Alliance for Healthier Communities
Advancing Health Equity in Ontario

Midtown Kingston Health Home – Kingston Community Health Centres

Over several years, Kingston CHCs (KCHC) has been operating beyond their panel and serving more clients than required according to their funding allotment for provision of access to primary care. The health system in Kingston is working beyond capacity: People are presenting in the Emergency Departments of hospitals within the area have for care that should be delivered in primary care; there is only one walk-in clinic for the whole Kingston area; and practices that have been in place for 20, 30, or even more years are regularly closing due to retirements, resulting in thousands more individuals becoming unattached.

This case study describes how the Midtown Kingston Health Home attaches and provides access to comprehensive, ongoing primary care that is equitable and sustainable.

Midtown Kingston Health Home Model

The Midtown Kingston Health Home has been cited by Jane Philpott as a living example of her Health Home Model. It consists of an entirely new clinic site and a newly hired multi-disciplinary team, community access points, access clinics and expansion of regional programs.

Getting Started

A site of KCHC, the Health Home was created by several partner organizations who came together to co-design a response to the growing population of individuals within the Kingston area who were not attached to primary care (approximately 20,000 individuals). These partners included the City of Kingston, Queen's University, Kingston Community Health Centres, local hospitals, and the Frontenac Lennox & Addington Ontario Health Team. For a few years, KCHC tested multiple population health initiatives, led various access-to-care projects, and exhausted their efforts in trying to meet the health care needs of the unattached population in Kingston.

A New Approach: A Dedicated Clinic with Many Referral Pathways

As the volume of unattached individuals grew beyond the capacity of what the KCHCs' existing sites could handle, it became clear that this approach was unsustainable. Recognizing this, KCHC and their partners developed a new approach: They would build an entirely new clinic and hire a new multi-disciplinary team to staff it, designed for maximal impact on population health through access and attachment to primary care. In many ways, shifting to this new approach solidified the sustainability plans of many of their earlier population health initiatives.

The new clinic is staffed by over 30 individuals. They provide team-based care and roster individuals from Health Care Connect who live within their catchment area, as well as other unattached individuals arriving from various areas within the health care system. This was accomplished through the establishment of formal partnerships and referral pathways between KCHC and key pressure points within the health care system (see figure 1).

