Health Care Connect Waitlist Clearing

Guidance for Ontario Health Teams and Primary Care Networks

June 2025

Ontario Health

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1 Introduction and Purpose

Introduction and Purpose

- In FY25/26, Ontario Health Teams (OHTs) will play a critical role in advancing Ontario's Primary Care Action Team (PCAT)'s goals to connect every person in Ontario to primary health care within five years
- As will be outlined in the OHT Transfer Payment Agreement (TPA) for FY25/26, OHTs will play a key role in advancing two PCAT priorities:

Clear the Health Care Connect (HCC) Waitlist (as of Jan 1, 2025) in partnership with Ontario Health atHome (OH atHome): OHTs to work with OH atHome Care Connectors to match patients on the HCC waitlist to available family physicians, nurse practitioners or primary care teams, initially leveraging existing primary care capacity

Interprofessional Primary Care Team (IPCT) Expansion: Create net new capacity for attachment through new and expanded primary care teams

This document is Part A of guidance for OHTs and PCNs related to the "Clear HCC Waitlist (as of Jan 1, 2025)" priority and is intended for OHT and PCN leadership and staff, representatives from OHT member organizations and participating clinicians.

A second guidance document (Part B) will be shared with OHTs and PCNs in the coming months with information to support OHTs with access to Patient Health Information (PHI) via existing provincial systems

Note: Guidance on IPCT expansion was shared with OHTs and PCNs in April 2025 and is accessible via contacting the OH OHT Regional Point of Contact.

Understanding the Opportunity

How does Health Care Connect currently operate?

- Patients use Health811 to register for HCC to find a family physician or nurse, nurse practitioner or primary care team. The program is voluntary. HCC Care Connectors, employed by Ontario Health atHome, conduct outreach to identify family physicians, nurse practitioners or primary care teams able to bring on new patients
- Once patient is matched, the patient and family physician, nurse practitioner or primary care team arrange an initial intake appointment
- Following the intake appointment, a family physician, nurse practitioner and primary care team will confirm patient attachment

What is the opportunity?

- **OHTs and PCNs** can partner with clinician networks and build on peer relationships to streamline how family physicians, nurse practitioners or primary care teams are engaged and more efficiently identify clinicians within existing, new or expanded teams who may be accepting new patients. In addition, OHTs and PCNs can connect unattached patients to interim clinical supports while they are waiting to be matched
- **The HCC Care Connectors** can focus on updating patient information, connecting patients with interim clinical supports and/or to family physicians, nurse practitioners or primary care teams able to bring on patients as identified by OHTs and PCNs

Outcome:

By partnering together, OHTs, PCNs and OH atHome Care Connectors can more efficiently work towards clearing the HCC waitlist (as of January 1st) by Spring 2026 and improve patient and clinician experience

Note: The Health Care Connect process will remain in place throughout the waitlist clearing efforts for 2025/2026

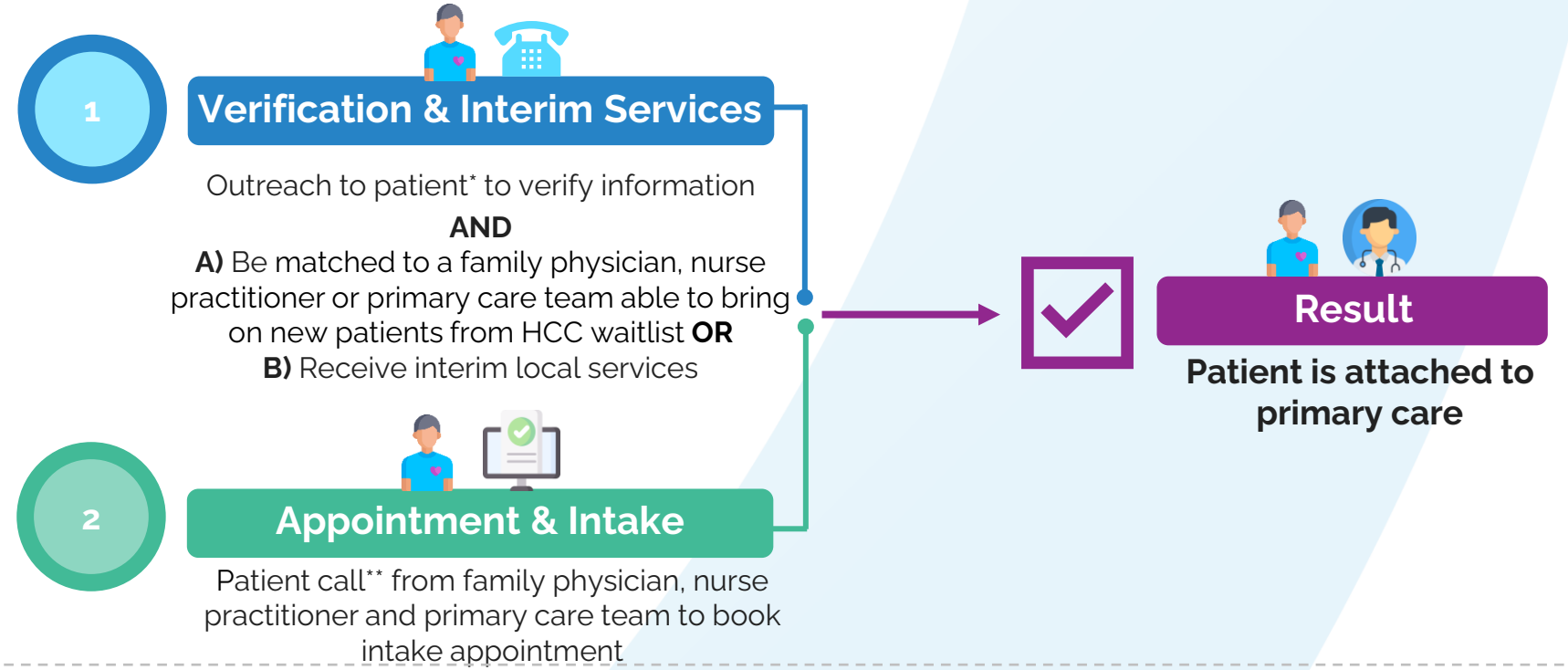
Two-Step Process For Clearing the Health Care Connect Waitlist

