



THEME AWARD:

High-Functioning Teams: Building Capacity for
Attachment, Access & Care Delivery

Organization	Initiative	Contact Information
Central Lambton Family Health Team	Lambton & Huron Primary Care Collaborative	Hannele Kivinen
Ancient Rivers Family Health Team	Accelerating Attachment Through Team-Based Onboarding Processes	Kate Jones Executive Director kjones@arfht.ca
City of Kawartha Lakes Family Health Team	Patient Attachment Innovation, City of Kawartha Lakes Family Health Team	Mike Perry Executive Director m.perry@cckfamilyhealthteam.com
Peterborough Family Health Team	Connect Clinic	Amber Brown Patient Services Supervisor amber.brown@peterboroughfht.com
City of Lakes Family Health Team	It Takes a Team: Advancing Attachment Through Supported Attachment Clinics	Meghan Peters Executive Director mpeters@yourfamilyhealthteam.com
Georgian Nurse Practitioner-Led Clinic	MSK Program	Kevin MacLeod Executive Director Kevin.MacLeod@GeorgianNPLC.ca
Central Lambton Family Health Team: Jaimelynn Smith, Beth	Rural Access to Care Clinic	Sarah Milner Executive Director sarah.milner@clfht.com

Machan, Linda Kremer, Tori Shaw		
The Eastern Ottawa Community Family Health Team	Social Prescribing for the Social Determinants of Health	Natasha Beaudin natasha.beaudin@allianceon.org
The St. Michael's Academic Family Health Team	Home Visiting Program	Abbas Ghavam-Rassoul



THEME AWARD: High-Functioning Teams: Building Capacity for Attachment, Access & Care Delivery

NOMINEE(S): Central Lambton Family Health Team

ORGANIZATION: Central Lambton Family Health Team

INITIATIVE: Lambton & Huron Primary Care Collaborative

AT A GLANCE

Five primary care organizations decided not to solve the same problems five different ways. The Lambton & Huron Primary Care Collaborative is redesigning workflows and testing AI-enabled tools together, building shared capacity to tackle attachment, administrative burden and workforce pressure across the region.

THE OPPORTUNITY

Since February 2026, five primary care organizations across Lambton and Huron Counties have come together to address one of the most significant challenges facing healthcare today: improving access to primary care while maintaining high-quality, continuous care for existing patients. Led by Family Health Teams and Community Health Centres serving rural and regional populations, this collaborative initiative has brought together clinicians, operational leaders, Ontario Health Team partners, and Amplify Care to identify shared barriers to patient attachment, optimize clinic capacity, and redesign workflows through innovative digital solutions. Rather than tackling challenges independently, participating organizations worked collectively to identify common issues, share leading practices, and evaluate AI-enabled tools capable of reducing administrative burden and creating additional capacity for patient care. The initiative leveraged the expertise of Amplify Care, a not-for-profit organization specializing in digital health adoption, workflow redesign, and change management, to support the practical integration of AI into clinical operations. By combining

collaboration, digital innovation, and implementation expertise, the initiative is advancing patient attachment, provider experience, and health system sustainability while creating a model that can be replicated in other regions.

WHAT WE DID

Participating organizations recognized growing pressures related to patient attachment, increasing demand for primary care services, workforce constraints, and administrative burden affecting clinicians and care teams. To address these needs, leaders from Family Health Teams, Community Health Centres, Ontario Health Teams, and Amplify Care established a regional collaborative focused on improving clinic capacity and strengthening patient access. The initiative engaged physicians, nurse practitioners, nurses, executive directors, CEOs, quality improvement specialists, information technology partners, and Ontario Health Team leadership in a structured co-design process.

- Examined common barriers to patient attachment, intake processes, and continuity of care.
- Identified workflow inefficiencies contributing to administrative burden and capacity limitations.
- Explored innovative approaches to redesigning care delivery processes. Recognizing that successful technology adoption requires more than simply introducing new tools, participating organizations partnered with Amplify Care to provide expertise in digital health adoption, workflow optimization, implementation planning, and change management.

Amplify Care supported teams in evaluating how emerging AI technologies could be integrated into existing clinical workflows in ways that were practical, sustainable, and clinician-centred. Together, participants introduced and tested three AI-enabled solutions. The focus was on AI Reception & Triage where local clinical expertise was combined with implementation and digital transformation support,

The initiative directly responded to community needs by identifying ways to increase care capacity, improve patient attachment processes, reduce administrative workload, and strengthen continuity of care.

THE IMPACT

While the initiative remains ongoing, early evidence demonstrates meaningful progress in strengthening collaboration, accelerating innovation, and identifying opportunities to improve access and capacity within primary care. This includes:

- Strong engagement from participating Family Health Teams, Community Health Centres, Ontario Health Team partners, and Amplify Care.
- Establishment of a regional learning collaborative focused on shared solutions to patient attachment and capacity challenges.
- Increased collaboration among organizations that historically addressed operational challenges independently.
- Positive feedback from participating clinicians and operational leaders regarding opportunities to streamline workflows and reduce administrative burden.
- Greater awareness and understanding of how AI-enabled solutions can support care delivery and clinic operations.
- Increased organizational readiness to evaluate and implement innovative solutions while reducing the risks often associated with introducing new technologies.
- Improved access to actionable information for clinicians and care teams.
- Streamlined intake, triage, and administrative workflows.
- More support for efficient patient attachment processes.
- Enhanced care coordination and continuity for patients with complex needs.
- Created additional capacity within existing resources.

SUSTAINING AND ADVANCING THE WORK

Sustainability has been built into the initiative through ongoing collaboration, shared learning and continuous improvement. Participating organizations continue to evaluate results, refine AI-enabled workflows and share implementation lessons, while building internal capacity for digital innovation and workflow redesign.

