Alliance for Healthier Communities
Advancing Health Equity in Ontario

Promising Practices to Support Equitable Access and Attachment to Primary Health Care for Uncertainly Attached and At-Risk Populations

This summary focuses on ongoing initiatives and practices that primary health care organizations in Ontario are using to:

- Make primary health care services more accessible for unattached and at-risk populations,
- Divert individuals from unattached and at-risk populations from emergency departments by making urgent and episodic care accessible in other settings, and
- Support equitable attachment of new clients to ongoing primary care in an interprofessional primary health care setting.

1. Overview of the promising practices

The Government of Ontario has set an ambitious target of ensuring that everyone living in the province will be attached to a primary care provider or team by 2030. Many of the 118 organizations that make up the Alliance for Healthier Communities are working towards this goal by increasing their operational capacity, identifying and connecting with unattached individuals in their communities, and enrolling them as ongoing primary care clients.

A key theme throughout this document, which is echoed extensively in Chapters 5 and 6 of the Toolkit, is the importance of connecting and collaborating deeply with other health and social care organizations in the community to create local systems of care. To meaningfully attach such a large number of new clients while honouring their commitment to health equity, members are undertaking community outreach, establishing low-barrier health clinics for special populations, and developing equitable intake processes. Many of them are partnering with other health and social care organizations in their communities to develop "Neighbourhood Health Homes" – connected networks that support

collaboration, care coordination, and system navigation across organizational and sectoral boundaries.

The practices described in this summary are all published on the Alliance for Healthier Communities website, in our Toolkit for Improving Access and Attachment to Primary Care[1]. They are listed in Table 1, below.

Organization	Description
Flemingdon Health Centre	• Neighbourhood Health Home (lead organization) • Centralized intake and triage • Holistic Intake & Navigation Counsellors • Community health hub
WellFort Community Health Services	• Neighbourhood Health Home (lead organization) • Centralized intake and triage
Chatham-Kent Community Health Centre & Chatham-Kent Ontario Health Team	• Low-barrier population health clinic • Mobile population health clinic
CMHA Durham	• Shelter-based population health clinic
Norwest Community Health Centres	• Mobile population health clinic
Thames Valley Family Health Team	• Low-barrier population health clinic • Community health hub • Local capacity-building partnerships
Grand River Community Health Centre	• Low-barrier population health clinic
Windsor-Essex Community Health Centre	• Drop-in screening event with attachment pathway
Seaway Valley Community Health Centre	• Drop-in screening event with attachment pathway

Table 1: List of promising practices described in this summary

2. Coordinating Care: The Neighbourhood Health Home and Centralized Intake

The Neighbourhood Health Home describes a vision for supportive, collaborative primary health care that reaches beyond the doors of a single organization, creating partnerships and integrating health and social care in networks that cover entire communities. In some cases, this community may be geographically determined; in others, it may refer to a population, such as Francophone, Black, or 2SLGBTQ+, that is spread across multiple regions. This vision was first shared with our members, system partners, and primary health care providers in early 2025, but it was grounded in

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work that our members have been doing for over 50 years – only on a larger scale. The neighbourhood health homes described below were already nascent before the term was coined.

2.1 The Thorncliffe Park Community Hub | Flemingdon Health Centre, Toronto, ON

The Thorncliffe Park Community Hub (TPCH), in northeast Toronto, opened in 2025. Co-led by the Flemingdon Health Centre (FHC) and The Neighbourhood Organization (TNO), The Hub is a community-driven initiative that provides a wide array of community, social, and health services. It is housed in a space contributed by the United Way and includes other partner organizations such as Michael Garron Hospital. Every day, more than 3000 people have local access to integrated primary health care, dental services, midwifery services, legal aid, childcare, language classes, homework help, and more.[2]

Although the partner organizations are co-located within the Hub, the organizations did not need to merge to offer seamless, integrated care. When clients enter the facility, they may encounter staff from FHC, TNO, or even the Michael Garron Hospital. A consistent HATP logo and "look and feel" visually erase the distinctions between the organizations, and linked health records ensure that clients will not have to re-tell their stories to multiple providers.

To learn more about this initiative, check out this interview with FHC's CEO Jen Quinlan, which was recorded for the *Community Matters* podcast hosted by the Canadian Association of Community Health Centres, and this Transformative Change Award video.

