Solving the Crisis of the Unattached Patient Problem in Ottawa & the Champlain Region

An OHT & Primary Care Collaborative Approach

The Vision

All City of Ottawa residents, as well as those living in the neighbouring regions, will be attached to a primary care team. We will reach all residents, retain, and revitalize our community of family practices, recruit new primary care team members, and respond to the most urgent needs of our communities.

We will reform and build a healthcare system that is robust and responsive to population health needs with primary care as the foundation.

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Table of Contents

The Vision 1

Executive Summary 3

The Problem and Causes 6

Proposed Strategy 12

REFORM 13

RESTRUCTURE 13

REVITALIZE 14

Appendix A 16

Appendix B 19

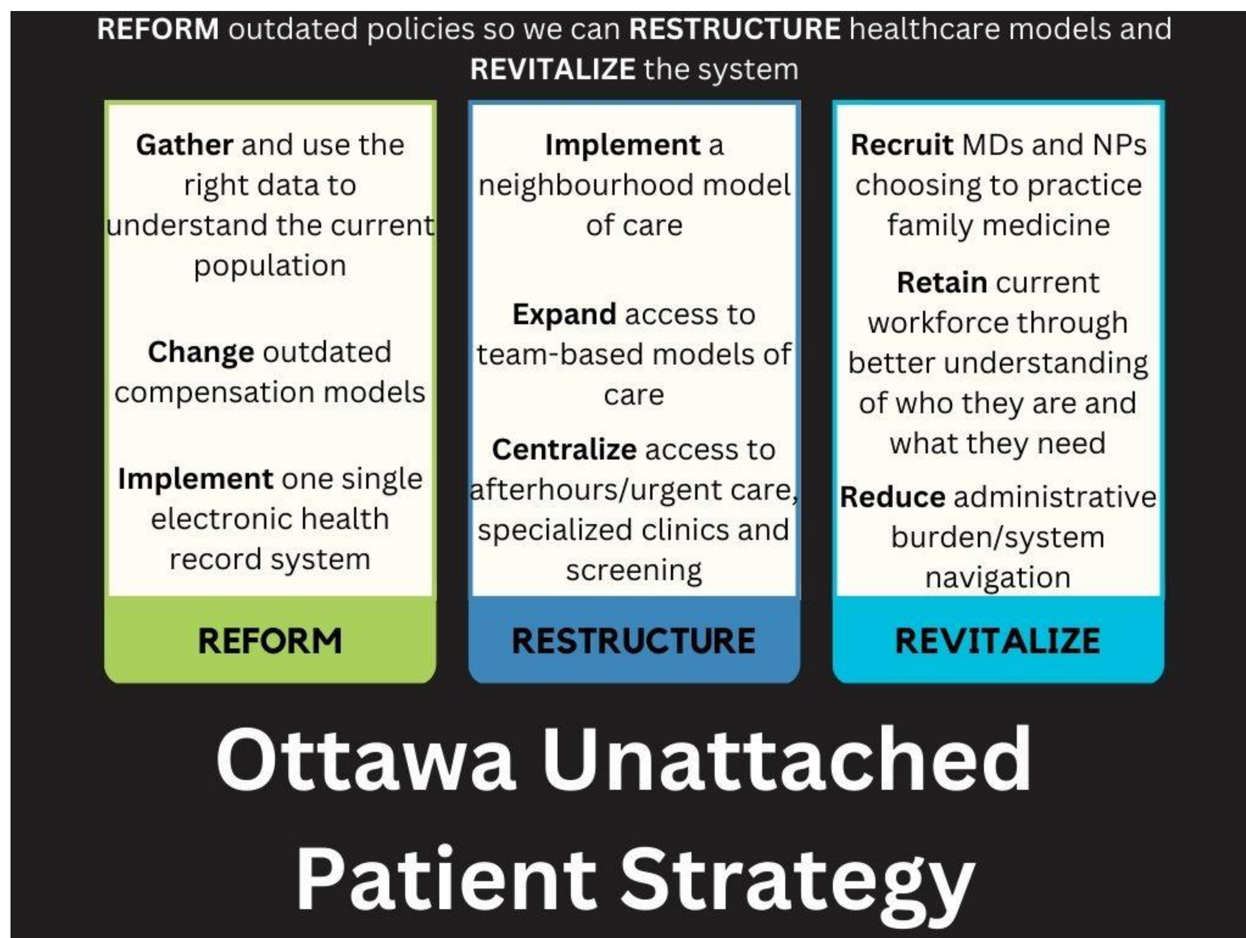
Executive Summary

The primary care system in Ottawa and the surrounding area is in crisis. It is facing a critical shortage of resources and infrastructure. Maintaining a "status quo" of care is impossible, with the dual pressures of expanding client needs and diminishing capacity. This is further exacerbated by a significant increase in retirements and practice closures, fewer graduates choosing to pursue primary care and comprehensive family medicine as a career, and even fewer choosing Ottawa as their place of residence. Additional factors that contribute to this crisis include a rapidly growing population (with particular growth in populations with specialized health needs, such as children and refugees); an aging population with a higher prevalence of chronic conditions and increased complexity; chronic underfunding of primary care with limited and inequitable access to team-based care models; and significant issues in retaining and recruiting primary care providers. There was further erosion during the pandemic until now, as primary care physicians staffed COVID testing clinics and urgent care hubs, compensated at rates that outweighed that of regular OHIP billing in family medicine practice. As a result, we have a rapid, continuing rise of "unattached" patients without access to primary care providers.

Data from Ontario Health profiles suggest that at least 56,675 individuals in the Ottawa Health Team- Équipe Santé Ottawa are currently without access to a primary care provider, with many of them likely being seniors or individuals from equity-seeking populations. Our rural communities surrounding Ottawa face a similar crisis in unattached patients and a lack of primary care providers. In Renfrew County, approximately 20% of residents are not attached to a family physician or nurse practitioner, which is well above the provincial average. In Stormont, Dundas and Glengarry, the lack of access to French-speaking providers further complicates and exacerbates the access to primary care problem.

