RISE
Rapid-Improvement Support and Exchange

Team-based Primary Care: Building teams

19 February 2026

Recording: https://youtu.be/Qk29MxED1z0.

McMaster University | HEALTH FORUM
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RISE facilitated primary care shared space

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Stay connected!
You can also post questions, share resources and watch previous sessions in the OHT/PCN shared space.

Joining is easy

1. Visit the OHT shared space platform and click the "Sign Up" button.

2. Join the RISE facilitated primary care shared space by clicking on the "Join Group" button

3. Click "**Subscribe to Updates**" to stay up to date on events and resources

BENEFITS

- ✓ **Group** for those leading OHTs/PCNs and responsible for PC TPA deliverables (e.g. PC AA)
- ✓ Receive email **notifications on sessions**
- ✓ Access **resources and templates**
- ✓ **Watch recordings** of previous sessions and discussions
- ✓ **Post questions** to other OHTs, PCNs and experts on the board

For any questions, please feel free to reach out to your coach or Leslie McGeoch (Leslie.McGeoch@outlook.com)

Land acknowledgement

"As we meet here today, we are in solidarity with Indigenous Peoples of Turtle Island and would like to begin by acknowledging that the land on which we gather is part of the Treaty Lands and Territory of the Mississaugas of the Credit, and before, the traditional territory of the Haudenosaunee, Huron and Wendat. We also acknowledge the many First Nations, Inuit, and Métis Peoples who call this area their home. We are grateful for the opportunity to be working on this land".

We invite you to visit the link provided, to learn more about treaties.

https://www.ontario.ca/page/treaties

Today's agenda

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Recap. Of core principles & concepts	Gain an initial understanding of primary drivers for building primary care teams.	**12:05-12:15**
Creating "teamness"	Learn from examples of creating functional teams through team structure, communication and process change	**12:15-12:50**
Group discussion	Participants to exchange learnings on how they are approaching this work	**12:50 – 1:25**

Objectives for Today

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- ✓ Understand **approaches for leaders to create "teamness"** within multidisciplinary primary care teams
- ✓ Learn from **examples of creating functional teams** through team structure, communication and process change
- ✓ Understand **barriers and facilitators** to enable team-based primary care
- ✓ Continue to **exchange learnings and problem solve with peer OHTs/PCNs** on how they're approaching this work.

Recall OHT Transformation: Integrated Local Care Systems

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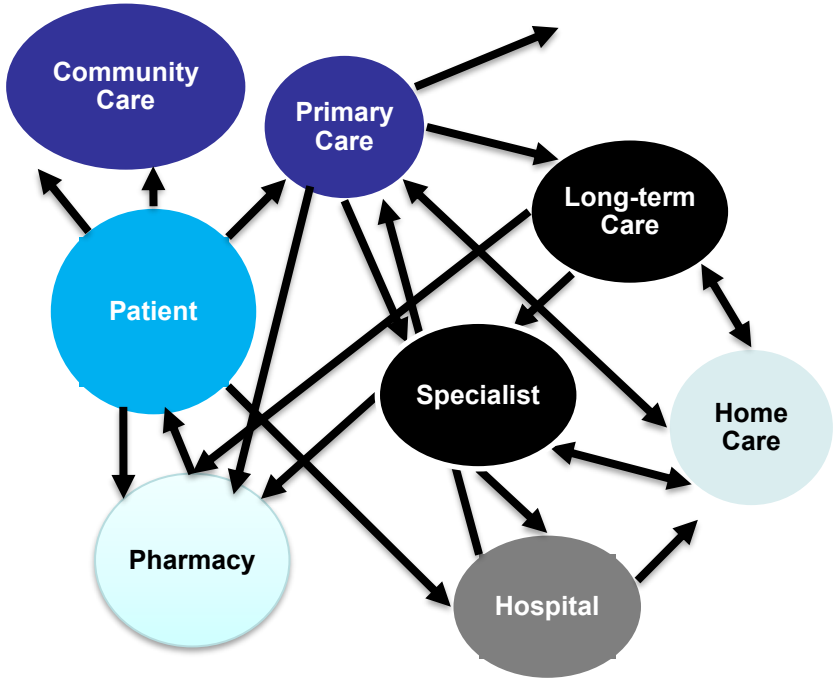
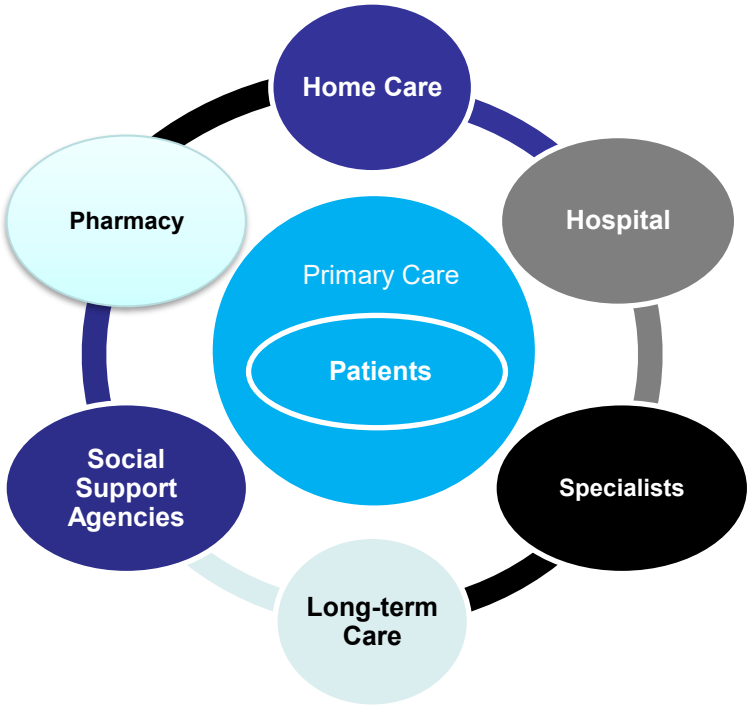


