SGFP
GENERAL & FAMILY PRACTICE

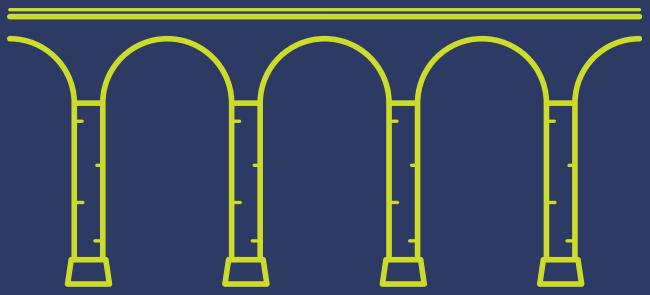
Access, Attachment & Continuity of Care

None without the other in our Primary Care Reform

Discussion Paper

MAY 2025

The Section on General & Famiy Practice is a section of the Ontario Medical Association representing over 15,000 family physicians.



"Continuity of care is the bridge between access and attachment. Without it, access is just an open door, and attachment is just a name on a roster. True primary care means knowing your patients, advocating for them, and ensuring they receive the right care at the right time, every time."

Dr. Beth Perrier, SGFP Policy Lead

TABLE OF CONTENTS

Authors

The SGFP Policy Team:
Dr. Beth Perrier, Lead
Lori Choma, Co-Lead
Dr. Ali Damji
Dr. Ramsey Hijazi
Dr. Ross Male
Dr. Catherine Yu

This important work is only possible through the contributions of our members, and dedicated colleagues. This advocacy effort has not been funded by the OMA.

SUMMARY

Our government talks often, rightfully so, about improving access and attachment in primary care. However, missing from their words and actions is one of the most impactful elements to patient outcomes, patient satisfaction and managing cost: Continuity of care. Attempting to improve access and attachment without the lens of continuity is a misguided effort if you want a healthy population and a sustainable health care system. This paper will define and explore each concept of access, attachment, and continuity of care, how they are intertwined, and why they should not be uncoupled from each other. There are also several practical recommendations for the government to inform their policy, rhetoric and action as related to each of access, attachment and continuity.

RECOMMENDATIONS

- **Define the long-term vision for attachment with the optimal and evidence-supported option: attachment to a family physician and team in a Patient's Medical Home.**
- **Through policy, rhetoric and action, demonstrate to family physicians that they are valued in the system and leverage their expertise in system redesign.**
- **For each government primary care policy or action, filter it through the lens of continuity; determine if the policy/action is supporting or eroding continuity of care.**
- **Define what patients can expect from the system with respect to access, attachment and continuity; educate patients and define accountabilities.**
- **Carefully select goals and their associated metrics to measure progress toward higher attachment and improved access with continuity.**
- **Support access, attachment and continuity with appropriate technology.**
- **Commit to improving access, attachment and continuity through systematic implementation and dedicated change management supports.**

INTRODUCTION

The government often talks, rightfully so, about improving access and attachment to primary care. However, missing from their words and actions is one of the most impactful elements to patient outcomes, patient satisfaction and managing cost: Continuity of care. Attempting to improve access and attachment without the lens of continuity of care is a misguided effort if you want a healthy population and a sustainable health care system. This paper will define and explore each concept of access, attachment, and continuity of care, how they are intertwined, and why they should not be considered without the other. There are also several practical recommendations for the government to inform their policy, rhetoric and action as related to each of access, attachment and continuity.

Access, Attachment, Continuity and the Patient's Medical Home

A key ingredient in transforming the primary care system is the development of a primary care strategy that defines a clear vision for the future along with associated goals and objectives. The SGFP strongly advocates for the government to work with system partners to produce this strategy. As the group that represents the profession delivering the majority of primary care to Ontarians, the SGFP is dedicated to collaborating with the government to build the strategy and ensure its success.

Figure 1: The College of Family Physicians of Canada Patient's Medical Home Vision, 2019.

The SGFP unequivocally backs the adoption of the Patient's Medical Home (PMH) as the vision for the future of the family medicine practice. The PMH is a well-defined, evidence-based, proven model that improves patient outcomes, manages costs, and improves the satisfaction of patients and health care professionals. Core components in the PMH vision include attachment, access, team-based care and continuity, among others. These are shared goals between government and family doctors.

