

**SUMMARY OF
TARGETED
INTERPROFESSIONAL PRIMARY
CARE TEAM EXPANSION IN THE
OTTAWA OHT-ÉSO
ROUND ONE**

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Background

In January 2025, the Ontario government announced a \$1.8 billion investment to support Dr. Jane Philpott and the Primary Care Action Team's plan to connect every person in Ontario to primary care by 2029. On April 10, 2025, the Ministry of Health launched the first call for proposals to create and expand up to 80 primary care teams to connect 300,000 people to a family doctor and primary care in 2025. This first call was targeted to communities, by forward sortation area (first three characters of a postal code), that had the highest number of people not connected to primary care.

Throughout the province, **80 eligible Forward Sortation Areas (FSAs)** were identified. These FSAs were then assigned to the Ontario Health Team who had the highest market share of attributed population in that FSA. OHTs were limited to submitting one proposal/ FSA, **up to a maximum of 5 proposals/ OHT**.

The Ottawa OHT-ÉSO assigned 8 FSAs, the second highest in the province.

Process



Supports provided by the Ottawa OHT-ÉSO

Information Webinar

On April 16 2025, the Ottawa OHT-ÉSO hosted an information session to share information on the interprofessional Primary Care Team Expansion targeted call for proposals for the purpose of leveraging our collective knowledge, strength, experience and commitment to coordinate a community response. The collective goal of this round of funding was to position Ottawa to successfully secure funding for Round One and increase our capacity to provide quality interprofessional primary care to all.

Expression of Interest

Following the webinar, those interested in submitting a proposal were asked to complete a Microsoft forms survey with contact information and the high priority FSA(s) of interest. This information was shared amongst everyone who had indicated interest in submitting a proposal to facilitate communication, partnership and service integration among various organizations and primary care professionals.

Data Support and Additional Resources

Interactive primary care data reports were developed for each priority FSA and posted on the Ottawa OHT-ÉSO website. Data drop-in sessions were hosted to support the use of data to strengthen submissions. The data reports had 380 views overall and 23 individuals attended the data support sessions.

Resources such as guidelines, templates, submission guides, and FAQs were made available via the OHT website to aid proposal development.

Ottawa OHT-ÉSO staff were available to answer questions and escalate questions to the Ontario Health East team. Questions and answers were all shared via the Ottawa OHT-ÉSO website.

Scoring and Selection of Proposals

A scoring matrix was developed to align with strategic priorities, primary care team principles and other proposal requirements. The scoring matrix was posted on the Ottawa OHT-ÉSO website and shared with partners via email prior to the draft submission deadline.

A review committee was established with diverse representation primarily from the Ottawa OHT-ÉSO Collaborative Leadership Group, including primary care, different sectors, bilingual, a client partner and a representative from the Archipel OHT. To address any real or perceived conflict of interest, anyone participating in the writing of a

proposal or with a close relationship was excluded from the process. In addition, acknowledgement of current and past relationships with proponent organizations and clinics were disclosed at the beginning of the review session to ensure transparency.

In total, eleven proposals were submitted and reviewed by the committee. Five proposals, the maximum allowed, were selected. All those whose proposals were not selected in this round were offered debrief meetings.

Proposal Submissions

All proposals selected were provided with detailed feedback and tailored recommendations, along with additional data to address specific areas for improvement and enhance the overall quality of submissions. The Ottawa OHT-ÉSO team also coordinated strategic linkages between proponents to foster collaboration and create stronger proposals. The Ottawa OHT-ÉSO provided continuous updates throughout the submission process to inform proponents of any changes or additional requirements.

For an overview of the proposals submitted, please see Appendix A.

Next Steps

Funding decisions on the proposals are expected by Summer 2025. Though it is not yet clear what each OHT's role will be in the funding roll out, the Ottawa OHT-ÉSO welcomes the opportunity to support successful applicants to implement their proposals. In addition, the Ottawa OHT-ÉSO welcomes the opportunity to provide feedback to the Primary Care Action Team and Ontario Health on the process and lessons learned from Round One. Lastly, targeted planning sessions will take place over the summer to prepare for Round Two, anticipated this fall.

Appendix A - Proposals Submitted

1. Bruyere Health Academic Family Medicine (FHT) – K1N
2. South East Ottawa Community Health Centre – K1G
3. Pinecrest Queensway Community Health Centre - K2B
4. Équipe de santé familiale académique Montfort – K1K
5. Équipe de santé familiale communautaire de l'Est d'Ottawa (ESFCEO) – K4A

K1N - BRUYERE HEALTH ACADEMIC FAMILY MEDICINE (FHT)

- **Total FSA Population:** 30,403
- **Unattached (N):** 8,521
- **Unattached (%):** 28%
- **Health Care Connect Waitlist (N):** 2,042
- **Proposed Budget:** \$7,033,153.00

The K1N-Bruyere Health Academic Family Medicine (FHT) proposal is designed to achieve the ongoing attachment of 100% of individuals residing in the K1N postal code area to a regular primary care clinician, including individuals currently registered on the Health Care Connect (HCC) waitlist. In this first phase of funding, 6 primary care clinics will meaningfully attach approximately 7,700 (91% of those unattached in K1N), or 1,440 persons per clinic (CHC, FHT, FHG, and FHO with IHP).