With this in mind, we have come together as a primary care collaborative to solve the unattached patient problem in Ottawa and the region. Working with primary care leads across the region, our proposed comprehensive strategy aims to increase patient attachment to primary care in the Champlain region, with the vision to have all residents attached to a primary care team. No one will be left behind. The strategy focuses on three main parts: REFORM outdated policies in order to recruit & retain primary care providers in the region, RESTRUCTURE healthcare models and REVITALIZE the system. Without intervention, the number of unattached patients and consequent lack of access to primary care in the National Capital Region will continue to grow at unprecedented rates leading to worsening acute care issues such as increased ED visits, readmission rates, and worsening overall population health. This strategy aligns with Ontario Health's vision of primary care as the foundation of the health system and with the Ontario College of Family Physicians' Plan of Action.[1]

[1] Ontario College of Family Physicians. Solutions for today: Ensuring every Ontarian has access to a family physician. Plan of Action. Published January 2023. Accessed February 1, 2023.
https://www.ontariofamilyphysicians.ca/advocacy/positions-discussions-reports/access-to-physicians/ocfp_fp_access_pp_execsummary_01_24.pdf



The principle: ***No one is left behind.***

Our healthcare system is grounded in primary care. This means that when primary care services are insufficient, this impacts population health. The driving force behind this strategy is recognizing that the primary care system as it now stands is not serving our community, nor does it adequately support the practice of comprehensive family medicine. Our proposed solutions seek to remedy the inequities in the system so that vulnerable populations, such as individuals with low income, recent immigrants, children, and seniors, have equal access to comprehensive primary care and to remove obstacles preventing and driving away providers from delivering primary care.

No one is left behind: no patient, no provider.

What actions do we need to take?

We need to work together to REFORM outdated policies so we can retain and recruit primary care providers to then RESTRUCTURE healthcare models and REVITALIZE the system.

Defining the Problem

The problem and causes:

Problem statement:

