Closing the Gap from Enrollment to Engagement: Advancing a Multi-Level Framework for Attachment Readiness in Primary Healthcare

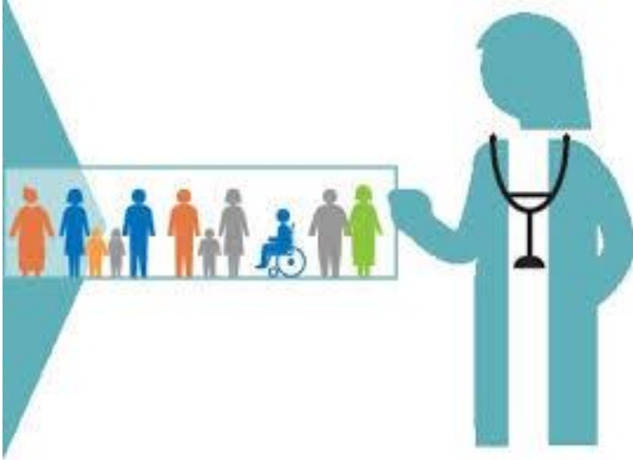
Reframe attachment from a bureaucratic transaction to a system-enabled relationship.

Alliance's Annual Conference 2026

June 4, 2026

Kasia Filaber, MHSc
Akm Alamgir, PhD
Jennifer Rayner, PhD

Why did we focus on attachment?



- **Primary care attachment as a major health care system priority AND a challenge**

- **Consequences of "unattachment"**
  - Fragmented care
  - Emergency department use increases
  - Poorer health outcomes
  - Healthcare costs rise

- **Lack of stable attachment disproportionately affects:**
  - Newcomers
  - Low-income communities
  - People with complex health/social needs
  - People facing language or system-navigation barriers

“Attachment” vs “Attachment Readiness”

- **" 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

Access Alliance
Multicultural Health and Community Services

Study Questions

- Is attachment simply registration?
    - ....Or readiness for a sustained relationship?
- What does "readiness" look like?

Findings

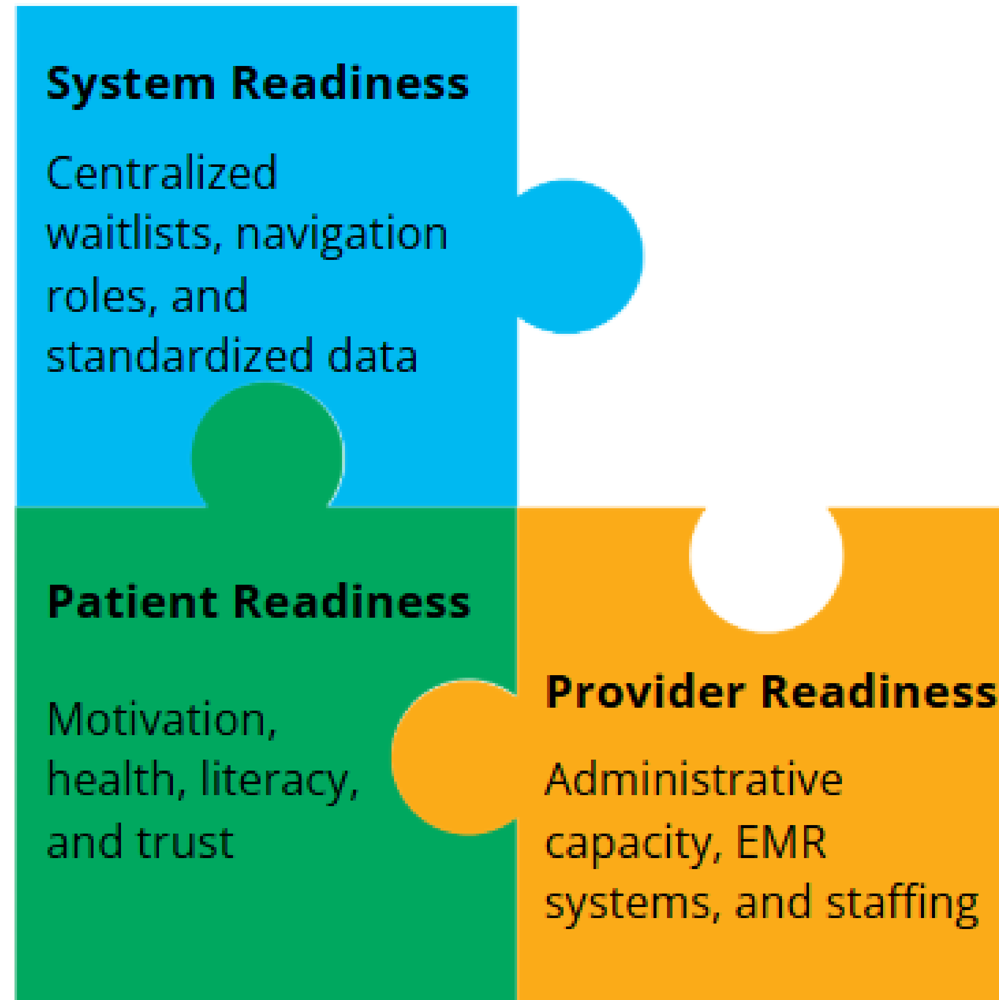
- **Attachment is a process, not a single event**

