# Onboarding New Patients in Primary Care:

## Strategies for Interprofessional Primary Care Teams (IPCTs)

**Practical Guide for Building Capacity in Ontario Interprofessional Primary Care Teams (IPCTs)**

### About This Series

This resource is part of a series of practical guides developed by the Department of Family and Community Medicine (DFCM) at the University of Toronto, in partnership with Ontario Health and the Primary Care Collaborative. The series is designed to support Interprofessional Primary Care Teams (IPCTs) in Ontario as they expand capacity and improve access to team-based primary care. Ontario's IPCTs include Family Health Teams (FHTs), Community Health Centres (CHCs), Indigenous Primary Health Care Organizations (IPHCOs), and Nurse Practitioner-Led Clinics (NPLCs). Each guide provides practical considerations, examples, and implementation strategies that teams can adapt to their local context. The series is informed by evidence, implementation science, and engagement with primary care and health system partners across the country. **For more information about this series, please visit our website: www.dfcm.utoronto.ca/ipct-team-supports**

### Who is This Guide For?

These practical guides are written for the executive directors, managers, clinician leaders, as well as frontline physicians and staff who are doing this work right now, trying to overcome constraints and manage uncertainty while under significant pressure. The aim is not to prescribe a solution, but to offer evidence-informed options that each team can implement using existing capacity and resources, and adapt to its own context, community, and workforce.

## Introduction

Even if a Family Physician (FP) or Nurse Practitioner (NP) has the time to see more patients, building the panel requires identifying unattached individuals, making contact with them, gathering their health information, and preparing for a meaningful first appointment. Without a well-designed onboarding process, this work falls disproportionately on FPs/NPs, slowing attachment and contributing to burnout.

Evidence from IPCTs in Ontario, as well as from innovative programs elsewhere, confirms that patient intake and onboarding is one of the most consistently under-resourced and under-systematized functions in primary care, and one of the highest-yield areas for redesign.

Attachment involves more than registering a patient with a family physician, nurse practitioner, or interprofessional primary care team. It is a relationship-based process that requires time, trust, continuity, cultural safety, and respect for individual choice and self-determination. Supporting attachment may also involve helping patients navigate services, connecting them with community resources, and, where desired or needed, facilitating access to traditional healing, Elders, and culturally grounded care. **Effective onboarding lays the foundation for this process by ensuring that patients are welcomed, informed, and connected to the care and supports they need.**

When onboarding is treated as a distinct process with its own dedicated workflow, assigned roles, and tools, rather than a task tacked onto the end of an FP/NP's busy day, teams are better positioned to build trusted relationships and grow panels sustainably.

**This practical guide is organized by task, not by professional title.** Different teams, in different communities, with different staffing mixes will find different solutions. What is shared across high-performing teams is the commitment to making onboarding an efficient process. Recognizing that onboarding is time-consuming and complex, the actions described here are designed to be implemented within existing IPCT capacity.

## Conditions for Successful Onboarding

Evidence from a study of high-performing Ontario IPCTs and a realist review of interventions identifies the following conditions for sustainable, scalable onboarding:

### Enablers to put in place:

- **Dedicated onboarding infrastructure:** Teams that treat onboarding as a distinct function, with its own assigned roles, standardized workflows, and scheduling templates, are more efficient than those where intake is handled in an ad-hoc way.
- **Administrative capacity:** Onboarding requires administrative time and expertise. Teams without sufficient administrative support find that clinical staff absorb this work, reducing direct care time. Teams that are able to optimize existing administrative resources by upskilling and rethinking workflow design can onboard more efficiently.
- **Pre-appointment chart preparation:** When an FP/NP arrives at their first appointment with organized and complete patient information, encounters are more efficient and the patient experience is better.
- **Connection to Supported Attachment services:** Teams that are able to engage with their Ontario Health Team's (OHT) Supported Attachment program can offload significant pre-appointment preparation work to a dedicated external team. The Supported Attachment program is described in more detail below.
- **Patient communication:** Proactive, clear communication about the care model and what to expect improves patient acceptance and reduces drop-off between first contact and first appointment.

