Elgin's Neighbourhood Health Home Model

Final Wrap-Up Report

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1.0 Executive Summary

The Elgin Ontario Health Team (OHT) undertook the development of a Neighbourhood Health Home (NHH) Model to strengthen access to primary care, improve service coordination, and respond to the diverse needs of residents across Elgin. This work aligns with provincial direction, including Ontario's Primary Care Action Team (PCAT) objectives, advancement of team-based care, and improved integration across health and social services.

Designing the Neighbourhood Health Home Model
A comprehensive design process was initiated including detailed data review and engagement with primary care, community partners, and residents. This process identified several system needs that the NHH Model must address: a high number of residents without a formal and ongoing relationship with a family physician or primary care nurse practitioner ("unattached"), significant material deprivation in parts of the region, variable access across rural communities, fragmented navigation and referral pathways, inconsistent digital infrastructure, and administrative burden affecting both providers and residents.

Overview of the Neighbourhood Health Home Model
The NHH Model sets out a geographic-based approach to service orientation and patient/client access. Upon full-implementation, Elgin's Model will include:

- Integrated leadership and planning across the OHT.
- A Central Hub which acts as the anchor of care in Central Elgin and coordinates regionalized services.
- East and West Spokes which act as anchor sites in East and West Elgin for primary care, social and community services.
- Satellites and mobile outreach (including community paramedicine) to ensure equitable access to care.

This approach will enable services to be delivered locally and tailored to local needs, while also enabling resources to be optimized and services to be coordinated.

Coordinating Council approved the NHH Model as a vision to work towards, guiding future decision-making and investment across the OHT. It is anticipated that implementation of the NHH Model will occur in steps, which may not be linear based on funding pockets and/or Government priorities.
Recommended priorities for implementation include:

- Harmonizing the Existing Primary Care Electronic Medical Records (EMRs)
- Unified Access and Navigation
- Coordinated Referral and Service Linkages
- Neighbourhood After-Hours Coordination
- Data and Population Health Intelligence

This report provides an overview of the NHH Model, the prioritization of key aspects and a high-level implementation plan.

2.0 Introduction

The Elgin Ontario Health Team (OHT) engaged EY to support the design of a Neighbourhood Health Home (NHH) Model tailored to meet the unique needs of Elgin. The goal of this work was to develop a model that:

- Supports whole-of-system collaboration (beyond a traditional medical home model),
- Reflects provincial priorities (e.g., enables attachment to primary care),
- Responds to local population needs (e.g., meets the unique needs of equity deserving populations),
- And advances the OHT's long-term vision for equitable, team-based care for all residents across Elgin.

2.1 Neighbourhood Health Home Model

A NHH can be defined as 'a concept that embodies the principles of community health care, where organizations reach beyond their doors to improve the lives of people in their communities.[1] In this model, a Health Home is the front door to the health-care system. It's where individuals are connected to a primary care team near their home, along with a network of other health professionals who support their unique health and wellness needs at every stage of life.[2]

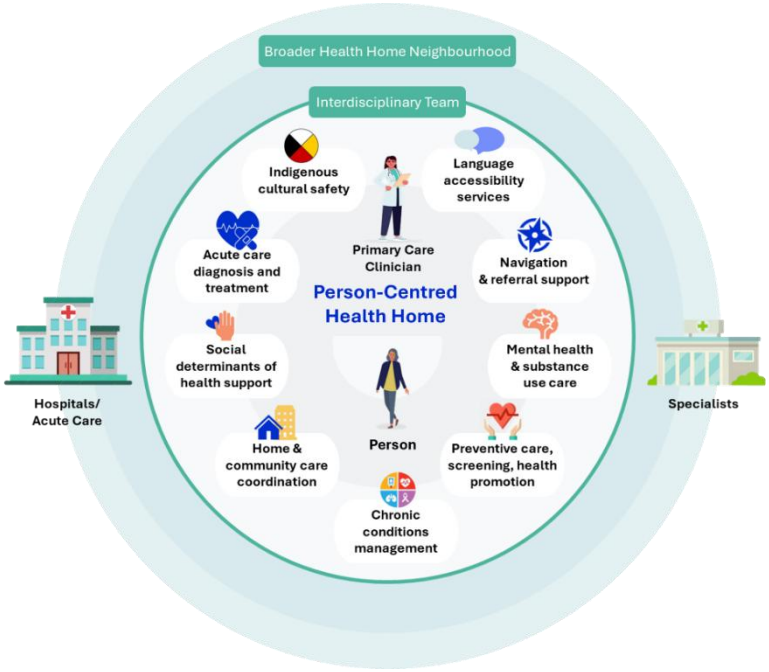

Figure 1: NHH Model (FLAOHT)