- **Attachment readiness is:**
  - Relational
  - Dynamic
  - Time-sensitive

- **Readiness depends on:**
  - Patients
  - Providers
  - Multiple external systems

Access Alliance
Multicultural Health and Community Services

Conceptual framework of attachment readiness

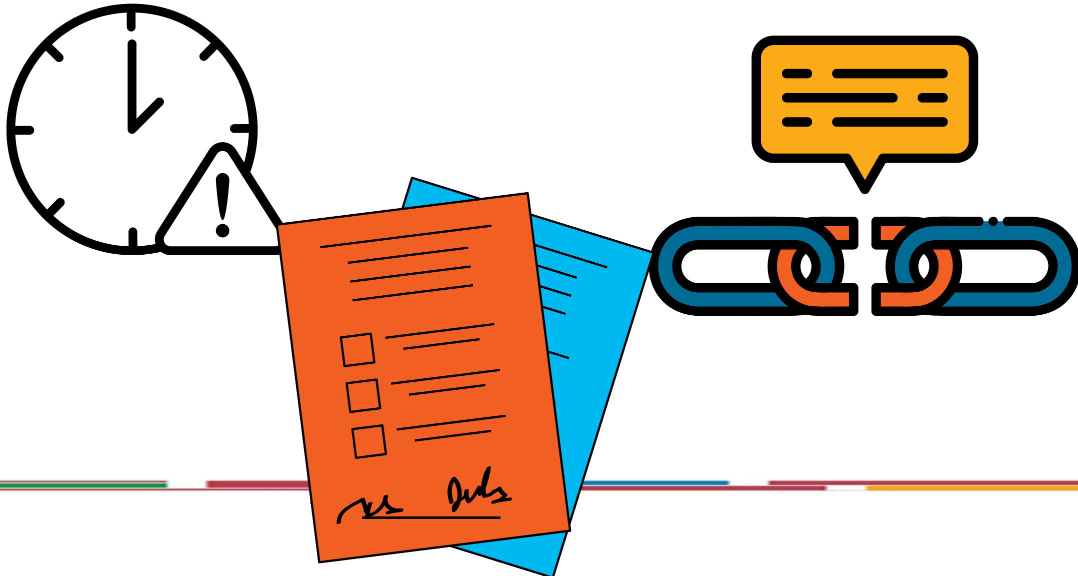


The ‘waiting gap’

Readiness can decay

- Patients may be ready today, but systems can unintentionally reduce readiness over time.

Patients described:

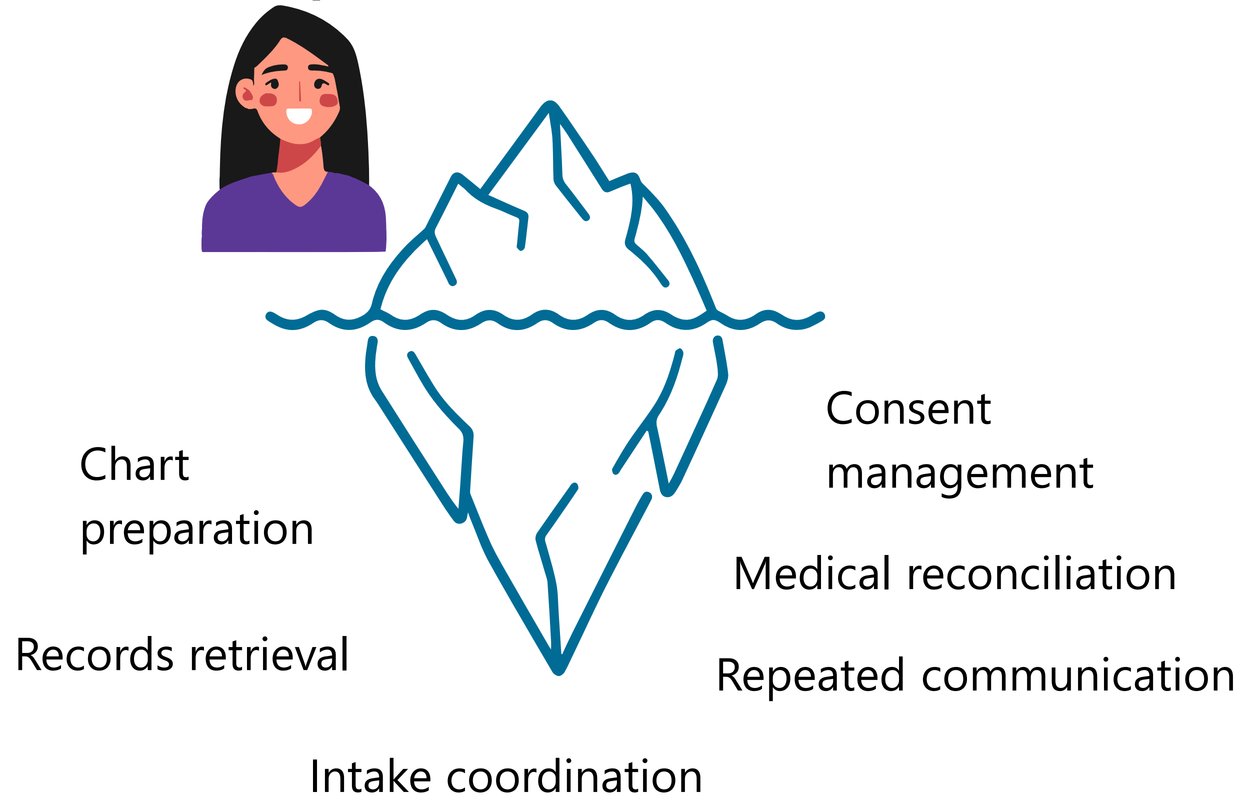


Impact:

- Frustration
- Disengagement
- Mistrust
- Delayed Care

Invisible work of attachment

Attached patient



Capacity is not just about physician numbers.

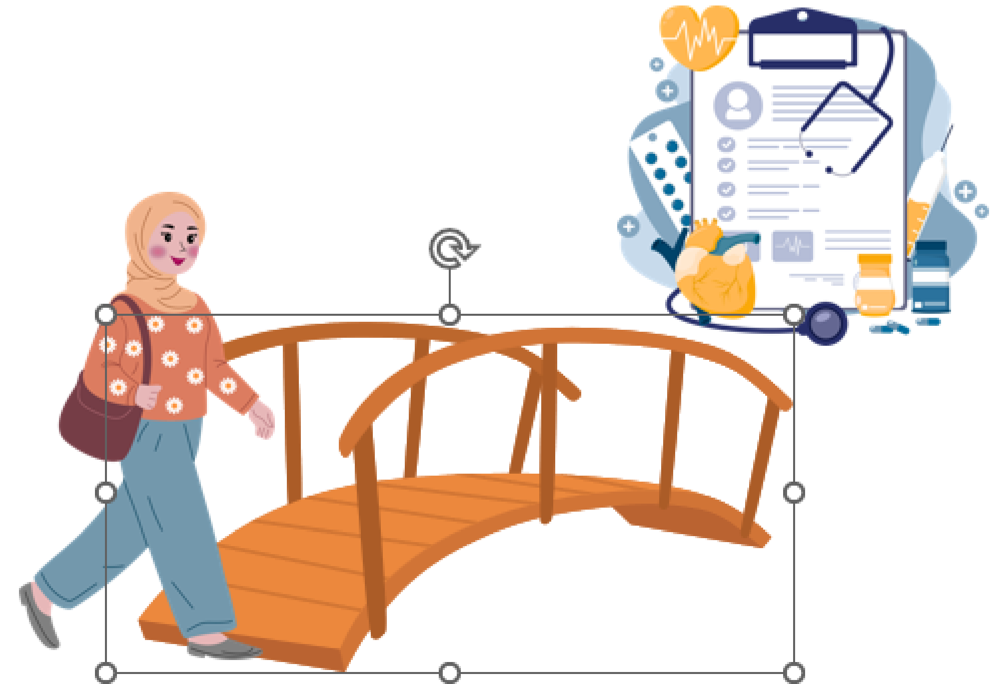
Impact:

- Provider burnout
- Limited onboarding capacity
- Reluctance to accept complex patients

System facilitators of sustainable attachment

- **System Supports:**
    - Centralized intake
    - Standardized onboarding
    - Integrated EMRs
    - Real-time coordination

- **Human Supports:**
    - Patient navigators
    - Concierge roles
    - Team-based care
    - Culturally responsive outreach



Access Alliance
Multicultural Health and Community Services

Recommendations

- **Standardize Onboarding**
  - Digital intake systems that speak to each other
    - Reduce duplication
    - Improve communication

- **Prioritize Vulnerability**
  - Move beyond "first come, first served."
  - Include social and clinical complexity

- **Support Provider Capacity**
  - Recognize onboarding labour
  - Invest in team-based models
  - Strengthen navigation roles

- **Measure Readiness – not only attachment numbers**
  - Include onboarding and retention indicators

Attachment readiness is not an individual responsibility alone – it is a shared system condition.

"Attachment-ready ecosystem" contributes to building an equitable, affordable and sustainable healthcare.

Reflection from Kasia's presentation

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.

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**.

Rationale

Investment Based

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

Value Based

Econometric modeling indicates that even a modest 5% increase in the overall attachment rate among high-risk, unattached populations across Canada can save an estimated $142 million CAD in a single fiscal year.

Hypotheses

1. Unattachment in Canada affects approximately 6.5 million residents that demands a shift in focus from mere system capacity to the nuanced concept of attachment readiness.

2. 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 =

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

How did we do?

Setting

This QI investigation was conducted at Access Alliance MHCS in Toronto.

