# Community of Practice for New and Expanded IPCTs

## Session 2: Onboarding New Patients

May 6, 2026

Ontario Health

Alliance for Healthier Communities
Alliance pour des communautés en santé

SGFP
GENERAL & FAMILY PRACTICE

afhto ASSOCIATION OF FAMILY HEALTH TEAMS OF ONTARIO

INDIGENOUS PRIMARY HEALTH CARE COUNCIL

NPLCA Nurse Practitioner-led Clinic ASSOCIATION

Ontario College of Family Physicians
*Thriving Family Physicians in a Healthy Ontario*

Family & Community Medicine
UNIVERSITY OF TORONTO

**Brian McKenna, MD**
Provincial Primary Care Clinical Lead
Ontario Health

**Jennifer Rayner, PhD**
Primary Care Collaborative
Alliance, Director of Research and Policy
INSPIRE Co-Lead

# IPCT Community of Practice Co-Chairs

# Agenda

| Agenda Item | Lead(s) | Time |
|---|---|---|
| Welcome & Introductions | Brian McKenna | 8:00 - 8:02 am |
| Land Acknowledgement | Brian McKenna | 8:02 – 8:05 am |
| Onboarding New Patients: Evidence Summary | Noah Ivers | 8:05 – 8:20 am |
| Panel Presentations | • Jonathan Fitzsimon (Renfrew County)<br>• Stephanie Hemmerick (Seaway Valley)<br>• Justine Humphries & Edward Aust (Mid-West OHT)<br>• Lindsay Wingham-Smith (Mississauga OHT) | 8:20 – 8:40 am |
| Panel Discussion and Q&A | Jennifer Rayner | 8:40 – 9:00 am |

# Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

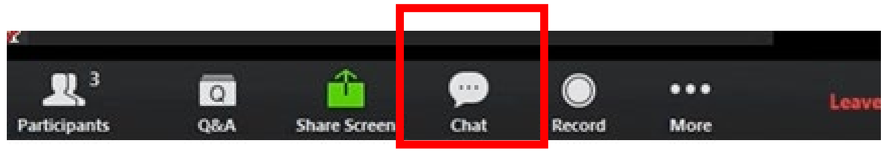
Ontario Health, the Primary Care Collaborative, and DFCM recognize the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. Ontario Health, the Primary Care Collaborative, and DFCM respect that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.

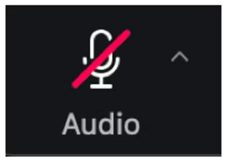
# How to Participate

- All questions should be asked using the Q&A function at the bottom of your screen.


- Please use the chat box for general engagement and networking purposes only. Questions posted in the chat may be missed.




- Please keep your microphone muted for the duration of the meeting.



# Introduction - Onboarding New Patients

- Even if a family physician or nurse practitioner has the time to see more patients, building the roster requires **identifying unattached individuals, making contact with them, gathering their health information, and preparing for a first meaningful visit.**
- Evidence from interprofessional primary care teams (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**.
- **Without a well-designed onboarding process**, this work falls disproportionately on family physicians or nurse practitioners and administrative staff, **slowing attachment and contributing to burnout.**

**When onboarding is treated as a *distinct process* with a dedicated workflow, roles, and tools, *teams are better positioned to grow panels sustainably.***

# Conditions for Successful Patient Onboarding

**Evidence from a study of high-performing Ontario IPCTs and a realist review of IPCT 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 assigned roles, standardized workflows, and scheduling templates, are more effective than those where intake is handled informally.

**Administrative Capacity:** Onboarding requires administrative time and expertise. Teams without sufficient administrative support find that clinical staff absorb this work, reducing direct care time.

**Pre-visit Chart Preparation:** When FP/NPs arrive at first visits with organized, complete patient information, visits are more efficient and the patient experience is better.