The collaborative has also established lasting relationships among clinicians, operational leaders and system partners that support continued innovation and broader adoption. With support from Amplify Care, participating teams are moving from pilot testing toward sustainable implementation while ensuring solutions remain grounded in clinical workflows and organizational priorities.

WHAT OTHERS CAN LEARN

This initiative provides a practical and transferable model for primary care organizations looking to increase capacity and adopt digital innovation. Key lessons include how to identify shared operational challenges, evaluate AI-enabled solutions, integrate new tools into existing workflows, engage clinicians in change, and balance innovation with operational and workforce realities.

The partnership with Amplify Care also demonstrates how external digital health and implementation expertise can accelerate adoption and strengthen internal capacity without requiring significant new infrastructure or resources.

SPREAD / KNOWLEDGE SHARING

Knowledge sharing has been central to the initiative. Participating organizations are sharing implementation experiences, resources and emerging findings through peer-learning sessions, collaborative forums and educational presentations focused on patient attachment, capacity, workflow redesign and AI-enabled innovation.

Partnerships with Ontario Health Team leaders and Amplify Care extend this learning beyond participating organizations and create opportunities to replicate successful approaches across primary care. Amplify Care's broader digital health networks and implementation expertise further support the spread of emerging practices across the system.





THEME AWARD: High-Functioning Teams: Building Capacity for Attachment, Access & Care Delivery

NOMINEE(S): Ancient Rivers Family Health Team

ORGANIZATION: Ancient Rivers Family Health Team

INITIATIVE: Accelerating Attachment Through Team-Based Onboarding Processes

AT A GLANCE

How many patients can a team thoughtfully onboard in a half-day? Ancient Rivers Family Health Team redesigned attachment as a team process, combining an NP, physician, learners, nursing support and digital intake to increase onboarding capacity from roughly four adults to as many as 17 in a session.

THE OPPORTUNITY

To accelerate patient attachment as our NP (MRP) began onboarding a new panel, our team designed intake and onboarding workflows to significantly increase the rate of attachment using a coordinated, interprofessional approach. Working independently, our NP could onboard approximately four adult patients per half day, quickly creating a bottleneck during this period of rapid panel growth. To address this, we introduced structured “onboarding blitz” sessions, where our FHT lead physician, Dr. Candice Cybulskie, and her medical learners worked alongside the NP to complete initial meet-and-greet appointments. The onboarding blitz model was initially proposed by Dr. Cybulskie. Building on this, our FHT designed and implemented a locally adapted version tailored to our team structure and provider availability. By leveraging strong physician partnership and optimizing roles and workflows, we significantly reduced time to attachment and enabled earlier access to care.

WHAT WE DID

Our team identified that traditional onboarding processes were limiting attachment rates in a rural setting where access to primary care is constrained and demand is high. In response, we implemented the following:

- Introduced structured onboarding “blitz” sessions (half or full day) approximately once per week during the onboarding of approximately 300 new NP patients
- Leveraged interprofessional collaboration to increase throughput, including the NP, lead physician, resident physician, and NP student
- Designed flexible patient flow, allowing patients to be seen by the next available provider for their meet-and-greet, with ongoing care transitioning to the NP. Patients were informed in advance that they would see one of four possible providers and expressed willingness to participate.
- Used digital intake tools (Ocean) to collect health history and onboarding forms in advance when possible
- Assigned RPN support to proactively build patient profiles in advance when intake forms were completed prior to visits, or following the visit if not completed beforehand

THE IMPACT

This model resulted in substantially improved timeliness of attachment, with up to 17 patients onboarded per half-day blitz compared to approximately 4 in the traditional model. In the first 16 days scheduled for onboarding new patients to our NP, we were able to complete 175 meet-and-greet appointments, as opposed to a maximum of 128 that the NP could have completed alone. Patients were able to connect to the FHT sooner and begin addressing health needs without prolonged delays. Pre-visit preparation and RPN-supported charting also reduced administrative burden during visits, allowing providers to focus on clinical care and relationship building, while supporting more sustainable NP workloads during a period of high-volume onboarding. Patients appreciated being able to establish care quickly and begin addressing their health needs without prolonged waiting periods for their intake appointment.

This model allowed for up to 17 new patients onboarded into the team in one half day!

SUSTAINING AND ADVANCING THE WORK

This model was designed as a targeted strategy to support high-volume onboarding rather than an ongoing operational approach. Sustainment and learning have focused on:

- Using onboarding blitzes selectively during periods of rapid panel growth

- Continuing pre visit preparation and chart setup as standard practice to reduce onboarding burden
- Leveraging digital intake tools to streamline information collection
- While blitz sessions will conclude once the panel is established, this model may be used again in future NP onboarding periods.

WHAT OTHERS CAN LEARN

This initiative provides a practical and transferable model for increasing attachment capacity using existing resources.

SPREAD / KNOWLEDGE SHARING

This approach is adaptable and can be implemented using existing team structures in other primary care settings, particularly within FHT–FHO models where physician participation can support onboarding capacity. Our team has supported broader adoption by sharing the model through Renfrew County Primary Care Network meetings, discussing the approach within the Ottawa Valley Primary Care Collaborative, and informally sharing workflows and learnings with peer organizations. The simplicity and flexibility of this model make it feasible to replicate or adapt for teams seeking to accelerate attachment and reduce time to care.





THEME AWARD: High-Functioning Teams: Building Capacity for Attachment, Access & Care Delivery

NOMINEE(S): City of Kawartha Lakes Family Health Team

ORGANIZATION: City of Kawartha Lakes Family Health Team

INITIATIVE: Patient Attachment Innovation, City of Kawartha Lakes Family Health Team

AT A GLANCE

Sometimes attachment starts with a card table, a laptop and a willingness to meet people where they are. City of Kawartha Lakes Family Health Team combines NP clinics, physician attachment opportunities, community outreach and shared nursing support to connect unattached rural residents with ongoing primary care.

