RISE
Rapid-Improvement Support and Exchange

Peer profile

RISE brief 36: Establishing a 'Primary Care Network'

Context

RISE co-designed with OHTs a process to create a peer profile for OHT priorities, The first wave of peer profiles is provided in Box 1, and this may change.

A peer profile describes the experiences and lessons learned from members of the I-12 and from other OHTs who have particularly rich insights to share about a given priority, while providing all OHTs with an opportunity to learn from peers and collaborate in efforts to advance a useful resource that can be used by all teams.

This peer profile is focused on establishing a 'Primary Care Network' (or PCN). It is complemented by: 1) a recording of the peer sharing and learning session where the slides on which the peer profile is based were presented by the OHTs, RISE and the Indigenous Primary Health Care Council (IPHCC) and discussed with participants (see Box 2); 2) the slides in PDF format; and 3) the slides developed specifically by RISE available in editable PowerPoint format. Readers are encouraged to listen to the recording or relevant 'chapters' in it and to adapt and use the PowerPoint if helpful.

Profiled OHTs were selected based on their self-identification as having experiences and lessons to share, a desire to ensure balanced coverage across the I-12 and the regions, and input from Ontario Health. The five profiled OHTs are:

- Durham OHT (DOHT)
- East Toronto Health Partners (ETHP)
- Greater Hamilton Health Network (GHHN)
- Nipissing Wellness OHT (NWOHT)
- North York Toronto Health Partners (NYTHP)

Additional details about each OHT – its region, attributed population size, and contributors to this peer profile – are provided in Exhibit 1.

Exhibit 1: Profiled OHTs

Box 1: Coverage of OHT priorities

This RISE brief addresses a primary care enablement priority – establishing a Primary Care Network (PCN) – and is part of a series of peer profiles. The first peer profile addressed 'implementing two or more integrated clinical pathways (ICPs) using a population-health management approach.' Our next peer profile will address another primary care enablement priority: improving primary-care access and attachment.

Box 2: Accompanying recording

This RISE brief is accompanied by a recording of a peer sharing and learning session in which the five profiled OHTs shared their 'story so far.' These OHT stories are bracketed by a RISE presentation of the key frameworks and concepts used in this peer profile and a RISE presentation about the cross-cutting experiences and lessons learned: 1) with the journey; 2) in relation to PCN functions; 3) in relation to OHT building blocks; 4) in relation to barriers and facilitators; and 5) from a Northern perspective. The recording concludes with: 1) a commentary from the Indigenous Primary Health Care Council; 2) some reactions from session participants; and 3) an overview of available resources and next steps. We encourage you to listen to some or all of the recording.

'Chapter' in recording	Minute mark	Direct link
Context for session	0:00	Context
'Story so far' from profiled OHTs	10:12	Story so far
• Durham OHT	• 10:52	• DOHT
• East Toronto Health Partners	• 25:26	• ETHP
• North York Toronto Health Partners	• 42:37	• NYTHP
• Greater Hamilton Health Network	• 57:45	• GHHN
• Nipissing Wellness OHT	• 1:09:29	• NWOHT
Experiences and lessons learned • From RISE's perspective	1:16:38	RISE
• From the perspective of the Indigenous Primary Health Care Council	1:18:42	IPHCC
Reactions from participants	1:22:23	Participants
Wrap up with resources & next steps	1:26:30	Wrap up

Note that the recording mentions the sequence and timing of future peer sharing and learning sessions, however, some of these have changed since the date of the recording.

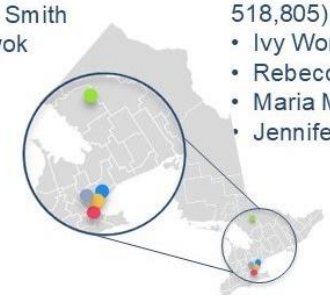
Durham OHT
(East Region,
485,498)
- Lisa Kitchen
- Lubna Tirmizi

East Toronto Health
Partners
(Toronto Region;
379,763)
- Anne Wojtak
- Catherine Yu
- Tach Murray

Greater Hamilton
Health Network
(West Region;
633,502)
- Melissa McCallum
- Marijke Ljogar