A two-step process is underway to support patients on the Health Care Connect waitlist for matching/attachment.

Preparation

a) Align Care Connectors to Ontario Health Teams and their Primary Care Networks

b) Ontario Health Teams/Primary Care Networks work with Care Connectors to identify family physicians, nurse practitioners or primary care teams able to bring on new patients, match patients, and provide interim local services.



1 ***Letter + Email + Text** informing patients on the waitlist of efforts to attach them to primary care by Spring 2026, ability to connect to services via Health 811, and that they can verify contact information, update their health needs and if still in need of primary care attachment by phone or email. Care Connector follows up on emails or voicemails from patients to verify info and need for primary care, and contacts patients who did not respond.

2 ****Patient Call:** Patient is notified of a potential match by the family physician;s, nurse practitioner's or primary care team's office. During this call:

- ✓ Schedule intake appointment
- ✓ Offer an intake interview to confirm patient medical information and ensure medical history is up-to-date
  - ➢ Development of coordinated patient intake/onboarding ("**Supported Intake**") models that leverages existing/leading practices is underway (e.g., 'catching patient up' before intake appointment through complete health history, basic screening/preventive care, etc.). Plan to implement as a key clinical support/incentive to assist with HCC waitlist clearance and ease constraints for family physician, nurse practitioner and primary care team.

6

Overarching HCC Waitlist Considerations

Key Considerations

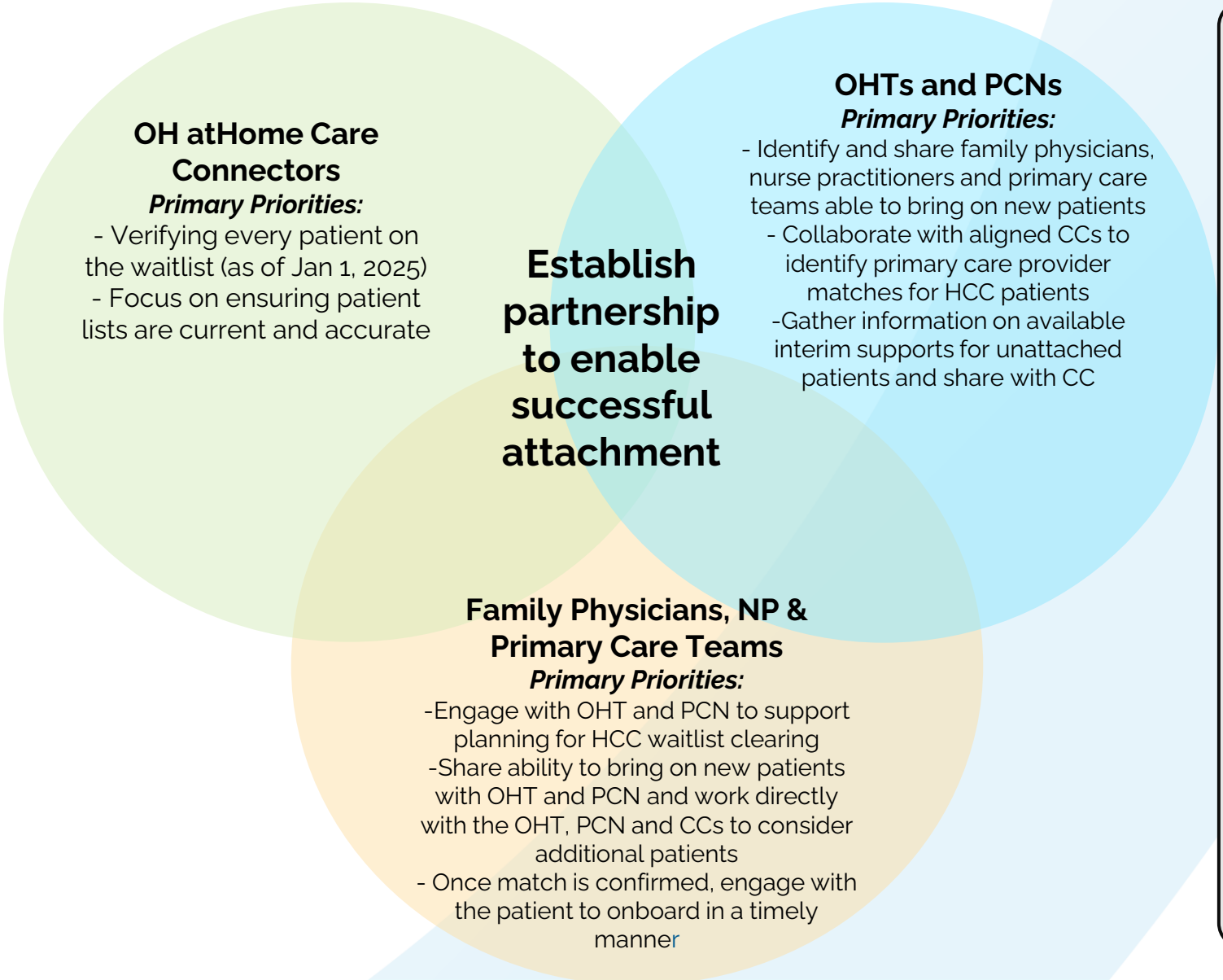
- **Partnerships with family physicians, nurse practitioners and primary care teams is essential** to support the HCC priority. We acknowledge the significant effort already underway by family physicians, nurse practitioners and primary care teams
- The Ministry and Ontario Health recognize that the HCC waitlist may not **accurately represent local attachment needs**
- **Many people, including those in Indigenous communities and equity-deserving populations, may not register with HCC** due to historical, systemic, or practical barriers. As a result, **some OHTs may see few or no patients on their HCC waitlist** as of January 1, 2025
- To better target individuals on the HCC waitlist, **OHTs may choose to partner with neighbouring OHTs to support provincial waitlist clearing efforts**
- While OHTs are expected to focus their efforts to match patients on the HCC waitlist, they are also encouraged to take a **broader view of attachment planning**, and will be supported with additional information on unattached populations as it becomes available
- Please note that while OHTs, PCNs and HCC Care Connectors will support family physicians, nurse practitioners and primary care teams to match additional patients, it will remain their choice as to whether or not they accept patients from HCC