- We are currently in a primary care crisis where providers are facing high demand, high expectations, and diminishing resources.
- Higher rates of retirement and practice closures are resulting in more unattached patients. In addition, factors such as a worsening work environment, staffing challenges, and increased administrative burden have led to at least 30 local family doctors in Ottawa alone closing their practices between 2020-2022.[2]
- The current restrictions for entry into capitated models remain a barrier for family physicians in our region to join the model of their choice. They do not afford our region the flexibility required to current practicing family physicians to reorganize into groups of choice, supporting longevity of practice and, in turn, ongoing patient needs. Our local family practice infrastructure, community practices, and existing groups are not easily fit into the current restrictions on group size, co-location and 5 km limits.
- Fewer healthcare workers are choosing comprehensive family medicine, and fewer are choosing to practice in Ottawa. Rural communities outside of Ottawa also struggle and, at times, worry about competing for limited resources with urban and suburban areas.
- Those practicing comprehensive family medicine have reduced clinical hours due to administrative tasks and overall burnout.[3]
- Nurse practitioners (NPs) trained in Ottawa generally stay in primary care and in the region, but the enrollment for NPs is limited by funding for education and clinical placement mentorship opportunities.
- Nurse practitioners are unable to bill OHIP and must seek out opportunities for salaried positions in primary care, which have remained stagnant.
- Data from Ontario Health profiles suggest that the Ottawa Health Team- Équipe Santé Ottawa (OHT-ÉSO) has at least 56,675 unattached people; Champlain overall has a staggering 134,000+ unattached. Ottawa Public Health estimates this could be as high as 150,000 people and warns that populations that tend to have the highest health care needs, including low-income, new immigrants, rural, racialized, and/or elderly, are disproportionately unattached.[4] These populations already face disproportionate poorer health outcomes.
- Renfrew County is the largest geographic county in rural Ontario, encompassing almost 7,500 km2, with a population of approximately 107,756.
  There are no walk-in clinics or urgent care centres anywhere in the county, so there is an overreliance on Emergency Departments as a means of accessing any form of healthcare,

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[2] Personal Communication. Dr Kamila Premji, Doctoral student.

[3] Kiran T. Keeping the front door open: ensuring access to primary care for all in Canada. Canadian Medical Association Journal. Published December 12, 2022. Accessed January 31, 2023. https://www.cmaj.ca/content/194/48/E1655

[4] Raza D. Community health hubs could provide sorely missing primary care. Policy options. Published December 13, 2022. Accessed January 31, 2023. https://policyoptions.irpp.org/magazines/december-2022/medicare-coverage-primary-care/; Ottawa Public Health Briefing note

exacerbating the issue of hallway medicine. Over 23,000 residents of Renfrew County (Population 107,000) currently do not have a Family Physician. In addition, three family physicians will retire/relocate by the end of 2023. A further 2-4 plan to retire in the next two years. This will result in an additional 7000 -10,000 patients impacted, resulting in well over 30,000 individuals without a primary care provider.

Factors contributing to the current crisis of primary care in the Ottawa region include:

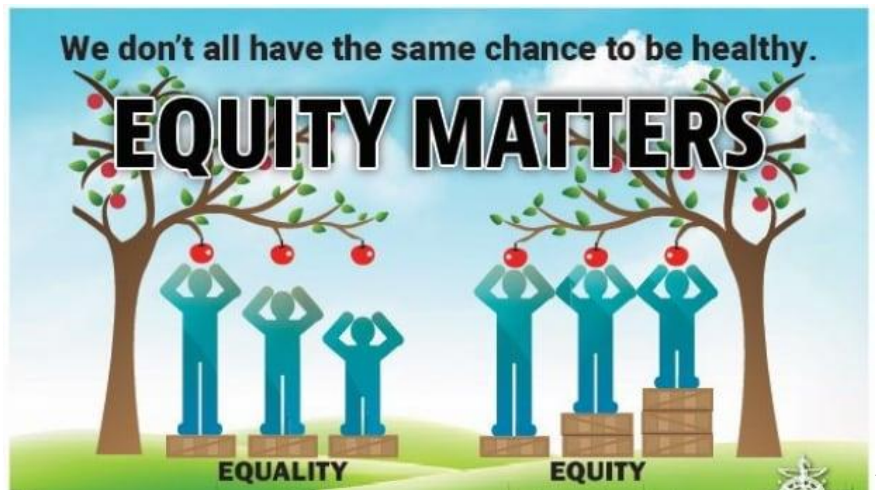
1. An increase in the population in Ottawa, including children and refugees.
2. An aging population with more chronic conditions and increased complexity.
3. Chronic underfunding in primary care leading to limited and inequitable access to team-based care models. There is also a need for more comprehensive data sharing for better understanding of patient and doctor distribution. These issues impede the flexibility required to reorganize primary care to meet the population's needs.
4. Issues with retaining and recruiting primary care providers.
5. Outdated funding models and compensation constraints that limit the utilization of the evidence-based service of nurse practitioners.

Primary care is associated with numerous benefits for individual and community health, including preventive care, early disease identification and treatment, personalized and relationship-based care, and better management of chronic conditions.[5] We know that without consistent and easy access to primary care, the cost of keeping people well will be exponential in our acute care system.

[5] The College of Family Physicians of Canada. 2019: Family Practice - The Patient's Medical Home, p. 16.