**Connection to OHT/PCN Supported Attachment Services:** Engaging with OHT's Supported Attachment resources can offload significant pre-visit preparation work to a dedicated external team.

**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 visit.

## 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.

**Panel growth and patient access can be in tension:** Rapidly onboarding large numbers of new patients can delay access for existing 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.

**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.

# Key Findings and Actions to Consider for IPCT Processes

**Four tasks represent the most consistently identified components of an effective onboarding process. Each task is presented with practical actions and notes on who might take them on.**

1. **Pre-Visit Chart Preparation and Health History Collection**
2. **Complexity Stratification: Tailoring Onboarding to Patient Need**
3. **The First Visit: Making First Contact Count**
4. **Patient Communication and Buy-In**

**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-Visit 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.**

## ☑ 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 history, surgical history, 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 EMR**, organizing information into the sections the FP/NP will use during the first visit (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 visit, so that the FP/NP is reviewing a full picture rather than ordering duplicates.

**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 community 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 EMR** 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 CPP, 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

**The goal of a well-designed onboarding process is to arrive at the first FP/NP visit with a prepared patient and a prepared chart, so that the encounter is spent on clinical assessment and relationship-building rather than form-filling.**

## ☑ Actions to Consider

**Offer virtual first visits for patients with lower complexity or who have recently been in care elsewhere.** A virtual intake can be just as effective for establishing a relationship and reviewing history and removes geographic and scheduling barriers.

**After the first visit, 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 and reduces inbound calls to the clinic.

**For patients being onboarded through a hybrid or virtual model, invest time in the first visit to explain how the model works,** including who the patient will see for in-person visits, how to book appointments, and how the team communicates. Provide a written patient navigation guide. 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 reduces pressure on the FP/NP to resolve everything in a single encounter while maintaining a reasonable pace of panel growth,

***Who might take this on?***

- **The supporting team's role at this stage is scheduling support, providing the patient with orientation materials, and sending post-visit confirmation communications.**
- **Administrative staff can manage the latter two functions efficiently once templates are developed.**

# 3. The First Visit: Making First Contact Count

**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.**

## ☑ 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 visit and more thorough pre-visit 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 with community partners. Rushing this process undermines both the quality of the relationship and the likelihood of lasting attachment.

**Schedule new patient intake visits using a scheduling template that balances longer intake visits with shorter episodic and return visits.** Both Nova Scotia and Ontario's IVC program use explicit scheduling approaches to protect FP/NP 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 FP/NPs in the team could help define the criteria for these tiers and review uncertain cases but need not be involved in routine triage decisions.**

# 4. Patient Communication and Buy-In

**Patients who are informed about what to expect, including who they will see and why they may be interacting with different team members, are significantly more likely to accept care 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 NP-led services, targeted education materials and community presentations can build familiarity and trust in NP-led care before patients arrive for their first visit**. Resistance to NP-led care is largely a knowledge gap; teams that invest in education see higher acceptance.

**Where possible, involve patient advisors or peer navigators 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 community members, social workers, and cultural health brokers to ensure accessibility and cultural appropriateness.**

# Supported Attachment & the Role of OHTs and PCNs

**Supported Attachment is primarily a clinical service offered before or just after a patient is matched with a primary care clinician for ongoing care. A dedicated individual or team, employed at the OHT level, facilitates patient onboarding by completing the tasks that would otherwise delay or burden the primary care team.**

## Tasks may include *(based on local context & scope)*:

- 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
- Basic physical examination (height, weight, blood pressure)
- Medication reconciliation in liaison with the patient's pharmacist
- Transfer of medical records from previous clinicians
- 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

**Note:** *For 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 visit, 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 OHT's Primary Care Network clinical lead to find out what Supported Attachment capacity exists or is being built in their region.**

# IPCT Community of Practice Guest Speakers

**Dr. Jonathan Fitzsimon**
Medical Lead, Renfrew County Virtual Triage and Assessment Centre
Assistant Professor, University of Ottawa Department of Family Medicine