Whole Person Equitable Care



So, what next? How does this help your work?

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Create a – local and provincial – **high-performing primary-care sector**
(regardless of the practice or funding model and location)

Your Associated TPA Requirements

- Develop a community-based plan for chronic disease prevention and management (CDPM), as well as an ALC action plan
- Increase participation in cancer screening
- Expand access to online appointment bookings
- Facilitate adoption and report on progress with eReferral solutions
- Curate information about local services

Corresponding Measurement Requirements

- CDPM
  - Hospitalization rate for ACSC
  - Admissions for HF & COPD
- Cancer screening
  - % of eligible people up-to-date with breast, cervical & colorectal screening
- Additional provider and patient experiences

Recall: Personnel that **can** make up a Primary Care Team

Clinicians ask: “WIIFM?” (What’s in it for me?)

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Primary Care Clinicians that work as a team*:

- ✓ Reduce ER visits and hospitalizations
- ✓ Deliver proactive population-based care
- ✓ Provide timely access and increase capacity
- ✓ Share workload and streamline workflows
- ✓ Reduce burnout
- ✓ Improve patient trust
- ✓ Increase safety with less medical errors
- ✓ Go home on time more often
- ✓ Experience higher levels of joy at work
- ✓ Feel they are making more of a difference in patients lives
- ✓ Feel more valued by their colleagues

Teams are more than just the sum of their parts

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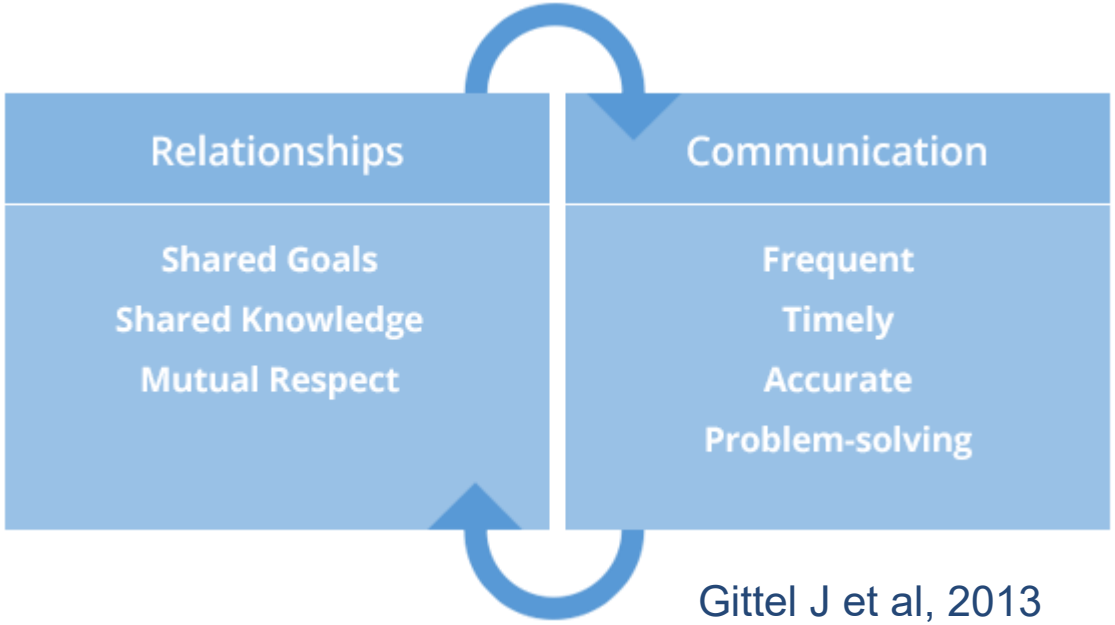
- Teams are more than just groups of individuals. Composed of people with complementary skills working collectively towards same goals
- Built on foundations of trust and mutual respect
- Effective primary care teams are relational and highly interdependent. Team members develop shared knowledge about each others roles & responsibilities
- Team members often role-blend, taking on tasks filled by people in different roles to gain efficiency & synergy
- Communication needs to be frequent, timely, accurate & problem solving. Communication channels must be created & used
- Effective communication facilitates effective relationships and vice versa. Known as “relational coordination’

