OCSA
Ontario Community Support Association

Community Partners in Primary Care

HOW ONTARIO'S COMMUNITY SUPPORT ORGANIZATIONS ARE ALREADY WORKING WITH PRIMARY CARE

Ontario's not-for-profit community support organizations are already part of primary care in communities across the province. They embed navigators in clinics, run social prescribing, find and attach unattached patients, get people to appointments, and in some places lead home-based primary care. This summary profiles ten of those partnerships so primary care teams, Ontario Health Teams and policymakers can see what is possible now and who to call.

At a Glance

Organization	Region	Partnership model	Primary care partner
Community Care Concepts	Waterloo (KW4 OHT)	Co-located community navigation team; co-leading team-based care design	Local family physicians and KW4 OHT
Thrive Group	Hamilton	Community connector embedded in clinical team and EMR	Hamilton Family Health Team
Eastern Ottawa Resource Centre	Ottawa	Navigator and case worker funded through FHT partnerships	Two local Family Health Teams
Eganville & District Seniors	Renfrew County (Ottawa Valley OHT)	Community Connector outreach, building on central intake	Ottawa Valley OHT primary care providers

Organization	Region	Partnership model	Primary care partner
Western Ottawa Community Resource Centre	West Ottawa	Social prescribing, navigation and health promotion in clinics	Six primary care clinics
Nucleus Independent Living	Central intake region	Identifying unattached people; shared care plans for complex clients	Primary care teams across sub-regional partners
SPRINT Senior Care	North Toronto	Lead agency for home-based primary care team	Family physicians and VHA Home HealthCare
Community Care Peterborough	Peterborough	PSW accompaniment to medical appointments	Peterborough Family Health Team
Head Injury Rehabilitation Ontario (HIRO)	Hamilton	Dedicated primary care for supportive housing residents	Partner family physicians
CareFirst	Greater Toronto	Community services and a Family Health Team under one integrated model	CareFirst Family Health Team

Navigators and connectors embedded in primary care

Primary care teams rarely have time to find the right community service, confirm eligibility and make the connection. Community organizations already know what exists locally, and several now bring that knowledge into the clinic.

Community Care Concepts - Community Navigation Team (Waterloo)

Community Care Concepts built on more than 15 years as a single point of contact for hospital-to-home referrals across Waterloo Wellington. Its Let's Go Home bundle provides up to six weeks of Meals on Wheels, transportation, homemaking and navigation support with no co-pay; 2,015 patients were supported home in the past fiscal year.

Its Community Navigation Team is co-located in medical buildings and embedded in the physicians' EMR, supporting e-referrals and ongoing communication with primary care. Patients can be supported online, by phone, in shared clinic space or at the team's office.

- **Impact:** one participating family physician estimates the team saves her practice 40 hours of physician time a month, the equivalent of about 160 more appointments.
- **What's next:** the local Ontario Health Team has asked Community Care Concepts to co-lead, with primary care, the design of an integrated team-based care model for the 75% of KW4 physicians who do not have access to team-based care.

Thrive Group - Embedded community connector (Hamilton)

For almost two years, Thrive Group has embedded a community connector and navigator in primary care, affiliated with the Hamilton Family Health Team at the Eva Rothwell Centre and two other Hamilton locations serving vulnerable residents.

- **What makes it a partnership:** the connector works directly with the integrated clinical team, participates in rounds and documents in the practice's EMR, so community supports are part of the care plan rather than a referral afterthought.
- **Supports attachment:** the role helps connect vulnerable residents to a primary care home.

Eastern Ottawa Resource Centre - Navigator and case worker in the clinic (Ottawa)

Through the first round of Interprofessional Primary Care Team funding, Eastern Ottawa Resource Centre partnered with a local Family Health Team, which now flows funding to the agency to provide a community support navigator. The navigator spends most of her time on-site in the clinic, connecting patients to community supports, and the partnership will open a pathway for agency clients without a family doctor to be attached to the clinic.

A second partnership with another Family Health Team, through round two funding, will fund a case worker for patients with complex needs.

- **Why it matters:** it shows primary care expansion funding can flow to a community partner to add capacity the clinic doesn't have.

Eganville & District Seniors - Community Connector (Renfrew County)

Eganville & District Seniors first led a central navigation project: a single point of intake for referrals from primary care and other providers to community support services. It proved the value of

streamlined access and showed that a single door isn't enough when people and providers don't know it exists.

Working with the Ottawa Valley Ontario Health Team, it has evolved into a Community Connector role. The Connector does outreach to emergency departments and the community, guides seniors to the services they need, and helps providers coordinate across multiple organizations, so clinicians spend less time searching and more time on patient care.

- **Lesson:** building the pathway is half the job. Proactive outreach makes it work.

Social prescribing and finding the unattached

Western Ottawa Community Resource Centre - Social prescribing in six clinics (West Ottawa)

Western Ottawa Community Resource Centre is a multi-service organization with community support services and more than 130 programs spanning the social determinants of health. Through two rounds of Interprofessional Primary Care Team funding, it has added health promotion and expanded social prescribing with rural clinics, and now offers social prescribing, system navigation, health promotion and mental health supports in six clinics and three community libraries. Its social prescribing model was co-designed with the Alliance for Healthier Communities.

Two examples of the partnership at work:

- **A senior with stage 4 cancer** was referred by a partner clinic. His immediate worry was nutritious meals. The social prescriber made a direct referral to the agency's Meals on Wheels program, which contacted him to arrange service, so he could stay safely at home and focus on his health.
- **An older adult living with isolation** wanted someone to talk to regularly. The team connected them to Telephone Assurance for ongoing check-in calls.