Focuses

- Blind spots in the ‘rapid’ attachment protocol(s)
- Tri-level readiness ecosystem
- Recommendations for a sustainable population health-based PC service framework.

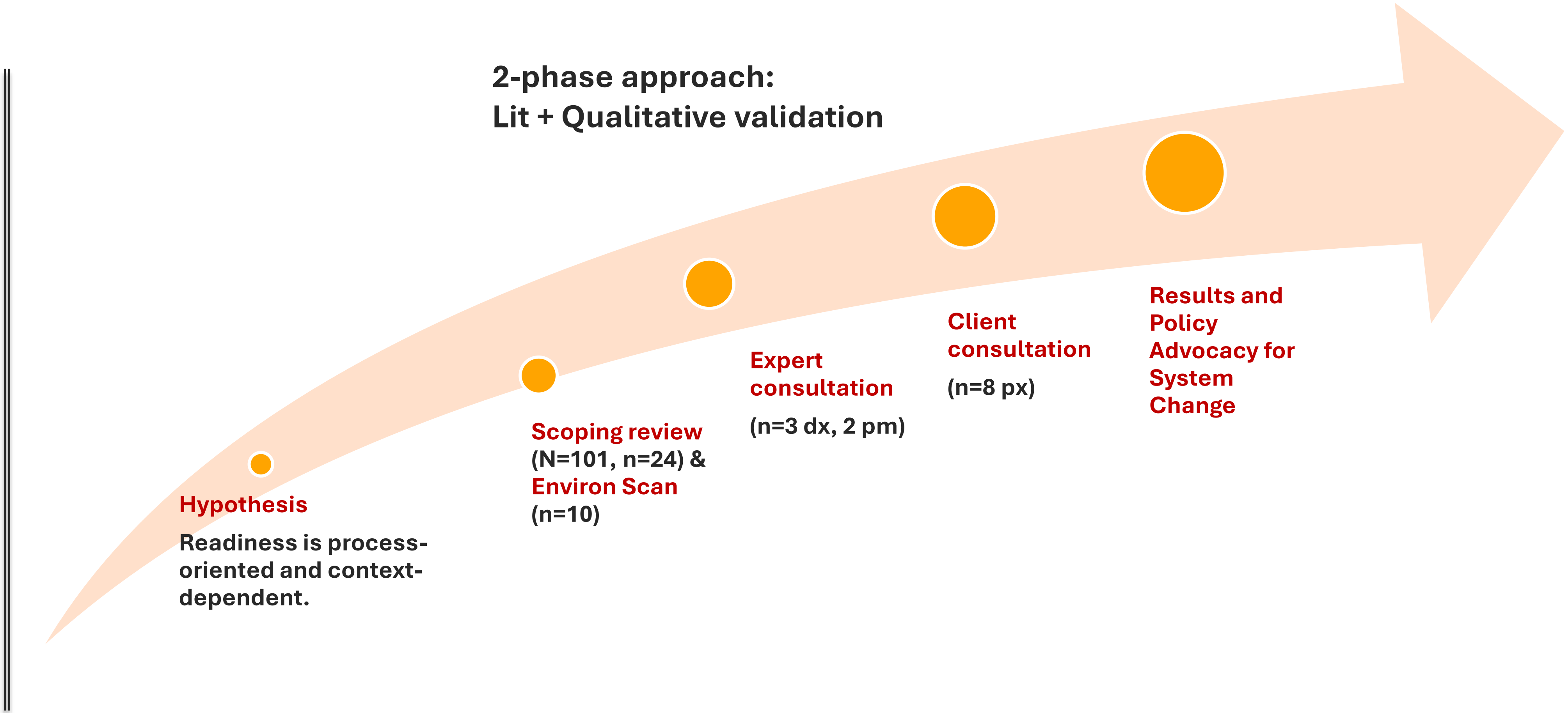
Design

The study was grounded on ‘inclusive and democratic’ community-based participatory action research principles.

We used a sequential mixed-method design consisting of:

1. Ideation and consultation
2. Instrument development
3. Pilot testing
4. Psychometric validation
5. Prospective outcome follow-up

