

**East Toronto
Health Partners**

Enhanced Home Support
Program (EHSP)
Finding Primary Care in East
Toronto

EastTCaN Health and Social Collaborative
May , 27,2026



East Toronto
Health Partners

Primary Care Access & Attachment in East Toronto

May 2026





Topics for Discussion

1. **PCAT Investments** in Team-Based Primary Care in East Toronto
2. **Communications Goals & Tactics**
3. **East Toronto Supported Attachment**, Central Intake and Provider Referral Options
4. **Impact & Implementation Progress**
5. **Discussion**

Ontario's Primary Care Action Plan

Ontario's Primary Care Action Plan



Mandate: Attach two million more people to primary care by 2029.



Connecting You to a Primary Care Team

- Create and expand **up to 300** additional primary care teams. These teams bring together health professionals—such as doctors, nurses, social workers, and dietitians—to provide coordinated, comprehensive care.
- Invest more than **\$235 million** in 2025-26 to establish and expand approximately **130** additional primary care teams across the province, attaching 300,000 more people to primary care this year as a first step toward connecting everyone in the province to primary care.
- In June 2025, Ontario became the **first Canadian jurisdiction** to pass **legislation** identifying primary care as the foundation of the health system and outlining what people can expect when accessing care.
- Provide **regular public updates** on progress and performance in achieving the Primary Care Action Team's mandate.



Making Primary Care More Connected and Convenient

- **Modernize Health Care Connect** to improve the user and provider experience, with the goal of establishing a wait time target of no more than 12 months.
- Connect everyone (as of January 1, 2025) on the **Health Care Connect waitlist** to a primary care team by **Spring 2026**.
- Enhance **digital tools** for providers and patients, improving patient navigation, reducing administrative burden and improving the **referral process**.
- Leverage Health811 to view **online health records**, **book an appointment** with their primary care provider, and discover care options.
- Set **regular performance indicators** of primary care teams.



Supporting Primary Care Providers

- Introduce targeted strategies to **recruit and retain** the workforce needed to support primary care providers and teams, including family doctors, nurse practitioners and other allied health professionals.
- **Address administrative burden** with digital tools, targeted recruitment and retention strategies for northern and rural communities and ensure all of Ontario's highly qualified health-care professionals can work to their full scope of practice.
- Add and expand community-based **primary care teaching clinics** in collaboration with academic institutions and other partners. These clinics train family doctors and other professionals—such as nurse practitioners, physician assistants, and registered nurses—by combining patient care with hands-on learning.



