# Interprofessional Primary Care Team (IPCT) Expansion - 2026-2027 Call for Proposals

A Guide for Primary Care Clinicians and Teams, Ontario Health Teams and Primary Care Networks

SEPTEMBER 2025

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## Contact information

For any questions about the submission of proposals, please e-mail primarycareexpansion@ontariohealth.ca or reach out to your Ontario Health Regional Representative listed in Appendix A.

The Ministry of Health and Ontario Health will be hosting a technical webinar on Friday, September 26th at 8:00 Eastern Daylight Time to share more information about the Call for Proposals and to answer any questions. You can register at: https://zoom.us/webinar/register/WN_dFNNueidQravuVpZdFcCxQ

# 1. Background

On September 22, 2025, the Ministry of Health ('ministry'), in collaboration with Ontario Health, launched the 2026-2027 Call for Proposals to expand or create approximately 75 primary care teams that will attach 500,000 more people to primary care.

This is part of the Government's $2.1 billion investment towards Ontario's Primary Care Action Plan which will expand or create over 300 new and expanded primary care teams across the province to attach two million more people to a primary care clinician or team by 2029.

The goal is to ensure that every person in Ontario has the opportunity to be attached to primary care that is comprehensive, connected, convenient, inclusive, empowered, and responsive. Primary care should be provided close to where Ontarians live or where it is most convenient for them and recognize and respond to the needs of the local population.

The 2026-2027 Call for Proposals builds on the momentum and successes of both the 2024 Primary Care Expression of Interest and the 2025-2026 Call for Proposals, both of which demonstrated the strength of local primary care planning, collaboration and innovation across the province.

# Overview of 2026-2027 Call for Proposals

Through the 2026-2027 Call for Proposals, the Government will invest more than $250 million to create or expand approximately 75 primary care teams that will attach 500,000 more people to primary care.

## Eligibility

Primary care clinicians and teams are invited to submit proposals for funding consideration through their associated Ontario Health Team (OHT) and Primary Care Network (PCN). All OHTs and their PCNs are eligible to submit a set number of proposals that align with the strategic evaluation priorities outlined in this document.

Proposals can be submitted to create or expand one of the following approved interprofessional primary care team models:

- Family Health Teams (FHTs)
- Community Health Centres (CHCs)
- Nurse Practitioner-Led Clinics (NPLCs)
- Indigenous Primary Health Care Organizations (IPHCOs)

## Approach

Each OHT has been allotted a specific number of proposal submissions, determined based on the number of people in their communities not attached to primary care. The number of proposals allotted to each OHT is based on different thresholds of unattachment in Southern and Northern Ontario to reflect relative population size and geography.

If there is strong rationale, OHTs and their PCNs may consider submitting up to two additional proposals for consideration that align with the strategic evaluation priorities of this Call for Proposal, including attaching their local populations to care. This could include proposals not selected for funding through the 2025-26 Call for Proposals that have been supported to refine and strengthen their proposal to align with the evaluation priorities of this Call for Proposal.

Before submitting an additional proposal, the OHT must first consult with their Ontario Health Region to ensure the rationale is well-supported.

For example, an OHT that has been allocated three (3) proposals could submit an additional two (2) proposals, with a strong rationale, for a maximum total of five (5) proposals.

In collaboration with Ontario Health Regions, OHTs and their PCNs are expected to work closely with their local primary care clinicians and teams to submit proposals and develop multi-year plans to achieve 100% attachment of their local population by 2029.

# Indigenous-led Proposals

The Ministry of Health and Ontario Health are committed to ensuring that primary care planning and delivery addresses the physical, spiritual, emotional and mental well-being of First Nations, Inuit, and Métis people.

While proponents of Indigenous-led proposals are encouraged to collaborate with their local OHT/PCN, support is not required to submit an Indigenous-led proposal.

**Please see the Indigenous led-proposal guidance document for detailed information.**

# Strategic Evaluation Priorities of the Call for Proposals

The ministry and Ontario Health are inviting proposals that demonstrate alignment with the following three priorities. Proposals will be evaluated against the following:

A. **Primary Care Attachment:** Provide net new, ongoing attachment to primary care, prioritizing communities with high rates of unattachment. This includes attaching people on the Health Care Connect waitlist.
B. **Readiness to Implement:** Demonstrating the ability to be operational and begin to attach people to a primary care clinician or team by spring 2026. This includes demonstrating how your proposed new or expanded team can leverage existing infrastructure, human resources and local partnerships to quickly meet the communities' attachment needs.
C. **Meeting Primary Care Objectives:** Commitment and demonstrated ability to meet the primary care objectives, as noted below, over time.
    1. **Province-Wide:** Ontarians should have the opportunity to have a documented and ongoing relationship with a primary care clinician or team.