THE OPPORTUNITY

Our Story

Some 15 years ago, team members from the City of Kawartha Lakes Family Health Team (CKLFHT) set up tables in the parking lots of grocery stores across their rural area and rostered patients on the spot: Rostering Days. No appointment. No form to take home and return...maybe. No phone number to call...if you remember. Just: you're here, we're here, let's get you connected. That was not a program, although a FHT Nurse Practitioner's entire

practice was built from Rostering Days. It was a conviction. A model of success to be replicated, if needed. The tools have changed. The conviction hasn't changed.

A Nurse Practitioner clinic specifically for unattached patients — running every Friday for over two years, without a dollar of additional funding, providing both clinical care and attaching patients with a dedicated attachment nurse on site;

A partnership with the local Family Health Organization (FHO) attachment at the After-Hours Clinic — to increase access and find patients where they are, receptionists on-site identify unattached patients and get their consent to pass their contact information along instantly to the CKLFHT Supportive Attachment Nurse through the patient EMR, ensuring each patient is registered with Health Care Connect (HCC) before they leave. FHT staff have also been onsite at the after-hours clinic – including the Executive Director and Manager of Operations, for unattached patients to get attached onsite with in-person technical assistance;

Collaborative outreach with the Ontario Health Team — CKLFHT staff in the community, at the table, wherever unattached residents already are, including the local Legion, recreation facilities, and community events;

A card table and a laptop at community events — registering patients with Health Care Connect (HCC) on the spot — the same unglamorous, exact-right approach, replicated rural approach including for example, at the Queer Health Fair.

“I love helping connect patients and supporting them in their important healthcare journey. This work thrives on building relationships within the community and ensuring they feel supported close to home. Having a direct impact on access to primary care and creating positive patient experiences is what makes this role so meaningful to me.”

Sarah B., shared Supportive Attachment RPN

In addition, patients are given the local contact number of the CKLFHT's manager of operations to call with any questions or support: **a local, real person, with all the knowledge and personal encouragement needed.** Running through all four elements of the CKLFHT's attachment strategy: a **Supportive Attachment RPN who functions as connective tissue** — at the unattached patient clinic, for the after-hours clinic, and in the field.

WHAT WE DID

Right now, as this nomination is being reviewed, a CKLFHT Nurse Practitioner is preparing to run a Friday clinic for patients who have no primary care home. The CKLFHT's Supportive Attachment RPN is contacting unattached patients referred directly as they present at the FHO after-hours clinic and a FHT team leader is ensuring unattached patients don't leave without a pathway. OHT partners and CKLFHT staff are coordinating the next joint community outreach; setting up a card table and attaching community members with primary care on the spot.

Attachment doesn't happen by asking people to navigate a system on their own. It happens when we meet them where they are and help them — with the tools ready to act and a person to help every time they're in front of you.

CKLFHT built a four-part attachment strategy designed around a rural reality: no single point of contact will reach everyone.

1. Unattached Care Clinic – the flagship

Since March 2023, nine CKLFHT NPs have rotated through an all-day Friday clinic for patients without a primary care provider, providing approximately 1,000 patient visits to date (over 2 years). The Supportive Attachment RPN is on-site so patients leave registered with Health Care Connect and on a documented pathway to permanent attachment. Complex and vulnerable patients can be identified immediately and connected with available primary care capacity.

2. FHO Partnership – attachment at the point of contact

At the local FHO After-Hours Clinic, medical receptionists identify unattached patients and, with consent, immediately send their information to the Supportive Attachment RPN through the EMR. CKLFHT staff have also attended in person to help patients complete the process before they leave. An encounter that might once have ended with treatment now becomes an opportunity for permanent attachment.

3. OHT Partnership – showing up together

The Supportive Attachment RPN works across CKLFHT, Kawartha North FHT and Haliburton Highlands FHT through the OHT, while CKLFHT staff participate directly in joint outreach. This takes attachment into pharmacies, community centres, recreation facilities and other places where unattached residents already are.

4. Community Outreach – going where people are

From grocery-store parking lots 15 years ago to community events and the Queer Health Fair today, CKLFHT continues to bring attachment directly to residents. Sometimes the infrastructure required really is a card table, a laptop and a person who knows how to help.

Across all four approaches, the “secret sauce” is remarkably low-tech: meet patients face-to-face, walk them through the process and stay with them until there is a pathway forward.

THE IMPACT

Why Rural Changes Everything

Kawartha Lakes is a large rural municipality: more than 3,000 square kilometres across Lindsay, Fenelon Falls, Bobcaygeon, Omemee, Kinmount, Little Britain, Woodville and dozens of smaller communities.

Without a primary care home, people manage. They wait until something is bad enough for the emergency department. They manage their blood pressure on their own, until they can't. In a rural community, every trip to a provider can mean time off work, access to a vehicle, forty minutes on a highway and the cost of gas. People recalibrate what counts as a medical emergency.

And when a solo rural physician retires without a replacement, hundreds of patients can become unattached overnight. Attachment processes that depend on patients successfully navigating phone systems, online forms and Health Care Connect can disproportionately leave rural and vulnerable patients behind.

Early Signals

CKLFHT's strategy is still growing, but the early results are meaningful:

- Approximately 1,000 patient visits have been delivered through the Unattached Care Clinic, with attachment support available on-site.
- Unattached patients are registered with Health Care Connect and given a documented pathway toward permanent attachment, with complex and vulnerable patients identified for more immediate support.
- Two CKLFHT NP practices have been built substantially through the original Rostering Days and, more recently, the Unattached Care Clinic, including many complex and vulnerable patients who now have a permanent primary care home.
- Patients identified through FHO after-hours encounters are now connected to attachment support rather than leaving after treatment with no pathway forward.

