Interprofessional Primary Care Team Expansion Call for Proposals:

November 2025 for 2026/27

Proposal Toolkit

Alliance for Healthier Communities

Advancing Health Equity in Ontario

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Background

The Ministry and Ontario Health have released another call for expressions of interest (EOI) to support the creation of approximately 75 interprofessional primary care (IPC) teams to support attachment of 500,000 people to primary care in 2026/27. The proposals are due November 15, 2025.

This toolkit will provide you with key points and reference materials that will help you to complete the EOI. Alliance members are positioned well to respond to the EOI due to their strong focus on team-based primary care, population health, equity and community engagement.

Primary care organizations (CHCs, NPLCs, CFHTs/FHTs) are invited to submit a proposal for consideration through their Ontario Health Team.

While this toolkit looks similar to the one we shared for the 2025/26 call for proposals – it **has been updated to reflect the most recent call,** and we encourage you to use this version.

Introduction & Strategic Considerations

The aim of this document is to provide guidance and suggested language for the various sections within the Interprofessional Primary Care Team (IPCT) proposal form – November 2025. These suggestions include aspects of the Neighbourhood Health Home as well as other key principles to support the collaborative spirit from which this proposal should be developed. These are all highlighted in the Vision for a Health Home paper.

The Alliance's team-based models (CHCs, CFHTs, NPLCs, IPCHOs) will have the benefit of building from an existing strong model with autonomous & accountable leadership, community governance and back-office support. We have a strong history of building partnerships, collaboration and seeking funding that support the community with additional services such as health promotion and disease prevention activities that are typically not provided in primary care organizations. We have existing relationships in our community and are often seen as a community hub already.

We recognize that IPCHOs may choose to play this hub role in the neighborhood health home model, but more likely, IPCHOs will choose to apply on their own or in partnership with other IPCHOs in their region. As a reminder, IPCHOs do not need to work in collaboration (although encouraged) with other primary care providers, and they do not require OHT support to submit an application. There is a separate proposal form and guidance document for IPHCOs. IPHCC is supporting IPHCOs with the application

process, however, the suggestions in this document may also prove helpful to IPCHOs making applications,

Important Considerations

Population-Based Organizations:

If your organization serves a priority population and is not geographically based, it will be important to work within your OHT and/or neighboring OHTs. if your OHT is submitting a proposal you could propose to be a hub or spoke for that specific population and ensure that equitable, tailored care is available (i.e. Black Health, 2SLGBTQ+, Francophone). This will ensure that you can expand your ability to serve the community that your population focusses on. This may result in your centre being involved in multiple applications now and over time as more calls for proposals emerge.

If you are not the lead organization

Each proposal will have a lead organization but that is primarily for the contract for accountability and as with the previously funded IPCTs there is an expectation that subcontracts will be created so that multiple sites can be involved. This rationale also supports the collaborative expectation within this call for proposals. If you are a population-based organization that is straddling many OHTs you may want to consider becoming a hub or spoke for that population and determining a path forward for you to get funding from one OHT to serve multiple areas.

Unapproved EOI Submissions from 2024 or spring 2025:

If you had an EOI that was not approved in the last round of funding, now is the time to bring that forward and emphasize any new partnerships or collaborations and include how you are working with the community. Ontario Health understands this takes time and recognizes that if you are submitting a new proposal you may not have time to do this work for this tranche of funding but are encouraging regions to start building relationships now.

Approved EOI Submissions from 2024 or spring 2025:

If you were already part of the previous expansion or are a newly created organization you can apply again in this call for further expansion to meet the needs of your unattached community.

Models that will be Funded & Working with Physicians and Physician groups:

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). We are proposing that the expanded (or new) organization be the Hub for the community (and beyond if applicable) and support all primary care organizations within the neighbourhood by creating a Neighbourhood Home Model and The webinar was recorded, and the video can be accessed here, along with the slide deck and links to additional resources. It will be important to collaborate with solo practice MDs and MD groups – ALL models can work with these groups and we encourage you to collaborate together. You could act as the hub (backbone support, hire & manage the interprofessional team or provide other resources).