**Stephanie Hemmerick**
Director of Programs, Services and Quality improvement, Seaway Valley Community Health Centre

**Justine Humphries**
Vice President, Strategy, People & Partnerships
Lead, Mid-West Toronto Ontario Health Team Secretariat

**Edward Aust**
Director, Corporate Planning
Mid-West Toronto Ontario Health Team Secretariat

**Lindsay Wingham-Smith, MSW RSW**
Executive Director, Mississauga Health, Trillium Health Partners
Adjunct Lecturer, University of Toronto

# A HYBRID APPROACH TO SUPPORTED ATTACHMENT

***Easing the burden of onboarding clinically complex patients.***

**May 06, 2026**


**Dr. Jonathan Fitzsimon**

Medical Lead, Renfrew County Virtual Triage and Assessment Centre
Medical Lead, Integrated Virtual Care
Assistant Professor, Department of Family Medicine, University of Ottawa
Clinician Researcher, Institut du Savoir Montfort

# Why do we need Primary Care Attachment?

## The impact of having and not having a family doctor

Open access — Systematic review


**Impact of changes in primary care attachment: a scoping review**

Leanda Godfrey [1], Antoine St-Amant [1], Kamila Premji [2,3], Jonathan Fitzsimon [1,2]

https://doi.org/10.1136/fmch-2024-003115

Fitzsimon *et al. BMC Primary Care* (2025) 26:72
https://doi.org/10.1186/s12875-025-02771-8

BMC Primary Care

RESEARCH — Open Access

Check for updates

**Assessing the impact of attachment to primary care and unattachment duration on healthcare utilization and cost in Ontario, Canada: a population-based retrospective cohort study using health administrative data**

Jonathan Fitzsimon[1,2*†], Shawna Cronin[2†], Anastasia Gayowsky[3], Antoine St-Amant[1] and Lise M. Bjerre[1,2]

Health Affairs Scholar

JOURNAL ARTICLE — ACCEPTED MANUSCRIPT

**Primary Care Unattachment; Impact on Mortality, Hospitalizations and Costs**

Jonathan Fitzsimon, MBChB, Antoine St-Amant, MSc, Michael E Green, MD, Richard H Glazier, MD, Anastasia Gayowsky, MSc, Kamila Premji, MD, Eliot Frymire, MA, Lise M Bjerre, PhD Author Notes

*Health Affairs Scholar*, qxag030, https://doi-org.proxy.bib.uottawa.ca/10.1093/haschl/qxag030

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TORONTO STAR

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MILAN CORTINA 2026
Striking gold, again
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Defending champions Isabelle Weidemann, Valérie Maltais and Ivanie Blondin compete in the women's speedskating team pursuit final at the 2026 Winter Olympics, in Milan, Italy, Tuesday to take home second straight Olympic gold medal.

STAR EXCLUSIVE
Study shows effects of GP shortage
Ontarians without family doctors face a higher death rate