- Joint OHT outreach has extended attachment efforts into communities and populations that may never have independently navigated their way to a clinic.

The numbers matter. But so does what they represent. Many of these are people living with unmanaged diabetes, overdue cancer screening or other conditions for which they had nowhere to go. They left with a registration, a connection to attachment, or a primary care provider.

That is the system doing what it is supposed to do.

SUSTAINING AND ADVANCING THE WORK

This work is sustainable in part because it was never designed as a stand-alone pilot. The four approaches are embedded in how CKLFHT and its partners work: nine NPs continue to rotate through the Friday clinic; the FHO After-Hours Clinic continues to identify unattached patients at the point of care; the Supportive Attachment RPN works across organizations; and CKLFHT continues to participate in community and OHT outreach.

More importantly, the strategy can evolve as the places and ways CKLFHT encounters unattached patients change. The grocery-store parking lot of 15 years ago has become the clinic, the after-hours encounter, the community event and the OHT partnership of today.

The work has largely been sustained without dedicated additional funding. NPs have operated the Unattached Care Clinic alongside their existing practices, while the FHO partnership, joint outreach and community attachment work have been built into existing relationships and resources.

That commitment is also the challenge ahead. CKLFHT has demonstrated what can be accomplished by redesigning workflows, sharing capacity and treating attachment as a collective responsibility. The next opportunity is to build on that foundation so successful approaches can be sustained and expanded without relying indefinitely on extraordinary effort from individual clinicians and staff.

WHAT OTHERS CAN LEARN

This application is not being submitted as a claim that CKLFHT's patient attachment strategy is perfect. It is being shared in the same spirit in which CKLFHT learns from colleague FHTs and provider partners every day: **if something is working, share it.**

Much of this approach is remarkably replicable. A rotating NP unattached care clinic can be adapted elsewhere. An FHO receptionist can turn an after-hours encounter into an attachment opportunity. OHT partners can share staff and conduct outreach together. And almost any team can take a laptop and a card table into the community.

For rural and small-town primary care organizations in particular, one of the greatest assets may already exist: relationships. Teams know their communities, local providers know one another, and residents often know and trust the organizations serving them. CKLFHT has demonstrated that those relationships can be activated for attachment rather than relying exclusively on forms, phone numbers and patients navigating the system themselves.

The sector does not need to start from scratch. CKLFHT is pleased to share what it has tried, what has worked, what has not, and what it continues to learn.

SHARING

Spread is already happening through CKLFHT's partnerships. The Supportive Attachment RPN works across CKLFHT, Kawartha North FHT and Haliburton Highlands FHT through the OHT, while joint outreach creates opportunities for organizations to learn from and build on one another's approaches.

CKLFHT is also intentionally sharing the practical elements of its strategy: the rotating NP clinic, point-of-contact attachment through the FHO, community-based Health Care Connect registration, and the workflows that allow staff to identify and support unattached patients in real time.

The opportunity for spread is not necessarily to reproduce every element exactly. It is to take the underlying principle into other communities: **find the places where unattached patients already encounter the health system or their community, and turn those moments into opportunities for attachment.**

Fifteen years ago, for CKLFHT, that meant a grocery-store parking lot. The table has moved. The idea hasn't.





THEME AWARD: High-Functioning Teams: Building Capacity for Attachment, Access & Care Delivery

NOMINEE(S): Peterborough Family Health Team

ORGANIZATION: Peterborough Family Health Team - Connect Clinic

INITIATIVE: Connect Clinic

AT A GLANCE

Access is useful, but attachment changes the destination. Peterborough Family Health Team's Connect Clinic has served thousands of unattached patients while building formal pathways with local primary care organizations to move people from episodic care toward a permanent primary care home.

THE OPPORTUNITY

The Connect Clinic team has developed and implemented an innovative, team-based model that addresses the critical need for improved access and attachment for unattached patients. Through intentional design of intake processes, care pathways, team roles, and partnerships, the team has created a sustainable approach that provides timely primary care while supporting patients in transitioning to permanent primary care teams. The Connect Clinic has transformed the challenge of unattached patients into an opportunity to build a coordinated pathway that balances immediate access needs with long-term attachment goals. Through collaboration, adaptability, and a strong focus on patient-centred care, the team has strengthened primary care capacity, improved navigation for patients, and created a model that supports the future of team-based primary care.

WHAT WE DID

The Connect Clinic team has developed an innovative, high-functioning model that improves access to primary care while creating pathways to permanent patient attachment. Recognizing the growing number of unattached patients in our community, the team designed and implemented a coordinated approach that provides timely, comprehensive care while actively supporting patients in finding an ongoing primary care provider. Through strong collaboration, the team established intake processes, care pathways, provider workflows, and community partnerships that maximize capacity and ensure patients receive the right care at the right time. By balancing immediate access needs with long-term attachment goals, the Connect Clinic has strengthened primary care delivery, improved patient experience, and enhanced system capacity within our region. This work demonstrates how a collaborative team-based model can address complex healthcare challenges and build sustainable solutions for access, attachment, and ongoing care

THE IMPACT

Since launching the Connect Clinic in 2023, the team has provided care to 6,849 unattached patients and delivered 23,674 appointments/visits. Through a coordinated attachment process, patients as of late

December 2025 have been connected to permanent primary care providers when one becomes available in our community, improving continuity of care and reducing barriers to accessing services. By implementing standardized intake, triage, and workflow processes, the team has increased access to

The clinic has established partnerships with our 5 Family Health Organizations, Community Health Centre and two NPLC's to support patient attachment to a permanent primary care team.

primary care while managing demand within existing resources. Qualitative feedback from patients highlights the value of having a trusted care team while awaiting permanent attachment. Team members and community partners have also noted improved coordination, communication, and efficiency in serving unattached populations.

