What drives patient attachment?

A provincial evaluation of organizational strategies associated with early attachment progress in Ontario interprofessional primary care teams

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Disclaimer

The views represented in this material are those of the authors and do not necessarily reflect the views of the province of Ontario.

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This program evaluation uses existing implementation and accountability information submitted through routine IPCT milestone reporting. It examines organizational attachment strategies and aggregate early progress to support implementation learning, program improvement and policy development.

No patient-level data or individual respondent identifiers were included in the analysis. Findings are presented as provincial or subgroup patterns and are not intended to assess individual organizations. Reported relationships are exploratory and should not be interpreted as causal effects.

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Why examine organizational attachment strategies?

- Attachment to a regular family physician, nurse practitioner or primary care team supports access and continuity of care
- To complement Health Care Connect (HCC), Ontario's provincial attachment pathway, Interprofessional Primary Care Teams (IPCTs) use other approaches to identify, engage and attach patients
- A provincial evaluation can help identify how these complementary approaches are being used, what early implementation patterns are emerging, and what may be needed to sustain attachment capacity over time

Evaluation question: Which organizational attachment strategies appear associated with early progress, and how do patterns vary across implementation contexts?

Program evaluation approach and six strategies

Review routine reporting

- Narrative information from September-April milestone reporting was coded into six organizational attachment strategies.

Explore patterns

- Reviewer-assessed strategy presence and strength were compared descriptively with early progress toward attachment targets

Test context

- Patterns were examined by region, rurality and IPCT model.



Community outreach

- Identify patients through community engagement



Partner-based referrals

- Referrals from organizations already serving unattached patients



Waitlist-based attachment (non-HCC*)

- Attach patients from internal waiting lists



Program-facilitated attachment

- Attachment through clinics or programs (e.g., diabetes clinic)