**PROTECT
ONTARIO**

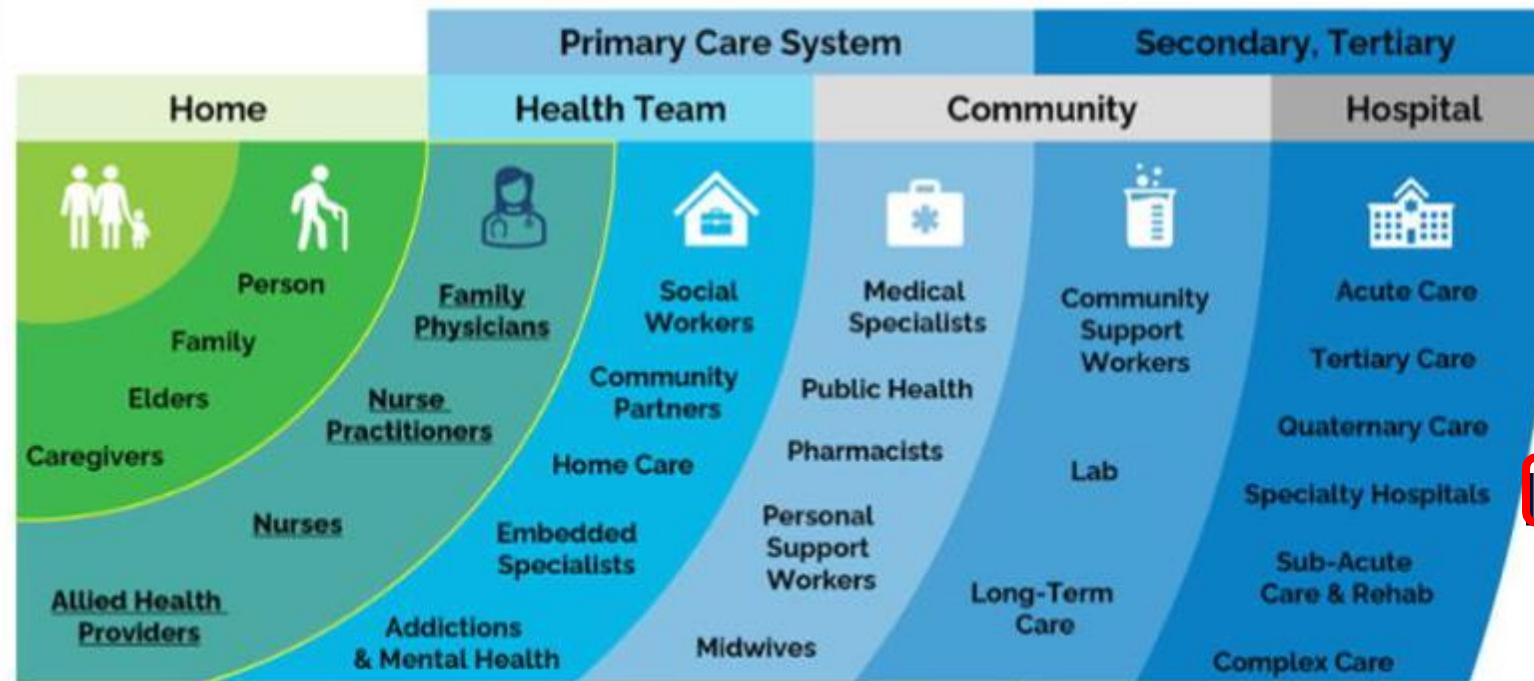
Ontario's Primary Care Action Plan

Connecting every person in Ontario to primary care

Mandate: 100% of people in Ontario are attached to a family doctor or a primary care nurse practitioner working in a publicly funded team, where they receive ongoing, comprehensive, and convenient care.



**PROTECT
ONTARIO**



Primary Care Action Plan: Targets & Timelines

	2025-26	2026-27	2027-28	2028-29	Total
New people to be attached	300,000	+500,000	+600,000	+600,000	2,000,000
People Attached	~275,000 (as of September 30, 2025)	TBC	TBC	TBC	TBC

- From January 1 to September 30, 2025, 275,000 people have been attached to primary care.
- Ontario is on track to meet or exceed its target of 300,000 attached in 2025-26. Full-year data through to the end of 2025 will be available as of June 2026.

East Toronto Data: people without primary care

Selected Indicator: Number of Unattached

Select an indicator for map from below:

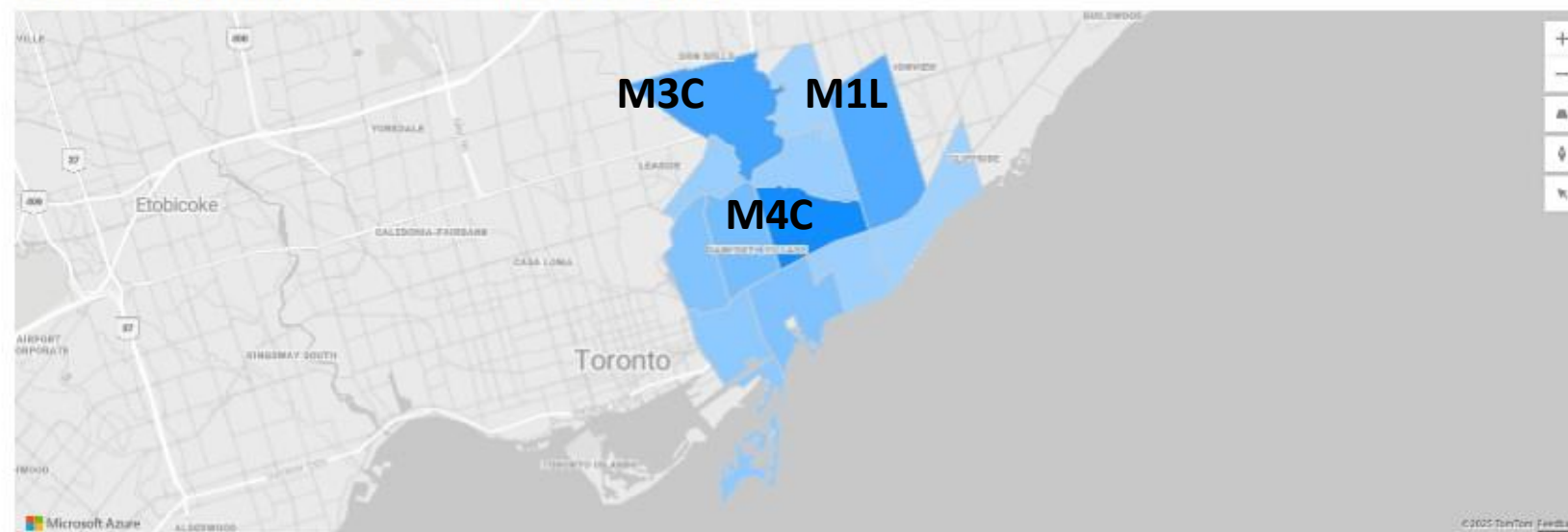
Note: selection does not filter table

Number of Unattached

Unattached (%)

Number of Pending HCC Referral

Pending HCC Referral (%)



OH Region Name	Number of FSAs	Total Population	Unattached (Number)	Unattached (%)	Pending HCC Referral (Number)	Pending HCC Referral (%)	Complex Vulnerable	Waited over 3 years	Waited over 5 years	Waited over 10 years
East Toronto Health Partners OHT	12	379,481	46,205	12.2 %	1,514	0.4 %	0	113	0	0
M1L		38,461	★ 5,421	14.1 %	138	0.4 %	0	15	suppressed	0
M1N		24,476	2,376	9.7 %	45	0.2 %	suppressed	suppressed	0	0
M3C		45,787	★ 5,926	12.9 %	133	0.3 %	0	8	0	0
M4A		15,658	2,341	15.0 %	77	0.5 %	0	suppressed	0	0
M4B		19,894	2,660	13.4 %	112	0.6 %	0	11	0	0
M4C		55,317	★ 7,981	14.4 %	329	0.6 %	0	32	0	0
M4E		26,993	2,536	9.4 %	96	0.4 %	suppressed	suppressed	0	0
M4H		22,579	2,704	12.0 %	85	0.4 %	0	suppressed	0	0
M4J		37,378	4,021	10.8 %	184	0.5 %	0	15	0	0
M4K		32,326	3,521	10.9 %	137	0.4 %	0	8	0	0
Total	12	379,481	46,205	12.2 %	1,514	0.4 %	0	113	0	0



East Toronto-Integrated Primary Care Team (ET-IPCT)

On June 23rd, 2025 Minister Jones and Dr. Philpott announced that FHC, EastT-FPN and EHP will receive **more than \$4.5 million annually to attach more than 11,000 people to comprehensive, integrated primary care in M3C & M4C**. ET-IPCT Partners will focus on stabilizing the most complex patients with the greatest needs, who often struggle to navigate the health-care system. This model helps increase system capacity across East Toronto and reduces reliance on emergency services by meeting patients' needs earlier and more effectively in the community.

INTEGRATION

3 core partners, + 12 health and social care partners, multiple primary care access points

SYSTEM CAPACITY

FTEs = 3 MDs, 3 NPs, 2 PAs, 12.5 IHPs, 4.0 Management, Stabilization of HATM, Establishment of MGH Primary Care Access Clinic, expansion of integrated primary care teams across East Toronto

IMPACT

Attachment Target = + 11K from M3C & M4C including attaching those on the Health Care Connect Waitlist across East Toronto



ETHP Communication Goals

1. Inform East Toronto residents that we are attaching individuals to primary care and let them know how they can be connected
2. Take an equity-based approach, aiming to reach individuals most in need first



Find a family doctor or nurse practitioner in East Toronto

Are you an East Toronto resident without
a family doctor or nurse practitioner?

We can help connect you!

Healthcare organizations
in East Toronto are working
together to match residents
with primary care.



WHO IS ELIGIBLE?

East Toronto residents who
do not have access to a family
doctor or nurse practitioner

SIGN UP NOW

Scan the
QR code or
visit the URL
below to
sign up!



ethp.ca/primarycare



ETHP Website (ethp.ca/primarycare)



Find a family doctor or nurse practitioner in East Toronto

Are you an East Toronto resident without a family doctor or nurse practitioner? We can help connect you!