SUSTAINING AND ADVANCING THE WORK

The Connect Clinic team is committed to sustaining and expanding its impact through ongoing investment, continuous quality improvement, and strong system partnerships. In Fall 2025, the clinic received funding through our local Ontario Health Team (OHT), recognizing the value of the model in addressing access and attachment challenges within the community. Building on this success, the clinic was awarded Interprofessional Primary Care Team (IPCT) Round 2 funding effective April 1, 2026, providing long-term stability and opportunities for growth. This funding supports the continued delivery of team-based care, expansion of service capacity, and enhancement of attachment pathways for unattached patients. The team regularly reviews patient demand, attachment outcomes, workflow efficiencies, and community needs to identify opportunities for improvement. By combining sustainable funding, data-driven decision-making, and a commitment to innovation, the

team is well-positioned to continue improving access, attachment, and care delivery for the patients and communities it serves.

WHAT OTHERS CAN LEARN

The Connect Clinic provides a scalable model that can support other teams looking to improve access, attachment, and care delivery for unattached patients. Through the development of intentional workflows, defined team roles, centralized intake processes, and coordinated transition pathways, the team has created a framework that can be adapted to meet the needs of different communities. The clinic demonstrates how interdisciplinary teams can leverage existing resources, partnerships, and innovative approaches to increase capacity while supporting long-term attachment goals. Key learnings include the importance of clear roles, collaborative care planning, data-informed improvement, and building strong relationships with primary care providers and system partners.

SPREAD / KNOWLEDGE SHARING

The Connect Clinic team has taken steps to share its experience, learnings, and approach with broader primary care partners. Over the past two years, the team has presented the Connect Clinic model at the Association of Family Health Teams of Ontario (AFHTO) conference, highlighting the development of the model, attachment strategies, team-based workflows, and approaches to improving access for unattached patients. The team has also engaged with other Family Health Teams interested in learning from the Connect Clinic experience and has shared insights, processes, and lessons learned to support their own planning and improvement efforts. The Connect Clinic team remains committed to knowledge sharing and collaboration, recognizing that improving attachment and access requires collective learning and system-wide partnership.





THEME AWARD: High-Functioning Teams: Building Capacity for Attachment, Access & Care Delivery

NOMINEE(S): City of Lakes Family Health Team

ORGANIZATION: City of Lakes Family Health Team's Supported Attachment Clinics

INITIATIVE: It Takes a Team: Advancing Attachment Through Supported Attachment Clinics

AT A GLANCE

City of Lakes Family Health Team turned attachment into a team event. Its Supported Attachment Clinics bring multiple interprofessional providers together in focused evening sessions, using redesigned workflows and digital tools to attach dozens of patients in a few hours while making fuller use of existing team capacity.

THE OPPORTUNITY

The Supported Attachment Clinics at the City of Lakes Family Health Team (CoLFHT) represent a transformative, high-functioning team-based approach that is redefining access to primary care. In a system where patient attachment has traditionally been time-intensive, administratively burdensome, and often disconnected from immediate patient needs, CoLFHT has introduced a bold, innovative model that places meaningful human connection at the centre of care. They redesigned the intake process so that it is led collaboratively by an interprofessional team. A process that once took thirty minutes per patient and often required multiple visits has been transformed into a streamlined model where 30 to 60 patients can be attached in a single three hour clinic. **More importantly, patients leave their first visit feeling connected.** It makes better use of existing workforce, improves access for patients, and strengthens how care is delivered across the team.

WHAT WE DID

The Supported Attachment Clinics were developed in direct response to a clear and pressing local need - attachment. **The traditional model of attaching patients placed significant administrative burden on physicians, requiring lengthy intake appointments focused on chart creation rather than patient care.** This approach did not make full use of physician expertise and often required patients to book multiple follow up visits before their health needs were addressed. In response, the team redesigned the intake process to prioritize access, efficiency, and meaningful patient engagement. Evening clinics were introduced to create additional capacity and better meet patient needs. These clinics bring together skilled health care professionals from the community who are seeking additional work or experience in primary care, as well as existing team members who were often working second jobs outside of the health system. The team also developed strong referral pathways to ensure the clinics reached those most in need. Patients are referred through Health Care Connect, local geriatric services, midwifery programs, Children's Aid Society, Public Health, and other community partners, reflecting a coordinated and responsive approach to local system needs. Wait times for attachment have been reduced, and fewer follow up visits are required to begin care. Patients leave their first visit with a clear understanding of their care plan and how to access their team, demonstrating stronger continuity, earlier engagement, and a more positive entry into the primary care system.

Evening clinics bring together underutilized health care providers to complete team based intakes, allowing physicians to focus entirely on patient needs. These health care providers were those working 2nd jobs outside of the health care system, or are waiting on the license, etc. The results have been significant.

THE IMPACT

The impact of the Supported Attachment Clinics is demonstrated through clear, measurable improvements in access, efficiency, and patient experience. Over the past 4 months, the team has successfully delivered 8 clinics. In each three hour session, between 30 and 60 patients are attached to primary care, supported by a team of 3 to 6 interprofessional providers. This represents a significant increase in capacity compared to traditional models, where individual intake appointments of 30 minutes, or more limited the number of patients who could be attached in a given timeframe. Individuals leave their first

This represents a **120% increase in attachment capacity**, more than doubling the team's ability to connect patients to primary care. Simply put - this means patient see meaningful attachment faster! Patient experience and continuity of care have also improved.

