# Introduction

Primary care is the foundation of any high functioning health system. It is the first point of entry into the health system, and primary care ensures continuous, comprehensive, coordinated, and person-focused care.

To continue to implement *Your Heath: A Plan for More Connected and Convenient Care*, the Government of Ontario established a Primary Care Action Team, in the Ministry of Health (Ministry), with a mandate to attach every person in Ontario to a primary care clinician or team.

In alignment with the *Primary Care Act, 2025,* the goal is to build a high-performing primary care system that meets the following objectives of care: (1) province-wide, (2) connected, (3) convenient, (4) inclusive, (5) empowered, and (6) responsive.

# Primary Care Action Plan

In January 2025, the Government of Ontario (government) announced its Primary Care Action Plan to connect two million more people – everyone in the province – to a primary care clinician or team by 2029, supported by a $2.1 billion investment.

On June 23, 2025, the government announced the outcomes of the 2025-2026 Call for Proposals that will see support for over 130 new and expanded primary care teams that will connect 300,000 people to primary care this year.

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.

The Ministry and Ontario Health will co-manage intake and assessment to allocate multi-year funding for new and expanded interprofessional primary care teams.

# 2026-2027 Call for Proposals

All Ontario Health Teams (OHTs) and their Primary Care Networks (PCNs) are eligible to submit a set number of proposals that align with the strategic evaluation priorities of the Call for Proposals.

Completing this proposal form is a requirement to be considered for the 2026-2027 funding.

Proponents may apply to create or expand one of the following approved interprofessional primary care models: Family Health Teams (FHTs), Community Health Centres (CHCs), Nurse Practitioner-Led Clinics (NPLCs), and Indigenous Primary Health Care

Organizations (IPHCOs). These interprofessional primary care models will be expected to meet the primary care team objectives specified below. Please refer to Appendix C, which provides a description of these models. The deadline for all submissions is **November 14th, 2025, 5pm** to primarycareexpansion@ontariohealth.ca.

**Submission instructions:**

- Applicants must not alter the format, font, or word count of the proposal form. Submissions that do not adhere to these specifications will not be accepted or reviewed.
- Only letters of support/commitment may be submitted as supplementary materials. All other attachments or documents not explicitly requested as part of the application will not be reviewed.

For more information, please visit *here.*

***Indigenous-Led Organizations may submit their application separate from OHT PCNs.***

## Strategic Evaluation Priorities

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

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 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 across the province 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.

## Submission of Proposal

- This is **not** a procurement process. This is a request for proposal process for the selection of Transfer Payment recipients, and the Ministry has full discretion and decision-making power in the evaluation and approval process. The Ministry may prefer any proposal over another proposal and is not required to select a funding recipient through this process.
- The Ministry, in its sole discretion, may deem a Proposal Form incomplete or unclear and, discontinue consideration of the proposal if the information provided in the Proposal Form is considered incomplete or unclear.
- The Proposal Form, the FAQs, any other supporting materials with the submission of the Proposal Form, and/or other material in connection with the request for proposals, do not create any contractual or other legally enforceable obligation on the Ministry, the proponent, or anyone.
- Failure to adhere to the requirements outlined in this document may result in the removal of the proposal from consideration.
- Any costs associated with preparing and/or submitting the Proposal Form are solely the responsibility of the proponent. Neither the Ministry nor any agency of the Government of Ontario is responsible under any circumstances whatsoever for any expenses incurred by the proponent related to the request for proposal process.

## Appendices

**Appendix A:** Proponent Signature and Acknowledgment
**Appendix B:** Budget Template
**Appendix C:** Description of Existing Interprofessional Primary Care Teams and How Physicians and Nurse Practitioners Can Participate
**Appendix D:** Proposal Checklist
**Appendix E:** French Designated Areas in Ontario

# Proposal Form

**Proposal ID:**

## Section A. Proponent Information

This section should be completed with the information of the proponent leading the expansion of an existing interprofessional primary care team or the creation of a net new interprofessional primary care team.

