**Expanding and Enhancing Interprofessional Primary Care Teams**

2023-2024

Expression of Interest

May 2023

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## Introduction

*Your Health: A Plan for Connected and Convenient Care* includes a commitment to connect more people with primary care in communities across the province, including additional funding to create more interprofessional primary care (IPC) teams to help make care more convenient for people. The Government of Ontario is taking immediate action to move forward with a process to expand existing teams and/or create up to 18 new teams in communities with the greatest need.

These multidisciplinary care teams will provide direct care to vulnerable and marginalized people as well as those without a family doctor across Ontario. This will help connect people to care when they need it without having to visit emergency rooms and experience long wait times, while also improving health outcomes by increasing preventive care and screening procedures.

Completing an Expression of Interest is a requirement for funding consideration by the Ministry of Health (ministry). The EOI should set out a convincing case or rationale and include all relevant details to enable the ministry to appropriately assess the need and effectiveness of the proposed programs and services in the community.

The ministry and Ontario Health (OH) are working together to manage the application process. Ontario Health will work with local primary care and community partners to support proponents’ EOI applications.

Completed EOIs should be submitted to the relevant OH region at the contacts below by **5 pm Eastern Daylight Time, June 16, 2023**. Completed EOIs can be submitted by e-mail **to the corresponding regional contact (below)** in PDF or Microsoft Word format **using the following subject line**: *(Name of Applicant) EOI – Interprofessional Primary Care*.

Applicants are encouraged to seek assistance via the designated regional contact if they have difficulty preparing or submitting electronic applications.

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| [**OH Region**](https://www.ontariohealth.ca/about-us/our-programs/ontario-health-regions) | **Contact for submission**  |
| Toronto | OH-Toronto.Funding@ontariohealth.ca |
| East | OH\_East\_IPC\_EOI\_Submissions@ontariohealth.ca |
| West | OH-West-PCEOI@ontariohealth.ca |
| Central  | OH-Central\_PrimaryCareAdvancement@ontariohealth.ca |
| North East | OH-NE-Finance@ontariohealth.ca |
| North West  | OH-NW-Submissions@ontariohealth.ca |

If you experience technical difficulty with the form, please contact your OH region using the e-mail above for assistance.

You are encouraged to answer each question clearly, completely, and concisely. Incomplete submissions will be evaluated according to the information provided.

You may resubmit completed EOIs until the closing date, but it is your responsibility to ensure that your OH region is aware of the new submission to ensure the most up-to-date EOI is evaluated.

You must:

* Ensure that the EOI is complete before submitting it to the OH Region.
* Affix any supporting or additional documentation in clearly defined appendices at the end of the EOI. Please include all copies of signed supporting documents.
* Ensure all supporting material is submitted by the closing date. Supporting material received after the closing date will not be considered.

The government is committed to enhancing equitable access to primary care and further strengthening the integration of primary care and other services, leading to connected care and improved patient experience. The creation or expansion of IPC teams aligns with ongoing efforts to strengthen primary health care as the foundation of the health care system in the province, ensuring Ontarians receive the right care in the right place. Accordingly, the ministry and Ontario Health are requesting proposals that demonstrate alignment with the following principles:

* Increasing access to care for unattached patients, patients with poorer health outcomes/health status.
* Ability to provide care to equity deserving populations with a demonstrated focus on reaching patients with poorer health outcomes.
* Efficient, effective and skills-based governance.
* Team based models of interprofessional primary care that maximize efficacy, scope of practice and how the team works together.
* Integration and collaboration with the broader health care system, including through Ontario Health Teams, as well as a commitment to participate in population-based planning for health service delivery.
* A commitment to using available data and evaluation for continuous quality improvement.
* The use of digital health to support care delivery and provide Ontarians with choice in how they interact with the health care system.

The ministry and Ontario Health will use an evaluation process, including criteria to assess for equity to review and assess EOI submissions. Based on the evaluation framework, the ministry will make recommendations for funding approval to expand and/or create IPC teams.

### Disclaimer

It is the applicants’ responsibility to ensure that all information provided is up-to-date and correct to the applicant's best knowledge and that the EOI reaches Ontario Health on or before the closing deadline. Ontario Health will support applicants in this effort. The ministry and Ontario Health are not responsible for EOIs that are lost, delayed, misplaced, or misdirected.

It is also the responsibility of applicants to ensure that all necessary legal and financial advice to complete this EOI is sought, if applicable.