visit with a clear understanding of their care plan, how to access services, and who is on their care team. At a system level, the initiative demonstrates effective and responsible use of health human resources. By mobilizing underutilized providers and creating flexible opportunities for both community clinicians and existing staff, the model expands care capacity without placing additional strain on physicians. The initiative has also been strengthened through close collaboration with the Sudbury Espanola Manitoulin Elliott Lake Ontario Health Team, which has provided funding support to enable and sustain the clinics. With demonstrated success, the model is now being adopted by additional teams across the region, highlighting its scalability, sustainability, and broader system impact. Seeing the pure joy, relief, and thankfulness our new FHT patients are expressing, knowing their health is now in the hands of a multi-disciplinary Family Health Team.” Catherine Pichette, Registered Nurse

SUSTAINING AND ADVANCING THE WORK

The sustainability and continued growth of the Supported Attachment Clinics is being actively supported through strong partnership with the Sudbury Espanola Manitoulin Elliott Lake Ontario Health Team. This collaboration has been instrumental in securing funding to establish and maintain the clinics, while also aligning the model with broader regional priorities around access to primary care and attachment. Through ongoing engagement with the Ontario Health Team, the model is being refined based on data, patient experience, and operational learnings. Sustainability is further demonstrated through the model’s adaptability and growing adoption across the region. With proven success, additional teams are beginning to implement similar approaches, reflecting both the scalability of the model and its alignment with broader system goals.

WHAT OTHERS CAN LEARN

The Supported Attachment Clinics offer significant learning and practical value for other teams seeking to improve access, efficiency, and patient experience in primary care. At its core, the model provides a clear and adaptable process for redesigning patient attachment by shifting from physician led intake to a coordinated, team based approach that maximizes the strengths of interprofessional providers. A key contribution is the development of a structured clinic model that other teams can replicate. This includes standardized workflows for high volume intake, defined roles for interprofessional team members, and processes that allow physicians to focus on patient needs rather than administrative tasks. The intentional use of evening clinics and flexible staffing models also demonstrates how teams can better leverage available health human resources, including underutilized providers within their own organizations and broader communities.

SPREAD / KNOWLEDGE SHARING

The model is already demonstrating strong spread across the region, supported through collaboration with the Sudbury Espanola Manitoulin Elliott Lake Ontario Health Team.

Early uptake by other organizations highlights that the processes, tools, and lessons learned are practical, transferable, and aligned with shared system priorities.

To support this spread, the City of Lakes Family Health Team has intentionally developed and shared a range of resources. These include clear process maps, digital health tools such as patient eForms, and a standardized intake encounter assistant that improves the efficiency and consistency of chart documentation. Both the clinic model and its supporting digital tools have been shared across the Sudbury Espanola Manitoulin Elliott Lake Ontario Health Team and beyond, with growing interest from organizations across Northeastern Ontario.

Tools are available to support the design and roll out of this model in other interprofessional team organizations.

Reach out to:

Meghan Peters

Executive Director

City of Lakes Family Health Team

mpeters@yourfamilyhealthteam.com





THEME AWARD: High-Functioning Teams: Building Capacity for Attachment, Access & Care Delivery

NOMINEE(S): MSK Program

ORGANIZATION: Georgian Nurse Practitioner-Led Clinic

INITIATIVE: MSK program

AT A GLANCE

Physiotherapy access should not depend entirely on a patient's ability to pay. Georgian Nurse Practitioner-Led Clinic built a partnership-based musculoskeletal program that connects patients facing financial barriers with physiotherapy, with early results showing meaningful improvements in pain and resolution of some conditions.

THE OPPORTUNITY

The GNPLC received limited PT funding as part of our EOI IPCT expansion funding in 2024. Our solution was to partner with a local 3rd party provider to perform funded physiotherapy services to our patients on our behalf. Patients were referred to PT by their NP for an initial assessment and up to 5 subsequent visits as necessary. Additional visits can be requested if issues are not resolved within 6 visits. A post discharge summary is shared with NP and NPs follow up with patients regarding progress post discharge. The program is specific for patients with financial barriers to accessing PT services, with MSK or pain issues. Not for OHIP eligible, WSIB or for patients with access to private coverage. An MOU was put in place and piloted starting in August 2025. Indicators of success of the program were identified in early 2026, and the program moved forward with permanent funding beginning of the 26-27 fiscal year.

WHAT WE DID

increased need for pain management solutions for patients. High number of patients onboarded to the clinic had years of fragmented and limited access to primary care services and long histories of high dose opioids for pain management prior to being onboarded to the GNPLC.

THE IMPACT

40% of patients case fully resolved (0/10 pain on VAS) at discharge

On average VAS score reduced by 3.4 points over course of treatment

SUSTAINING AND ADVANCING THE WORK

GNPLC was able to move beyond initial pilot project to ongoing program. Funding has now been allocated permanently to support this program year over year. The patient feedback, through the use of surveys sent via patient messaging in the EMR, will be integrated into reporting metrics in 2026-27.

WHAT OTHERS CAN LEARN

Integration of non-traditional clinical resources, such as physiotherapy, can have significant impact on the well-being of patients. Identifying barriers to access and finding solutions to resolve those barriers in innovative ways can help increase availability of a robust team of providers to support overall wellness of patients.





THEME AWARD: High-Functioning Teams: Building Capacity for Attachment, Access & Care Delivery

NOMINEE(S): Central Lambton Family Health Team

ORGANIZATION: Rural Access to Care Clinic: Jaimelynn Smith, Beth Machan, Linda Kremer, Tori Shaw

INITIATIVE: Small Team, Huge Impact. Rural Access to Care Clinic

AT A GLANCE

A tiny rural team is carrying a very large access load. Central Lambton Family Health Team's Rural Access to Care Clinic uses an NP, RN and RPN to provide weekday and evening care with minimal administrative infrastructure, delivering thousands of visits while supporting both attached and unattached patients.