This discussion paper will describe in detail, the interdependencies of access, attachment and continuity, as well as their interdependency with other PMH elements. Uniting the elements under a common language and framework will help system partners align under a shared vision, provide a roadmap for implementation, and establish a basis for measuring progress. The PMH is explored in detail in the SGFP Discussion Paper, Adopting the Patient's Medical Home – The Framework to Evolve Ontario's Family Medicine Practices.

CONTINUITY OF CARE

This discussion begins with the most critical, yet least recognized element by the government: continuity of care. A firm commitment to continuity of care, *anchored in relationships with family physicians and teams*, is essential to transforming Ontario's primary care system into one that is both effective and sustainable. The evidence is unequivocal: continuity of care is not a luxury but a necessity. As previously highlighted, continuity is deeply interconnected with access, attachment, team-based care, and numerous other principles of the Patient's Medical Home, which remain central to the government's priorities.

Continuity of care is a multi-faceted concept that includes **relational continuity, informational continuity,** and **management continuity**. These dimensions must all be addressed in efforts to transform the primary care system. At present, continuity of care in Ontario is under threat, driven by corporate interests in primary care, such as the expanded scope of pharmacists and the rise of corporate virtual care platforms, which continue to undermine its benefits.

Continuity of Care Defined

Continuity of care is the ongoing, trusting therapeutic relationship between a patient and their family physician and team, where the patient sees this family physician most of the time. From the lens of the patient, is the degree to which a series of discrete healthcare events is experienced as coherent, connected and consistent with their medical needs and personal context.

Continuity with a Family Physician and Team

The evidence supporting a continuous relationship with a family physician is robust and compelling. According to a 2020 systematic review by Baker and colleagues, higher continuity of care in primary care settings is consistently associated with a significant reduction in mortality. In fact, the mortality benefit of strong continuity with a family physician in some robust studies is nearly double that of statin therapy, which reduces mortality by approximately 28%. While the exact magnitude varies across studies, several studies in the review reported mortality reductions of up to 50% with higher continuity of care. Importantly, this mortality benefit is observed both in populations with chronic diseases and in generally healthy individuals, underscoring the broad impact of sustained, trusting relationships between patients and their family physician.

Continuity of Care: The Prescription for Saving Lives

In addition to this stunning reduction in mortality, continuity with a family physician reduces emergency room visits, hospital admissions, and specialist consultations. It results in system cost savings; heightened health professionals and patient satisfaction; and improved quality and outcomes. It is crucial to note, however, that access can exist without continuity, but continuity cannot exist without access (more on this in the access section of this paper). Creating access to family physicians is imperative for good health outcomes, patient and health professional satisfaction, cost management, and health equity. In short, **access to continuity of care** significantly contributes to the quintuple aim, a key outcome measure identified by the Ministry of Health.

The literature often highlights the high value patients place on continuity of care, especially older patients with chronic conditions. However, all patients, including young and well individuals benefit from continuity of care. While episodic care often suffices for transient illnesses, continuity of care is clearly superior for patients with chronic diseases. Thus, continuity is a critical tool in our system where chronic disease represents a major burden of illness.

The Dimensions of Continuity: Relational, Informational and Management Continuity

Continuity of care is a multi-dimensional concept with interrelated components. There are three main concepts described in the literature. While they are interrelated, the evidence does not suggest they are hierarchical. However, for an effective healthcare system, all forms of continuity must be in play.

Dimensions of Continuity

Relational continuity refers to the ongoing therapeutic relationship with one or more health care professionals spanning different health care episodes. This relationship is built on accumulated knowledge of patient preferences and circumstances that is rarely recorded in the formal record of care. Interpersonal trust is built on experiences of past care and positive expectations of future competence and care.

Informational continuity links past care with current care by transferring and using patient medical history and personal circumstances. Clinician-held tacit knowledge is complemented by formally recorded information, which is accessible within the patient's circle of care. Additionally, strong evidence supports that patient access to their own health information is a key aspect of informational continuity. For both providers and patients, a single sign-on system is essential to streamline access, as multi-sign-on remains a barrier where records are shared.