Relational Coordination



Gittel J et al, 2013

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Leading & Managing for Teamwork

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- Teams built on relationships & effective communication don't 'just happen'. They are built & nurtured over time by leaders, managers & coaches
- Key structures assist with team development, including:
  - Shared protocols, directives & standard work templates
  - Shared meetings, huddles & opportunities to reflect, learn & plan
  - Shared information systems (EMRs)
- Leaders / managers can also facilitate effective teams by:
  - Selecting & training for teamwork
  - Developing shared accountabilities & performance metrics
  - Developing shared recognitions & rewards
  - Developing conflict resolution processes
  - Team-based job design & creating 'boundary spanning' roles
  - Creating QI initiatives with all team members contributing

Building High Performing Primary Care Teams: Essentials for Leaders & Managers

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- **Change the practice mindset**

  Independent Practitioners working alone → Team-based work with many professionals (MDs, RNs, MOAs, Mental Hlth etc)

- **Anchor on vision & core values** to deliver accessible, continuous, comprehensive & coordinated care for populat'n
  - Respect all members' contributions to patient care (clinical & non-clinical tasks)
  - Standard work expected of all team members based on role. Expectation to share tasks to get "today's work done today"
  - Share rewards in "work well done" but also look for ways to improve

- **Promote teamwork with key leadership practices**
  - Select, onboard & train people for team-work
  - Clarify team roles/tasks and ensure awareness across team members.
  - Provide psychological safety for all members to contribute
  - Frequent team huddles (at least daily), team meetings, & improvement cycles
  - Establish accountability metrics for teams (e.g., access, patient satisfaction)
  - Celebrate success & challenges
  - Create reliable ways to resolve conflicts

Building High Performing Primary Care Teams: Essentials for Leaders & Managers

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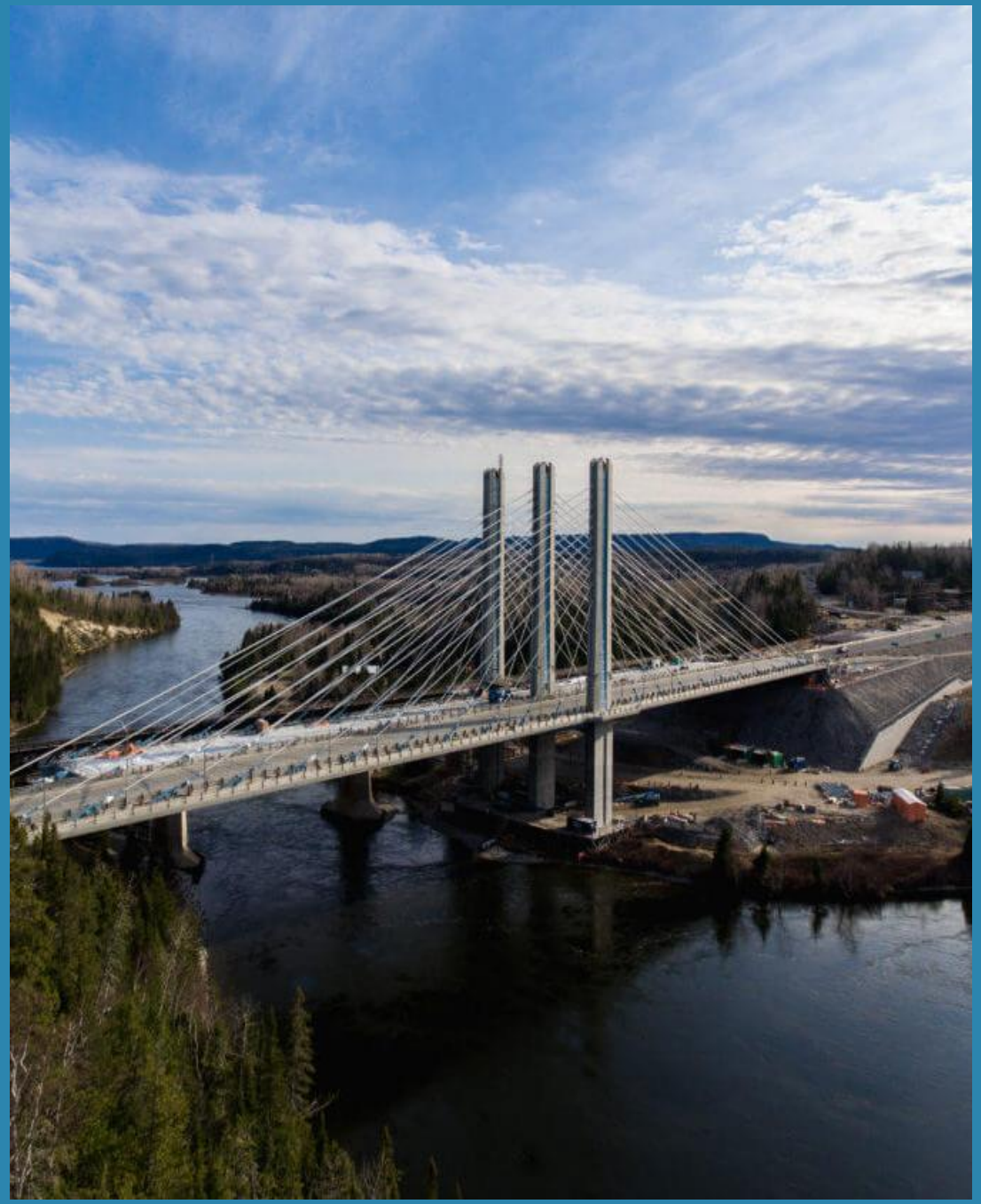