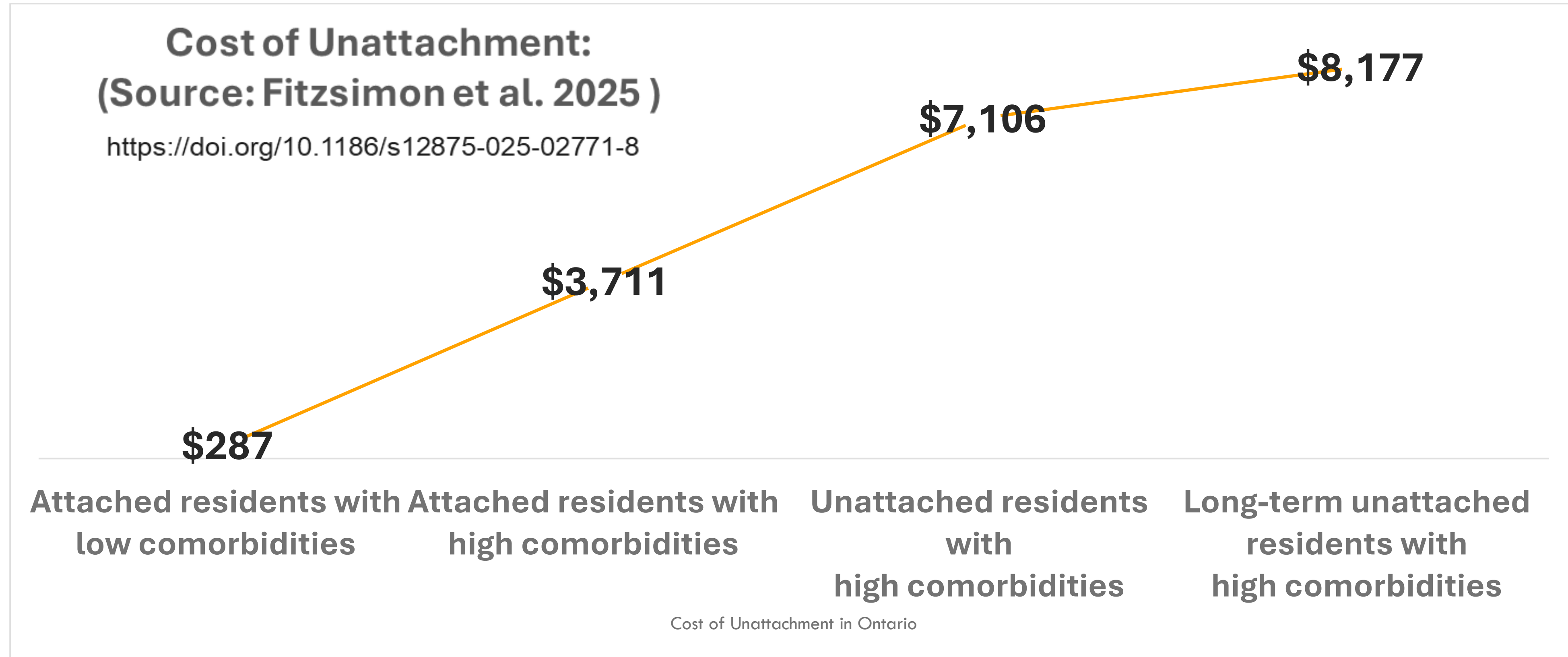
How did we do?