2.2 Primary Care Neighbourhood Network with Centralized Intake and Triage | WellFort Community Health Services, Peel Region and North Etobicoke, ON

The Primary Care Neighbourhood Network, envisioned and established by WellFort Community Health Services (CHS) and its partners, increased attachment and access to primary care for over 3600 patients in just its first three months and has continued to attach new clients at a similar rate since then.[3] Nine primary care organizations are partners in this project, with WellFort CHS providing backbone support.

The network began with coordinated sharing of resources, including interprofessional support for primary care providers in the community. This approach ensures that people who receive primary care from a solo provider can easily access interprofessional care while maintaining their trusted patient-provider relationship. This reduces administrative burden for primary care providers, enabling them to roster additional patients, increasing the system's capacity to attach people to primary care.

With so many partners providing care, a central coordinating body becomes essential. WellFort CHS drew on its existing expertise to take on that responsibility, supporting access to both clinical

[2] A case study of this Community Hub is currently underway. Cumulative access and attachment numbers will be available on the Alliance website when it is completed.
[3] A new case study of this Neighbourhood Network is currently underway. Updated attachment numbers will be available on the Alliance website when it is completed.

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and social care. The centralized intake process includes a single point of contact, where clients are assessed and a care plan is developed, including mental health supports through the Canadian Mental Health Association, and navigation to primary care if needed.

As the central fundholder for the project, WellFort CHC provides backbone supports for other members of the network, including the hiring of interprofessional staff for physician groups; coordination of professional development; oversight of policies and practices; and support for the Electronic Medical Record (EMR) systems and other IT infrastructure.

This case study describes the Neighborhood Network in more detail. This slide deck provides details of the central intake process and illustrates how it ensures that newly enrolled clients are equitably distributed among the partner organizations.

2.3 Tools for Building Your Neighbourhood Health Home

Partnership Agreements

It is recommended that when an organization is planning to build a neighbourhood health home, they express this vision right from the start, identifying local partners and inviting their participation in the initial expression of interest (EOI) for funding for IPCT Expansion, and that they continue to document and formalize the partnership in writing as they implement the vision. The Alliance has created tools to support this. They can be found Chapter 5 of our toolkit. These tools include templates for letters of support from partners and clinicians to be included in a funding application, templates for partner agreements and purchase-of-service agreements, and videos that present practical guidance for organizations applying for IPCT expansion funding to build a neighbourhood health home.

Link Workers

A key element of the Neighbourhood Health Home is the link worker. Often associated with social prescribing, link workers support clients to improve their health and wellbeing by connecting them to nonmedical, community-based supports and services. They can help coordinate care among partner organizations in diverse health and social care organizations, allowing physicians, nurse practitioners, and their teams to focus on medical care while ensuring their clients get support for social and practical issues affecting their health.

- The Alliance has created a Link Worker Job Description Template to help you recruit a link worker to your team.
- This short report created by the Alliance outlines the evidence for the impact of link workers on community and individual health.
- This position statement outlines the case for including link workers in every neighbourhood health home. Consider drawing from it when advocating for funding to build your capacity for attachment.

Social Prescribing

Since long before the full NHH vision was articulated, the Alliance and its members and partners have been working to create more seamless and integrated systems of care in communities across Ontario. Social Prescribing is one way this work can be formalized. It is a holistic approach to health care that brings together the social and medical models of health and wellbeing, providing a

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formal pathway for health providers to address the diverse determinants of health. Each "prescription" is co-designed with the client to create a suite of supports tailored to their goals, needs, and gifts.

Social prescribing also facilitates partnerships between health and social care agencies and supports equitable, meaningful attachment to primary care Screening clients for social needs at intake is an effective way to ensure they are connected with holistic health supports beyond primary care. Taking the burden of navigating social care away from clinical providers also frees up their time to attach more patients. If your organization is not yet ready to collaborate at the level of a neighbourhood health home, consider implementing a social prescribing program to start building your local network.