Nipigon District Primary Care Team

NDFHT
Nipigon District Family Health Team

Nipigon Doctors Group
Box 699, 123 Hogan Rd Nipigon, ON P0T2J0

Presented by:
Melissa Harvey, BSc, MSc(PT), PT
Executive Director
Nipigon District Family Health Team

Nipigon Doctors Group

- Funded under the Rural and Northern Physicians Group Agreement (RNPGA) from Ministry of Health
- Nipigon is funded for 5.5 Full-Time Equivalent (FTE) physicians
- Currently all positions are filled by 6 physicians
- Support staff includes a clinic manager and 3 receptionists
- Under the RNPGA, physicians cover primary care clinic, emergency department, long-term care home, and patients in hospital

Nipigon District Family Health Team

- Funded through Ontario Health
- Currently funded positions:
  - 2 Full-Time Registered Nurses (RN)
  - 1 Part-Time Registered Practical Nurse (RPN)
  - 1 Full-Time Registered Psychotherapist (RP)
  - 1 Full-Time Registered Dietitian
  - 1 Full-Time Mental Health Support Worker
  - 1 Full-Time Addictions Program Care Coordinator
  - 1 Full-time Receptionist
  - 1 Full-time QIDSS (shared among 5 FHTs)
  - 1 Full-time Executive Director
- No vacancies

Bringing Two Organizations Together

- **Relationship building** is the cornerstone
- Regular meetings with **set dates** well in advance
- Action items with **accountability** built into meeting minutes/agendas
- Shared **education** sessions
- Offsite events for **teambuilding**

Communication Strategies for Shared Care

- Ensure **reliable** IT infrastructure
- **One EMR** for all
- FHT staff and physician staff **message** within the EMR
- **VPN** access for continuity of care and community outreach
- **Co-location** allows for in-person, informal discussions

Co-Designing Programs

- Use **evidence-based** guidelines to build the foundation of the program
- Create program **specific procedure** documents to clearly outline who is involved in the program, **key roles** outlined and program **goals**
- FHT programs are aimed to utilize FHT staff to the **full scope** of practice
- Staff receive necessary **training** either from outside sources or from one another
- Associated **medical directives** are tied to the program procedures
- Created and reviewed by **both** FHT and NDG staff
- Edits made based on **feedback** – both positive and constructive

Optimizing the Nipigon Primary Care Team to Work at Full Scope

Medical Directives and FHT Programs

- Medical Directives:
  - Important to stick to annual reviews
  - Co-design with PCPs and IHPs
  - Embed into FHT program procedures
  - Lab and referral templates co-created
- HTN Program Example:
  - Based off evidence-based guidelines
  - Reviewed by both PCPs and IHPs
  - Annual review and training opportunities
  - New communication strategy for medication changes

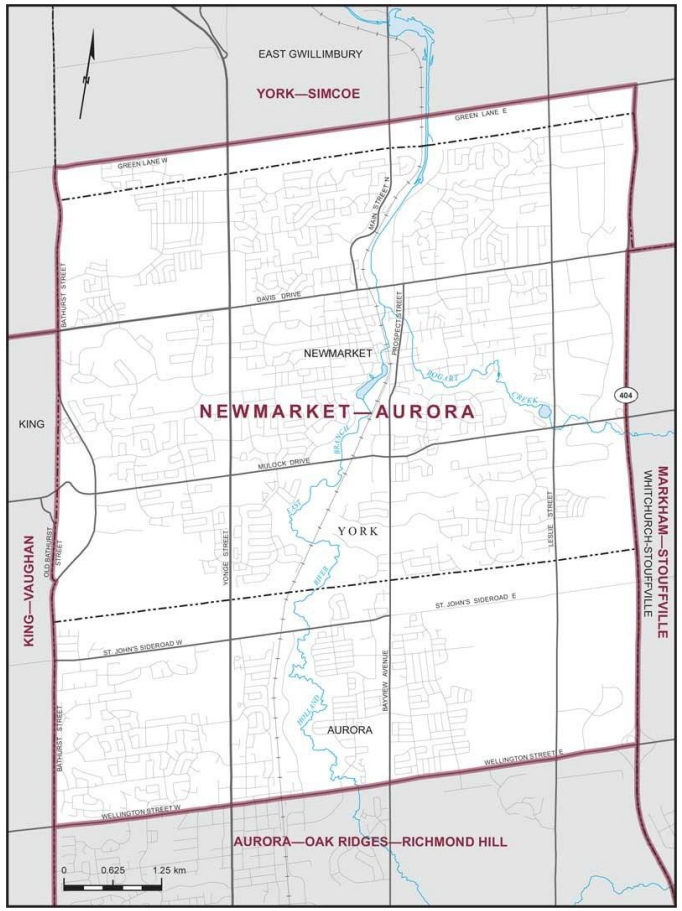
Building Capacity Through Professional Development