2. **Connected:** Ontarians should have the opportunity to receive primary care services that are co-ordinated with existing health and social services.
3. **Convenient:** Ontarians should have access to timely primary care services.
4. **Inclusive:** Ontarians should have the opportunity to receive primary care services that are free from barriers and free from discrimination prohibited by the Human Rights Code or the Canadian Charter of Rights and Freedoms.
5. **Empowered:** Ontarians should have the opportunity to access their personal health information through a digitally integrated primary care system that connects insured persons to primary care clinicians or teams involved in their care.
6. **Responsive**: The primary care system should respond to the needs of the communities it serves, and Ontarians should have access to information about how the system is performing and adapting.

# 2. Proposal Process: Roles and Responsibilities

## Overview

OHTs and their PCNs are central to ensuring every person in Ontario is attached to primary care clinician or team. Together, they are leading efforts to identify and close primary care attachment gaps, including working to ensure that all patients on the Health Care Connect waitlist (as of January 1st, 2025) are attached to primary care.

OHTs and PCNs are coordinating primary care in their communities. Earlier this year, the Ministry of Health and Ontario Health requested all OHTs to begin developing multi-year plans to achieve 100% attachment to primary care in their local communities by 2029. A critical part of this work is the engagement of and collaboration with primary care clinicians and teams directly through PCNs to identify and enable local solutions. This includes facilitating collaboration across local teams and primary care clinicians to better coordinate and organize responsive and culturally appropriate care in neighbourhoods within their communities.

PCNs, compromised of front-line primary care clinicians or team members, are the voice of primary care within each OHT. Their role is to connect and support primary care clinicians and other team members, ensuring their perspectives are central to decision-making within their OHT. By helping to organize care within their local communities, PCNs improve efficiency, reduce duplication and keep care coordinated locally. At maturity, PCNs will drive greater integration and collaboration across primary care organizations and community partners so that patients receive the high-quality, connected care, close to home.

Primary care clinicians and other primary care team members and organization leaders are strongly encouraged to get involved in their PCN so the local primary care sector has a collective voice at their OHT decision-making table and can lead primary care planning in their communities. Primary care teams, organizations and other health system partners are encouraged to identify and work together to share resources (e.g. programs, back office supports, staff) to deliver care for their local population.

## Roles & Responsibilities

Responsibilities for the 2026-2027 Call for Proposals funding include:

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| **Ontario Health Teams and their Primary Care Networks** | • Distribute proposal packages to local primary care clinicians, teams, and partners.<br>• Support local primary care clinicians and teams, including those not selected for funding through the 2025-2026 Call for Proposals, to collaborate and submit proposals aligned with the strategic evaluation priorities.<br>• Use OHT Data Packages and local data to develop proposals that prioritize communities with high rates of unattachment. |

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| | • Meet regularly with Ontario Health Regional Representatives during the proposal development window. At least one meeting should occur in the first week to ensure alignment and a clear understanding of the Call. Please refer to Appendix A for the list of Ontario Health regional contacts.<br>• Encourage and facilitate collaboration across primary care and other health and social service partners to strengthen proposals.<br>• Ensure proposals reflect fair engagement and collaborative decision-making arrangement (CDMA) procedures, including conflict-of-interest.<br>• Submit proposals to Ontario Health. |
| **Primary Care Teams and Clinicians** | • Request the proposal package, confirm eligibility, and obtain a unique identifier from your associated OHT/PCN. Please reach out to your Ontario Health regional contact (Appendix A) if you are unsure about your OHT/PCN.<br>• Lead proposal development, including defining the model of care and completing the proposal form and budget templates.<br>• Collaborate with and receive support from the OHT/PCN to develop proposal(s).<br>• Submit the finalized proposal to your OHT/PCN. |
| **Ontario Health Regions** | • Connect primary care clinicians and teams with their associated OHTs/PCNs.<br>• Meet regularly with OHTs/PCNs during the proposal development window. At least one meeting should occur in the first week to ensure alignment and a clear understanding of the Call.<br>• Share resources (e.g., data packages, webinars, and guidance) with OHTs/PCNs and respond to inquiries throughout the proposal period.<br>• Support OHTs/PCNs in working with primary care clinicians and teams, ensuring at least one meeting and regular-check-ins with proponents to support proposal development. |