3. Finding and Serving the Unattached: Population Health Clinics, Community Outreach, and Community Access Points

To ensure that the attachment of new clients to primary care is done equitably, many organizations are working with their partners to reach people with complex health and social needs who face the steepest barriers to accessing care. Some of these efforts move people quickly towards ongoing attachment, while others are focused on addressing immediate needs while building trusted relationships with people who may not be ready for attachment. When the capacity to attach new patients has been delayed by logistical challenges, such as space shortages or clinical vacancies, organizations have worked together to provide timely care and system navigation while establishing the groundwork for formal attachment later. In each case, the work is dependent on deep collaboration among local health and social care partners.

3.1 Community access clinics and community-based link workers | Flemingdon Health Centre, Toronto, ON

In addition to the development of a community health hub, described in Section 2, Flemingdon Health Centre has also established three Access Clinics, located at Health Access Thorncliffe Park, the Flemingdon Health Centre, and Michael Garron Hospital, where both attached and unattached community members can access the following supports:

- Interim care from a family doctor
- Help in finding ongoing support with a permanent family doctor
- Cancer screening
- Vaccination
- Connections to social supports such as settlement, housing, food security, and employment
- Access to other health care services, including dental care and optometry.

Holistic Intake and Navigation Counsellors (HINCs) are community members employed at each access point to help establish personalized connections between clients and primary care providers. They act as specialized link workers, supporting attachment to care by providing culturally sensitive services, including client intake, waitlist management, and orientation. Key duties include:

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- Maintaining documentation
- Triaging calls
- Coordinating referrals
- Helping to develop personalized care plans
- Peer crisis counselling
- Collaborating with service providers to streamline care
- Contributing to outreach, advocacy, and local community events

3.2 Community access point and mobile population health clinic | Chatham Kent CHC, and Chatham-Kent OHT, Chatham and area, ON

In 2024, the Chatham-Kent Ontario Health Team (CHOHT) launched two initiatives to meet the primary care needs of unattached residents, address the region's high need for chronic disease management, and support people living with low incomes.

- BridgeCare is a weekend walk-in primary care clinic serving people in the community who are waiting to be attached to primary care. Between April 2024 and July 2026, over 3000 unattached people received primary health care services from BridgeCare. A second location has now opened, and services have been expended to include cervical cancer screening and follow-up care.
- MobileCare is walk-in clinic on wheels that provides barrier-free access to primary care and care for mental health and addictions. Between April 2024 and July 2026, more than 2500 received services from MobileCare.

BridgeCare and MobileCare have relieved pressure on the local hospital and have created options for referral pathways after hospital discharge. Chatham-Kent Community Health Centre (CKCHC), one of the CKOHT partners, has been able to access more resources for attaching high-needs clients, and the OHT has been able to provide a greater focus on providing primary care as well as care for mental health and addictions to underserved community members.

In addition to being part of the BridgeCare and MobileCare initiatives, CKCHC operates First Five preventative health promotion services for children aged 0-5 who do not have access to a primary care provider, regardless of OHIP coverage.

3.2.1 Population health clinic in a shelter setting | CMHA Durham, Durham, ON

The Mission United Program in Durham Region is a centralized, low-barrier health hub that offers integrated primary health care, mental health supports, crisis counselling, housing, and addiction services. It also serves as a rest centre where individuals can receive a daily meal between 10 a.m. and 1 p.m. It receives backbone support from CMHA Durham and is housed at the Back Door Mission. Numerous other social care agencies also offer services at the hub.

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In spring 2026, the hub strengthened its model with the addition of the CMHA Durham HART Hub, where people can access primary care, mental health and addictions services, case management for income support and social supports, supportive housing, and Indigenous services.

In 2025-26, the program supported 1,174 with 13,755 visits, serving 316 new patients with complex mental health and chronic health needs. Clients receive specialized primary care, mental health and addictions services, case management for income support and social supports, supportive housing, and Indigenous services. 19 street-involved palliative clients received specialized care, supporting comfort and dignity. Nearly 600 emergency department visits were avoided, and nearly 300 vulnerable clients entered long-term addictions treatment.

- In 2025, The Mission United Program received a Transformative Change Award from the Alliance for Healthier Communities for this work; watch their award video here to learn more about the program.

3.3 Mobile population health clinic | NorWest CHC, Thunder Bay, ON

The Care Bus is a low-barrier transportation service and mobile service hub in Thunder Bay, spearheaded by NorWest Community Health Centres in partnership with the Ontario Native Women's Association, Lutheran Community Care, and Team DEK. In addition to these formal partnerships, this program has helped NorWest build collaborative relationships with nine organizations at regular CareBus stops.

