Supported Attachment

2025/26 Guidance for Ontario Health Teams and Primary Care Networks

December 2025

Executive Summary

On October 15, 2025, as part of an announcement marking progress on reducing the January 1, 2025 Health Care Connect (HCC) waitlist, the Ministry of Health announced an investment of more than $22 million over two years (2025/26 and 2026/27) to support Ontario Health Teams (OHTs) and their Primary Care Networks (PCNs) in attaching patients to primary care.

This guidance has been developed to support OHTs and their PCNs to implement **Supported Attachment** programs as part of a province-wide effort to clear the **HCC waitlist (as of January 1, 2025)** by **Spring 2026** and once that goal is reached, broaden efforts to ensure all people in Ontario are attached to primary care. Supported Attachment (sometimes referred to as central primary care intake or centralized patient onboarding) has been identified by primary care clinicians as a mechanism that eases the onboarding of new patients and facilitates timely and lasting attachment to primary care.

Several OHTs and primary care teams across Ontario have adopted similar programs, demonstrating promising results in streamlining attachment to primary care. Through targeted funding and strategic guidance, this investment aims to accelerate and, where already in place, scale that success, enabling OHTs to engage and support their primary care partners in local attachment efforts, to connect more patients to ongoing primary care.

Illustrative Examples to Support Application of Guidance
To enhance the practical relevance of this document, a series of illustrative examples are included throughout. While not based on specific real-world cases, they aim to demonstrate how the principles and recommendations outlined in this guidance can be applied to diverse contexts to support OHTs and their PCNs in planning and service delivery.

Contents

Definitions

Attachment
A documented and ongoing relationship with a primary care clinician (family physician or nurse practitioner) or primary care team, working in a publicly funded system. The documentation could be through formal registration or signed enrolment and consent form.

Care Connectors
Care Connectors are individuals, usually nurses, employed by Ontario Health atHome who support Health Care Connect by assisting unattached patients find a primary care clinician.

Care Connector Tool (CCT)
This web-based case management system is used to support the matching of patients by applying patient information and matching with primary care clinicians and practices that have identified availability. The CCT pulls in data from the Unattached Patient System (UPS) and other provincial sources like the ministry's Corporate Provider Database (CPDB), organizing it into a centralized dashboard that helps manage patients awaiting referral, primary care practice and clinician profiles that are accepting new patients and uses matching criteria to facilitate matches.

OHT Lead Organization (Personal Health Information Protection Act (PHIPA) agent)
OHT lead organizations who sign a PHIPA agent agreement with the ministry, are authorized by and act on behalf of the ministry, as a Health Information Custodian, in accordance with the agreement and the permitted purpose set out in the agreement.

Supported Attachment
Primarily a clinical service offered prior to attachment, where a dedicated individual or team facilitates patient onboarding to primary care, setting up a successful relationship for future ongoing attachment.

Unattached Patient System (UPS)
When an individual registers for the HCC program—either by calling Health811 or visiting ontario.ca/healthcareconnect—their information is captured in UPS. This includes basic demographics, contact details, and insights into their health needs, chronic conditions, and personal circumstances. The system checks their eligibility using their health card number and postal code to link them to their local OHT.

Program Overview

Core Supported Attachment Service Components

Supported Attachment will be implemented and offered at the OHT-level, creating a coordinated mechanism to support patient onboarding across the community. Supported Attachment programs delivered by OHTs must include a set of core components grounded in best practices to support a baseline level of consistency across the province.

Beyond these core components, OHTs and PCNs may choose to implement complementary components tailored to local priorities, population needs, and available resources. This approach balances provincial alignment with local flexibility, supporting both the program's intent and responsiveness to community context. OHTs and their PCN clinical leads will need to work closely with their PCNs and local primary care community to select Supported Attachment service components and inform associated resourcing decisions that reflect the needs and realities of local primary care clinicians and teams.

Core activities should include:

- Facilitating collection of standard intake and/or screening forms and supporting patients in completing forms where applicable.
- Documenting a comprehensive health history and Cumulative Patient Profile (CPP).
- Navigating patients to social and community supports and services, as needed.
- Ensuring language interpretation and cultural translation are available, as needed.
- Collecting other information as needed such as patient emergency contact information, substitute decision maker, other specialists or supports involved in the patient's circle of care.

Complementary Supported Attachment Service Components

Supported Attachment staff should deliver services within the scope of practice for their profession and in compliance with professional and organizational expectations (including standards of practice, policies and protocols). The following services may be considered for inclusion, where clinically appropriate and operationally feasible as determined between the OHT, PCN and local primary care community:

- Performing a basic physical examination (height, weight, blood pressure).
- Liaising with patient's pharmacist to complete medication reconciliation and update their Coordinated Care Plan and/or medication list accordingly.
- Facilitating the transfer of medical records.
- Performing clinical administrative functions (e.g., review of practice policies/attachment and patient enrollment forms, scheduling appointments).

- Recommending self-initiated screening, health promotion activities, and providing or linking to self-management education.
- As appropriate under medical direction or delegation, referring to screening or diagnostic services (e.g., immunizations, cancer screening, blood tests).