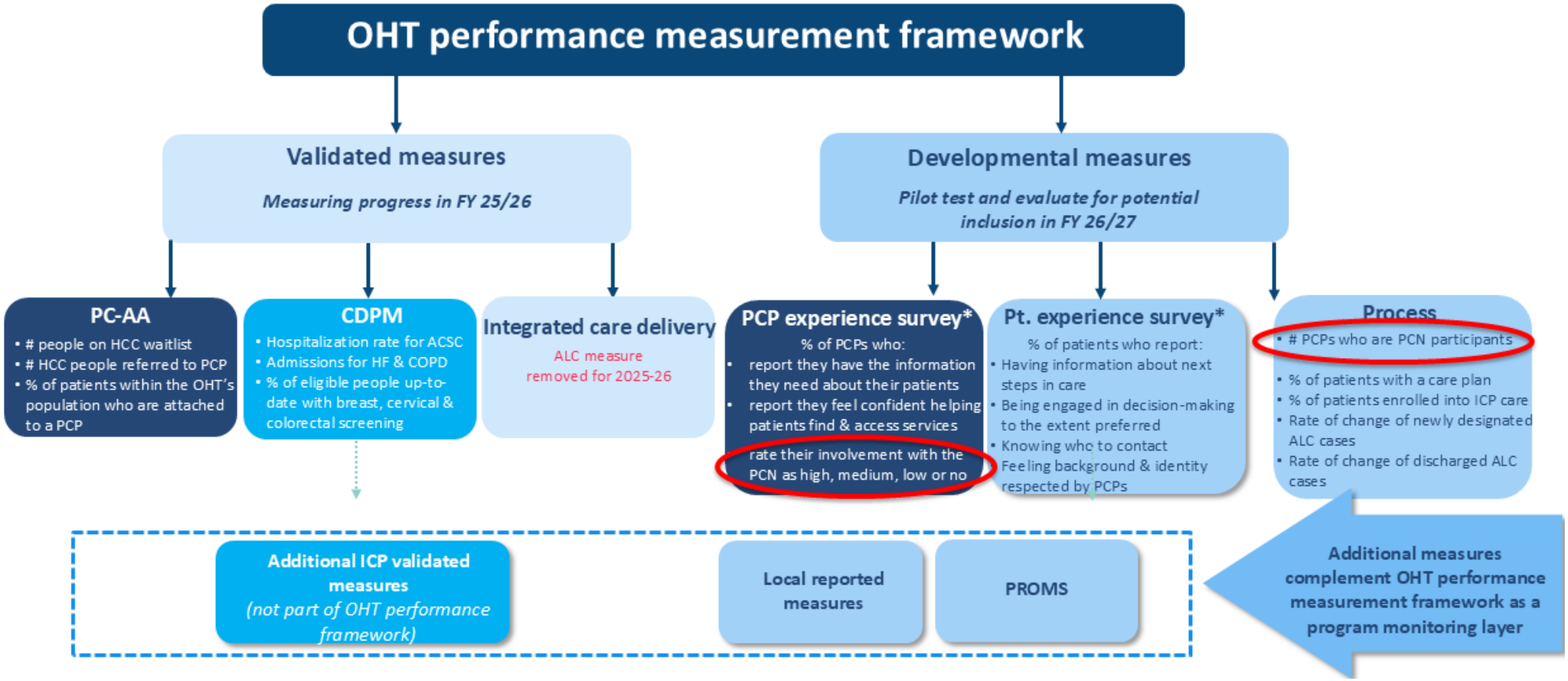
Nipissing Wellness OHT
(North East Region;
99,096)
- Wendy Smith
- Jon Kwok

North York Toronto
Health Partners
(Toronto Region;
518,805)
- Ivy Wong
- Rebecca Stoller
- Maria Muraca
- Jennifer Winter Di Cola



Some measures included in the OHT performance measurement framework pertain directly to PCNs, while other measures could be influenced by PCNs, including primary-care access and attachment. These measures are shown in dark blue in Exhibit 2.

Exhibit 2: PCN measurement and evaluation overview [Source: Ontario Health]



Legend for abbreviations

- ALC = alternative level of care
- ACSC = ambulatory care-sensitive conditions
- CDPM = chronic disease prevention & management
- COPD = chronic obstructive pulmonary disease
- HCC = Health Care Connect
- HF = heart failure
- PC-AA = primary-care access & attachment
- PCN = Primary Care Network
- PCP = primary-care provider

Legend for colours

- Red is a primary focus here
- Yellow is a secondary focus

PCN functions can be derived from the PCN readiness assessment released by Ontario Health, as shown in Exhibit 3.