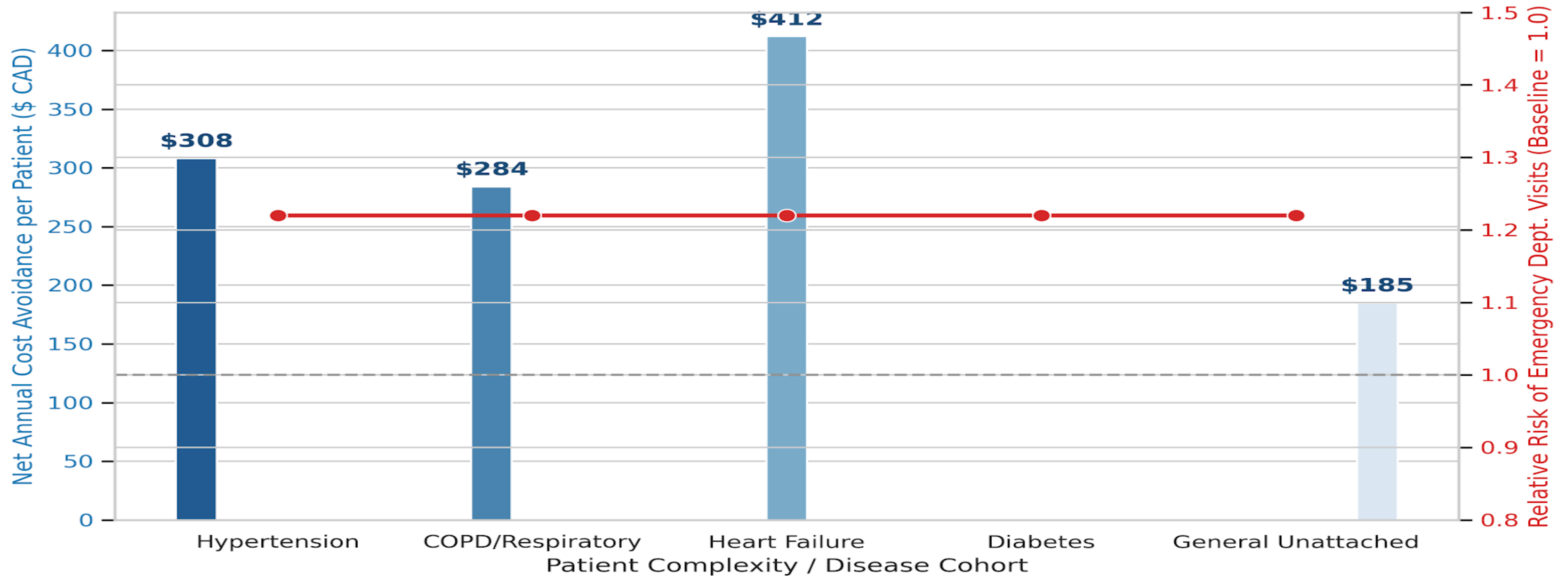


$$\text{Attachment} = \frac{\textit{Complex SDoH} * * \textit{Perceived benefit} * \textit{Medical Complexity} * \textit{Perceived Discrimination} * \textit{Stigma}}{\textit{Availability of SPs} * \; * \textit{Cultural Relativism in Healthcare Access and Delivery} * \textit{Social Support System} * \textit{Healthy Public Policy}}$$

Implications

- **Reduced ER Strain: Unattached patients are 1.22 times more likely to visit an ED; and 1.32 times more likely to experience a non-elective, acute hospital admission..**





Access Alliance
Multicultural Health and Community Services

Readiness Determinant

Tri-metric Domain	Key Determinants	Barriers to Success
Patient Readiness	Health literacy, system trust, life stability, and cultural safety.	Prolonged wait times (1–7 months), language barriers, and opaque communication.
System Readiness	Intermediary roles (e.g., Navigators), standardized data, and CWL transparency.	Inconsistent prioritization, lack of interoperable data, and "matching" without support.

Key Insight:
Development and Validation of the Primary Care Attachment Readiness Scale for Newcomers (PCARS-N): A Community-Based Study in Ontario, Canada to overcome the ‘Decay of Readiness’.

Access Alliance
Multicultural Health and Community Services

Pillar 2 – Provider Readiness

Tri-metric Domain	Key Determinants	Barriers to Success
Patient Readiness	Health literacy, system trust, life stability, and cultural safety.	Prolonged wait times (1–7 months), language barriers, and opaque communication.
Provider Readiness	Administrative infrastructure, EMR optimization, and panel capacity.	Uncompensated onboarding labour, staffing volatility, and excessive administrative burden.
System Readiness	Intermediary roles (e.g., Navigators), standardized data, and CWL transparency.	Inconsistent prioritization, lack of interoperable data, and "matching" without support.

- **Key Insight:** Onboarding as an "unfunded mandate"; how administrative friction leads to selective attachment (avoiding complex cases).

Pillar 3 – System Readiness

Tri-metric Domain	Key Determinants	Barriers to Success
Patient Readiness	Health literacy, system trust, life stability, and cultural safety.	Prolonged wait times (1–7 months), language barriers, and opaque communication.
System Readiness	Intermediary roles (e.g., Navigators), standardized data, and CWL transparency.	Inconsistent prioritization, lack of interoperable data, and "matching" without support.

Key Insight:

Matching a patient to a doctor in a vacuum is often a recipe for failure, rather by By investing in the system's ability to stabilize a patient *before* they reach the clinic door, we move from a reactive model to a proactive, integrated service delivery model.

Access Alliance
Multicultural Health and Community Services

Reality Today

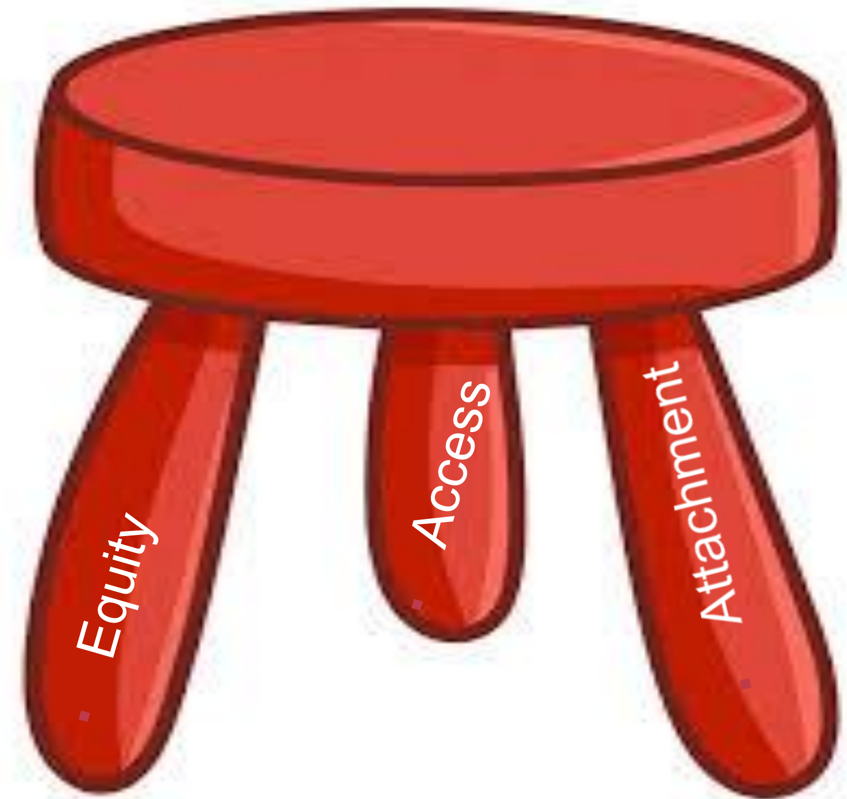
- By 2026, 1 in 4 Ontarians are predicted to be without a family physician
- Retirements, burnout, fewer family physicians to fill these voids
- Unequal access to interprofessional team-based care and people most at risk more likely to be without a family physician
- Primary Care Action table established and 3.4 billion allocated to ensure 100% attachment by 2029
- As of April 1st, 2026, over 330,000 people have access to a primary care clinician