Healthcare organizations in East Toronto are working together to match residents with primary care.

Sign up now

**CLICK HERE TO FILL OUT THE
ONLINE FORM**

Your personal information is stored securely and only accessed by authorized healthcare and community partners involved in your care.

Who is eligible?

East Toronto residents who do not have access to a family doctor or nurse practitioner

How do I get connected?

To get connected, residents should [click this link](#) and fill out the online form.

How will my provider be selected?

Our team will connect you with the most appropriate provider based on several factors, including your location, your health needs and cultural needs such as language.

What is primary care?

Primary care is a person's first point of access to the healthcare system. The most common forms of primary care are family doctors, nurse practitioners and primary care teams.

What is a nurse practitioner?

Nurse practitioners are primary care providers who have met additional education, experience and exam requirements. They are authorized to diagnose, order and interpret diagnostic tests, and prescribe medication and other treatments.

Is there a phone number I can call to learn more?

We are setting up a phone number for this program. For now, residents must register through [the online link](#).

Are there any income restrictions?

No, there are no income restrictions. This program is open to anyone living in East Toronto who needs a primary care provider.

Is there a catchment area?

Yes, you must live in East Toronto to participate. [Please click here to view a map of the ETPH catchment area](#) to determine if you are eligible.

Who will have access to my information?

Your personal information is stored securely and only accessed by authorized healthcare and community partners involved in your care.

Do you have information in multiple languages?

Digital flyers in multiple languages are available below. Please note that the online form is only available in English. We suggest using a tool such as Google Translate to translate this form into your language, if needed.



- EHPH Primary Care Flyer - English
- EHPH Primary Care Flyer - Amharic
- EHPH Primary Care Flyer - Arabic
- EHPH Primary Care Flyer - Bengali
- EHPH Primary Care Flyer - French
- EHPH Primary Care Flyer - Hindi
- EHPH Primary Care Flyer - Simplified Chinese
- EHPH Primary Care Flyer - Spanish
- EHPH Primary Care Flyer - Tagalog
- EHPH Primary Care Flyer - Urdu

Why do I need a family doctor or nurse practitioner?

Having a family doctor or nurse practitioner means you have a dedicated care team that knows you, understands your health history and is there to support you at every stage of life. Your primary care team focuses not only on treating illness, but also on keeping you well, through regular check-ups, preventative care and recommended screenings that help you catch potential concerns early. They provide timely care when you're sick and partner with you to manage ongoing conditions such as diabetes, high blood pressure or asthma. When additional support is needed, they connect to a specialist or community services, helping to coordinate your care so it feels easier to navigate.

I have a family doctor or nurse practitioner but would like to transfer. Can I still sign up?

Individuals who have access to a family doctor or nurse practitioner are encouraged to continue receiving care from their current provider. At this time, we are prioritizing individuals who are not connected to a family doctor or nurse practitioner and/or are experiencing difficulty accessing their current provider. If you are having challenges accessing your current provider, you can sign up and a member of our team will follow up with you.



**العثور على طبيب أسرة
أو عضو هيئة تدريّس ممارس
في شرق تورنتو**

هل أنت من سكان شرقي تورنتو وليس لديك طبيب أسرة أو عضو هيئة تمريض ممارس؟

يمكننا مساعدتك في التواصل معهم!

تتعاون منظمات الرعاية الصحية في شرق تورنتو لتوفير الرعاية الصحية الأولية للسكان.

من المؤهل؟

سكان شرق تورنتو الذين لا يستطيعون الوصول إلى طبيب أسرة أو عضو هيئة تمريض ممارس.