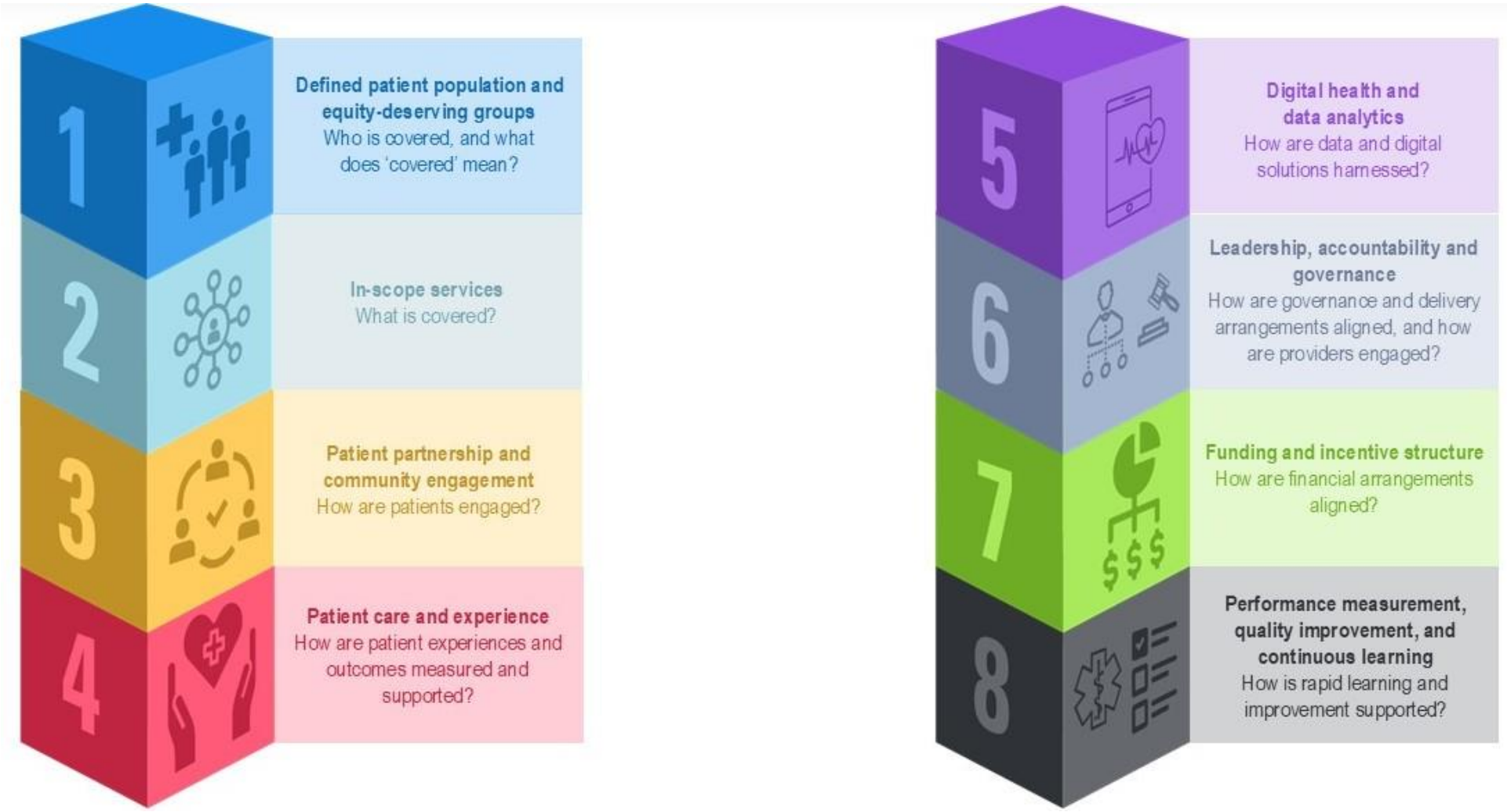
Exhibit 3: PCN functions

Functions	Operationalizations
Overarching	• **Foundational PCN documents** (e.g., terms of reference, governance model, membership agreement, charter) • **Collaborating with patients, families, caregivers and the community** (e.g., OHT PFaC Council) • **Operational staff**: 1) has volunteer/in-kind or external financial support; 2) resources non-clinical roles; 3) has agreement with OHT to support non-clinical roles; 4) participates in recruitment and performance review of shared non-clinical roles
1. Connects primary care within the OHT	• **Membership composition**:1) includes family physicians from all practice models; 2) includes nurse practitioners and pediatricians; 3) includes Indigenous clinicians and organizations; 4) includes other types of clinicians • **Membership recruitment and tracking**: 1) has a process to recruit and track; 2) has a process to measure % who are members; 3) has a process to measure and track engagement; 4) has recruitment and retention strategies • **Communications**: 1) has a dissemination process and count of those reached; 2) has an incoming communications process; 3) develops and adapts communications based on feedback; 4) has a process to measure satisfaction with communications
2. Brings primary-care voice in OHT decision-making	• **Clinical leadership selection**: 1) has identified clinical leaders; 2) has a process for selecting clinical leaders; 3) has clinical leadership that reflects membership composition; 4) has an Indigenous clinical lead • **Voice**: 1) has clinical leaders participating in OHT executive decision-making structures; 2) has clinical leaders or members participating in working, implementation and advisory groups; 3) has clinical leaders who feel that they have a leadership voice in all OHT decision-making and that OHT priorities reflect member priorities; 4) has members who feel that their input is influencing local change and that OHT priorities reflect primary-care priorities • **Leadership training**: 1) has clinical leaders with training in EDI, anti-racism and Indigenous cultural safety; 2) facilitates access to leadership training for current and emerging clinical leaders; 3) facilitates access to leadership training in EDI, anti-racism and Indigenous cultural safety; 4) has a process to track which members have which training
3. Advances clinical change and population-health management	• Data and population-health management (PHM): 1) has access to population-health data for attributed population; 2) has access to Indigenous-specific data or a data-sharing agreement with Indigenous organizations; 3) analyzes data in equity-focused ways (e.g., population segmentation, social determinants, attachment among equity-deserving populations, need for Indigenous data governance); 4) has the enablers for co-designing population health-based initiatives (e.g., data-sharing agreements, digital PHM tools); 5) analyzes outcomes including PREM and PROM data to inform learning and improvement • Access and attachment: 1) has clinical leaders and a working group to lead this work; 2) has a process for reviewing and addressing their Health Care Connect waitlist and consider other waitlists if those exist; 3) has started initiatives to increase access and attachment (e.g., temporary clinics); 4) has begun planning an overall strategy with

Functions	Operationalizations
	equity-deserving populations involved in co-design and Health Care Connect resources engaged in collaboration • Integrated chronic disease prevention and management (including ICPs, or integrated clinical pathways): 1) has clinical leaders planning integrated clinical pathways (ICPs); 2) has members who feel that ICPs have been co-designed with primary care in mind; 3) has members participating in the implementation of ICPs; 4) has most members actively adopting ICPs • Local primary-care priorities: 1) has local primary-care priorities (e.g., reducing administrative burden; improving referrals); 2) has work underway to address these priorities; 3) completed and measured success with such initiatives; 4) has seen its priorities including in OHT operating and other plans
4. Facilitates access to clinical supports and improvements	• Digital interoperability: 1) is aware of the EMRs used by members; 2) aware of the digital solutions used by members (e.g., EHR, eReferral/eConsult, and online appointment booking or OAB); 3) has the ability to implement digital initiatives across all EMR platforms; 4) has a collaborative plan for digital-solution harmonization (e.g., single EMR or single OAB) • Clinical supports (both roles and programs like BestCare, SCOPE, OAB): 1) has an inventory of all existing clinical supports available to members; 2) has an equity-based needs assessment on access to clinical supports and allows members to self-identify needs; 3) has a way to facilitate access to clinical supports based on need; 4) has become a coordination hub for facilitating access to new and existing clinical supports
5. Supports local health human resource (HHR) planning	• Local HHR planning: 1) has identified HHR capacity constraints (e.g., population growth, clinicians retiring, clinics closing); 2) has analyzed data on HHR capacity to define needs for team-based care; 3) is working with key partners (e.g., local recruiters, HealthForceOntario, Indigenous organizations);4) is implementing with the OHT a primary care HHR plan, including sharing HHR resources