Please note that where controlled acts (e.g., prescribing, ordering tests/diagnostics) will be performed by individuals who do not have the independent authority to undertake those activities, delegation by a physician and / or nurse practitioner should take place in accordance with College of Physician and Surgeons of Ontario's Delegation of Controlled Acts policy and / or the College of Nurses of Ontario's Practice Standard on Scope of Practice.

Alignment with Provincially Available and OHT Initiatives

OHTs and PCNs are encouraged to identify opportunities to align Supported Attachment program activities and resources with existing programs and supports, where possible. Several provincially available initiatives may support Supported Attachment programs, for example:

- **Self–Management Programs.** OHTs may wish to familiarize Supported Attachment teams with local and provincial Self-Management Programs to support chronic disease management. Online Self-Management is available to patients across the province and Regional Self-Management Programs are available to specific communities.
- **Health 811.** Navigation services should be integrated into Supported Attachment workflows. Health811 should continue to be promoted by the OHT and PCN as a health navigation hub and a resource for patients to connect with a registered nurse day or night for free, secure and confidential health advice.
- **Ontario Health Preventive Care Program**. Where they already exist, OHTs may choose to consider how prevention specialist roles may be involved in Supported Attachment workflows. These roles, informed by the *Ontario Health Preventive Care Program Toolkit FY25–26* (p 10-21), can support primary care access & attachment and navigation to community and social supports. A sample job description for prevention specialist roles is available *here* for reference.
- **STOP on the Net, Online Smoke Cessation.** The Smoking Treatment for Ontario patients (STOP) Program is a province-wide initiative delivering smoking cessation treatment and counselling support.

OHTs and PCNs should continue working with partner organizations to identify additional local, regional, or provincial programs that could be integrated into or aligned with Supported Attachment workflows.

Illustrative Examples to Support Application of Guidance

Integrating *Core* and *Complementary* Supported Attachment Components in a Mid-Sized Urban OHT Without Pre-Existing Supported Attachment Services

An OHT, serving a diverse urban population, collaborates with the PCN clinical lead to convene their PCN to engage primary care clinicians on how *core* components of the program will be implemented to best meet their needs.

The PCN informs a scope of work for the Supported Attachment Registered Nurse (RN), the development of standardized intake forms and training for Supported Attachment staff, including the part-time Supported Attachment Coordinator, to conduct comprehensive health histories. A partnership with a local settlement agency enables seamless navigation to social supports, and language interpretation service is arranged to support cultural translation needs.

In response to local resources and needs, the OHT also incorporates *complementary* components. They use Supported Attachment funding to hire a RN to work alongside local primary care clinicians. The Supported Attachment RN—working within their defined scope—conducts basic physical exams during the Supported Attachment visits. They also liaise with patients' pharmacists to conduct medication reconciliation. In response to needs expressed by some local primary care clinicians, the part-time Supported Attachment coordinator assists with transferring medical records (in alignment with required consents and/or local data sharing agreements) for newly attached patients.

Sample Program Workflows

Below are two sample Supported Attachment program workflows that depict how Supported Attachment could be implemented within an OHT to facilitate attachment of patients from the HCC waitlist. These workflows are not prescriptive but are intended to offer a starting point for OHTs and their PCNs as they co-develop or expand locally tailored programs. Supported Attachment workflows (i.e., when and where services are delivered and how visits are documented) will vary between OHTs based on needs and available resources. OHTs and their PCN clinical leads should work closely with their PCNs and local primary care community to co-design supported attachment pathways and inform associated resourcing decisions that reflect the needs and realities of local primary care clinicians and teams.

Note: all references to 'referrals' in the workflows below relate to referrals from HCC and not, for example, referrals from physicians to specialty or community care.

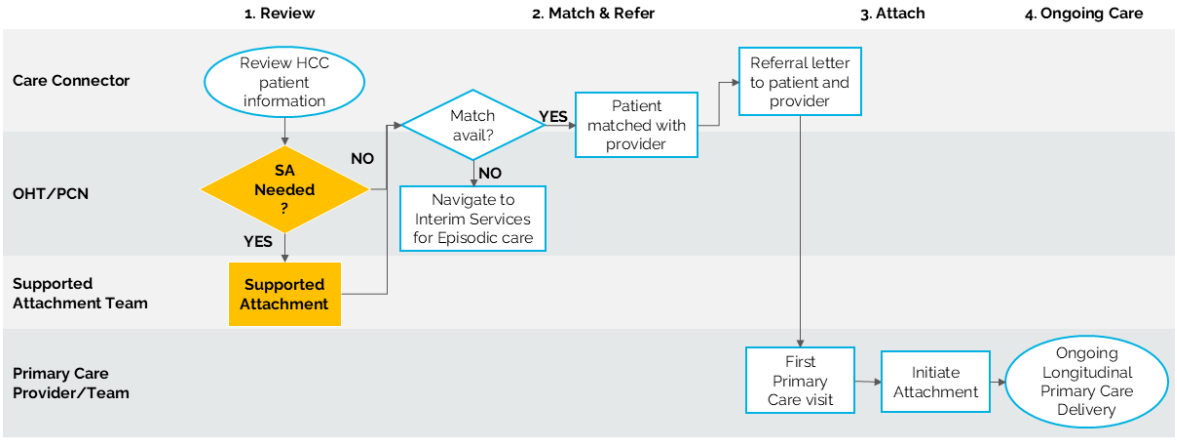
Nothing in this guidance should be construed as in conflict with professional obligations. If there are concerns of a conflict, legal advice is recommended. For greater clarity, if there is a conflict between guidance in this document and any laws or regulations, the latter will govern.