2 Core OHT and PCN Expectations & Performance Measurement

Clearing the HCC Waitlist: Summary Roles & Responsibilities

OH atHome Care Connectors will:

- Remain OH atHome employees
- Align with OHTs and PCNs based on HCC caseloads
- Lead communications, navigation and matching of HCC patients in partnership with the OHT and PCN
- Update all provided changes in both Unattached Patient System (UPS) and Care Connector Tool (CCT)
- Support navigation to interim supports for unattached patients provided by members of the OHT and PCN or Health811, and connect patients directly to OHT-level navigation supports where and when available
- Match HCC patients to family physicians, nurse practitioners and primary care teams
- Leverage provincial systems (e.g., UPS and CCT) and workflows to complete matching (based on OHT-level identified capacity) and expedite reporting



OHTs and PCNs will:

- Rapidly develop a plan to match patients on the HCC waitlist (as of Jan 1, 2025) to family physicians, nurse practitioners or primary care teams
- Review aggregate data on the overall number of unattached patients and number of HCC patients assigned to the OHT (as of Jan 1, 2025) to support development of an overall access and attachment plan
- Work with OH regions and OH atHome to identify milestones to clear the HCC waitlist (as of Jan 1, 2025)
- Work with OH atHome, OHT and PCN partners/ primary care to develop a workflow to facilitate attachment of HCC patients
- Identify and document interim supports for unattached patients within the OHT and PCN while they are waiting to be matched and share information with CC
- Identify a Lead Health Information Custodian (HIC) to receive HCC data, (including PHI)
- Provide peer leadership to primary care clinicians via the PCN

Core OHT and PCN Expectations

Deliverable: Develop and implement a plan to support matching of patients on the Health Care Connect waitlist (as of Jan 1, 2025) by Spring of 2026

Minimum Requirements for all OHTs and PCNs:

- **Review aggregate data on the overall number of HCC waitlist patients aligned to your OHT to support planning**
- ENgage with family physicians, nurse practitioners and primary care teams to inform HCC planning, identify **family physicians, nurse practitioners and/or primary care teams able to bring on** HCC patients and assess opportunities to implement supports that will increase clinician capacity
    - Further, engage and partner with primary care clinicians beyond those currently involved in the PCN
- Work with OH regions and OH atHome to identify milestones for their HCC target. **Note:** OHTs are to prioritize attaching patients registered with HCC (as of Jan 1, 2025) until the waitlist provided has been cleared
- Work with OH atHome, OHT and PCN partners to develop a **workflow to facilitate matching of HCC patients.** This includes:
    - Identify a primary point of contact to work with the aligned HCC Care Connector to coordinate all access and attachment activities, including referrals for HCC waitlist (as of Jan 1, 2025) patients
    - Identify a Lead HIC within the OHT and PCN to receive patient-level HCC data through provincial systems (e.g., CCT and UPS)
    - Collaborate with aligned HCC Care Connectors to **provide information to HCC patients about available local and interim supports for unattached patients**, that they can access while waiting to be matched
- Collaborate with **aligned HCC Care Connector** to identify primary care matches for HCC patients
- Once the HCC waitlist (as of Jan 1, 2025) has been cleared, OHTs should continue facilitating matching for other unattached patients

For More Information

See slide 17 for guidance on **data supports**

See slide 15 for guidance **on PCN readiness**

See slides 18-19 for guidance on OHT **digital capabilities**

See slide 11 for guidance on **partnering with HCC Care Connectors**

Partnering with HCC Care Connectors

OHTs and PCNs will work collaboratively with HCC Care Connectors to advance the joint goal of facilitating the matching of patients on the HCC waitlist (as of Jan 1, 2025) to available family physicians, nurse practitioners and primary care teams

HCC Care Connectors will:

- Remain OH atHome employees
- Be aligned with OHTs and PCNs based on HCC caseloads
- Partner with OHTs and PCNs to facilitate matching of patients registered with the HCC Program
- Continue to perform regular duties, but will ensure their activities are coordinated with OHTs and PCNs
- Continue to lead all communications with patients registered with HCC
- Support OHTs and PCNs with coordinated primary care clinician communication, engagement, and referrals on weekdays between 8:30 – 4:30
- Use a batched patient referral process where high volume capacity exists (e.g., IPCTs)

Each OHT and PCN should:

- Work with the aligned HCC Care Connector(s) to **establish a collaborative working relationship** (e.g., communication preferences, meetings, information sharing)
- Meet with the identified HCC Care Connector(s) to **review and discuss approaches for enabling team-based collaboration** to facilitate matching of registered HCC patients (e.g., participation in meetings, file-sharing)
    - **Note:** HCC Care Connectors will initially prioritize waitlist verification ("cleaning") processes. During this time, OHTs and PCNs should focus their efforts on identifying capacity of family physicians, nurse practitioners and primary care teams involved in PCN currently (and those not yet involved in the PCN), access and match planning, and building PCN capacity. OHTs and PCNs should also inform the HCC Care Connectors of family physicians, nurse practitioners and primary care teams able to bring on new patients from the HCC waitlist
- Determine a **communications plan** with HCC Care Connectors to ensure patients remain updated, including communicating available interim supports for unattached patients while patients are waiting to be matched and meet with a family physicians, nurse practitioners and primary care teams able to bring on new patients from the HCC waitlist
- Keep HCC Care Connectors informed about primary care communications and engagement relating to facilitating matches
- Share information /key messages about the benefits and process for joining PCNs to primary care clinicians who are not yet participating
- Communicate any concerns relating to the partnership with OH atHome to **Aruna Mitra,** Patient Services Director, Aruna.mitra@ontariohealthathome.ca

Measuring Progress

In FY25/26, OHTs will work with **OH atHome Care Connectors to advance the goal of all patients on the HCC waitlist (as of Jan 1, 2025) being matched and attached** to a family physician, nurse practitioner and primary care team. This will support the multi-year goal of increasing the attachment rate to 100%

- In FY25/26, the ministry and OH will measure the shared progress of HCC Care Connectors, OHTs and PCNs in achieving this goal via **two primary measures**
- OHTs will not be required to collect or report data relating to these two measures. Regular updates on these indicators will be provided to OHTs via the OHT Data Dashboard and quarterly OHT Performance Reports to enable ongoing monitoring

Measures

of patients on the HCC waitlist (Jan 1, 2025), per OHT

# of HCC patients referred to a primary care clinician, per OHT

Note: Additional measures (including OHT level reporting requirements) will be confirmed through future guidance.

3 Enablers

Enablers: OHT TPA Amendment and Funding

All OHTs will be responsible for supporting to clear their assigned HCC waitlist (as of Jan 1, 2025) by Spring 2026. This will be reinforced in the OHT TPA Amendment and supported through dedicated funding

OHT TPA Amendment FY25/26 - Deliverables

The OHT TPA for FY25/26 will include the following deliverables associated with clearing the HCC waitlist (as of Jan 1, 2025):

- Via collaboration between PCN Clinical Lead(s) and OHT non-clinical staff:
  - **Develop and implement a plan to facilitate matching and attachment of patients on the Health Care Connect waitlist (as of Jan 1, 2025) by Spring of 2026**
  - Develop an initial plan to support 100% attachment of local population by 2029, based on identified primary care attachment and access gaps and aligned to provincial direction
  - Implement collaborative initiatives to provide clinical services to unattached patients while they await matching/attachment to family physicians, nurse practitioners and primary care teams

25/26 OHT Funding

- Access & attachment are among clinical priorities associated with the OHTs' continued implementation funding ($750K/OHT)
- In addition to this, OHTs will also receive **$313K/OHT** in FY 25/26 to support this work
- **Spending Eligibility Highlights:**
  - Remuneration for PCN clinical leadership
  - Staffing (i.e., admin)
  - Clinical supports for primary care clinicians, including the provision of health services (advance practice nurses, community nurse specialists, social workers, pharmacists, specialized program educators, nurse navigators, chiropodists, etc.)

Note: TPA amendment and funds expected to be released in Summer 2025. More details will be available within the TPA amendment schedules.

Enablers: Primary Care Network (PCN) Readiness

High-functioning PCNs are a critical enabler to advance HCC waitlist clearing

Attachment and access to primary care is a core clinical priority for PCNs, as identified in *Primary Care Networks in OHT: Guidance Document (2024).* OHTs should continue to advance their PCNs in alignment with the guidance, with a particular focus on the following:

1 **Primary care clinical leadership**	• OHTs should ensure that one or more primary care clinical leaders (i.e., family physicians or nurse practitioners) are being remunerated to support the advancement of the PCN and participate formally in OHT decision-making related to planning, budgeting, performance etc. • PCN Clinical Leadership will form clinician-clinician peer relationships with other family physicians or nurse practitioners in the community, provide peer leadership regarding the HCC waitlist clearing work, and provide leadership for initiatives aimed at increasing capacity of the primary care sector (for example, the adoption of digital health solutions that can reduce burden on primary care clinicians
2 **Operational support for PCNs**	• OHTs should ensure there is operational and back-office support (e.g., staff resources) available to support PCNs, to enable clinician engagement, facilitate matching of HCC patients to family physicians, nurse practitioners and primary care teams and identify or design clinical supports for unattached patients
3 **Ability to connect to the local primary care sector, which can be supported via digital solutions** *(Refer to Enablers: Digital Capabilities for more)*	• OHTs should ensure they can communicate with primary care clinicians to share messages/ information related to HCC waitlist clearing activities and to collect information such as family physicians, nurse practitioners and primary care teams able to bring on new patients from the HCC waitlist • OHTs should also explore opportunities to recruit additional primary care clinicians to the PCN (including by leveraging the Physician Business Contact Information report, when available). OHTs and PCNs should offer programs/services for PCPs to encourage involvement in the PCN (e.g., webinars, etc.) and enhancing recruitment efforts through direct PCP engagement

