indigenous residents, and seniors	L7M, L7R, L7S, L7T
Emergency Department and Mental Health and Preventative Care	• High rates of ED visits for MHA, often as first contact • Lower screening rates and lower preventative care uptake	L7M, L7N, L7S, L7T

4) Burlington Ontario Health Team Population Health and Evaluation Team. (2024, June). *Descriptive characteristics of the Burlington Ontario Health Team attributed population and primary care context*. https://wordpressuploads.blob.core.windows.net/uploads/2024/08/BOHT_Data-Package.pdf

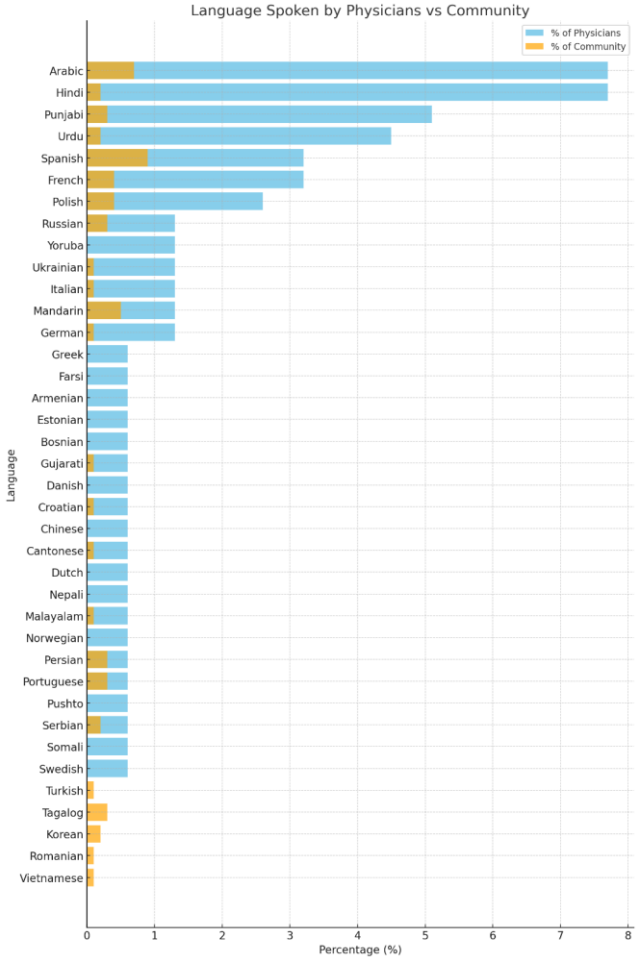
PRIMARY CARE LANDSCAPE

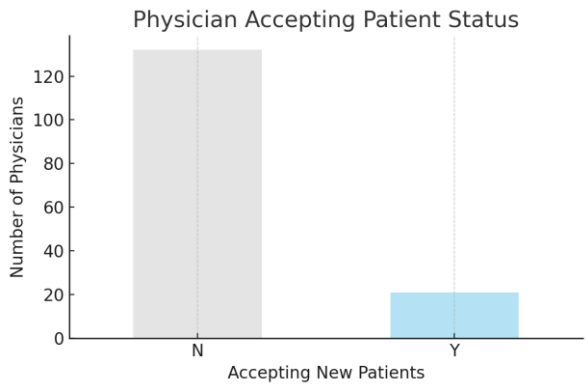
To better understand the local primary care landscape, we analyzed CPSO data for the Burlington Primary Care Network (PCN) and identified 153 active family physicians and 9 nurse practitioners practicing in the area. Note that only one NP is currently working in a private practice alongside a general practitioner.

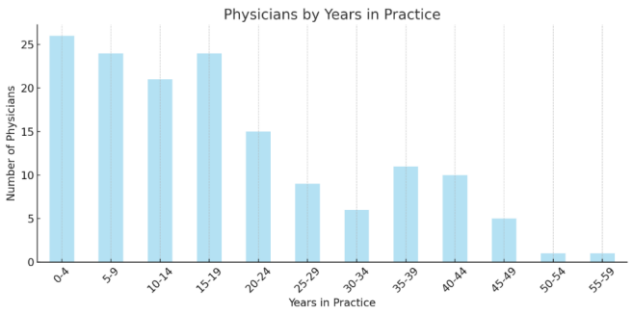
The following section provides a high-level snapshot of the physicians, highlighting key characteristics such as top schools attended, languages spoken, and year of initial registration with the CPSO. This snapshot helps illuminate the composition and diversity of Burlington's primary care workforce.

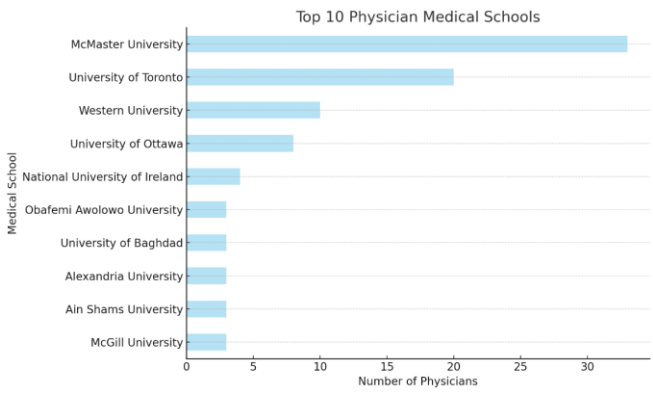
In Burlington, 58% of Primary Care Physicians are women and 41% are men.

The average # of years registered as an independent practice is 18 years





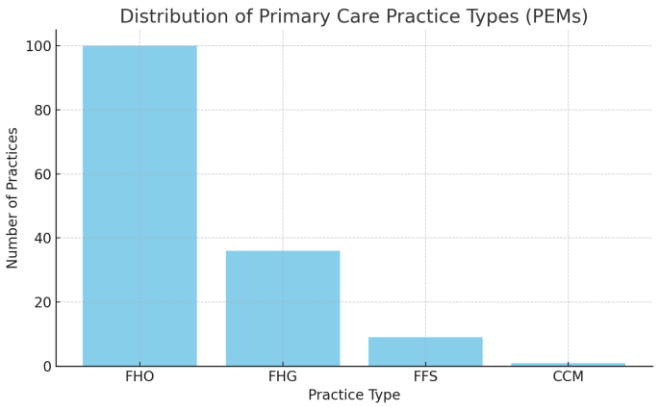




PRIMARY CARE LANDSCAPE

Primary Care Practice Types (PEMs)

The majority of primary care practices in Burlington operate under the Family Health Organization (FHO) model, which supports comprehensive, team-based care and patient enrolment. Family Health Groups (FHGs) and Fee-For-Service (FFS) practices are also present but in significantly lower numbers.



Digital Health Capacity

EMR Use:
100% of family physicians surveyed by BOHT reported use of an EMR (1)

AI Tools:
66% currently use AI scribe tools; same proportion interested in learning more (1)

Top Tools Used:
Phone/video visits, eReferral, eConsult, secure messaging

Top EMRs:
Telus PS Suites, Oscar

Online Appointment Booking:
Used by 60 Primary Care Providers in the PCN

Walk-In Clinics

Burlington is home to 10 walk-in clinics, providing vital access to primary care for residents without a regular provider or needing urgent, same-day care. These clinics are geographically distributed across the city, offering convenient entry points into the health system. They serve an essential role in the primary care ecosystem, especially for unattached patients or those navigating gaps in availability.