THE OPPORTUNITY

Central Lambton FHT, through IPCT round 1 funding secured a NP, RN, RPN to run a rural access to care clinic. Since 2024, visit rates have surpassed their urban counter part. This past year, visits totaled 5,928. This added access to same day/urgent care has contributed to altering utilization patterns of the local rural hospital emergency department. The small investment of staff and partnership with the municipality for space has led to the emergency department being considered for service downgrading due to fewer visits. CTAS 4 and 5 are being seen daily at the access to care clinic with extended hours twice a week into the evening. In many rural communities, the assumption persists that emergency departments remain the primary unavoidable

Three interdisciplinary team roles assist in altering rural hospital emergency room department utilization patterns.

access point for urgent, low-barrier healthcare needs. The rural access to care clinic is having a direct positive impact in changing this narrative. This clinic has directly made a significant impact.

WHAT WE DID

The NP, RN and RPN triage, book and see patients 5 days a week plus 2 evenings per week. There is no admin at their site, they do it all. They promote services at community events such as community picnics and winter parades. They are well known and respected as staff live and work in the same community. The local rural hospital emergency department is considering down grading due to a decrease in utilization from a 4A to 3A.

THE IMPACT

The number of visits by month totaling 5,928 utilizing just 3 IHPs. Visits surpassed the urban counter part. 241 people seen were unattached.

SUSTAINING AND ADVANCING THE WORK

The rural access to care IHPs are expanding their skills, taking education and training to be able to provide pap tests, memory assessment and other programs to help expand care. They also assist with helping unattached patients attach to providers.

WHAT OTHERS CAN LEARN

Funding does not have to be extensive to make positive system change. Every bit of access and support assists in helping change utilization patterns. What began as a relatively small investment into community primary care to increase access may have unintentionally demonstrated just how powerfully accessible primary care infrastructure can alter health-care seeking behaviour within a rural population. In many ways, this realization is both remarkable and complex. On one hand, reduced emergency department utilization may reflect improved access pathways, earlier intervention opportunities, and redistribution of lower-acuity care into more appropriate community based settings. On the other hand, it raises important questions regarding how healthcare systems measure utilization, allocate resources, and interpret success within rural environments. The learnings revealed an important systems-level insight - many patients may not necessarily be seeking emergency department care itself, they may simply be seeking timely, geographically accessible care. When meaningful access appeared within the community through a flexible interdisciplinary clinic model, patient behaviour appeared to change rapidly. From a systems perspective, the rural access to care clinic functioned as a decompression pathway for emergency department pressures, an urgent episodic care hub, a geographically accessible reassurance pathway, a transitional attachment mechanism and a low barrier entry point into broader primary care systems. The rapidity and scale of patient uptake suggest that many rural communities may contain substantial reservoirs of previously under-served or

poorly access healthcare demand that can rapidly shift utilization patterns when community based access improves. Instead, the model relied upon: strong NP leadership and interdisciplinary collaboration, physician support, flexible scheduling structures, targeted rural accessibility, integration within existing primary care systems and municipal support. This experience is not presented as proof it will solve all system challenges or emergency department pressures, Rather, it represents a practical operational signal emerging from real-world implementation, one that may warrant broader exploration, replication, and study across Ontario. At it's core, the rural access to care experience may reflect a larger truth emerging within the current "attachment era" - patients do not simply seek emergency departments, patients seek timely and meaningful access.

SPREAD / KNOWLEDGE SHARING

Information regarding system impact and consideration regarding rural emergency department downgrading has just been provided in the past two weeks to the FHO physicians affiliated with the FHT who also work in the emergency department.





THEME AWARD: High-Functioning Teams: Building Capacity for Attachment, Access & Care Delivery

NOMINEE(S): The Eastern Ottawa Community Family Health Team

ORGANIZATION: The Eastern Ottawa Community Family Health Team

INITIATIVE: Social Prescribing for the Social Determinants of Health

AT A GLANCE

Social needs belong in the care plan too. Eastern Ottawa Community Family Health Team's social prescribing program connects patients with a link worker and community-based supports such as a garden and collective kitchen, addressing isolation and other social determinants alongside traditional primary care.

THE OPPORTUNITY

The Eastern Ottawa Community Family Health Team has successfully implemented and expanded a social prescribing program that addresses the social determinants of health and improves access to community-based supports. Through this program, the link worker, Stéphanie, conducts comprehensive assessments to identify clients' social and non-clinical needs, including food security, income support, social isolation, and community engagement. She works with the Francophone population across two sites, helping connect individuals to appropriate resources, services, and social opportunities, such as seniors' Active Living Centre programs. In addition to providing individualized support, Stéphanie has demonstrated leadership and innovation by developing new community initiatives, including a community garden and a collective cooking group, with an outdoor walking group planned for the fall.

WHAT WE DID

The Eastern Ottawa Community Family Health Team (EOCFHT) recognized that many patients in its community were experiencing challenges related to social isolation, mental health, chronic disease management, and other social determinants of health that could not be addressed through medical care alone. Through patient interactions, provider referrals, and ongoing collaboration with community partners, EOCFHT identified a need for greater access to community-based supports and opportunities for social connection. To address these needs, EOCFHT implemented and expanded its social prescribing program, connecting patients with community resources, wellness programs, support groups, volunteer opportunities, and educational workshops tailored to their individual goals and circumstances. The program adopted a person-centred approach, helping patients improve their overall health and well-being by addressing both social and clinical needs.

THE IMPACT

Evidence demonstrating the impact of this achievement includes both quantitative outcomes and patient experiences. Between April 1, 2025, and March 31, 2026, the social prescribing program supported 284 unique patients, exceeding the annual target of 250 patients served. During this period, 468 therapeutic interactions were provided, demonstrating ongoing engagement and follow-up support for individuals with social, emotional, and practical needs. In addition, 79 new referrals were received, reflecting growing awareness of and confidence in the program among healthcare providers.

