RISE
Rapid-Improvement Support and Exchange

Team-based Primary Care: models of sharing resources in primary care

19 March 2026

https://youtu.be/y94onA-LfJo

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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

Objectives for Today

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- ✓ Learn approaches and strategies **for building a team regardless of patient enrollment/funding model** (e.g., solo practitioners etc.)
- ✓ Understand models of shared **resources to support small group and solo practices**
- ✓ 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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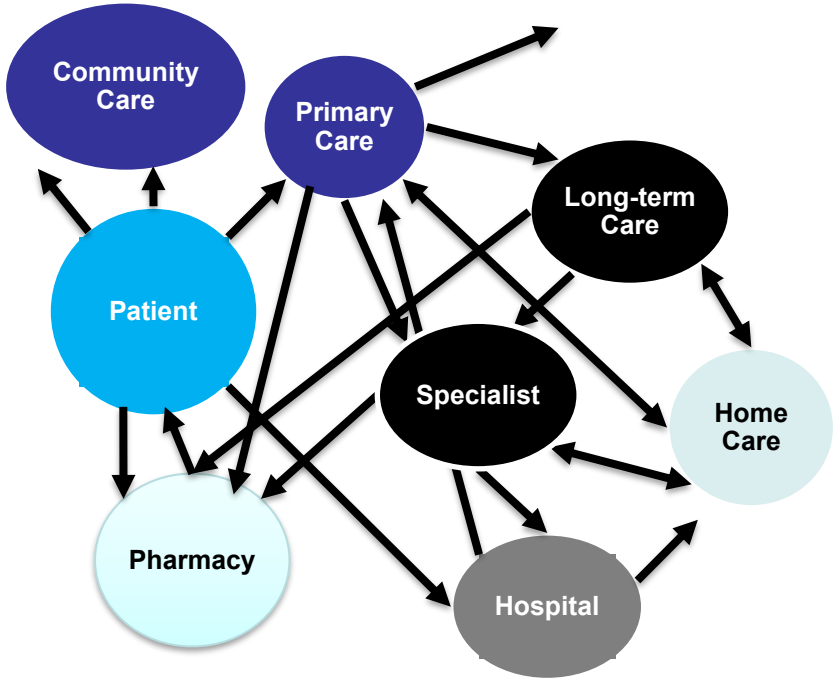
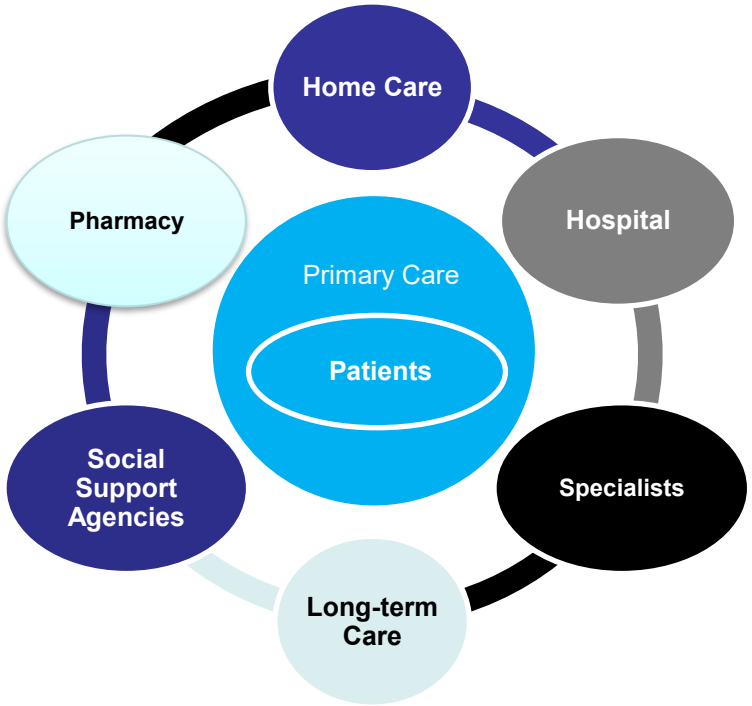


Whole Person Equitable Care



High-Performing Primary Care: Principles & Drivers

Principles
What are we trying to accomplish?