Workflow A: Supported Attachment Before HCC Match and Referral

In sample Workflow A, Supported Attachment occurs **prior to the HCC care connector matching and referring a patient to a primary care provider or team.** The information gathered during Supported Attachment helps to inform the matching process, ensuring patients are paired with primary care clinicians suited to meet their clinical and non-clinical needs (e.g., language, cultural needs, gender preference, etc.). This model can support sustainable attachment by improving complexity distribution among local primary care clinicians.

During this interim period, the Supported Attachment team coordinates care and navigation support until the patient is formally attached. Supported Attachment is a short-term, point-in-time service designed to help patient attachment to primary care. It does not replace or provide ongoing comprehensive primary care. Patients remain unattached and, for ongoing needs, should continue to access services available to unattached individuals (e.g., walk-in clinics, urgent care, or emergency departments).

Figure 1. Workflow A



Illustrative Examples to Support Application of Guidance

Pre-Match Supported Attachment with Complexity-Informed Matching

While the patient awaits matching and referral a to a new primary care clinician, the Supported Attachment team facilitates the completion of a standard intake form and collects a health history to better understand the patient's needs. Based on this information, the team connects the patient to aligned offerings from OHT member organizations, such as newcomer programs, housing support, and community mental health services.

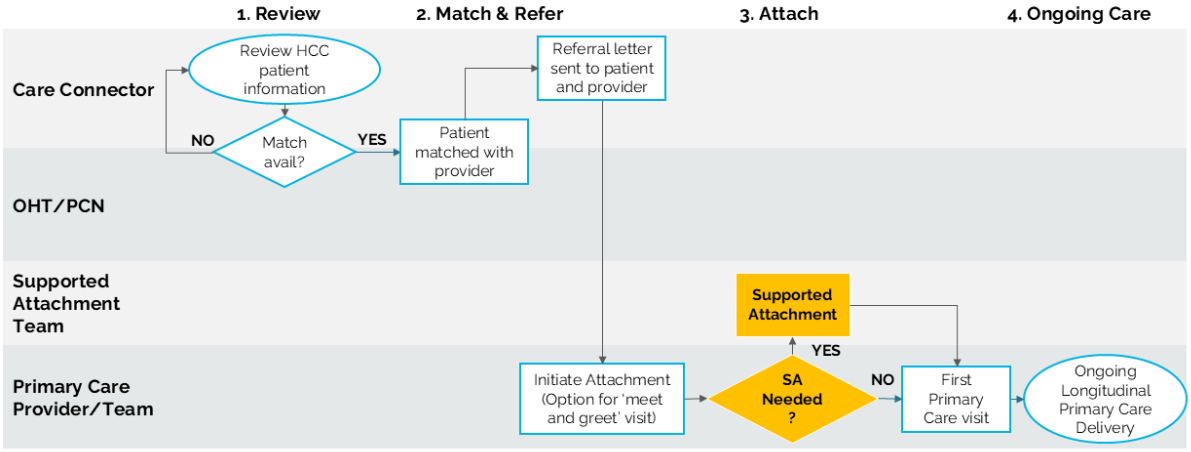
The OHT uses information collected through Supported Attachment to complement the existing HCC matching process, ensuring matches reflect patients' needs and preferences for primary care while balancing the distribution of complex and less complex patients among primary care clinician based on their capacity and preferences.

Workflow B: Supported Attachment After HCC Match and Referral, Before First Visit

In Workflow B, Supported Attachment takes place **after a patient is matched and referred to with a primary care clinician but before their first visit**. The Supported Attachment team may be the first point of contact, depending on local agreements and primary care clinician preferences.

In this workflow, primary care clinicians and teams may help determine which patients would benefit most from Supported Attachment. This model ensures patients are prepared for their initial visit, reduces workload for primary care clinicians, and promotes smooth transitions into care.

Figure 2. Workflow B



Illustrative Examples to Support Application of Guidance

Post-Match Supported Attachment Prior to First Visit

A patient is matched with a primary care clinician based on information available from HCC and a referral is initiated. The Supported Attachment team acts as mobile support, with access to the resources of local clinics being supported (e.g., EMR, clinic space) enabling them to assist with patient onboarding and continuity of care.

As this patient has been on the HCC waitlist for almost three years, the primary care clinician feels that the Supported Attachment program will make it significantly easier to onboard this patient, so they notify the Supported Attachment team. Before the patient's first visit with the primary care clinician, the Supported Attachment team schedules an appointment with the patient for comprehensive onboarding. Information gathered from Supported Attachment is used to populate the patient's EMR and to identify needs that could be addressed within the community. As a result, the primary care clinician's first visit with the patient is an informed and effective discussion, with the primary care clinician able to access up-to-date patient information. Based on the positive experience and level of support provided, the primary care clinician chooses to continue leveraging the Supported Attachment team to onboard additional patients.

General Guidance

Supported Attachment will be implemented and offered at the OHT level, creating a coordinated mechanism to support patient onboarding across the community. It is important to acknowledge that primary care clinicians and teams may already have well-established attachment or patient onboarding processes that are familiar, effective, and responsive to the needs of their patients.

