OMA Ontario Medical Association

Interprofessional Primary Care Team Expansion - Call for Proposals

Recommendations for the Next and Future Rounds

August 2025

Introduction

The Ontario Medical Association (OMA) strongly supports the objective of the Primary Care Action Team (PCAT) to attach all Ontarians to physicians practicing comprehensive, longitudinal primary care. Physicians, who are responsible for attachment, play a vital role in achieving this mandate through working with team members to enable attachment. We are keen to work together to create a system that empowers physicians and provides necessary supports to attach more patients with timely access to quality primary care.

We understand that Round 2 of the call for proposals for Interprofessional Primary Care Team (IPCT) expansion is being released shortly. In advance of the next round, it is important to prepare physicians and provide the profession with the opportunity to connect with PCAT. The OMA continues to press on the need for educational webinars and informative FAQs, and is eager to collaborate with PCAT to deliver these in a timely manner. Physicians are keen to be a part of the next round of IPCT expansion, and as the ones responsible for providing 98.5 per cent of total patient attachment in Ontario, future expansion cannot be achieved without them.

Prior to and during Round 1 of the call for proposals, the OMA provided feedback and recommendations on the application process through various channels, including to PCAT and at the bilateral Physician Leadership and Engagement Table (PLET). We were pleased that some of our recommendations were implemented, including establishing a bilateral table between PCAT and the OMA's Primary Care Action Group (PCAG) to engage in discussions to advance the PCAT objective, as well as leveraging Ontario Health Teams (OHTs) and Primary Care Networks (PCNs) in the submission process.

To support the next phase of IPCT expansion, the OMA is building on lessons learned and reaffirming recommendations previously submitted to ensure continued progress and success in achieving PCAT's mandate.

Patient Core Team

To achieve the shared goal of increased attachment to comprehensive, longitudinal primary care, it is essential to enhance the capacity of those who attach, such as family physicians and primary care pediatricians (who in some areas of the province provide comprehensive, longitudinal care to patients 18 years of age and younger). This additional capacity would be used to attach more patients and fulfill PCAT's objective. To free up this capacity to attach more patients, physicians need to be able to offload and share tasks with other team members. This means we need to build team models that have the objective of enabling those who attach (e.g. physicians) to direct resources to expand their capacity to attach patients with timely access to quality primary care. This can be achieved through building and funding patient core teams.

A patient core team is comprised of a physician and other health care professionals who work to their optimal scope to provide comprehensive, longitudinal primary care to the patient. The entire team is focused on the objective of attaching patients and providing them with timely

access to quality primary care. This includes providing routine and acute care visits, chronic and preventive services, and coordinating care with outside services. Physicians, who are responsible for attachment, direct and share clinical and administrative tasks with their patient core team members. This frees up the physician's capacity to attach more patients and focus on care decisions with the patient. Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physician Assistants (PAs), and practice support staff (e.g., patient navigators, Medical Office Assistants) are highly effective in expanding physician capacity to attach.

System investments need to be made to increase the workforce required to fill these patient core team roles. This includes pay parity for patient core team members across all models (i.e. between hospital and community-based teams) to attract and retain these professionals in primary care teams.

To achieve PCAT's overall mandate of attaching all Ontarians to primary care, the OMA strongly recommends PCAT invest in building and funding patient core teams. Specific recommendations are detailed in the OMA's paper on *Building Capacity to Attach All Ontarians to Primary Care: The Patient Core Team.*

Recommendations for Next and Future Call for Proposals

Recommendations on IPCT Funding Eligibility and Application Process

1. Clarify the Definition and Mechanism of Attachment

Issue: There was a lack of clarity regarding patient attachment, as the Round 1 application did not clearly define who is responsible for attaching patients (i.e. family physicians or nurse practitioners). Entities such as Family Health Teams (FHTs) do not attach patients, and therefore cannot fulfill deliverables associated with the six principles such as developing a plan on how to attach (including patients from the Health Care Connect waitlist) without family physicians who are responsible for attachment. This issue was further exacerbated in the funding agreement for successful FHT applicants, where many of the deliverables outlined would be the responsibility of physicians. However, as physicians are not party to the funding agreement, it is unclear and unlikely that physicians are aware of these obligations.

Recommendation: Add explicit language in the application form clarifying that only family physicians or nurse practitioners can attach patients.

2. Broaden Eligibility for Physicians to Apply for Funding

Issue: Eligibility for IPCT funding in Round 1 focused narrowly on FHTs, Community Health Centres (CHCs), Indigenous Primary Health Care Organizations (IPHCOs), and Nurse Practitioner-Led Clinics (NPLCs). This excluded the majority of Ontario's 16,402 family physicians (i.e. 7,083

Fee-For-Service (FFS) physicians and 6,393 physicians in Patient Enrollment Models not affiliated with FHTs) and primary care pediatricians.