***Management continuity** is another way of describing the major goal of Ontario Health Teams, that is, to provide coordinated and integrated care.*

Management continuity is the perception of the degree to which health services are delivered in a coherent and complementary manner to achieve health goals. These are shared management plans or care protocols outlining explicit responsibility for follow-up and coordination. When done effectively, it provides a sense of predictability and security in future care for both patients and health professionals. While the literature does not expose a hierarchy between the three dimensions, management continuity is not as easily achieved without relational and informational continuity in place.

Continuity of Care and Corporate Interests

Corporations are keen to profit off the current primary care crisis. Two prominent and current examples include increasing access to corporate virtual care options and expanding the scope of pharmacists, the latter potentially driven by large pharmacy corporations than by pharmacy professionals themselves.

The SGFP wholly supports the expansion of virtual care options; however, these options must support continuity of care. Corporations offering virtual care services provide access but do not typically or intentionally provide continuity.

Family physicians who have access to team members highly value pharmacists as part of their care teams. The primary issue is not the expansion of pharmacist scopes but rather the push for patients to seek care for minor ailments in pharmacies, especially in the absence of meaningful ways to access patient data and communicate with the patient's family physician, which erodes continuity of care.

While corporations can quickly fill access gaps, these solutions undermine continuity of care. The current trajectory of government actions favoring access over access to continuity contradicts their own goals.

Patient Perspectives on Continuity of Care

As stated earlier, all patients, regardless of age and health status, benefit from high continuity of care with a family physician and team. However, recent data shows that younger generations increasingly value quick and easy access to care over continuity. The system must be designed so that access to continuity of care is reasonably convenient, and patients' accountabilities for accessing primary care must be made clear. Highlighting the importance of continuity to patients should be a priority, with each Patient's Medical Home and the government sharing the responsibility to engage with and educate patients.

Continuity Recommendations

- **Commit to advancing of continuity of care to a family physician and team.**
- **To achieve high continuity of care, apply the lens of continuity for policy decisions and government actions. Policy decisions should be measured against their ability not only to provide access, but to ensure continuity of care.**
- **Implement province wide technological solutions that support informational continuity.**

ATTACHMENT

Attachment Defined

Attachment describes Ontarians having a formalized or unformalized relationship with a safe, culturally appropriate clinic providing longitudinal, comprehensive services of a family physician and the team they work with.

Continuity of care and access are key elements of the attachment relationship. There is no benefit to attachment if you cannot provide access to continuity of care.

Attachment to a Family Physician & Team

The overwhelmingly positive evidence for a continuous relationship with a family physician and team was addressed in the previous section. Ontario's family doctors believe that all Ontarians should have access to a family doctor and their team. This is not intended as an affront to other health care professionals, mainly nurse practitioners, who provide important and valuable care to Ontarians every day. Nurse practitioners play a vital role in diagnosing, treating, and managing health conditions, often serving as the first point of contact for patients and contributing significantly to health promotion and chronic disease management.

However, it remains true that no other health professional offers the same level of medical expertise and comprehensive scope that all Ontarians deserve for their everyday health needs. There are no jurisdictions working on improving attachment to the exclusion of family physicians; instead, the focus is on the ideal complement of team-based care, with the family physicians at the centre, supported by other health professionals.

Being attached to a family physician does not mean that patients will not see other professionals for most of their care or that they will see the family doctor at every visit. Instead, it ensures that a family doctor is available for consultation and provides medical oversight as part of the broader primary care team. Other healthcare professionals complement this model by offering specialized care and collaboration within the team, ensuring patients receive well-rounded support.

The Current Reality: Not Enough Family Physicians to Attach all Ontarians

Within the existing model of family medicine delivery, Ontario is facing a significant shortage of family physicians—insufficient to ensure attachment for every Ontarian. This crisis will continue to escalate unless the systemic challenges that undermine family medicine as a profession are addressed. These challenges include inadequate remuneration, excessive administrative burdens, and a pervasive lack of respect and recognition for the critical role that family physicians play in the healthcare system.

Despite this grim reality, we must retain and champion a future vision, rooted in evidence, that every patient should be attached to a family physician and their team. Achieving this vision will take time, even with immediate efforts to resolve the underlying issues in family medicine. Short-term, interim solutions must bridge the gap while systemic change takes root.