This program is not intended to replace or disrupt existing programs, nor is it mandatory for primary care clinicians who are accepting new patients to engage with the program. Rather, it is offered as an optional service that primary care clinicians or teams may choose to adopt if it complements their current approach and supports their capacity to onboard new patients.

Flexible Implementation Based on Local Needs

OHTs and their PCN clinical leads will need to work closely with their PCNs and primary care community to co-design Supported Attachment pathways and processes and inform associated resourcing decisions that reflect the needs and realities of local primary care clinicians and teams. This includes ensuring that Supported Attachment programs are integrated equitably across participating primary care practices and tailored to support the workflows of primary care clinicians and teams.

Prioritization of Patients on the HCC Waitlist (as of January 1, 2025)

Local Supported Attachment programs should prioritize patients from the HCC waitlist (as of January 1, 2025). OHTs and their PCNs should work collaboratively with the OHT Lead Organization and aligned Care Connector to support planning for patients on the HCC waitlist in the OHT's geography.

To support the province's goal of 100% attachment by 2029, we recognize that OHTs and their PCNs may include unattached patients who are not on the HCC waitlist for entry into their Supported Attachment program based on the health needs of other priority populations in the community. However, when doing so, they should first map out their HCC waitlist and broader attachment needs, prioritizing patients on the HCC waitlist (as of January 1, 2025) to meet 2025/26 attachment targets, and HCC sub-targets for Interprofessional Primary Care Teams, where applicable.

Equity Considerations

This program is designed to also enable OHTs to implement services that address the equity needs of their local populations recognizing that equitable access to primary care is foundational to a high-performing health system. The funding provided through this initiative can support OHTs in responding to barriers faced by First Nations, Inuit, Métis and urban Indigenous (FNIMUI), Francophone communities and other equity-deserving groups, including language, cultural, geographic and systemic challenges.

Equity considerations should inform the planning, design, and rollout of Supported Attachment programs. OHTs and PCNs are encouraged to ensure that Indigenous perspectives are respected and reflected at each stage of the process. OHTs and PCNs are strongly encouraged to work in partnership with local FNIMUI, Francophone, and other equity-deserving communities to co-design attachment programs and services that are culturally safe, linguistically appropriate and responsive to the diverse needs of the populations they serve. This collaborative approach ensures that Supported Attachment programs not only improve access but also foster trust and inclusivity in care delivery. OH regional support can be provided as a resource if needed.

OHTs should actively engage their Patient, Family, and Caregiver councils to ensure that attachment processes are informed by lived experience and reflect the needs, preferences and expectations of the communities they serve. This collaborative approach helps build programs that are patient-centered, fostering stronger relationships between patients and their care teams.

The following considerations offer a starting point for embedding equity into the delivery of Supported Attachment services.

- *Partnering with Indigenous Primary Care Clinicians and Teams:* Where applicable, OHTs and PCNs should collaborate with local Indigenous-led primary care organizations—such as Indigenous Primary Health Care Organizations—to co-design Supported Attachment service pathways that uphold Indigenous models of care and ensure seamless, culturally safe attachment for Indigenous Peoples and communities.
- *Language Accessibility:* Funding may be used to ensure that Supported Attachment is available in languages that reflect the needs of the local population. Additionally, OHTs and PCNs are encouraged to review RISE resources to support planning, design and delivery of services that meet the needs of Francophones.

- *Equity-Focused Training:* OHT implementation funding allocated for equity capacity building should be leveraged to ensure that individuals providing Supported Attachment services are equipped with appropriate knowledge and skills to apply equity-informed approaches. For example, ensuring that those individuals complete Indigenous cultural safety (ICS) training, Indigenous relationship and cultural awareness training, Active Offer of French Language Health Services training, etc.
- *Social Determinants of Health:* To support equity-informed approaches, OHTs may also refer to *Ontario Health's Social Determinants of Health Framework and Resource Guide,* which offers actionable tools and real-world examples for integrating social needs into care planning.

Partnership and System Integration

OHTs are uniquely positioned to lead the implementation of Supported Attachment, having spent the past several years building infrastructure and relationships that support local system integration. Many OHTs have already implemented navigation services at the team level, which are essential for guiding patients through complex care pathways and connecting them to appropriate supports. By integrating these existing services, OHTs can create a coordinated attachment experience that:

- Enhances the patient journey from waitlist to attachment
- Strengthens primary care clinician connections to system supports as patients are onboarded
- Avoids duplication of services, ensuring efficient use of resources
- Maximizes alignment across provincial and local programs

To support this integration, HCC guidance has already been provided to OHTs[1]. These resources are available via OH Regions and should be referenced to ensure attachment processes are aligned, and duplication is avoided (e.g., clarifying the role of system partners, such as Care Connectors, working alongside each other in this space). These materials offer practical direction and examples of best practices on how to coordinate attachment efforts across partners.

[1] Health Care Connect Waitlist Clearing – Guidance for Ontario Health Teams and Primary Care Networks Access to Health Care Connect Patient Information for OHT Lead Organizations

Data Sharing & Privacy Considerations

Supported Attachment programs must be developed and implemented in alignment with Ontario's legislative and regulatory frameworks. This includes compliance with medical-legal accountabilities for regulated health professionals and adherence to the *Personal Health Information Act (PHIPA)* governing the collection, use, and disclosure of personal health information. All OHTs are responsible for implementing safeguards to prevent unauthorized access, use, or disclosure of personal health information. Please see the "Access to Health Care Connect Patient Information for OHT Lead Organizations" guidance (available via OH Regions) for more details.