Unattachment to primary care is correlated with:	Increased use of acute care resources for mental and physical health issues
	Poor care coordination
	Decreased access to preventative care (e.g., vaccination, cancer screening)
	Decreased access to chronic disease management support (e.g., diabetes)
	Increased illness incidence and severity of illness in the community

But we also have clear evidence of the impact on equity-seeking communities and the importance of a strategy grounded in health equity principles. Newcomers to Canada and those living in low-income or marginalized neighbourhoods were less likely to have a regular family doctor even before the pandemic.[6]



[7]

From data available for the three OHTs within the City of Ottawa boundaries, we also see that equity-deserving groups such as those living in low-income areas, high-deprivation areas, areas with a high proportion of visible minorities (ethnic concentration) or are recent immigrants to Ontario, are more likely to be unattached than those in the general population. (Figure 1)

[6] https://www.cmaj.ca/content/194/48/E1655
[7] Northwestern Health Unit: Health Equity Matters

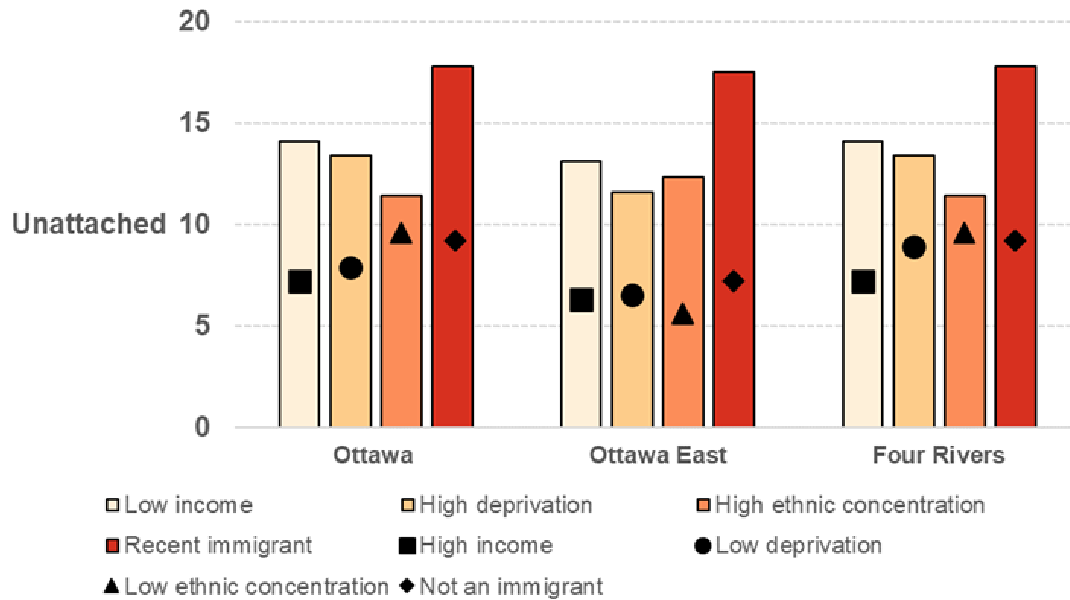


Figure 1: Percent of attributable population uncertainly attached by level of advantage for 3 Ottawa OHTs

- In the Ottawa Valley OHT covering the neighbouring Renfrew County, health inequities are also a significant contributor to the complexity of existing health conditions. Some residents are experiencing systematic and unfair disadvantages that contribute to poor health. This knowledge provides a compelling case for action to reduce health inequities in all areas across the Champlain region.[8]
- Family doctor attachment for recent immigrants (within the last ten years) to Canada is of particular concern. Not only are recent immigrants much less likely to be attached to a doctor, but there are also indications that the process of finding family doctors for newcomers in Ottawa is currently failing. The Ottawa Newcomer Health Centre (ONHC), which sees many newcomers to Ottawa (primarily refugees) for initial health visits, reports that prior to 2020, they successfully attached 75% of their clients with a family doctor. However, since 2020 and the beginning of the pandemic, this has reduced dramatically and now, no doctors are accepting new patients from the ONHC. It is even more difficult to find French-speaking clinicians for refugees and immigrants with French as a second language.
- Data on new immigrants, particularly refugees, may also be poorly captured in some analyses (such as by INSPIRE-PHC) because many immigrants cannot be differentiated from Canadians who moved to Ontario from other provinces or are not captured in Provincial data because they do not have provincial health card numbers (e.g., those covered by the Interim Federal Health Program).