High-Performing Primary Care that is:

- continuous
- collaborative
- accessible
- comprehensive & coordinated
- equitable & culturally safe
- connected digitally
- accountable
- learning & improving

Drivers
Key contributor to principles

Interprofessional Team-based care	Relational continuity
Timely Access to Care	Population Health Management Approach
Patient partnership and community engagement (BB3)	Digital health & data analytics (BB5)
Leadership, accountability & governance (BB6)	Performance measurement, QI & continuous learning (BB8)

Poll: What primary care topics would you like to learn more about? Please select your top three.

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- ❑ Interprofessional Team-based care
- ❑ Relational continuity

- ❑ Timely Access to Care
- ❑ Population Health Management Approach (including chronic disease prevention & management)

- ❑ Digital health & data analytics
- ❑ Performance measurement, QI & continuous learning
- ❑ Patient partnership and community engagement
- ❑ Leadership, accountability & governance

- ❑ Equity considerations in building high performing primary care
- ❑ Overview of all of the above (building high performing PC models and examples)
- ❑ Other (please specify in the chat box)

Creating Effective Teams in Primary Care

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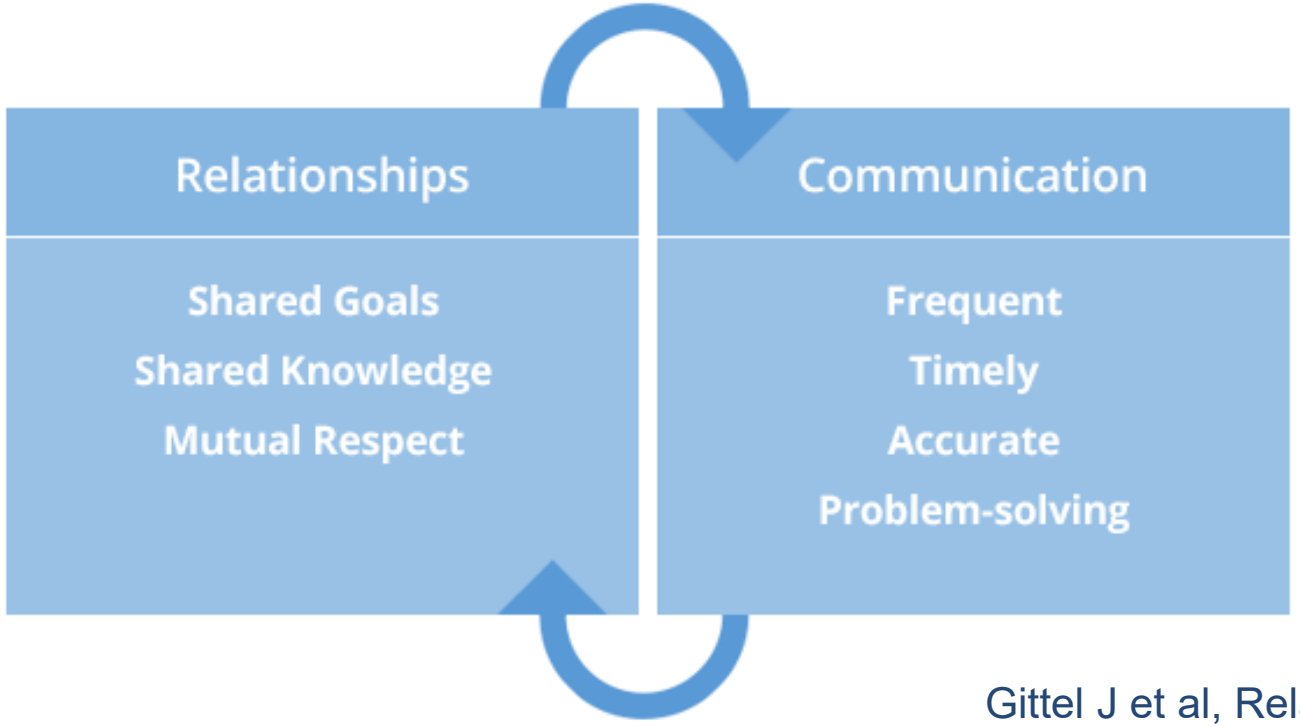
- Contemporary primary care is a “team sport” with MDs, nurses, MOAs, SWs, MH professionals, etc
- Highly interdependent work - members rely on each other for many clinical & non-clinical tasks.
- The most effective teams do this by building relationships and communication channels.