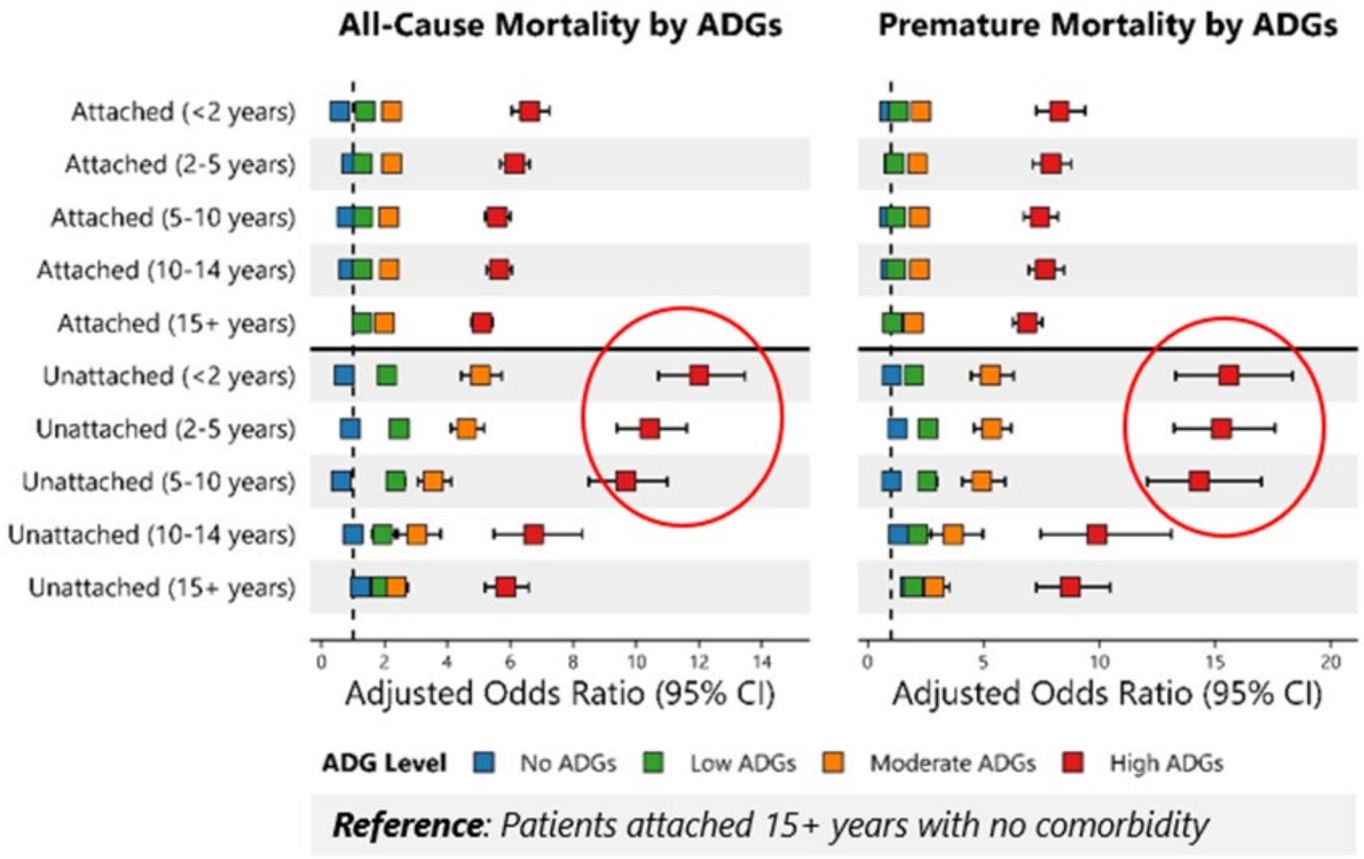
STAR EXCLUSIVE
Shooting victim's family 'in disbelief' about SIU report
Watchdog released findings of death without private briefing

FEDERAL POLITICS
Plans to reduce U.S. 'dependency' unveiled
Carney claims Liberals can triple annual revenues of domestic defence sector

INSIDE
'We shared him with the world'
Rev. Jesse L. Jackson, civil rights leader and two-time presidential candidate, dead A8

# Quantifying the Burden of Unattachment

## The Impact on Mortality




Those with high comorbidities and unattached for <2 years had:

***~12-fold higher odds of all-cause mortality***

***~16-fold higher odds of premature mortality***

Compared to those with no comorbidity and long-term attachment

# What is a Hybrid Approach?

A response to ongoing workforce shortages in hard-to-serve communities

## There are two key components to a Hybrid Approach

1. It **leverages underutilized capacity** within the existing primary care workforce and redistributes it to hard-to-serve communities with insufficient supply to meet demand.