Sharing of Information to Facilitate Attachment
The sharing of information must rely on secure document exchange methods, such as encrypted email. Efforts should be made to adopt compliant electronic solutions where feasible.

Getting Started

OHTs and PCNs are encouraged to initiate the steps below to implement Supported Attachment in their communities.

Spend Eligibility to Facilitate Timely and Effective Implementation

The primary purpose of this funding is to support staffing to deliver Support Attachment services.

Recognizing that the successful implementation of new or expanded programs often requires initial investments; certain one-time expenses are permitted to support the delivery of high-quality and effective care. These allowable expenses are intended to facilitate the optimal launch and operation of the program.

- Digital enablers such as one-time costs to develop form templates and acquire software to facilitate data collection.
- Translation and interpretation services to facilitate equitable care delivery.
- Start-up costs include laptops, EMR licensing fees, and supplies for the delivery of Supported Attachment services.

- Communications such as printing costs for patient consent forms and materials to promote the Supported Attachment model with patients and primary care clinicians and teams.
- Legal costs associated with establishing data sharing agreements among primary care practices.

OHTs are encouraged to refer to the 2025/26 Transfer Payment Agreement (TPA) Amendment for further details regarding eligible and ineligible expenses. For example, digital enablers or services that duplicate required provincial digital health solutions in functionality or purpose are an ineligible expense.

OHTs are also encouraged to work closely with their OH Regional points of contact to identify potential opportunities to align and/or find cost-savings through group investments across neighbouring teams, and/or sharing of materials/resources (e.g., forms, job descriptions, workflows).

Program Development in Collaboration with Primary Care Clinicians and Teams

OHTs and their PCNs are responsible for co-developing a local Supported Attachment program that aligns with provincial guidance, while being responsive to local context. Development of a local Supported Attachment program may include:

- Communicating broadly to all primary care clinicians and teams about the opportunity.
- Identifying primary care clinicians and teams that have capacity to attach patients who have received Supported Attachment services.
- Via consultation with primary care clinicians and teams, identifying local needs and challenges that Supported Attachment can help to address or mitigate to facilitate ongoing attachment to primary care.
- Determining which complementary components (if any) will be included.
- Developing OHT-specific workflows, which includes determining when Supported Attachment will be initiated (See Figures 1 and 2 in Program Overview).
- Developing or adopting standardized forms.

To accomplish this, OHTs must develop Supported Attachment programs jointly with their PCN clinical leadership and consult with their broader PCN for their input. This will ensure Supported Attachment works best for the local primary care clinicians and teams that will be using the program. OHTs should work with OH Regions to learn from each other on common practices and needs.

Informing Hiring

OHTs and PCNs should leverage information collected through program development to support the shaping of job description(s), in collaboration with the relevant employer, for OHT Supported Attachment roles. Depending on local context, Supported Attachment roles could be adapted for provision by a variety of professionals (e.g., Registered Nurse (RN), Registered Practical Nurse (RPN), Social Worker (SW), Community Health Worker, medical office assistant, etc.). Sample job descriptions are available in the Appendix to support this work.

Alignment of Navigation Supports and Services

OHTs and their PCNs are responsible for system navigation in alignment with their OHT Implementation TPA deliverables. In the context of Supported Attachment, OHTs and their PCNs are responsible for ensuring that any Supported Attachment staff interacting with patients are aware of the OHT and PCN navigation capabilities, including any priority health or social services for which the OHT and PCN are actively providing information to patients.

Program Awareness and Scaling

In addition to consulting with primary care clinicians and teams on the development of the program, OHTs and their PCNs are responsible for raising awareness of their local Supported Attachment program (e.g., with Care Connectors, patients, providers) and supporting primary care clinicians and teams with adoption.

Supports Available

A range of implementation supports are available to help OHTs successfully operationalize the Supported Attachment program. These supports include coaching via OH Regional Points of Contact and provincial support partners associated with the OHT Central Program of Supports. OHTs and their PCNs are encouraged to review the Appendix in this Guidance for key contacts, resources and tools to facilitate their local implementation efforts.

Measuring Impact

Data collection related to the scope and impact of Supported Attachment is a funding requirement for OHTs. Data collection and monitoring is best practice in implementing new models of care; it supports accountability, informs ongoing quality improvement, and enables responsive service design. This section outlines the early data collection plans that OHTs and their PCNs should establish to meet reporting requirements.

Required Data Collection and Reporting

OHTs will be required to report bi-monthly on the following locally collected performance measures:

1. The number of patients who receive Supported Attachment services, distinguishing:
    a. The number of patients on the HCC waitlist who received Supported Attachment services
    b. The number of patients who were not on the HCC waitlist who received Supported Attachment services (if applicable).
2. The number of clinical and non-clinical resources (i.e., staff) hired for the purposes of implementing and advancing Supported Attachment.
3. The number of primary care clinicians and teams accessing Supported Attachment services.