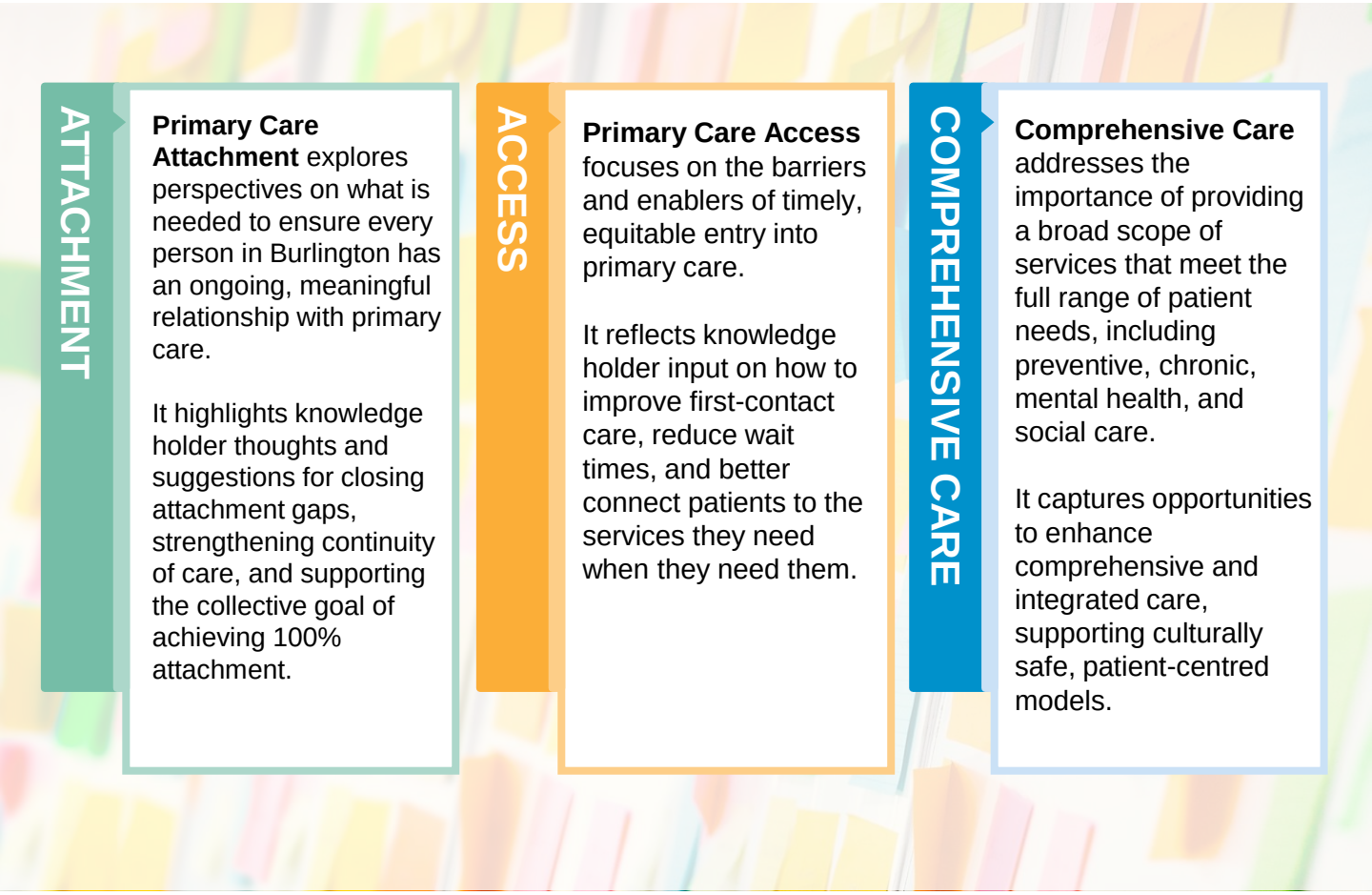
- Aldershot Village Medical Centre
- Brant Family Health & Walk-In Clinic
- Burlington Walk-In Clinic
- East Waterdown Walk-In Clinic and Family Practice
- Maple Mews Medical Clinic
- North Burlington Medical Centre
- Plainsview Medical Centre and Walk-In Clinic
- St. Joseph Family & Walk-In Clinic
- Walkers Medical Centre Walk-In Clinic
- Woodview Medical Clinic

04.

INTRODUCING INSIGHTS & OPPORTUNITIES

KNOWLEDGE HOLDER INSIGHTS & OPPORTUNITIES

This section presents a synthesis of what was heard from diverse knowledge holders about the challenges and opportunities facing Burlington's primary care system. The insights shared here have been thoughtfully analyzed and organized into three key thematic groupings that reflect the core priorities of this work: **Primary Care Attachment, Access, and Comprehensive Care**.



By organizing knowledge holder insights and identified opportunities into these three groupings, this section aims to provide a clear, actionable foundation for planning and prioritization. It reflects a shared understanding that while attachment, access, and comprehensive care are deeply interconnected, each represents a critical dimension of strengthening Burlington's primary care system to better serve all residents.

SUMMARY INSIGHTS & OPPORTUNITIES

Improving primary care attachment in Burlington means more than increasing roster numbers. It needs a shared commitment to building trusting, continuous, and culturally safe relationships between patients and care teams. While many opportunities were identified—some practical, others more aspirational—a key starting point is developing shared perspective and empathy across providers, patients, and partners.

PATIENTS

Importance of Fit, Trust, and Continuity
Patients emphasize that attachment is more than being rostered—it's about having a good personal fit and a trusting, continuous relationship. Disruptions (like retirements) undermine connection, and previous experiences can create reluctance to reattach.

Equity and Navigation Challenges
Marginalized groups face greater gaps in culturally safe care, language barriers, and system complexity. Unattached patients often feel "adrift," without clear, accessible mechanisms to find providers or navigate the system.

SYSTEM PARTNERS

Equity-Focused Solutions
Partners stress that local planning must go beyond roster counts to address equity, complexity, and culturally safe care. They call for alternative, assertive outreach models to connect with high-need populations.

Need for Integrated, Community-Based Supports
System partners highlight the value of wraparound, community-based care settings to build trust and engagement. They emphasize integrated approaches that combine primary care with mental health, social services, and navigation supports

OPPORTUNITIES

1. Create clear, equity-based navigable pathways
- Develop centralized systems to match patients to providers.
- Define attachment locally around trust, continuity, and cultural safety.
- Offer multilingual, non-digital, and low-barrier options.

2. Plan equity-focused outreach
- Target underserved groups with tailored approaches.
- Use mobile clinics, embedded services, and community partnerships.

3. Strengthen comprehensive integrated primary care
- Support models with wraparound services in one place.
- Enable continuity even when providers change.

4. Invest in relationship-building and cultural safety
- Train providers in trauma-informed, culturally responsive care.
- Encourage fit-based, trust-building approaches in patient matching.

PRIMARY CARE PROVIDERS

Need for Coordinated, Centralized Access - Providers highlight the lack of a clear, navigable system for unattached patients, leading people to walk-ins even when same-day bookings exist. There's a strong call for centralized, transparent pathways to help match patients to appropriate providers and support continuity of care.

Barriers from System Design and Policy - Funding models (like negation penalties) and administrative burdens drive fragmentation and discourage collaboration. Providers want better-integrated systems and local flexibility to respond to Burlington's needs, resisting one-size-fits-all provincial metrics.

OPPORTUNITY PRIORITIZATION MATRIX

A framework was developed to support BOHT and System Partners to review and evaluate key opportunities to help inform the development of a tailored BOHT Primary Care Action Plan. The matrix considers both feasibility and impact within Burlington's context and capabilities, while recognizing the limits of its direct influence over provincial policy and funding decisions.

	High	Medium	Low
Local Influence / Control	Can be fully led, implemented, or modified locally by Burlington system partners (OHT, PCNs, community agencies) with existing authority.	Requires partnership, alignment, or advocacy across local partners to implement; partial local control.	Primarily dependent on provincial policy, funding, or directives; little to no local ability to implement.
Potential Impact	Expected to deliver significant, meaningful improvements in attachment, access, or comprehensive care for many people or priority populations; closes major gaps.	Provides measurable, worthwhile improvements for a moderate number of people or for targeted issues; helps reduce gaps.	Offers limited or incremental benefits; narrow scope, unlikely to drive major system change alone.
Feasibility	Realistic with current local resources, partnerships, and capacity; can be implemented in short term (1–2 years).	Requires moderate new resources, planning, or coordination; achievable in medium term with effort.	Needs substantial new resources, policy change, or major system redesign; unlikely achievable locally soon.
Equity, Diversity & Inclusion (EDI) Impact	Directly reduces barriers and improves access for equity-deserving populations; strongly supports culturally safe, inclusive care.	Includes some elements that address EDI but not designed specifically for equity-deserving groups.	Little to no expected impact on reducing disparities or improving culturally safe care.

Priority Level	Definition	Typical Characteristics
Priority 1 – Do Now	Recommendations that can and should be acted on immediately by local partners. Highly feasible, locally controllable, with strong impact and EDI value.	High local control/influence, high feasibility, high impact, strong equity alignment.
Priority 2 – Plan / Consider	Recommendations worth pursuing soon but needing further planning, alignment, or modest new resources. These are next in line for action.	Moderate local control or feasibility, clear impact, at least some equity benefit.
Priority 3 – Build Capacity / Advocate	Recommendations that address important gaps but require significant new resources, system changes, or provincial policy support. Local partners should prepare for them and advocate jointly.	Low local control or feasibility, potentially high impact or equity value but dependent on external enablers.
Defer / Monitor	Recommendations that are low priority for now, due to limited impact, low feasibility, or misalignment with current local goals and capacity.	Low across multiple domains; may revisit in future planning cycles as context changes.

05.

ATTACHMENT INSIGHTS & OPPORTUNITIES

UNDERSTANDING **ATTACHMENT**

Attachment is more than simply being assigned to a provider; it means having a continuous, trusting relationship with a primary care provider that understands and responds to a person's health needs over time.

Attachment rates are shaped by complex systemic factors that extend beyond individual choice. This section explores both, drawing attention to the barriers and opportunities within each. By understanding these systemic influences, Burlington can better design strategies to improve attachment for all residents, particularly those facing the greatest barriers to care.

PROVIDER/HEALTH SYSTEM FACTORS

APPROACHABILITY

- **Transparency:** Clear, open communication about services and expectations.
- **Outreach:** Efforts to actively connect with and engage local populations.
- **Retirement & practice change plans:** Planning for provider retirements and transitions to ensure continuity of care and minimize disruptions in attachment.