[1] Alliance for Healthier Communities. Vision for a Health Home.
[2] FLAOHT. About Health Homes. Health Home – The Frontenac, Lennox & Addington Ontario Health Team

The NHH Model is aligned to the objectives of Ontario's Primary Care Action Team (PCAT) and to the Elgin OHT's agreed guiding principles:

1. **Person-Centred and Comprehensive**: Care respects and responds to the individual's full spectrum of unique needs, preferences, values, and lived experience. People are empowered to be leaders in their own health and care, with focus on physical, mental, emotional, social, cultural and spiritual well-being.
2. **Equitable:** Care is available to everyone regardless of geography, culture, language, income, or background. Services are culturally safe, trauma-informed, linguistically appropriate, and responsive to the needs of underserved and marginalized populations, including newcomers and rural residents.
3. **Accountable:** Everyone shares responsibility for delivering high-quality care to and for the entire population with clear roles and expectations.
4. **Connected:** Connections are smooth between all needed services and supports. Teams are digitally and operationally connected across health and social care. People are empowered with access to their health records and clear communication about their care.
5. **Accessible:** People can access care when and where they need it—close to home, virtually, or in-person. Services are intentionally designed to be convenient and barrier-free, especially for those in rural or high-needs areas.
6. **Continuous:** Care relationships are consistent and long-term, with smooth transitions between providers and care settings. Ongoing connections between people & their care teams foster trust, stability, and improved health outcomes over time.
7. **Collaborative:** Interdisciplinary teams work together across sectors with the people they serve. There is shared leadership, mutual respect, and aligned goals.

A NHH Model has many benefits including enabling equitable access to care for everyone; shorter wait times by ensuring the right care is provided by the right provider and empowering all team members to work to top of scope; providing wholistic care; providing access to care closer to home; reducing duplication of service efforts and improving communication among providers.

2.2 Designing Elgin's Neighbourhood Health Home Model

A robust design process commenced in 2025 to develop a NHH Model that was tailored to the unique needs of Elgin and aligned to Elgin OHT's agreed guiding principles. Through data analysis and initial interest holder engagement (including with the Elgin Primary Care Network and Elgin OHT Community Council), it was identified that a comprehensive NHH Model needed to tailor six key elements to be fit-for-purpose in Elgin (Fig. 1).

Figure 2: NHH Model Elements for Consideration

Through significant engagement and data analysis into each element of the NHH Model, the following key findings emerged:

- **Attachment to Primary Care**: Over 9,000 residents in Elgin were unattached to primary care at the time of completing the model and an additional 20% were attached to a primary care provider outside of Elgin.
- **Material Deprivation and Equity Deserving Populations:** There is a high level of material deprivation in Elgin, with certain areas of the region experiencing much higher levels of material deprivation than provincial averages. Further, the model needed to be designed to better meet the needs of equity deserving populations.
- **Rurality:** Due to the geographic diversity of Elgin, interest holders raised a strong preference for a hub and spoke design which incorporated outreach services.
- **Integrated Health and Social Care:** Current service orientation is not always co-located or coordinated. The model needed to improve service coordination within each region while allowing appropriate services to continue to be delivered in a distributed model. It was identified that there should be single points of access insofar as possible.
- **Flexible and responsive:** The needs across the region varied and as a result, the model needed to ensure that services could be tailored to the unique needs of the neighbourhood. Further, all services should be trauma and culturally informed.
- **Clear pathways:** As services become more effectively coordinated, pathways of care should be more visible and accessible.

- **Administrative burden**: Reducing administrative burden was identified in all provider engagements as critical to improving access and attachment to care (including but not limited to primary care). Considerations such as EMR harmonization or standardization and further adoption of AI tools (e.g., inbox assistant) should be considered.
- **Recruitment:** Across all organizations, recruitment and retention is a key priority. Coordination of these efforts and increasing the mobility of teams/staff was identified as a key priority for a future NHH Model.