1. **Name of the OHT this proposal is associated with**

   --- (No Associated OHT)

2. **Name of the Ontario Health Region**

3. **Name and Location of Proponent(s)/Organization(s)**

Organization name:

Team Model:

City: Postal code:

Organization name:

Team Model:

City: Postal code:

Organization name:

Team Model:

City: Postal code:

Organization name:

Team Model:

City: Postal code:

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4. **Name of the Lead Organization** *(This is the organization that will be responsible for holding funds, being the primary contact with MOH/OH, working with partner organizations to establish the interprofessional primary care model)*

**5. Name, Email and Phone Number of Primary Contact at the Lead Organization**

Name of Primary Contact:

Email address of Primary Contact:

Phone Number of Primary Contact: Extension:

Street address:

City:

Postal code:

**6. Does the organization have a Board of Directors or Band Council?**

**7. If the organization has a Board of Directors or Band Council, have they endorsed this application?**

**8. Is your proposed service area located in or serving a designated area[1] under the French Language Services Act (FLSA)?** *(See Appendix E for a list of French language designated areas in Ontario)*

**9. Do you provide programs and/or services in French for patients whose mother tongue is French, or patients who are more comfortable speaking French?**

## Section B. Team Model

**10. Please check whether the proposal is to:**

- ☐ Expand an existing team by adding new team members (i.e., salaried clinicians) at an existing location
- ☐ Expand an existing team by adding new partner organizations (e.g., Family Health Organization [FHOs], existing FHT, CHC or NPLC) to broaden service delivery and attach more patients
- ☐ Expand an existing team by adding a satellite location or mobile unit
- ☐ Create a net new team

**11. Please specify the type of team and identify which model is being proposed to expand or create: Family Health Team (FHT), Community Health Centre (CHC), Indigenous Primary Health Care Organization (IPHCO), or Nurse Practitioner-Led Clinic (NPLC).**

**Priority will be given to creating new teams in areas where none currently exist. In regions with an existing team, proponents are encouraged to submit collaborative proposals. Please refer to Appendix C for descriptions of interprofessional primary care team models.**

- ☐ CHC
- ☐ FHT
- ☐ IPHCO
- ☐ NPLC

## Section C. Primary Care Teaching Clinic

A primary care teaching clinic (also known as family medicine teaching units) refers to a clinical setting, affiliated with a university, where medical students, resident doctors and other interprofessional care team members receive training under the supervision of experienced family physicians and other clinicians. The ministry will be providing universities with funding to support the establishment of new primary care teaching clinics and will be engaging primary care teams to provide clinical support. Primary care teams that have a formal arrangement to support a university's medical primary care teaching clinic are asked to identify this in their application, and provide confirmation of this partnership (e.g., letter of support from the medical school). Primary care teams that don't have a formal arrangement, but are interested in supporting new learners, are also asked to identify their interest in working with universities.

**12. Is your team interested in becoming a primary care teaching clinic?**

**13. If yes, identify the name of the university your team would be interested in or is already working with:**

Name of university:

Street address:

City:

Postal code:

## Section D. Proposal Summary and Rationale for Need

**14. Please provide a short summary of the proposal (3-5 sentences).**

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**15. Based on the OHT data packages, please identify the geographic area you are planning to serve by specifying the forward sortation areas (the first 3 digits of the postal code), aggregate dissemination areas (8-digit codes) or census subdivisions (7-digit codes).**

**Forward Sortation Area (FSA):**

| | | |
|---|---|---|
| 1) | 5) | 9) |
| 2) | 6) | 10) |
| 3) | 7) | 11) |
| 4) | 8) | 12) |

**Aggregate Dissemination Area (ADA):**

| | | |
|---|---|---|
| 1) | 5) | 9) |
| 2) | 6) | 10) |
| 3) | 7) | 11) |
| 4) | 8) | 12) |

**Census Subdivision (CSD):**

| | | |
|---|---|---|
| 1) | 5) | 9) |
| 2) | 6) | 10) |
| 3) | 7) | 11) |
| 4) | 8) | 12) |

16. **Please provide rationale for why that geographic area was selected for an expanded or new primary care team, and why the proposed partners are best positioned to serve the geographic area?** *Proponents may use local data that further demonstrates the need for this proposal (sociodemographic needs, health system utilization, etc.).*

## Section E. Geographic Zones and Team Attachment*

17. **How many net new patients will be attached when the team is at full Full-Time Equivalent (FTE) complement in 2026-2027?** *Attachment obligations will be outlined in funding letters for successful candidates.*

*Attachment: Documented and ongoing relationship with a primary care clinician (i.e., physician or nurse practitioner) or team working in a publicly funded system. The documentation could be through formal registration or signed enrolment and consent form.