Attachment vs Access:

This round of funding has a focus on attachment not on access. Ensure that you can demonstrate how you will attach people to ongoing primary care. It is critical you discuss how you will work with the Health Care Connect waitlist and ensure attachment, prioritizing communities with high rates of unattachment.

HHR Concerns:

We advise that you apply for funding and apply for what you need to serve your unattached community. That being said, you must be able to justify how the IHPs you are requesting will assist with attachment.

Ask for Everything you Need but be Prepared to Scale Back:

We advise that you ask for what you need to fully attach your community to primary care - salaried and blended salaried MDs, NPs, RNs, Health promoters, outreach workers, community ambassadors, link workers, therapists, medical secretaries, receptions, managers etc. Also ask for rent, supplies, interpretation funding, IT etc. However, we encourage you to align the asks to the goal of attachment. As we saw in the last round of funding, proposals were not fully funded. The more people you can attach to ongoing primary care the better. All team members should support increasing attachment within your community.

OHTs/PCNs Leading the Proposal Submission:

OHTs and their affiliated PCNs will lead the process. They will play three roles, including local engagement, proposal development and proposal coordination and submission. All OHTs have been given a specific number of proposals that they can submit which has been calculated based on the number of unattached people in the regions. Two additional proposals may be submitted if there is a strong rationale and they must be endorsed by an OH regional rep.

Ensure you are reaching out to your OHT to demonstrate that you ready and willing to expand and collaborate. OHTs have been given direction to address conflicts of interest and to use good governance throughout this process. If you feel like you are being left out of discussions/planning/proposals, please let Sarah Hobbs sarah.hobbs@allianceon.org know ASAP.

Note that 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. In addition, only letters of support/commitment may be submitted as supplementary materials. Do not attach anything else to your proposal – it won't be reviewed.

Highlighting Equity:

While addressing the needs of equity-denied people isn't at the forefront of the proposal, there are questions about how you will ensure expansion is addressing the health needs of people that face inequities in the system. Highlight how you will attach equity-denied populations immediately and how you are well suited to do so. Ensure you highlight the trust and experience you have with particular communities and how this will impact ability to attach people. Ensure you articulate that addressing inequities early in this planning will strengthen the neighbourhood health home in the future for equity denied people as well as all people living in the region.

Now is the time to expand gender affirming care in your organization and to demonstrate how you will do this. If you work with other priority populations, ensure you demonstrate this in your proposal. If you are in rural, remote or northern communities, demonstrate how you will reduce the barriers to access that are unique to your community. If you are a Francophone organization, demonstrate how you will comprehensively serve patients you attach with a breadth of services offered in French. Demonstrate how investing in your organization will ensure that all people in the region that speak French will have linguistically and culturally appropriate care.

Transitions in Care:

For CHCs and IPCHOs that are currently part of the Transitions in Care project, or for those that wish to implement this in your region. Please indicate this in your proposal and ask for the relevant positions to be funded. This project works to attach people leaving corrections to primary care.

Resources

Frequently Asked Questions:

English: Frequently Asked Questions 2026-27 Call for Proposals for New and Expanded Primary Care Teams
French: Foire aux questions Appel de propositions pour les équipes de soins primaires nouvelles et élargies – 2026-2027

IPCT Expansion Technical Webinar recording:

https://www.youtube.com/watch?v=6MzOKuzN_GU

Evaluation Criteria

Proposals will be evaluated against three areas:

1) **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.
2) **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
3) **Meeting Primary Care Objectives:** Commitment and demonstrated ability to meet the primary care objectives over time.

    a. **Province-Wide:** Ontarians should have the opportunity to have a documented and ongoing relationship with a primary care clinician or team.
    b. **Connected:** Ontarians across the province should have the opportunity to receive primary care services that are coordinated with existing health and social services.
    c. **Convenient:** Ontarians should have access to timely primary care services.
    d. **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.
    e. **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.
    f. **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.