These findings informed the development and design of Elgin's NHH Model. Further, there were several service gaps identified, including:

- Existing providers face capacity constraints and administrative burden.
- Lack of consistent navigation and referral pathways leads to patient/client and provider confusion and inefficiencies.
- Variable EMR systems across providers with lack of ability to effectively share information hinders shared care planning and communication.
- After-hours services are fragmented and often rely on the Emergency Department for non-emergent care needs.
- Strong appetite for interdisciplinary team integration and shared infrastructure.

Through this process, it became clear that the proposed NHH Model in Elgin required both localization at neighbourhood level as well as standardization and integration at an OHT level. The agreed NHH Model is designed as a connected network which supports patient/client choice, promotes equitable access to care, and streamlines service delivery to the most appropriate level of care.

3.0 Approved Neighbourhood Health Home Model

The NHH Model for Elgin is depicted in Figure 3. Upon full-implementation, Elgin's NHH Model will have integrated leadership and planning across the OHT, with service delivery occurring in a Central Hub, East and West Spokes, satellites, and mobile outreach (including community paramedicine). This will enable services to be delivered locally and tailored to local needs, while also enabling resources to be optimized and services to be coordinated.

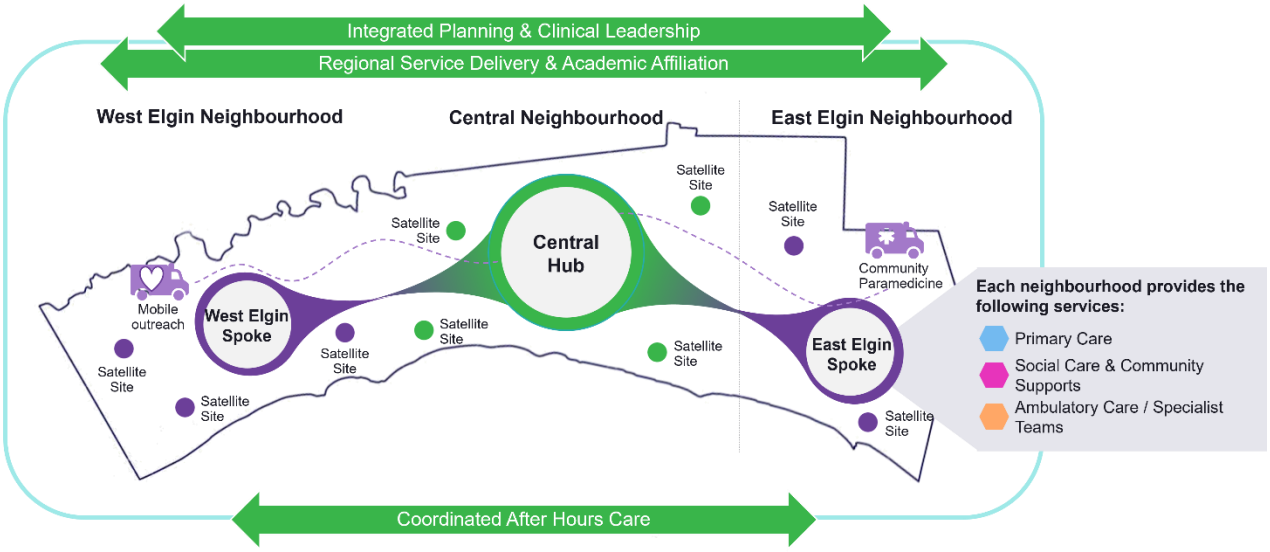

Figure 3: Elgin NHH Model

The NHH Model includes three Neighbourhoods: A Central Neighbourhood (Central Elgin, St. Thomas, and Southwold), an East Neighbourhood (Aylmer, Bayham, and Malahide), and a West Neighbourhood (West Elgin and Dutton-Dunwich). The Model adopts a Hub and Spoke approach which enables services to be delivered in each neighbourhood, while remaining connected and coordinated across the OHT region.

3.1 The Central Hub

The Central Hub will be located in St. Thomas and will act as the anchor for care in the Central Neighbourhood. This Hub will be accessible to all residents of Elgin and will also provide regional (OHT level) programs and services that may not have sufficient demand or expertise to be operationalized within the East and West Spokes. Services provided through the Central Hub will be coordinated with existing services, including social services. Many services will be co-located or delivered at the Hub; however, not all services will become co-located.