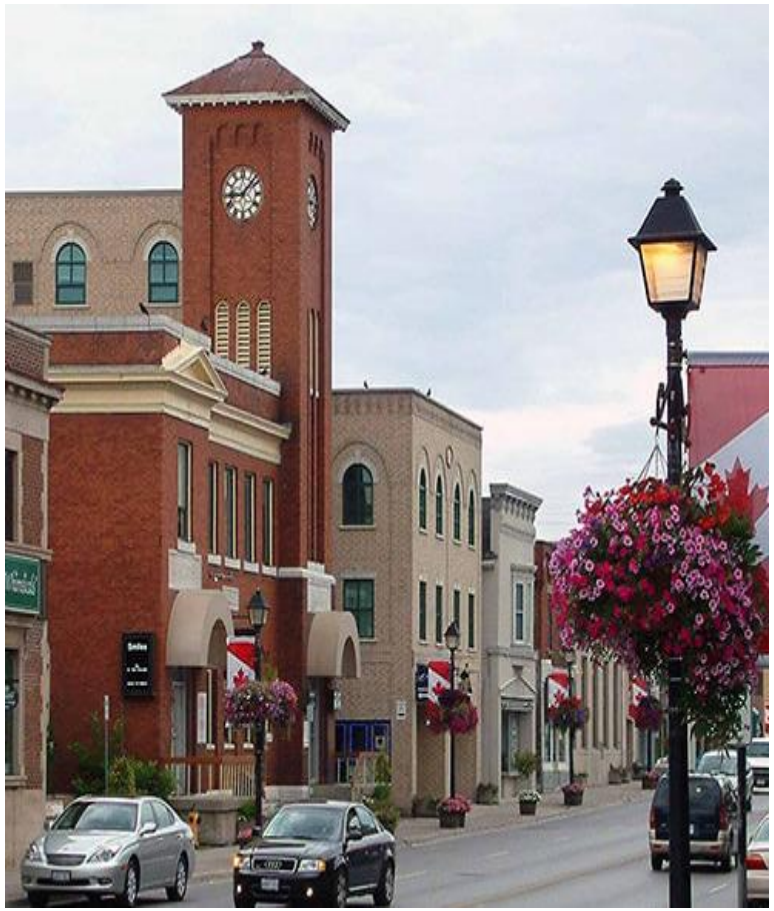
- Professional development
  - Geared towards staff interests/passions
  - Aids in retention of IHP staff
  - Working towards cross-training for key FHT services (example: DM footcare)
- Cross-training benefits:
  - Less staff professional isolation
  - Better distribution of workload
  - Able to continue a service when a staff is on leave

Thank you for this opportunity to share our learning experiences.
We are continuously learning, evolving, and building
on what we've achieved.

The Nipigon District Family Health Team and the Nipigon Doctors Group

Aurora-Newmarket
Family Health Team





Presented by:

Mary-Jane Rodgers, Executive Director

Aurora-Newmarket Family Health Team

AURORA-NEWMARKET FAMILY HEALTH TEAM

Established – October 2008 – with 3 Physicians

Current Family Health Organization

- 5 Physicians currently
- 7900+ Patients
- 1 Physician manages LTC
- Responsible for 58% of all operating costs
- Responsible for 4 administrative supports

Current Family Health Team

- 1 Nurse Practitioner, 1 Social Worker,
  1 Occupational Therapist, 2 Registered Nurses,
  .5 Dietitian
- Responsible for 42% of all operating costs
- Responsible for 2.5 administrative supports

19 Programs, 13 services

Primary Care (Physicians, NP, RN)

Mental Health (Physicians, NP, Social Worker)

Occupational Health (Physicians, Occupational Therapist)