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. This does not exclude other organizations from being included as part of a collaborative response, but this organization will be listed on the contract and be responsible for creating subcontracts.

This section requests information about your board of directors. Ensure to stress that the board is made up of community members and that it is entirely a community-based board.

In this section, ensure to highlight if your proposed service area is a located in or serving a designated area under the French Language Service Act. If you provide programs and/or services in French ensure to describe this in detail in this section.

Section B. Team Model

This section describes your plan for expansion (or the creation of a new organization). You can only select one model type (FHT, NPLC, CHC or IPCHO) but the intention is that you would be working with multiple models within your Neighbourhood Health Home.

Section C. Primary Care Teaching Clinic

This section asks about existing teaching clinics but also asks about interest in becoming a teaching clinic.

A primary care teaching clinic 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.

Many Alliance members provide opportunities for students but may not be affiliated with an academic institution. If possible, we are encouraging applicants to say yes that they would be a teaching clinic. If you already have relationships with academic institutions – include that information and a letter of endorsement from the institution.

The Alliance has recently created a partnership with the University of Toronto, Department of Family and Community Medicine and a handbook is being developed and tested to pilot 'academic CHCs'. This handbook streamlines the process for physicians to become affiliated with your local medical school and can be easily translated to other provider teaching roles (e.g. nursing, social work, etc).

Section D. Proposal Summary and Rationale for Need

Question 14.

If implementing the Neighborhood Health Home –

This proposal is a hub and spoke model that will attach *X number* of people. The hub will utilize an existing *CHC, NPLC, CFHT, IPCHO* that will provide team-based care and health promotion/prevention and social prescribing support to the entire community. Working in collaboration with *physicians and other teams* throughout the community the Neighbourhood Health Model will support attachment to comprehensive primary health care and address inequities.

Question 15.

Identify all geographic areas that your proposed expansion will be serving (FSA, ADA, CSD). This data is available in the OHT data package. If you don't have access to the OHT data package please let Jen jen.rayner@allianceon.org know.

Question 16.

Highlight numbers of unattached people. In addition, discuss sociodemographic characteristics and levels of health system utilization. This data is available in the OHT data package.

Section E. Geographic Zones and Team Attachment

Determine the number of new patients that will be attached to a primary care provider when the team is fully staffed. This should include physicians and NPs working within the HUB (or your own organization) as well as those outlined in partnership agreements with community physicians. The expected number of patients for physicians are 1400 and 800 for Nurse Practitioners. For each additional interprofessional team member an extra 250 patients are added. It is important to remember that this number can be supported by physicians and nurse practitioners within your organization and through the physician partners in the community.

You must confirm that you will commit to attach patients from the Health Care Connect Wait List.

Section F. Team Composition

This section includes a table that will identify the proposed net new primary care clinicians, including identification of the most responsible primary (MRP) care clinicians for patients

(for Alliance members these could be physicians or nurse practitioners), as well as administrative/clinical staff. If available, attach a letter from primary care physicians (or groups of physicians) or nurse practitioners that will be joining the team.

Ensure that all other interprofessional team members required to serve your community are included (e.g. Dietitians, Social Workers, Community Health Workers, Link Workers, Community Ambassadors, medical secretaries, clinic receptionists, managers). It will be important to note that the positions are tailored to your community need and will enable and support attachment.

Consider including roles such as a system navigator/link worker(s) to provide social prescribing. A guide to Social Prescribing can be found here and a short summary of the role of a Link Worker can be found here. It has been demonstrated that incorporating this position into a team can significantly reduce the number of visits clients have their primary care practitioner, freeing up their time to see more people.