At full implementation the Central Hub will provide:

- **Primary Care:** Coordinated access to interdisciplinary team-based primary care – enabling collaborative working with primary care clinicians who practice in off-site locations. While primary care services will be provided at the Central Hub, the intention is not to centralize all primary care services into the Hub.
- **Social Care and Community Supports**: Coordinated access to social care and community supports – services may be delivered on-site or in separate locations.
- **Ambulatory Care and Specialist Teams:** Space for specialty clinics to be delivered in the community improving access and reducing travel for residents.
- **Navigation, Intake & Triage Centre**: The single-entry point for residents, ensuring consistent intake, prioritization, and routing to the right neighbourhood service.
- **Centralized Primary Care Waitlist Management:** Oversight and coordination of the Elgin-wide primary care waitlist to support equitable attachment, population health planning, and alignment with recruitment and resourcing across neighbourhoods.
- **Referral Management Unit**: A centralized process that manages referrals on behalf of providers, ensuring timely transitions and reducing administrative burden.
- **After-Hours Coordination Capacity**: The infrastructure needed to coordinate after-hours access, documentation, and triage across all practices in the neighbourhood – ensuring equitable access to after-hours care.
- **Digital & Virtual Care Infrastructure**: Shared digital tools, virtual visit capabilities, and supports for EMR harmonization and clinical collaboration. Digital tools will be coordinated across the OHT region.

3.2 East and West Elgin Spokes

There will be an East and a West Spoke in the respective Neighbourhoods, which will act as the anchor sites in these Neighbourhoods. All residents of the Neighbourhood will have access to team-based primary care, social and community services, as well as other supports (e.g., system navigation) through the Spoke. The spokes will support individuals and providers throughout the neighbourhood and ensure equitable access to care.

At full implementation the Spokes will provide the majority of the services that are provided within the Central Hub, except for specialized serviced and programs that cannot feasibly and safely be provided in the smaller Spoke settings. For example, there may be a level of specialist/ambulatory care provided in each hub (if there is sufficient demand at the time of full implementation of this model), however, it is envisioned that the majority of specialist and ambulatory care provided in the community will be provided in/coordinated through the Central Hub.

The Spokes are a critical component of the future NHH Model in Elgin and will support both residents and providers in those neighbourhoods.

3.3 Satellite Sites and Mobile Outreach

Satellite Sites and Mobile Outreach services will be expanded or established upon full implementation of the NHH Model to ensure equitable access to care. These services will include:

- **Satellite Locations:** A number of satellite locations will be identified in underserved areas to ensure equitable access to care. The satellite locations will be facilities which can be accessed by health and social care services to provide care closer to home, reducing travel and enabling equitable access to interdisciplinary care.
- **Mobile Outreach:** Elgin has a highly effective mobile outreach program serving equity-deserving populations across the region. At full implementation of the NHH Model, the mobile outreach service may be expanded to further improve access to care, based on the evolving care requirements of the population.
- **Community-Paramedicine:** Community Paramedicine is an integral part of Elgin's health and social care system and was highlighted as a critical requirement to be reflected in the NHH Model.

4.0 Implementing the Neighbourhood Health Home Model

Achieving full implementation of the NHH Model requires extensive transformation, change management and investment. The Elgin OHT Coordinating Council approved the Model as a vision to work towards, which would guide future decision-making and investment across the OHT. It is anticipated that implementation of the NHH Model will occur in steps, which may not be linear based on funding pockets and/or Government priorities.

4.1 Progressing Implementation of the Neighbourhood Health Home Model through Interprofessional Primary Care Team Funding

Interdisciplinary Primary Care Team (IPCT) Expansion and other funding is already being leveraged in Elgin to progress aspects of the NHH Model (e.g., the Primary Care Mental Health and Addictions Navigator, Elgin Community Health Hub, and expansion of mobile outreach services).

Additionally, the most recent IPCT proposal (Phase 2, November 2025), for which TVFHT is the lead organization, outlines an ambitious plan to make significant progress on the implementation of the NHH Model. Obtaining 100% of the funding that was requested would enable the following:

- 10,000+ individuals who are currently unattached to primary care to be attached to a continuous Family Physician, Primary Care Nurse Practitioner, or team within two years.
- 100% of individuals residing within each Neighbourhood to have access to team-based care services through the Hub/Spoke in their Neighbourhood
- Implementation of a Central Referral Navigation Team as an initial step towards the Regional/Neighbourhood Navigation envisioned through the NHH Model.
- Increased access to digital tools to support efficiency and enable increased attachment to primary care.