Engaging family physicians in this transformation is vital. As the most prominent providers of primary care, they are uniquely positioned to develop and implement solutions that address both short-term needs and the long-term sustainability of the system. Their insights and frontline experiences are indispensable for driving meaningful, impactful change.

The Dilemma of Increasing Family Physician Roster Sizes

If you ask most family physicians working in comprehensive, longitudinal care right now if they would increase their roster or panel size, even with higher remuneration, their response will likely be an emphatic no. Patient age and complexity continue to rise, administrative burdens grow heavier, and the current environment often leaves family physicians feeling undervalued and unsupported by government. Asking them to take on more without addressing these fundamental issues is neither realistic nor sustainable.

While team support is a key solution to enabling increased roster sizes, this approach is not without its challenges. Attachment must remain to the family physician, but the responsibility cannot fall squarely on them when team dynamics shift—for instance, due to illness or the departure of team members. To succeed, team-based models will require robust enablers that ensure continuity and consistency.

One potential solution lies in hubs for cross coverage, which could provide stability and support when team capacity changes. However, these approaches need clear definition, thoughtful planning, and guarantees that team support will remain reliable as family physicians grow their roster sizes. Without these assurances, family physicians may be understandably hesitant to expand their patient panels, risking further delays in resolving the attachment crisis.

The path forward requires not only innovative solutions but meaningful engagement with family physicians themselves. Respectfully involving those who do the work in planning and ongoing management and leadership will be critical to ensuring changes are practical, effective, and sustainable.

100% Attachment

The concept of 100% attachment, implying all citizens are connected to a family physician or nurse practitioner, has garnered significant attention. Several current and high-profile and influential documents underscore this initiative:

- The College of Family Physicians of Canada's A New Vision for Canada, The Patient's Medical Home (2019): This report highlights that "every patient is registered with a Patient's Medical Home" as a core recommendation within the accessible care pillar.

- Primary Care Needs OurCare Report (2024), led by Dr. Tara Kiran: This report indicates that patients overwhelmingly support the idea that access to primary care should be as universal and fundamental as access to public education.

- Health for All – A Doctor's Prescription for a Healthier Canada (2024) by Dr. Jane Philpott: Dr. Philpott envisions a healthcare system where every Canadian has a health home, ensuring comprehensive, continuous care.

Ontario's Primary Care Action Team led by Dr. Jane Philpott has used specific language, "…to implement its action plan to build a primary care system that draws on best-in-class models from across the province and connects everyone to a primary care team, made up of a family physician or nurse practitioner and other health care professionals such as nurses, physician assistants, social workers, physiotherapists and more."

This is a worthy goal. The SGFP strongly supports the idea that every person should have the opportunity to be attached to a Patient's Medical Home. The SGFP also acknowledges that there will always be patients who choose not to be attached, making 100% attachment unattainable, but we agree to strive to get as close to this goal as possible.

Attachment must work not only for the patients but also for the communities and the professionals serving them. The SGFP is committed to contributing to ongoing discussions and efforts to make this vision a reality, recognizing needs will vary across the province. Systematically engaging family physicians in these discussions will be crucial, as their frontline experience and insights are invaluable for developing and implementing effective solutions.

Tracking and Measuring Attachment

Given the variety of family physician remuneration models in place, effectively tracking attachment and measuring progress toward the 100% attachment goal requires a province-wide commitment to formal rostering or a combined approach utilizing both formal rostering and informal paneling. Additionally, a central roster registry integrated into health information systems is essential for document routing, informational continuity, and accurate measurement of attachment levels.

Formal Rostering: Formal rostering involves officially registering patients with a specific primary care clinician or practice and is a feature of the current patient enrolment models. Each "rostered" patient has a designated family physician responsible for their ongoing care. Formal rostering includes an agreement between the patient and the clinician, outlining expectations and responsibilities. It facilitates comprehensive and continuous care, enabling better management of patient health records and more effective coordination of healthcare services.

Informal Paneling: Informal paneling refers to the practice of associating patients with primary care clinicians without a formal registration process. It often relies on historical patient-clinician relationships or patterns of care. Informal panels help distribute patient care responsibilities among clinicians in a more flexible manner. While it may not provide the same level of formal commitment as rostering, informal paneling still ensures that patients have access to consistent and familiar primary care clinicians. If informal paneling will be used for tracking, a structured method to record these relationships and a repository to hold the information will be required.