System-enabled attachment

- Shared intake, triage or attachment pathways across a geographic area



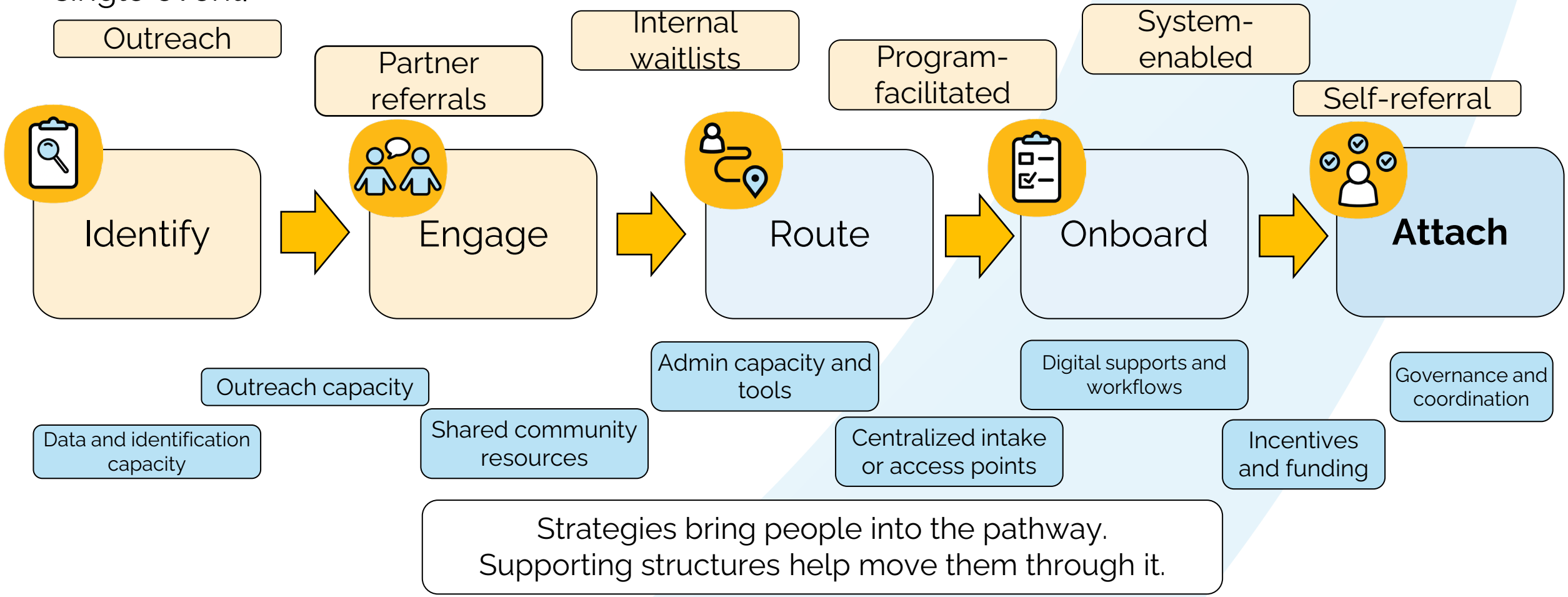
Low-barrier self-referrals

- Patients directly self-identify and seek attachment (e.g., phone call, walk-in)

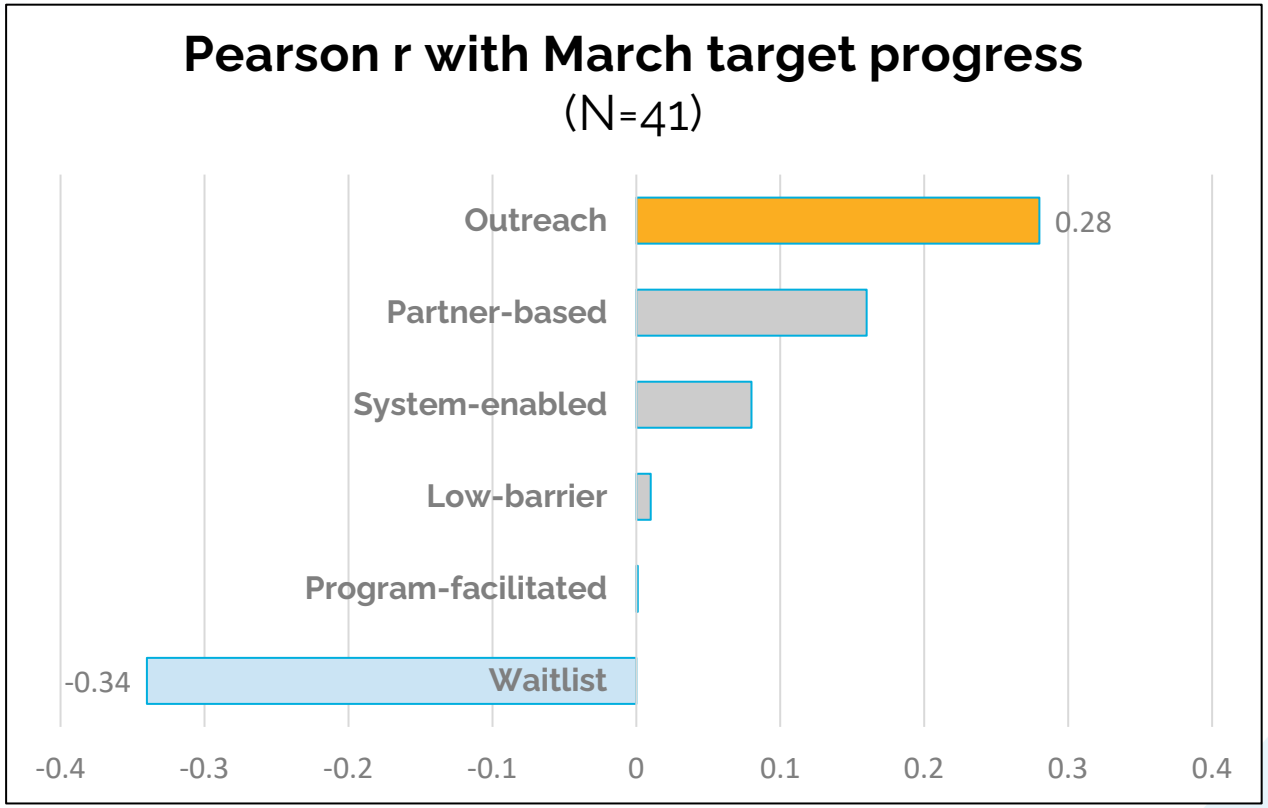
**HCC helps Ontarians connect patients to a family doctor, nurse practitioner or primary care team accepting new patients in their local community.*
Exploratory program-evaluation findings; observed relationships should not be interpreted as causal effects.