Gittel J et al, Relational Coordination 2013

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Configuring Primary Care Teams

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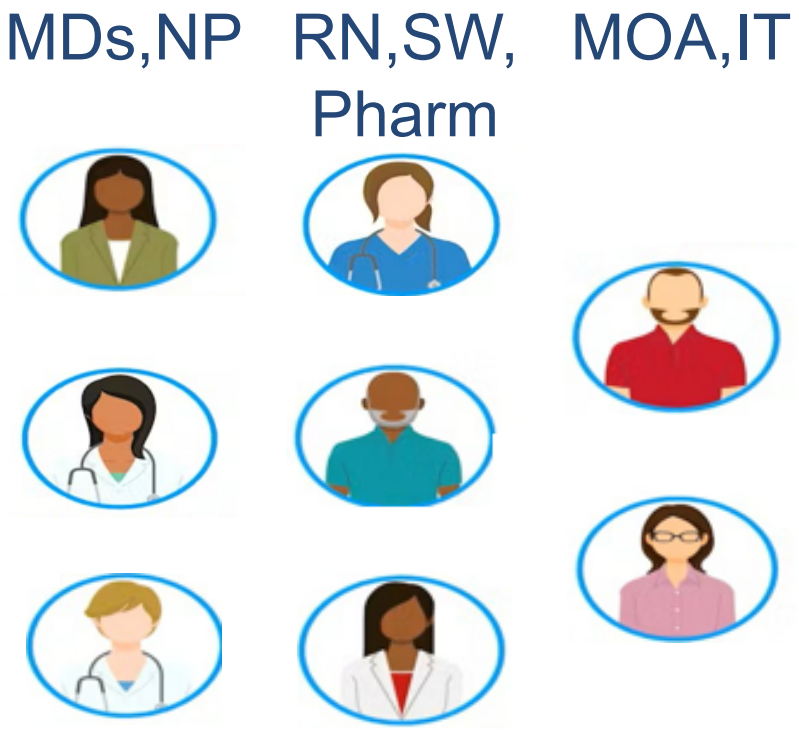
Teams can be configured with different memberships shared across different practices

Example of a Primary Care Team



Configuring Primary Care Teams

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One Organization
(e.g., CHC)

Configuring Primary Care Teams

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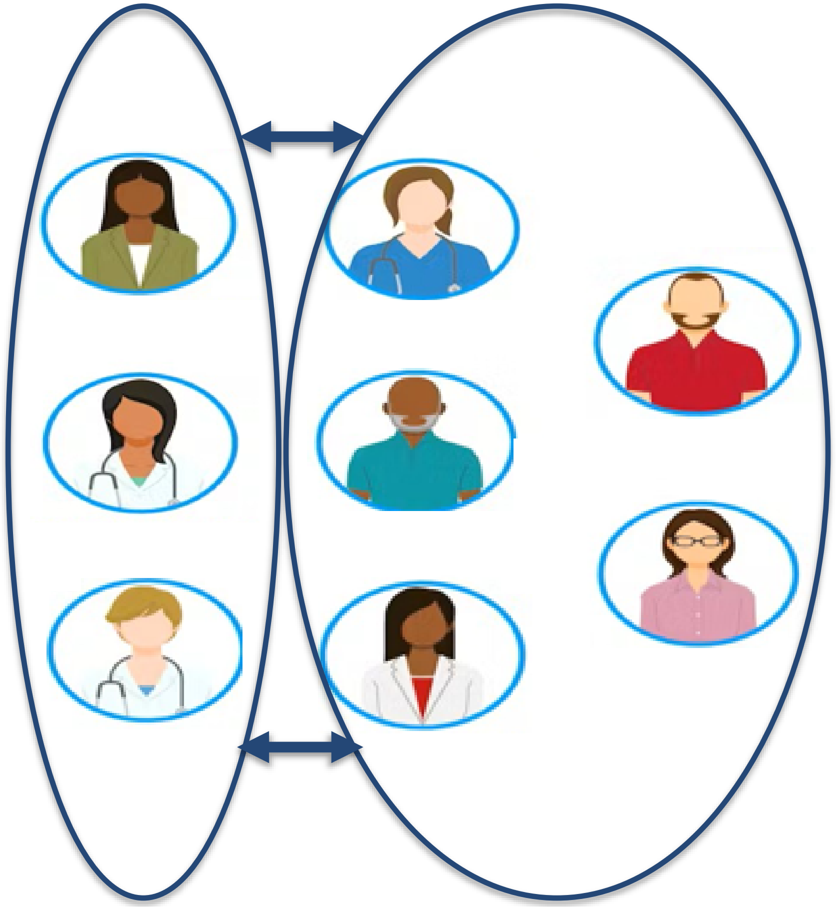
Two Affiliated Organizations