Include all teams, affiliated physician groups or solo practice physicians that you are collaborating with. Include all letters of commitment that will include a start date. You do not need to be a FHT to work with affiliated physician groups. There are numerous examples of Alliance members working in collaboration with FHOs, FHGs and other models. See Appendix A for examples/case studies.

Section G. Plan to Meet Primary Care Team Objectives

This proposal includes objectives that new and expanded interprofessional primary care teams will be expected to achieve The objectives 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 We have provided some potential language to assist in this section.

For each section, describe how the team will meet the objectives over time through the design and delivery of specific programs and services. We have repeated some of the advice and encourage you to include this repetition in each section. Decision makers acknowledged that the answers to this section should overlap.

Principle 1 Province wide

Description: Ontarians across the Province should have the opportunity to have a documented and ongoing relationship with a primary care clinician or team.

Proposed Approach: Please describe how this proposal will achieve the attachment target noted above for people within the identified catchment area. How will the team attach people from the Health Care Connect waitlist?

- 100% attachment will be achieved through a Neighbourhood Health Home that is nestled within neighbourhoods working in a Hub and Spoke model (the HUB will be the community governed team-based organization applying for the expansion/new organization). The Health Home will reflect the geographical areas and ensure that every member of the community has an interprofessional primary care team that they can access while working with primary care providers throughout the area.
- The Health Home vision is one that is supportive and collaborative and is aligned to a population-based approach that is grounded in health equity.
- Discuss how the entire community (100% of the population) is part of this neighbourhood – not just the patients that walk through the clinic doors and that by building on existing team-based models as the HUB you will build **a collaborative group of providers that will work to full scope of practice** and ensure that all people can receive care when they need it that is seamlessly linked across providers, teams and settings. The Alliance has tools and resources available to assist with ensuring the team is working to full scope. You can reference these materials as an asset in ensuring that teams will be working to full scope, thus enabling increased attachment.
- Describe how you will work with the Primary Care Network (PCN) and other primary care providers. This is important to ensure co-design and oversight of the Neighbourhood Health Home. Ensure that primary care clinicians are involved in every step of the proposal to ensure a tailored approach to this re-design and how you are confident that this will lead to strengthened comprehensive primary health care that is the foundation of the system where 100% of the population will have access.
    - In addition, the Alliance is working with the OCFP to attach physicians to Alliance member organizations to help with this co-design if relationships do not exist.
- Ensure you have the data package that is being provided by each OHT. This data package will help you determine what would be required to meet the needs of your

entire population (FTEs, programs, services, interpretation, non-insured funding, health promotion supports, interprofessional team resources, etc).
    - If you do not have access to the data package contact OHTanalytics@ontariohealth.ca (copy the OHT that you are working with when you request access). You must be associated with an OHT (or their supporting partners)
    - This data package is an on-line (downloadable) tool that includes FSA, ADA, CSD data on attachment rates, sociodemographic information, Health Care Connect Wait Lists, health utilization data, and locations of existing IPCTs.
    - If you have questions about the data package, please reach out to Jen Rayner, Jennifer.rayner@allianceon.org
- Alliance members embrace the models of health and wellbeing or wholistic health and wellbeing that are perfectly aligned with comprehensive primary health care. These model have demonstrated results and are comparable to a neighbourhood home in that we reach beyond our doors to improve the lives of our community.

Principle 2: Connected

Description: Ontarians should have the opportunity to receive primary care services that are coordinated 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?

- Describe how your organization has ensured that all staff work to full scope. For example, NPs have their own panel and are responsible and accountable for this panel, RNs working to full scope, use of medical directives, social workers, link workers, etc.
- Social prescribing is an initiative that most Alliance members have taken part in. Social prescribing ensures that connections are made between primary care and social and community services. This is often done by working with a link worker. Social prescribing tools, learning modules and other supports are available from the Alliance. We know that Social Prescribing works – it ensures that people get the care that they need but also ensures that clinical time is focused on those clients that benefit most from a primary care clinician (studies have shown that primary care providers that take part in social prescribing can free up to 40% of their time). Social prescribing could be included as a key resource that will be included in your HUB and all clinicians (across models) and their patients could access.