PCNs can both leverage the OHT building blocks, which are shown in Exhibit 4, and provide a vehicle for creating or strengthening some of these building blocks.

Exhibit 4: OHT building blocks



‘Story so far’ from profiled OHTs

RISE asked each OHT to tell the ‘story so far’ in their efforts to establish PCNs. You can listen to the recordings of each of these ‘stories’ by clicking on a link in Box 2, as well as access the slides in PDF format. We encourage you to listen to these OHTs’ stories in their own words.

RISE summarized the highlights from these stories based both on each team’s presentation at the peer sharing and learning session and on our original interviews with each OHT prior to the session. These highlights can be found in Exhibits 5-9.

Exhibit 5: Durham OHT (DOHT) highlights from RISE’s perspective

- Journey
  - Foundation: Virtual urgent care strategy, regional response team and primary-care website during COVID-19; legacy leadership from LHIN
  - Near-term wins: Primary care advisory council and working group, PCN strategic plan that is action oriented, and PCN website (see OHT resources near the end of this slide deck)
  - Long-term goal: Standardized offer of comprehensive primary care (across funding ‘models’) and ‘healthy hubs’
- Experiences in relation to PCN functions
  - Overarching: PFaC collaboration – Primary care co-leads attend PFaC Council meetings, virtual community town halls, and patient-outreach activities
  - Function 1 (connects primary care within OHT): Communications – Community of practice for about 200 primary-care providers
  - Function 2 (primary care voice): Clinical leaders – Indigenous co-lead at Lakeridge Health
  - Function 3 (clinical change & PHM): Access & attachment – Episodic Access to Virtual Care (now for East Region), Regional Response Team, patient navigation pilot in downtown Oshawa, improving referrals and access to care for people living with mental health and addictions, and implementing ICPs
  - Function 5 (HHR): Local HHR planning – Queen’s @ Lakeridge Extended Program (QALEP) to build family-medicine residents’ roots in region, communications strategy (including PCN website), and social events
- Experiences in relation to OHT building blocks
  - Building block (BB) # 3: Patient partnership & community engagement (see PFaC collaboration above)
  - BB #4: Patient care and experience (see clinical change and PHM above)
- Experiences in relation to facilitators (and barriers)
  - COVID-19 engagements with primary care; partnership with Queen’s University; and new funding for team-based models
  - Very large number of unattached patients; significant challenges with the social determinants of health (in downtown Oshawa)

Exhibit 6: East Toronto Health Partners (ETHP) highlights from RISE's perspective

- Journey
  - Foundation: Hospital willing to share funding; primary care council set up, and primary care leads hired, with funding from Toronto Central LHIN; five functions already familiar to primary-care providers; incorporated entity (East Toronto Family Practice Network)
  - Near-term wins: Moving from advising on pilot projects to a voice in the functions and accountability for delivering on them; mapping the key players in geographic areas; advocating for a maturity model and infrastructure support
  - Long-term goal: Primary care is at the core of an integrated health and social care system and co-leading the OHT (see vision of a maturity model on the OHT resources slide)
- Experiences in relation to PCN functions
  - Overarching: EasT-FPN has a skills-based board of directors – with 15 directors – and two board committees; governing bodies are made up of members that bring legal, financial, strategic planning, governance and primary-care leadership skill sets and expertise; governance bodies include a range of family practice representatives, practicing in various Ontario family medicine compensation and practice models; representation of the primary care executive leadership at the ETHP CEO table
  - Function 1 (connects primary care within OHT): EasT-FPN members are family physicians and/or healthcare providers (NPs) who provide comprehensive and long-term primary care to individuals and families, in East Toronto; through various EasT-FPN and ETHP program and project working groups, committees and tables, the Network has representation from various healthcare professionals who practice primary healthcare, including NPs, nurses and social workers, who practice in East Toronto interprofessional primary-care teams and settings, like CHCs and FHTs
  - Function 2 (primary care voice): Active contributor to OHT decision-making; approximately 3.0 FTE distributive leadership, supporting executive leadership and program clinical leadership, to support EasT-FPN and ETHP priorities, programs, projects and initiatives
- Experiences in relation to PCN functions (continued)
  - Function 3 (clinical change & PHM): Addressing local priorities like reducing administrative burden (and anticipating and preparing for retirements, which links to function 5)
  - Function 4 (clinical supports): Expanded SCOPE for mental health and more generally co-designing digital supports 'first'
  - Function 5 (HHR): Local HHR planning – Building capacity of primary-care providers to take on patients who will be 'orphaned' by five family physicians retiring
- Experiences in relation to OHT building blocks
  - Building block (BB) #6: Leadership, accountability and governance – Years of attention given to this for primary care
  - BB # 8: Performance measurement, QI & continuous learning – Using tests of change
- Experiences in relation to facilitators (and barriers)
  - Primary care already centred in the conversation and hospital was willing to work differently long before the OHT was formed
  - Need local data to understand family-practice characteristics and capacity, including the attributed population being served