ACCEPTABILITY

- **Patient fit:** Ensuring a good match between patient needs/preferences and provider approach.
- **Shared culture and connection:** Cultural competence and sensitivity that foster trust and belonging.
- **Funding models:** Financial and policy structures that influence providers' capacity or willingness to accept new patients.

PATIENT FACTORS

ABILITY TO SEEK

- **Health literacy**: Patients' ability to understand and navigate health information and services.
- **Beliefs & trust**: Confidence in the health system or providers, shaped by past experiences and broader social contexts.
- **Health care needs:** The complexity or urgency of individual health conditions that can complicate or prioritize attachment.
- **Structural/systemic barriers & previous care experiences:** Wider societal or system-level obstacles (e.g., transportation, discrimination, administrative complexity) that limit access.
- **Desire for care**: Personal readiness or motivation to engage with health care services.
- **Personal & social values, culture, gender**: Individual identity and cultural factors that shape how, when, and where people seek care.
- **Autonomy**: Patients' ability and freedom to make informed choices about their care.
- **Health system knowledge**: Understanding of how to find, access, and use health services effectively.

INSIGHTS ON **ATTACHMENT**

Our conversations with patients, system partners, and primary care providers offered valuable insights into what shapes attachment to primary care in Burlington. These insights highlight both system-level factors that affect how accessible and welcoming care is, and patient-level factors that influence people's ability and readiness to seek and sustain care.

PATIENTS

- **Fit is Critical:** Fit plays a critical role in supporting attachment
- **Previous Experience**: Not everyone wants to be attached. Previous experiences with the medical system can influence the ability and interest to attach and access primary care.
- **Equitable Access**: Marginalized and racialized communities face greater gaps in accessing culturally safe and knowledgeable care.
- **Impact of Practice Change:** Patients experience disruption and lack of connection when their physician changes (e.g., retirement, reassignment).
- **Two-Way Interview Process:** There is a need for a two-way interview process with new providers to ensure fit.

PRIMARY CARE PROVIDERS

- **Lack of Streamlined Access:** The lack of centralized, navigable access (like a trusted point-of-entry or directory) was noted, leaving patients unsure where or how to connect.
- **No Support for Patients**: Unattached patients are “adrift” with no clear or centralized mechanism to find a provider.
- **Bi-Pass Process**: Patients bypass existing attachments (e.g., walk-ins despite same-day bookings), revealing a mismatch between what’s offered and what’s perceived as accessible.

SYSTEM PARTNERS

- **Equity-Based Attachment Gaps**: Attachment rates are a key provincial driver, but local data shows some subpopulations remain underserved (e.g., transition age youth, elders, unhoused).
- **Narrow Definition of Attachment:** Concern that attachment metrics overshadow equity, complexity, and local needs and don’t show the full picture.
- **Population Health Approach with Focus on Mental Health:** Encouragement to collect and analyze data to identify and address gaps for subpopulations, including integrating mental health and addictions with primary care.
- **Crisis-Based Access:** Challenges in connecting unattached individuals (e.g., those with addictions, language barriers, low income) to primary care, as many rely on crisis services and do not follow linear healthcare journeys.
- **Social Determinants:** Individuals experiencing homelessness, poverty, or food insecurity often deprioritize healthcare as they focus on immediate survival, with lack of stable housing and transportation severely limiting access.
- **Mistrust in Health System**: Equity-deserving groups, particularly Indigenous individuals, report deep mistrust in health systems due to previous harm and the persistent absence of trauma-informed, culturally safe care.
- **Assertive Outreach Models**: There is a need to explore assertive outreach and hub-based models highlighted as effective for engaging hard-to-reach populations, including the unhoused and those with high addiction needs.
- **Newcomer Attachment & Navigation**: Many newcomers are unaware of available services or how to seek help, often resulting in delayed or missed care.

OPPORTUNITIES FOR **ATTACHMENT**

1 BOHT to Redefine and Measure Attachment More Meaningfully

- Broaden the definition of attachment for BOHT planning - beyond being rostered to a provider; include:
  - Ongoing continuity of care
  - Culturally and psychologically safe relationships
  - Trauma-informed and relationship-based care models
- Develop metrics that measure the quality, inclusivity, and stability of attachment, not just volume or enrollment rates.

"They miss two appointments and get dropped — but we know what's going on in their life."

Local Influence:
BOHT can define its own planning language and metrics.

Impact:
Improves quality of attachment, not just enrollment numbers; supports trust-building.

Feasibility:
Needs agreement, data work, and buy-in.

EDI Impact:
Centers culturally safe, trauma-informed care.

Recommendation: Priority 1 – Do Now

2 Streamline and Strengthen Patient-Provider Matching

- Create a centralized, transparent process to match unattached patients to providers, with a focus on priority populations.
- Use population-level planning tools to forecast demand and plan for provider retirements or practice shifts.
- Implement a two-way matching process when patients are newly assigned (e.g., after a provider retires) to foster alignment and trust.
- Explore interim care coverage for patients with complex needs during provider absences or retirement to protect continuity of care.

"We know lots of docs are retiring, so how can we plan for the next few years?"

Local Influence:
Can improve local matching processes, but full integration with the provincial HCC registry is limited.

Impact:
Better matching can reduce churn and frustration, improve continuity.

Feasibility:
Aligns with the work of the PCN Attachment Group, requires buy-in and further refinement.

EDI Impact:
Can prioritize vulnerable and high-need populations.

Recommendation: Priority 1 – Do Now

3 Target Attachment Strategies for Equity-Deserving Populations

- Use local data and partner insight to focus attachment efforts on:
  - Children and Transitional-age youth
  - Indigenous community members
  - Elders with complex needs
  - Individuals with concurrent mental health and substance use challenges
  - Newcomers with limited system knowledge
  - Unhoused individuals
- Use data from crisis services and walk-in clinics to identify and engage persistently unattached patients.
- Explore opportunities for post-discharge from hospital connections for transitional clinics or mobile teams.

Local Influence:
Can prioritize local resources and planning toward these populations.

Impact:
Directly addresses those at highest risk of being unattached.

Feasibility:
Uses local data and partnerships already in place or possible to develop.

EDI Impact:
Explicitly equity-focused.

Recommendation: : Priority 1 – Do Now

OPPORTUNITIES FOR **ATTACHMENT**

4 Expand Assertive and Flexible Attachment Models

- Develop low-barrier, mobile, and drop-in models to serve individuals not accessing traditional care (e.g., unhoused, those with mental health or substance use needs).
- Embed primary care in trusted community spaces like shelters, churches, and food programs.
- Use relationship-based outreach with consistent staff and flexible hours to build trust over time.
- Explore use of mobile units for underserved areas and embedding primary care in schools and community hubs

"Mainstream care ignores our food, our grief, our language. It's not just inconvenient, it's unsafe."

Local Influence:
Ability to build on local capacity and experience in Mobile CHC but may require new funding.

Impact:
Directly reaches people who remain unattached in current models.

Feasibility:
Needs staffing, funding, and partnerships with community organizations.

EDI Impact:
Designed specifically for equity-deserving groups.

Recommendation: Priority 2 – Plan

5 Increase Public Awareness and System Literacy

- Develop and distribute plain-language, multilingual resources explaining what primary care is, how to access it, and what to expect.
- Host community workshops through trusted organizations to improve understanding of patient rights and available services.
- Equip patients to self-advocate and seek alternatives if denied care or faced with system barriers.

Local Influence:
Fully controllable locally through communication and partnership.

Impact:
Enables better system use, reduces inappropriate care-seeking.

Feasibility:
Can be developed with existing partners, using plain-language tools.

EDI Impact:
Multilingual, culturally relevant outreach addresses disparities.

Recommendation: Priority 1 – Do Now

06.

ACCESS INSIGHTS & OPPORTUNITIES

UNDERSTANDING **ACCESS**

Access is more than simply having a place to go for care; it means being able to obtain timely, appropriate, and equitable primary care services when they are needed.

Access to care is shaped by a range of systemic factors that go beyond personal choice or preference. This section explores both system-level and patient-level influences on access, highlighting barriers and enablers that affect whether people can reach the care they need.

PROVIDER/HEALTH SYSTEM FACTORS

AVAILABILITY & ACCOMODATION

- **Hours of operation:** Flexible, extended, or convenient hours to match diverse schedules and reduce barriers to ongoing care.
- **Appointment mechanisms:** Easy, user-friendly systems for booking, confirming, and managing appointments, including online or phone options.
- **Resource availability:** Sufficient staffing, space, and supplies to meet patient demand without long waits or service gaps.
- **Funding models (Negation):** Financial structures that shape how many patients providers can accept, what services they offer, and whether care is sustainable over time.
- **Technology supports:** Tools that facilitate scheduling, communication, virtual care, and patient records, making attachment more seamless and efficient..