سجل الآن

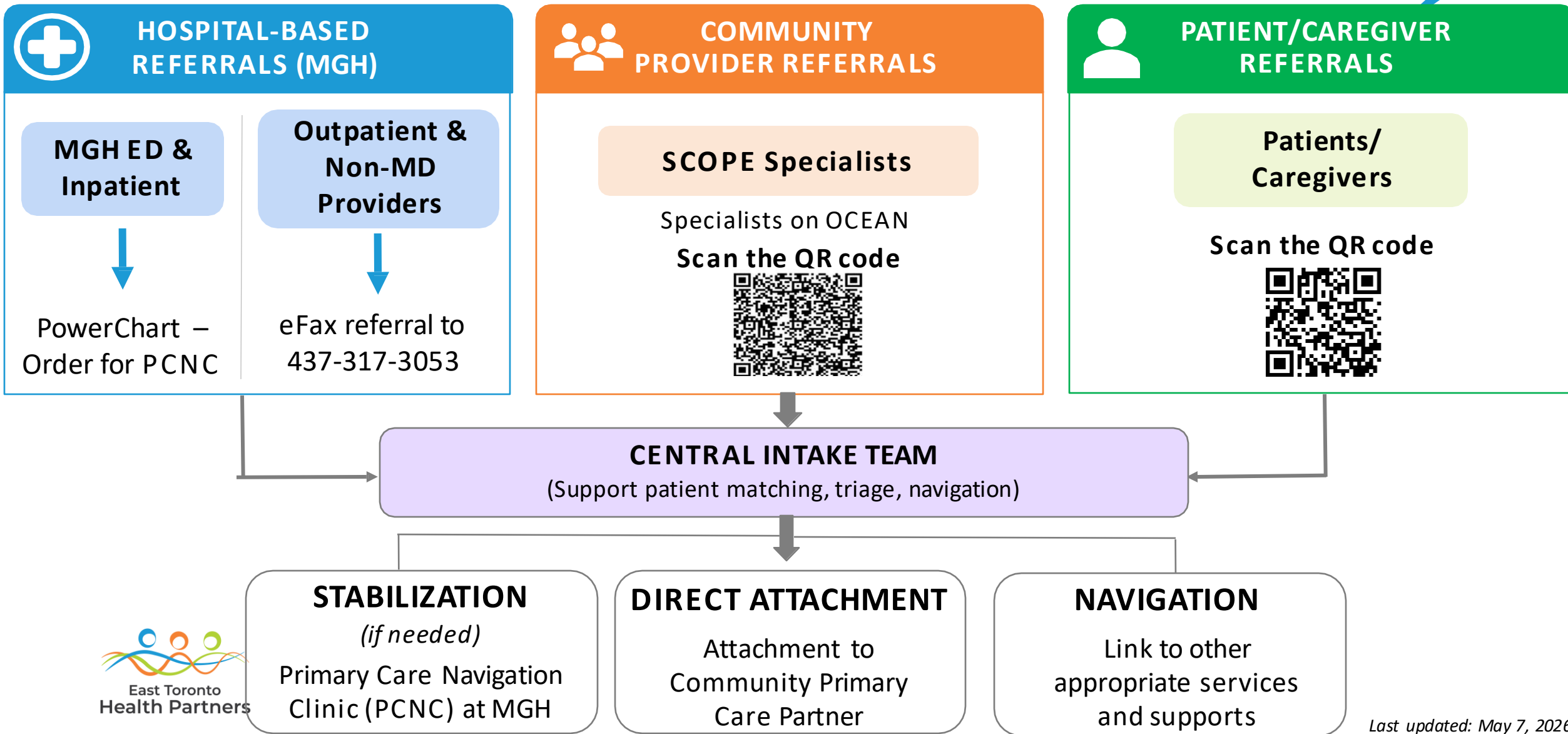


امسح ضوئياً
رمز الاستجابة السريعة (QR code)
أو تفضل بزيارة الرابط أدناه
للتسجيل!

