RISE
Rapid-Improvement Support and Exchange

Team-based Primary Care: Role Definitions and Working to Scope of Practice

15 January 2026

https://youtu.be/ed7k4_PnM5k

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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)

NEW resources!

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Primary Care Resources

- Peer Profile on Primary Care Networks (PCNs): This brief profiles five I-12 OHTs and their learnings establishing a PCN.

- Primary-care access and attachment (PC-AA): This brief profiles seven OHTs and their learnings improving PC-AA

Additional Resources

- Integrated clinical pathways: This brief profiles four I-12 OHTs and their learnings implementing ICPs.

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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Team-based Care: Role definition and working to scope of practice	Gain an initial understanding of primary drivers for building primary care teams.	**12:05-12:15**
What's a team and who does what?	Learn about examples of efficient team-based care, scope of practice and building trust in teams	**12:15-12:40**
Discussion	Participants to exchange learnings on how they are approaching this work	**12:40 – 1:25**

Objectives for Today

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- ✓ Gain an initial understanding of primary drivers for building primary care teams.
- ✓ Learn about examples of efficient team-based care, roles on the team, working to scope of practice and building trust among team members
- ✓ Discuss change ideas to test within your own context to create team-based care
- ✓ Continue to learn from peer OHTs/PCNs on how they're approaching this work

Recall OHT Transformation: Integrated Local Care Systems

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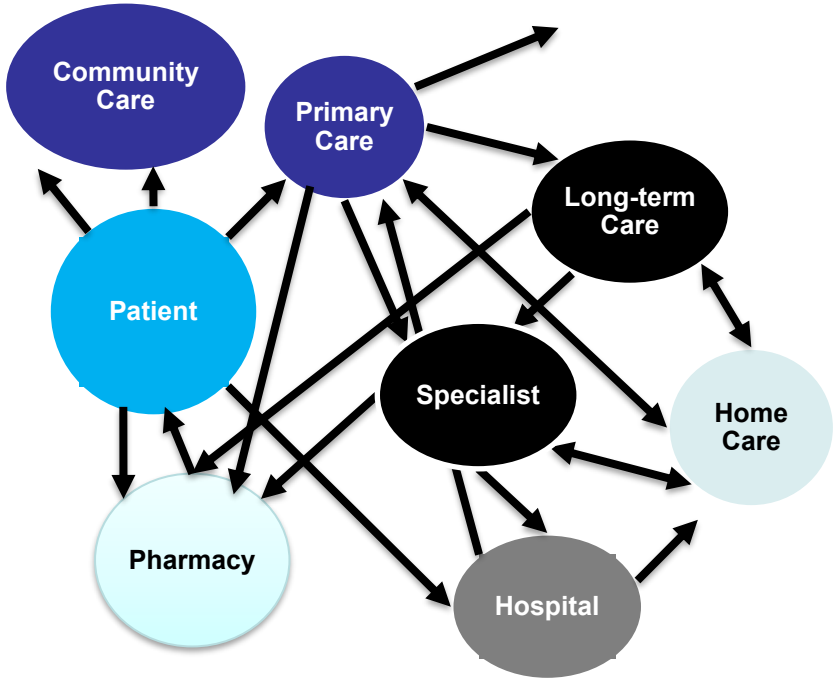
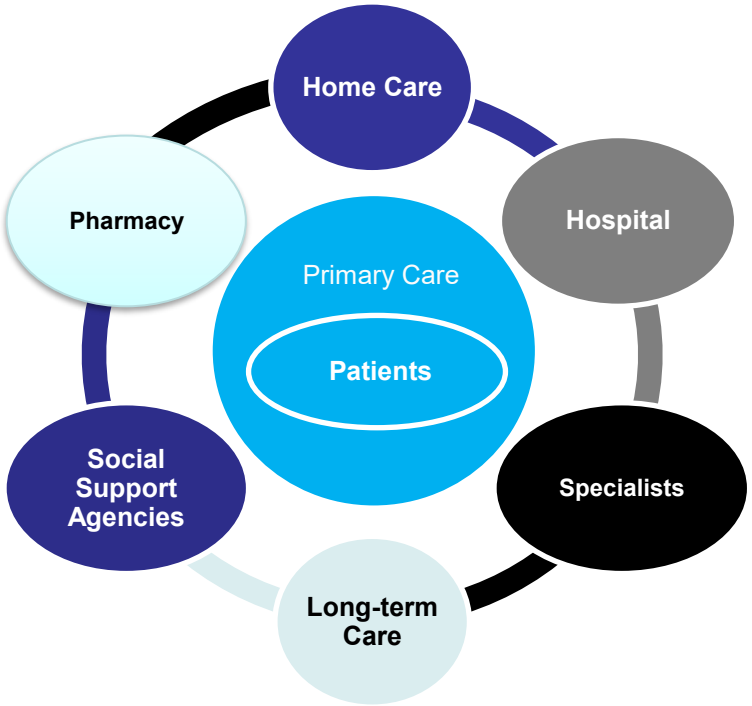