The focus of CareBus is to extend supports to unattached or uncertainly attached people in the community, particularly those experiencing homelessness or housing precarity, and to make it easier for them to access care and resources from local agencies. In addition to free transportation and a place to warm up, riders get a snack or a meal and may access winter clothing, harm reduction supplies, personal care products, health education, and referrals to health care, social services, and addictions care. The CareBus is staffed by individuals with lived experience, which helps to make it one of the most vital winter services in the community.

In 2025-26, the Care Bus served nearly 14,000 clients and connected 335 people to health or social care organizations.

- The Care Bus received a 2025 Transformative Change Award from the Alliance for Healthier Communities. Watch their award video here learn more about the program.
- This report describes the program and its impact in 2025-26 in more detail.

3.4 Population health clinic and community access point | Thames Valley FHT and partners, London and Elgin County, ON

Thames Valley Family Health Team (TVFHT) has expanded its services and group programs in a shift towards a population-health model based on deeper integration with community partners. This case study describes how TVFHT's two Interprofessional Primary Care Team (IPCT) projects are facilitating access and attachment to team-based primary health care for individuals living within City of London and nearby Elgin County.

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London: Health & Homelessness

In London, TVFHT has expanded primary care access for people experiencing homelessness through its participation in Health & Homelessness along with the London InterCommunity Health Centre (LIHC) and other local partners. Health & Homelessness provides low-barrier access to primary care and system navigation services, including:

- Care for acute and chronic illnesses
- Preventative health screening, immunizations, and vaccines
- Foot and wound care
- Medication and injection help
- Diagnostic test orders and lab collection (blood & urine)
- Women's health and family planning
- Connections to dental care and optometry services
- Accompanied travel to medical appointments
- Help with government forms

Several social care organizations are also partners in this program and provide additional supports.

Elgin County: Community Health Hub

In Elgin County, TVFHT operates a Community Health Hub. It opened in September 2024 and had served over 5600 unattached individuals by March 2025.

Planning is underway to recruit clinical and interprofessional providers so they these clients can be attached to ongoing primary care. In the meantime, unattached community members can visit the Hub to access:

- Episodic care for illnesses and injuries
- Chronic disease management support
- Prenatal care

TVFHT has also partnered with other local health care providers to create more seamless, coordinated care. They helped with recruitment and funding of new staff for Central CHC's mobile healthcare clinic, created a direct referral and attachment pathway from the St. Thomas - Elgin General Hospital for unattached people visiting the Emergency Department for primary care services, and established partnerships with pharmacies in Elgin who can provide low-barrier care for minor ailments.

3.5 Population health clinic for newcomers | Grand River CHC, Brantford, ON

The Grand River Community Health Centre (GRCHC) created a new Interprofessional Primary Care Team (IPCT) in 2024 to address several intersecting areas of need. The community has high rates of unattachment to primary care, particularly among newcomers and people affected by low income and/or housing instability and newcomers. It also has higher-than-average rates of mental illness and other chronic conditions.

The new team worked with partner agencies in health and social care to assess gaps in the regional health system. Based on what they learned, the IPCT launched two specialized primary care

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clinics: an outreach clinic for people who are homeless or precariously housed, and a population health clinic tailored to newcomers. Partnering with other agencies, they conducted outreach through physical and social media. In its first year, the new team saw:

- 596 individuals newly attached to a nurse practitioner or family physician
- 54,029 individual primary health care encounters
- 14,816 participants in group programs.

3.6 Outreach: Pop-up population health clinics for sexual health screening | Windsor-Essex CHC, Leamington, ON

In October and November of 2025 and in January of 2026, the Leamington Site of the Windsor-Essex Community Health Centre (weCHC) worked with local partner agencies to hold three screening and diagnostic care events that resulted in 250 new clients being attached to primary care.

The events were focused on new clients, migrant workers, refugees, and other community members facing significant barriers to care. Participants received vaccinations and diagnostic screenings, including pap tests, mammograms, and bloodwork; colon screening kits were also distributed. Some also received preventative dental cleaning or new winter coats. These services were provided by the CHC and other community organizations, including the Migrant Worker Community Program, Smile Wagon, Med Labs of Windsor, and LifeLabs.