Barriers to Attachment

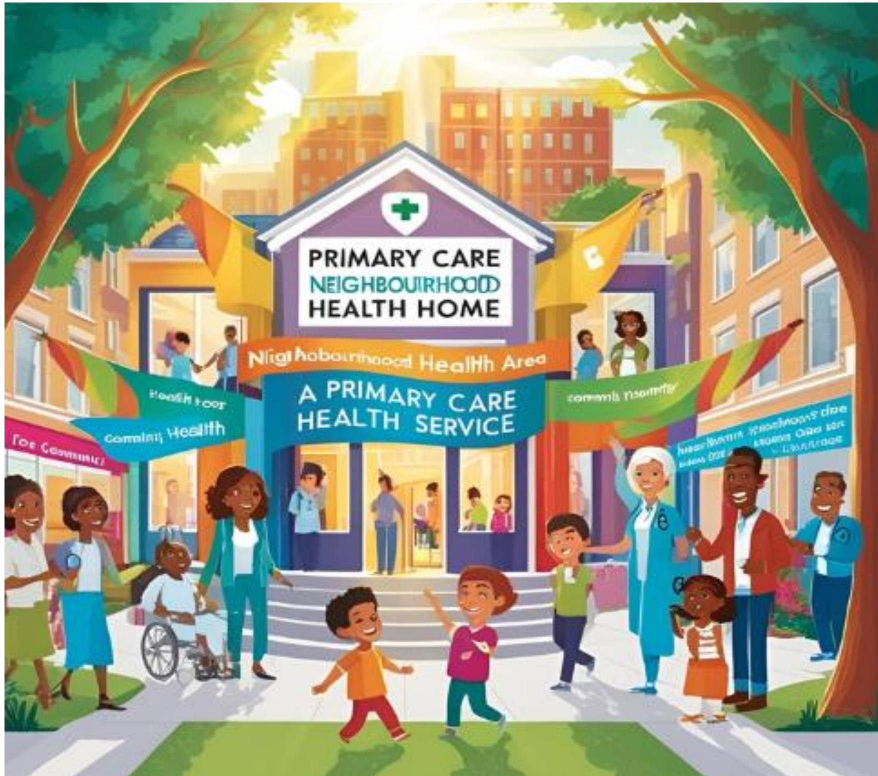
- Primary care clinicians working in silos – many without access to teams
- Meaningful attachment and providing PC to large #s of people --> backlog
- Health Human Resources
- Finding unattached patients --> beyond Health Care Connect
- Siloed reporting --> population/regional approach

Attachment + Access + Equity

- Strong primary care foundation must include Attachment + Access + Equity
- Neighbourhood Health Home model—developed by the Alliance, grounded in the real-world experience



Neighbourhood Health Home with Equity at the Core (Alliance)