Major requirements for measuring attachment with both rostering and informal paneling:

- Alignment of attachment tracking with family physician remuneration models.
- Implementation of a province-wide roster registry integrated into health information systems.
- A mechanism to track informal panels at both clinic and provincial levels.
- Integration of attachment tracking with document routing and continuity of care efforts.

Attachment Recommendations

- **Through policy, rhetoric and action, demonstrate to family physicians that they are valued in the system.**
- **Engage family physicians in creating and implementing the solutions to increase attachment.**
- **Increase roster sizes through the thoughtful, systematic implementation of team-based care and concerted efforts to reduce administrative burden to increase family physician capacity for rostering.**
- **Develop a plan to formally roster and/or informally panel province wide.**

ACCESS...TO CONTINUITY OF CARE

Hopefully it is becoming clearer why it is not just access to care that is needed but access to continuity of care. Access alone (i.e., without attachment to a continuous relationship with a family physician and team) does not create the better outcomes, high patient satisfaction and lowering of costs (all elements of the quintuple aim) that the government claims to desire.

Definition of Access

Access to primary care refers to the availability and timely ability of individuals to obtain needed health services from a family physician or their team of qualified health professionals, ensuring that care is geographically accessible, culturally appropriate, and equitable.

Measuring Access

The measurement of access will need to be consistent, easy, meaningful and appropriate.

Consistent: A measure/measures that can be applied across all primary care settings to provide a provincial snapshot of access will be needed.

Appropriate: Although the family physician remains the most responsible provider (in most cases) they are not intended to be gatekeepers of care. The measurement of timely access should be to the most appropriate team member. The family physician will need to remain informed but not always directing all aspects of care.

Easy: Measures of access will need to occur at the level of the most responsible provider. If the measure is to be taken reliably at the clinic level, it will need to be a quick and easy measure.

Person-centred: Consider patient preferences and patient need.

Meaningful: The access measure(s) should not be limited to just measuring same-day access. As Premji (2018) stated, “Patients’ perceptions of the acceptability of their wait time is arguably more important than the elapsed time to an appointment, and excessive focus on same-day or next-day access can result in unintended negative effects on other aspects of high-quality primary care.” This perspective underscores that patients do not necessarily require same-day access but rather value the perceived acceptability of their wait time more than the actual time elapsed. In the United Kingdom, for example, incentives aimed at improving same-day or next-day access not only failed to improve patient-reported access but also led to decreased continuity of care. Ontario can take heed of the UK lesson learned and measure access with a broader perspective—one that includes acceptability to patients and maintenance of continuity of care.

Time to Third Next Available Appointment

A commonly used access measure is time to third next available appointment. While this measure could certainly fulfil the criteria of being consistent, easy, meaningful, and appropriate, its success hinges on the nuances of how it is implemented and utilized. Implementing and using such a measure province-wide will require thoughtful consultation with family physicians and their teams. For instance, how a family physician structures their practice around commitments, like a focused practice, must be considered.

Strengthening Access Without Overburdening Care

While measuring and improving access are essential, they must be implemented with a realistic understanding of the current state of primary care. Years of underinvestment have left many clinics facing workforce shortages, financial constraints, and administrative burdens that limit their ability to provide timely access and/or expand services.

Access solutions must be designed to strengthen primary care rather than impose additional pressures on an already strained system. Sustainable improvements will require strategic investment, collaborative planning, and support mechanisms to ensure that access goals align with the practical realities faced by family physicians and their teams. Importantly, the Quintuple Aim highlights provider well-being as a foundational element in achieving healthcare system success. Ensuring that access improvements support clinician resilience, mitigate burnout, and enhance workplace satisfaction is crucial—otherwise, even well-intended initiatives risk becoming unsustainable.

Patient Education

Ensuring patients understand how to access care in the right place at the right time is essential for an effective healthcare system. Patients need guidance on when to seek care from their family physician, when alternative providers such as pharmacists, nurse practitioners or physiotherapists may be appropriate, and how to navigate urgent or emergency care settings.