This will be accomplished through an integrated, two-pronged approach: (1) Attachment to Clinics and (2) Right Care in the Right Place (Community-Based Outreach Clinics and Mobile Care), with active support from five primary care clinics, ten community partners, and the Department of Family Medicine at the University of Ottawa.

The K1N area, characterized by its diversity and socioeconomic challenges, has high rates of unattached patients, poverty, and mental health crises. The proposal emphasizes the need for specialized, coordinated care for individuals facing complex health challenges, including physical and mental health and substance use issues. Strategies include clinic-based patient attachment, community outreach, specialized trauma-informed care, and workforce development through partnerships for training and integration of healthcare students into high-need clinics.

Submission Partners

- ✚ Primary Care Clinics (CHC, FHT, FHG, and FHO with IHP)
- ✚ Sandy Hill Community Health Centre

- ✚ Ste-Anne Medical Clinic
- ✚ Byward Family Health Team
- ✚ Restore Medical Clinic

- ✚ Bruyere Health Academic Family Medicine (FHT)
- ✚ Community Partners (Confirmed – In Kind resources or space)
- ✚ Options Bytown/Ottawa Community Housing
- ✚ Ottawa Inner City Health
- ✚ CMHA Ottawa
- ✚ Vanier Community Service Centre
- ✚ Lowertown Community Resource Centre

- ✚ City of Ottawa, Employment and Social Services (ESS) Outreach and Mobile Services Case Worker
- ✚ University of Ottawa, Department of Family Medicine
- ✚ Rideauwood Addiction and Family Services*all FSA
- ✚ Voice Found, the Clinic*all FSA
- ✚ Monarch Centre for Maternal and Newborn Care*all FSA

K1G - SOUTH EAST OTTAWA COMMUNITY HEALTH CENTRE (SEOCHC)

- **Total FSA Population:** 38,565
- **Unattached (N):** 7,448
- **Unattached (%):** 19.3%
- **Health Care Connect Waitlist (N):** 1,543
- **Proposed Budget:** \$4,045,891.00

SEOCHC and their partner Gloucester Family Health Organization aim to attach 100% (7,500) of K1G residents to primary care clinicians by March 2027, including those on the Health Care Connect (HCC) waitlist. By March 2026, the goal is to connect approximately 3,500 unattached residents (46%) together and with partnerships with community-based organizations.

The community is diverse, with many low-income and socially frail older adults, as well as New Canadians, facing a high disease burden and complex health needs. The proposal prioritizes HCC referrals from K1G using expedited intake and assessment processes. It emphasizes multilingual support and culturally responsive care for underserved communities, including Indigenous, Francophone, Black, and 2SLGBTQIA+ populations.

The strategy includes recruiting additional family physicians and nurse practitioners as well as hiring additional allied health to meet community demand for primary care attachment. SEOCHC and GFHC will work together to support socially and medically complex clients, including those without insurance. Proactive outreach will target unattached individuals through community partnerships.

Collaboration with the Dementia Society of Ottawa and Renfrew County will expedite attachment for geriatric patients from local emergency departments, integrating referral processes and post-ER discharge pathways into clinics. Additional support from

Rideauwood Addiction and Family Services will help those community members experiencing mental health issues, addictions and substance use disorders.

Submission Partners

-  Gloucester Family Health Organization
-  Dementia Society
-  Rideauwood Addiction and Family Services

K2B - PINECREST QUEENSWAY COMMUNITY HEALTH CENTRE

- **Total FSA Population:** 36,913
- **Unattached (N):** 7,232
- **Unattached (%):** 19.6%
- **Health Care Connect Waitlist (N):** 1,866
- **Proposed Budget:** \$2,208,656.00

The proposal presented by PQCHC focuses on ensuring that all 7,232 unattached residents in the K2B FSA are connected to the appropriate clinic to meet their healthcare needs by March 2027. This initiative involves a collaborative effort among three primary care clinics, two Community Health Centres (CHCs), and one Family Health Group (FHG) to address the diverse and growing health demands of the K2B population. By March 2026, the proposal aims to connect approximately 3,000 individuals, accounting for 41% of the unattached residents in the area. PQCHC is committed to enrolling all individuals in Health Care Connect, with approximately 25% (1,866 individuals) of the unattached population already registered. Two of the three clinics have successfully begun attaching clients from this program. For the remaining 75% (approximately 5,366 individuals) who are still unattached, PQCHC will collaborate with various partners to facilitate their connection to the most suitable primary care clinics and services. To enhance accessibility, they will implement a low-barrier centralized intake process that prioritizes flexibility and tailored support for clients.