PATIENT FACTORS

ABILITY TO REACH

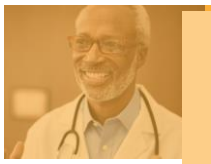
- **Trust & expectations:** Confidence in the provider or system and belief that care will be respectful, effective, and culturally safe.
- **Health-seeking behaviours:** Patterns of when, how, and why people choose to engage with care, shaped by knowledge, culture, and experience.
- **Desire for care:** Motivation or readiness to seek, accept, and maintain an ongoing care relationship.
- **Living environment:** Housing stability, safety, and household conditions that impact the ability to attend appointments and prioritize health.
- **Transportation & mobility:** Access to reliable, affordable transportation and physical ability to travel to care sites.
- **Technology literacy:** Comfort and skill using online booking, virtual visits, and electronic communication with providers.
- **Primary language:** Ability to communicate effectively with providers in one's preferred language, supporting clear understanding and trust.

INSIGHTS ON **ACCESS**

Our conversations with patients, system partners, and primary care providers offered valuable insights into what shapes access to primary care in Burlington. These insights highlight both system-level factors that affect how accessible and welcoming care is, and patient-level factors that influence people's ability and readiness to seek and sustain care.

PATIENTS

- **Navigation Challenges:** Access often requires personal advocacy, with patients needing to navigate complex, inconsistent booking systems (phone, online, in-person) that vary in responsiveness and availability.
- **Timely Access Matters:** Same- or next-day appointments are highly valued but not reliably available, leading to frustration and workarounds.
- **Digital Barriers:** Low digital literacy and limited access to technology block many patients—especially seniors—from using online booking or virtual care, underscoring the need for alternative pathways like home visits.
- **Importance of Team-Based Care:** Patients want reliable, continuous access to a team where "there is always someone there," helping to build trust even when they can't choose a specific provider.
- **Need for Flexible Options:** A variety of appointment types (in-person, virtual, home visits) and easy, convenient scheduling are essential to meet diverse patient needs.



PRIMARY CARE PROVIDERS

- **Fragmented System Incentives:** Misaligned funding models and negation policies penalize providers when patients seek care elsewhere, pushing practices into siloed, less collaborative approaches.
- **Trade-offs with Walk-in Care:** While walk-ins can ease patient access and reduce administrative load, they often undermine continuity and trusted patient-provider relationships.
- **Value of Improved Booking Tools:** Online booking and rapid access clinics are seen as major improvements that help manage demand and enhance patient experience.
- **Need for Centralized Navigation:** Both patients and providers highlight the absence of a clear, trusted entry point or directory to guide patients to appropriate care, contributing to system complexity and inefficiency.

SYSTEM PARTNERS

- **Equity and Inclusion Gaps:** Digital-first, online-only systems often exclude low-income, elderly, newcomer, neurodivergent, and disabled populations, who may lack devices, internet access, or digital literacy.
- **Language and Literacy Barriers:** Limited multilingual support and lack of plain language resources make navigation difficult for those with language barriers or lower health literacy.
- **Over-Reliance on Self-Navigation:** Systems expect patients to independently navigate complex processes, disadvantaging those who need more support or have cognitive challenges.
- **Rigid and Exclusionary Policies:** Strict appointment rules, proof-of-address requirements, and bureaucratic reapplication processes create barriers to maintaining or regaining attachment for vulnerable populations.
- **Need for Inclusive Pathways:** Alternative models are needed to address both access and attachment, designed to serve populations not well-supported by traditional, mainstream approaches.

OPPORTUNITIES FOR **ATTACHMENT**

1 Reduce Variability in Appointment Access

- Explore alignment of appointment booking processes across clinics to reduce inconsistencies in how patients access care (e.g., phone response times, portal access).
- Maintain alternative booking options (phone, in-person) to support patients with low digital literacy, language barriers, or disabilities.
- Ensure that all access strategies include inclusive design principles, accommodating those without internet access, digital devices, or digital fluency.

Local Influence:
Dependent on local partners, varied technology and booking systems, and administrative burden.

Impact:
Directly improves access for all patients, with particular benefit for vulnerable and equity-deserving populations.

Feasibility:
Requires coordination, willingness and technology and process impacts across multiple clinics and providers.

EDI Impact:
Explicitly designed to reduce access barriers for people without stable housing, internet, digital literacy, or consistent phone access.

Recommendation: Priority 3 – Advocate

2 Enhance Equity and Access for Vulnerable Populations

- Provide multilingual and plain-language appointment booking materials and systems.
- Offer in-person or telephone support for patients who cannot use online systems, especially seniors, newcomers, and neurodivergent individuals.
- Explore solutions to reduce documentation-related barriers (e.g., requiring a fixed address for subsidized programs) to increase accessibility for vulnerable populations.
- Create policies allowing easy re-entry for patients who miss appointments, reducing barriers to re-establishing attachment.
- Explore youth-centred, youth-friendly protocols and spaces

Local Influence:
Requires local providers to implement multilingual materials, staff training, and phone/in-person support.

Impact:
Directly improves access and equity for multiple vulnerable groups: newcomers, seniors, neurodivergent individuals, youth.

Feasibility:
Requires investment and buy-in. Additional barriers are harder to solve locally. Targeted activities may be feasible.

EDI Impact:
Prioritizes multilingual, culturally safe, and inclusive design.

Recommendation: Priority 2 – Plan

OPPORTUNITIES FOR **ATTACHMENT**

3 Expand Same-Day or Walk-In Access while Advocating for Policy Changes

- Advocate for policy changes to allow shared after-hours coverage and seamless referral between different primary care models (FHO, FHG, FHT). Negation penalties disincentivize collaboration and penalize providers for patients accessing care outside of their group.
- Develop geographically distributed after-hours clinics that are coordinated across practices to reduce patient confusion and provider burden.
- Establish system-wide agreements and platforms to promote shared care across practices.

"We're all sitting at the table; we're trying to work together. We want to work together.

Local Influence:
Local planners can develop and coordinate shared after-hours clinics and agreements, but changes to billing rules and negation penalties require provincial policy advocacy.

Impact:
Would significantly improve after-hours access, reduce ED visits, and support consistent care across practices.

Feasibility:
Some solutions are implementable locally, but significant barriers to seamless integration.

EDI Impact:
Improves access to regular providers, those needing urgent care after hours, and populations relying on walk-in models.

Recommendation: Priority 2 – Plan

07.

COMPREHENSIVE CARE INSIGHTS & OPPORTUNITIES

UNDERSTANDING **COMPREHENSIVE CARE**

Comprehensive primary care is more than simply addressing a single health concern; it means providing whole-person care that meets the full range of a patient's needs over time.

Comprehensive care includes prevention, chronic disease management, mental health support, and coordination with other health and social services. It is shaped by systemic factors that extend beyond individual choice, requiring strong collaboration among providers and services. This section explores both system-level and patient-level influences on delivering comprehensive care, highlighting enablers and gaps that determine whether people receive coordinated, appropriate support.

PROVIDER/HEALTH SYSTEM FACTORS

AFFORDABILITY

- **Ministry funding model:** The way provincial funding is allocated influences what services are available, provider capacity, and whether costs are covered for patients.
- **Geographic location:** Costs for patients to get to appointments, including direct and indirect costs.
- **Virtual/In Person visits:** Flexibility in visit types can reduce patient costs related to travel, time off work, or childcare.

ACCESSIBILITY & APPROPRIATENESS

- **Geographic location:** The physical distance to services affects how easily patients can attend appointments and get timely care.
- **Virtual care:** Online or phone-based care options improve access for patients who face barriers to traveling in person.
- **Translation & interpretation service:** Language supports ensure patients understand their care and make informed decisions, improving cultural safety and quality.
- **Access to allied health:** Availability of team members like social workers, dietitians, and physiotherapists supports comprehensive, appropriate care for diverse patient needs.

UNDERSTANDING **COMPREHENSIVE CARE**

PATIENT FACTORS

ABILITY TO PAY

- **Indirect costs (travel, parking, lost wages, etc.):** Out-of-pocket expenses that make accessing care harder for patients, especially those with limited income.
- **Opportunity costs (missed work, school, caregiving, etc.):** The personal or family sacrifices required to attend appointments, which can deter seeking care.
- **Non-OHIP covered services:** Services not funded by the provincial plan, creating financial barriers for necessary treatments or supports.

ABILITY TO ENGAGE

- **Trust & expectations:** Confidence that providers will deliver respectful, high-quality, culturally safe care; shapes willingness to seek and continue care.
- **Personal & social values, culture, gender:** Individual identity and cultural context influence comfort with care models and communication.
- **Autonomy & support:** The ability to make informed choices about care, with appropriate help navigating the system when needed.
- **Health literacy:** Understanding health information and instructions to participate effectively in care and make informed decisions.
- **Complexity of need:** Managing multiple health issues or social challenges that require coordinated, tailored care approaches.
- **Continuity of information:** Ensuring providers have access to accurate, shared patient information to support seamless, coordinated care.

UNDERSTANDING **COMPREHENSIVE CARE**

Our conversations with patients, system partners, and primary care providers offered valuable insights into what shapes access to primary care in Burlington. These insights highlight both system-level factors that affect how accessible and welcoming care is, and patient-level factors that influence people's ability and readiness to seek and sustain care.