Whole Person Equitable Care



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

AIM (System)

What are we trying to accomplish?

We aim to create a – local (and provincial) – **high-performing primary-care sector** (regardless of the practice or funding models and locations) that is:

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

[List adapted from FLA OHT]

PRIMARY DRIVERS

- Relational continuity (i.e., ongoing therapeutic relationship between a patient and a single healthcare provider (or a small team))
- Team-based care (i.e., clinical and non-clinical staff work together and with specialists & broader social services)
- Timely access to care (i.e.. prompt access to care when people seek it)
- Population health management approach (i.e., holistic, proactively offered & organized care for all who need it)

PHM approach

- Patient partnership and community engagement (BB3)
- Digital health & data analytics (BB5)
- Leadership, accountability & governance (BB6)
- Performance measurement, QI & continuous learning (BB8)

OHT building blocks (BB)

Learning health system

SECONDARY DRIVERS

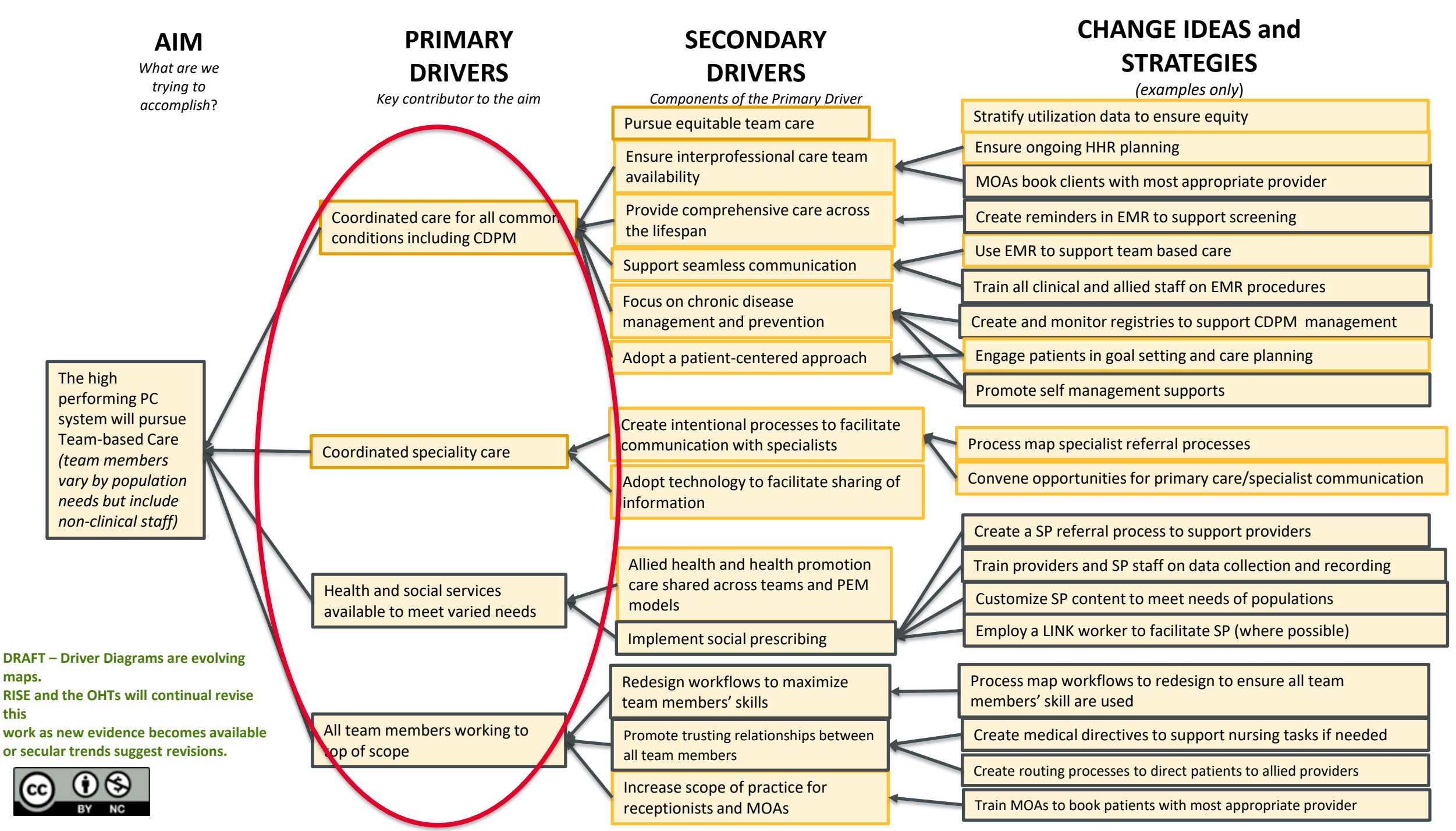
Select examples only

- Design & use a reliable attachment process (to FP, NP or IP PC team)
- Ensure all clinical & non-clinical staff value & pursue relational continuity
- Leverage specialty care efficiently
- Ensure all team members work to top of scope
- Understand needs, supply and demand for appointments
- Find efficiencies in non-clinical work (e.g., AI Scribe)
- Segment into groups with shared needs, risks and barriers to access
- Implement with a focus on reaching all, including vulnerable people & non-users
- Understand what's important to your community
- Develop data-sharing agreements with key partners
- Make decisions with clinicians and system partners
- Generate analytics and population insights
- Evaluate, feed back & adapt