- Every Alliance member has access to an Expanding Attachment and Access Toolkit that supports teams in optimizing attachment through access and efficiency tools, scope of practice, use of technology, data and quality improvement supports. Highlight this in the proposal as a key resource. The current learning collaborative is focused on intake for attachment.
- List all existing and proposed partners (ensure that physicians, the PCN, and all other community and social partners are included. Consider creating an inventory of expertise so that this can be included. Consider having formal MOUs with these partners.
- Consider getting letters of support from these partners.
- If you have existing partnerships where you have increased access to health services or attachment, list those successes here (proving capacity to do this work in collaboration with others).

Principle 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?

- If you are required to provide after-hours care on evenings and weekends and/or currently demonstrate timely access to primary care, discuss how you are currently doing this (include any partnerships you have with other primary care organizations in your community to meet this expectation).
- Indicate that you participate or will participate in on-going improvement to ensure timely access to primary care (through the learning health system activities at the Alliance).
- Describe the client experience indicators that measure timely access. If you need more information about this, please contact Christine Randle, Christine.randle@allianceon.org.
- If you use 3NAA (third next available appointment) describe how you will continue to use this and ensure timely access. If you do not use this and want to implement it, the Alliance LHS team can support you.
- Discuss how virtual care is currently being used and include any client experience measures that you have from previous client experience surveys.
- Discuss how convenient and timeliness is only one aspect of access and how in addition you focus on culturally safe, anti-oppressive care.
- Describe ways you have increased availability to primary care in the past (i.e. offering walk in clinics for your clients, block scheduling, open access etc).

- Remember that this call is about attachment, whereas the previous call focused on access for unattached without the expectation to attach people to ongoing primary care. Therefore, address access with the assumption that people will be attached.

Principle 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?

- Discuss how your Neighbourhood Health Home will embrace a population-based approach and be the home for people over their life course.
- Describe how the HUB will collect and use individual level sociodemographic and race-based data as well as community level data to support tailored service delivery and program planning as well as allowing for population segmentation.
- Describe how you use neighbourhood level data as well as community engagement to inform program and service planning.
- Describe how you have adopted population segmentation to ensure a proactive approach to service delivery that includes health promotion and prevention within the community.
- Describe how the HUB will promote health equity by addressing the social determinants of health. Include how the provision of comprehensive primary health care will include attention and action on factors that significantly impact a person's health, such as income, education, housing, racism, and access to quality healthcare, with a focus on reaching populations that might otherwise face barriers to care due to their social circumstances. Describe how this will be done by integrating social and community services alongside clinical care in a seamless approach through the Hub (e.g. link worker, health promotion, community health, community ambassadors, etc.). The Hub will ensure that services are planned by the community members and tailored to local needs. If you are planning on including a Link Worker discuss how access to a link worker/system navigator will be provided in the Hub.

- Describe how, as an Alliance member, you have adopted, endorsed and actioned the Health Equity Charter and that social justice and anti-oppressive care will be embedded in the Hub mandate.
- Consider including training that will be provided for all primary care organizations and teams through the Hub. This training will include Indigenous Cultural Safety, Anti-black racism, 2SLGBTQ+ and trauma-informed care.
- Explain how you are already providing service and programming to people that have been equity denied
- Explain how you are Community Governed which contributes to health equity. You can find a short description and evidence here.
- Explain how you will tailor the services and care to the specific needs of the community
- Identify if you will be providing French Language services. See the Principles for French Language Health Services in OHTs for more information.
- If you have an inventory of populations served by the partners in the collaboration and can identify who has expertise in serving equity denied groups, please share how and who.