ethp.ca/primarycare

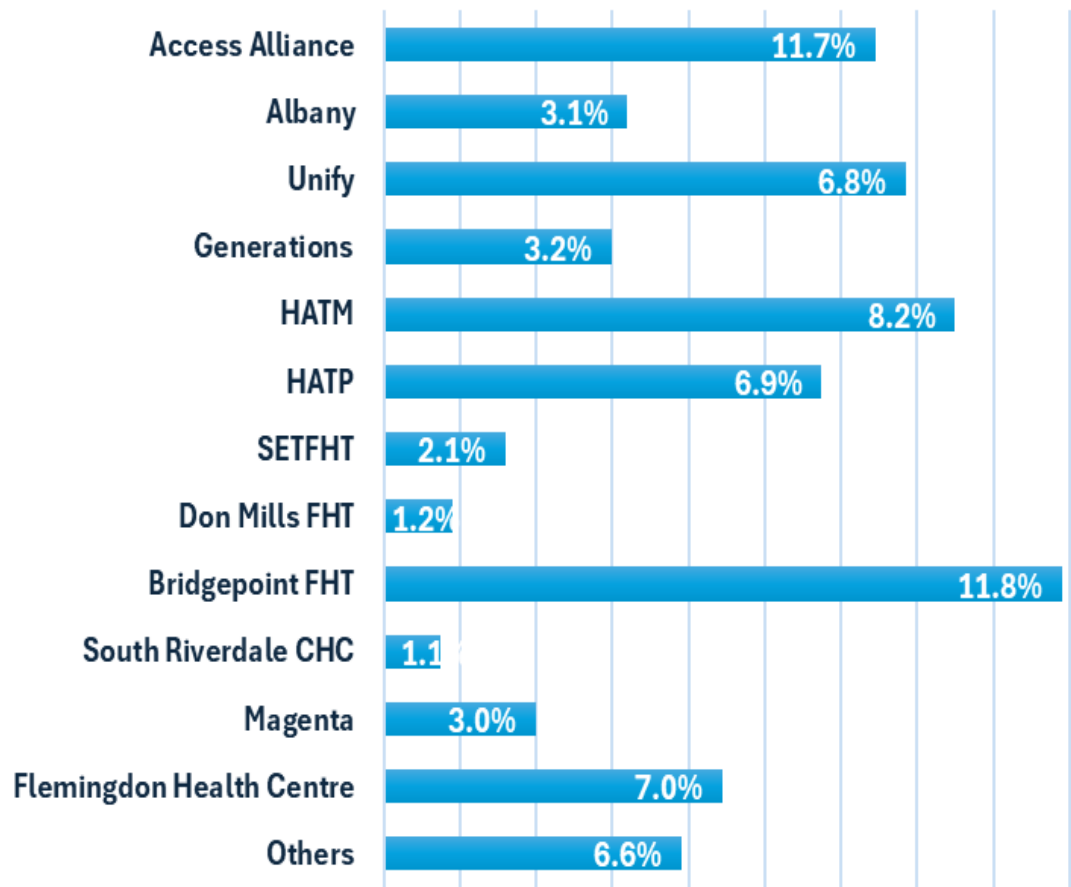


East Toronto OHT Central Intake System Referral Flowchart



East Toronto Central Intake & Primary Care Attachment – Implementation Overview

Number of patients referred from Central Intake (January 2026 onwards)



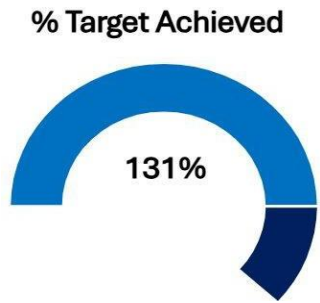
Central Intake Referrals to Community Primary Care Clinics (Oct 2025 – April 2026)

Total Patients Referred: **1,105**
96% reside in East Toronto

- **17%** reside in M3C
- **16%** reside in M4H
- **14%** reside in M4J
- **10%** reside in M4K
- **10%** reside in M4C

5% reside outside of East Toronto FSAs

Attachment to Date	Target (by July 31/26)
14,412	11,025



Communications Tactics

Phase 1: Targeted communications

- Flyer (translated into top languages)
- Targeted email to EPHP partners
 - Flyer + suggested social media post/newsletter blurb
- Community Health Ambassador support
 - Distributing flyer
 - Tabling at events or in public areas

Phase 2: Wide communications

- Media
- Elected official newsletters
- EPHP channels
 - Website
 - Social media
 - Newsletters



Discussion Questions:

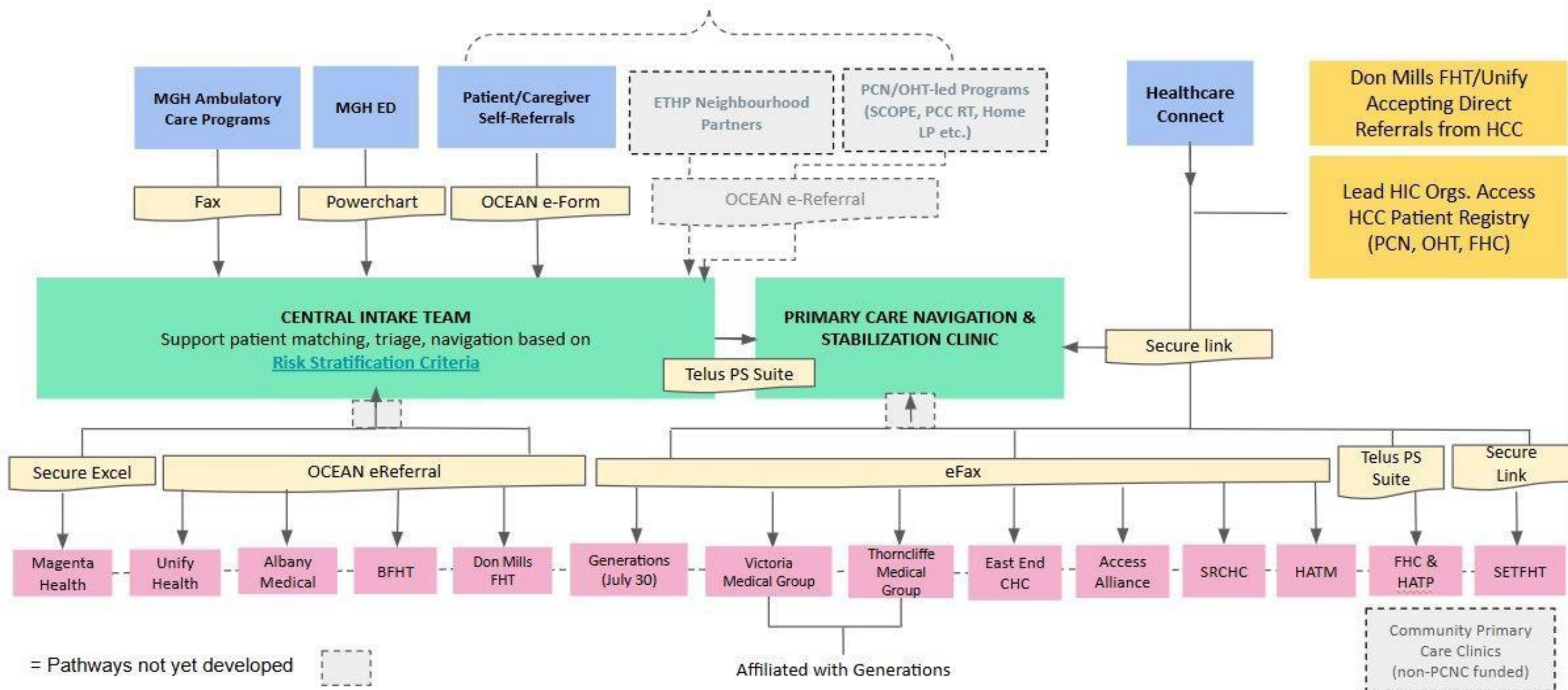
1. What other ways can we spread awareness?
2. What other channels can we use to reach people?

APPENDIX



East Toronto OHT Central Intake System (Draft)

ETHP Communications & Outreach
strategy in development



Primary Care Navigation Clinic (PCNC)

Our Purpose

A partnership with Flemingdon Health Centre, The Neighbourhood Organization, and WoodGreen this clinic offers short-term primary care for patients without a regular provider after a hospital visit. Our interprofessional team supports your smooth transition back to the community and helps connect you to a primary care practitioner long term. You'll have an in-person follow-up within 2 weeks of discharge.

**INTEGRATING CARE.
BOLD IMPACT.**

Compassion * Respect * Integrity * Inclusion * Courage

Contact Us



PCAC@tehn.ca



416-461-8272
Extension: 2766



Michael Garron Hospital
825 Coxwell Avenue

About Us

Monday to Friday 1100-1900

Michael Garron Hospital- T2
Please start at registration on the main floor.

Please arrive 30 minutes before your appointment to register at Patient Registration (located on M1). Please allow 2 to 3 hours for your initial appointment. Please bring your health card.

Referral/appointments **required**- no walk in appointments

The team

Physicians

The team of physicians are partnered with the East Toronto Primary Care Navigation Clinic through Flemingdon Health Center.