Exhibit 7: Greater Hamilton Health Network (GHHN) highlights from RISE's perspective

- Journey
  - Foundation: Previous 'PCN' iterations (HFAM); information sharing began during COVID-19 (e.g., newsletters and townhalls); primary-care leaders willing to 'step up'
  - Near-term wins: Dedicated primary-care seats on the board of the province's first incorporated OHT; hired a dedicated manager for primary care; robust PCN governance structure
  - Long-term goal: Primary care is centred in health, social and community systems resulting in improved delivery and coordination of care for patients (team-based primary care for all) and an improved experience for providers
- Experiences in relation to PCN functions
  - Function 1 (connects primary care within OHT): Recruitment and tracking – Paid CPSO to access publicly available data about primary-care providers in a form useful to them, developed a welcome package, and hosted a membership drive; Communications – Biweekly newsletters (local plus OCFP and OMA news), monthly townhalls, and transitioning legacy website to PCN website
  - Function 2 (primary care voice): Robust PCN governance, including a PCN Leadership Council – with members including family physicians, admin/operations, IHPs and other primary-care champions – that meets monthly for 90 minutes; De dwa da dehs nye>s (Indigenous community health centre, or CHC) representative attends council; 100 'seats' in Indigenous cultural safety training paid for; two reserved primary care seats on GHHN Board
  - Function 3 (clinical change & PHM): Basing ICP work in primary care; hired a clinical lead for ICP work; collaborating with Burlington and Middlesex London OHTs (and HealthPathways) on ICP work; PCN has identified priority pathways for first wave of ICP development; developing a primary-care atlas (map with primary care and population health trends)
  - Function 4 (clinical supports): Addressing digital interoperability as the top 'pain point' for primary-care providers; next steps to include building out a CRM to build out 'inventory list' of digital tools
  - Function 5 (HHR): Local HHR planning – local recruiter moved over to GHHN; recruiter program expanded with an emphasis on rural recruitment
- Experiences in relation to OHT building blocks
  - Building block (BB) #6: Leadership, accountability and governance – Significant attention paid to governance model and to recruitment of new members and engagement of existing members
- Experiences in relation to facilitators (and barriers)
  - New funding for team-based models (and their 'expression of interest' provides a roadmap for further expansions)
  - Insufficient funding for PCN operations; 'finding' unattached patients; connecting with 'unaffiliated' PCPs (i.e., walk-in clinics)
  - Context rather than facilitators or barriers per se: Three previously discrete sub-regions (Hamilton, Haldimand, and northwest Niagara); home to largest Family Health Team in the province (Hamilton FHT); and more team-based models in rural areas

Exhibit 8: Nipissing Wellness OHT (NWOHT) highlights from RISE's perspective

- Journey
  - Foundation: Recognition that primary care should be a foundational element of the OHT; group of primary-care providers who were already meeting to discuss how to become better organized
  - Near-term wins: Clinical council; small, engaged 'coalition of the willing;' collaboratively developed 'terms of reference'
  - Long-term goal: To be the voice of primary care providers within the Nipissing Wellness OHT; at maturity, the PCN will include representatives from allied health provider groups within the district so that decisions reflect all who work collaboratively to deliver primary healthcare in Nipissing
- Experiences in relation to PCN functions
  - Overarching: Developed a fulsome 'terms of reference' document, including roles and responsibilities
  - Function 2 (primary care voice): A primary-care provider is co-chair of the OHT Council; five lead primary-care providers – four geographic and one for nurse practitioners – are 'elected' from broader group and remunerated for their work on the clinical council; Indigenous clinical lead and continuing to explore ways to engage Indigenous partners; two individuals supported with leadership training
  - Function 3 (clinical change & PHM): Consolidating wait lists for primary care while alert to a re-opening of a call for new funding for team-based models; showcased their ICP work in the ICP peer profile
  - Function 4 (clinical supports): Front-line supports for digital solutions is a key value add; partnering with BestCare on ICPs
- Experiences in relation to OHT building blocks
  - Building block (BB) #3: Patient partnership & community engagement – Strong PFaC engagement, including working through what can be done to help unattached patients
  - BB #6: Leadership, accountability and governance – Clinical council meets every few weeks and works through everyday needs of providers
- Experiences in relation to facilitators (and barriers)
  - Single EMR (Telus) although multiple instances, plus single EHR (Meditech); all primary-care providers want access to other types of providers and some are discussing how to share access across 10 organizations; launched a few initiatives that demonstrated the value of being connected to an OHT PCN
  - Challenges engaging the wider community of primary-care providers

Exhibit 9: North York Toronto Health Partners (NHTHP) highlights from RISE's perspective