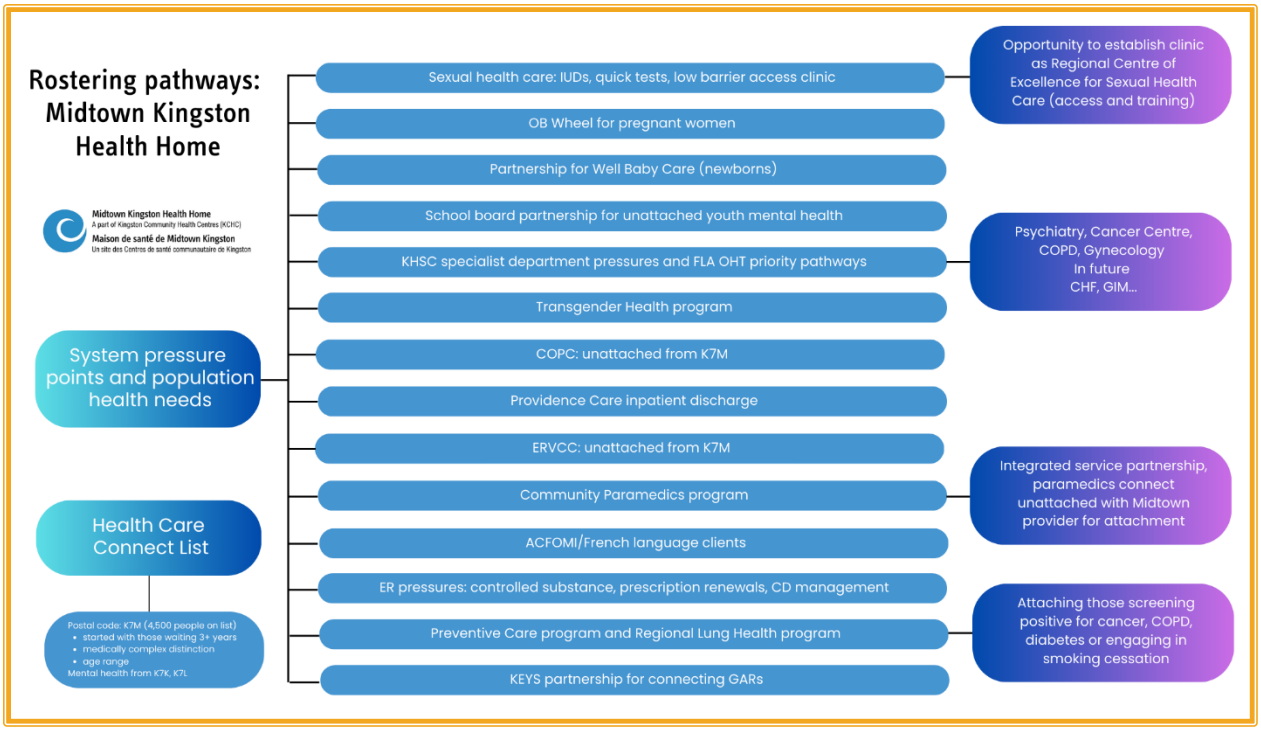

Figure 1. Rostering Pathways
Click image to access an enlarged and accessible PDF.

These pathways were intentionally created as an easy way for partners to redirect and refer people for attachment to primary care. For example, when an unattached person goes to hospital for COPD, it may be determined that their needs could be better met through connection to ongoing primary care. If they live in the relevant geographical area, the hospital will send a fax to the Midtown Kingston Health Home when they discharge the person, referring them for primary care attachment. In less than 7 months, over ten such rostering pathways have been formalized, including speciality departments in hospitals – such as psychiatry, gynecology, and cancer care – that were previously bottlenecked by having to provide primary care services.

Extending the Reach of the Health Home

Like all CHCs, KCHC has extensive partnerships with other community organizations. This has enabled them to extend the reach of the new clinic by sending some of the clinic's funded staff to provide on-site primary care where these partner organizations are located. This is particularly important in areas with a disproportionately high number of marginalized people. For example, some of the clinic's providers deliver primary care at youth shelters; others participate in PORCH, a program in which an outreach vehicle is driven to areas of high need to provide care.

The model also includes low-barrier access clinics open to various unattached populations within the region. People who access these clinics receive primary care to address general health needs, such as reproductive and sexual health, well baby care, and support for smoking cessation.

Finally, KCHC was able to leverage new clinic staff to increase the capacity of their existing regional programs focused on Transgender Health and Respiratory Rehab as examples.

Impact

A shared goal of providing meaningful attachment has been the grounding principle and philosophy of the Health Home team and model, and KCHC has been able to achieve it by leveraging processes, procedures and infrastructure that already existed at the CHC.

> There are differing opinions around the access clinics as a band-aid solution to care, but we stand behind it.
>
> So many people have been so thankful just to have access to primary care and knew it was inappropriate to be going to the hospital, but they were left with no other choice.
>
> Creating these access clinics plus attachment has led to the biggest impact – we're serving the largest number of people this way and are trying to have the biggest impact in the community by improving population health outcomes.
>
> – Meghan O'Leary, Director, Clinical Services, Kingston Community Health Centres

Within three months of receiving funding, they set up an entirely new clinic. It began operating with only a few new staff on board; the majority were hired later, in a staggered fashion, due to the ongoing human health resource crisis. By the end of February 2025, seven months after opening its doors, the Health Home team had already recorded 13,377 encounters with 3,742 unique clients. More than 1,700 previously unattached people are now attached to and actively receiving ongoing primary care there.