# 3. Instructions for Completing the Proposal Form

This section outlines instructions to support the development of strong, informed, and impactful proposals that align with the strategic evaluation priorities for the Call for Proposals For illustrative examples of how these priorities may be applied in practice, refer to the case studies in Appendix D, which demonstrate this information in action across diverse team contexts.

## Collaboration for Expanded or New Teams

The Ministry and Ontario Health strongly encourage collaborative, partnership-based proposals with larger targets where possible, prioritizing ongoing attachment specifically in communities with a high number of people who do not have a regular primary care clinician. Collaborative models promote scalability, sharing of resources, and better connection across the continuum of care.

To support planning, all OHTs have been provided data packages that include provincial data on attachment rates filterable by various geographic units such as Forward Sortation Areas (FSAs), Aggregate Dissemination Areas (ADAs), and Census Subdivisions (CSDs). This data should be used to inform decisions around team expansion or creation (see Appendix C for more information on how to use data packages for the planning and development of proposals). Supplementary local data may be used to support the case for a new or expanded team.

Proposals for new and expanded teams will be accepted.

For team expansions into new communities, proponents can consider hub-and-spoke or similar collaborative models, where local populations are served by satellite teams operating under a centralized governance structure.

## Considerations in Proposal Development

This section provides guidance on identifying and addressing the needs of key populations to ensure that new or expanded IPCTs are inclusive, culturally responsive, and linguistically accessible.

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| **Indigenous Populations** | • Please refer to the Indigenous Populations guidance document for detailed information. |
| **Francophone Populations** | • Assess whether located in or serving a designated area under the French Language Services Act (FLSA).<br>• If located in or serving a designated area under the FLSA, as part of the Inclusive objective, describe a clear plan to identify and serve Francophone patients including establishing designated bilingual positions within the team, forming partnerships or referral pathways with Francophone |

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| | community-based organizations, and implementing active offer strategies to ensure access to French-language primary care services.<br>• A proposal is considered Francophone focused if the lead or co-lead organization is fully or partially designated under the FLSA.<br>• In areas without designated teams, one team applicant would be encouraged to work with their OH Region to achieve FLSA designation.<br>• If located in or serving a population outside of designated areas under the FLSA, as part of the Inclusive objective, describe tailored measures aiming to ease pathways to health services in French for Francophone populations (e.g. identification of Francophone patients, forming partnerships with Francophone organizations with bilingual capacity, offering translation solutions, etc.). |
| **Local Populations** | • Identify primary care clinicians or teams in geographic area who offer culturally responsive and language accessible services for local priority populations, so needs of these populations can be reflected in submitted proposals.<br>• For example, in areas with a high proportion of a specific population, strong proposals should demonstrate leadership or partnerships with community-based organizations that have experience serving the needs of these communities. The proposals should also outline specific approaches and service pathways to meet the needs of these populations. This may include highlighting culturally relevant service providers with whom the proponent will be collaborating within the geographical area to ensure services are culturally responsive, language accessible, and safe. |

When planning your submissions, consider the following questions that can be used to ensure that underserved populations will have access to services that meet their needs, for example:

- What experience does the team or collaborating partners have in delivering services to underserved populations?
- What approaches will the team use to ensure language accessibility for underserved populations?
- How will you reach and engage underserved populations? How will the team address barriers and ensure accessibility for priority populations that face challenges to accessing services?

## In-scope Health Human Resources (HHR)

Primary care teams are interprofessional groups made up of individuals with health, wellness and social care expertise, working together to support patients' unique health and wellness needs. Interprofessional primary care teams connect people to a range of health professionals that work

together under one roof, including family physicians, nurse practitioners, registered nurses, registered practical nurses, physician assistants, physiotherapists, social workers, dieticians, midwives and pharmacists, working to their full scope of practice. Depending on the population served, teams may also collaborate with additional experts to meet patient needs, such as Traditional Healers.