Attachment depends on both the pathway and the conditions that support it

To interpret emerging evaluation patterns, we considered attachment as a pathway rather than a single event.



Outreach showed the strongest positive association with early progress among the strategies examined



Positive signal

Outreach had the strongest positive association with early progress to target, but the correlation was weak (r=0.28).

Negative signal

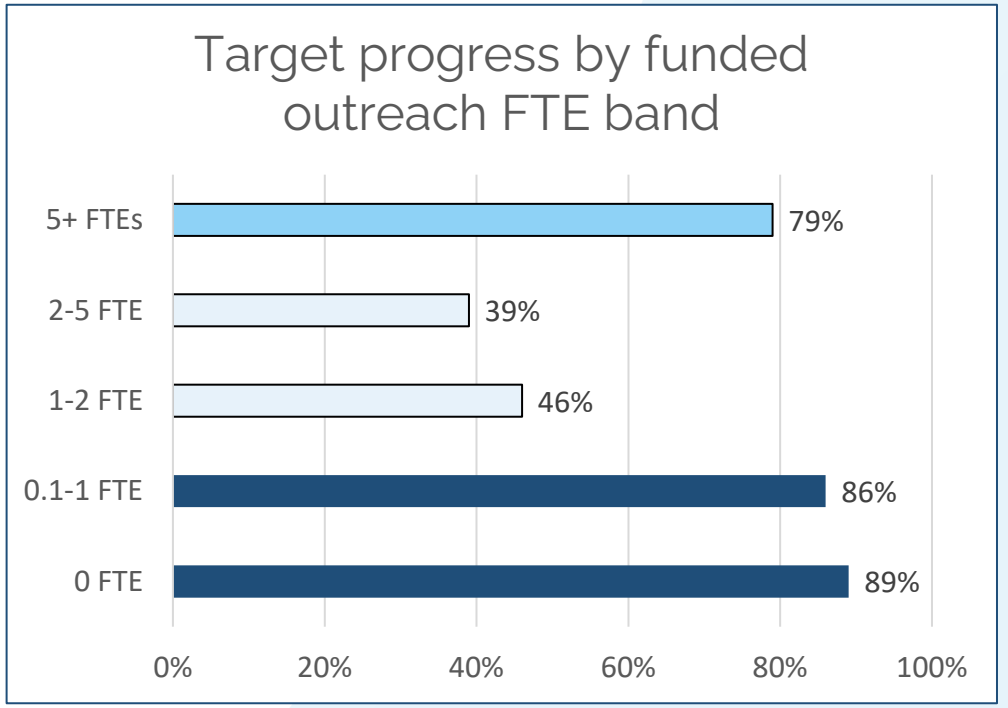
Greater reliance on internal waitlists was negatively associated with slower progress, also a weak to moderate correlation (r=-0.34).

Strategy alone does not explain performance.

Outreach capacity may be embedded across teams and partnerships

60% **of teams with substantial outreach activity and at least 90% to target did not report dedicated outreach roles.**

Early progress did not show a consistent linear pattern across funded outreach FTE bands.



