Alliance for Healthier Communities
Advancing Health Equity in Ontario

Addition of Link Workers to the Health Team Improves Attachment and Access to Care

Link workers play a key role in the primary health care team, by spending time with clients to hear their needs and understand their interests. They shift the focus from "what's the matter with you?" to "what matters to you?". They take a holistic, community-focused, and evidence-based approach to people's health and wellbeing to connect them to appropriate community groups, services and supports. This approach ensures that clients get the care they need and ultimately frees up time for primary care providers to see clients that need clinical services.

Link workers connect clients to non-clinical programs or services that support their health and wellbeing. Examples include seniors programming, food security, transportation, physical activity, access to technology, social opportunities and volunteering.

Case Study: Woolwich Community Health Centre (CHC)

Woolwich CHC was founded in 1985 to serve a rural community lacking local health services. Woolwich CHC has three locations in St. Jacobs, Wellesley, and Linwood, which supports their rural community members.

At Woolwich CHC, having a full-time staff member in the link worker role has been an essential part of increasing access for the large number of newly attached clients. At intake, nurses assess clients' clinical and non-clinical needs such as food insecurity or social isolation. If non-clinical needs are identified, clients are immediately referred to the team's link worker to address these needs while waiting to connect with their primary care provider. At intake, 95% of clients referred to a link worker meet with them before seeing their primary care provider. Through this approach, clients also build trust with the team and gain a better understanding of the CHC's wider supports beyond primary care appointments.

Social prescribing, as offered by the link worker, is available to anyone living within the Townships of Woolwich, Wellesley, and Wilmot. It is not limited to rostered CHC clients and ultimately supports attachment by building trust within the primary care system and/or supporting clients to become attached to primary care. Social prescriptions might look like:

- Connecting with the local food bank
- Learning more about social activities and volunteer opportunities in your community
- Referrals to additional health care services such as dietitians, or mental health counsellors
- Assistance with completing forms for things such as Ontario Works or Canada Pension Plans
- Connecting with transportation assistance for medical appointments or recreational needs
- And more

The link worker can support clients in connecting with specific services in the community or existing programs at the CHC. This saves time for the primary care team. In 2025, 39% of Woolwich CHC's referrals were to support social isolation, 17% were for seniors supports in the home, 17% were to support completing applications for government services, and 15% were for rural transportation support.

Case Study: Harrow Health Centre Family Health Team (FHT)

Harrow Health Centre FHT serves the rural communities of Harrow and southern Essex County and also has a full-time link worker on staff. After analyzing EMR data, the team found that high-frequency primary care clients had fewer appointments with their primary care provider within 12 months of connecting with the link worker. Non-clinical needs that previously would have been brought to their physician were being addressed by the link worker, increasing the teams overall efficiency.

Link Worker Evidence

- Primary care providers with a full-time link worker on staff were more likely to report that clients were booking fewer primary care appointments because their non-clinical needs were being addressed through the link worker
- A 2018 evaluation revealed that health care providers suggested having a link worker decreased the number of repeat visits for clients by 42%
- A 2023 evaluation indicated that 96% of health providers strongly agreed or agreed that collaborating with social prescribing staff is helpful for supporting their clients
- 96% of clients felt that a link worker heard their needs and interests very well or somewhat well when they were first connected to community programs