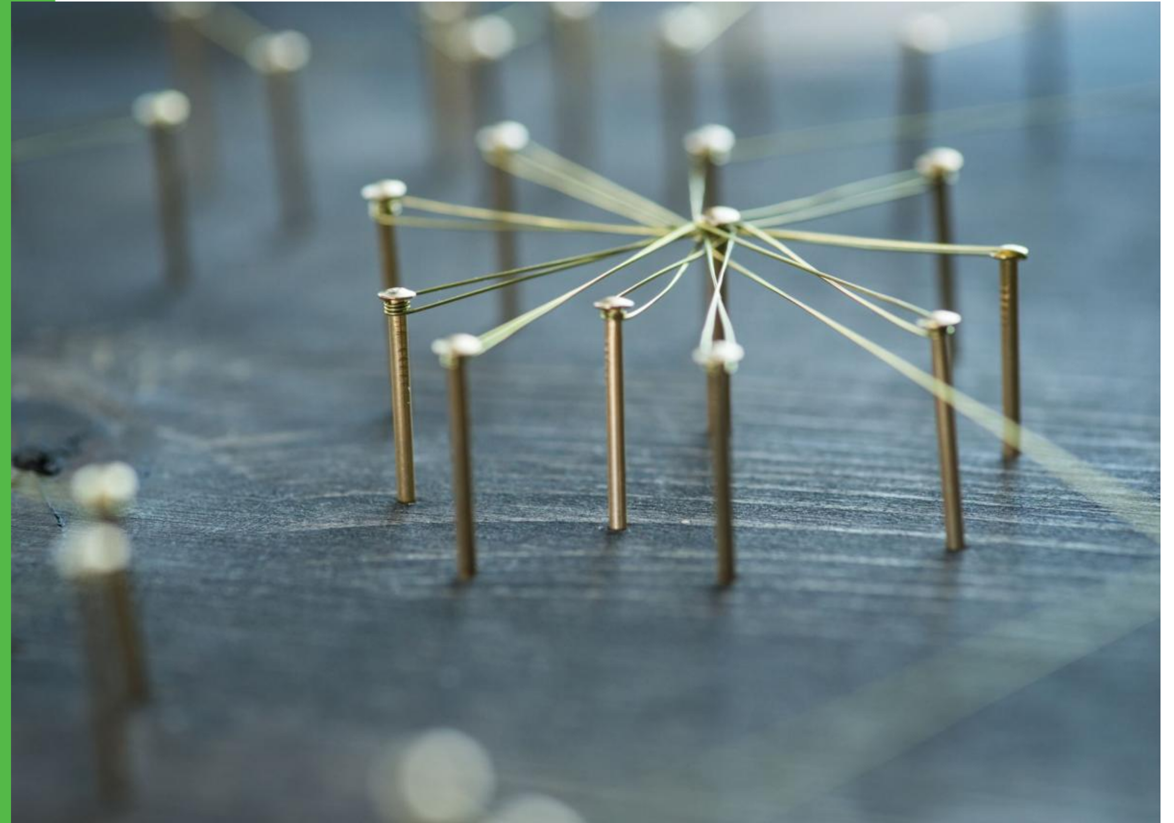


- Health Homes nestled within neighbourhoods serving people from geographical areas or priority populations
- Every person will have barrier-free access to an interprofessional team, health promotion and community supports
- Community members involved with governance, decision-making and co-design
- Build on existing team-based primary care models (and establishing new ones where necessary) – hub and spoke model
- Primary Care Networks – essential to co-design and oversight

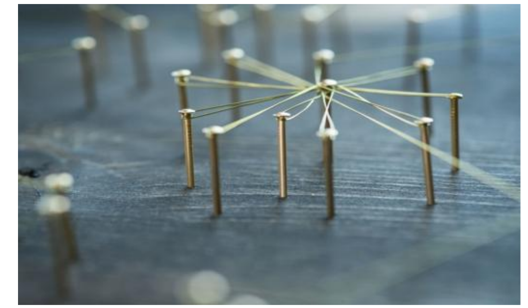
Alliance for Healthier Communities
Alliance pour des communautés en santé

Hub and Spoke Model

- All primary care providers in the Neighbourhood Health Home will have access to the team, in hub and spoke model
- Primary care providers and teams will collaborate to meet local needs
- Each Neighbourhood Health Home will work with the PCN to meet physician and community needs



Hub and Spoke Model



- Ideally, the HUB will be an existing interprofessional team-based primary care organization → several benefits such as existing accountable leadership, community governance, equity focussed and back-office support (including data, learning, quality improvement, etc)
- SPOKES will include all primary care providers within the Primary Care Network
- GOAL will be to ensure that every primary care provider is part of a team – regardless of location. Communication and care coordination will be seamless
- Similar models have been developed with strong results

Population Health and Regional Approach

- Alliance is advocating for a regional approach to attachment
- Load balance clinician panels based on teams available and clinical and social complexity
- Every region would have to fulfill their goal of 100% attachment, but method recognizes that not all people are the same and some people require more care than others

Community Health – No Wrong Door

- Role of community health workers and community ambassadors
- Trusted members of the community
- Important to recognize that some people may be on the road to attachment and this is okay
    - Client has signed documentation (or intends to sign documentation at first visit), but a clinical intake appointment hasn't happened yet

Centralized Intake

- Centralized intake and triage to all participating providers in the community – typically done by the HUB
  - Ensures that people can access the provider that is best able to provide care
  - Patient choice respected
- **Use a standardized digital intake form** to collect patient information before the first appointment that includes sociodemographic and race-based data
- If not in a NHH → all OHT regions offering Supportive Attachment and may be happening automatically for clients registered on Health Care Connect

Other Change Ideas: Client Onboarding

- Evidence from IPCTs, confirms that **client intake & onboarding is one of the most consistently under-resourced activities** in primary care, and **one of the highest-yield areas for redesign**.
- Onboarding as a distinct process
- Change ideas include:
  - Group intakes over several visits
  - Link worker to help navigate supports (social, community, preventive)
  - Medication reconciliation
  - Virtual triage and intake

Alliance Attachment Supports

- IPCT Tool kit developed that includes access and efficiency tools, reports, technology supports, case studies, and other resources
- Individual QI coaches available to teams
- Case studies describing innovation and exemplar sites
- Community of Practice established to share and learn from each other
- Contact QI@AllianceON.org for more information

Primary Care Act → enables primary care to be the foundation of the health system

Primary care expansion → massive financial commitment for primary care teams

Questions and Discussion