## Barriers to anticipate:

- **Equity-deserving populations may require a different approach:** For populations experiencing homelessness, language barriers, trauma, or distrust of the health system, a more resource-intensive approach may be required that prioritizes trust-building, cultural safety, and sustained outreach. Future Practical Guides will highlight practical strategies that have been successfully used to support equitable onboarding and engagement of equity-deserving populations.
- **Panel growth and patient access can be in tension:** Rapidly onboarding large numbers of new patients can delay access for existing patients (and appointment slots for follow-ups in new patients) if the team's capacity is not structured to absorb both. Explicit scheduling templates that protect slots for both new and returning patients are essential. This can be adjusted over time based on appointment demand and supply. Teams should also account for the downstream demand created by onboarding patients with more complex health or social needs, as these initial visits frequently require multiple follow-up appointments.
- **Unresolved contact information:** Failed outreach due to outdated phone numbers, spam-filtered emails, or patients who have since found care elsewhere is a significant source of administrative burden.

# Supported Attachment and the Role of OHTs and PCNs

Before describing what teams can do internally, it is important to recognize a significant resource available to primary care teams: the **Supported Attachment program**, implemented through Ontario Health Teams (OHTs) and Primary Care Networks (PCNs). Supported Attachment was intentionally designed to support local flexibility, and implementation therefore varies considerably across OHTs and PCNs. While there are common principles and approaches, there is no single standardized provincial model for how SA is implemented in practice. The examples in this guide reflect approaches that may be adapted to local context.

Funding for Supported Attachment is currently time-limited through the 2026/27 fiscal year. Organizations should consider this funding horizon when planning for the sustainability of Supported Attachment activities, as future funding will be at the discretion of the Ministry of Health.

Supported Attachment is primarily a clinical service offered before or just after a patient is matched with an FP/NP or team for ongoing care. **Coordinated by the OHT, services delivered by a dedicated individual or team facilitates patient onboarding by completing the tasks that would otherwise slow onboarding or create inefficiencies for primary care teams.**

**These tasks may include:**

- Collecting intake and screening forms, and supporting patients in completing them
- Documenting a comprehensive health history
- Navigating patients to social and community supports
- Ensuring language interpretation and cultural translation are available
- Collecting emergency contact information, substitute decision maker details, and other circle-of-care information

**Additional activities that OHTs may choose to add based on local context and scope include:**

- Basic physical examination (height, weight, blood pressure)
- Medication reconciliation in liaison with the patient's pharmacist
- Transfer of medical records
- Clinical administrative functions (reviewing practice policies, scheduling appointments)
- Recommending preventive care and linking patients to self-management programs
- Referring to screening or diagnostic services under medical delegation or directive

In the case of patients who are registered with Health Care Connect (HCC), Supported Attachment may occur before the HCC Care Connector matches the patient to a specific clinician, which helps inform complexity-sensitive matching. It may also occur after the match but before the first clinical appointment, which prepares the patient and their chart so that the FP/NP's first appointment is substantive and efficient rather than administrative.

**Teams should connect with their Ontario Health Team's Primary Care Network clinical lead to find out what Supported Attachment capacity exists or is planned in their region.**

# Key Findings & Actions to Consider for Interprofessional Primary Care Team Processes

The tasks described below represent the most consistently identified components of an effective onboarding process. Each task is followed by practical actions and suggestions on who might take them on. **The goal is for each IPCT to clarify what the team can prepare, coordinate, and complete in advance, so that when the FP/NP meets a new patient, that encounter is focused on clinical assessment and relationship-building rather than paperwork.**

## 1. Pre-Appointment Chart Preparation and Health History Collection

One of the highest-yield changes a team can make to its onboarding process is ensuring that a complete and organized patient chart exists before the FP/NP's first appointment with the patient. When the FP/NP spends their first visit gathering basic history, the encounter is less effective for the patient and less efficient for the team. Recognizing this, various programs, including the Integrated Virtual Care program in Renfrew County, Ontario and the Rapid Onboarding program in Nova Scotia, have built chart preparation into a dedicated pre-visit step led by non-physician team members.