By submitting an EOI, you acknowledge that this is not a competitive procurement/tender and that the recommendation of successful applicants for further funding shall be made at the ministry’s sole and absolute discretion.

In reviewing EOIs, the ministry reserves the right to discuss and disclose the contents of such applications within the broader public sector and the applicants; and by submitting EOIs, expressly consent to such disclosure in addition to the following consent.

### Consent

The ministry frequently receives requests for the release of contact information. The requestors for this information include individuals or organizations such as health care providers looking for jobs in family care practice models and media enquiries.

Consistent with the ministry’s desire to protect the privacy rights of IPC team applicants, contact information will not be released to the public during the application stage. Once successful partners are announced, the ministry will only release the contact information of the successful IPC teams. The information will only be provided to individuals and organizations who have requested the same.

## Interprofessional Primary Care (IPC) Team EOI

### Section 1 About You

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| **SECTION 1: ABOUT YOU**This section provides your organizational contact information and confirms whether the application is to create a new IPC team or to expand one or more existing IPC team(s). It also confirms the type of IPC team model proposed. For successful applicants, the information in this section may be released to requesting individuals or organizations with prior consent (as outlined in the "Consent" section of page 3). |

#### 1.1 Applicant Information

This section should be completed with information on the community applicant leading the creation or expansion of an IPC team.

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| Name of Applicant / Organization  |  |
| Location of Applicant / Organization |  |
| Name of Primary Contact/ Lead  |  |
| Title |  |
| Mailing Address of Primary Contact |  |
| City / Town |  |
| Postal Code |  |
| Phone |  |
| E-Mail Address  |  |
| Name of the Ontario Health Team the applicant is or will be part of  |  |

Please indicate whether the proposal is for expanding an existing team (adding new team members, adding a satellite location) or creating a new team, and please identify the proposed IPC team model i.e., Family Health Team (FHT), Nurse Practitioner-Led Clinic (NPLC), Community Health Centre (CHC), Indigenous Primary Health Care Organization (IPHCO) or Other.

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|  | **Proposed Model of IPC Team****(FHT, NPLC, CHC, IPHCO or Other\*)** |
| Expansion of an existing IPC Team | (Include the legal name of the existing organization) |
| Creation of a new IPC Team |  |

\*If the proposal is for a new model of care, please describe.

#### 1.2 Governance Structure

Please describe the existing or proposed governance structure for the expansion or creation of an IPC team, including incorporation status, board composition, engagement of patients, people with lived experience, community members, and community partners and other relevant information about the existing or proposed governance of the IPC team. If this EOI is for the development of an IPC team outside of the current models (FHT, NPLC, CHC, IPHCO) and is not incorporated as a not-for-profit corporation, please describe the organizational structure of the proposed recipient of funds in full.

Applicants are encouraged to leverage an existing governance structure rather than create a net new structure. You may include an organizational chart detailing the structure of the new or existing IPC team.

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| *e.g., You may include a description of any sub-committees of the Board, the member selection process, terms, evaluation processes and patient and family contribution.* |

#### 1.3 Team Composition and Model

Please complete the table below to identify the proposed/net new interprofessional primary health care providers (including identification of the most responsible primary care providers for the patients), as well as any specialists, if appropriate, that will be affiliated with the IPC team, including their role(s). You also can add provider type under 'other.’ Where applicable, attach a letter from the primary care physician, physician

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| **Interprofessional Primary Care Provider Type** | **Proposed FTE** | **Description**  | **Letter of Commitment Attached *(Yes/No)*** |
| Physician or Physician Groups |  |  |  |
| Nurse Practitioner |  |  |  |

group, or nurse practitioner and any individual specialists confirming their commitment to join the IPC team.

| **Interprofessional Primary Care Provider Type** | **ProposedFTE** | **Description** |
| --- | --- | --- |
| Traditional Wellness Practitioner |  |  |
| Registered Nurse |  |  |
| Registered Practical Nurse |  |  |
| Pharmacist |  |  |
| Psychologist |  |  |
| Psychological Associate |  |  |
| Psychotherapist |  |  |
| Mental Health / Social Worker (BSW) |  |  |
| Social Worker (3 yrs. Exp + MSW) |  |  |
| Dietitian |  |  |
| Health Educator/ Promoter  |  |  |
| Respiratory Therapist |  |  |
| Chiropodist |  |  |
| Case Worker / Manager |  |  |
| Occupational Therapist |  |  |
| Chiropractor |  |  |
| Physician Assistant |  |  |
| Physiotherapist |  |  |
| Kinesiologist |  |  |
| Midwife |  |  |
| Care Coordinator / System Navigator |  |  |
| Community Ambassador |  |  |
| Other: (specify) |  |  |