Configuring Primary Care Teams

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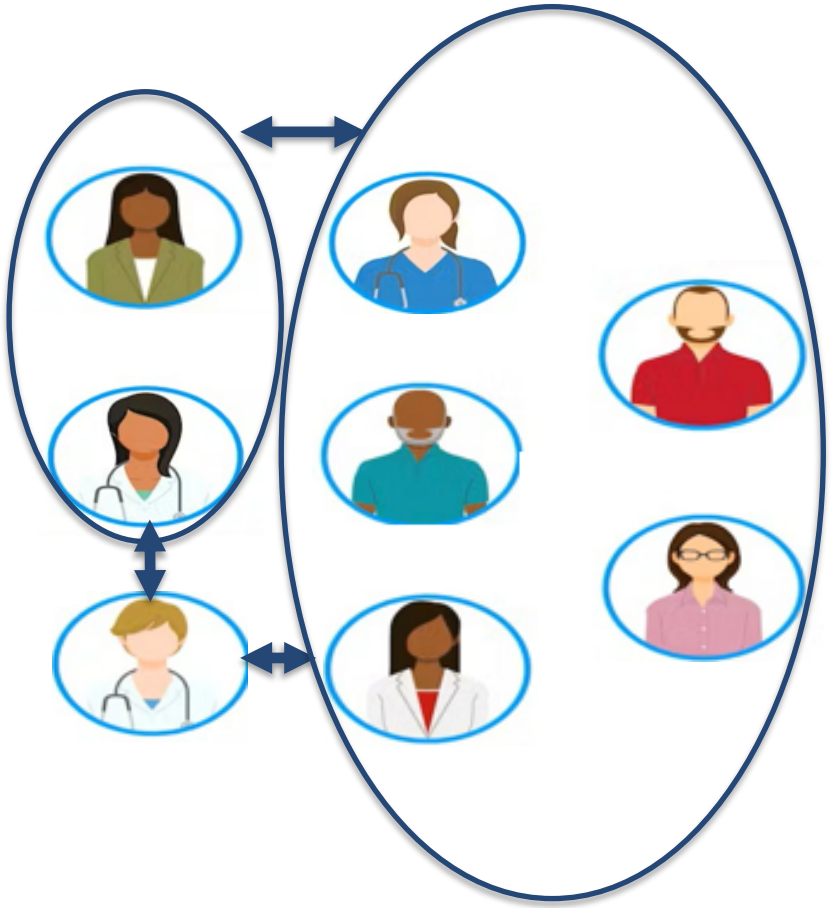
Multiple Organizations & Solo Practitioners



Building Effective Teams that Cross Organizations

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- Importance of ground rules across organizations & participating practices
  - Common vision, goals, & governance structures
  - Service agreements, standards, & accountabilities
  - Defined roles & responsibilities for team members who work across practices
- Shared structures for “teamness”
  - Shared Protocols, directives & standard work templates
  - Information systems (including EMRs if possible)
  - Shared meetings & huddles
  - Performance metrics
  - Conflict resolution processes
  - Team building events

CarePoint Health

A unique approach to integrated team-based care in Mississauga

Andrew Bilton, Executive Director

Dr. Sundeep Banwatt, Clinical Director & Family Physician

CarePoint Health

Focus for today…

- An overview of CarePoint Health including the local context driving our approach, our key areas of focus and detail how we are supporting primary care and the needs of our community.