Performance data will be collated, analyzed, and monitored at the provincial level to inform ongoing guidance and program direction, recognizing that initial implementation represents a critical learning period for Supported Attachment services. Reporting start date, template, and process for submission will be communicated to OHTs.

OHTs and their PCNs should begin planning as early as possible to establish the processes, structures, and tools needed to ensure that data is captured at appropriate points, is well-documented, and readily retrievable to support timely, regular reporting and continuous improvement.

OHT TPA – Supported Attachment Reporting Requirements

As a requirement of the OHT TPA amendment, OHTs will be required to report on the following:

- **Supported Attachment Implementation Plan and Budget:** A template will be provided to OHTs to capture key milestones, projected patient volumes, staffing plans, alignment with existing primary care access initiatives and identification of key risks and planned mitigation strategies.
- **Supported Attachment Progress/Year-End Report** and **Financial Expenditure Statements** as part of regular OHT TPA reporting.
- **Performance Metrics** as set out in the TPA amendment and guidance, above.

The OHT TPA Amendment sets out further details, including required information and deadlines. Reporting templates will also be shared with OHTs in advance of reporting due dates.

Appendix

Sample Tools

The sample tools included in this section have been shared with permission from OHTs with Supported Attachment-like services, as of December 2025. These resources are provided for reference and learning purposes. If adopting or adapting any of these tools, please ensure appropriate credit is given to the originating OHT.

OHT Role Description

Primary Care Attachment Liaison Registered Nurse
Mid-West Toronto (MWT) OHT

The MWT-OHT represents a self-organized group of strategically and philosophically aligned community service providers, primary care providers and hospital partners (Our OHT Partners — Mid-West Toronto Ontario Health Team). We share an interest in advancing collaboration and shared accountability for the ~575,000 patients residing in our uniquely urban community and attributed to our network of clinicians.
We believe, if we can design a health care system that works for our most structurally vulnerable populations, then we will be designing a health care system that works for everyone.

Our near-term focus is on improving care coordination and support for marginalized communities who choose to seek services within the Mid-West Toronto region. Our goal is to co-design care with individuals with lived experience to actively remove the systemic barriers that prevent meaningful attachment to primary care, that obscure clear access points to the network of clinicians, and that prevent seamless transitions in care between clinicians.

Embedded in all of the work are the many dedicated primary care providers who work in Mid-West Toronto. The Mid-West Toronto Family Practice Network (MWT-FPN) was established as a non-profit organization that represents the voices of the myriad primary care models practicing in the MWT-OHT region and is leading the planning of primary integration initiatives in the MWT-OHT.

Position Overview/Summary:

We are seeking a highly motivated and equity-driven Registered Nurse (RN) to join the Mid-West Toronto Ontario Health Team Secretariat at Kensington Health. This role will support

the implementation of the newly developed Primary Care Attachment Liaison Model to increase access and attachment to primary care within our community.

In this role, the RN will act as a key clinical point of contact for individuals who have faced barriers to accessing ongoing primary care. The successful candidate will play a central role in facilitating a smooth transition into care by onboarding patients into solo or small practice primary care clinics. The RN will gather health histories, initiate EMR documentation, identify unmet clinical and social needs, and support structurally vulnerable patients as they connect with a new primary care provider.

The successful candidate will have experience working independently across diverse care settings, including small practices or solo clinics, with a focus on connecting patients with appropriate supports. They will have a strong background in program implementation, health system navigation, and applying health equity principles to reduce barriers to care. In this role, the Primary Care Attachment Liaison will navigate unique challenges of small practice settings, including limited administrative support and variable workflows. They will help build processes and foster partnerships across community and primary care sectors to enhance patient access and continuity of care.

This role will be supported by Kensington's strong clinical and community infrastructure including access to a community of practice of nurses across community and ambulatory care settings and a network of health navigators across Kensington. The successful candidate will have a circle of support, collaboration and share learning opportunities across the organization and the OHT.

The Primary Care Attachment Liaison Registered Nurse (RN) will report to the Director overseeing the Health System Planning and Primary Care Transformation team of the MWT-OHT Secretariat and work closely with the Family Practice Network Co-Chairs. This is an exciting opportunity to be part of a new and innovative model of care, aimed at improving how patients are connected to primary care in Mid-West Toronto.

The successful candidate will be part of a collaborative, forward-thinking team and will play a key role in building and shaping this emerging approach. The Primary Care Attachment Liaison will support a welcoming, clinically informed onboarding experience for unattached or newly attached patients, helping to reduce the burden on providers by ensuring key information, screenings, and supports are in place before the patient's first visit. This role is central to the MWT-OHT's sustainable attachment strategy and supports equity-driven initiatives aimed at improving access to care for patients facing systemic barriers, including those with complex medical or social needs.