18. **Please confirm that your team will commit to attaching patients on the Health Care Connect wait list.**

## Section F. Team Composition

**19. Please complete the table below to identify the proposed net new primary care clinicians, including identification of the most responsible primary care clinicians for patients, as well as interprofessional and administrative/ management staff. For proposals aiming to serve Francophone communities, please indicate designated bilingual positions, where applicable.**

**Where applicable, attach a letter from the family physician, physician group, nurse practitioner, specialist, or other team members, confirming their commitment to join the primary care team.**

Please refer to the Guidance Document to complete this section.

| Additional Provider Type | Proposed Total of Additional FTE(s) | Letter of Commitment with Start Date Attached (Y/N) |
|---|---|---|
| Salaried Physician (only for Blended Salary Model-FHTs, CHCs, IPHCOs) | | |
| Nurse Practitioners | | |
| Physician Assistants | | |
| Interprofessional team members (e.g. Registered Nurse/ Registered Practical Nurse, Registered Dietitian, Midwife, Social Worker, Traditional Healer, Community Health Worker etc.) who will enable attachment | | |
| Administration (e.g., receptionist, medical office assistant, data coordinator) | | |
| Management (e.g., executive director) | | |

**20. Please identify the affiliated physician group(s) (if applicable).**

| ***Other Affiliated Physicians** *(e.g., Family Health Organization (FHO), Family Health Network (FHN), Rural and Northern Physician Group Agreement (RNPGA))*<br><br>*An Affiliated Physician Group must agree to be affiliated with the Recipient and act as the physician service provider.*<br><br>*This information is to identify the affiliated group with the new team and not for funding purposes.* | **Name of the Physician Group(s)** *(i.e., FHO # BA xxxx that will be affiliated with the team [existing and new group(s) affiliating with the FHT]). )* | **Letter of Commitment from the Physician Lead (Y/N)** *Include Start Date If Applicable* |
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## Section G. Plan to Meet Primary Care Objectives

The objectives below represent a long-term, aspirational vision for the future of the primary care system. Specific expectations and outcomes related to these objectives will be integrated into funding accountabilities and deliverables for the recipient.

**21. Please describe how the team will meet the objectives over time through the design and delivery of specific programs and services.**

| **Objective 1: Province wide**<br><br>Description: Ontarians across the Province should have the opportunity to have a documented and ongoing relationship with a primary care clinician or team.<br><br>*Proposed Approach: Please describe how this proposal will achieve the attachment target noted above for people within the identified catchment area.*<br>*How will the team attach people from the Health Care Connect waitlist?* |
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**Objective 2: Connected**

Description: Ontarians should have the opportunity to receive primary care services that are co-ordinated with existing health and social services.

*Proposed Approach: How will the team ensure that team members are working to their full scope of practice to enhance attachment?*
*How will the team enhance coordination of services, including services to those who experience health disparities?*
*How will the team enable coordinated and integrated delivery of primary care services?*

**Objective 3: Convenient**

Description: Ontarians should have access to timely primary care services.

*Proposed Approach: What strategies will the team implement to ensure timely access to primary care?*
*How will you support patients to have access to necessary primary care services after-hours, and on evenings and weekends?*
*What strategies will the team implement for patients who face access barriers?*

**Objective 4: Inclusive**

Description: 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.

*Proposed Approach: How will the team identify the primary care needs of the entire local population, including priority populations (e.g., Indigenous, Francophone, Black, 2SLGBTQIA+, persons living with disabilities)? How will the team address ongoing challenges and barriers to accessing primary care?*
*How will the team ensure people receive care that is accessible, culturally appropriate, and reflective of the local population?*
*If the team is located in or serving a designated area under the FLSA, what is the plan to ensure access to French language care?*

**Objective 5: Empowered**

Description: 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.

The Ministry recognizes that digital integration may be more constrained for providers operating in remote Northern regions.

*Proposed Approach: How will the team leverage and expand the use of digital solutions?*
*How will the team address barriers for patients accessing digital technology?*
*Please outline if digital integration is constrained by infrastructure and/or remoteness.*

**Objective 6: Responsive**

Description: 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.

*Proposed Approach: How will the team use population data to create responsive strategies to increase attachment for populations experiencing health disparities?*
*How will the team use data and evaluation for continuous quality improvement and learning?*
*How will the team include patients in the design and delivery of services?*

## Section H. Implementation Plan and Readiness

Please outline a plan that details the timeline when the team will start attaching people to a regular primary care clinician, beginning **April 1, 2026**. The plan should include, but not be limited to, key activities including Milestones, recruitment plans, and roles and responsibilities.