An option was provided to physicians to apply for funding by joining or creating a FHT. However, given the limitations of this option including the time-consuming and cumbersome process to join or create a FHT as well as the lack of decision-making power in many current FHT structures, most physicians were still excluded from applying.

Given physicians are responsible for the vast majority of patient attachment in Ontario, it is essential that they are eligible to apply for IPCT funding to achieve PCAT's mandate. As mentioned above, the key to achieve PCAT's mandate is to build patient core teams, and as such, physicians need to be eligible to apply for funding to build patient core teams.

Recommendation: In the next and future rounds of IPCT funding, eligibility needs to be opened to all family physicians and primary care pediatricians to apply for funding to build patient core teams.

Specific recommendations on mechanisms on how to make funding available to physicians are detailed in the OMA's paper on *Building Capacity to Attach All Ontarians to Primary Care: The Patient Core Team.*

3. Address Health Human Resource Constraints

Issue: The Round 1 call for proposals did not consider the significant health human resource (HHR) capacity issues that exist given the current shortage of family physicians and nurse practitioners, inadequate incentives to expand rosters in an already overextended system, and lack of support for family physicians with larger rosters to retain them in practice for as long as possible. Proposals that include expanded after-hours, in-person, and virtual access would require significant HHR investments, which were not supported under the Round 1 application.

Recommendation: Introduce targeted incentives to help existing teams expand their capacity, improve access to care, and support physicians managing larger patient rosters to enhance physician retention.

4. Standardize Funding Requests

Issue: There was a wide variation in funding requests by applicants in Round 1 due to lack of clarity on how much to ask for. Successful recipients also received significantly less funding than requested, which will now require them to modify their implementation plans. Receiving minimal funding may also not be useful to achieve the goal of attachment.

Recommendation: Provide clarity on how much funding is available and clear direction on how much funding applicants should request based on attachment goals; Ontario Health has

mentioned they had a cost per patient target and this should be transparent. Clarity should also be provided on whether cost effective quality options are being looked for in applications and not premium options (i.e. high costs per patient).

5. Simplify the Application

Issue: Physicians who applied in Round 1 reported finding the application process cumbersome. The disproportionate effort of completing the application was especially felt when successful physician proponents were not awarded sufficient funding.

To enable everyone with meaningful ideas to seamlessly submit an application and reduce the administrative burden, the application process should only require the necessary information. Making the process simpler and more accessible will help ensure that all eligible physicians and teams, regardless of their administrative capacity, have a fair opportunity to apply. Administrative barriers should not preclude those who are eligible to apply. Further, OHTs and PCNs, where mature, should continue to provide administrative support to local physicians to complete the applications. Lessons can be drawn from other successful examples of manageable application processes. For instance, the current FHO Expression of Interest (EOI) process requires only a concise submission (five pages) and provides clear next steps upon approval. Streamlining the IPCT call for proposals in a similar way could significantly reduce unnecessary administrative burden.

Recommendation: Simplify the application process by requiring only the necessary information, and utilizing lessons learned from other manageable application processes.

6. Provide High Touch Support to FSAs in Need

Issue: We were pleased to see that based on our previous recommendations, OHTs and PCNs played a key role in coordinating and submitting the applications in Round 1. However, OHTs and PCNs vary significantly in their maturity across the province, and Forward Sortation Areas (FSAs) with a high need for resources due to high unattachment rates lacked support to apply for funding in Round 1, as they often had immature OHTs/PCNs. As applications in Round 1 were required to be submitted via OHTs and PCNs, for FSAs with immature OHTs/PCNs, this was not possible.

Recommendation: Provide high touch support for those FSAs with high unattachment but immature OHTs/PCNs on submitting an application that works in their area.

7. Transparency on Criteria and Evaluation Process

Issue: Applicants were unaware of the process and what determines a successful submission, as aside from the 3 high-level criteria, no details were provided about the evaluation process.

Physicians have expressed a need for greater transparency regarding the specific criteria and requirements Ontario Health used to determine funding allocations for successful teams, and what PCAT used. Increased clarity would:

- Help clinics and teams assess whether they meet the eligibility criteria before submitting a proposal; and/or
- Enable them to tailor their proposals and allocate resources strategically, ensuring they can effectively utilize the funding to enhance patient enrollment and service delivery if awarded.

In addition to transparency around criteria, there is also a need for clearer communication about timelines. In Round 1, many applicants were left uncertain about when funding decisions would be made or whether their proposal was still under consideration. Sharing expected decision dates, as well as regular status updates, would help manage expectations, and support better planning for applicants.

Recommendation: Provide transparent information on the process undertaken to review and evaluate the applications, including the criteria and requirements used for funding allocation, scoring process, and clear communication on timelines.