- Share our approach and experience with a targeted focus on extending access to team-based programs and services to community physicians. This includes:
  - Engaging local community physicians
  - Affiliating physicians to the team including expectations and roles
  - Lessons learned
  - Our maturity journey and where we want to go

Mississauga Primary Care Landscape

Mississauga

Highly urbanized

6th Largest city

Population: 771,891

Attributed Population: >900k

Highly Diverse

60%+ residents identify as a visible minority

Limited access to team-based care

Prior to CPH: ~8% PCPs have access to team-based programs and services

Current: ~25% have access

700+ family physician practitioners

Numerous family physician funding models and practice sizes

~88% Attachment Rate

Numerous walk-in clinics providing access

CAREPOINT HEALTH

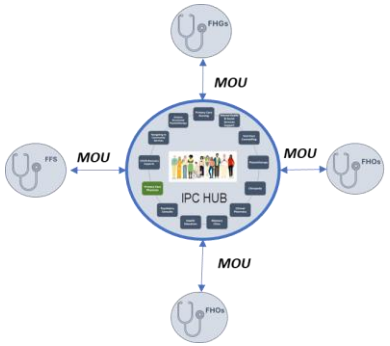
- CPH is an Ontario Health funded not-for-profit health service provider organization. Two main streams:
  1. Integrated Primary Care Centre (funded through MSAA as a CHC) – Our focus today
  2. Network Lead Organization for Ontario Structured Psychotherapy Program for Brampton, Halton and Mississauga region
- CPH deploys a practical and scalable approach to connecting community primary care providers to teams and supporting community needs that demonstrates how it's possible to overcome the barriers of multiple physician funding models and significant numbers of solo practitioners.
- This patient medical **neighborhood** model connects resources across a large urban area like Mississauga
- CPH has affiliated with over 130 primary care physicians in Mississauga and provides a wide range of services, including mental health and social services navigation support, nursing, social, pharmacy, physiotherapy, and nutrition counseling. CPH currently operates out of two main hub locations.

OUR IHP PROGRAMS & SERVICES

- Preventative Care (vaccines, well-baby, cancer screening)
- Women's Health
- Chronic Disease Management (COPD, CHF, Diabetes)
- Mental Health Counselling & Structured Psychotherapy
- Social Service Supports
- Physiotherapy
- Foot Care
- Primary Care Pharmacist Services
- Smoking Cessation
- Memory Clinic
- Health Education
- Psychiatry Consults
- Nutrition Counselling
- Home visits
- Nursing procedures
- Episodic care
- Breastfeeding support
- Mississauga Attachment Program

CAREPOINT HEALTH: KEY FEATURES OF OUR APPROACH

1

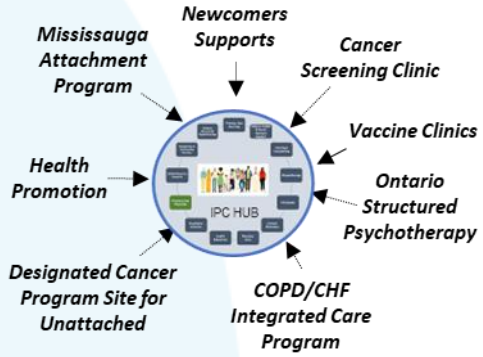


Through an affiliation MOU, extend access to a coordinated, comprehensive team of health care professionals, regardless of the physician's funding model or practice size

2

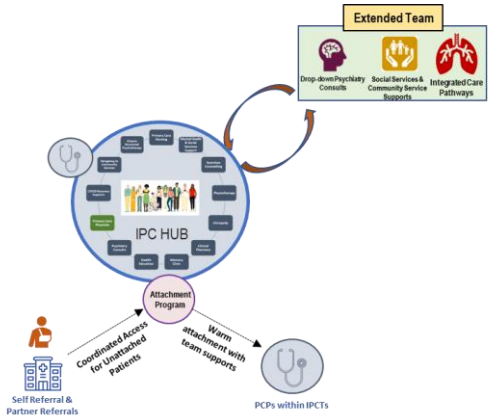
Build local networks anchored through connection to a team supported by practice facilitation and engagement for planning, education, community of practice, and optimizing digital tools

3



Provide community-focused programs and services targeting population health priorities and support better access to health care resources

4



Provide service navigation and integrated programs and pathways

PHYSCIAN AFFILIATION: WHAT'S THE DEAL?

- ❑ Affiliation relationship is defined by parties' willingness to engage and participate in a **shared care** model for patients.
- ❑ The physician and CarePoint Health enter into an **affiliation agreement**, which outlines our desired relationship and our roles and responsibilities as team members.