2. It then **blends virtual care options with locally available in-person care** resources in order to increase system capacity and deliver more equitable access and attachment to primary care.

## We have evaluated the impact of a Hybrid Approach in the context of:

a) Using a hybrid approach to deliver **access to urgent care (VTAC).**

b) Using a hybrid approach to deliver **attachment to comprehensive, team-based primary care (IVC).**

# A Hybrid Approach

## Supported Attachment

- **Administrative onboarding.** Explain the process, set expectations and confirm patient understanding that they remain officially unattached until a final transition occurs.
- **Pharmacist intake.** Comprehensive review of multiple prescription data sources and a direct patient encounter.
- **Designated family doctor intake.** Understand patient goals and concerns, developing an initial management and care plan, and addressing the patient's most pressing concerns.
- **Bridging support.** Designated VTAC doctor to provide bridging support.
- **Local in-person clinical support.** Low-acuity tasks from community paramedics (vital signs, measurements and injections) and limited local MD and NP support for in-person physical examinations when clinically necessary.
- **Transition and handover to local attachment.** Once a locally based family doctor or NP is available.

# A Hybrid Approach to Supported Attachment

## Supporting Patients, Clinicians and the Healthcare System

**Patients**

**Healthier Patients**
Lower mortality risk[1]
Better preventative care[2]
Increased patient satisfaction[3]

**Primary Care Clinicians**

**Positive Clinician Experience**
Leverages latent capacity in the system
New clinicians are supported in set up
Increased clinician job satisfaction[4]

**System Benefits**

**Improved Quality and Efficiency**
Significant ROI per patient[5]
Decreased ED visits[5]
Decreased hospital admissions[1,5]

## Benefits

- Leverage latent primary care capacity and provide care now to those who need it the most
- Immediately reduce the burden on emergency departments and hospital in-patient units
- Avoid overburdening newly recruited primary care clinicians by ensuring clinically complex patients have a period of intensive administrative and clinical support prior to attachment


1. Primary care unattachment: impact on mortality, hospitalizations and costs – *Health Affairs Scholar*
2. Assessing new patient attachment to IVC – *Canadian Journal of Rural Medicine*
3. Evaluating Patient Experience with Integrated Virtual Care (IVC) - *Journal of Primary Care & Community Health*
4. Understanding the experience of clinicians and non-clinical staff in a hybrid primary care program in rural Ontario, Canada – *BMC Health Services Research*
5. Assessing the impact of attachment to primary care and unattachment duration on healthcare utilization and cost in Ontario, Canada – *BMC Primary Care*

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# Client Onboarding & Orientation Overview

***Presented by Stephanie Hemmerick***
***Director of Programs, Services and QI***


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# From Bottleneck to Scale: Transforming Client Onboarding

**2023**

- Medically and socially complex individuals in community requiring care
  - Low literacy, multiple languages, equity-focus
- Unable to keep up with regular discharges and requirements for roster
- Lengthy, fragmented onboarding process
- 3–4 month timeline from registration to first visit – many lost within process
- Only 1–3 new clients onboarded per week

**Impact:**

Providers under-rostered despite high community need

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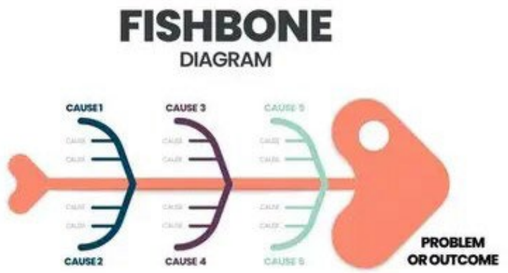
# OUR APPROACH (QUALITY IMPROVEMENT)

**2023-2024**

**Using QI to Identify and Address Inefficiencies**

- Interdisciplinary QI team (admin, clinical, management)
- Weekly working sessions
- Detailed process mapping (PAPER WORK DELAY)
- Plan–Do–Study–Act (PDSA) cycles
- Supported by Alliance for Healthier Communities