The allied HHR should be hired with the intention to maximize attachment for family physicians in patient-enrolled models that could be affiliated with an FHT, or with family physicians or nurse practitioners employed by IPHCOs, CHCs or NPLCs.

# 4. Completing and Submitting the Proposal

## Proposal Completion Process

Ontario Health will provide the proposal package and unique identifiers to all OHTs/PCNs who are then responsible for sharing with local primary care clinicians and teams.

Primary care clinicians and teams should work with their associated OHTs/PCNs to complete the proposal package. Completing the proposal and budget templates is a requirement to be considered. Please follow the instructions as provided on the proposal template and please refer to Section 2 of this guidance document for more details on roles and responsibilities.

## Proposal Package Components

The proposal package includes:

- Proposal form (fillable PDF) with the following sections:
    - Section A: Proponent Information
    - Section B: Team Model
    - Section C: Primary Care Teaching Clinic
    - Section D: Proposal Summary and Rationale for Need
    - Section E: Geographic Zones and Team Attachment
    - Section F: Team Composition
    - Section G: Plan to Meet Primary Care Objectives
    - Section H: Implementation Plan and Readiness
    - Section I: Risks and Mitigations

- The following appendices are also a part of the proposal package:
    - Appendix A: Proponent Signature and Acknowledgment - must be submitted with the proposal
    - Appendix B: Budget Template (Excel) - must be submitted with the proposal
    - Appendix C: Description of Existing Interprofessional Primary Care Teams (IPCT) and How Physicians and Nurse Practitioners Can Participate
    - Appendix D: Proposal Checklist
    - Appendix E: French Designated Areas in Ontario

**Note:** Proposal packages with blank or missing sections will be considered incomplete and not be evaluated. Only letters of commitment may be submitted as supplementary materials. All other attachments or documents not explicitly requested as part of the application will not be reviewed.

### Proposal Submission Process

The deadline for OHTs to submit proposals to Ontario Health is **5:00 pm Eastern Daylight Time, November 14, 2025.**

Proposals must be submitted to primarycareexpansion@ontariohealth.ca and include in the email subject line the respective unique identifier.

Attached documents must use file names that include the OHT name, applicant name, and unique identifier.

Only completed proposals and supplementary materials submitted directly to the email address above by the deadline will be accepted.

An acknowledgement of receipt will be sent for all proposals submitted by the deadline, from the email above.

For any questions about the submission of proposals, please contact primarycareexpansion@ontariohealth.ca.

### OHT Attestation

In addition to the proposal package, the following must be completed and submitted by the OHT:

- Proposal Submission Attestation Form

Please reach out to your Ontario Health regional contact for support with proposal completion (see Appendix A for the contact list).

# Important Dates

**Friday, September 26, 2025, at 8:00 am EDT:** Technical webinar, hosted by Ontario Health, to walkthrough the forms and answer questions

**November 14, 2025, at 5pm EDT:** Deadline for proposals to be submitted by OHTs/PCNs to Ontario Health.

**Spring 2026:** Communication of successful proposals and funding letters issued.

**Fall 2026:** The process for Call for Proposals 2027-2028 will be announced.

# FAQs

Please refer to the 'Frequently Asked Questions' (FAQs) document on the Ministry of Health website.

# Appendix A: Ontario Health Regional Contacts

Ontario Health contacts will work with OHTs and proponents throughout the process. See below for the list of contacts for your region.

| Region | Primary Care Contacts | OHT Contacts |
|---|---|---|
| **North East** | oh-ne-finance@ontariohealth.ca | lynne.kinuthia@ontariohealth.ca<br><br>laura.boston@ontariohealth.ca |
| **North West** | OH-NW-Submissions@OntarioHealth.ca | kiirsti.stilla@ontariohealth.ca |
| **East** | OH_East_Clinical_Submissions@ontariohealth.ca | laurel.hoard@ontariohealth.ca<br><br>oheast-ohts@ontariohealth.ca |
| **Central** | OH-Central_PrimaryCareAdvancement@ontariohealth.ca | OH-CentralOHTs@ontariohealth.ca |
| **Toronto** | OHTorontoIPC@ontariohealth.ca | TorontoRegionOHTs@ontariohealth.ca |
| **West** | OH-West-PCEOI@ontariohealth.ca | OHWest-OHTs@ontariohealth.ca |

If you are unsure of your region, this Census Subdivision to Ontario Health Look Up Tool may be of assistance.