### Actions to consider:

Use a **standardized digital intake form** (via the clinic's patient portal, a secure survey platform, or a direct form on the clinic website) to collect medical, surgical, and family history, allergies, current medications, immunization status, and social history before the first appointment.

Assign a team member to **review completed forms and populate the cumulative patient profile (CPP)** in the electronic medical records, organizing information into the sections the FP/NP will use during the first appointment (problem list, medications, allergies, preventive care gaps).

Request and **download recent records from OLIS or Clinical Viewer** (lab results, imaging, specialist reports) before the first appointment, so that the FP/NP is reviewing a full picture and avoiding duplication.

Assign a **pharmacist** (where available) or nurse to complete medication reconciliation as part of chart preparation: requesting a current medication profile from the patient's pharmacy, updating the medication list in the chart, and flagging polypharmacy concerns for the FP/NP's attention.

Set up **preventive care reminder flags** in the electronic medical records based on information gathered in the intake form (e.g., overdue cancer screening, missing immunizations) so that these are visible to the FP/NP at first contact.

### Who might take this on:

The core chart preparation work, including populating history, organizing records, and updating the cumulative patient profile, is well suited to an administrative role, with a defined template and training. Medication reconciliation is best led by a pharmacist; in teams without one, an RN or RPN with appropriate delegation for changes to prescriptions, can carry out a simplified version.

## 2. Complexity Stratification: Tailoring Onboarding to Patient Need

Not all new patients require the same onboarding process. Teams that apply a complexity stratification approach at intake are better positioned to manage the administrative burden of onboarding while still giving appropriate attention to patients with greater needs. If applying this approach, it is important to consider FP/NP capacity and ongoing access to relevant team members to support the need of the newly attached patient (i.e., can the FP/NP roster patients who require ongoing mental health, addictions, or social work care, etc.). Attaching patients without considering the ability to provide the ongoing care they need creates further challenges.

### Actions to consider:

Use information gathered in the intake form to **sort incoming patients into complexity tiers** before scheduling. Lower-acuity patients who are relatively healthy can often be attached immediately and scheduled for a brief intake visit concurrent with a clinically necessary service. Higher-complexity patients benefit from a longer, more comprehensive first appointment and more thorough pre-appointment chart preparation.

Ensure that when **complex or equity-deserving patients** are being onboarded, additional time and resources are planned. For populations facing structural barriers to care (homelessness, active substance use, significant language barriers, trauma histories), attachment is a process that may need to span multiple contacts and may require coordination by administrators with community partners. Rushing this process undermines both the quality of the relationship and the likelihood of lasting attachment.

Schedule new patient intake appointments using a **scheduling template** that balances longer intake appointments with shorter episodic and return appointments. Renfrew County's Integrated Virtual Care program use explicit scheduling approaches to protect family physician and nurse practitioner time while maintaining access for existing patients.

### Who might take this on:

An intake coordinator or nurse can review completed forms and assign complexity tiers. The FPs/NPs in the team could help define the criteria for these tiers and review uncertain cases but do not need to be involved in routine triage decisions.

## 3. The First Appointment: Making First Contact Count

The goal of a well-designed onboarding process is to arrive at the FP/NP's first appointment with a prepared patient and a prepared chart, so that the encounter is spent on clinical assessment and relationship-building. High-performing programs report that when pre-appointment preparation is complete, a first appointment of 15 to 30 minutes (family physician) or 45 to 60 minutes (nurse practitioner) is sufficient for most patients.

### Actions to consider:

Offer **virtual first appointments** for patients with lower complexity or who have recently received care elsewhere. A virtual intake can be just as effective for establishing a relationship and reviewing history and removes geographic and scheduling barriers. Renfrew County's Integrated Virtual Care model demonstrates this at scale: patients primarily receive virtual care from their FP/NP, with in-person components handled by on-site team members as needed.

For patients being onboarded through a **hybrid or virtual model**, invest time in the first appointment to explain how the model works, including who the patient will see for in-person appointments, how to book appointments, and how the team communicates. Provide a written patient navigation guide, if appropriate. Patients who understand the model are more likely to use it effectively and remain engaged.