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| **Management/Administration** | **ProposedFTE** | **Role(e.g., consultation, program delivery)** |
| Executive Director |  |  |
| Office Administrator /Manager |  |  |
| Human Resources support  |  |  |
| Finance Manager |  |  |
| Program Administrator |  |  |
| Clerical /Receptionist |  |  |
| IT Support vs purchase of service |  |  |
| Data Specialist |  |  |
| Other (please describe) |  |  |

| **Specialist Type** | **ProposedFTE(# of 3-hour sessions)** | **Role(e.g., transfer of care/consultation)** | **Letter of Commitment Attached *(Yes/No)*** |
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| *Note: Please add more rows as needed.* |

#### 1.4 Primary Care Model

Please describe how the IPC team will work together in this model including with non-IPC team primary care providers (i.e., family physicians unaffiliated with the IPC team, community pediatricians, pharmacists, and nurse practitioners) to:

1. Provide attachment and comprehensive primary care for currently unattached patients.
2. How the model will maximize the scope of practice of the various interprofessional providers.
3. Whether the IPC team supports future practitioners and those new to practice.

Please also describe how care delivery by the IPC team will be organized (co-location, virtual, mobile, common EMR / information sharing) to maximize efficacy, team integration and reach.

#### 1.5 Ontario Health Team (OHT) and Community Partnership and Collaboration

It is strongly encouraged that applicants partner with the local Ontario Health Team (OHT), depending on OHT maturity, and obtain a letter of commitment for that partnership. If you are not part of an OHT, please describe plans to partner with other individuals, groups, or organizations (including home and community care providers, educational institutions, health service agencies, pharmacies, public health units, mental health and addictions organizations or municipalities) in the community to organize the delivery of services to the community and prevent duplication of services, if applicable. As identified, the ministry and OH are continuing to work with First Nations, Inuit, and Métis and urban Indigenous partners to ensure we are taking the most appropriate approach to addressing specific challenges and unique needs throughout the province. For Indigenous Primary Health Care Organizations (IPHCOs) not presently engaged in OHT activities, please provide a detailed rationale and response regarding efforts undertaken to build partnerships across the continuum of care. This will help the ministry and OH better understand challenges and unique needs when assessing applications.

It is also encouraged that applicants include a letter of support from their respective municipality. See section 2.3 for more information on what elements should be part of the discussion with the OHT. Please complete the following table for each service partner, adding more rows as needed.

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| **Name and Contact Information of Partnering Organization** | **Describe the Planned Collaborative** **Service Delivery** | **Letter of Commitment Attached *(Yes/No)*** |
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| *Note: Please add more rows as needed.* |

##### 1.6.1 Community Consultation and Co-Design of Programs and Clinical Services

Please describe community consultation activities that demonstrate the application has the support of community partners and planned mechanisms for ongoing co-design of programs and clinical services with community partners.

Please provide details of consultations with different community groups including those that represent a variety of populations (i.e. Black, Indigenous, Francophone and other racialized communities, community partners that serve clients with disabilities or experiencing homelessness, newcomers etc.).

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| e.g., format, date, length, and frequency of community consultations; names of the organizations consulted; name(s) of local health care providers and description of involvement.  |

##### 1.6.2 Patient, Family, Caregiver Consultation in the Community and Co-Design of Programs and Clinical Services

Please describe patient, family and caregiver engagement activities done within the community that demonstrate the application has the support of patients, families and caregivers and planned mechanisms for ongoing co-design of programs and clinical services with patients and families.

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| e.g., format, date, length, and frequency of patient, family and caregiver engagement and description of involvement.  |

#### 1.7 Physician Engagement

Please describe physician consultation engagement activities done that demonstrate the application has the support of physician partners. Proponents are encouraged to attach documentation such as letters of endorsement from physicians and/or physician groups consulted.