- Journey
  - Foundation: Community hospital with longstanding culture of support for primary care; engaged Chief of Department of Family and Community Medicine at a hospital which is a popular site for medical trainees; engaged heads of large Family Health Organizations (FHOs) and large North York Family Health Team (NYFHT) where residents receive some of their training; highly engaged and success-oriented physician leaders (co-chairs); COVID-19 provided leadership opportunities for primary care (and new priorities like surge planning continue to provide them) and opportunities to demonstrate benefits of OHT partners working together.
  - Near-term wins: Membership form; tracking template (Excel); terms of reference; roles developed, with two staff people (Project Director and Project Coordinator) and one consultant (Digital Support Consultant) hired (see OHT resources slide)
  - Long-term goal: Have all PCPs in our OHT catchment as engaged members of the PCN to enable information dissemination, integrated regional healthcare planning, and program development based on needs of the community (as provided by those in the PCN); improve health data sharing to allow seamless care and transitions
- Experiences in relation to PCN functions
  - Overarching: Developed and continuing to refine terms of reference; hired key non-clinical roles
  - Function 1 (connects primary care within OHT): Recruitment – membership drive, engagement events, office canvassing, outreach to walk-in clinics, consolidated emails, clarifications of 'what is in it for me,' and offers to help address pain points (e.g., administrative burden and trial of AI Scribe); Communications – Newsletters, website, and emails
  - Function 2 (primary care voice): Clinical leaders – Primary care leadership represented at almost all committees of the OHT; primary care sits at the OHT governance table; each Primary Care Advisory Council member leads a portfolio of primary-care work
  - Function 4 (clinical supports): Leveraged SCOPE program in response to requests for help; access to clinical and digital supports; novel role in the digital support consultant; central repository of clinical information regarding surge on the website
- Experiences in relation to OHT building blocks
  - Building block (BB) #6**:** Leadership, accountability and governance – Significant attention paid to recruitment of new members and engagement of existing members; success facilitated by dyad admin/clinical primary-care leadership roles to provide support for initiatives and accelerate the work
- Experiences in relation to facilitators (and barriers)
  - Building upon a primary care-centred hospital and community
  - Several EMRs and multiple instances of one widely used EMR
  - Challenging to engage all family physicians in catchment area, especially those practicing in solo physician models of care

Experiences and lessons learned from RISE's perspective

RISE also summarized particular highlights from the OHT stories as they pertained to: 1) the journey; 2) experiences in relation to PCN functions; 3) experiences in relation to OHT building blocks, and experiences in relation to barriers and facilitators. These highlights can be found in Exhibits 10-14.