**22. Recruitment: Please specify recruitment plans including a timeline for hiring and onboarding.**

**23. <u>Location(s)</u>: Has a location been identified for the proposed services?**

**24. <u>Location(s)</u>: Please describe if the proposed site(s) is co-located with other health care services?**

**25. <u>Location(s)</u>: Please confirm the date (month) when the site(s) will be "move in ready".**

**26. <u>Partnership(s)</u>: If a new partnership is being proposed, please outline:**

- **a. The roles and responsibilities of each partner;**
- **b. Whether the partnership(s) has/have or will be formalized (e.g., through a Memorandum of Understanding);**
- **c. How service providers will increase attachment for underserved populations;**
- **d. Accountability measures that will be used to enable success of the partnership(s).**

**Letter(s) of support from partnering organizations are recommended.**

27. **<u>Start-up costs</u>: Please identify any start-up costs required e.g. minor capital, furnishing, equipment, recruitment costs, etc.** *Please note, large scale new builds or renovations over $100K will not be considered.*

28. **<u>Operationalization</u>: Based on the plan outlined above, what is the estimated start-up date (i.e., when first patient will be seen and attached) for the new or expanded team?**

29. **<u>Operationalization</u>: Based on the plan outlined above, what is the estimated timeline for when the new or expanded team will be fully operational (i.e. team at full FTE complement)?**

30. **<u>Accountability and Oversight</u>: How will the team track, measure and report on progress against your plan? Who will lead this work and who will support data collection?**

31. **<u>Governance</u>: Please describe the governance structure of the new or expanded team. How will partner organizations, primary care clinicians, and community members and patients be fairly represented in the governance structure?**

**32. <u>Long-term Planning</u>: How will your team and (where applicable) partners support the attachment of 100% of the population within your OHT's geographic area to primary care over the next three years?**

## Section I. Risks and Mitigations

**33. Please identify and describe any risks, contingencies, issues, and circumstances which you may encounter in the development and implementation of the proposed services. Please include applicable mitigation strategies for each identified risk.**

*E.g., ability to operationalize within a given time frame, including HHR recruitment, breakdown of existing partnerships.*

| Risk | Mitigation |
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## Appendix A: Proponent Signature and Acknowledgment

Please refer to separate “Proponent Signature and Acknowledgment” document –

*included as part of proposal form package*

## Appendix B: Budget Template

Please refer to separate Budget Template (in Excel format) –

*included as part of proposal form package*

## Appendix C: Description of Existing Interprofessional Primary Care Teams (IPCT) and How Physicians and Nurse Practitioners Can Participate

| Description of Interprofessional Primary Care Models | | | |
|---|---|---|---|
| **Family Health Team (FHT)** | **Community Health Centre (CHC)** | **Indigenous Primary Health Care Organizations (IPHCO)** | **Nurse Practitioner-Led Clinic (NPLC)** |
| FHTs are community-centered 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 operate under multiple funding models. The Blended Salary Model (BSM), which compensates physicians primarily through a salary and non-BSM models, which compensate physicians under a 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.<br><br>For an overview of the FHT, please refer to Family Health Teams \| ontario.ca | CHCs provide comprehensive, Interprofessional primary health care services with an emphasis on health promotion, disease prevention and addressing the social determinants of health. They are designed to serve 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. They are governed by volunteer community boards and operate with a mandate to improve health equity and access.<br><br>Salaried physicians are employees of the CHC. For an overview of the CHC, please refer to Community Health Centres I ontario.ca | IPHCOs are Indigenous-governed, community-led health organizations that provide culturally safe, holistic and integrated primary care services to First Nations, Métis, Inuit 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.<br><br>(Note: Teams formerly known as Aboriginal Health Access Centres) | 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.<br><br>For an overview of the NPLC, please refer to Nurse Practitioner-Led Clinics I ontario.ca |

*Please note the compensation rates for physicians working in or collaborating with these models are established through negotiations with the Ontario Medical Association.