This funding is specifically targeted at increasing attachment to continuous primary care in line with the Government's Primary Care Action Plan. However, the IPCT funding does not address the other system requirements (e.g., increased community care and social service needs) which are required to achieve full implementation of a high-functioning NHH Model. Future funding models should be considered to increase access to broader health and social care services.

4.2 Highlighted Priorities for Implementation

During the development of the NHH Model, several key priorities emerged which should be considered during initial implementation. These priorities and considerations for next steps are outlined below:

Enabling timely and accurate sharing of clinical information:

Lack of ability to access and share information in a timely manner was identified as a key barrier to implementing the model and operating as a clinical team across the neighbourhood. For example, this challenge creates a major obstacle to delivering coordinated after-hours care.

Many OHTs have made significant efforts to address this issue including Couchiching OHT which recently migrated most Family Physician EMRs to a single instance to enable integrated ways of working. The following options were discussed throughout the NHH development process and considered during the IPCT Phase 2 proposal:

1. **Harmonizing/standardizing existing primary care EMRs**: There are currently several different EMRs in place (e.g., Telus PS Suites and Accuro). It is recognized that conversion to a single instance of an EMR is not feasible, nor recommended in this report due to change management requirements and affordability. However, to achieve the benefits of 'one' EMR (e.g., efficient communication/coordination, standardized data entry, etc.), harmonization and standardization should be considered.
    a. **EMR harmonization** refers to developing an integration layer that allows information to flow bi-directionally between existing EMRs based on agreed workflows and role-base access. This does not require a change to the clinicians current EMR (i.e., Physician A will continue to use PS Suites, while Physician B will continue to use Accuro).
    b. **EMR Standardization** is often considered a step in progressing towards harmonization. Standardization refers to standardizing data entry and streamlining workflows to drive efficiency and clean the data in preparation for harmonization. Once data is standardized, it is easier to pull accurate and timely data. This step also prepares the system to progress towards EMR harmonization by ensuring that data and information is accurate and in a useable format.

    Next steps to progress harmonization or standardization include (i) gathering future-state requirements, (ii) developing a roadmap outlining the proposed change over time, (iii) developing a patient/client mastering strategy and a clinician mastering strategy so that the data can be linked to enable harmonization, and (iv) commencing terminology mapping (e.g., top 50 diagnosis codes). Recommendations to change EMR instances or current licensing is NOT within scope of this report.

2. **Patient/Client Summary and QR code:** A patient/client summary is not an individual's entire health record, but a portion of it. It's comprised of a standardized collection of information: the necessary minimum and sufficient data to inform a person's treatment at a point of care. It may include elements like an individual's medications, allergies and immunizations[3]. In 2021, Canada and the other G7 nations committed to "…work towards adopting a standardised minimum health dataset for patients' health information, including through the International Patient Summary (IPS) standard." The concept of empowering the individual to own a real-time patient/client summary, which could be shared with providers via a QR code or web-link was discussed at length with Family Physicians, Nurse Practitioners, and other Integrated Health Professionals, as well as with community members. To progress a patient/client summary locally, a harmonization layer with key data points would need to be established.

[3] Canada Health Infoway. Patient Summary | Canada Health Infoway

3. **Access to Clinical Connect:** In absence of migration to a single instance or harmonization, the requirement for all clinicians to have access to Clinical Connect was noted. Next steps include identifying the gaps in access and the barriers to access and escalating through the OHT.

Reducing Administrative Burden:

The administrative burden associated with navigation and referral management was identified most commonly while developing the NHH Model and writing the IPCT Phase 2 proposal. Currently, too much time is diverted from clinical care to administrative tasks such as identifying the most appropriate service, completing the required forms (often manually), re-routing referrals which have been declined, and tracking referrals which are outstanding. Many OHTs, including Elgin, have been piloting tools (e.g., AI Scribe) which reduce administrative burden and some OHTs have been implementing practice facilitation supports which assess uptake of digital tools, provide hands-on support to optimize implementation and utilization of tools (including EMRs), and support practices to build these tools into their day-to-day clinical workflows.