Enablers: Trust & Collaboration with Primary Care

OHTs that foster transparent, collaborative relationships with primary care - through shared governance, co-design, and ongoing dialogue - are showing higher clinician satisfaction and more successful patient outcomes. **Some key enablers and themes that came out of discussions with OHTs are listed below.**

1

Shared Leadership with Primary Care

- Co-led planning tables, shared staffing, and integrated governance structures foster alignment between OHTs and Primary Care Networks (PCNs).
- Family physician/nurse practitioner-led initiatives and joint recruitment efforts help build trust and amplify primary care voice in system transformation.

2

Engagement Through Co-Design & Local Planning

- Early and ongoing engagement with primary care through surveys, design days, and one-on-one outreach fosters buy-in and builds collaborative cultures.
- Conversations centered on "What would keep you in family practice?" have helped surface resource needs and guide capacity planning.

3

Enabling Primary Care Capacity through Targeted Supports

- Interprofessional supports, streamlined referral pathways, and interim care models increase clinician confidence in accepting complex or socially vulnerable patients.
- Integrated digital infrastructure (e.g., shared EMRs, automated care plans) facilitates continuity of care and reduces fragmentation.

Enablers: Data Supports

OHTs will have access to data to facilitate matching/attachment of patients on the HCC waitlist (as of Jan 1, 2025). This data will support OHTs to understand their primary care landscapes, monitor progress on their HCC waitlist and engage family physicians, nurse practitioners and primary care teams.

Data Sources

Health Care Connect Waitlist Data

- Aggregate waitlist (as of Jan 1, 2025) data is accessible via the *OHT Data Dashboard* as of April 2025 and will be refreshed on a quarterly basis
- These data, provided for each FSA, include:
  - Number of active patients registered with HCC
  - Number of active patients that are "complex vulnerable"
  - Length of waiting
- Can be used by OHTs and PCNs as they plan for and monitor progress with HCC waitlist clearing
- Patient-level information about patients on the HCC waitlist (as of Jan 1, 2025) will be provided to OHT HICs beginning summer 2025 (via existing provincial systems, e.g., UPS and CCT)
- More information to be provided on data access in future guidance

Note: Beginning May 2025, OH atHome will verify the status of all registered patients to confirm they are still interested in being attached and to ensure their information is up to date. Updates to the data on the OHT Data Dashboard will be made when refreshed information is available

Physician Business Contact Information

- Physician business contact information is expected to be accessible via the *OHT Data Dashboard* targeted for summer 2025
- This data includes:
  - Name and practice contact information for physicians connected to the OHT
- Can be used by OHTs and PCNs to enable engagement with physicians

Note: OHTs and PCNs are encouraged to speak to their aligned care connectors about other available data on clinicians currently participating in the Health Care Connect program

Enablers: Digital Capabilities

Establishment of core **digital functions** will support OHTs and PCNs to achieve the goal of engaging with clinicians to enable HCC waitlist (as of Jan 1, 2025) clearance.

Note: OHT-level digital capabilities that support patient engagement and matching of unattached patient is currently out of scope

OHT and PCNs should focus on developing digital, data and analytics capabilities that enable the following functions/activities:

1. Distribute communications to clinicians involved in PCN and other clinicians – unidirectional communication (from PCN to clinicians)
2. Enable clinician outreach and engagement (e.g., campaigns, surveys) – Bidirectional communication (both PCN to clinician and vice versa)
3. Identify family physicians, nurse practitioners and primary care teams able to bring on new patients to support HCC waitlist (as of Jan 1, 2025) clearing, including clinicians with specific skills (e.g., pediatrics, French-language services) and clinicians willing to provide care in remote communities (where applicable)
4. Support primary care capacity planning to inform plans for new or expanded teams to reach the goal of 100% attachment

Note: There are no current plans for a provincial Customer Relationship Management (CRM) solution that will be accessible to OHTs and PCNs

Key Notes

- OHTs should leverage data from the OHT Physician Business Contact Information Report and supplement with other available clinician data, when developing their clinician directories
- OHTs should not invest in patient registration solutions that duplicate HCC Program functionality
- OHTs should consult with their Regional Digital Leads and other OHTs within their region to identify opportunities to partner to develop common capabilities. Please see the **Appendix** for a summary of digital capabilities based on a review of documentation shared by several OHTs.

Enablers: Digital Capabilities cont.

OHT and their PCNs can consider the following best practices to enable the digital capabilities.