Exhibit 10: Experiences with the journey

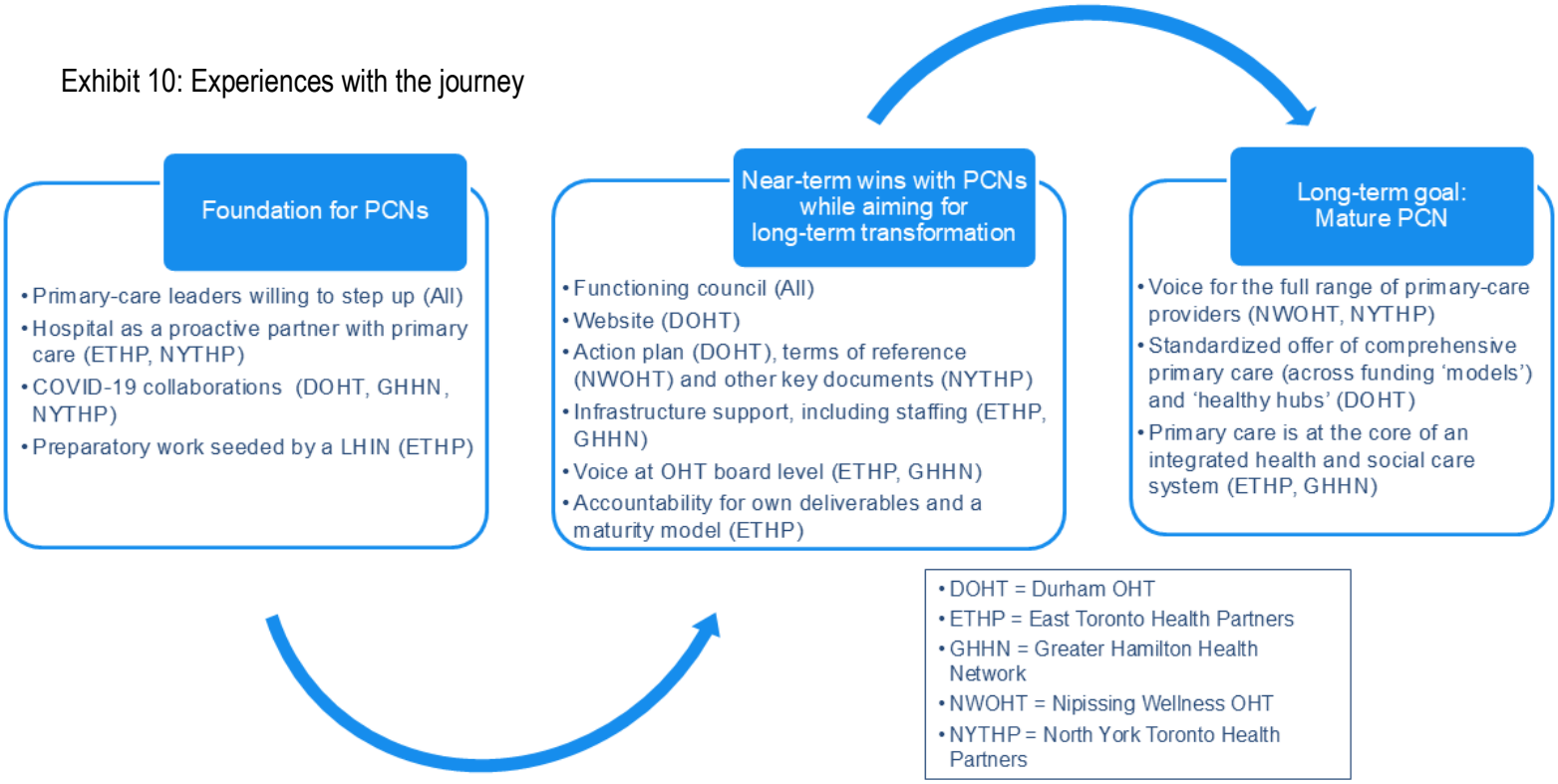


Exhibit 11: Experiences in relation to PCN functions

Functions	Experiences
Overarching	• Foundational documents • PFaC collaboration • Non-clinical roles • Skill-based board of directors
1. Connects primary care within the OHT	• Members of all types, including Indigenous providers • Recruitment & tracking, including both lists and customer-relationship management tools • Communications
2. Brings primary-care voice in OHT decision-making	• Clinical leaders, including an Indigenous clinical lead • Voice, including in governance • Leadership training
3. Advances clinical change and population-health management	• Data and PHM, including Indigenous-specific data • Access and attachment, including consolidating wait lists for primary care • ICPs • Local priorities like reducing administrative burden and improving referrals
4. Facilitates access to clinical supports and improvements	• Digital interoperability (EMRs) and digital solutions (AI Scribe, EHR, eReferral/eConsult, and OAB) • Clinical supports, both roles and programs like BestCare, SCOPE and OAB
5. Supports local health human resource (HHR) planning	• Local HHR planning

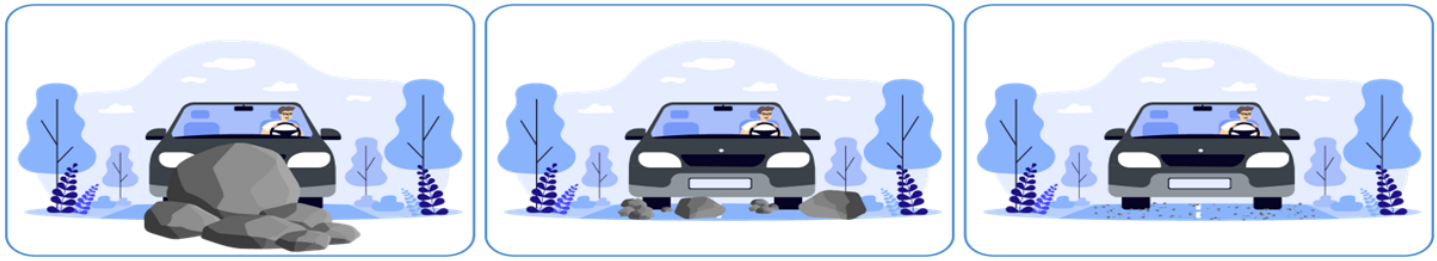
Exhibit 12: Experiences in relation to OHT building blocks

Building block	Experiences
1) Defined patient population and equity-deserving groups	
2) In-scope services	
3) Patient partnership & community engagement	• Primary care co-leads attend PFaC Council meetings, virtual community town halls, and patient-outreach activities (DOHT) • Strong PFaC engagement, including working through what can be done to help unattached patients (NWOHT)
4) Patient care & experience	• Implementing ICPs (DOHT) • Other care priorities, such as virtual care, regional response team, patient navigation pilot, improving referrals and access to care for people living with mental health and addictions (DOHT)
5) Digital health and data analytics	
6) Leadership, accountability and governance	• Years of attention given to leadership, accountability and governance in primary care (ETHP) • Significant attention paid to governance model and to recruitment of new members and engagement of existing members (GHHN) • Clinical council meets every few weeks and works through everyday needs of providers (NWOHT) • Significant attention paid to recruitment of new members and engagement of existing members; success facilitated by dyad admin/clinical primary-care leadership roles to provide support for initiatives and accelerate the work (NYTHP)
7) Funding and incentive structure	
8) Perf. measurement, QI & continuous learning	• Using tests of change (ETHP)

Exhibit 13: Experiences in relation to facilitators (green) and barriers (red)

	COVID-19 engagements with primary care, as well as more recent initiatives demonstrating the value of PCNs • e.g., DOHT
	Primary care already centred in the conversation and hospital was willing to work differently • E.g., ETHP and NYTHP
	New funding for team-based models (and ways to share access to other types of provides across organizations) • e.g., DOHT, GHHN
	Partnership with other institutions • e.g., DOHT with Queen's University
	Electronic medical records (EMRs) • NYTHP: Several EMRs and multiple instances of the same EMRs
	Data sharing • ETHP: Not knowing the attributed population or being able to find 'unattached' patients (although this is now being addressed through improvements in Health Care Connect data)
	Funding • GHHN: Insufficient funding for PCN operations • NYTHP: Lack of innovative payment mechanisms • NWOHT: Challenges engaging the wider community of primary-care providers

Exhibit 14: Experiences from a Northern perspective



Roadblocks

- Chronic, extreme shortages in health workforce resources – hard to get diverse perspectives across the multiple advisory opportunities (beyond OHT: OH, academic, organizational)
- Remuneration for time – multiple (siloed) streams of funding for non-patient care roles (e.g., research, teaching, administration, professional development)

Challenges

- Multiple, sometimes overlapping, asks of clinicians to provide insight (e.g., regional clinical networks, OHT primary-care councils, professional organizations)

Facilitators

- Explicitly integrate primary-care provider expertise into OHT priorities and regional priorities – strengthening purpose and value for PCN participants
- Existing relationships with NOSM University networks, leveraging academic relationships and intersection with OHT work
- Existing ways of working together (e.g., regionally) builds upon strong relationship
- Rural generalism

RISE invited the Indigenous Primary Health Care Council (IPHCC) to share their experiences with supporting the establishment of PCNs. You can listen to the recording of their presentation by clicking on a link in Box 2, as well as access the slides in PDF format.