| Scenarios - Family Health Team | |
|---|---|
| **Expansion** | **New Teams** |
| • An existing FHT that is affiliated with one or more Family Health Organizations (FHOs) or Family Health Networks (FHNs) plans to expand their practice and would like to invite another FHO to join their team so they can roster more patients. They could apply for more interdisciplinary health providers (IHPs) and administrative staff and become an extension or satellite of the FHT.<br><br>• An existing FHT that is affiliated with a Blended Salaried Model (BSM) would like to expand and roster more patients. They could apply for an additional salaried physician FTE or IHPs.<br><br>• An existing FHT would like to expand their services and affiliated physicians plan to roster all unattached patients in a geographic area. They could apply for new IHPs. | • One or more FHOs or FHNs without an affiliation to a FHT would like to expand their practice. They could propose to create a new FHT and apply to add IHPs and administrative support to their practice.<br><br>• A group of physicians who are in a Family Health Group (FHG) could apply to become a FHO which could then be eligible to apply to become a FHT, if there is no FHT in the area.<br><br>• A group of physicians want to work in a salaried model with interprofessional and administrative support. They could create a new blended salary model (BSM) FHT.<br><br>• An RNPGA could decide to apply to become a FHT that will provide attachment for people living within the geographic area. |

| Scenarios - Community Health Centre | |
|---|---|
| **Expansion** | **New Teams** |
| • An existing CHC would like to expand their services to a growing population in the catchment area. They could apply for an additional salaried physician or IHPs. | • A group of physicians or NPs decide to create a team of interprofessional providers and administrative support, creating a new CHC.<br><br>• Community organizations with an interest in primary care could collaborate with local clinicians and apply to be a new CHC that would take on all unattached patients in a geographic area. |

| Scenarios - Nurse Practitioner-Led Clinic | |
|---|---|
| **Expansion** | **New Teams** |
| • An existing NPLC would like to expand their services to a growing population in the area. The team could apply for an additional salaried NP to attach more patients.<br><br>• An existing NPLC would like to expand services for residents of a local community housing unit (satellite or mobile services), where the NPLC provides primary care. The team could apply for additional funding that enable them to attach patients to ongoing primary care. | • A group of NPs decide to apply for funding to create a team of interprofessional clinicians and administrative support, creating a new NPLC. |

| Scenarios - Indigenous Primary Health Care Organizations | |
|---|---|
| **Expansion** | **New Teams** |
| • An existing IPHCO would like to expand their services for Indigenous peoples. The team could apply for an additional salaried physician or IHPs and demonstrate they will attach more people to ongoing primary care. | • An Indigenous organization or Band Council seeks to expand interprofessional primary care to the community. The group can apply for funding to create a new IPHCO. |

## Appendix D: Checklist for Interprofessional Primary Care Team Expansion

- ☐ Completed Proposal Form
- ☐ Completed Proposed Budget
- ☐ Proposal Signature and Acknowledgement
- ☐ Letters of Support/Commitment

## Appendix E: French Designated Areas in Ontario

Designated areas in Ontario are shown on this map and are also listed below (updated map coming soon):

- City of Toronto – all
- City of Hamilton – as boundaries existed on Dec. 31, 2000
- Cities of Port Colborne and Welland in Regional Municipality of Niagara
- City of Ottawa – all
- Cities of Mississauga and Brampton – Regional Municipality of Peel
- Sudbury – city and greater Sudbury area
- Township of Winchester – Dundas County
- Essex County:
    - City of Windsor
    - Towns of Belle River and Tecumseh
    - Townships of Anderdon, Colchester North, Maidstone, Sandwich South, Sandwich West, Tilbury North, Tilbury West and Rochester
- Glengarry County – all
- Kent County:
    - Town of Tilbury
    - Townships of Dover and Tilbury East
- Prescott County – all
- Renfrew County:
    - City of Pembroke
    - Townships of Stafford and Westmeath
- Russell County – all
- Simcoe County
    - Town of Penetanguishene
    - Townships of Tiny and Essa
- Stormont County – all
- District of Algoma – all
- District of Cochrane – all
- Township of Ignace in District of Kenora
- District of Nipissing – all
- District of Sudbury – all
- District of Thunder Bay
    - Towns of Geraldton, Longlac and Marathon
    - Townships of Manitouwadge, Beardmore, Nakina and Terrace Bay
- District of Timiskaming – all
- City of London
- Municipality of Callander in District of Parry Sound
- City of Kingston
- City of Markham in Regional Municipality of York
- County of Lambton
- City of Sarnia