This education must be a shared responsibility between government and family physicians and their teams. Government initiatives can provide public awareness campaigns, clear guidelines, and accessible digital resources to support patient decision-making. Meanwhile, family physicians and their teams play a crucial role in reinforcing these principles through direct patient interactions, clinic-level education, and community engagement.

Patient Engagement

It is important to acknowledge the critical role of patient participation in shaping how attachment and access to continuity of care are achieved in their communities. Patients are valuable partners in the healthcare process and should have opportunities to provide input on how attachment is established and how timely access to care is ensured. Their insights and experiences can help tailor healthcare services to better meet the needs and preferences of the community, ultimately leading to more effective and responsive care.

Barriers to Access

Access to primary care is also influenced by a range of factors that collectively determine whether individuals can receive timely and appropriate care. Geographic location, socioeconomic status, language barriers, and the availability of healthcare professionals are primary determinants that create disparities in access. Particularly, rural, remote, and underserved communities face unique challenges that compound these barriers, often leaving residents with limited options for essential healthcare services.

The intersection of these factors means that access to care is not solely about the presence of healthcare facilities but also about ensuring that care is reachable, affordable, and culturally competent. It is crucial to address the systemic issues that perpetuate these disparities, from policy-level interventions to community-based solutions that enhance both physical and virtual access. Moreover, improving health literacy and leveraging technology can play significant roles in bridging the gaps, ensuring that everyone, regardless of their background, has equitable access to quality primary care. This is reinforced by evidence from the WHO, which highlights that digital health investments yield substantial returns and have the greatest impact when inclusive of marginalized and vulnerable populations.

Addressing these barriers requires a holistic approach that considers the social determinants of health, and the unique needs of diverse populations. It involves engaging with communities to understand their specific challenges and developing targeted strategies that promote inclusivity and accessibility. The Patient's Medical Home model includes Patient and Family-Partnered Care as one of ten pillars, meaning the implementation of the PMH could work to address access barriers. And Primary Care Networks could be the mechanism with provincial reach to address barriers, working directly at the local level with the ability to inform provincial policy.

Leveraging Innovations for Access

There are many innovations that can be leveraged to improve access. Some of these are already in play to varying extents across the province and could be scaled up. To have measurable success, spread and scale of the approaches will be necessary.

Enhanced/Advanced Access Approaches: Implementing systems such as open scheduling, same-day appointments, and flexible booking methods to ensure patients can get timely care when they need it.

Virtual Care: Utilizing telehealth and telemedicine technologies to provide remote consultations, follow-ups, and healthcare services, making it easier for patients to access care without the need to travel.

Mobile Clinics: Deploying mobile health units to reach underserved and remote communities, providing essential services like screenings, vaccinations, and routine check-ups directly to those who have limited access to healthcare facilities.

Clinic Hours: Extending clinic hours to evenings and weekends can improve accessibility for patients with varying schedules. This approach has already been successfully implemented in Family Health Organizations (FHOs) and could be expanded with appropriate human resource planning and compensation structures. A sustainable model might include shared responsibility frameworks, such as call groups, expanded team-based scheduling, and centralized call centers to support after-hours care.

Team-Based Care: Enhancing care delivery by utilizing a collaborative approach where healthcare professionals, including physicians, nurse practitioners, pharmacists, and other specialists, work together to provide comprehensive care to patients.

Group Visits: Organizing group medical visits for patients with similar conditions, such as chronic disease management groups, to provide education, peer support, and efficient care delivery. This can improve access by reducing appointment bottlenecks and offering valuable group learning experiences.

Integrated Care Models: Implementing integrated care models that combine physical, mental, and social health services under one roof, ensuring comprehensive care and easier access for patients.

As mentioned earlier, effective patient education and navigation will be essential to ensure the successful implementation and uptake of these innovations, helping individuals understand how to best access care within an evolving system.

Access to Team

This concept was discussed in an earlier section of this paper, but bears repeating. Access is not only about access to the family physician but also access to the best healthcare professional for the patient's presenting issue. In a Patient's Medical Home, each member of the team is encouraged and supported in developing ongoing relationships with patients. The family physician is the quarterback of care, not the gatekeeper of care.