General Implementation Considerations:

- Leverage existing initiatives for shared resources and assets within the OHT and PCN wherever possible to enable the capabilities; consider partnering with other OHTs to build a common set of digital capabilities
- Focus on putting in place basic capabilities quickly that can optionally be enhanced over time

If OHTs are interested in exploring a digital solution to enable the outlined digital capabilities, OHTs should:

1. Consult with Regional Digital Leads before investing in new solutions
2. Identify existing data sources, assess their quality, and build a plan to fill knowledge gaps over time
3. Collaborate with HCC Care Connectors to leverage their expertise around clinician attributes and data, which goes as an input in solution development and implementation
4. Explore data sharing agreements (if required) and integration strategies to augment the digital solution data for more comprehensive insights; moreover, the solution operationalized should be compliant with applicable privacy laws
5. Look for opportunities to create a comprehensive plan for the solution design and implementation, which takes into consideration the needs of the broader primary care sector and the ability to integrate with other ongoing initiatives/systems in the long run
6. Allocate sufficient time and resources for staff training to ensure effective adoption of the digital solution

4 OHT Examples/Lessons Learned

South Georgian Bay OHT

CENTRAL REGION

THEME
- Facilitating Patient Matching
- Interim Clinical Supports for Unattached Patients

Summary

Facilitating Patient Matching

- OHT leads a **Physician Recruitment Council and Campaign** in collaboration with the SGB OHT PCN and local municipalities, which has successfully recruited three new physicians to the community.
- **Strategic Growth** supported by 2024–2025 Interprofessional Primary Care Teams (IPCT) funding, which has facilitated the expansion of primary care services and local patient attachment.
- **Care coordination** is enhanced through **real-time data sharing** to improve care delivery for patients.
- Success driven by **effective communication, digital advancement, and strong collaboration and trust among partners** within the SGB OHT and Provider Care Network.

Interim Clinical Supports for Unattached Patients

- Patients facing social determinants of health challenges are electronically referred to 211 via **integrated EMR,** enabling automatic outcome updates in their medical charts and improving continuity of care.
- **Navigator** supports **access to existing community services,** including 211, while patients await formal attachment to a primary care provider.
- For immediate health needs, unattached patients are referred to Shoreline Health Clinic which operates as an **interim primary care service**
- **OHT/PCN Coordinates** with primary care providers to transition patients to long-term attachment through a local OHT patient attachment framework.

Impact

- **In the 24/25 fiscal year, over 400** patients attached, and **over 825** individuals have contacted the OHT to use navigation services
- Extremely high patient and provider satisfaction reported with the services provided at Shoreline Health Clinic

Key Learnings

- **Foster a collaborative culture** with physician leadership and engagement as a key enabler
- **Dedicated navigators and OHT-led clinics bridge the gap for unattached patients**, ensuring no one is left without access to care.
- **EMR-integrated social support referrals and care pathways** (e.g., to 211 and mental health) help address SDOH, access community services and broaden the scope of care delivery.
- **Collaborative, multi-sectoral partnerships**—including municipalities and community organizations—are critical to recruitment and system design.
- **Integrated EMRs enable real-time data sharing** and support streamlined referrals, attachment, and continuity of care.
- **Long-standing use of digital infrastructure (e.g., e-prescribing since 2009)** and continued innovation creates a strong foundation for innovation and collaboration.

Noojmawing Sookatagaing OHT

NORTHWEST REGION

THEME
- Interim Clinical Supports for Unattached Patients
- Building Capacity to Enable Matching/Attachment

Summary

Interim Clinical Supports for Unattached Patients

- Established partnership with the Lakehead Nurse Practitioner Led Clinic to **improve access** for unattached patients through the Lake Superior Connect Clinic to support patients with **complex chronic conditions**
- Access through multiple referral pathways that includes comprehensive assessment, stabilization and optimization of health
- OHT funded system navigator plays a key role in preventing repeat visits to multiple clinics; creates shared care plans accessible to PC care providers, paramedics and other care partners

Building Capacity to Enable Matching/Attachment

- The Lakehead NPLC is actively **collaborating with primary care providers** in the region to transition patients from the Connect Clinic to attachment to primary care providers
- To further support this work, the OHT is planning "Design Days" in each local health hub across the region (21 municipalities, 15 First Nations). These sessions will focus on defining **current vs. ideal state, developing strategies for attachment**

Impact

As of May 2025, **175 patients have been provided interim primary care** services via the clinic, including 15 confirmed heart failure patients and 41 confirmed COPD patients.

Key Learnings

- **Phased approach** is recommended (stabilize → attach); improves provider confidence in accepting complex patients.
- Unattached clinics can be successful through **clear referral pathways** with key partners (e.g., community paramedicine, hospitals)
- Networking and **building trusting relationships** among health and social service providers is critical for the success of unattached clinics
- Essential to **engage primary care early** and through dedicated planning sessions across the region (i.e.., design days) supports buy-in and collaboration

Note: The Lakehead NPLC is supported through IPCT expansion funding initiated in FY24/25

East Toronto Health Partners OHT

TORONTO REGION

THEME
- Facilitating Patient Matching
- Building Capacity to Enable Attachment

Summary

Facilitating Patient Matching

- **East Toronto Family Practice Network (EasT-FPN) and ETHP OHT** are improving primary care access and patient matching through a multi-faceted strategy that includes a practice survey, investment in neighbourhood-based integrated care hubs, and the deployment of **Holistic Intake and Navigation Counsellors (HINCs)**
- HINCs are community-based workers **who build trust, support navigation, and act as physician extenders** to improve attachment for equity-deserving populations; launched at 2 clinic sites and the Michael Garron Hospital ED, with plans to scale ETHP-wide with IPCT funding and in-kind support.
- Efforts underway to identify additional primary care providers who would be willing to take on additional patients – if supported by a HINC. This approach helps **address early social complexity, making it easier for primary care providers to accept patients**.

