Improving Equitable Access to Primary Care Through Priority Attachment Pathways for Marginalized Populations and Children

- **Organization: Ottawa Nurse Practitioner Led Clinic; www.ottawanplc.org**
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Overview

The Ottawa Nurse Practitioner Led Clinic (ONPLC) introduced an equity-focused intake and referral model to improve access to comprehensive primary care for people in Vanier and Overbrook who face barriers to attachment. The initiative replaces a first-come, first-served approach with transparent priority pathways based on health equity and clinical need. It focuses on children and families, newcomers, people experiencing material deprivation or housing instability, people with complex mental health or substance-use concerns, community-partner referrals, and people without primary care.

Key Elements of Initiative

Change Ideas Tested or Implemented

- Standardized electronic referrals through Ocean eReferral.
- Centralized intake and consistent screening criteria.
- Equity- and clinical-need-based priority referral criteria.
- Referral tracking, intake management, and reporting through OscarPro and Ocean.
- Community partnerships to identify and refer marginalized patients.
- Regular review of referral trends and workflow refinements through QI cycles.

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Objective of Change Ideas

Improve equitable and timely attachment to primary care for marginalized patients through coordinated referral and intake pathways.

Team Members Involved

Nurse practitioners, registered nurses, registered practical nurse, patient navigator, medical office assistants, clinic leadership, community partners, Ontario Health Teams, Ontario Health at Home, and the Ontario Health implementation team.

Target Population

Unattached patients, children and families, newcomers, people experiencing homelessness or housing instability, and people with complex medical and social needs.

Measurement Progress

Referrals received and processed; patients attached; referral sources; priority-population attachment rates; intake completion; wait times and accessibility; community-partner feedback; and patient survey feedback.

Implementation Experience: Successes & Challenges

Results/Early Wins

- Implemented standardized referral pathways with multiple community organizations.
- Cleared the pre-January 2025 Health Care Connect (HCC) waitlist for K1L/K1K.
- Increased access for priority populations and improved consistency and transparency in intake decisions.
- Strengthened partnerships with hospitals, community agencies, and social-service organizations.
- Reduced duplicate referrals and manual tracking.

Enablers of Success

- Leadership support, an engaged interdisciplinary team, community partnerships, Ocean and EMR reporting tools, OntarioMD support, and continuous workflow review.
- The Health Matrix supported referral triage and balanced nurse-practitioner caseloads.

Challenges and Solutions

- Demand exceeded clinic capacity; partner organizations used different referral processes; maintaining fair prioritization and communication was challenging.
- ONPLC responded with clear eligibility criteria, standardized workflows, regular partner meetings, and ongoing intake-process refinement.

Advice for Other Teams:

Build partnerships before designing pathways, define priority populations collaboratively, use electronic referrals, apply clear eligibility criteria, monitor data, involve frontline staff, and meet regularly to assess workload and sustainability.

Future Steps & Sustainability

Next Steps and Embedding into Practice

Next Steps:

Expand partnerships across Vanier and the East region; refine equity-based attachment criteria; continue indicator monitoring, staff education, and QI cycles; and use referral and attachment data for planning.

Embedding into Practice:

Make standardized referral and intake workflows part of routine clinic operations, supported by Ocean, OscarPro, and partnerships with organizations including Montfort Hospital, CHEO, Wabano, CMHA, newcomer services, and community paramedics.

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