Descriptive averages; FTE bands differ in size and context.

These findings do not indicate that dedicated outreach positions lack value. They suggest that role count alone may not capture outreach capacity, which can be embedded.

Outreach capacity may extend beyond dedicated role count.

- Dedicated or embedded roles
- Community partnerships
- Communications and promotion
- Training and skills
- Accessible entry pathways

Geography and team model shape how strategies function

Urban settings

- Stronger associations with progress with partner-based and system-enabled strategies
- More strategies used overall
- Coordination and shared infrastructure may be more available

Partner referrals	System-enabled

Rural and remote settings

- Outreach and program-facilitated pathways had stronger association with progress
- Fewer system-enabled attachment approaches reported
- Workforce availability, geography, transportation and local infrastructure may influence feasibility

Outreach	Program-facilitated

Emerging model pattern: BSM-FHTs

- Within this evaluation, BSM-FHTs consistently showed positive associations between several reported strategies and progress, including outreach, waitlist-based and program-facilitated pathways
- *Further evaluation question: which contextual or implementation factors may help explain this pattern?*

Partner referrals	Waitlists	Program-facilitated	Low-barrier

Policy and implementation priorities



Outreach capacity

- Outreach roles (community ambassadors, community health workers, etc.) and community-facing functions of teams, and outreach infrastructure including communications campaigns, patient awareness activities and community engagement
- Skill training and development for outreach roles and functions to build capacity



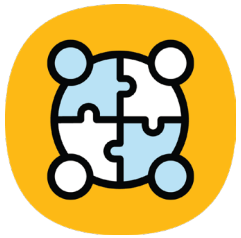
Strengthen the attachment infrastructure

- Strengthen administrative and navigation functions that support intake, patient matching, onboarding and follow up (i.e., supported attachment)
- Strengthen coordination between HCC and local attachment pathways to reduce duplicate referrals, unnecessary outreach, waitlist reconciliation efforts and other administrative burden



Establish a rural and remote approach

- Consider transportation, workforce and administrative constraints; Indigenous partnerships and geographic realities when designing supports
- Determine what local or regional backbone support is needed where system-enabled pathways are less available



Create a continuous provincial learning system

- Develop and share implementation case studies and practical workflows
- Continue to leverage and support the IPCT Community of Practice for rapid provincial learning
- Collect and maintain reusable tools for outreach, intake and follow up

Invest in the people, operating infrastructure and shared learning mechanisms that make locally appropriate attachment strategies work.

Next steps: strengthen the evaluation and translate learning into action

Model and implementation follow-up

Examine the BSM-FHT signal

- Governance and accountability
- Physician-team alignment
- Intake and administrative capacity and workflows
- How effects differ by region

Use ongoing evaluation findings to refine implementation guidance, supports and shared learning

Rural and remote follow-up

Further evaluate outreach and program-facilitated pathways:

- Which programs lead to ongoing attachment?
- Which resources and partnerships enable implementation?
- Where is additional backbone support required?

Outreach-capacity evaluation

Identify what effective outreach capaci
includes

- Dedicated vs embedded responsib
- Communications and media
- Training and role preparation
- Community partnerships
- Patient reach and completed attachment

Thank you!

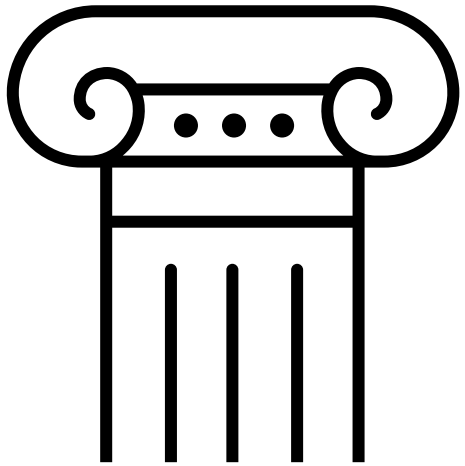
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Appendix