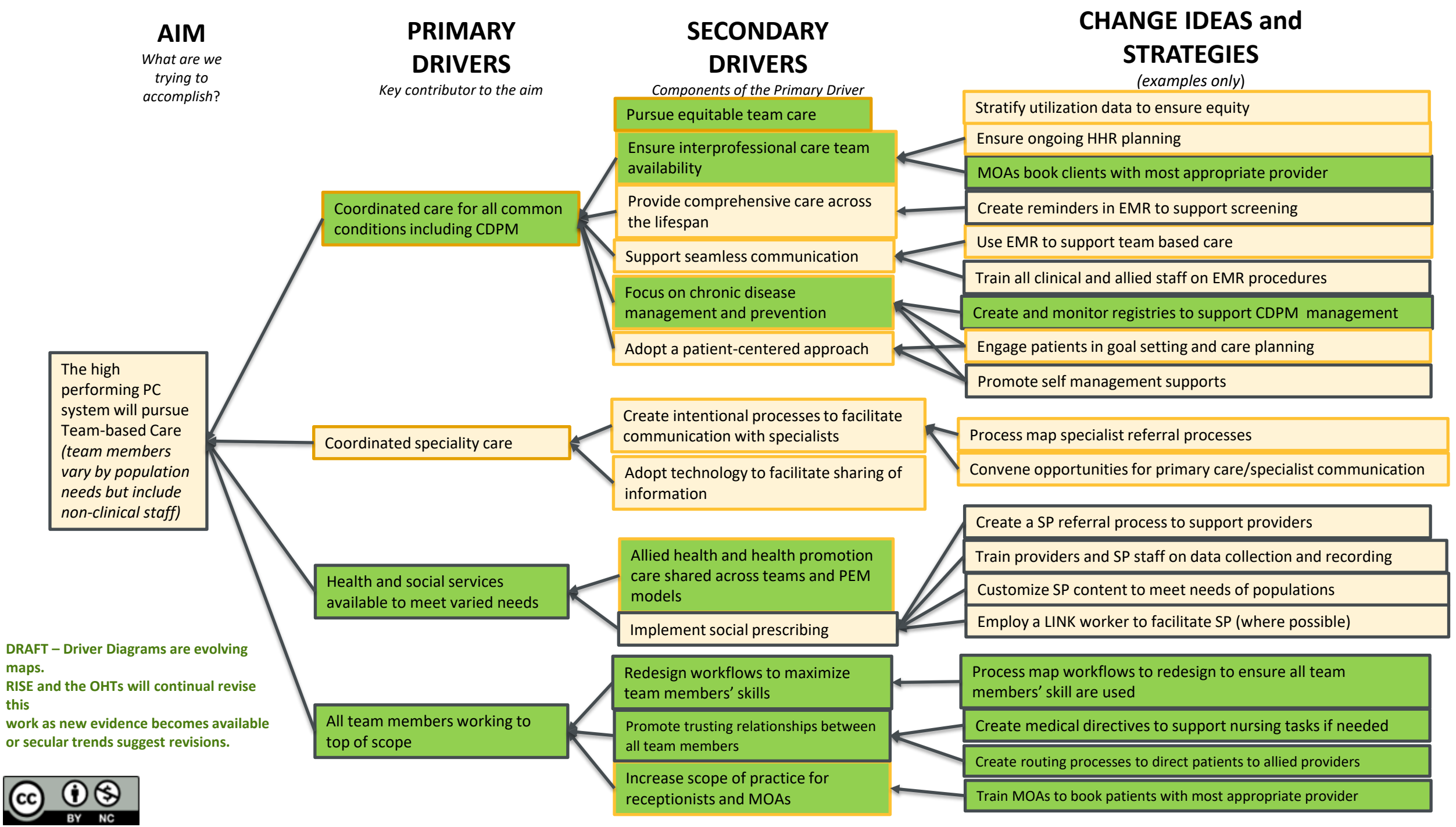
CHANGE IDEAS & STRATEGIES

See following pages for examples

DRAFT



DRAFT – Driver Diagrams are evolving maps.
RISE and the OHTs will continual revise this work as new evidence becomes available or secular trends suggest revisions.



DRAFT – Driver Diagrams are evolving maps.
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What is Team-based Care?[1]

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Primary team-based care that includes **population-based care** is a collaborative model where a multidisciplinary group of health professionals works together to provide comprehensive services to a **defined population** (panel, roster)rather than just focusing on individual episodic visits. The roster includes people who come in for care and those that do not (and require outreach)
This approach integrates traditional patient-centered care with public health-style functions to improve outcomes for a specific community or clinical population.

1. AI synthesis of various sources using phrase “definition of primary team-based care that includes population-based care”

Key Components of the Primary Care Team[2]

- **Multidisciplinary Teams:** A core group—often a physician or nurse practitioner, nurses, and medical office assistant (teamlet)—supported by pharmacists, social workers, dietitians, and mental health workers that may be shared across other group practices and teamlets.
- **Defined Patient Panels:** The team is responsible for a specific "practice population" or a geographic community ensuring no one is "unattached" or falling through the cracks.
- **Proactive Chronic Disease and Multimorbidity Management:** Instead of waiting for patients to seek help, the team uses health data (such as electronic medical records) to identify high-risk individuals/populations or those due for screenings (e.g., cancer or chronic disease management).
