

Scaling Equity-Based Attachment: A Collaborative IPCT Model across Three Toronto OHTs



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**Agenda and
objectives**

- **Conceptualization and situation analysis of current attachment status from an equity perspective.**
- **Access Alliance's collaborative governance model with CHCs and three OHTs.**
- **Action-impact, challenges, and outcomes.**

Defining the Framework

- "**Attachment**" (refers to the system intake of a resident for ongoing care by a registered healthcare professional)
- "**Attachment Readiness**" (refers to the preparedness of the resident and also the system to accept the resident for ongoing medical care.
- **Attachment readiness is not merely an administrative milestone or a matching process; it is a systemic capacity** to ensure a **sustainable temporal relationship** between PC service providers and consumers.
- For newcomers, refugees, and uninsured individuals in Toronto, "**attachment**" is often blocked by linguistic barriers, and the complexity of navigating fragmented social services.
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Mandate

Attachment is the structural and relational willingness of our primary care systems to safely, equitably, and effectively receive individuals and communities who have historically been underserved, marginalized, or actively harmed by institutional gatekeeping.

Reflection

Analogy

Attachment to primary care is like one leg of a three-legged stool: It is upheld and sustained by the two others: Equity and access. [[EPIC News: Issue 33: Feb 2026](#)]

Impact

If a primary care medical home is not ready to provide culturally responsive, equity-centred mental health support, then **"attachment" is just a metric on a spreadsheet, not a pathway to wellness.**

Unattachment in Canada affects approximately 6.5 million residents

This demands a shift in focus from mere system capacity to the nuanced concept of attachment readiness.

Conceptualization

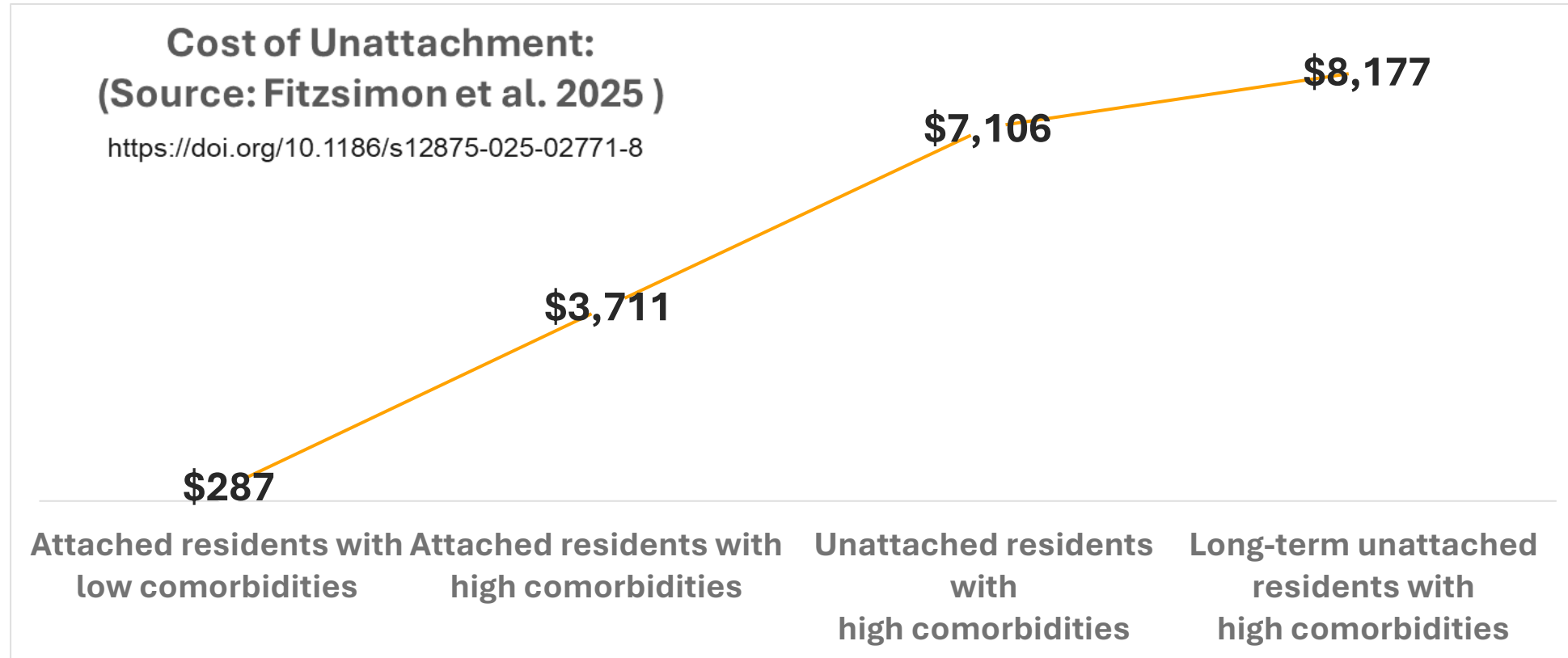
Readiness is not a static attribute but a dynamic state influenced by health literacy, trust, and life transitions for patients; and by administrative support, electronic infrastructure, and panel management for providers