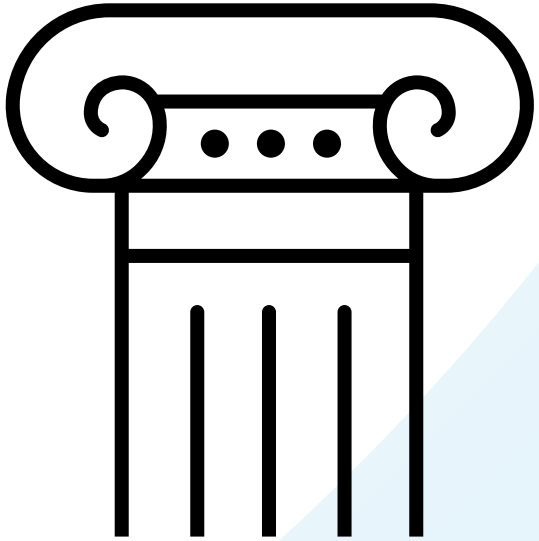
Three Pillars of Attachment

Conceptual framework under development (Hurst & Mahdavi, 2026)

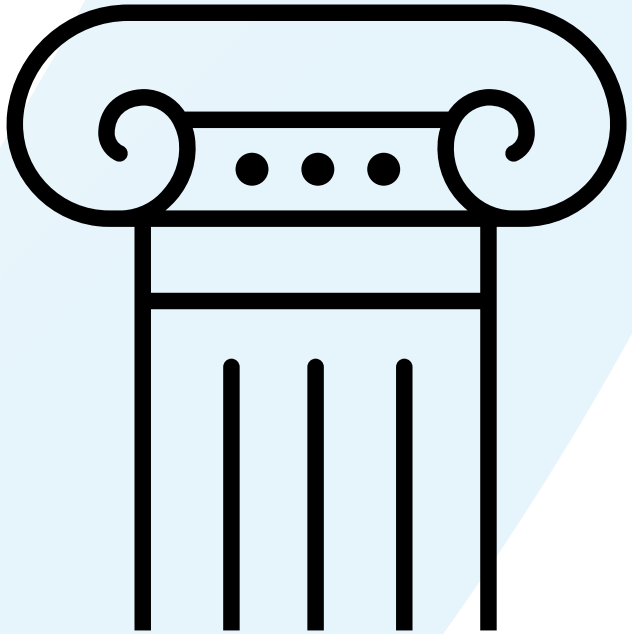
Principles
What shapes decisions about who is attached and how choices are made



Supporting Structures
What enables strategies to function or scale; infrastructure, tools, teams, governance



Strategies
Distinct, actionable ways patients are identified or attached



Program evaluation questions

1. Which reported strategies appear associated with early attachment progress?
2. How do observed patterns vary by geography, team model and local context?
3. Is the use of multiple strategies associated with early progress?
4. What implementation characteristics are reported by teams with higher early progress toward target?

Core Strategies for Attachment (Expanded)

Community outreach and engagement

- Proactive efforts to promote attachment capacity, identify and engage unattached patients/clients in community settings or with the support of community partners or ambassadors.

Partner-based referral pathways

- Attachment through direct referrals from external organizations or clinicians that identify unattached patients they already serve.

Waitlist-based Attachment (non-HCC)

- Attachment of patients identified through structured lists of people actively seeking primary care, maintained by clinics, partners, or systems, and used to prioritize attachment when capacity becomes available

Program-facilitated attachment

- Attachment that occurs through a defined time-limited or condition-specific program, where patients/clients transition or are connected to ongoing primary care

System-enabled attachment

- Attachment enabled through coordinated, system-level mechanisms that triage, distribute or support patients across multiple providers or organizations, rather than through a single clinic's processes.

Low-barrier self-referrals

- Attachment initiated by patients/clients themselves, enabled through accessible, low-barrier entry points.