The K2B community faces significant barriers to accessing care, particularly due to its high proportion of newcomers. Additionally, 33% of the population are older adults, and 13% identify as Black— groups that often encounter systemic challenges in accessing appropriate health services. PQCHC is leveraging CHCs unique position to serve these complex client needs, which emphasizes health equity and offers wrap-around community support through services such as system navigators and community developers, translation services and transportation assistance. This proposal brings together three agencies—Nepean, Rideau and Osgoode Community Resource Centre (NROCRC), Britannia Woods Community House, and Jewish Family Services—each recognized for delivering high-quality mental health services. Through this partnership, they will build the capacity of all three agencies to provide accessible, culturally sensitive, multi-language mental health services for primary care clients attached within the K2B area.

Submission Partners

- ✚ Carlington Community Health Centre
- ✚ My Medical Centers
- ✚ Nepean Rideau Osgoode Community Resource Centre
- ✚ Britannia Wood Community Services
- ✚ Jewish Family Services of Ottawa

K1K- ÉQUIPE DE SANTÉ FAMILIALE ACADÉMIQUE MONTFORT (ESFAM)

- **Total FSA Population:** 37,578
- **Unattached (N):** 7,728
- **Unattached (%):** 20.6%
- **Health Care Connect Waitlist (N):** 2,012
- **Proposed Budget:** \$434,144.00

ESFAM aims to enroll 2,500 individuals by March 2027, which is about 32% of the unattached population, and 2,000 individuals by March 2026, or approximately 26%. About 30% of these unattached individuals report French as their first language, meaning roughly 2,318 Francophones lack a family physician. This enrollment will ensure all Francophone residents without a physician are accommodated, while also providing equitable access for Anglophone residents.

Dual focus on patient attachment and provider development:

Patient attachment - Enrolled individuals will be connected to existing or newly recruited family physicians through an online enrollment portal and innovative, low-barrier strategies, such as custom QR-coded registration cards, to facilitate guaranteed enrollment.

To support this initiative, ESFAM has partnered with various organizations, including the Monarch Centre for Maternal and Newborn Care and the Centre des services communautaires Vanier, which will serve as referral partners to ensure smooth access for discharged patients. The Équipe de santé familiale communautaire de l'Est d'Ottawa will also support the referral process, alongside collaboration with specific departments at Hôpital Montfort and outreach efforts by La Maison de la Francophonie d'Ottawa, Public Health, and community support services.

Provider Development - ESFAM aims to enhance their medical teaching capacity by increasing training days from 1,500 to at least 1,950 per year, contributing to the preparation of future physicians and health professionals.

Submission Partners

- ✚ Centre des services communautaires Vanier
- ✚ Monarch Centre for Maternal and Newborn Care
- ✚ Équipe de santé familiale communautaire de l'Est d'Ottawa

K4A - ÉQUIPE DE SANTÉ FAMILIALE COMMUNAUTAIRE DE L'EST D'OTTAWA (ESFCEO)

- **Total FSA Population:** 71,982
- **Unattached (N):** 9,271
- **Unattached (%):** 12.9%
- **Health Care Connect Waitlist (N):** 2, 913
- **Proposed Budget:** \$2,457,065.00

The proposal from ESFCEO outlines a commitment to attaching approximately 2,900 individuals without primary care by March 2027, representing around 31% of the target within their FSA. It aims to reach an interim goal of 2,000 individuals by March 2026, which accounts for roughly 21%. This will involve proactive outreach and targeted engagement strategies, with a focus on francophone and other under-served communities.

To support these objectives, ESFCEO plans to expand its resources by adding 2.0 Full-Time Equivalent (FTE) BSM physician positions, including the recruitment of a family doctor set to join in July 2025. This growth is intended to facilitate the attachment of at least 2,900 new patients. The proposal includes integrating 1.0 FTE Seniors Navigation resource at CREO, 2.2 FTE Social Workers, and 1.0 FTE Community Health Worker at CRCOC, along with a shared 1.0 FTE Data Management/Digital Health resource with ESFAM. They are also committed to supporting other teams that cannot offer services in French within priority FSAs.

ESFCEO plans to leverage ESFAM's existing online enrollment portal to implement low-barrier, partner-driven enrollment strategies. These strategies will include the use of custom QR-coded registration cards that directly link patients to guaranteed enrollment.

Submission Partners

- ✚ Hôpital Montfort
- ✚ Centre de ressources communautaires Orléans-Cumberland
- ✚ Centre des ressources de l'Est d'Ottawa
- ✚ Équipe de santé familiale académique Monfort