For more details about these events and their impact, check out these handouts from Windsor-Essex CHC:

- Women's Health Event – October 2025
- Men's Health Event – November 2025
- Women's Health Event – January 2026

3.7 Outreach: Pop-up population health clinics for heart health screening | Seaway Valley CHC, Cornwall, ON

Since July 2025, Seaway Valley Community Health Centre (SVCHC), located in Cornwall, ON, has been holding free pop-up hearth health screening events for individuals on their waitlist for primary care. This is being done in partnership with the Ottawa Heart Institute (OHI) as part of the OHI's "One Million Canadian Hearts"[4] campaign, along with other community partners. Without primary care partners, OHI would not be able to do this screening.

The program was initially focused on heart-valve screening for people over 65 – a routine test that is often missed when people are not attached to a primary care provider or team. With funding support from local sponsors, including two Rotary clubs, the program has now expanded to serve people aged 40-64, with events taking place in several underserved locations. Screenings include a brief health assessment, blood pressure check, and rapid blood test. Participants receive personalized results and recommendations on-site. Those whose test results indicate a need for

[4] French: https://www.ottawaheart.ca/fr/1mcoeurs

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timely follow-up also receive specialist referrals, system navigation support, and fast-tracked intake into primary care.

So far, 204 people have participated in heart-health screenings hosted by SVCHC. About 60% of them were previously unattached to primary care and have since been attached to the CHC. Some participants have also been referred to other programs at SVCHC, including lung health, stress management, dietitian support, and Heart Healthy Eating, as well as the Diabetes Education program at their nearby sister CHC, Centre de santé communautaire de l'Estrie.

SVCHC and the One Million Canadian Hearts campaign are working together to spread this model of outreach to more of their region, including rural and Indigenous communities. SVCHC has also offered to take on anyone not currently attached to primary care who attends a clinic in their region and requires follow-up care, even if SVCHC is not the event host.

4. Finding the unattached: Other ways Alliance members are reaching out to their communities

Not every initiative to reach unattached clients requires the creation of a new team or facility. Some Alliance members have been able to increase their operational capacity and take on more primary care clients in their regular clinic practices. They have successfully recruited new patients with targeted outreach, including:

- Advertisements in community movie theatres, on local/multicultural radio stations
- Flyers in neighbouring apartment buildings
- Promotional materials in places of worship, cafes, barbershops, and other places where people gather
- Interactive kiosks in community malls
- Participation in community events, such as Pride and Christmas parades

In order to ensure these efforts reach those who experience barriers to accessing care, organizations work with local community leaders to identify locations and events where people gather and to ensure that materials are culturally safe and linguistically appropriate.

5. Looking ahead: Supports from the Alliance for continued learning, scale, and spread

In addition to the Access & Attachment toolkit described here, the Alliance has been providing a variety of other supports to help our members improve operational efficiency, increase capacity, and expand access and – ultimately - attachment to primary health care. These include:

- Year-long learning collaboratives focused on focused on implementing better intake processes to facilitate rapid attachment (concluded Spring 2026) and increasing primary care capacity by improving operational efficiency (concluded Fall 2024).
- Ongoing one-on-one quality improvement and implementation coaching.
- A community of practice for organizations who have received IPCT Expansion funding.

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- Multiple ongoing supports for implementing and improving social prescribing: a learning collective, an online course, tailored coaching, two communities of practice, and annual in-person learning events.
- Educational webinars
- E-newsletters

Now that our two learning collaboratives about access and attachment have concluded, we are working with the participating teams to learn more about the successful change ideas that are ready for scale and spread, such as:

- Conducting group intake and orientation sessions
- Developing centralized intake processes for multi-site organizations
- Involving interprofessional health care providers in the intake process
- Using secure portals to complete forms and pre-populate patient profiles
- Implementing digital health solutions for waitlist management
- Using empty appointment slots to see people with urgent issues
- Addressing root causes of staff turnover

Some of these have already been shared at our annual conference and in our communities of practice. Over the summer, we will gather the stories, learnings, and attachment data, and we will use them to create an evidence-informed Rapid Action Learning Intensive (RALI). RALI is a self-paced, coach-supported learning model used by the Alliance to help our members adapt and implement the processes developed and tested in our learning collaboratives and pilots.

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