In its rural communities, primary care expansion funding has helped attach more than 5,000 people to local primary care. The agency also has the physical and governance infrastructure to host primary care on-site, and is exploring that with partners through its Ontario Health Team.

Nucleus Independent Living - From anonymous data to named people (central intake)

Nucleus is the central intake and waitlist management body for its region, operating fully digitally and integrated with sub-regional partners. Of more than 3,200 people on its waitlist, about 40% are not connected to primary care.

- **Finding the unattached:** Ontario Health Teams receive attachment data by postal area, which is anonymized. Nucleus can turn that into identified individuals and work to connect each of them to a primary care home.
- **Shared care for complex clients:** for a client living with diabetes, Nucleus staff in the home several times a day see medication, diet and daily routines. With digital integration, that information feeds the existing care plan and goes back to the physician who is monitoring blood glucose, while staff identify lifestyle supports.

Getting people to care, and bringing care home

Attachment only helps if people can actually reach their care team. Some can't get to the clinic without help; some can't leave home at all.

Community Care Peterborough - Access to Primary Care

Some of Community Care Peterborough's most complex clients were missing medical appointments and follow-ups, and volunteer driving alone wasn't enough. Its Access to Primary Care program provides, at no cost, help preparing for the appointment, transportation there and back, a PSW who accompanies the client, and notetaking during the visit.

- **Results (2018–19 to 2022):** more than 550 clients accompanied to over 2,800 appointments, with at least 62 emergency department diversions. 38% of visits were to primary care providers.
- **Partnership:** a collaboration with the Peterborough Family Health Team, which also increased referrals to other community support services.

SPRINT Senior Care - House Calls (North Toronto)

House Calls brings primary care home for frail seniors whose needs can't be met in an office or virtually. SPRINT Senior Care is the lead agency, partnering with family physicians and VHA Home

HealthCare in a multi-agency team of physicians, nurse practitioners, nurses, occupational therapists, physiotherapists, social workers and coordinators, with consulting geriatric and psychiatric specialists from Toronto hospitals.

The team provides primary care, chronic and acute disease management, system navigation, at-home vaccination, ongoing case management and end-of-life care. Physicians are paid through OHIP, and there is no cost to patients.

- **Results (as reported in 2025/26):** more than 3,700 patients over 15 years; up to 671 patients a year; nearly 20,745 home visits a year; over 1,491 fewer hospital admissions and hospital days; and 92% of patients rating the care excellent or very good.

Head Injury Rehabilitation Ontario (HIRO) - Primary care for supportive housing residents (Hamilton)

People with acquired brain injuries often have high emergency department use and weak connections to primary care. HIRO partnered with two family physicians experienced with vulnerable populations, and a single pharmacy, to provide proactive primary care to nearly all of its residential supportive housing clients.

- **Example:** one client had eight flare-ups of cellulitis in the 24 months before the model, six requiring emergency visits and one a hospital admission. Since the model began, the client has had no emergency visits or hospitalizations for cellulitis.
- **Evaluation:** the model has been evaluated with McMaster University.

Integrated models: community and primary care under one plan

CareFirst - A made-in-Ontario adaptation of PACE (Greater Toronto)

CareFirst offers a full basket of community support and home care services and has operated a Family Health Team for almost 20 years, recently expanded through Interprofessional Primary Care Team funding. After studying the PACE model (Program of All-Inclusive Care for the Elderly) in California, it adapted the approach to Ontario's funding context, built around adult day programs, primary care and home care working as one team.

- **One patient, one care plan, one team:** intensive, interdisciplinary case management with regular case conferencing for the most complex clients, about 5% of its client population.

- **Partner, don't build it all:** CareFirst checked itself against PACE's 18 essential components, found it already had 15, and partnered for the rest.
- **Hub and spoke:** a hub coordinates complex care, spokes deliver it close to home, and asset mapping starts from what a community already has, such as malls, YMCAs and community centres.
- **Results:** in a cohort of 13 very high-need older adults, all were still living at home after 12 months, with no unplanned long-term care admissions. CareFirst estimates the cost at about $3,000 a month in home settings, against about $60,000 a month for a hospital bed.

What these partnerships have in common

- **They go beyond referral.** The strongest models put community staff in the clinic, in rounds and in the shared record, so support is part of the care plan.
- **They build on what already exists.** Each draws on community capacity that was already in place, such as meals, transportation, navigation and trusted local relationships, instead of creating new programs.
- **They free up primary care time.** Navigation, appointment support and coordination take work off physicians and nurse practitioners so they can see more patients.
- **They reach people the clinic can't.** Community organizations know who is unattached, who can't leave home, and who is struggling before they reach the emergency department.
- **Primary care funding can flow to community partners.** Several were made possible by Interprofessional Primary Care Team funding shared with a community agency.

What holds them back is also consistent: most rely on short-term or partial funding, community services are funded and measured by volume rather than outcomes, and many depend on local leaders who made them happen. Scaling what works will take sustained funding for navigation and coordination, community providers at the primary care planning table, and shared digital infrastructure that includes them.

Connect with us

The Ontario Community Support Association (OCSA) represents more than 220 not-for-profit organizations delivering home care, community support services and independent living across Ontario, supporting more than one million Ontarians each year.

To learn more about these partnerships, connect with a member in your region, or share a partnership example of your own, contact:

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