# Appendix B: IPCT Model Overview

Proponents can submit a proposal to create or expand one of the existing team-based models:

| DESCRIPTION OF INTERPROFESSIONAL PRIMARY CARE TEAM MODELS | | | |
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| **Community Health Centre (CHC)** | **Family Health Team (FHT)** | **Indigenous Primary Health Care Organization (IPHCO)** | **Nurse Practitioner-Led Clinic (NPLC)** |
| CHCs provide comprehensive, interprofessional primary health care services with an emphasis on health promotion, disease prevention and addressing the social determinants of health. They serve general and priority populations who face barriers to care such as people living on low income, newcomers, individuals with complex mental health needs and the uninsured<br><br>CHCs tailor their programming to local needs and often include services like health education, chronic disease management, mental health supports and community outreach.<br><br>They are governed by volunteer community boards and operate with a mandate to | FHTs are community-centred primary care organizations that bring together interprofessional teams, including family physicians, nurse practitioners, nurses, social workers, community health workers and other professionals, to provide comprehensive, coordinated care tailored to local population needs.<br><br>They focus on the delivery of primary care services with a focus on health promotion, disease prevention and chronic disease management.<br><br>FHTs affiliate with physicians in eligible funding models. The Blended Salary Model (BSM) compensates physicians primarily through a salary and non-BSM models, which compensate physicians under a | IPHCOs are Indigenous-governed, community-led health organizations that provide culturally safe, holistic and integrated primary care services to First Nations, Inuit, Métis, and Urban Indigenous individuals and families. IPHCOs blend traditional Indigenous healing practices with mainstream clinical services, offering care that reflects Indigenous worldviews and values.<br><br>In addition to primary care provided by family physicians and nurse practitioners, IPHCOs provide services such as traditional healing, cultural programming, system navigation and maternal and child health programming.<br><br>Salaried physicians are employees of the IPHCO. | NPLCs are interprofessional teams led by NPs, designed to provide comprehensive primary care services. They support those in need of primary care, including underserved communities.<br><br>In this model, patients are registered to the clinic where nurse practitioners and nurses work to full scope of practice, in addition to other interprofessional team members. NPLCs offer primary care services and other need-responsive services.<br><br>NPLCs can receive stipend funding for collaborating physicians. |

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| improve health equity and access.<br><br>Salaried physicians are employees of the CHC. | blended capitation-based model.<br><br>Family Health Network (FHN), Family Health Organization (FHO), and Rural and North Physician Group Agreement (RNPGA) are examples of blended capitation models. Solo fee-for-service physicians are not eligible to affiliate with a FHT. | IPHCOs were formally known as Aboriginal Health Access Centres. | |

# Appendix C: How to use Data Packages for Planning and Developing Proposals

### OHT DATA DASHBOARD

To support the attachment of 100% of the population to primary care and to enable OHTs to clear their Health Care Connect wait lists, the Ministry of Health and Ontario Health provided OHTs with data to understand their local population. This data is available in the "PCAT Data Package," which was launched in April 2025 within Ontario Health's OHT Data Dashboard and has been updated as noted below. Note: The number of proposals allotted to each OHT is based on unattached patient information using updated attribution data.

The report includes information on the following topics (new and updated areas are noted):

- Sociodemographic indicators, including % Francophone, % Indigenous, and quintiles from the Ontario Marginalization Index
- Updated information on the unattached population, including estimated Francophone unattached population, and Health Care Connect waitlist which can be filtered by two new geographies -- census subdivision (CSD) and aggregate dissemination area (ADA) -- in addition to forward sortation area (FSA)
- Physician business contact information (new), including name, CPSO number, spoken languages, specialty and address
- Updated team locations

OHTs can view data for neighbouring OHTs who serve the residents of their geography, or any OHT of interest, to identify opportunities for cross-collaboration.

The Ministry of Health and Ontario Health will continue to share updated data and new indicators as they become available. The Ministry of Health and Ontario Health are committed to engaging with OHTs and other health system stakeholders to further refine OHT data supports.

### OHT DATA DASHBOARD REGISTRATION

Registering for the OHT Data Dashboard requires two elements: (1) a OneID credential, and (2) confirmation that you are part of an OHT or supporting an OHT with analytics.