Consider a **"book 3, block 1" scheduling approach** for new patient periods: scheduling three appointment slots per hour with one blocked for administrative follow-up or quick phone visits reduces pressure on the FP/NP to resolve everything in a single encounter while maintaining a reasonable pace of panel growth.

After the first appointment, **send a letter or secure message to the patient**, confirming their attachment, their FP/NP's name, and instructions for ongoing booking and access. This closes the loop for the patient, reducing inbound calls to the clinic.

### Who might take this on:

The FP/NP conducts the **appointment** itself. The team's role at this stage is scheduling support, providing the patient with orientation materials, and sending post-appointment confirmation communications. Administrative staff can manage these functions efficiently once templates are developed, informed by FP/NP input.

## 4. Patient Communication and Buy-In

Evidence consistently shows that patients who are informed in advance about what to expect, including who they will see, what the care model is, and why they may be interacting with different team members, are significantly more likely to accept care from team members who are not their FP/NP and remain engaged with the practice.

### Actions to consider:

Develop **accessible, plain-language patient materials** that explain the team-based care model: who is on the team, what each member does, and how to access care. These should be available in the languages common to your community.

When new patients are first contacted, **proactively address the care model**, including any virtual or hybrid components, rather than leaving patients to discover these features on their own. Patients who feel surprised or unprepared are more likely to disengage.

For practices expanding **nurse practitioner-led services**, targeted education materials and community presentations can build familiarity and trust in nurse practitioner-led care before patients arrive for their first appointment. Resistance to nurse practitioner-led care is largely a knowledge gap; teams that invest in education see higher acceptance.

Where possible, **involve patient advisors, peer navigators** or equivalent roles in shaping communication materials, particularly for equity-deserving populations. Materials co-designed with the communities they are intended to reach are more likely to be accessible, trusted, and effective.

### Who might take this on:

Administrative staff can distribute and manage communications. The development of patient-facing materials benefits from input from patient, family and community members, and cultural health brokers to ensure accessibility and cultural appropriateness.

# Detailed Examples and Case Studies

The following examples are drawn from qualitative evaluations of high-performing Interprofessional Primary Care Teams and documented innovation programs.

## Case Study 1: Dedicated Attachment Team (Urban Family Health Team)

Facing a large volume of unattached patients in a high-need community, one Family Health Team assembled a dedicated attachment team, consisting of administrative staff, a registered nurse, a nurse practitioner, and community outreach workers, to take full ownership of the attachment and onboarding process. This team managed everything from coordinating with community referral partners to completing intake, conducting health histories, preparing charts, and onboarding patients ready for a first FP/NP appointment. The team's Executive Director described it directly: "*The attachment team is a superstar team. They actually go out to hospitals, they go out to food banks, they go out to shelters trying to find people who need a family doctor, and they do the warm handoff.*" By fully separating the logistically intensive rostering work from FP/NP's clinical time, the team was able to grow its panel while maintaining access for existing patients.

## Key Takeaway for Teams

A dedicated attachment team does not need to be a new team. It can be a defined function assigned to existing staff, with a clear mandate, workflow, and scheduling block. The key is to make onboarding someone's defined responsibility and not something added onto everyone's workload.

## Case Study 2: The Integrated Virtual Care (IVC) Model (Renfrew County)

Developed in response to a community-wide physician shortage, with approximately 20% of Renfrew County residents lacking a primary care clinician, the Integrated Virtual Care program created a systematic, 10-step onboarding process that allowed a remote physician to take on new patients with minimal administrative burden at the point of first contact.

The process works as follows: once a patient agrees to join, consent and registration forms are sent digitally via a secure patient portal. A pharmacist requests and reviews the patient's medication profile from their community pharmacy and updates the CPP. Administrative staff download recent lab results, organize the patient chart according to the physician's preferences, and set reminders for pending preventive care. Only after all of this is complete does the physician's first appointment take place, usually a 20-minute virtual appointment, compared to the 60-plus minutes typically required when chart preparation has not been done.

The clinical onboarding guidance sets this out explicitly: "*New patients should have extensive chart prep completed prior to your first appointment with them... Past medical history questionnaires are completed by the patient and then populated into the Cumulative Patient Profile, medication history is reviewed by the Family Health Team pharmacist and populated in the Cumulative Patient Profile, plus anything else we can get our hands on such as allergies.*" The physician's first encounter is spent on clinical relationship-building rather than administrative history-taking, and patients are onboarded at a pace that does not overwhelm the administrative team.