**Key Insight:**

- Delays driven by paperwork, back-and-forth communication, and inefficient 1:1 orientation model

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# THE KEY INNOVATION

**Group Orientation Model**

- Clients complete all paperwork during one session
- Policies, expectations, and services explained once to many
- Real-time verification → improved accuracy
- Nursing visits streamlined and more focused

**Shift:**

From individual onboarding → standardized group process

**Result:** Faster, more consistent, and scalable onboarding

**ANNOUNCEMENT!**

***IPCT Round "0" Funding, four partners, 26.6 FTEs, attachment and access to over 16,000 clients!***

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# IMPACT

- **Before vs After**
- Registration completion: **15 days → 1 day**
- Form accuracy: **60% → 100%**
- New clients/week: **1–3 → 8–10+ → 20-40**
- **1,215 new clients rostered in 2025**
- **172 in April 2026**
- **Supporting of clearing HCC list by June 20 2026**

- **Scaling Forward:**
- Weekly orientations → moving to 2/week
- Capacity target: **up to 65 clients/week ++**
- **Dual pronged approach – Oceans completion + video and in-person**

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# CONSIDERATIONS

- Constant need to revisit for improvements and bottlenecks

- Current integrations – improved use of technology for those who are capable
  - Maintaining in-person group orientation and Oceans option for those who are capable (equity focus)
  - Exploring maximizing in-person time for some (group medical visit?)

- SVCHC providers prefer completed chart and nursing visit before first visit
  - Front loading of admin/nursing work to allow for more clients to be seen
  - Complex clients require more time and multiple visits – equity-focused policies

- Shared orientation process with other CHC in area; working with other partners for streamlined process depending on client population

- Costly implementation for implementation of supported attachment for whole region of Great River OHT (nursing and admin staff required)

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# Questions?

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613-936-0306 ext 117

# Primary Care Attachment Liaison Model

mid-west toronto
ontario health team

mid-west toronto
FAMILY PRACTICE NETWORK

# Centralized Physician Supports

The Mid-West Toronto **Family Practice Network (FPN),** a network of family physicians and nurse practitioners representing primary care across Mid-West Toronto identified a growing need for support for primary care providers as they faced burn out and heavy admin burden.

## Attachment Liaison

A dedicated role to streamline and manage onboarding for unattached patients leveraging supported attachment funding.

The Primary Care Attachment Liaisons at Kensington Health are virtually and physically embedded in primary care offices and act as first point of contact and navigation.

**Topic of Today's Discussion**

## Community Team

Wrap-around services (e.g., social work, dietitian) that provide equitable access to resources for patients, increase capacity and alleviate care burden for primary care providers.