The following options were discussed throughout the NHH Model development process and considered during the IPCT Phase 2 proposal:

1. **Streamlined Navigation Service:** Following extensive engagement, a streamlined navigation service, including navigation support in each Hub/Spoke with access to a specialized Navigation Team across the OHT, was included in the NHH Model. The aim of this team is to deliver standardized navigation processes, maintain clear pathways, and support providers to ensure people are directed to the most appropriate services. This is a hands-on support where providers refer people for navigation support, however, it is not directly accessible to the public. Next steps to implement this service may include (i) mapping the future state service (including governance arrangements), (ii) identifying existing navigation resources and mapping against the regional future state requirements to identify opportunities to streamline existing roles and gaps where new funding is required, and (iii) commencing service re-design.

2. **Centralized Referral Service:** This service is complementary to the Navigation Service and would leverage the clinical teams in each Neighbourhood Navigation Service (therefore no new clinical roles would be required to establish this service). However, this service differs from the Navigation Service as it is specifically designed to support referral management end-to-end. This service would accept requests from referring clinicians and would be responsible for managing the referral end-to-end (e.g., completing the required forms, sending the referral, tracking the referral, re-routing the referral, etc.). Automatic updates

from this service would be sent to the provider and patient/client at agreed points (e.g., upon acceptance by receiving service/provider). In current state, patient/client information will need to be attached to the request, however, if EMR harmonization/migration is completed, the required information can be accessed directly. A referral management service is already offered in some team-based settings in Elgin. Next steps to implement this service may include: (i) Mapping current referral pathways across primary care, speciality, diagnostics, and community services, (ii) Mapping future-state processes to ensure clarity between Family Physicians, Nurse Practitioners, and Referral Service, (iii) Agreeing future-state model, including governance structure, resource requirements and digital enablers, (iv) commencing pilot for Referral Service limited to specific services/specialities.

Note: Funding to support the referral service was embedded within the IPCT Phase 2 proposal, as 100% of partner Family Physicians and Nurse Practitioners identified this as an enabler to achieving their attachment target.

3. **Centralized Waitlist:** Work to establish a coordinated primary care waitlist is already underway in Elgin and was identified throughout the NHH Model and IPCT engagement processes as a critical enabler of equitable attachment and population-level planning. A regional waitlist will support consistent intake processes and help align staffing and resourcing decisions with neighbourhood-level needs, while strengthening the foundation for long-term recruitment and retention. Next steps may include: (i) confirming governance and operational responsibilities for the region-wide waitlist and integrating ongoing work into the broader NHH Model implementation plan, (ii) establishing standardized intake and prioritization criteria to support equitable attachment and neighbourhood-aligned capacity planning, and (iii) connecting the centralized waitlist with navigation, triage, and digital tools to streamline information flow and further reduce provider administrative burden.

4. **AI Inbox Assistant:** AI inbox assistants in primary care use artificial intelligence to help clinicians manage the growing volume of patient/client messages, faxes, and results by automatically sorting, prioritizing, and routing communications within the EMR. In Canada, these tools are increasingly being adopted to reduce administrative burden and clinician burnout while improving response times and safety. There are several Ontario-based solutions which use AI agents to classify unstructured faxed documents and streamline inbox management, saving clinics substantial staff time and reducing errors. These tools focus on workflow efficiency rather than replacing clinical decision-making. Next steps may include: (i) identifying requirements and (ii) agreeing scope for implementation to support required procurement efforts.

Optimizing Team-Based Care:

Optimizing team-based care emerged as a key priority throughout the NHH Model and IPCT Phase 2 proposal engagement processes. Clinicians and partners noted that while

interdisciplinary providers are already present across the region, inconsistent workflows, variable role clarity, and uneven digital adoption limit the ability of teams to work to full scope. These challenges contribute to inefficiencies, bottlenecks in access, and an over-reliance on Family Physicians and Nurse Practitioners for visit types that could be effectively managed by other team members. Strengthening team-based care through clearer roles, standardized processes, and shared decision-making supports was identified as critical to improving capacity and enabling neighbourhood-level care delivery.

1. **Practice Facilitation:** During the NHH Model development process, it was noted that there is wide variation in digital adoption and workflow maturity across the primary care sites and many Family Physicians or Nurse Practitioners who are not currently working in a team-based setting will require support developing team-based care workflows if IPCT Phase 2 proposal is approved. Throughout the engagement process, practice facilitation was highlighted as a required support/enabler by many interest holders. Practice facilitation is a service which assesses and optimizes workflows and adoption of digital tools. This service would facilitate the development of team-based care workflows for partners who have committed to the IPCT proposal and do not currently work in a team-based model, enabling the full benefit of IPCT expansion to be realized. After IPCT Phase 2 implementation, a practice facilitation model would ensure the region could continue to support integrated ways of working, practice optimization, and uptake of digital tools (including for existing and new clinicians in the region). Next steps may include: (i) deploying a proven practice facilitation approach for IPCT proposal partners, (ii) building local capacity to sustain practice facilitation locally, (iii) enabling ongoing continuous improvement.