## Key Takeaway for Teams

The Integrated Virtual Care (IVC) model demonstrates that pre-appointment chart preparation, including pharmacist-led medication reconciliation, administration-led history organization, and records downloading, can transform the efficiency of a first appointment.

Teams without a virtual care model can still adopt these pre-appointment preparation steps for any new patient onboarding.

## Case Study 3: Nova Scotia's Rapid Onboarding Program

Nova Scotia Health developed a centralized Rapid Onboarding Team, composed of a licensed practical nurse (LPN), a family practice nurse (FPN), and a coordinator, to support primary care practices across the province in onboarding patients from the provincial registry of unattached patients (equivalent to Ontario's Health Care Connect). The team manages patient outreach using a standardized two-step communication process: first, a notification that the patient is being placed with a practice; then, a confirmation once the first appointment is booked. Between these two steps, the Rapid Onboarding Team sends a digital health history survey to the patient, populates the chart in the practice's electronic medical records upon receipt, and conducts a virtual intake session with the patient to confirm details and identify any immediate concerns before the first appointment with the FP/NP.

Practices that engage with the Rapid Onboarding Team establish a designated virtual intake appointment type and assign an administrative contact for coordination of electronic medical records. In return, the Rapid Onboarding Team manages the outreach, intake, and chart preparation, allowing the practice to focus on clinical care.

## Key Takeaway for Teams

Nova Scotia's approach maps closely to what Ontario is now building through the Ontario Health Team-led Supported Attachment programs. IPCTs could familiarize themselves with the Supported Attachment models being developed in their region through their Ontario Health Team (OHT) and Primary Care Network (PCN).

**Please contact OntarioHealthTeams@ontariohealth.ca to find out which OHT serves your area and then connect with the OHT to learn more about their Supported Attachment plans and current capacity.**

## Case Study 4: Supported Attachment Through OHT Infrastructure (Mid-West Toronto OHT)

The Mid-West Toronto Ontario Health Team implemented a Primary Care Attachment Liaison model as part of its Supported Attachment program. The key role, a Registered Nurse, acts as a dedicated clinical point of contact for individuals who have faced barriers to accessing primary care. The registered nurse gathers health histories, initiates EMR documentation, identifies unmet clinical and social needs, and supports structurally vulnerable patients as they connect with a new primary care clinician. Rather than requiring each individual practice to build its own intake infrastructure, the Ontario Health Team deploys this registered nurse across several participating solo and small group practices in the community, practices that often lack the administrative depth to systematize onboarding on their own.

For practices participating in the program, new patients arrive for their first appointment with a completed health history in their electronic medical records, identified social needs already linked to appropriate supports, and a relationship with a team member who has guided them through the process. This model is particularly valuable for onboarding patients with complex social and clinical needs, where the initial contact and trust-building period would otherwise require significant FP/NP time.

## Key Takeaway for Teams

For primary care teams that do not have the internal capacity to build a dedicated onboarding function, particularly small practices or Family Health Organizations, engaging with the Ontario Health Team (OHT)'s Supported Attachment program may be the most direct path to increasing attachment without increasing clinical burden.

**Please contact OntarioHealthTeams@ontariohealth.ca to find out which OHT serves your area and then connect with the OHT to learn more about their Supported Attachment plans and current capacity.**

*This practical guide was prepared by the Department of Family and Community Medicine at the University of Toronto to support the Interprofessional Primary Care Team (IPCT) Community of Practice (CoP). It draws on findings from a qualitative evaluation of high-performing Interprofessional primary care teams in Ontario, a rapid realist review of the impact of interprofessional teams on FP/NP capacity, the Integrated Virtual Care Implementation Guidebook (Petawawa Centennial Family Health Centre / Healthcare Excellence Canada), Nova Scotia Health's Patient Onboarding Guidelines and Rapid Onboarding program, and Ontario Health's 2025/26 Supported Attachment Guidance for OHTs and PCNs.*