Building Capacity to Enable Attachment

- The ETHP PCN (EasT-FPN) conducted in-person focus groups, 1:1s, and surveys to understand **physicians' ability and willingness to take on new patients**, and what additional supports providers need to sustain and support their practices with supports needed.
- This physician-led effort has been foundational in identifying opportunities and challenges for attachment and enhancing care delivery for patients. The approach deeply engaged providers around the question: **"What would keep you in family practice?"**

Impact

2,545 patients attached to primary care across two of the larger primary care practices due to the inclusion of HINC and community-based wrap around support

Key Learnings

- ETHP frames PC attachment as a 'neighbourhood model' with **focus on health access points & connecting PC with community partners**
- Despite strong engagement, **aligning patient needs** with available providers remains a major challenge,
- This work is aligned with Home Care Leading Projects to **integrate and build a system of support** with OH at Home at the neighbourhood level
- Having access to HCC data and support from a OH@H connector will help inform neighbourhood needs and HHR capacity planning
- **Leveraged local PCN** with focus on individual relationships to build trust and engagement
- ETHP/EasT-FPN are **leveraging PC census and initial PCAT planning work** to understand what capacity currently exists in the system and what it will take to scale to 100% attachment

Greater Hamilton Health Network OHT

WEST REGION

THEME
- Facilitating Patient Matching
- Interim Clinical Supports for Unattached Patients
- Building Capacity to Enable Matching/Attachment

Summary

Facilitating Patient Matching

- The **GHHN PCN Access and Attachment Committee brings together diverse primary care stakeholders** to collaboratively design local strategies, recognizing and supporting leadership within each participating organization.
- The Attachment Team at Hamilton FHT **coordinates patient placements** using local provider capacity data.
- The Attachment Coordinator, jointly funded by the PCN and 2024–25 IPCT, builds connections across schools, hospitals, public health, and social services **to enable real-time patient attachment from multiple access points.**
- **A data-driven mapping tool**, integrating ED visits, refugee data, chronic disease prevalence, and the ON-Marg index, identifies high-need areas by postal code to support focused outreach and patient attachment efforts.

Interim Clinical Supports for Unattached Patients

- **Invested in fixed and mobile services** to reach "Code Red" areas and deliver primary care to underserved groups,
- Expanded to rural areas with Nurse Practitioner and nursing supports,
- Supported **low-barrier drop-in clinics and shelter-based care** to support service access and transition to permanent providers

Building Capacity to Enable Matching/Attachment

- The GHHN's PCN share their governance with the OHT, enabling **fast action**, coordinated planning, and a **unified vision for primary care transformation**.
- Advocating for funding and operational models that support integrated care. The PCN's role in independently advancing primary care priorities reflects a **maturing leadership voice within a cohesive system.**

Impact

- **6,000** patients newly attached to team-based primary care.
- **8,500** unique access points to interim and supportive care modalities.
- Increased care access in underserved urban and rural areas.
- Improved targeting of outreach and services through enhanced population health data analytics (GHHN Atlas).

Key Learnings

- **Whole-community collaboration is essential:** Strong ties with public health, the municipality, and other sectors enabled a shared data environment and streamlined patient pathways.
- **Integrated leadership between OHT and PCN is foundational:** A shared governance and staffing model eliminated silos and fostered unified action.
- **Primary care transformation requires systemic change:** Legacy models have treated primary care as separate; attachment work requires embedding it within a larger, supported ecosystem.
- **Expanding the provider base supports sustainability:** Including non-traditional and allied health providers expands capacity to support patient attachment.
- **Equity-driven targeting works:** Using marginalization data from partners,listening to the lived experience of residents, and embedding an equity approach from day one has enabled GHHN to focus primary care efforts where need is greatest.
- **Funding models need modernization:** The current compensation structures do not fully support team-based or collaborative models of care delivery.

Durham OHT

EAST REGION

THEME
- Facilitating Patient Matching
- Interim Clinical Supports for Unattached Patients
- Building Capacity to Enable Matching/Attachment

Summary

Interim Clinical Supports for Unattached Patients

- Partnered with Ontario Health and Health 811 to launch the **East Region Virtual Care Clinic** (ERVCC), evolving from a virtual urgent care model.
- Nurse Practitioner-led clinic improves timely access, **supports remote care delivery**, and helps **reduce ED wait times** for patients across the region and beyond.
- **The Virtual Primary Care Team** (icarevirtual.com) provides care for unattached patients, supported by local providers and endorsed by the PCN, in partnership with community paramedics, Community Care Durham, and pharmacists

Facilitating Patient Matching

- Supported **in-person unattached clinics across** North, West, and Central Durham, offering episodic and stabilizing care to help primary care providers more easily onboard patients.
- Clinics backed by core partners (e.g., FHTs, FHOs, CHCs) to ensure **localized support** and **continuity**.
- **Leveraged digital tools** to align data on unattached patients with primary care capacity, with a digital champion automating patient-matching, identifying system gaps, and improving workflows to reduce delays and enhance the attachment experience.

Building Capacity to Enable Matching/Attachment

- A **strong PCN** has been central to Durham OHT's attachment strategy, **enabling sector-wide collaboration and engagement.**
- Co-hosted events and **interactive sessions** (e.g., Vision2030 spring event with ~200 providers) to foster networking and. **promote shared goals**
- Supports a **Community of Practice for PCN members**, offering webinars, newsletters, and resource sharing to expand regional insight and **identify providers open to taking new patients.**

Impact

- **1,964 patients received episodic access to care** via the ERVCC in 23/24.
- Durham West unattached clinic has **seen 1,194 patients** and **attached 320 of these patients** to permanent primary care
- North Durham Family Health Team unattached patient clinic has **attached 223 patients** to permanent primary care

Key Learnings

- **Supports for unattached patients should focus beyond the provision of episodic care** and support stabilizing patients to prepare for long term attachment to primary care providers.
- **A strong primary care network –** built on trust and ongoing engagement is a strong enabler for local attachment efforts
- **Effective PCNs** require strong physician leadership/ champions, backbone support from the OHT, and providing a clear value proposition for providers.