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| e.g., format, date, length, and frequency of physician consultations; names of the physicians/organizations consulted; name(s) of local health care providers and description of involvement, and/or co-design.  |

### Section 2 About the Community

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| **SECTION 2: ABOUT THE COMMUNITY**This section describes the community(ies) in which the proposed IPC team will be located and provides information on the region, the availability of existing population-based health information, health care services, and the rationale for establishing or expanding an IPC team. |

#### 2.1 Population Health Status

Please describe the health status of the population the proposed IPC team will be serving. Include data about population size and demographics, including specific needs of the population, and social determinants that contribute to the health status of clients in the community(ies). Please describe population groups such as Indigenous and Francophone Ontarians, newcomers, racialized people or others, and the differing needs, barriers to equitable care access, and health status they may have that are relevant to this exercise.

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| e.g., community profile information, including the prevalence of chronic disease, racialized newcomers, socioeconomic data, availability of culturally appropriate services common languages spoken etc. |

#### 2.2 Existing Primary Care Capacity

Elaborate where there are gaps in access to primary care, attachment rates and the provision of interprofessional care (i.e. existing primary care practices without access to IPC teams such as solo practices and some group practices). Please describe how the proposed model will support the integration and collaboration with existing primary care services and other community-based health care services available in the catchment area.

Primary care services may include Nursing Stations, primary care physicians, Family Health Teams (FHTs), Indigenous Primary Health Care Organizations (IPHCOs), Nurse Practitioner-Led Clinics (NPLCs), Community Health Centres (CHCs), hospitals, mental health and addictions services, community support services, Public Health Units (PHUs) etc.

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| e.g., describe the current capacity for primary care in the community and where you have identified any gaps. |

#### 2.3 Strategic Alignment

Please describe how the planning, design and delivery of programs and services will align with key provincial and OH priorities; in particular, how the proposed IPC team will demonstrate and contribute to the following:

* Increase patient attachment to a regular source of primary care (enrolment to a family physician or registration to a nurse practitioner/primary care team).
* Reduce barriers to care for historically disadvantaged populations.
* Increase access to primary care through additional hours and/or days of availability.
* Efficient and effective governance (i.e., board operations).
* Team-based models of care that maximize scope and how the team works together.
* Integration and collaboration with primary care partners and Ontario Health Teams and participation in population-based planning and service delivery.
* A commitment to a learning health system philosophy (using data and evaluation for continuous quality improvement).
* Improve patient engagement (including diversity that represents the community served) and patient-centred care.
* Use digital health solutions to support care delivery.
* Support the principle of providing the right care in the right place.
* Be agile and responsive to the needs of the community over time and in crisis responses (including providing guidance or referrals to social service supports).

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| e.g., which of the above will be addressed; how the IPC team will address the above (actions planned, timelines). |

### Section 3 About the Clients and Programs

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| **SECTION 3: ABOUT THE CLIENTS AND PROGRAMS**This section provides information about the services the IPC team proposes to deliver to meet the community's health care needs.NOTE:To help you fill this section, please refer to the [Health Equity Impact Assessment (HEIA) Tool](https://www.health.gov.on.ca/en/pro/programs/heia/). The HEIA Tool helps users to advance quality and equity in health care service design and delivery. By using this tool, users will be able to identify priority populations, mitigation strategies (e.g., proposed programs, improved process) and potential community collaborations.  |

#### 3.1 Priority Populations Served

Please briefly describe the priority population(s) the IPC team plans to serve, including a target for the number of people without a primary care provider that will receive primary care services (e.g., unattached patients, uninsured patients, patients with chronic diseases, HIV+ patients, mental health or addictions issues, elderly, newcomers and refugees, young families, socioeconomically disadvantaged groups, Indigenous people and communities, Black, other racialized or Francophone communities, and people in supportive care/long-term care, etc.).

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| e.g., type and size of priority population(s).  |

#### 3.2 Proposed Programs and Services

Please complete the following table (adding additional rows as needed), indicating the services the IPC team will provide directly or in coordination with others. Please also indicate whether the programs will be accessible to all residents in the community. Please describe, for each program and/or service offering outlined, how it will be enabled by communication/shared care planning across the IPC team.

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| **Program Name** | **Staff Involvement** **(Type and FTE)** | **Program Description** | **Goal** | **Target Population** | **Target # of Patients** |
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| *Note: Please add more rows as needed.*  |

#### 3.3 Integration and collaboration with OHT and local primary care sector

In 2019, OHTs were introduced to better connect a fragmented health system. Since then, 54 OHTs have been approved and are creating successes, including more efficient hospital-to-home transitions, strengthened primary care foundations locally, improved digital health and virtual care access, better data and analytics, and more meaningful partnership and engagement with patients, families, and caregivers.