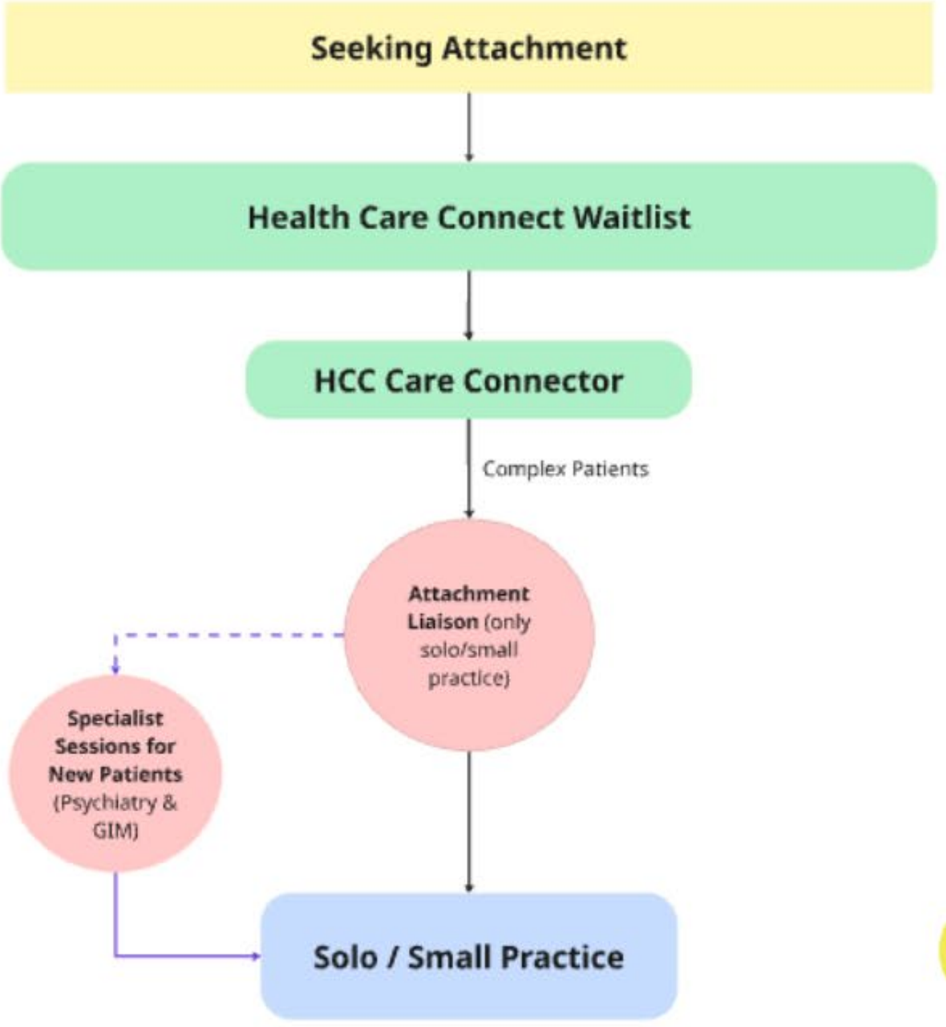
## Digital Support

Streamlines administrative tasks and enhances EMR-enabled coordination. Providers can focus on patient care and expand their capacity to onboard unattached patients.

# MWT Centralized Attachment Pathway

**Legend**

- Attachment Mechanism
- Primary Care Providers Accepting Patients
- Resources Available to Solo/Small Practice
- Attachment Pathway (primary expected flow)
- Resource Pathway for Solo/Small Practice

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Ontario Health atHome

Kensington Health

SCOPE
A virtual team for primary care providers

WCHRI
WOMEN'S COLLEGE HOSPITAL
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# Types of Patients Seen

Complex patients from HCC are validated using a complexity tool, the Patient Centered Assessment Method which is a holistic assessment of four domains: health and wellbeing, social environment, health literacy and communication, and service coordination.

Examples of types of patients seen:

**Complex Medical & Coordinated Care Needs**

- Multiple chronic conditions (e.g., diabetes, CHF, COPD)
- Frailty, disability, medication complexity
- High ED use or recent hospital discharge
- Mobility or home-care needs
- Identified through ED, hospital pathways, or referral partners

**Seniors with Frailty**

- Age-related decline affecting ability to access primary care
- Cognitive changes (memory impairment, dementia)
- Unstable supports (caregiver burnout, living alone, language barriers)
- Frequent ED use or ALC risk

**Family & Pediatric Attachment Needs**

- Children needing immunizations, development screening, or preventive care
- Urgent child health concerns
- Family-based attachment encouraged

# Model Success Factors

- Early EMR access is critical to the coordination and operationalization of the model
- Co-design with FPN, partners, and physicians ensures success and improves adoption
- Relationship building with HCC and clinics drives participation
- Standardize workflows reduce operational burden
- Start small and iterate before scaling
- Build communication loops between liaison, HCC, and clinics
- Formalizing legal agreements for patient data access and sharing