In brief, the IPHCC made the following observations:

- self-reported data are provided to the Ministry of Health by Indigenous Primary Health Care Organizations (e.g., Aboriginal Health Access Centres, Indigenous Community Health Centres, Indigenous Interprofessional Primary Care Teams, Indigenous-led Nurse Practitioner-Led Clinics, Indigenous Family Health Teams) and the ministry is working with the IPHCC and Indigenous health providers to explore opportunities to include data about Indigenous populations in OHT attribution in the future;
- the preamble to the Connecting Care Act, 2019 "recognize[d] the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities
- the IPHCC is committed to 'Indigenous health in Indigenous hands'
- the IPHCC worked with the Ministry of Health and Ontario Health, and in reciprocal partnerships with Indigenous-governed organizations, individuals, and communities, to develop an Indigenous-focused PCN self-assessment tool that complements others currently available.

Resources and next steps

The profiled OHTs, the Ministry of Health, Ontario Health and OHT support partners have made available resources to support the establishment of PCNs. These resources are listed in Exhibits 15-17.

Exhibit 15: Resources from the profiled OHTs

OHT	Resources	Description or consideration
Durham OHT	• Connecting the Durham OHT to primary care in Durham region: 2023-24 strategic action plan • PCN Durham website	• Example of a PCN strategic plan • Example of a PCN website
East Toronto Health Partners	• Proposed approach to developing OHT primary care networks: The East Toronto experience (23 January 2023)	• Example of leadership in advancing thinking about what a PCN could look like
Greater Hamilton Health Network	• GHHN primary care governance (version July 2024; note that this will continue to evolve) • GHHN PCN membership drive package • GHHN PCN clinical lead job posting	• Example of a fully developed governance mechanism • Example of a membership drive package • Example of a role description
Nipissing Wellness OHT	• Nipissing PCN terms of reference, including purpose, roles and responsibilities (and remuneration), consensus decision-making framework, and dispute-resolution process	• Example of a fully developed terms of reference
North York Toronto Health Partners	• PCN action plan 2024-25 • PCN terms of reference (version 2024-10-22) • PCN membership form (version June 2024) • PCN member list template • Role description for primary care advisory council (PCAC) co-chairs • Role descriptions for: 1) project director, primary care transformation; 2) project coordinator, primary care transformation; 3) consultant, primary care digital support • NYTHP PCN website	• Example of a term of reference • Example of a membership form • Example of an Excel file template for tracking • Examples of role descriptions • Example of a website

Exhibit 16: Resources from the Ministry of Health and Ontario Health

Type	Resources	Value add of key resources
PCNs	• PCNs in OHTs: Guidance document (2024-01-24) • PCN readiness assessment tool (2024-01-24) – available upon request (email to: PrimaryCareProgram@ontariohealth.ca) • Excerpt from recording and deck of the acceleration-priorities webinar • Recording and deck (English and French) from the webinar about PCNs (24 January 2024) • Physician business contact information (available via the OHT data dashboard summer 2025)	• Key guidance document for PCNs • Description of functions expected of PCNs • Example of FLA's PCN work • Initial guidance about PCNs • If working with an OHT, please contact OHTanalytics@ontariohealth.ca for access
Communities of practice	• OHT Shared Space, and the Primary Care QI Hub	• Opportunities for shared dialogue on PCNs, as well as a collection of resources

Exhibit 17: Resources from OHT support partners

Developer	Resources	Value add of key resources
RISE	• RISE rapid-evidence profile on the structural features, processes associated with, and improvements that have resulted from the establishment of primary-care networks	• Findings from one evidence synthesis, seven single studies, and a jurisdictional scan of experiences in all Canadian provinces and territories and in 12 countries
	• Rapid evidence profile about what is known from the evidence about the size and nature, impact and drivers of physician administrative load, as well as the approaches that can be adopted to manage physician administrative load (31 August 2022)	• Context for PCN work on addressing administrative burden
IPHCC	• Indigenous patient, family and community engagement framework • Culturally appropriate language guide • Suggestion to read the preamble to the Connecting Care Act, 2019, S.O. 2019, c. 5, Sched. 1	• Framework to support keeping Indigenous health in Indigenous hands • Guide for individuals and organizations in using language that promotes respect, inclusion and cultural safety when engaging with Indigenous communities
HSPN	• Primary-care engagement recording and slide deck	• Insights about primary-care engagement

RISE welcomes feedback on this peer profile, as well as additional resources to share, and will update it as new resources come online. Please send feedback and resources to rise@mcmaster.ca.

Lavis JN, Moat KA, Reid R, Wood B, Hindmarsh M, McGeoch L. RISE brief 36: Establishing a 'Primary Care Network.' Hamilton: McMaster Health Forum, 2025.

RISE prepares both its own resources (like this RISE brief) that can support rapid learning and improvement, as well as provides a structured 'way in' to resources prepared by other partners and by the ministry. RISE is supported by a grant from the Ontario Ministry of Health to the McMaster Health Forum. The opinions, results and conclusions are those of RISE and are independent of the ministry and Ontario Health. No endorsement by the ministry or Ontario Health is intended or should be inferred.

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