[8] **Health Inequities in Renfrew County and District, 2018, (Renfrew County District Health Unity)**

- Recent immigrants to Canada need special consideration in analysis of primary care doctor attachment and access as they represent the largest annual increase in population growth, are marginalized and have unique healthcare needs, and may not be properly captured in traditional analyses of healthcare systems. Recent immigrants also need special consideration for action for assistance in becoming attached to a primary care doctor as they are likely to be unfamiliar with the Canadian healthcare/primary care system and navigating the complexity of finding a primary care doctor is likely to be a major barrier.
- There are also many populations without health cards, such as undocumented refugees, homeless people and those facing barriers to accessing appropriate identification.
- "Communities that face the highest barrier to access primary care also tend to be those with the highest healthcare needs. They are low-income, new immigrants, rural, racialized, elderly and/or those with the highest degree of family or housing instability."[9]
- This is a crisis as we have a large population of equity-seeking people as well as a growing number of complex and aging patients in the community with a corresponding decrease in the number of PCPs practicing family medicine.[10]

Continued impacts of the pandemic include:

- Pandemic response necessitated that PCPs take on multiple roles
- Managing COVID infections in-office and remotely
- Supporting public health
- Providing surge capacity in acute care settings
- Supporting outreach to equity-deserving populations
- Provide ED services
- Resources to the tertiary care (hospital) system and not the primary care system
- PCC reported burnout rates tripled in 2021, with 51% stating they were working beyond capacity

The urgency

[9] https://policyoptions.irpp.org/magazines/december-2022/medicare-coverage-primary-care/
[10] Mangin D, Premji K, Bayoumi I, et al. Brief on Primary Care Part 2: Factors affecting primary care capacity in Ontario for pandemic response and recovery. Science Briefs of the Ontario COVID-19 Science Advisory Table. 2022;3(68). https://doi.org/10.47326/ocsat.2022.03.68.1.0

There is no shortage of painful client stories or headlines outlining the desperation felt by people without a primary care provider. At the same time, there is a strong interest and willingness across primary care providers in the region to work together to address the issue.

Ontario family details the frustrating struggle to find a family doctor

By Sawyer Bogdan • Global News
Posted November 3, 2022 11:42 am · Updated November 4, 2022 7:31 am

CANADA | News

6M Canadians don't have a family doctor, a third of them have been looking for over a year: report

Ottawa · CBC Investigates

Only a handful of family doctors in Ottawa accepting new patients

CBC was only able to find 3 family doctors accepting patients

Michelle Allan · CBC News · Posted: Nov 15, 2022 4:00 AM ET | Last Updated: November 15

1-in-5 Ontarians could be without a family doctor by 2025

Ontario's family doctors stand ready to work with the Government of Ontario

September 13, 2022

OTTAWA | News

'It's unending:' Ottawa doctor says shortages are creating burnout

Colton Praill CTV News Ottawa Multi-Skilled Journalist
@ColtonPraill | Contact
Published Tuesday, June 21, 2022 6:31PM EDT
Last Updated Tuesday, June 21, 2022 6:31PM EDT

Busing and Rourke: Canada must rapidly shift to team-based health care | Ottawa Citizen

Only a handful of family doctors in Ottawa accepting new patients | CBC News

THE PATIENT'S MEDICAL HOME 2019 (patientsmedicalhome.ca)

Patient's Medical Home - OCFP (ontariofamilyphysicians.ca)

https://www.cbc.ca/news/canada/ottawa/ottawa-family-doctors-new-patients-shortage-1.6643412

The Solution

PRIMARY CARE COLLABORATIVE STRATEGY

REFORM outdated policies to *retain & recruit* primary care providers, RESTRUCTURE healthcare models and REVITALIZE the system

Reform

We need to reform our healthcare system by modifying existing policies to release us to work toward the restructuring and revitalization we need. To do this, we need to use the right population and workforce data to assess and meet the changing needs of the community, change the compensation model, and pave the way for one single Electronic Health System that allows for integration of records and includes the identification of social determinants of health.

Gather and use the correct data to understand the current population

- OHTs have access to data and monitor population growth, health, and the primary care landscape to ensure an appropriate provider-to-patient ratio.
- Focused practices are excluded from the comprehensive primary care data.

Change outdated Compensation Models

- Set aside Physician Service Agreement restrictions to allow physicians to join capitated models.
- NPs to bill OHIP, fund allied health directly in team-based models rather than compensation via physician-directed hourly wages. Remove the limit on alternative funding plans to allow for multiple plans per physician and increase funding for specialized care.
- Allow NPs to bill for care and funding NPLC clinics.
- Revisit the compensation model to move away from fee-for-service and provide fair compensation based on age, complexity, and access to care.
- Use time-based requirements to plan physician workload and allocate funding based on gross billing data.