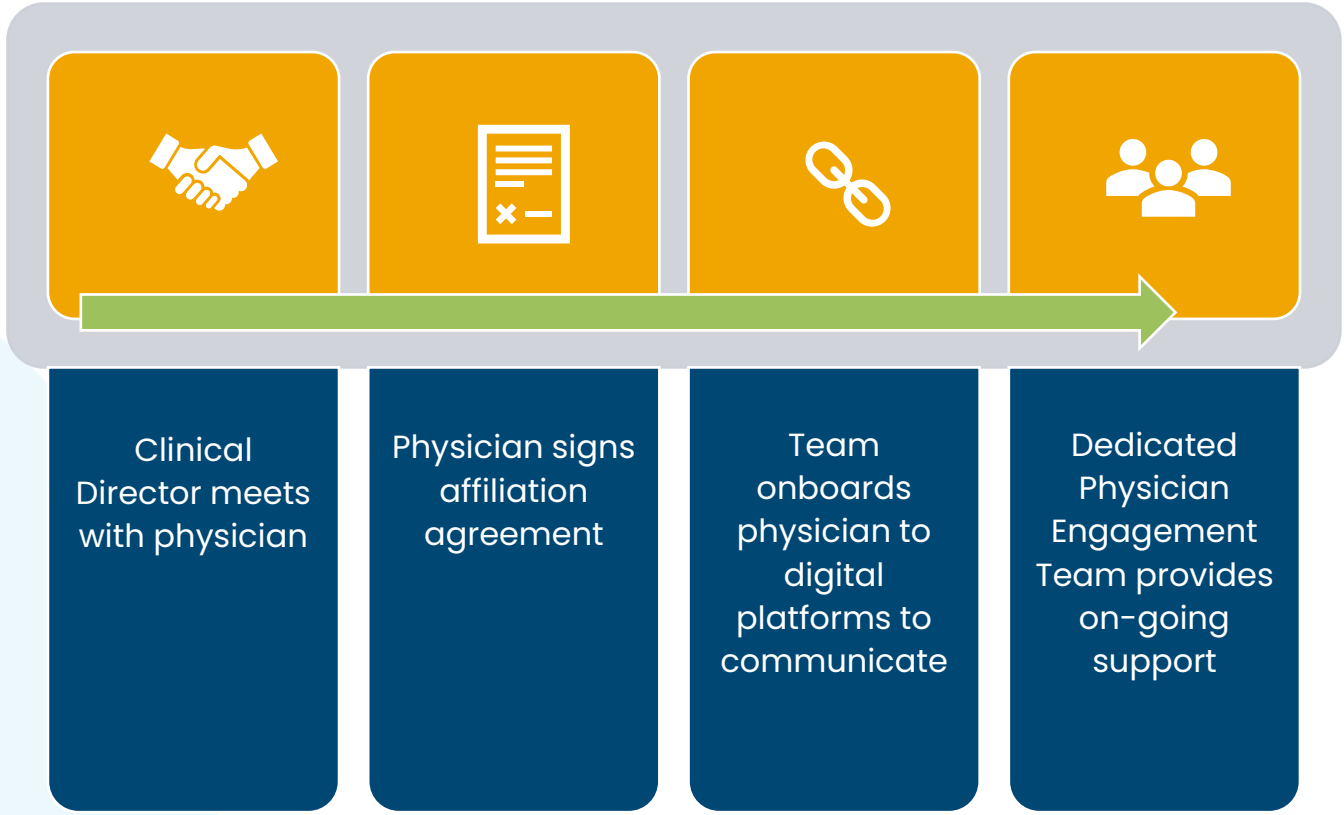
Physician agrees to:

- Collaborate respectfully within the team-based care model
- Actively refer appropriate patients to CarePoint Health programs
- Participate in initiatives (e.g., Patient Attachment Program, surveys, events)
- Submit patient attachment data
- Remain the most responsible provider for your patients
- Use required digital tools to connect patients and receive reports back (OCEAN, HRM) and adopt digital tools where possible
- Communicate/respond to CarePoint staff in a timely manner; Consult on challenging cases as needed
- Comply with applicable Medical Directives for certain services
- Participate in on-site meetings with Clinical Director/Engagement Staff
- Authorize contact for updates, communications, and feedback

CarePoint Health agrees to:

- Provide access to clinical programs and services to support patients
- Provide written reports to physician after we see their patients
- Provide consultation support with CPH staff on challenging cases physicians are facing
- Provide service navigation supports
- Provide practice supports including help removing barriers to team-based care (EMR/Ocean support, patient connections)
- Support implementing digital tools (e.g., EMR, Ocean)Access to resources (SCOPE, PsychChat, OTN, Primary Care Network)
- Provide learning and training opportunities
- Facilitate networking events with affiliated physicians and community partners