If you already have a OneID credential, send your login ID to OHTanalytics@ontariohealth.ca. Either send the email from an OHT email address or copy someone from the OHT who can confirm you are supporting their team.

If you do not have a OneID credential, send your email address and phone number to OHTanalytics@ontariohealth.ca. Either send the email from the OHT email address or copy someone from an OHT who can confirm you are supporting their team. The team will guide you through the OneID process.

# Appendix D: Case Scenarios and Examples

This section presents illustrative examples designed to support primary care clinicians and teams, in collaboration with their OHTs and PCNs, in enhancing patient attachment and advancing the objectives of the Primary Care Action Plan. They are intended to inspire proponents to design innovative, collaborative, equitable and context-responsive models that align with the strategic priorities of the Call for Proposals.

## 1. Team Optimization

Optimizing teams is a key strategy to increase primary care capacity for access and attachment. This includes both maximizing the scope and impact of individual team members and refining team structures to enhance efficiency and responsiveness.

### FULL SCOPE OF PRACTICE IN A SUBURBAN FHT

A FHT in a rapidly growing suburban community was facing long wait times for patient attachment and increasing demand for chronic disease management care. To address this, the team implemented a strategy to maximize the scope of practice for its interprofessional healthcare providers (IHPs) enabling more efficient use of clinical resources.

Key changes included:

- Registered Nurses (RNs) leading well-baby visits, conducting chronic disease education and managing routine follow-ups for stable chronic conditions including diabetes, congestive heart failure and hypertension.
- Social Workers (MSWs) providing mental health counselling and brief interventions for anxiety and depression
- Pharmacists conducting medication reconciliation, managing refills, and offering medication education sessions for patients with polypharmacy

The FHT used regular huddles to coordinate care, address any challenges, and ensure continuity. These changes allowed family physicians and nurse practitioners to focus on existing patients and new patient assessments. Over the course of a year, the clinic was able to attach over 1000 new patients. The approach also improved team satisfaction and reduced burnout by distributing the workload more efficiently.

### A RURAL HUB AND SPOKE MODEL

A CHC serving a large rural area implemented a hub and spoke model to improve access and attachment. The central hub, located in a mid-sized town, houses an interprofessional team including family physicians, social workers and pharmacists. Smaller satellite clinics (spokes) in surrounding communities are staffed by nurses and nurse practitioners, with access to the hub site team.

The model was developed through collaborative planning with the OHT and supported by local health equity data. The CHC used shared EMRs, standardized intake protocols and monthly interprofessional case conferences to ensure continuity and quality across sites. Key features included:

- Virtual consults between spoke sites and hub teams
- Mobile outreach for immunizations
- Culturally tailored services for local Indigenous and Francophone populations
- Outcomes included an increase in patient attachment over a year, reduced travel-related barriers for rural residents, improved continuity of care and reduced duplication of services, and enhanced collaboration and retention through team-based support.

**TEAMLET MODEL IN A LARGE URBAN FHT**

A large FHT located in a diverse urban neighbourhood faced challenges with care coordination, team burnout and long wait times for attachment. The team serves a population with a high prevalence of chronic conditions, mental health needs, and social complexity, including newcomers, racialized communities and individuals with limited English proficiency.

To improve efficiency and attachment capacity, the FHT adopted a teamlet model. This change was guided by internal quality improvement efforts with the support of a Quality Improvement Decision Support Specialist (QIDSS). The clinic reorganized its staff into consistent micro-teams, each consisting of:

- One family physician
- One registered practical nurse (RPN)
- and a medical office assistant (MOA)
- Supported by shared access to a social worker, registered dietitian and pharmacist.

Each patient was attached to a family physician and their specific teamlet, fostering continuity, trust and a sense of belonging. The teamlets conducted daily huddles to review patient needs, coordinate follow ups, and plan care. Defined roles and shared workspaces enabled efficient management all comprehensive primary care needs.

The model was supported by standardized workflows and regular team meetings. It was also embedded into the clinic's Quality Improvement Plan (QIP). Outcomes included an increase in patient attachment capacity over a year, improved team satisfaction and retention, enhanced continuity of care and reduction in duplication of services.