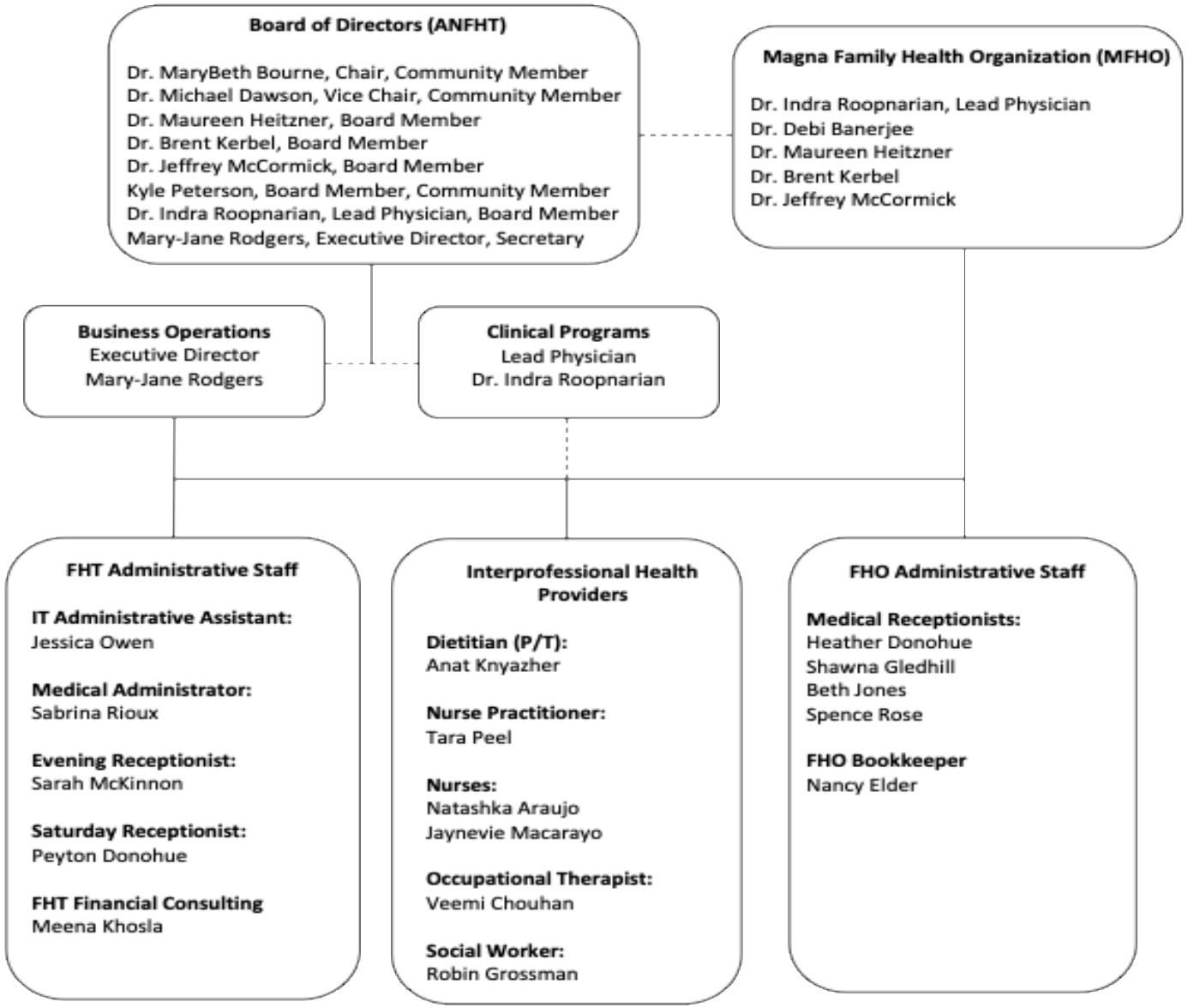
Nutritional, Lifestyle (Physicians, Dietitian)

Home and Community Care, Public Health (Team)

Administration, Management (Team)

Aurora-Newmarket Family Health Team (ANFHT)

Up to date as of November 13, 2025



ANFHT – SCHEDULE A – PROGRAMS & SERVICES

19 Programs:

Caring for the Caregiver - *Updated*
Diabetic Program
Cognitive Behavioural Therapy - *New*
Falls Prevention
Cardiovascular Program
Smoking Cessation Program
Advance Care Planning Program
Prenatal/Post Partum Education Program - *Updated*
Respiratory Health
Concussion Program
Sexual Health Clinic
Eating the Mediterranean Way - *Updated (Community)*
Diabetes Conversations
Aging in Place/Strong and Steady - *Updated*
Adult ADHD Assessment and Management Program
Adult ADHD Workshop – *New*
Thrive and Bloom Therapeutic Eco-Art Group– *New (Community)*
Allergist – *New (Community)*
Menopause Clinic – *(YRDSB, Southlake Cardiac Rehab Collaborations (Community)*

13 Services:

Allergy Desensitization Service
Immunization Clinic - *Updated*
Screening for Risk - Breast Cancer
Screening for Risk - Cervical Cancer
Screening for Risk - Colorectal Cancer
Home Visits
IUD or Implant Insertion/Removal
Mental Health Service - Social Worker
Single Session Counselling Clinic - *New*
Occupational Therapy - Occupational Therapist
Dietitian Counselling
Nurse Practitioner
Registered Nurses

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ANFHT QUALITY SCORECARD

Aurora-Newmarket Family Health Team — **Scorecard**
As of 14 January 2025

Legend	
Within 10% of our goal	🟢
Within 20% of our goal	🟡
Less than 20% of our goal	🔴