PATIENTS

- **Mobility & Transportation Challenges:** Transportation and mobility challenges, especially for seniors, require options like home visits, online scheduling, and multiple ways to connect with care.
- **Confusion on OHIP Coverage:** There is variable understanding of what OHIP covers, and out-of-pocket costs for non-OHIP services can be significant barriers.
- **Language and Cultural Safety Are Essential for Equity:** Lack of adequate language services and culturally safe care limits access, trust, and quality of the care experience.
- **Patients Need Time and Space to Engage in Their Care:** Patients want to discuss more than one issue per visit, ask questions, and learn about their health without feeling rushed or dismissed.
- **Coordination Across Providers Matters:** Interoperability and shared access to patient charts are important for seamless, high-quality care. Referral processes to specialists also shape perceptions of primary care access.
- **Social Determinants of Health Shape Access and Outcomes:** Health literacy, living conditions, caregiver roles, and other social factors significantly influence patients' ability to engage with and benefit from care.

PRIMARY CARE PROVIDERS

- **Fragmented Systems Undermine Care Quality:** Providers are frustrated by poor integration across settings, reliance on faxes, and lack of shared EMRs, which lead to lost information and weaken continuity of care.
- **Policy and Funding Models Discourage Collaboration:** Fee structures, negation penalties, and misaligned incentives create fragmentation and disincentivize team-based, comprehensive care.
- **Administrative Burden Takes Time Away from Patients:** Heavy non-clinical tasks—like paperwork, and chasing referrals—are seen as wasteful, detracting from the time providers want to spend delivering care.
- **Access to Allied and Mental Health Services is Limited:** Providers strongly want better access to supports like mental health care, physiotherapy, and dietitians to deliver truly comprehensive, patient-centred care.
- **Navigation is a Shared Challenge for Patients and Providers:** There is a clear need for centralized navigation support to help both patients and providers manage complex, fragmented systems more effectively.
- **Coordination Across the Care Continuum is Essential:** Providers deeply value strong coordination with specialists and hospitals but see current gaps as a major barrier to delivering seamless, patient-centred care.
- **Patient Access is Impacted by Specialist Access:** Wait time concerns persist for both primary and specialist care

UNDERSTANDING **COMPREHENSIVE CARE**

SYSTEM PARTNERS

"We should see attachment as access to a system of care — not just a doctor."

- **Affordability Barriers Extend Beyond Care Visits:** System partners highlighted transportation costs, internet and technology access, prescription medications, assistive devices, and uninsured specialist services as major affordability barriers—particularly for people on fixed incomes, those without cars, and those experiencing homelessness.
- **Need for Trust-Based, Relational Models of Care:** Partners emphasized that trust, continuity, and personalization are essential. Concerns were raised about rushed "one issue per visit" approaches, failing to listen fully, and filtering out critical patient context.
- **Caregiver Roles Are Overlooked and Unsupported:** Family members and other caregivers play central roles in managing care, yet their needs are often excluded. Caregiver burden is especially acute in marginalized or multi-generational households, and non-traditional or chosen families frequently go unrecognized.
- **Access to Allied and Mental Health Services is Limited and Uneven:** Partners identified a strong need for better access to allied health services like mental health care, social work, and resource consultants—resources that are critical for comprehensive, wraparound care.
- **Specialist Access is Confusing and Unequal:** Delays and confusion in accessing specialists were noted, with particular challenges for marginalized patients. Specialty services are not always culturally relevant, and there is often poor collaboration or information-sharing between specialists and primary care providers.
- **Fragmented Communication Undermines Continuity:** System partners described persistent issues with fragmented provider-to-provider communication, forcing patients to retell their stories repeatedly and leading to frustration and disengagement.
- **Navigation Supports Are Essential but Often Missing:** Equity-deserving populations need dedicated patient navigators or advocates to help them access, coordinate, and understand care. Indigenous communities in particular require culturally appropriate navigational supports and resources within primary care.
- **Cultural Safety is Insufficient in Mainstream Healthcare:** Mainstream care settings often fail to deliver culturally safe experiences, overlooking practices related to food, communication, and identity. This contributes to care that can feel unsafe or alienating, reducing engagement and trust.
- **Importance of Community-Based, Wraparound Supports:** Partners stressed the value of delivering care in familiar, community settings that offer wraparound supports, helping to build trust and facilitate sustained engagement and continuity of care.

UNDERSTANDING **COMPREHENSIVE CARE**

1 Expand Access to Comprehensive Care Models for Priority Populations

- Invest in interprofessional teams within community-based care that include mental health professionals, chronic disease specialists, and social care workers.
- Develop longer-visit and higher-touchpoint care models that accommodate relationship-building and wraparound support for complex patients.
- Support integrated teams including lived experience/ peer support workers, outreach staff, and registered practical nurses (RPNs).
- Explore models that rely on brief, single-issue appointments, which are incompatible with the needs of high-complexity populations.
- Support the co-location of services so individuals can access mental health, primary care, housing, and social supports in one setting.

Local Influence:
Local system planners can plan and design these models now.

Impact:
Supports equity, improves quality, reduces avoidable acute care use.

Feasibility:
Implementation depends on securing new funding and policy supports for staffing, infrastructure, and model approvals.

EDI Impact:
Strong focus on priority and equity-deserving populations, culturally safe and integrated care, supports for complex needs, and family-based approaches.

Recommendation: Priority 2 – Plan

Identified Strategies to Expand Access to Comprehensive Care for Priority Populations:

Improve Caregiver & Chosen Family Inclusion

- Recognize the vital role of caregivers and chosen family, especially in marginalized and multi-generational households.
- Explore group visits or family-based care approaches that support multiple generations or family members in shared care experiences.

Integrate Use of Peer Support and Lived Experience Roles

- Integrate peer support workers into primary care teams to foster trust and reduce barriers to care.
- Build training and supervision structures that support peer roles across settings and ensure alignment with care goals.

"Peer workers open the door in ways clinical staff often can't."

Expand Language and Navigation Supports

- Improve access to language interpretation services and ensure multilingual resources are available in both digital and non-digital formats.
- Embed system navigation supports that help patients schedule care, understand available services, and make informed decisions—particularly important for non-English speakers and underserved communities.
- Recognize and reduce the advocacy burden on patients and caregivers by proactively offering navigation assistance.

Integrate Mental Health, Addictions, and Primary Care

- Build blended care models (e.g., CHC-CMHA partnerships) where mental health and addictions services are fully integrated with primary care.
- Develop shared governance and accountability frameworks across sectors to enable true collaboration.
- Shift from viewing attachment as a tie to an individual provider to attachment as connection to a system or team.

"There is no access point if you don't speak English or don't know what you're entitled to."

UNDERSTANDING **COMPREHENSIVE CARE**

2 Promote Holistic, Trauma-Informed and Culturally Responsive Care

- Provide training in cultural humility and trauma-informed care as ongoing professional development.
- Promote strategies to engage diverse providers who understand and reflect the communities they serve.
- Apply structured frameworks such as the Urban Indigenous Action Plan to guide culturally safe service design, delivery, and evaluation.
- Encourage providers to go beyond the single-issue visit model by routinely asking, “Do you have any other concerns today?”
- Promote collaboration to reflect the cultural and linguistic identities of the patient population served.

Local Influence:
Requires buy-in from local clinics and providers.

Impact:
Supports culturally safe, patient-centred care across all interactions.

Feasibility:
Requires commitment, time, and resources for training and hiring strategies.

EDI Impact:
Directly strengthens culturally safe, trauma-informed care; centers equity by engaging diverse providers and respecting patients’ cultural and linguistic needs.

Recommendation: Priority 1 – Do Now

3 Implement Community-Based System Navigation Supports

- Establish patient navigators or care coordinators who can assist individuals throughout their entire primary care journey—particularly those who face systemic barriers such as language, discrimination, or unfamiliarity with the healthcare system.
- Embed navigators within community-based settings (e.g., libraries, shelters, cultural centres), not just clinical environments, to improve visibility and accessibility.
- Ensure navigators reflect the diversity of the community, including representation from Indigenous, Black, 2SLGBTQ+, newcomer, and other equity-deserving populations.

“Patients need a single point of contact to help them navigate… not a patchwork of websites and word of mouth.”

Local Influence:
High degree of local control over design and implementation.

Impact:
Supports more equitable, person-centred care journeys.

Feasibility:
Requires new resources for hiring and training navigators, establishing partnerships with community sites, and building sustainable funding models.

EDI Impact:
Strong EDI alignment, centering culturally safe, inclusive access.

Recommendation: Priority 2 – Plan

UNDERSTANDING **COMPREHENSIVE CARE**

4 **Strengthen Provider Communication and Shared Accountability**

- Explore access to real-time consultations between providers (e.g., psychiatrist to family physician) to improve continuity and care coordination.
- Ensure that referral systems are trackable and timely, reducing the reliance on outdated or unreliable channels such as fax machines.
- Create standardized protocols for closing the loop on referrals, including feedback mechanisms between primary care providers and specialists.
- Support the use of shared digital platforms that allow for real-time updates on referral status, reducing administrative burden and improving patient experience.