Responsibilities:

- Work with the Central Intake Team to screen and triage patients, determining eligibility for the Primary Care Attachment Liaison Model and ensuring patients are

directed to the most appropriate pathway (Primary Care Attachment Liaison Model, direct attachment, or interim supports).
- Conduct pre-visit assessments to gather detailed medical history and social determinants of health.
- Initiate the patient's Cumulative Patient Profile (CPP) in the Electronic Medical Record (EMR).
- Onboard patients (including those who are structurally vulnerable who face language barriers or have complex care needs) into solo or small primary care clinics adapting workflows to each clinic's processes and ensuring effective handoff to providers.
- Provide individualized care navigation and referrals to clinical and community services (e.g., cancer screening, chronic disease management, social supports), with a focus on culturally safe and accessible care.
- Act as a liaison between patients and primary care providers, helping to build trust and ensuring patients understand clinic processes and next steps.
- Work closely with the Primary Care Transformation Specialist, primary care physicians, and OHT partners to enable a warm handoff.
- Contribute to the ongoing development, testing and refinement of quality improvement initiatives and the model through opportunity and gap identification, process optimization, data collection, workflow design, evaluation, and scaling.
- With support from OHT colleagues, ensure smooth digital or in-person transfer of patient information.
- Support cross sector partnerships to enhance model adoption sustainability, and scalability across community, primary care, and hospital sectors.
- Demonstrate empathy, professionalism, and clear communication to deliver responsive, respectful, and person-centered service to both doctors and patients.

Required Skills and Abilities:
- Demonstrated ability to translate conceptual models into practice and use quality improvement methodologies (e.g., PDSA cycles) to test, refine, and scale new approaches.
- Ability to perform comprehensive health assessments and exercise clinical judgment in triaging patients based on medical and social complexity and identify immediate care needs.
- Demonstrated ability to collaborate effectively with diverse internal teams and external partners, and community stakeholders.
- Demonstrated commitment to and understanding of equity, anti-racism, and anti-oppression principles and practices is required.
- Detail-oriented with excellent time management and organizational skills.
- Excellent verbal and written communication skills, including accurate and timely documentation.
- Sound judgement in identifying and raising process concerns to management.
- Analytical thinker with the ability to apply structured problem-solving approaches.
- Adaptable, self-motivated, and able to thrive in dynamic or evolving care models.

Required Knowledge and Experience:

- Minimum 2 years of experience in primary care, community health, care coordination, or health system navigation.
- Familiarity with Primary Care Electronic Medical Records (e.g., TELUS PS Suite, OSCAR Pro, Accuro, etc.)
- Excellent understanding of the Ontario health care system, primary care delivery models, and solid understanding of local health issues, priorities and needs.
- Demonstrate experience working independently across diverse care settings including small or solo clinics, with a focus on connecting patients to appropriate supports.
- Strong background in applying health equity principles to reduce barriers to care for structurally vulnerable populations.
- Experience onboarding patients, building workflows and supporting clinic staff in smaller or less-resourced practices.
- Experience supporting process design or program evaluation is considered a strong asset.
- Additional leadership experience or responsibilities will be considered an asset.
- Bilingual or multilingual abilities are considered a strong asset.

Required Professional Designation/Certificate:

- Registered Nurse (RN) in good standing with the College of Nurses of Ontario (CNO).

OHT Role Description

Intake Coordinator

Lanark, Leeds and Grenville OHT

SUMMARY OF JOB:

The overall function of this position is to support the timely and efficient transition of clients to a Primary Care home. They will work with the primary care pilot sites identified across LLG to develop and implement processes which maximize client access to resources both in primary care and social supports.

KEY RESPONSIBILITIES:

Client Transition:

- Utilize a client-and-family-centered approach to care.
- Work with the Leads of the Pilot Primary Care Teams to determine expectations and develop a standard operating procedure for processing new clients which is effective, efficient, and people centered.
- Serve as the contact point in collaboration with the appropriate identified resource in the pilot sites, to advocate and provide resources for all new clients, family, and

community partners to support coordinated transitions in care.
- Gather and document client data and information through chart review and records entry, client interviews, and refer to appropriate resources as appropriate.
- Assess and triage clients to determine complexity and level of support required including social prescribing needs.
- Coordinates the collection of appropriate information to facilitate transitions to a primary care clinician.
- Act as liaison between primary care and community supports.

System support:
- Develops and manages a work plan.
- Minimum monthly meetings to review and refine work plan.

Community Partnerships:
- Establishes alliances and collaborates with appropriate community partners.
- Collaborate to improve systems of care within LLG.
- Documentation of system issues and resolutions, if achieved.

Change Agent Role:
- Manage change in a constructive positive fashion.
- Advocate to improve systems of care and participate in system level change, and client level improvement.
- Proactively promotes change by integrating services with primary health care.

Teamwork
- Incorporate and strengthen collaborative and interdisciplinary teamwork.
- Evidence of broad interdisciplinary approach within LLG OHT interprofessional team and beyond.

COMMON RESPONSIBILITIES:
- Works in a manner that preserves confidentiality and seeks to minimize risk.
- Incorporates and strengthens collaborative and interdisciplinary teamwork.
- Respects and values the diversity of communities and individuals.
- Maintains competence.
- Promotes awareness of and participates in LLG OHT activities.
- Contributes to the work by participating in meetings and committees.
- Participates in the efforts to enhance its capacity through staff development.
- Supports and complies with the Occupational Health and Safety policies and procedures.

Risk Management
- Reducing risk by contributing to a safe workplace.
- Working in a manner that preserves confidentiality.

- Adherence to RCHS policies and procedures and relevant legislation, as well as the standards of practice of regulatory bodies where applicable.