Recommendations on Collaborative Communications

8. Develop a Communications Strategy

Issue: Round 1 of the call for proposals resulted in many communication challenges. Family physicians were largely excluded from applying for funding (aside from the limited option of joining or creating a FHT). This compounded existing frustration from previous rounds in 2023, which many felt disproportionately benefited existing FHTs and CHCs, despite proposals submitted by FHO physicians who do not have access to similar supports. However, there was no explanation or rationale provided to the profession about why they were once again excluded. It is critical to establish the trust and support of physicians in PCAT's mandate, given physicians are the ones responsible for attaching patients.

Several myths also proliferated during the first call for proposals, including that funding received by a FHT could not be used to support physician capacity to attach. Without clarifying these myths, the goal of PCAT to attach all Ontarians is hindered.

There is significant interest from physicians in PCAT's mandate and primary care reform. Proactive and collaborative communication could better leverage this interest to advance systemic changes and support positive change management.

Recommendation: To improve clarity, and increase participation in the call for proposals, we recommend the PCAT do the following:

- **Share materials with the OMA in advance of dissemination:** The OMA and SGFP will avail themselves as willing partners and keen to review communications prior to sharing with the field. We have the ability to identify unintended consequences and propose solutions to try to help outreach to the field to be successful.
- **Deliver webinars or town halls with family physicians:** These should occur at the provincial, regional, and local levels, in advance of and during the call for proposals launch. These sessions should explain the objectives, process and timelines for the call for proposals, and provide an opportunity for physicians to ask direct questions and receive timely information. The OMA can support by facilitating engagement and addressing questions related to physician compensation. PCAG remains keen to set up webinars in advance of the next round.
- **Provide physicians and system stakeholders with FAQs:** FAQs that are updated on a timely basis should be provided to physicians and system stakeholders. This would be extremely useful in providing up-to-date information as well as clarifying areas of confusion and myth-busting to ensure all system stakeholders are aligned on the same messaging and objectives. The OMA is keen to collaborate on co-developing an FAQ with PCAT, and has provided PCAT with a frame for the FAQ which was built based on what physicians need to know.
- **Provide educational sessions on previous successful models:** These should include examples from the first round of funding that achieved strong patient attachment results. Sharing case studies, and successful models, both from Ontario and other jurisdictions can offer helpful guidance in developing effective and successful models. At these sessions, the OMA and SGFP can help explain how team-based models impact physician income and expenses.
- **Leverage OMA and SGFP communication channels:** The OMA and SGFP communication channels can be used to share updates. Educational resources, and supportive messages throughout the application to ensure that physicians receive consistent and reliable information.
- **Convene system stakeholders for alignment on objective**: PCAT should convene system stakeholders including OMA, OCFP, SGFP and AFHTO to align on messaging and objective of attachment.

Recommendations on Complementary Solutions

9. Set Realistic Timelines and Provide Ramp-Up Support

Issue: The timeline in Round 1 to operationalize and attach patients by Summer 2025 was not feasible.

Recommendation: Set a realistic and extended timeline for attachment, and provide transition funding and administrative support for team formation and ramp-up.

10. Clarify Limits of Digital Tools Without Rostered Physicians

Issue: In Round 1, digital tools were positioned as standalone solutions to attachment without physician availability.

Recommendation: Emphasize that digital tools do not substitute for physician rostering capacity, and proposals should identify actual Most Responsible Provider (MRP) availability. Digital tools must complement—not replace—physician rostering capacity. Digital tools are only complementary tools that can be used if there is capacity to attach.

11. Incorporate Physician Evaluators

Issue: There is a need for a clinical lens to determine resource allocation in future rounds. Physicians are well-positioned to inform resource allocation based on the clinical needs of the community and patient population.

Recommendation: Work with the OMA to identify physician(s) that can be added as clinical reviewers on the evaluation panel of the next and future rounds of applications.

12. Provide Transparency on Resource Allocation

Issue: Clarity needed that successful proponents of Round 1 call for proposals were not only the i12s, and resources went to others beyond the i12s. This is important to show physicians and teams that it is not only the those who 'have' getting more resources.

Recommendation: Provide a map and breakdown of where resources have been allocated in Round 1, including type of team and any unaffiliated FHOs connected with FHTs/CHCs.

Next Steps & Conclusion

Given the complexities and limitations of Round 1 as described above, a new approach should be utilized for subsequent rounds of funding, leveraging the recommendations in this paper and additional lessons learned to ensure a process that enables achievement of PCAT's objective. PCAT should share feedback and lessons learned from the first and subsequent rounds with the OMA so that we can codevelop a new process for future rounds to ensure family physicians are eligible and empowered to apply and receive funding. This evaluation process should be iterative and completed after each round.

Further, while this paper does not address opportunities to consider the future state of FHTs, we look forward to engaging in a collaborative discussion on this with AFHTO and PCAT.

The OMA remains eager and committed to working with PCAT to achieve the shared goal of ensuring all Ontarians have a physician practicing comprehensive, longitudinal primary care.