Local Influence:
Encourage approaches and provide supports.

Impact:
Strengthens trust between providers and patients.

Feasibility:
Requires commitment, time, and resources.

EDI Impact:
Strong EDI alignment, reducing barriers for patients who face the greatest systemic challenges.

Recommendation: Priority 2 – Plan

08

APPENDIX: BEST PRACTICE MODELS

CMHA WINDSOR ESSEX

Canadian Mental Health Association
Windsor-Essex County
Community well-being is our sole focus.

ABOUT

The Canadian Mental Health Association Windsor-Essex County Branch (CMHA-WECB) offers a wide range of recovery-based services for individuals living with serious mental illness. The organization integrates primary care, mental health promotion, education, and supportive housing to support community well-being.

FOCUSING ON UNDERSERVED POPULATIONS

In 2024, CMHA WECB received a significant investment in provincial funding to enhance access to primary care services for underserved populations in the region. This initiative aims to integrate primary care with mental health and social services, focusing on individuals who face barriers to accessing traditional healthcare settings.

This includes a partnership with several other agencies including Shelter Health Initiative, City of Windsor, Erie Shores HealthCare's Mobile Medical Support Team, and other community help centres and family health team.

LEARN MORE:

- CMHA Health Centre Youtube Summary
- CMHA Health Centre Website

CMHA HEALTH CENTRE

The CMHA Health Centre offers a wide range of recovery-based services for individuals living with serious mental illness. The organization integrates primary care, mental health promotion, education, and supportive housing to support community well-being.

CMHA Health Centre offers high-quality care to residents living in Windsor and Essex County. An interprofessional group of health care practitioners, including Family Physicians and Nurse Practitioners provide health care in an integrated, respectful and holistic environment. The focus of the health team is on disease management and prevention, rehabilitation, and health promotion.

They serve adults, children, babies, and families who need health care. They specialize in working with individuals with serious mental illness and are committed to providing the best health care possible.

MOBILE MEDICAL SUPPORT

Mobile outreach team including:

- Primary care check-ups (e.g. prescriptions, referrals)
- Chronic disease support (e.g. chronic obstructive pulmonary disease, congestive heart failure, diabetes)
- Preventative care (e.g. vaccinations, fecal immunochemical test, Pap test, mammogram referrals, health teaching)
- Testing (e.g. Covid-19, sexually transmitted infections, pregnancy)
- Wound care
- Foot care
- Mental health support
- Substance/addiction services (e.g. overdose prevention, harm reduction supplies)
- Community connections (e.g. housing assistance, forms, Ontario Works, social supports)

INNER CITY HEALTH ASSOCIATES

ICHA

ABOUT

The Inner City Health Associates (ICHA) is the largest homeless health organization in Canada, comprising over 200 physicians and nurses dedicated to serving individuals who are homeless or precariously housed in Toronto. ICHA provides a wide range of services, including transitional primary care, psychiatry, palliative care, and population health initiatives.

Care is delivered directly in community-based settings such as shelters, drop-in centres, encampments, isolation and recovery facilities, and physical distancing hotels. Funded by the Ontario Ministry of Health, ICHA collaborates closely with the City of Toronto, hospitals, and various community organizations to deliver integrated, on-the-ground care tailored to the unique needs of marginalized populations.

ADDRESSING POPULATION NEEDS

The populations served by the ICFHT often experience complex challenges, including physical and mental health issues, substance use, and social isolation. Many are in the process of transitioning from homelessness or institutional living to more stable, community-based housing.

The ICFHT addresses not only immediate healthcare needs but also the broader social determinants of health, such as housing stability and community integration, which are critical for long-term well-being.

LEARN MORE

- Inner City Family Health Team
- Inner City Health Associates

EQUITY-BASED PRIMARY CARE

The Inner City Family Health Team offers a comprehensive range of services designed to meet the complex health and social needs of homeless and previously homeless individuals in Toronto. Their multidisciplinary team provides primary care through family doctors, nurse practitioners, nurses, and physician assistants, ensuring coordinated assessment and treatment of injuries and illnesses. Specialized services include chiropody (foot care), neuropsychology, physiotherapy, and psychiatry, as well as social work and counselling to address mental health and substance use challenges.

By integrating medical, psychological, and social supports, the Inner City Family Health Team addresses not only immediate health concerns but also the broader determinants of health, including housing stability and community reintegration, for some of Toronto's most vulnerable residents

EQUITY-BASED PRIMARY CARE

In addition to direct medical care, the ICFHT collaborates with organizations like Inner City Health Associates to reach individuals living on the street, in shelters, encampments, and precarious housing situations. This partnership allows for a multidisciplinary approach that integrates physical health, mental health, substance use support, and social care, aiming to improve health outcomes and contribute to the broader goal of ending chronic homelessness in Toronto.

NUKA SYSTEM OF CARE ALASKA

ABOUT

The Southcentral Foundation's Nuka System of Care is a relationship-based, customer-owned health care model serving over 65,000 Alaska Native people in Anchorage, Alaska. Providing fully integrated services—including medical, dental, behavioral, and community health—Nuka is grounded in Indigenous values and cultural strength.

The term "Nuka" means "strong" or "big" in Alaskan Indigenous languages. Alaska Native people are considered "customer-owners," holding true ownership and shared responsibility in their care. Governance is led by a board of customer-owners, and engagement is fostered through tools like surveys, comment cards, hotlines, and advisory committees. The system's vision is a Native community enjoying full-spectrum wellness, supported by a mission to achieve this through collaboration and quality care.

LEARN MORE:

- NUKA SYSTEM OF CARE

The Nuka model emphasizes wellness of the whole person, family, and community through principles of trust, simplicity, access, and co-design. Services are intentionally designed to minimize duplication, improve coordination, and ensure financial sustainability. Customer-owners are active partners in care, with the family serving as the hub of the system. Core values are captured in the acronym R-E-L-A-T-I-O-N-S-H-I-P-S, reflecting priorities such as holistic wellness, population-based approaches, culturally grounded services, and a system that is driven by the needs and interests of the people it serves.

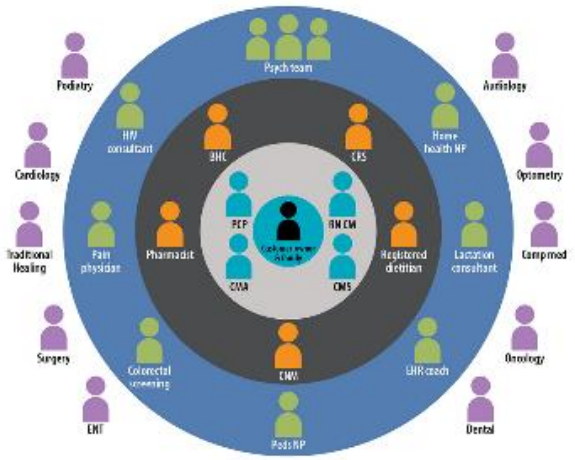


FIGURE 1B. The Nuka System of Care's revised work flow relationship between customer-owner (patient) and primary and specialty care.

Light gray ring: Integrated primary care team—primary care provider (PCP), who may be an MD or nurse practitioner; certified medical assistant (CMA); care management support (CMS); and registered nurse case manager (RN CM).

Dark gray ring: Support services—behavioral health consultant (BHC); pharmacist; community resource specialist (CRS); registered dietitian; and certified nurse midwife (CNM).

Dark blue ring: Shared services—available to customer-owners in all their various distributed teams.

Purple figures: Specialty resources.

Source: Figures 1A and 1B come from the Behavior Health Integration, Participant Guide, provided in the Behavior Health Integration course.

08. APPENDIX: KNOWELDGE HOLDER ANALYSIS

WHAT WE HEARD:
PATIENT VOICE

Continuity & Trust in Provider Relationships

- Patients experience disruption and lack of connection when their physician changes (e.g., retirement, reassignment).
- Complex patients require consistent, trusted relationships, which are difficult to maintain with transitions in care teams.
- Trust across providers with each other as well as between patients and providers.
- Two-way interview processes with new providers is necessary to ensure fit with patient.
- Access to a team-based approach can help build and reinforce trust when you cannot change physicians.
- Patients value opportunities to ask questions and learn about their care.
- Recognize that patients aren't trying to be a burden when seeking care.

Equity, Diversity & Inclusion

- Marginalized and racialized communities face greater gaps in accessing culturally safe and knowledgeable care.
- Lack of adequate language services and interpretation support is a notable challenge.
- Patients often must advocate for themselves or rely on third parties to navigate the system.
- Need for culturally safe care with providers.

Inconsistent Access

- Navigation of these systems often requires patient advocacy or workaround strategies.
- Significant variation exists in how and when appointments can be accessed (e.g., phone response time, online booking availability).
- Variability around "only 1 issue at a time".
- Looking for a provider where "there is always someone there".
- Variety of options, in-person, home visits, virtual etc.