Nurses

The nurses work closely with the team to provide comprehensive care, bringing their expertise in community, acute, maternal newborn and emergency room nursing.

HINC

A Holistic Intake Navigator and Counsellor supports patients by assessing their health and social needs, connecting them to appropriate services.

Unit Clerk

The Unit Clerk supports the clinic by ensuring smooth communication between patients and the care team.

Social Worker

A social worker from WoodGreen supports people with single-session supportive counseling or case management.

Questions?

Please raise your hand or
use the chat



Enhanced Home Supports Program (EHSP)

ENHANCED HOME SUPPORTS PROGRAM

- One-time financial disbursement (up to \$1000)
- Short-term support during transition home
- Urgent situations where no alternatives available
- Enables earlier discharge/prevents readmission to hospital
- Once per client per fiscal year



ENHANCED HOME SUPPORTS PROGRAM

Common Requests:

- Food access (Meals on Wheels, grocery gift cards, food delivery)
- Medical equipment (walker, hospital bed rental)
- Extreme Clean services/pest control
- Transportation

Many more services can be requested for consideration



ENHANCED HOME SUPPORTS PROGRAM

Ineligible Uses:

- Supports/interventions already supported by OH@Home
- Rent arrears or debt consolidation
- Ongoing source of income or support
- Cash transfers to clients



ENHANCED HOME SUPPORTS PROGRAM

How You Can Use The Program

- [Apply](#) on behalf of client in need of urgent, short-term service(s) once all other resources have been explored/exhausted
- Costs incurred by referee: referee sends receipt(s) for reimbursement -- immediate
- Invoiced to vendor(s): can take up to 3 weeks to process



ENHANCED HOME SUPPORTS PROGRAM

- Please fill out the form as *accurately as possible* for the review and approval process to occur promptly
- Please note that the first section of the application (Applicant Information) is where you should be inputting *your* contact information, not the client's (you are applying on behalf of the client)
- **We need your contact information for follow-up**

Enhancing Home Supports Fund FY26/27

Please ensure you complete all sections of this form accurately.

Once submitted, you will receive email notification confirming your submission that includes the application #. **Do not lose this information.**

The coordinator will review the application and then notify you of their decision. Once approved, you will need to submit invoices for purchase/reimbursement as applicable. If the intervention is immediately required and does not allow for WoodGreen to be billed, you will need to purchase the item(s) and submit receipts for reimbursement from WoodGreen via cheque or ETF.

When you submit this form, it will not automatically collect your details like name and email address unless you provide it yourself.

* Required

Please ensure all information entered is complete & correct.

1. Applicant Name: *

2. Applicant Organization: *

EHSP Application #99

Summarize

RB

Rhiannon Bryce

To: Rhiannon Bryce



Reply

Reply all

Forward



Thu 4/16/2026 11:49 AM



Hi Rhiannon,

Please see the attached quote for application #99.



Opportunity made here.

Rhiannon Bryce (she/her)

Coordinator, Enhanced Home Support Program

Phone: 647-920-1853 | Email: RBryce@woodgreen.org |

Website: woodgreen.org

721 Broadview Ave, Toronto, ON M4K 2P5

Charitable Registration Number: 891038507 RR0001



More than ever, Toronto needs our help. More than ever, WoodGreen needs yours. [Learn more about the UNMET Needs Campaign.](#)

Situated on the traditional territory of the Haudenosaunee, Wendat and Anishnabeg and still home to many Indigenous people from across Turtle Island. Read our [full acknowledgement here.](#)



East Toronto Care Network
(EastTCaN)



ENHANCED HOME SUPPORTS PROGRAM

Rhiannon Bryce

Coordinator, Enhanced Home Supports Program

E-mail: RBryce@woodgreen.org

Phone: 647-920-1853

Office Hours: Wed-Fri, 9am-5pm



ENHANCED HOME SUPPORTS PROGRAM

Questions?



Resources Shared During Session

- Resources shared:
- [Extreme Cleaning and Hoarding Support Program - CMHA Toronto](#)
- [Housing Law - Steps to Justice](#)
- [Situation Table for Housing-at-Risk \(STAR\)](#)
- [Home - Don Valley Community Legal Services](#)
- [Safer Spaces: Hoarding Support - VHA Home HealthCare](#)