Measure	Month	YTD	Goal 24/25	Goal 23/24	Indicator	Definition
Colorectal Cancer Screening - Internal **Colorectal Cancer Screening - SAR**	69.5% 81.6%	70.5% 83.3%	85%	80%	🟢	Percent of patients aged 50 to 74 who have had a FIT within the past 2 years, sigmoidoscopy within 5 years, or a colonoscopy within the past 10 years
Cervical Cancer Screening - Internal **Cervical Cancer Screening - SAR**	59.4% 71.6%	61.9% 71.6%	80%	80%	🟢	Percent of patients aged 21 to 69 with a cervix (who have not had a hysterectomy) who have had a Pap Smear in the past 3 years
Breast Cancer Screening - Internal **Breast Cancer Screening - SAR**	69.1% 73.6%	68% 73.2%	75%	80%	🟢	Percent of eligible women, Two-spirit, trans and nonbinary people ages 50-74 that had a mammogram within the last 2 years
Flu Shots	32	389	350	350	🟢	Patients 65+ who are up to date with the seasonal (October-April) flu vaccine
COVID Vaccines (3 doses)	49.3%	49.3%	50%		🟢	Percent of patients over the age of 18 who have had 3 or more COVID vaccines
Immunizations (18-29 months)	65.6%	68.8%	80%	75%	🟡	Percent of patients 18 to 29 months who are up to date with their immunizations per month
Immunizations (30-42 months)	78.4%	74.9%	80%	75%	🟢	Percent of patients 30 to 42 months who are up to date with their immunizations per month
Allergy Shots	25	271	100	30	🟢	Number of patients with IgE Mediated allergies coming to our office for allergy injection
HTN Management (Virtual/In Office)	67%	65.6%	75%	67%	🟢	Percent of patients who reach their individually set Blood Pressure Target
Third Next Available (Virtual/In Office)	10.5	9.4	3	3	🔴	Average length of time between the day a patient makes a request for an appointment with a physician and the third next available appointment for a non-urgent initial or follow-up appointment. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability
In-Person vs. Virtual Appointments - Doctors	80.9%	76.6%	85%	N/A	🟢	Percent of physician appointments completed in-person
In-Person vs. Virtual Appointments - IHPs	57%	55.2%	80%	N/A	🔴	Percent of IHP appointments completed in-person
Readmission Rates (PCPR) *Note: Last updated March 2024*	6.7%	6.9%	5%	5%	🟢	Percent of inpatients discharged with selected Case Mixed Group (CMG's) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge. (Calc.: total rostered patient with readmission x 100/total number rostered patients)
Post-Discharge Follow-Up (PCPR) *Note: Last updated March 2024*	61.1%	61.2%	70%	70%	🟢	Percent of patients who see their Primary Care provider within 7 days of discharge from hospital (admitted, surgery and ER)
Post-Discharge Follow-Up (Internal)	40.0%	50.3%	70%	70%	🟡	Post hospital appointments within 7 days of discharge, with health care providers at ANFHT.
ED Use (PCPR) *Note: Last updated March 2024*	28.8%	29.3%	10%	10%	🟡	Percent of patients who visited the Emergency Department for conditions Best Managed Elsewhere (BME)
Diabetic Management	67.0%	68%	70%	70%	🟢	Percent of patients within our Diabetic Program with 'At Target' HbA1c levels
Falls Screening	0	68	200	150	🔴	Number of patients over the age of 50 who receive a falls screen by our Occupational Therapist

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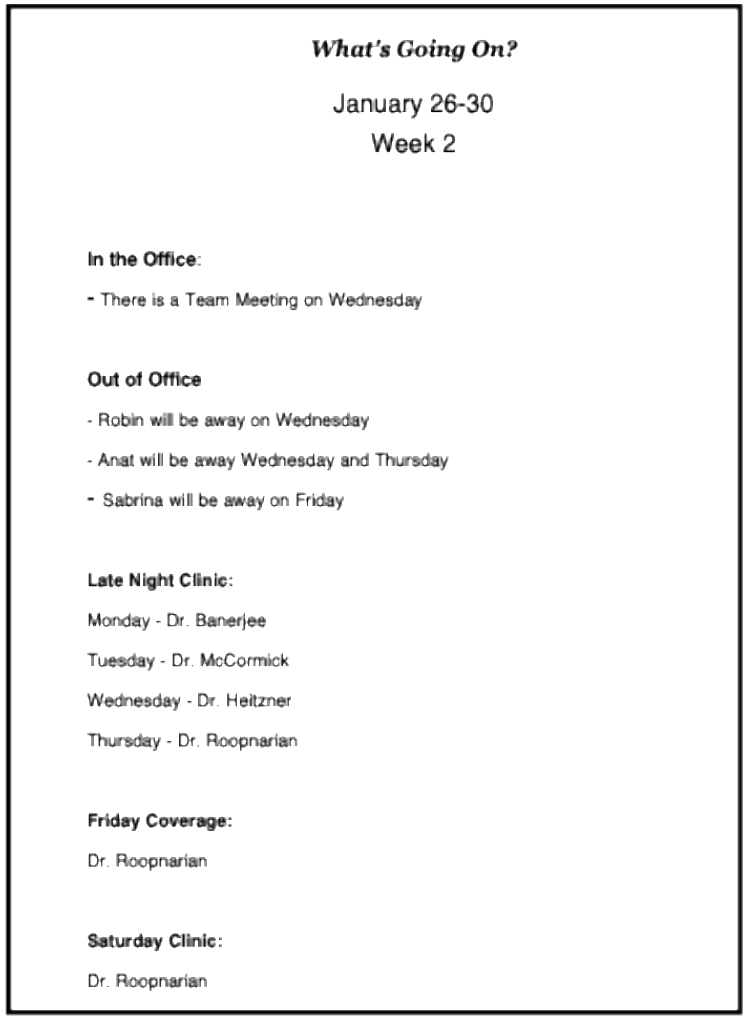
COMMUNICATION IS THE KEY TO OUR SUCCESS

Daily Huddle – 8:30

Weekly Meeting FHO/FHT Leads

Bi-Monthly QHPSC Meetings

Email Updates



What's Going On?