Digital Divide & Virtual Care Limitations

- Many patients lack access to or knowledge of how to use apps and platforms for digital/virtual care.
- Seniors struggle with virtual appointments due to mobility issues or tech literacy, suggesting a need for home visits or alternative care pathways.
- Importance of online appointment scheduling for convenience.
- Importance of interoperability across providers to access patient charts.

WHAT WE HEARD:
PRIMARY CARE VOICE

Fragmented Primary Care

- Unattached patients are “adrift” with no clear or centralized mechanism to find a provider.
- Patients bypass existing attachments (e.g., walk-ins despite same-day bookings), revealing a mismatch between what’s offered and what’s perceived as accessible.
- The lack of centralized, navigable access (like a trusted point-of-entry or directory) was noted repeatedly by both providers and patients.

> “Patients need a single point of contact to help them navigate… not a patchwork of websites and word of mouth.”

Structural Barriers Undermining Continuity

- System design issues, including negation and lack of integrated data, undermine continuity of care.
- Providers are penalized when patients seek care elsewhere (e.g., walk-ins, hospitals).
- Physicians feel forced into siloed care to protect income or avoid administrative penalties.
- Lack of shared EMRs and ongoing fragmentation with faxes were cited as major technical hurdles.

> “Negation drives siloed behaviour… it's a disincentive for collaboration.”

Misalignment Between System Design and Community Needs

- The policy and funding structures often fail to reflect Burlington’s realities.
- Many agreed the Ministry’s priorities (e.g., blanket attachment goals) don’t always apply locally.
- The need to localize solutions and resist one-size-fits-all models was a strong current.
- Providers expressed frustration that provincial direction often ignores their on-the-ground experiences.

> “We keep coming back to the table—but Ontario Health isn’t listening to what we need.”

Provider Burnout and Administrative Overload

- The administrative burden on providers emerged as both a direct barrier to care and a quality issue.
- Heavy non-clinical tasks (de-rostering, referral follow-ups) were seen as draining and non-value added.
- Providers want to focus on care but feel buried by bureaucracy.
- Walk-in models may reduce administrative weight but at the cost of continuity.

> “We’re drowning in admin… that’s why people go part-time or walk away from family practice.”

Desire for Integrated, Tech-Enabled Care

- Online booking and rapid access clinics were praised as game changers.
- Integrated models (including NPs, social workers, and therapists) are seen as ideal but unevenly available.
- Coordination between specialists, hospital, and primary care is weak but deeply valued.

> “Let’s stop relying on faxes and start building a connected care ecosystem.”

WHAT WE HEARD:
SYSTEM PARTNERS

Attachment Rates and Subpopulation Needs

- Attachment rates are a key provincial driver, but local data shows some subpopulations remain underserved (e.g., transitional age youth, elders, unhoused).
- Emphasis on the importance of not letting attachment metrics overshadow equity, complexity, and local needs.
- Encouragement to collect and analyze data to identify and address gaps for subpopulations, including integrating mental health and addictions with primary care.

Alternative and Integrated Care Models

- Examples of integrated care models (e.g., CMHA-CHC partnerships, Inner City Health Associates) discussed as best practices for combining primary care and mental health under one roof.
- Assertive outreach and hub-based models highlighted as effective for engaging hard-to-reach populations, including the unhoused and those with high addiction needs.
- Need for alternative pathways and models that address both access and attachment, especially for populations not well-served by traditional systems.

Barriers to Access & System Navigation

- Challenges in connecting unattached individuals (e.g., those with addictions, language barriers, low income) to primary care, as many rely on crisis services and do not follow linear healthcare journeys.
- Barriers within the system, such as strict appointment policies and lack of fluid re-entry, make it difficult for vulnerable populations to maintain attachment.
- Importance of building trust and providing wraparound supports in familiar community settings to facilitate engagement and continuity of care.

Future Planning & Comprehensive Care

- Recognition that comprehensive care must go beyond attachment to include access, equity, and integration of mental health and primary care.
- Plans to follow up with participants for more detailed data and to revisit the definition and implementation of comprehensive care in future meetings.
- Emphasis on peer support and lived experience as valuable members of a comprehensive care team in breaking down barriers and improving care integration.

WHAT WE HEARD:
SYSTEM PARTNERS

Barriers to Attaching & Accessing Primary Care

- Social Determinants: Individuals experiencing homelessness, poverty, or food insecurity often deprioritize healthcare as they focus on immediate survival, with lack of stable housing and transportation severely limiting access.
- Systemic & Structural Barriers: Online-only systems and complex bureaucratic requirements (like proof of address or reapplication processes) disproportionately exclude those without internet access, literacy supports, or secure housing.
- Trauma and System Mistrust: Any equity-deserving groups, particularly Indigenous individuals, report deep mistrust in health systems due to previous harm and the persistent absence of trauma-informed, culturally safe care.

Equity and Inclusion Gaps

- Lack of representation in planning and services: Black, Muslim, and 2SLGBTQ+ communities are often excluded from engagement and system design, resulting in care models that don't reflect their realities or needs.
- Newcomers lack entry points and system knowledge: Many newcomers are unaware of available services or how to seek help, often resulting in delayed or missed care.

Equity and Inclusion Gaps – Cont'd

- Cultural safety is insufficient or absent: Mainstream healthcare often overlooks cultural practices related to food, communication, and identity, leading to care that feels unsafe or alienating.
- Navigational supports are missing for Indigenous communities: Participants highlighted the need for Indigenous patient navigators and culturally appropriate resources within primary care settings.
- Systems are not accessible to all: Individuals with intellectual disabilities, language barriers, or limited health literacy face significant challenges navigating fragmented healthcare systems.

System Navigation and Communication Gaps

- Need for patient navigation: Equity-deserving populations require dedicated navigators or advocates to help them access and coordinate care.
- Fragmented communication: Poor provider-to-provider communication forces patients to repeatedly share their stories, causing frustration and disengagement.
- Caregiver burden: Families—especially in marginalized or multi-generational households—carry much of the responsibility for navigating complex systems.
- Lack of support for chosen families: Non-traditional caregivers often go unrecognized despite playing critical roles in after-care and advocacy.

ACCESS & ATTACHMENT

This flow diagram was developed as part of the Access and Attachment initiative to visually represent the patient journey through Ontario's primary care system. Its creation was informed by key research on the foundational principles of primary care, specifically, the "four Cs": first contact, continuity, comprehensiveness, and coordination.

These principles served as the basis for mapping distinct stages in the journey, from initial attachment status (unattached or attached) through to appointment booking, engagement with primary and allied health care, specialist referrals, and information-sharing between providers. The purpose of the flow was to illustrate a typical and idealized care pathway, capturing how individuals move through the system when access and attachment function optimally.

Contact		Comprehensive		Coordination	Continuity
Unattached	**Attached**	**Appointment**	**Primary & Allied Health Care Visit**	**Coordinated Care Delivery, &Specialist Referral**	
Does not have a sustained, therapeutic relationship with primary care, including CHCs, and NP-led clinics	Sustained, therapeutic relationship with a provider who can offer first-contact, comprehensive, continuous, and coordinated care.	Book appointments or visit walk-in clinics for immediate care.	Visit family doctor or nurse practitioner for health concerns. May receive support from a care team including nurses, social workers, and other professionals.	Delivery of care Coordination of services, information and support Referral to specialists when needed.	Information from specialists is shared back to the primary care provider to support ongoing care.

SYSTEM & PATIENT FACTORS

PRIMARY CARE - HEALTH SYSTEM FACTORS						
Approachability	*Acceptability*	*Availability & Accommodation*	*Affordability*	*Accessibility & Appropriateness*	*Coordination*	*Continuity*
• Transparency • Outreach to community • Retirement plans	• Information sharing • Patient fit • Shared culture and connection • Funding model	• Hours of operation • Appointment mechanisms • Resource availability • Negation • Technology supports	• Ministry funding model • Geographic location Virtual/In Person visits	• Geographic location • Virtual care • Translation & interpretation service • Access to allied health	• System navigation • Specialist wait-times	• Shared records & technology solutions • Timely access to information

PATIENT FACTORS					
Ability to Seek		*Ability to Reach*	*Ability to Pay*	*Ability to Engage*	*Ability to Action & Communicate*
• Health literacy • Beliefs & trust • Health care needs • Structural/ Systemic barriers • Desire for care	• Beliefs & trust • Personal & social values, culture, gender • Autonomy • Desire for care • Health system knowledge	• Trust & expectations • Health seeking behaviours • Desire for care • Living environment • Transportation & mobility • Technology literacy • Primary language	• Indirect costs (travel, parking, lost wages, etc.) • Opportunity costs (missed work, school, caregiving, etc.) • Non-OHIP covered services	• Trust & expectations • Personal & social values, culture, gender • Autonomy & support • Health literacy • Complexity of need • Continuity of information	• Empowerment • Technology literacy • Adherence • Family & caregiver support • Social determinants of health