Implement one single Electronic Health Record System

- Implement a single electronic health record system that integrates all medical records and includes social determinants of health, ensuring a single, comprehensive record for patients and ease of access for primary, tertiary, and allied care.

Restructure

We need to restructure how primary care is funded, accessed, and practiced, moving away from a fee-for-service model and advancing Neighbourhood Models of Care with equitable access to team-based practices at the center. This will ensure access to primary care for all individuals and healthier working conditions for physicians and allied health. In rural areas, neighbourhoods will be larger but are still a model that works, as it ensures all people residing in a broad geographic area are cared for and included.

Implement Neighborhood Model of Care

- Implement a Neighborhood Model of Care that prioritizes equity in access and is led by patients and primary care providers in collaboration with the acute care sector.
- Will have neighbourhood and regional support for after-hours and urgent care, using virtual triage systems and a group of providers, including NPs and paramedics.
- Will be centralized in areas with easy light rail transit access and high walking indices for the elderly and frail.
- In rural areas where there is no public transit, it will depend on the virtual triage system (i.e. VTAC) to receive, assess and triage primary care needs and direct the most appropriate clinician to support the individual.
- Includes working with municipalities to ensure additional clinic space is available through partnerships with developers, social housing, and urban and rural development as the population grows.

Expand Access to Team-Based Models of Care

- Increase investment in expanding community health centers (CHCs), family health teams (FHTS), NPLCs and other innovative models of care that prioritize equity-seeking groups.
- Conduct an analysis of the health needs of the population to ensure the care is delivered by the most appropriate clinician, building up the primary care teams to add additional health care providers to meet the identified need.
- Increase access to care teams for fee-for-service and family health organizations. Consider subsidizing team-based care and public-private partnerships (e.g. with universities and colleges).
- Drop the distance limit for new family health organizations (FHOs) and reduce the minimum number of doctors per FHO to 3.

Centralize access to after-hours/urgent care, specialized clinics, and screening

- Increase community services, both in-person and virtual, and make them open to the public. For instance, chronic disease management, mental health and PAP clinics.
- Streamline screening processes for patients, making it easier and more convenient (e.g. a one-stop shop for all screening appointments).
- Standardize screening programs, such as mammograms, FIT tests, LDCT scans, AAA scans, BMD scans, etc., so that no primary care referral is needed.

Revitalize

We need to revitalize our healthcare system and ensure that the primary care workforce is equipped to meet the needs of the population by making family medicine an attractive career choice. To do this, we need to recruit and retain new family physicians and nurse practitioners and clear the way for them to focus on patient care by reducing the burden of cumbersome administration and system navigation.

Recruit to increase MDs and NPs choosing to practice family medicine

- Provide funds for NP and physician recruitment and retention personnel and offer one-time bonuses to physicians willing to move to Ottawa to provide primary care.
- Provide reimbursement to clinics that recruit physicians from overseas and are willing to take on patients.
- Develop a formal mentorship program for international medical graduates (IMGs), allowing them to get familiar with the system and receive paid work opportunities.
- Open seats in medical school for those willing to practice family medicine and offer loan forgiveness to FM residents who commit to providing comprehensive family medicine.
- Include more teaching of interdisciplinary care with MDs, NPs, and RNs and provide outreach and a recruitment package to new graduates.
- Include leadership training with residency.
- Provide funding to support a "Grow-Your-Own NP" model to assist RNs interested in becoming an NP to acquire the qualifications. Attach a return of service commitment to those who enter the program.

Retain the current workforce by gaining a good understanding of who they are and what they need

- Provide existing MDs/RNs and semi-retired MDs/RNs with opportunities for retraining in family medicine.
- Consider subsidizing office overhead to reduce income differences, potentially through partnerships with the city of Ottawa and community centers.
- Absorb existing physicians considering retirement into "transitional practices." Individual physicians can be grandfathered into FHOs for a short term to support them rather than forcing early retirement.
- Work with the city to provide parking permits for in-home health and community care workers and to enhance childcare options for health care workers.