January 26-30
Week 2

In the Office:

- There is a Team Meeting on Wednesday

Out of Office

- Robin will be away on Wednesday
- Anat will be away Wednesday and Thursday
- Sabrina will be away on Friday

Late Night Clinic:

Monday - Dr. Banerjee

Tuesday - Dr. McCormick

Wednesday - Dr. Heitzner

Thursday - Dr. Roopnarian

Friday Coverage:

Dr. Roopnarian

Saturday Clinic:

Dr. Roopnarian

Board Meetings

Bi-Monthly Clinical

Meetings

Monthly Team Meetings

Monthly Check ins – for All

ANFHT – INTEGRATION ACROSS THE TEAM

- Informal and formal consultation between all providers
- Shared administrative support
- Coverage and coordination to support continuity of care
- Clear roles across clinical and administrative levels
- Leveraging the support of IHP's and FHT Resources Internally
  - IT/EMR support both internally and through external supports

ANFHT – TEAM-BASED CARE

Patient Centered – what the patient wants – in-person vs. virtual
- Inclusive approach to decision-making
- Focus on shared priorities and patient needs

Advance Access, timely care

Right Care at the Right Time

Collaboration – in-house and community

Health Promotion, Preventative Care, Chronic Disease Management

OHT Support, AFHTO, Networks

Continuous feedback

ANFHT – BUILDING TRUST & TEAM CULTURE

- Trust developed over time, not instantly
- Learning and respecting each other's roles
- Safety to ask questions and give input – always
- Shared recognition of contributions – this is key!

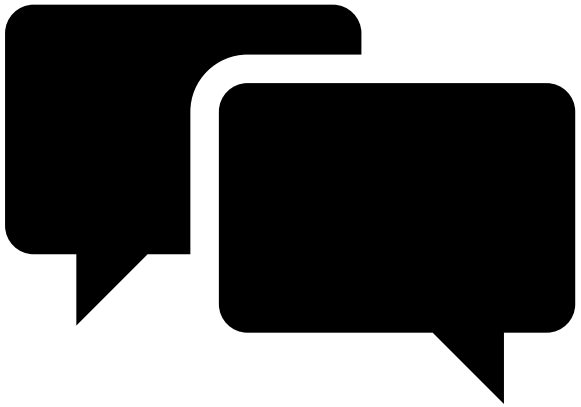
ANFHT – TAKE AWAYS

What Makes Our Team Work

- Structure, stability and trust
- Involvement, collaboration
- Strong communication systems
- Trust and mutual respect as core values
- Kindness – my favourite word

What questions do you have? What else would you like to know?

Please raise your hand and come off mute/place your comments in the chat box



Reminder: Questions you start thinking about and things you can start testing?

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1. **What do the current compositions of PC teams look like in your OHT** (including complements of other staff outside of MD/NP)**?**
   - How are these different compositions spread across OHT?
   - ***Tip:*** OH regions may have some data to help you understand this
2. **How are you thinking about developing teams** (e.g., do you have team building events? What are your information systems? Communication mechanisms?)**?**
3. **What is your model** (e.g., single clinician and MOA [more traditional model] or 5 clinicians and MOA which can manage larger numbers of patients)?
4. **How are you thinking about best leveraging existing skillsets on the team? New roles and responsibilities of clinicians; especially RN and MOAs?**
5. **How will existing information systems be optimized to enhance the "team's" work?**
6. **What specific strategies to enhance team function could you use?** e.g., daily huddles, dedicated phone triage times during the day, population monitoring to deliver care proactively, sharing resources across teams, especially for small group or solo practice.

We are currently offering three types of RISE supports for OHTs/PCNs

RISE
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RISE peer sharing and learning sessions

Monthly sessions which provide evidence-based core concepts and principles on PC-related topics connected to OHT/PCN deliverables and building a high-performing PC sector

Coaching

Customized 1:1 or group supports based on OHT/PCN need

Deeper dives

Between peer sharing and learning sessions, ‘deeper dives' into PC concepts (e.g., zooming into the ‘how-to', collaborative problem solving with peers at similar stages)

Audience / participants

Those from OHTs/PCNs who are leading PC work and those participating in OHT/PCN PC working groups

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March 19, 2025 (12-1:30pm)

Next RISE OHT peer sharing & learning session with a continued focus on optimizing team-based primary care

Please reach out to leslie.mcgeoch@outlook.com , if you do not see the invite in your calendar

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Merci
Thank you