   Note: Funding for a full-time resource for practice facilitation was requested through the IPCT Phase 2 proposal.

2. **Triage to the most appropriate provider:** Throughout the NHH Model and IPCT Phase 2 proposal engagement processes, clinicians emphasized that expanding capacity requires better processes to ensure people are connected to the right provider at the right time. Many partners noted that visits are still commonly routed to Family Physicians and Nurse Practitioners by default, even when another member of the interdisciplinary team, such as a registered nurse or social worker, may be better positioned to address the individual's needs. This limits providers' ability to work to top of scope and contributes to uneven workload distribution across the team. Clinicians highlighted that improved triage could play a critical role in creating a more effective team-based care model by matching individual needs with provider skills, reducing bottlenecks in scheduling, and improving timely access across neighbourhoods.

   A standardized triage process will ensure that people are directed to the most appropriate clinician based on presenting issue, urgency, and provider scope of practice. The

foundational building blocks for this work are already emerging across Elgin, including increased role clarity across interdisciplinary providers, development of consistent medical directives to optimize non-physician roles, expanded navigation supports to reduce administrative burden, stepped-care approaches, adoption of integrated digital tools, and strengthened referral pathways between health, community, and social services. Next steps to advance triage may include: (i) defining and aligning scope-of-practice roles and responsibilities across the interdisciplinary team, using international best-practice standards to inform which provider types should manage specific visit types, (ii) establishing shared triage workflows and digital supports (e.g., EMR prompts, standardized intake questions, role-based care pathways) to ensure consistent routing of visits, and (iii) piloting the triage model with the Central Hub to evaluate impacts on workload distribution, access, and patient/client experience before broader implementation in the East and West Spokes.

Recruitment and Retention:

Recruitment and retention emerged as a significant barrier during both the NHH Model design and IPCT Phase 2 proposal processes. Data analysis underscored pronounced provider distribution gaps across Elgin, including municipalities with limited or no primary care presence and areas with persistent attachment challenges despite providers being located nearby. These geographic disparities contributed to high reliance on emergency services, uneven access to team-based care, and constrained capacity for neighbourhood-level service delivery. These findings directly informed the development of the NHH Model, which aims to close these gaps by aligning resources more equitably across neighbourhoods and strengthening interdisciplinary team capacity. Partners also emphasized that current recruitment efforts are fragmented and organization-specific, making it difficult to attract and retain the workforce required to operationalize the NHH Model at scale. The long-standing Elgin St. Thomas Healthcare Recruitment Partnership has had good recent success, though recruitment has primarily been to St. Thomas and physician focused. Strengthening regional recruitment infrastructure and establishing sustainable workforce pathways will therefore be essential to successful implementation. The following options were discussed throughout the NHH Model development process and considered during the IPCT Phase 2 proposal:

1. **Establishing an Academic Site:** Establishing an academic site within Elgin was identified as a key strategy to strengthen long-term recruitment and retention by creating a local training pipeline and increasing exposure to team-based primary care models. An academic site would enable learners to train within neighbourhood teams, build familiarity with Elgin's community context, and develop ongoing professional relationships that increase the likelihood of remaining in the region after graduation. It would also support providers through opportunities for teaching, mentorship, and interdisciplinary collaboration. Next steps may include: (i) partnering with Western University to define residency training streams aligned to neighbourhood needs and scopes of practice, (ii) assessing space, preceptor capacity, and resource requirements to host residents across the Hub, Spokes, and satellite sites, and (iii)

developing a staged plan to establish a formal academic site with clear governance, faculty roles, and evaluation processes.