Attachment =

Complex SDoH * Perceived benefit* Medical Complexity * Perceived Discrimination * Stigma
Availability of SPs * Cultural Relativism in Healthcare Access and Delivery *Social Support System* Healthy Public Policy

**The Current Landscape
Problem Statement**

- **Reduced ER Strain: Unattached patients are 1.22 times more likely to visit an Emergency Department (ED) and 1.32 times more likely to experience a non-elective, acute hospital admission compared to those safely attached to a primary care provider..**



Estimated ROI

| Indicator | Number |
|---------------------------------------|---------------------------|
| High Co-morbidity Cost Gap | \$4,466 |
| ED Visit Vs Family Physician | 3x |
| Fewer ED Visit with Attachment | 36% |
| Return on PC Investment | \$13:\$1 in 5 year |

IPCT round 1 – Lead Agency & Partners

Access Alliance's
Collaboration

| OHT | Partners | Neighbourhood focused |
|-------------------------------------|--|-----------------------|
| LEAD: Mid-West OHT | <ul style="list-style-type: none"> • Parkdale Queen West CHC • Village FHT • Mid-West Toronto Family Practice Network (MWT-FPN) | M6J |
| PARTNER: West Toronto OHT | <ul style="list-style-type: none"> • Crosstown Family Health Team | M6N |
| PARTNER: East OHT | <ul style="list-style-type: none"> • Flemington Health Centre • East Toronto Family Practice Network • South Riverdale CHC • East End CHC • Don Mills FHT, South East Toronto FHT Bridgepoint FHO • Albany Medical Clinic • Magenta Health • Unity Health • Multi-Generational Housing and Community Centres of Toronto | M3C, M4C |

IPCT round 2 – Lead Agency & Partners

**Access Alliance's
Collaboration**

| OHT | Partners | Population focused |
|-------------------------------|--|-------------------------------------|
| LEAD: Mid-West OHT | <ol style="list-style-type: none"> 1. Davenport Perth Neighbourhood Community Health Centre 2. Women's College Academic Family Health Team 3. Toronto Western Family Health Team 4. Mount Sinai Academic Family Health Team 5. Mid-West Toronto Family Practice Network (MWT-FPN) | Solo practitioners, small practices |
| LEAD: West Toronto OHT | <ol style="list-style-type: none"> 1. Parkdale Queen West CHC 2. Black Creek CHC 3. Canadian Centre for Refugee and Immigrant Healthcare | Inclusive care clinic |
| PARTNER: East OHT | <ol style="list-style-type: none"> 1. Scarborough Centre for Healthy Communities 2. East Toronto Health Partners – Flemingdon HC Lead | Population Health Clinic |

Attachment pathways

- **Centralized Intake:** connecting patients with appropriate PC team based on health, language, proximity and social needs.
- **Community outreach:** Culturally responsive outreach- CHA model, utilizes trusted relationship, health education, system navigation support
- **Inclusive Design:** Incorporate patient voices, underserved population, professional interpretation, peer health workers.
- **Social Prescribing:** Linking patients to community resources that address SDH- housing, employment, food security
- **Digital Equity:** Screening for digital literacy to ensure virtual care options, technology doesn't create new barriers.

Low-Barrier Access Points

- **Multiple referral pathways:** self-referral, community agency referrals, collaboration with pharmacies
- **Simplified intake process:** shorter screening questions, faster follow up
- **Open Door Program:** meet with people where they are- pop-up health information, screening and assessment support, group education and health coaching.
- **Non-Insured Clinics (NIC):** Providing episodic care, bridge to permanent attachment.
- **Inclusive attachment project:** dedicated to attach newcomers, people with experiences of trauma, 2SLGBTQ+ people, racialized people, women who are pregnant with limited prenatal care, youth, people experiencing homelessness, and people with language barrier
- **Community Team model:** Collaboration with Solo and Small Practice Physicians (SSPP). Non medical care to IHPs, reduce physician burnout, improve patient care