Achieving Access Improvements

Evidence suggests achieving timely access is unlikely to happen in isolation to other clinical improvement efforts. In addition to the underlying structural changes, for example, family physician compensation and clinic infrastructure, other clinical processes need to be optimized as access is just one component of a high functioning practice. Some of these clinical processes include practices for delivery of proactive care and optimizing team-based care.

It should also be noted that achieving timely access is a highly complex clinical process improvement activity that requires careful integration into broader practice enhancements. While it is possible to implement access improvements without first building capacity, evidence suggests that optimizing other quality improvement (QI) efforts, such as team-based care and proactive care delivery, can significantly strengthen a clinic's ability to sustain meaningful access changes. Successful and lasting improvements are far more likely when supported by highly skilled practice facilitators, who work alongside clinics over extended periods to foster a culture of continuous improvement and provide the necessary guidance for integrating structured, data-driven approaches that support access and overall care enhancement.

Access Recommendations

- **Leverage proven innovations from other jurisdictions that support access improvements.**
- **Provide change management supports for implementation of team and access improvement.**
- **Include patient in the design process; set and manage patient expectations of appropriate access.**

THE ROLE OF EMERGING AI IN ACCESS AND CONTINUITY

Advancements in artificial intelligence (AI) present new opportunities to enhance access, continuity, and attachment in primary care. AI-driven tools can support predictive analytics for patient demand, optimize appointment scheduling, and streamline triaging processes, ensuring patients receive timely and appropriate care. AI Scribes are already reducing administrative burden of users across the province and has the potential to create increased capacity for timely access.

Additionally, AI can strengthen continuity by enhancing clinical decision support, translating complex medical jargon into patient-friendly language to improve health literacy, and assisting providers in managing complex patient needs efficiently. AI also offers potential for reducing paperwork burdens, such as completing forms, insurance requests, and other documentation, allowing providers to focus more on patient care.

However, successful AI integration requires comprehensive education for patients, providers, and the healthcare system on its functionality, limitations, and risks. Challenges remain, including high upfront costs and the absence of a safe, structured framework for training AI to meet Ontario's healthcare needs. Thoughtful implementation, guided by strong digital health policy frameworks and data governance rules, is essential to ensuring AI strengthens rather than disrupts primary care relationships.

CONCLUSION

The successful transformation of Ontario's primary care system hinges on the interdependent principles of access, attachment, and continuity of care. While the government has rightfully focused on improving access and attachment, the critical element of continuity of care must be given equal prominence in policy decisions and actions.

Recommendations:

- **Define the long-term vision for attachment with the best and evidence-supported option: attachment to a family physician and team.**
- **Through policy, rhetoric and action, demonstrate to family physicians that they are valued in the system and then leverage their expertise in system redesign.**
- **For each government primary care policy or action, filter it through the lens of continuity; determine if the policy/action is supporting or eroding continuity of care.**
- **Define what patients can expect from the system with respect to access, attachment and continuity; educate patients and define accountabilities.**
- **Carefully select goals and their associated metrics to measure progress toward higher attachment and improved access with continuity.**
- **Support access, attachment and continuity with appropriate technology that enables each.**
- **Acknowledge improving access, attachment and continuity will require systematic implementation and change management supports.**

By focusing on these interconnected aspects of primary care, Ontario can build a healthcare system that not only improves patient outcomes and satisfaction but also ensures long-term sustainability. The path forward requires collaboration between government, healthcare professionals, and patients, with a shared commitment to the principles of access, attachment, and continuity of care.

REFERENCES

Aggarwal, M., & Glazier, R. H. (2024). Toward a universal definition of provider-patient attachment in primary care. Canadian Family Physician, 70(10), 634-641.

Baker R, Freeman GK, Haggerty JL, Bankart MJ, Nockels KH. Primary medical care continuity and patient mortality: a systematic review. BMJ Open. 2020 Jun 28;10(6):e036925. doi: 10.1136/bmjopen-2020-036925

Baskerville, N. B., Liddy, C., & Hogg, W. (2012). Systematic review and meta-analysis of practice facilitation within primary care settings. Annals of Family Medicine, 10(1), 63-74.

Canadian Institute for Health Information (CIHI). Continuity of Care with Family Medicine Physicians: Why It Matters. Mississauga, ON: CIHI; 2015.