## 2. Community Partnerships to Support Primary Care Capacity for Attachment

Strategic partnerships with community organizations including public health units, health and social service agencies can extend the reach and capacity of primary care teams, enabling more Ontarians to access comprehensive primary care.

**COLLABORATING WITH COMMUNITY AGENCIES**

A team partnered with a community mental health agency to improve access to primary care for underserved populations. The mental health agency contributed insights on the local population health needs and services they delivered to inform planning. It also leveraged its established relationships with equity-deserving communities to support culturally appropriate care and

coordinated outreach. Mental health and primary care services were co-located to support joint planning and streamlined referrals and access for patients.

Joint initiatives included:

- Embedding mental health case workers into the practice to support care coordination
- Implementing a common intake process to streamline referrals and improve continuity
- Coordinating service delivery to ensure highest need individuals received appropriate services through those channels
- Collaborating on design of services for group mental health programs
- Providing in-kind clinical space to the team to enhance service capacity.

Key outcomes of this partnership include:

- Increased attachment to primary care, including for high needs populations.
- Services are more accessible through targeted outreach and partnerships.
- Streamlined and integrated service delivery that focuses primary care and mental health resources to appropriate areas of need.
- Improved decision making to inform primary care planning, delivery, and evaluation.
- Stronger ties between community mental health and primary care, resulting in more responsive and coordinated care.

**INTEGRATED OUTREACH IN AN URBAN CHC: HOSPITAL-SUPPORTED PARTNERSHIP**

A CHC in a densely populated urban setting partnered directly with a local hospital to co-deliver services for equity-deserving populations, including newcomers and people experiencing homelessness.

The partnership was initiated through the local OHTs equity planning table, which identified gaps in preventative care and transitional support. A collaborative service agreement was developed to formalize coordination and resource sharing. While the CHC led the outreach delivery, the hospital supported the model by:

- Providing expedited access to diagnostics and specialist consults for patients identified through outreach
- Participating in shared care planning for patients with complex needs
- Supporting data exchange and referral pathways to ensure continuity between primary and acute care

These services were integrated into the CHC's outreach programming, including drop-in clinics and newcomer health assessments, supported by shared planning and data exchange through the OHT. The hospital's involvement strengthened the clinical depth of outreach and improved transitions and continuity into acute and specialty care.

Outcomes included an increase in patient attachment over 6 months, improved trust and engagement with local populations, and reduced reliance on emergency departments for episodic care.

**WRAPAROUND SUPPORT IN A RURAL NPLC**

An NPLC in a rural community partnered with a community support service organization to enhance care for patients with complex social needs. The clinic served a population with high rates of poverty, housing insecurity and limited transportation options, including Indigenous residents and newcomers.

The partnership was formalized through a memorandum of understanding (MOU). The community partner embedded a system navigator within the clinic to assist patients with:

- Housing applications and income support,
- Legal aid and transportation coordination
- Culturally appropriate services and interpretation

The navigator worked closely with the clinic's interprofessional team, participating in care planning meetings and using shared documentation tools to ensure continuity. Outcomes included a reduction in missed appointments, attachment of over 400 new patients within the first year of collaborative services, and improved patient satisfaction.

**COLLABORATION ACROSS TEAMS TO PROVIDE PREVENTIVE CARE SUPPORTS**

A NPLC, FHT and CHC work collaboratively to deliver the Preventive Care Program with a focus on ensuring access to high needs populations across a lager shared geography. Together the teams use data to understand the needs of the full population in their geographic area and identify where there are gaps or higher need for preventive care services. Across the teams, specific team members are identified to help address these needs.

Registered Nurses (RNs) and Registered Practical Nurses (RPNs) act as prevention specialists offering health education, risk assessment, health coaching and preventive care planning, system navigation. Prevention specialists are embedded in primary care teams and work alongside Community Health Ambassadors and Community Paramedics to support outreach and attachment. This includes facilitating access to clinical services (e.g., cancer screening, diabetes services) and community services that address social needs.

Implementation considerations included ensuring prevention specialists were integrated into team workflows and supported through shared protocols, data systems and referral pathways. Outreach strategies were tailored to local population needs, with flexible scheduling and mobile service delivery where appropriate. Training and role clarity across teams were essential to maximize impact and avoid duplication.

Key partnerships with the OHT's Indigenous Communities Advisory Council, PCN, community paramedicine programs and pharmacies enable prevention specialists to reach Indigenous communities as well as adults ages 40 years and older in rural and low-income urban areas.