Description: Ensure that both patients and clinicians have access to digital tools and services, as they become available, that enable navigation of the primary care system.

Proposed Approach: How will the team leverage and expand the use of digital solutions in alignment with the provincial digital health strategy?

Principle 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

- A strong data infrastructure will be enabled that includes data for all interprofessional teams and providers. This includes the collection of sociodemographic and race-based data for all patients and encounter level details for every provider/staff interaction recorded in an EMR. This data is linked to administrative data (e.g ICES, and OH) and used for accountability, improvement

and planning. The Alliance has a strong framework to enable this work and will be used for all teams.

- Describe how you are using e-consult, e-referral
- Describe how you are using on-line scheduling
- Describe how being part of the Alliance encourages shared decision making and support for digital tools (AI scribe, EMR, etc)
- Describe how through BIRT, data is extracted to IDS which allows you to manage healthcare service utilization outside of the organization and/or how you currently use Hospital Report Manager.
- Describe how your strong data foundation supports a culture of learning and improvement operationalized through dashboards, benchmarking reports and other tailored reports that result in action and improvement.
- Describe how your providers and teams will be enabled to use their data for improvement and planning, and this will be seamless within the culture.
- Describe any patient reported experience and outcome measures that are collected and how these will be embedded in the expansion
- If your OHT/collaboration is insisting that primary care organizations change their EMR to one instance of an EMR, please inform Sarah Hobbs sarah.hobbs@allianceon.org. This is not a requirement of this expansion.
- Discuss how you will continue to embrace digital solutions to improve the work over time.

Principle 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

- The Hub will be community governed – this goes beyond patient and caregiver representation on the board this ensures that the patient and community make up the entirety of the board ensuring that they have an explicit voice in decision making and accountability.
- Discuss how meaningful community governance goes beyond having a board comprised of community members; the voice of the community must be centred in decision-making across the organization. It is through effective community

engagement and governance that organizations orient and tailor services to meet ongoing and changing population health needs. Discuss other advisory tables you have to ensure the patient and caregiver voice are included.

- Describe Board QI committee that already exists and the role that they play in ensuring continuous QI and commit to continuing this.
- Describe community needs assessments and how you have used needs assessments to inform your programing and services. Explain your plans to continue this process.
- Describe any programs or services that have been co-designed with community and/or clients.
- Include any patient reported outcomes (PROMS) that you are collecting. If you are not collecting PROMs data consider including that you will collect this data for your expansion with the support from the Alliance LHS team.
- Include any patient reported experience measures PREMS that you are collecting. If you are not collecting PREM data, consider including new questions that will evaluate the experience of clients in your expansion.
- Describe the Alliance learning health system work that ensures that meaningful reports, analytics, shared learning and QI is provided to ensure ongoing improvement and learning.
- Describe the shared EMR that includes standardized data for all clinicians and team members that ensures meaningful reporting and accountability internally and externally.
- Describe any integration data tools you are using (OCEAN, Hospital Report Manager, Integrated Decision Support (IDS), etc.
- Suggest that in future, the neighbourhood health home (collaborative) undergo accreditation together.

Section H. Implementation Plan and Readiness

Recruitment: Please specify recruitment plans including a timeline for hiring and onboarding. If you have physicians or Nurse Practitioners who are locums or have expressed interest in working with your organization include this and get a letter of support from them. Discuss any successes you have had with recruitment in the past.

Locations: Specify if a location(s) has been identified for the proposed services and describe if the proposed site(s) is co-located with other primary health care services. Confirm when the site(s) will be “move in ready”.

Partnerships: If a new partnership is being proposed, ensure to outline the following:

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. Describe the accountability measures that will be used to enable success of the partnership(s);
e. Attach letter(s) of support from partnering organizations.