CAREPOINT HEALTH AFFILIATION APPROACH



AFFILIATION: ENGAGING COMMUNITY PHSYCIANS

Top reasons for <u>interest</u> included:

Top reasons for <u>hesitation</u> included:

GETTING PHYSICIAN BUY-IN: LESSONS LEARNED

- Sustained engagement requires dedicated time and resources – this is not a project
- Physician to physician engagement was critical
- Language matters (connections vs referrals)
- Keep the message simple!
- Keep the requirements for participating minimal (i.e. don't ask too much in return)
- Show value first and then build off that
- Building trust takes time - meeting the team had a big impact
- Communication is hard – multiple communications channels help
- Not all physicians are ready or want to participate – and that's OK. Start with the early adopters.

PHYSICIAN ENGAGEMENT SUPPORT

Engagement Specialists serve as dedicated partners, ensuring physicians can focus on what matters most – patient care.

Direct practice engagement support

- Direct relationship for two-way communication
- One-on-one support for supporting digital adoption
- Regular onsite visits to address needs and feedback
- Integration of technology with existing workflows

Professional development

- Organized continuing Medical Education (CME) events
- Resource sharing
- Networking opportunities with peers

Strategic leadership

- Physician Advisory Council participation opportunities
- Input into program development and services
- Regular updates on regional healthcare initiatives

PHYSICIAN FEEDBACK

I was completely burned out.

And so, being able to share that burden, I never want to see that a patient doesn't get what they need because I am overworked.

To be able to give them that thing [that] they need, I feel less burdened, and I think that the patients feel that they have a higher level of care, too.

Affiliated Physician

91% Reported that their patients' needs were met

95% Satisfied with communication with the CarePoint Health team

91% Stated that affiliation with CarePoint Health improved their work

Affiliated PCPs made over 8000 patient connections to our IHP programs and services in 2024-25

A MATURITY JOURNEY

CURRENT CHALLENGES:

- ❑ Managing expectations – prioritizing expanding ACCESS to team-based services across Mississauga (still >550 PCPs not able to connect to interdisciplinary programs and services)
- ❑ Different EMRs requires additional tools and data challenges
- ❑ Existing physical infrastructure creates some geography constraints for patients
- ❑ Every team member is different – no one size fits all (we can't be everything to everybody)
- ❑ Team-work and culture is hard work and requires a relentless focus to develop and sustain. Decentralized model requires even more work
- ❑ HHR – like everyone else!

WHERE WE WANT TO GO NEXT:

- ❑ Develop more localized physical infrastructure to support better geographical access for patients
- ❑ Enhanced practice supports (e.g., panel management) and realistic and practical strategic clinical resource deployment opportunities for highly engaged affiliated practices
- ❑ Centralized infrastructure role for primary care in Mississauga
- ❑ Better tools to share health information and data

IS THIS APPROACH FOR YOU?

Overcomes barriers to accessing team-based services
between different physician funding models

Bridges isolation and burnout
of solo practitioners

Connects individual practices
into care networks and communities of practice

Tackles growing crisis
of unattached patients and aging populations

Eliminates service fragmentation
by establishing a single point of contact for ICPs and social service supports

Addresses healthcare inequity
by supporting underserved populations

Fills crucial infrastructure gaps
for rapid community response led by primary care

Resolves the disconnect
between healthcare planning and community needs

Not every region has the same challenges

This is a scalable and cost-effective approach to providing local neighborhood-based interdisciplinary primary care, particularly in urban areas with large numbers of disconnected PCPs in solo or small practice models and limited IPCT capacity

Activity

20 minutes

1. **Please stay in the Zoom meeting**
2. **There will be three options for participating in the discussion**
   - **Option 1:** Click on the link to Mural board provided in the chat box and post on the board (you do not need a Mural account to access)
   - Option 2: Unmute your mic (a RISE rep will add your comments to the board)
   - Option 3: Leverage the Zoom chat box (a RISE rep will add your comments to the board)
3. **RISE will share the Miro board on-screen and provide a demo of Miro**
4. **RISE coaches will provide an overview of the activity**

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.

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Thank you