**STRENGTHENING FRANCOPHONE ACCESS THROUGH DESIGNATION AND STRATEGIC EXPANSION**

Two interprofessional primary care teams, one a mid-size urban area and one in a rural region, have implemented innovative strategies to improve access for Francophone populations. Together, they

demonstrate how designation under the French Language Services Act (FLSA), strategic partnerships, and service planning can support equity-focused expansion and process improvement.

**Urban Team:**

- Partially designated under the French Language Services Act (FLSA)
- Serving over 2,500 unattached Francophone persons including newcomers, long-established Franco-Ontarians, and racialized Francophone populations
- Team includes bilingual nurse practitioners, social workers, and system navigators in designated positions
- They use key strategies to support Francophone access and expansion such as active offer of services in French and EMR-based language identification; partnerships with Francophone organizations; virtual care provision in French; and monitoring and evaluation of attachment and satisfaction among Francophone patients

**Rural Team:**

- Geography with no existing FLSA-designated providers
- New team in the area has the goal of addressing the needs of over 2,200 unattached Francophones and has committed to FLSA designation within four years
- They used the key strategies to support local Francophone patient needs through the recruitment of bilingual staff; offering mobile clinics and virtual care in French; providing referral pathways for Francophone mental health and social services; and applying a phased capacity-building plan to report on progress toward designation

## 3. Population health planning and use of local data

Grounding planning in local data helps teams identify health needs, target resources effectively and design care that reflects community realities. This approach supports more equitable, proactive and integrated care delivery.

### NEIGHBOURHOOD MAPPING TO ADVANCE PRIMARY CARE ATTACHMENT

An OHT in a diverse urban area developed a Neighbourhood Model to guide the design and implementation of team-based care. This model was developed by a Primary Care Planning Committee, which included representation from multiple neighboring OHTs, hospitals and community support service providers.

Neighborhood mapping was conducted using local health utilization data (e.g. ED visits, screening rates, unattachment count) and population growth metrics.

Priority neighbourhoods were identified using tools like the OHT Data Dashboard, Aggregate Dissemination Area (ADA) level data and Health Care Connect waitlist data

This data was then used to:

- Engage with the communities and co-design with equity-deserving populations
- Establish hubs in high-needs areas, integrating IPCTs with needed specialist services (e.g. mental health)
- Support a centralized coordination team for after hours-care, locum coverage and training placements (e.g. preceptorships)
- Forge partnerships with hospitals and local pharmacies to enable wraparound services and improved system navigation

This approach enabled targeted outreach, improved equity and laid the foundation for a strategy that aligns fragmented clinic-level activities under a cohesive, neighbourhood model.

**GEOGRAPHIC PRIMARY CARE CAPACITY PLANNING FOR RURAL AND NORTHERN COMMUNITIES**

In a large rural geography in the North, an OHT developed a strategy to expand access to primary care across their communities. This approach built on prior collaborative planning efforts by the OHT in collaboration with OH Regions and aligned with a past proposal submitted through an earlier call for IPCT expansion.

Geographic planning was guided by data, where they mapped unattached patients by naturally occurring communities. Planning focused on identifying underserved areas and assessing local capacity to support new or expanded teams. The OHT worked directly with teams, physicians and nurse practitioners to understand what they would need to attach more patients. The OH Region was available for support to the OHT to assist.

The strategy included enhancing existing primary care clinician capacity through shared interprofessional support and fostering the beginnings of a rural health neighbourhood model by integrating services such as community paramedicine, mental health, palliative care and geriatric assessment teams.

They used the OHT data dashboard and a data planning tool of their own making to support this work, as well as formed a collaborative planning table with primary care and community partners, including Indigenous Primary Health Care Organizations.

Outcomes of the geographic planning work included:

- **Improved understanding of local needs and capacity**: mapping and engagement helped identify specific gaps and tailor strategies to contexts
- **Strengthened partnerships**: Collaborative planning fostered alignment across teams and organizations
- **Scalable planning model development**: the approach created a foundation for future implementation of team-based care, with clear pathways for expansion as resources become available
- **Enhanced readiness for funding**: The OHT is well-positioned to respond to future calls for proposals with a data and community-driven plan that reflects local priorities