Start-up Costs: Identify any start-up costs required e.g. minor capital, furnishing, equipment, recruitment costs, etc. Important Note: large scale new builds or renovations over $100K will NOT be considered

Operationalization: Based on the plan you have outlined, what is the estimated start-up date (i.e., when first clients will be seen and attached) for the new or expanded team? Remember that proposals will be evaluated on the speed at which clients can be attached.

Operationalization: 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)?

Accountability and Oversight: You may want to consider creating a new advisory table or committee for the implementation of this expansion. This group should be responsible to the board. Suggested activities and responsibilities could include:

- Responsibility for guiding stakeholder engagement activities, selecting programs and services based on local need, the implementing service delivery, as well as supporting the measurement and evaluation.
- Suggest that this group would be composed of partner health and social services agencies, key community stakeholders, primary care physician(s), nurse practitioners from the Steering Committee identified below, internal staff, and IPC Team patients/clients.
- Ensure that external Primary Care Providers without access to team-based care are included.
- Ensure that you note your collaboration with the Primary Care Network

Governance: Describe the Governance model: How will you track, measure and report on progress against your plan? In this section you might want to consider the following:

- Indicate if there is already a board/governance structure in place.
- How board members are selected (using what criteria) and elected.

- Describe your membership structure and if clients, community, community partners or others are members of your organization and if they have voting rights.
- Include the number of board members.
- Include information on board evaluations (the Alliance has board evaluation tools it can share if required please contact Oleksandra Budna Oleksandra.budna@allianceon.org).
- If you go through accreditation indicate some of the standards that your board is held accountable for.
- Describe any clients, community members or people with lived experience on the board and how they are involved in decision making (describe communities that face barriers to access and health inequities and partners).
- Include information about advisory committees or ways that communities, clients/patients, families and/or caregivers provide input to the board.
- Indicate the board's authority and responsibility for making decisions.
- Indicate that you have by-laws and governance policies that guide the work of the board.
- Indicate the governance model that the board follows.
- Indicate that you do not have staff or providers on your board (but will create an advisory board and describe your plan to work with the primary care network).
- Indicate how you include community partners on the board or how they interact or will inform the board or steering committee for the IPCT expansion.
- Describe board committee structure including Executive Committee, Finance, Policy, Evaluation, Quality Improvement, etc.
- How will patients and family inform the process (if you have patients/clients on your board – mention this and include that they are involved in making decisions about the organization).
- Include information about a skills/lived experience matrix if you use one.
- Describe any other relevant information about the board i.e. they must live in the catchment of the organization, etc.
- If you don't have a board or governance structure in place, describe how it will operate (using the above) once in place.

Long-term Planning: Describe 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

In the chart, list any anticipated risks related to ability to implement the new or expanded IPCT along with steps you will take to mitigate the risk.

Consider including any of the following relevant risks.

- HHR risk and potential difficulty in filling roles.
- On-boarding of new staff → discuss all HR procedures currently in place.
- Large expectations and short time frame → discuss participating in Community of Practice to learn from other sites and share innovation. Reference the IPCT Toolkit.
- Challenges of bringing together primary care models to work collaboratively in a short amount of time and how you will work towards greater collaboration over time.
- Having letters of commitment from doctors or nurse practitioners, but they accept other positions before the spring approval.

Budget

Please refer to separate Budget Template (in Excel format). The budget template includes specific instructions for completion.

included as part of proposal form package

- Include all expenses that will be required to successfully implement including:
    - One time start-up costs
    - Recruitment costs
    - Rent
    - Non-Insured Funding (if CHC)
    - Interpretation
    - Administrative/management positions
    - EMR/IT costs (for expansion only)
    - Cybersecurity costs

Appendix A: Case Studies

The Alliance has case studies that demonstrate the Neighbourhood Home Model. There will be additional case studies included over time, but we wanted to include these early examples to demonstrate how Alliance members have created a Neighbourhood Health Home. We have attached a generic example that is an example of the Neighbourhood Health Home.