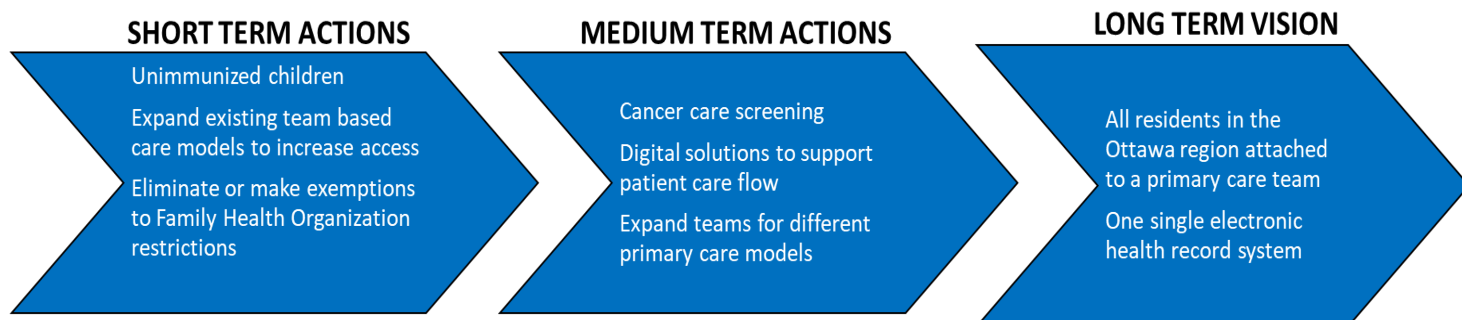
Reduce administrative burden and system navigation

- Support team efficiency and mitigate burnout by reducing administrative burden and freeing up time for clinical work.
- Provide access to digital technology that supports reduced administration.
- Create centralized referral systems to streamline specialist referrals,
- Offer system navigator services and consider scribes for charting and enhancing data.
- Decrease HR rules that need to be signed off by primary care.

Conclusion

The issues that have brought us to this crisis point are numerous. Some are long-standing, while newer challenges are accelerating decline. As organizations, front-line practitioners, client partners and administrators, we understand that the solutions are complex. We have come together to offer a strategy endorsed for its comprehensiveness and cooperative design. We offer it in that spirit of cooperation as we all work to improve our collective health.

Appendix A – Overview of Actions with timelines and leads



In the short term:

What	Potential Lead
Continue to engage with primary care providers in our OHTs to build an understanding of landscape and plan collective and collaborative actions; explore readiness for Primary Care Networks	**OHT PC leads**
Provide OHTs with workforce data, including practicing provider information, to assess and meet the changing needs of the community in the region	**OH**
Gather data from Health Units that also have access to extensive data on health inequities and healthcare needs	**OHT/PHU**
Set aside Physician Service Agreement restrictions to allow physicians to join capitated models regardless of distance between clinics or group size.	**OMA/MOH**
Absorb existing physicians considering retirement into "transitional practices." Individual physicians can be grandfathered into FHOs for a short term to support them rather than forcing early retirement.	**OMA/MOH**
Support mid-career physicians to be organized into larger groups/FHOs	**MOH**
Invest and expand existing team-based models to create immediate access to care. (*See Appendix B for list of prepared business cases.)*	**MOH**
Increase access to care teams for fee-for-service and family health organizations with adequate compensation and recognition of the role of NPs.	**MOH**
Reduce administrative burden related to municipal forms (OW, ODSP, etc.) Decrease HR rules that need to be signed off by primary care.	**OH**
Simplify/Centralize specialist referrals for primary care. Implement OHT-led centralized booking.	**OHTs**
Provide access to digital technology that supports reduced administration. Systematically enhance data (AI, “bots,” autogenerated preventative measures, etc.)	**OH/OHTs**
Develop a formal mentorship program for international medical graduates (IMGs), allowing them to become familiar with the system and have opportunities for paid work.	**DFM/OHTs**
Open seats in medical schools for those willing to practice family medicine and offer loan forgiveness to residents who commit to providing comprehensive family medicine.	**DFM**

Include more teaching in interdisciplinary care for MDs, NPs, and RNs and provide outreach and a recruitment package to new graduates. Include leadership training with residency.	
Provide existing MDs/RNs and semi-retired MDs/RNs with opportunities for retraining in family medicine.	**DFM**
Provide funds for physician recruitment and retention personnel and offer one-time bonuses to physicians willing to move to Ottawa or rural communities to provide primary care.	**Municipality**
Provide reimbursement to clinics that recruit physicians from overseas willing to take on patients.	**MOH**
Open seats in COUPN for nurse practitioners and offer loan forgiveness to NPs who remain in the area.	