College of Family Physicians of Canada. A New Vision for Canada: Family Practice – The Patient's Medical Home 2019. Mississauga, ON: College of Family Physicians of Canada; 2019.

College of Family Physicians of Canada. Best Advice Guide: Timely Access to Appointments in Family Practice. Mississauga, ON: College of Family Physicians of Canada; 2012.

College of Family Physicians of Canada. Patient's Medical Home. Best Advice Guide: Rostering. Mississauga, ON: Patient's Medical Home; 2024.

Gupta R, Bodenheimer T. How Primary Care Practices Can Improve Continuity of Care. JAMA Intern Med. 2013 Nov 11;173(20):1885–6.

Haggerty JL, et al. Continuity of care: a multidisciplinary review. BMJ 2003;327:1219–21. 10.1136/bmj.327.7425.1219

Knox, L., & Brach, C. (2015). Establishing Patient Panels in Primary Care: How and How Big. Rockville, MD: Agency for Healthcare Research and Quality.

Nowak MM, Niemczyk M, Florczyk M, Kurzyna M, Pączek L. Effect of Statins on All-Cause Mortality in Adults: A Systematic Review and Meta-Analysis of Propensity Score-Matched Studies. J Clin Med. 2022 Sep 25;11(19):5643. doi: 10.3390/jcm11195643. PMID: 36233511; PMCID: PMC9572734.

Nutting PA, Goodwin MA, Flocke SA, Zyzanski SJ, Stange KC. Continuity of primary care: to whom does it matter and when? Ann Fam Med. 2003 Oct;1(3):149–55.

Ontario Ministry of Health. Your Health: A Plan for Connected and Convenient Care. Toronto, ON: Ontario Ministry of Health; 2024.

Peckham, A., Ho, J., & Marchildon, G. (2018). Policy innovations in primary care across Canada. North American Observatory on Health Systems and Policies.

Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors-a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open. 2018 Jun 28;8(6):e021161.

Premji, K., Ryan, B. L., Hogg, W. E., & Wodchis, W. P. (2018). Patients' perceptions of access to primary care: Analysis of the QUALICOPC Patient Experiences Survey. Canadian Family Physician, 64, 212-220.

Rubenstein, L. V., Hempel, S., Danz, M., Rose, D. E., Stockdale, S., Curtis, I., & Kirsh, S. (2019). Eight Priorities for Improving Primary Care Access Management in Healthcare Organizations: Results of a Modified Delphi Stakeholder Panel. Journal of General Internal Medicine, 35(5), 523-530.

Schang, L., Waibel, S., & Thomson, S. (2013). Measuring care coordination: Health system and patient perspectives. Report prepared for the Main Association of Austrian Social Security Institutions. LSE Health, London, UK.

Schwarz D, Hirschhorn LR, Kim JH, Ratcliffe HL, Bitton A. Continuity in primary care: a critical but neglected component for achieving high-quality universal health coverage. BMJ Glob Health. 2019 May 23;4(3):e001435. doi: 10.1136/bmjgh-2019-001435. PMID: 31263586; PMCID: PMC6570977.

Section on General & Family Practice. Discussion Paper, Adopting the Patient's Medical Home – The Framework to Evolve Ontario's Family Medicine Practices. Toronto, ON. (2024).

Section on General & Family Practice. Discussion Paper, Implementing Team-Based Care in Ontario through Primary Care Networks: A Roadmap for Equitable, Effective and Sustainable Implementation. Toronto, ON. (2024).

Section on General & Family Practice. Discussion Paper, The Role and Value of Family Physicians in Ontario: The Keystone of Primary Health Care. Toronto, ON. (2025).

Sharma, A. E., & Grumbach, K. (2017). Engaging patients in primary care practice transformation: theory, evidence and practice. Family Practice, 34(3), 262-267.

World Health Organization. (2025). Every dollar invested in digital health returns up to 24-fold. ICT Health. Retrieved from https://icthealth.org/news/who-every-dollar-invested-in-digital-health-returns-up-to-24-fold

SGFP
GENERAL & FAMILY PRACTICE

150 Bloor St W, Suite 900
Toronto, ON M5S 3C1

www.SGFP.ca
ChairLetterSGFP@outlook.com