We surpassed our target to support 250 patients over one year by 34 patients!

The program also facilitated participation in community-based health and wellness initiatives, with 39 participants attending the collective kitchen designed to reduce social isolation, improve mental well-being, and increase community connectedness. Qualitative feedback from patients and providers further demonstrates the program's impact. Patients report feeling more connected to their community, better supported in addressing social determinants of health, and more confident in accessing available resources. Providers have noted that the program helps address underlying social needs that may otherwise affect patients' physical and mental health outcomes, contributing to a more holistic and patient-centred approach to care.

SUSTAINING AND ADVANCING THE WORK

EOCFHT continues to embed social prescribing within everyday clinical practice, promote referrals from all members of the interdisciplinary team, and strengthen relationships with community agencies. By supporting patients in accessing community-based resources and opportunities for social connection, EOCFHT seeks to reduce social isolation, improve mental and physical well-being, and address the social determinants of health that influence

long-term outcomes.

WHAT OTHERS CAN LEARN

This achievement demonstrates that social prescribing can be successfully implemented within a smaller Family Health Team, allowing organizations to "punch above their weight" and better address the social determinants of health affecting their patients. The program provides a practical model that other primary care teams can adapt to their local context, highlighting the value of dedicated link worker support, strong community partnerships, and integrated referral pathways. By sharing processes, outcomes, and lessons learned, this initiative can help other teams strengthen their capacity to address non-clinical needs, improve patient well-being, and enhance connections between primary care and community services. The program demonstrates how relatively modest investments in social prescribing can result in meaningful patient engagement and improved access to community resources. Other teams can learn from the referral processes, partnership-building strategies, and patient-centered approach used to identify and address social needs such as social isolation, food insecurity, income support, and access to community programs.





THEME AWARD: High-Functioning Teams: Building Capacity for Attachment, Access & Care Delivery

NOMINEE(S): St. Michael's Academic Family Health Team

ORGANIZATION: The St. Michael's Academic Family Health Team Home Visiting Program

INITIATIVE: The St. Michael's Academic Family Health Team Home Visiting Program

AT A GLANCE

Homebound patients need a primary care model that can cross the front door. St. Michael's Hospital Academic Family Health Team brings family medicine, nursing, pharmacy, social work, palliative care and coordination into patients' homes, supporting frail seniors while also building teaching and practice knowledge around home-based care.

THE OPPORTUNITY

The St. Michael Academic Family Health Team has a unique expertise in the care of older adults in the inner-city. The team serves a population with high rates of poverty, social isolation, mobility limitations, dementia, and complex medical needs. Their innovative interdisciplinary model combines family medicine, nursing, pharmacy, social work supports, palliative care, and care coordination, ensuring highly responsive, compassionate care for some of Toronto's most vulnerable populations.

WHAT WE DID

The team adapts care around individual patient goals, whether pursuing active medical treatment or comfort-focused care at home. The team leverages strong partnerships with Ontario Health at Home, community organizations, palliative care providers, and health professionals to address medical, functional, and social needs. Practically this can mean many things, but at the core the team is truly patient centred. This can involve attending specialist appointments with patients so that the visit happens, being present in a home so that needed equipment can be delivered. Finding ways for a patient to access meal supplements when the usual mechanisms aren't available.

In the words of a team member:

"Sometimes our patients have unconventional needs/wants – “I want to stay at home and smoke and die in my own bed.” Sometimes we do a “tune up” through our team based approach - by engaging physio, OT, pharmacy, social work, the person is able to resume outside activity (we've even had people start coming to clinic).”

THE IMPACT

The impact of the program is demonstrated through both patient outcomes and system-level contributions. Patients report improved quality of life, greater emotional well-being, and the ability to remain safely in their homes despite complex health conditions. Qualitative feedback from patients, caregivers, and physicians highlights the team's responsiveness, compassion, and ability to maintain dignity and autonomy for patients.

SUSTAINING AND ADVANCING THE WORK

The team continues to strengthen and sustain its model through interdisciplinary collaboration, education, quality improvement, and community partnerships. An embedded care coordinator, strong links with Ontario Health atHome, and partnerships with palliative care and community organizations help maintain seamless care for patients with complex needs. The team actively trains medical students, family medicine residents, and Care of the Elderly Residents, building future capacity in home-based care.

WHAT OTHERS CAN LEARN

This program is a transferable model for caring for frail, homebound older adults in diverse communities. The team has developed practical approaches to integrating primary care, palliative care, rehabilitation, pharmacy and social work services, and care coordination within patients' homes. The team has contributed to resources such as the Preventive Care for Older People initiative and educational tools including the Frailty Five Framework. They regularly supervise medical students, family medicine residents, and Care of the Elderly

trainees, many of whom have gone on to incorporate home visits into their own practices. Team members have delivered presentations at national and provincial conferences and have published peer-reviewed articles, developed educational resources, participated in podcasts and supported trainee research projects. Here are links to some of their work:

Unity Health Coverage

<https://unityhealth.to/2020/12/st-michaels-family-health-team-home-visiting-program-doubles-its-capacity-to-care-for-frail-seniors-during-the-pandemic/>

CEP - Clinical tool developed / contributed to by team members

<https://cep.health/clinical-products/preventive-care-for-older-people/>

CMAJ Article on Bed Bugs

<https://pmc.ncbi.nlm.nih.gov/articles/PMC10205909/>

Accompanying patient perspective on Bed Bugs

<https://www.cmaj.ca/content/195/20/E717.full>

CFP Article - Frailty 5 Checklist: Teaching Primary Care of Frail Older Adults

<https://www.cfp.ca/content/65/1/74>

BMJ Open Article: Assessing the ...Episodic Disability Questionnaire with older adults living with complex health needs

<https://bmjopen.bmj.com/content/15/9/e097504>