# Next Steps

## Continue Onboarding Patients

- Maintain steady referral intake
- Prioritize patients based on urgency and complexity
- Continue supporting clinics during initial attachment

## Increase Clinic Participation

- Recruit additional primary care clinics
- Re-engage clinics with limited capacity
- Strengthen relationships with participating clinics

## Evaluation

- Embed feedback loops and continue to monitor implementation, outcomes, and provider/patient experience to inform continuous improvement
- Ongoing codesign with FPN and practices using the service
- Efficiency and time saved of onboarding workflow
- Impact on provider workload
- Patient experience and preparedness for first visit
- Clinic readiness/fit and patient fit for the Liaison model
- Sociodemographic data of patients

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# THANK YOU

# Questions?

# Post-Session Survey

- Please take a few minutes to complete this optional, anonymous survey to share your feedback on today's session.
- Your input will help inform future IPCT CoP sessions and support ongoing improvements to their relevance and usefulness.
- The link will also be shared in the chat.

IPCT CoP Post-Session Survey

# Thank You!

**Next Session:** Wednesday, June 3, 2026 - Health Human Resources (HHR)

**Feel free to contact us if you have questions:**

Provincial Primary Care Program
primarycareexpansion@ontariohealth.ca

Jennifer Rayner
jennifer.rayner@allianceon.org

Brian McKenna
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# Appendix

# Supported Attachment & the Role of OHTs and PCNs

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- Referring to screening or diagnostic services under medical delegation or directive

**Note:** *For 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 visit, 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 OHT's Primary Care Network clinical lead to find out what Supported Attachment capacity exists or is being built in their region.**

# Examples of Onboarding Processes

**The following examples are drawn from qualitative evaluations of high-performing IPCTs and documented innovation programs.**

| Example | Scenario | Key Takeaway for Teams |
|---|---|---|
| **Dedicated Attachment Team**<br><br>***Urban Family Health Team*** | Facing a large volume of unattached patients in a high-need community, one FHT assembled a dedicated attachment team, consisting of administrative staff, an RN, an NP, and community outreach workers, to take full ownership of the attachment and onboarding process.<br><br>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 visit. By fully separating the logistically intensive rostering work from FP/NP clinical time, the team was able to grow its panel while maintaining access for existing patients. | **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 somebody's actual job, not everybody's extra job. |
| **The Integrated Virtual Care (IVC) Model**<br><br>***Renfrew County*** | Developed in response to a community-wide physician shortage, the IVC 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.<br><br>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, typically a 20-minute virtual visit, compared to the 60-plus minutes typically required when chart preparation has not been done. | **Pre-visit chart preparation can transform the efficiency of a first visit.** Teams without a virtual care model can still adopt these pre-visit preparation steps for any new patient onboarding. |

# Examples of Onboarding Processes

**The following examples are drawn from qualitative evaluations of high-performing IPCTs and documented innovation programs.**

| Example | Scenario | Key Takeaway for Teams |
|---|---|---|
| **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).<br><br>Practices that engage with the Rapid Onboarding Team establish a designated virtual intake appointment type and assign an administrative contact for EMR coordination. In return, the Rapid Onboarding Team manages the outreach, intake, and chart preparation, allowing the practice to focus on clinical care. | **Nova Scotia's approach maps closely onto what Ontario's OHT-led Supported Attachment program is now building.** Ontario primary care teams could familiarize themselves with the Supported Attachment models being developed in their region through their OHT and PCN. |
| **Supported Attachment Through OHT Infrastructure**<br><br>***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 RN 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.<br><br>Rather than requiring each individual practice to build its own intake infrastructure, the OHT deploys this RN 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 primary care teams that do not have the internal capacity to build a dedicated onboarding function, engaging with the Supported Attachment program may be the most direct path to increasing attachment without increasing clinical burden.** Teams should contact their OHT and PCN leaders to find out about the Supported Attachment program in their region. |