QUALIFICATIONS:

- Member of a Regulated Health Profession.
- Three to five years' experience in a community health setting or primary care setting
- Philosophy and values consistent with client centered approach to care.
- Experience in health system leadership or demonstrated leadership skills an asset.
- Fundamental knowledge of quality improvement.
- Advanced analytical and problem-solving skills.
- Excellent interpersonal, verbal, and written communication skills (interviewing, counselling and facilitation skills).
- Networking and system navigation skills.
- Knowledge and understanding of health system.
- Proficiency with electronic health records and computer skills are essential.

Key Contacts to Support OHTs

OH Regional OHT Leads	• OH North West: Kiirsti.Stilla@ontariohealth.ca • OH North East: Lynne.Kinuthia@ontariohealth.ca and Laura.Boston@ontariohealth.ca • OH West: Jennifer.Peckitt@ontariohealth.ca • OH Toronto: Madeleine.Morgenstern@ontariohealth.ca • OH Central: Amy.Khan@ontariohealth.ca • OH East: Laurel.Hoard@ontariohealth.ca
OH Regional Digital Leads	For OHT digital questions and supports, contact the OH Regional Digital Leads: • OH-Central_DigitalVirtual@ontariohealth.ca • OH-East_DigitalVirtual@ontariohealth.ca • OH-North_DigitalVirtual@ontariohealth.ca • OH-Toronto_DigitalVirtual@ontariohealth.ca • OH-West_DigitalVirtual@ontariohealth.ca
OH Regional Equity Teams	For supports with completion of equity-related deliverables and reporting requirements, contact the OH Equity Leads: • OH East: Denise.Graham@ontariohealth.ca • OH West: OH-West-EIDAR@ontariohealth.ca • OH Central: Trish.Chatterpaul@ontariohealth.ca • OH Toronto: Fatima.ulhaq@ontariohealth.ca • OH North East & North West: Rutendo.Madzima@ontariohealth.ca

OH Regional French Language Service (FLS) Leads	For FLS related questions and supports, contact the OH Regional FLS Leads:
	• OH West:
	  • FLS Lead: Marthe.Dumont@ontariohealth.ca
	  • FLS Planner: Suzy.Doucet-Simard@ontariohealth.ca
	  • FLS Planner: Leila.Beybouchouika@ontariohealth.ca
	• OH Central FLS Lead: Eric.Sona@ontariohealth.ca
	• OH Toronto FLS Lead: Renee.Huntley@ontariohealth.ca
	• OH East FLS Lead: Pascal.Lumbala@ontariohealth.ca
	• OH North:
	  • FLS Lead: Sophie.Lefrancois@ontariohealth.ca
	  • FLS Lead: Angele.Jean@ontariohealth.ca

OHT Central Program of Supports	• **RISE (Rapid-Improvement Support and Exchange)**
	  ○ https://www.mcmasterforum.org/rise
	  ○ rise@mcmaster.ca
	  ○ Provides coaching and customized supports for teams to implement a population health management (PHM) approach and support primary care access and

attachment; supports for shared learning for OHTs across all 8 OHT building blocks and OHT priorities; and hosts the OHT Supports Events Calendar and an OHT Resource Hub.

- **PPEC (Public and Patient Engagement Collaborative)**
  - https://ppe.mcmaster.ca/research/supports-for-ohts/
  - ppec@mcmaster.ca
  - Provides OHTs with coaching, training, tools and resources to support patient, family and caregiver engagement and partnership including the evaluation and measurement of patient, family and caregiver engagement to build capacity on key competencies to advance patient, family and caregiver engagement.
- **HSPN (Health System Performance Network)**
  - https://hspn.ca/evaluation/oht/
  - hspn@utoronto.ca
  - Provides OHTs with expertise and resources to build OHT capacity in evaluation, performance measurement, and data interpretation and application.
- **ALIGN (Advancing Leadership and Integrated Governance Networks)** (formerly the ADVANCE program)
  - https://hspn.ca/advanceoht/
  - Align.oht@gmail.com
  - Provides OHT and PCN leaders with training and coaching on collaborative leadership and integrated governance networks.
- **INSPIRE-PHC (Innovations Strengthening Primary Health Care Research)**
  - https://inspire-phc.org/
  - info@inspire-phc.org
  - Provide primary care research and data support on access and attachment of attributed populations and supports identification of primary care priorities within OHTs.
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- **IPHCC (Indigenous Primary Health Care Council)**
  - https://iphcc.ca/ontario-health-teams/
  - oht@iphcc.ca
  - Provides supports to build OHT capacity to ensure Indigenous inclusion and engagement in the OHT model.

Implementation Resources

The following resources have been curated to support OHTs and PCNs in implementation efforts. They include evidence-informed tools, guides and frameworks designed to facilitate effective planning and program implementation.

- Alliance for Healthier Communities, Toolkit: Interprofessional Primary Care Team Expansion
- Health Commons Solutions Lab, Expanding Access and Attachment to Primary Care
- A Compendium of Roles in Team-Based Primary Care TPC April 2025
- Alliance for Healthier Communities, The Black-Focused Social Prescribing Program: Insights, Impacts, and Recommendations for the Future
- Wellesley Institute, Policy Brief: Barriers and Enablers to Primary Care Access for Equity-Deserving Populations in Ontario
- Ontario Health, Locally Driven Population Health Models 24/25 Impact Report
- Ontario Health, Social Determinants of Health Framework and Resource Guide
- Ontario Health, Preventive Care Program Toolkit FY25–26