WHAT WE HEARD:
THE PATIENT VOICE

Ability to Seek		*Ability to Reach*	*Ability to Pay*	*Ability to Engage*	*Ability to Action & Communicate*
• Fit plays a critical • Not everyone wants to be attached • Previous experiences with the medical system can influence ability and interest to attach and access primary care	• Gaps in knowledge of how the healthcare system works influences the ability to attach • Cultural alignment with a provider is an important factor • Should be a two-way interview to determine fit	• Access often requires advocacy and navigation • Booking processes vary (e.g., phone, virtual) • Variability in timely access Same or next day access important • Low digital literacy can block online booking	• Variable understanding on OHIP covered vs. non. OHIP covered services • Access to transportation can be a challenge • Appointment schedule misalignment (work/ family/ school commitments)	• Trust with providers is essential • Team-based care means someone is always available • Mobility can influence access • Want time to discuss more than one issue per visit • Don't want to feel like a burden • Need language support and translation • Want time to learn and ask questions • Equity means more than access—it means full, integrated care	• Referrals to broader specialties is an issue and impacts peoples perception of primary care access • Role of family and caregiver support is significant • Health literacy • Social determinants of health play a significant role

WHAT WE HEARD:
PRIMARY CARE PROVIDERS

Approachability	*Acceptability*	*Availability & Accommodation*	*Affordability*	*Accessibility & Appropriateness*	*Coordination*	*Continuity*
• Limited access; patients unsure where or how to connect	• Burnout among GPs affects care consistency • Attachment undermined by negation penalties and administrative burdens	• Lack of aligned incentives and negation policies creates fragmentation and discourages collaboration • Online booking seen as a significant improvement • Even with same-day availability, patients may choose walk-ins for convenience	• Fee models can discourage comprehensive care (e.g., negation penalties, lack of hospital support)	• Strong desire for better access to services like mental health, physiotherapy, dietitians • Lack of aligned incentives and negation policies creates fragmentation and discourages collaboration • Fragmentation from system workarounds (e.g., pharmacy visits, virtual care apps)	• Need for centralized navigation support for both patients and providers • Frustration over lack of integration and follow-up between providers • Reliance on faxes or paper hinders coordination • Providers burdened with navigating fragmented systems on behalf of patients	• Wait time concerns persist for both primary and specialist care • Major gaps in information sharing due to poor lack of shared records • Loss of information across care settings weakens longitudinal relationships

WHAT WE HEARD:
SYSTEM PARTNERS

Approachability	*Acceptability*	*Availability & Accommodation*	*Affordability*	*Accessibility & Appropriateness*	*Coordination*	*Continuity*
• Housing, food, safety priorities override health-seeking behavior • Some choose not to pursue attachment due to past harms and ongoing stigma in health systems • Unattached individuals may not be captured in formal data • Unattached individuals often don't know how to enter the healthcare system	• Narrow definition of "attachment" – having a doctor doesn't equate to culturally safe or trauma-informed care • Attachment mis-match between patient and provider • Reports of practices denying patients with complex needs (mental health, addictions, homelessnes s) even when open for new patients	• Digital-first systems exclude many including: low-income, elderly, newcomer, and neurodiverge nt populations • Lack of multilingual support or plain language resources • Over-reliance on self-navigation	• Cost of transportation was repeatedly flagged as a barrier, especially for people on fixed incomes, those experiencing homelessnes s, or individuals without access to a car • Internet and technology access emerged as a modern affordability issue • Prescription medications, assistive devices, and specialist services cost barrier for uninsured	• Need for trust-based, relational models • Continuity, safety, and personalizatio n • Concerns around not listening fully or filtering out critical context • One issue per visit limits comprehensiv e care • Excludes the needs of caregivers or family members, despite their central role in care management	• Unaware of what allied services are available within a clinic or hospital • Need for access to mental health, social work, resource consultants, etc. • Delays and confusion around specialist access, particularly for marginalized patients • Specialty services not always equipped to deliver culturally relevant care	• Specialists and PCPs often don't share information or plan care collaboratively

08

APPENDIX: ASSET MAPPING

ASSET MAPPING

To understand the landscape of supports influencing primary care attachment, we mapped community assets across four key domains: Health Care Facilities, Home Health and Community Supports, Public Health, and Integrated Services. These assets offer both direct and indirect pathways to attachment by enhancing access, continuity, and coordination of care.

Direct Health System Entry Points

A range of facilities serve as common first points of contact or bridge supports to primary care:

- Walk-in Medical Clinics and Emergency Departments offer episodic care, often serving unattached patients and signaling demand for attachment pathways.
- Family Health Teams, Ontario Health atHome Clinics, and Community Nursing Clinics are structured to provide longitudinal care and can play a strong role in formal attachment strategies.
- Pharmacies and Immunization Clinics provide preventive services and act as community touchpoints, particularly for marginalized populations.

Health Maintenance and Management Supports

- Programs that help manage chronic conditions or support recovery can improve attachment outcomes by reducing barriers to primary care engagement:
- Diabetes Education, Cancer Centres, Mental Health Programs, and Rehabilitative Care services (hospital-based, in-home, and private pay) extend care beyond physician offices, supporting continuity.
- Diagnostic Imaging and Medical Labs support referral-based coordination and follow-up with primary care.

Home and Community Supports

These services are critical for individuals with mobility, cognitive, or economic challenges:

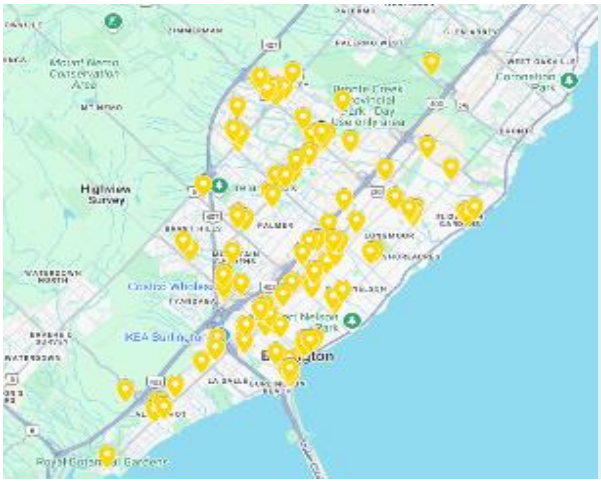
- In-Home Personal Support, Meal Delivery, Home Modification, and Transportation (Accessible/Non-Accessible) services reduce non-medical barriers to primary care access.
- Caregiver Support, Companionship, and Adult Day Programs promote stability in the home and reduce the risk of care disruptions.

Public Health and Preventive Services

Preventive programming improves population health while creating regular contact points with the system:

- Smoking Cessation, Breastfeeding Support, Sexual Health Clinics, and Fitness Programs indirectly support attachment through health promotion and trust-building with service providers.
- Safety and Injury Prevention and Parenting Education programs support early intervention and family engagement with the system.

ASSET MAPPING

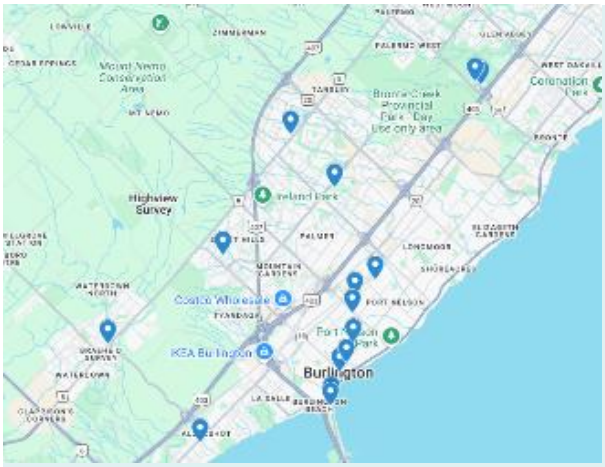


Health Care Facilities

This map highlights the network of health care facilities across Burlington including walk-in clinics, hospitals, diagnostics, pharmacies, labs, and specialized services that support both episodic and longitudinal care. These locations are essential infrastructure for enabling primary care attachment, offering residents multiple entry points into the health system and ongoing supports to maintain health and well-being.

Home and Community Health Services

This map visualizes the breadth of home and community health services across Burlington, including in-home care, assisted living, respite, equipment, and transportation supports. These localized assets play a vital role in enabling access to care, especially for seniors, people with disabilities, and those with limited mobility helping bridge gaps in primary care attachment.



Public Health Services

This map showcases public health programs that support healthy living and prevention across Burlington from sexual health and smoking cessation to parenting education and recreation. These services foster upstream engagement and strengthen primary care attachment by promoting early intervention and building trust with the health system.

BURLINGTON
ONTARIO HEALTH TEAM

The Burlington OHT is supported by funding from the Government of Ontario.

BOARDWALK

BOARDWALK GROUP
180 Booth Ave, Toronto, ON, M4M 2M4
E-mail: Jennifer.Wilkie@BoardWalk-Group.com
Info@BoardWalk-Group.com
Phone: 416-738-6815
www.BoardWalk-Group.com