Frontenac, Lennox and Addington OHT

EAST REGION

THEME Facilitating Patient Matching

Summary

Facilitating Patient Matching

- People-centred Health Home model defines health neighbourhoods, promotes **culturally responsive care**, and **extends team-based services equitably across the region**.
- Collaborative, **region-wide campaign** shaped through engagement with community members, partners, and primary care teams to promote attachment to Health Homes.
- Streamlined attachment process integrates Health Care Connect with local coordination via OH atHome, resulting in **rapid, high-volume rostering** (e.g., 1,000 people attached at one event).
- To support successful attachment, FLA OHT **partnered with primary care providers** on **a strategic communications approach** that built public trust**, raised awareness of team-based care**, and set clear expectations for the rostering process.
- **Data-informed approach** using INSPIRE-PHC and HCC to identify priority populations (e.g., pregnant individuals, chronic disease) **and match them geographically to Health Homes.**
- FLA OHT applied a strategic, **community-informed communications approach** to support each rostering initiative, with tailored goals, clear messaging about the Health Home model and Health Care Connect and coordinated public outreach. Robust internal and external communication resources, proactive media planning, and **ongoing evaluation** ensured consistent messaging, rapid issue response, and **continuous improvement.**

Impact

- Established a shared vision and commitment towards people-centred care, access and attachment, increased readiness to support attachment objectives
- 8632 HCC files were closed through connection to primary care Jan1, 2024- March 31, 2025.
- Over 13,000 people were attached to primary care providers across the region in 2024-25

Key Learnings

1. A **shared vision**, transparent communication, and **collective commitment** to a coordinated process are essential to efficiently attach large numbers of individuals and ensure **mutual benefit for both primary care teams and the community**.
2. Effective communication takes time and planning—FLA OHT's strategy combined tailored messaging**, proactive outreach**, and continuous evaluation to **build trust** and adapt to emerging needs throughout the rostering process.

5 Resources & Supports

Resources

Who To Contact for More Support:

OH atHome:

- **Aruna Mitra,** Patient Services Director: Aruna.mitra@ontariohealthathome.ca
- **Rosina Montemarano,** Provincial Manager, Health Care Connect: Rosina.Montemarano@ontariohealthathome.ca

Ontario Health:

Region	OHT Regional Point of Contact	Primary Care Lead	Digital Lead
Central	amy.khan@ontariohealth.ca	juliana.french@ontariohealth.ca	deborah.schwartz@ontariohealth.ca
Toronto	madeleine.morgenstern@ontariohealth.ca	fatima.ulhaq@ontariohealth.ca	sid.suwande@ontariohealth.ca
East	laurel.hoard@ontariohealth.ca	jeanne.thomas@ontariohealth.ca	michael.spinks@ontariohealth.ca
North East	lynne.kinuthia@ontariohealth.ca laura.boston@ontariohealth.ca	jenn.osesky@ontariohealth.ca	mark.stevens@ontariohealth.ca
North West	kiirsti.stilla@ontariohealth.ca	jenn.osesky@ontariohealth.ca	mark.stevens@ontariohealth.ca
West	jennifer.peckitt@ontariohealth.ca	jennifer.mackey@ontariohealth.ca	bonnie.scott@ontariohealth.ca

Appendix

Examples of Digital Capabilities

OH has developed the following summary of digital capabilities based on a review of digital requirements documentation shared by several OHTs. Please consult with your Regional Digital Lead before investing in a new digital solution.

Category 1: Clinician Data Management Capabilities:

- **Intake, curate, and permanently maintain clinician information** (business contact information – e.g., email address, geography served by clinician etc.) **from multiple sources** (such as Ontario Health atHome templates, CCT, etc.)
- **Filter/stratify clinician data** based on various attributes (postal codes, languages spoken, digital assets, implementation status of e-Referral, etc.)
- **Export clinician data** for downstream analysis purposes if required (including information sharing with OH and other health system stakeholders if required in the future)

Additional Advanced Capabilities

- Create **custom ad-hoc reports** to understand the clinician data better for targeted engagement
- Ability to **measure and analyze engagement metrics** (such as email click-through rates, etc.) to enhance engagement approach and strategy

Category 2: Communication and Engagement Capabilities

1. Send **emails/newsletters** to all clinicians for regular updates, information exchange, broadcasts especially related to access and attachment
2. Engage with specific clinicians on an ongoing basis for **general relationship building** and **determine, document and track the available capacity on an ongoing basis** and **communicate it to the HCC Care Connectors** to help facilitate matching
    - Includes the ability to list all practice locations for each clinician (if applicable) and capacity/availability in each location
3. Curate and maintain a **list of interim supports for unattached patients**, including walk-in clinics, virtual care services, OHT-level navigation supports, etc. and share with clinicians and other stakeholders on an ongoing basis

Additional Advanced Capabilities

- Create **tailored messages and send targeted emails** based on clinician needs/ demographics and engagement metrics
- **Compile and share a resource library** of educational health content
- Conduct surveys to collect **clinician experience data** relating to OHT and PCN priorities