Please describe how the proposed IPC team will work within the OHT to improve the integration and coordination of care for the attributed population. For Indigenous Primary Health Care Organizations presently not connected to one OHT, please provide additional details regarding how you intend to work to build partnerships across the continuum of care.

Please describe how the proposed IPC team will leverage and expand the use of digital health solutions in alignment with the provincial digital health strategy and digital health priorities for OHTs.

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| e.g., the proponent should discuss with the OHT and describe how the proposed location will advance population health management and equity in support of the OHT’s plan. Include summary of results of [Healthy Equity Impact Assessment](https://www.health.gov.on.ca/en/pro/programs/heia/). The proponent should discuss with the OHT its plan to address unattached patient needs especially those with worse health outcomes. The primary care providers that are associated with the application should commit to being a member of the primary care network or association where it exists. The proponent should commit to enabling online appointment booking, on opening day and indicate where it is supported by the OHT. The proponent should actively contribute to the development and implementation of integrated clinical pathways supported by OH, including helping to define the role of primary care in the integrated care model.  |

#### 3.4 Digital Health Solutions and Provision of Care

Please describe how your existing or new team will incorporate digital health solutions into the provision of care and provide digital health and virtual care options to your community.

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| As part of your response, please outline:* The key digital health and virtual care tools that your team currently uses and/or plans to implement as part of its establishment.
* How your team would work to ensure its implementations of digital health and virtual care tools aligns with the provincial digital health strategy and enables an integrated patient experience across the circle of care.
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| **SECTION 4: IMPLEMENTATION**This section provides information about the implementation plan, associated risks, and how you plan to manage and control these risks to ensure successful implementation. |

### Section 4 Implementation

#### 4.1 Implementation Plan

Please provide a plan detailing how you intend to implement and deliver the proposed program and service(s). The implementation plan shall include, but not be limited to, all activities required to be completed and by whom, and a detailed implementation schedule including all milestones.

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| e.g., key deliverables and milestones, actions to meet these deliverables, timelines including recruitment plans, and roles and responsibilities of those involved. |

#### 4.2 Capital Needs

Has a location(s) been identified to provide the proposed IPC team services? In the box below, please provide the exact address(es) if your location has been identified. Please also describe the scope of any renovations or construction the location(s) will require before being fully operational, and the approximate length of time it will take for your proposed site to be “move-in ready” following approval. Please be sure to identify or reference the contributions towards capital or infrastructure (if any).

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| e.g., the exact location of the facility, including confirmation of the space meeting all technical requirements; the type, estimated budget and timelines required to renovate/upgrade the space to be operational.  |

#### 4.3 Risks and Mitigations

Please identify and describe any risks, contingencies, and circumstances, which are inherent in, or which you may encounter in the development and implementation of the proposed services, as well as the applicable mitigation strategies for all risks, contingencies, and circumstances.

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| e.g., description of specific risks, contingencies, and circumstances, and proposed mitigation strategies (including resources needed).  |

#### 4.4 Health System Learning and Quality Improvement

Please briefly describe how the IPC team will adhere to learning health principles (e.g., how evidence will be systematically gathered and applied to guide care, how patients will be included as learning team members and a description of the planned feedback cycle for improvement and learning).

Please identify and/or describe the plan to ensure and improve the quality of care and services. If there is no Quality Improvement Plan (QIP) in place, please describe how you would collaborate with the ministry to develop and implement a QIP [(Guidance for developing a QIP can be found here).](https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-Plans/Quality-Improvement-Plan-Guidance)

It is recommended that MDs sign up for their Ontario Health Screening Activity Report, myPractice Report, or equivalent.

The most recent information about provincial QIPs can be found here: <https://www.hqontario.ca/Portals/0/documents/qi/qip/annual-memo-2023-2024-en.pdf>

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| e.g., plan for a revised QIP or development of a new QIP, including indicators to improve access to primary care.  |

## Checklist for IPC Team Expansion EOI Template

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| ☐ | Completed Document #1 *– IPC Team**Expansion EOI Template*Application(s) to be sent in PDF or Word format |
| ☐ | Supporting or additional documentation in clearly defined appendices |
| ☐ | Scan and attach all commitment letters as identified in the application |
| ☐ | Proposed Budget |