In the medium term

What	Potential Lead
Revisit the primary care compensation model to move away from fee-for-service and provide fair compensation based on age, complexity, and access to care. All models should include paid sick leave, ability to access retirement support, support for taking vacations for all allied health professionals in the team-based models. Consider use of time-based requirements to plan physician workload and allocate funding based on gross billing data.	**OH/MOH**
Provide funding to support a "Grow-Your-Own NP" model to assist RNs interested in becoming an NP to acquire the qualifications. Ensure ongoing financing for the NPs to remain in the practice.	**OH/MOH**
Consider innovative ideas such as the Mall Kiosk Outreach. Increase community services (e.g., chronic disease management, PAP clinics), both in-person and virtual, and make them open to the public. Streamline screening processes for patients, making it easier and more convenient (e.g., a one-stop shop for all screening appointments). Partner with Cancer Care Ontario to lead preventive screening and standardized screening programs, such as mammograms, FIT tests, LDCT scans, AAA scans, BMD scans, etc., so that no primary care referral is needed.	**OH/OHTs**
Ensure funding for team-based models to hire allied health care providers such as RNs and NPs and adequately compensate them for their expertise outside of physician billing as a funding mechanism. Provide NP billing codes and have them bill OHIP directly, including for Interim Federal Health.	
Remove the limit on alternative funding plans to allow for multiple plans per physician and increase funding for specialized care.	
Offer system navigator services and scribes for charting and enhancing data.	
Develop a regional strategy for remote care monitoring (RMC) to support team-based care	
Continue to negotiate changes to insurance forms that require primary care providers to complete (i.e. OMA forms committee is working with Canadian Life and Health Insurance Association).	**OMA forms committee**

In the long term

What	Potential Lead
Implement one single Electronic Health Record System. Include social determinants of health.	**OH**
Implement a Neighbourhood Model of Care. The model prioritizes equity in access and is led by patients and primary care providers in collaboration with the acute care sector. In rural areas, neighbourhoods will be larger but are still a model that works, as it ensures all people residing in a broad geographic area are cared for and included. Neighbourhood and regional support for after-hours and urgent care, using virtual triage systems and a group of providers, including NPs and paramedics.	**OHTs**
Working with City planners to ensure additional clinic space is available as the population grows through partnerships with developers, social housing, and urban and rural development. In urban/suburban areas, centralize in areas with easy light rail transit access and high walking indices for the elderly and frail. Subsidize office overhead to reduce income differences, potentially through partnerships with the municipality and community centers. In rural areas where there is no public transit, utilize virtual triage systems (i.e. VTAC) to receive, assess and triage primary care needs and direct the most appropriate clinician to support the individual.	**Municipality**
Work with the City of Ottawa to provide parking permits for in-home health and community care workers. Enhance childcare options for healthcare workers.	**Municipality**
Explore potential of a digital umbrella organization for FHOs, FFS, etc. – “Digital Health shared service organization.”	**OH East**

Appendix B – Contacts for fulsome Business Cases to increase access to Primary Care

Type of Model	Total # of people attached	Estimated budget	Exec. sponsor
Ottawa CHC Collaborative	17,000- 25,000	$15 - $ 25M	Michelle Hurtubise, Executive Director, Centretown Community Health Centre

			MHurtubise@centretownchc.org
Nurse Practitioner-Led Clinic	10,000	$7M	Joanna Binch, RN(EC), Ph.D., Adjunct Professor, University of Ottawa jbinch@uottawa.ca
The Ottawa Hospital Family Health Team	10,000- 20,000	$10 - 20M	Dr. John Brewer, Medical Director, The Ottawa Hospital Department of Family Practice jobrewer@toh.ca
Restore Medical Clinic	13,000	$5M	Dr. Danielle Brown-Shreves, Founder/CEO, Restore Medical Clinic drshreves@restoremedicalclinics.ca
Renfrew County Primary Care Expansion (FHT/FHO expansions and expansion through VTAC to unrostered patients through Primary Care Partnerships)	5500+	$4.8M	Karen Simpson, Executive Director, Arnprior & District Family Health Team KSimpson@arnpriorfht.ca Dr. Richard Johnson Clinical Lead, Ottawa Valley OHT, PFMTU Postgraduate Director and FHO Lead Physician 613-717-2914
Academic Family Health Team expansion (2 sites)	20,000	$16 - 20 M	Dr. Clare Liddy, Chair, Department of Family Medicine, University of Ottawa cliddy@uottawa.ca
Total Estimated:	93,500	$81.8	