2. **Developing a region-wide recruitment and retention strategy:** Engagement across the OHT highlighted that recruitment and retention efforts are currently fragmented, vary significantly by organization, and are not fully aligned to the future NHH Model. As part of the IPCT expansion, recruitment will focus on the interdisciplinary roles required to operationalize the NHH Model across the Hub, Spokes, and neighbourhood teams. This includes newly developed positions such as centralized referral support, navigation roles, and after-hours coordination capacity, as well as clinical providers needed to expand team-based care and increase attachment. As the Lead Organization, Thames Valley Family Health Team (TVFHT) will coordinate recruitment across all participating partners, ensuring role specifications, compensation, and onboarding processes are aligned, and that resources are equitably distributed based on neighbourhood need and available funding. TVFHT's recently updated compensation framework, now above provincial standards, will support the region's competitiveness in hiring and retaining these positions.

   Recruitment efforts will be implemented collaboratively across the OHT and supported by existing partnerships such as the Elgin St. Thomas Healthcare Recruitment Partnership and the local healthcare recruiter. Next steps may include: (i) finalizing job specifications for all roles identified through the IPCT Phase 2 proposal to ensure the region is ready to begin recruitment immediately upon approval, (ii) activating a coordinated, OHT-wide recruitment process led by TVFHT, with partner organizations initiating hiring simultaneously and distributing resources equitably based on approved funding, and (iii) implementing consistent regional onboarding processes, ensuring new staff are oriented to shared workflows, team-based care practices, and neighbourhood-aligned responsibilities to support long-term retention.

In addition to the highlighted priorities for implementation, there are many key enablers which will need to be progressed to implement the NHH Model.

5.0 Key Enablers

Successful implementation of the NHH Model requires several system level enablers that support and sustain the foundational service functions. These enablers provide the governance, resources, and infrastructure needed to deliver coordinated, team-based care across Elgin. A coordinated, OHT-wide strategy is needed to articulate a shared value proposition, reduce competition for the same limited pool of providers, and ensure that incentives, onboarding supports, and career pathways are consistent across neighbourhoods.

1. Governance and Accountabilities

Clear governance structures and defined decision-making processes are required to support implementation, oversee progress, and maintain alignment across the OHT. A robust governance model which meets the evolving needs of the OHT will articulate roles and responsibilities (e.g., decision-making authority), define escalation processes, ensure clear accountability, and prepare the OHT to support the whole-of-system reform that is required to achieve the implementation of the NHH Model.

2. Workforce and Change Management

Successful implementation of the NHH Model relies on dedicated workforce planning, clearly defined implementation roles, and strong change management supports. This includes identifying the staffing required to operationalize the NHH Model ensuring providers and staff receive training to adopt new workflows. Co-design with providers, ongoing communication, and structured change management will help embed new practices and sustain adoption across neighbourhood teams.

3. Digital Tools

A unified digital foundation underpins all aspects of the NHH Model. Investment in interoperable tools, such as harmonized EMRs, Ocean eReferrals, shared care plans, secure messaging, and virtual care platforms, is essential to support navigation, referrals, after-hours care, and analytics. This requires establishing clear data governance, standardizing digital workflows, and building the technical capacity needed for integration, reporting, and long-term system reliability.

4. Physical Infrastructure

To enable integrated, team-based care, each neighbourhood requires physical infrastructure that supports core NHH Model functions. This includes Hub and Spoke space for navigation teams, referral coordination, after-hours services, interdisciplinary collaboration, and digital supports. In addition, satellite spaces and mobile outreach infrastructure are required to extend access into rural and high-need areas, ensuring residents receive care as close to home as possible.

6.0 Conclusion

The development of the NHH Model represents a significant step toward strengthening access to primary care, improving system coordination, and supporting equitable service delivery across Elgin. Through comprehensive data analysis and engagement with primary care, community partners, and residents, the model establishes a clear and locally responsive structure, anchored by a Central Hub, supported by East and West Spokes, and extended through satellite sites and mobile outreach, to ensure services are available as close to home as possible.

The accompanying implementation priorities outline the foundational changes required to begin operationalizing this model. These include strengthening digital and clinical information-sharing through EMR harmonization, advancing navigation and referral processes, introducing a coordinated region-wide primary care waitlist, and supporting neighbourhood after-hours coordination. Additional priorities, such as reducing administrative burden, optimizing team-based care, and developing shared recruitment and retention strategies, will be essential to increasing capacity and enabling providers to work to full scope.

Achieving full implementation of the NHH Model will require sustained collaboration, thoughtful change management, and ongoing investment across the OHT. Together, these efforts provide a clear roadmap for building a more connected, sustainable, and responsive primary care system that reflects Elgin’s priorities and advances the OHT’s long-term vision for integrated, team-based care for all residents.