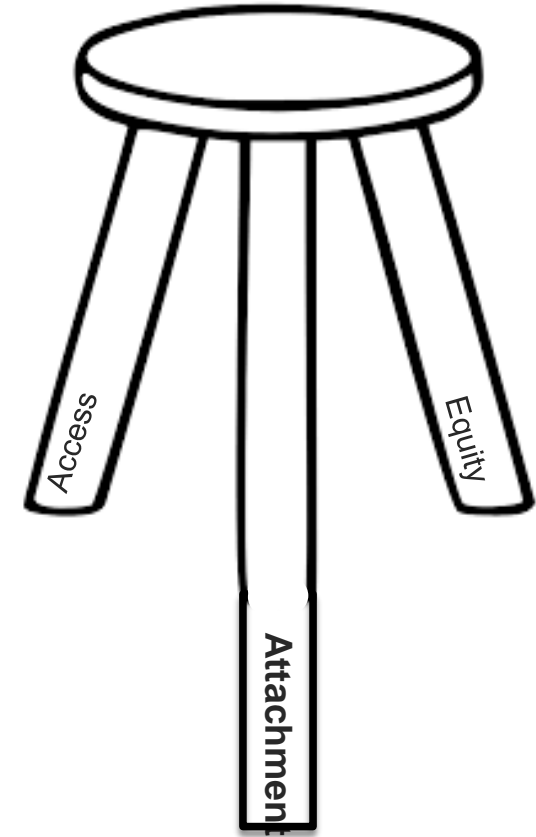
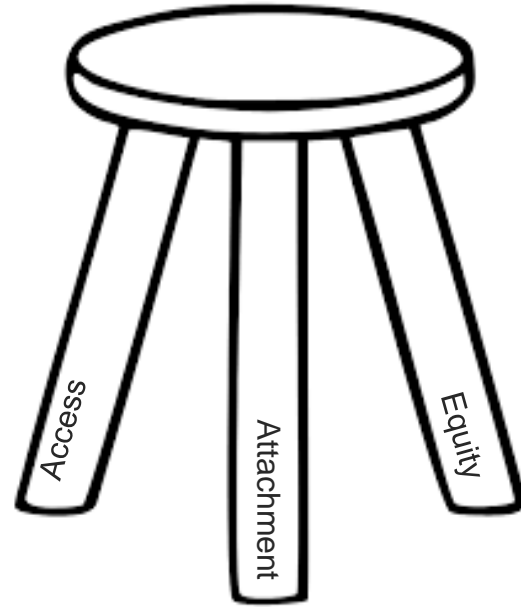
Desired Outcome of Attachment

- **Continuity of care:** Having one provider will ensure your medical history is properly taken and built upon leading to more accurate care.
- **Preventative Care:** Regular check ups, cancer screening, vaccinations.
- **Management of Chronic conditions:** DM, Hypertention, Asthma, CVDs, arthritis need to be managed on the long term care.
- **Easier referrals and feedbacks:** Providers refer to specialists and other services and receive the reports in one place.
- **Better follow up on test results:** Centralized management of all reports.
- **Better Care coordination:** What services could be done before what and what needs to be managed before what.

Challenges

- **Sources of Clients and wait lists:** Some lists on HCC are outdated.
- **Variable clients needs:** A young healthy client who might not need a Dr for 3 years is seen like a complex client with language barrier and impacted social determinants of health.
- **Target numbers pressure:** People are not numbers, the moment we see people as numbers the moment we close the door on Health equity.
- **Access:** If a provider has 500 patients on their roster and the patient gets an appointment after a week, imagine if the provider has 2000 clients on their roster, how far will be the appointment ???

**When Attachment works
AGAINST
Access and Equity**



**Trajectory:
The Road to
2029**

Looking toward 2029, the IPCT model aims to serve as the blueprint for "*Equitable Scaling*." Our trajectory involves:

- **Policy Advocacy:** A shift from volume to quality. Using our multi-OHT data to advocate for funding models that account for social complexity, not just patient headcount.
- **SAMI (Standardized Adjusted Clinical Group Morbidity Index)** needs to be part of the equation to ensure equity and Access.
- **Digital Integration:** Unifying EMR, referral and online booking platforms, as well as onboarding forms and metrics, will greatly simplify and expedite the processes.
- **Unifying Attachments:** It shouldn't matter who gets to report on that client attachment; we all work on removing barriers to clients' access to care.
- **Team-based Care:** Fund team-based onboarding infrastructure and collaborative care.

Conclusion & QA

Key Takeaway:

- Attachment needs to work with and for Access and Equity, not against.
- CHCs deal with Clients' lives in a holistic approach, not in numerical values.
- Partnership is a key to success.

Future Questions?

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