- **Focus on Equity:** Population-based care specifically targets social determinants of health and health inequities by connecting marginalized or at-risk groups to community supports (housing, income assistance, etc.).

2. AI synthesis of various sources using phrase “definition of primary team-based care that includes population-based care”

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

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Primary Care Models

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Enhanced Fee-for-Service Models (Blended Payments)

- **Comprehensive Care Model (CCM):** For solo physicians, offering FFS plus capitation for enrolled patients and after-hours services.
- **Family Health Group (FHG):** Groups of 3+ physicians, using FFS with premiums and some capitation, suitable for high-volume practices.

Capitation-Focused Models (Blended Payments)

- **Family Health Organization (FHO):** Groups (3+ physicians) paid primarily through capitation (per patient, adjusted for age/sex) plus FFS.
- **Family Health Network (FHN):** Similar to FHOs but often emphasizes capitation more, with bonuses for quality/services like chronic care.

Interprofessional Team Models

- **Family Health Teams (FHTs):** Teams (including nurses, dietitians, social workers) offering comprehensive care, often built around FHOs/FHNs, focusing on integrated care.
- **Aboriginal Health Access Centres (AHACs):** Indigenous-specific centres providing integrated health and social services.
- **Nurse Practitioner-led Clinics (NP-led Clinic)** Funded like FHTs to deliver comprehensive, integrated care.
- **Community Health Centers (CHCs)** Salary-based interdisciplinary teams providing comprehensive, integrated primary care

Teams are more than just the sum of their parts

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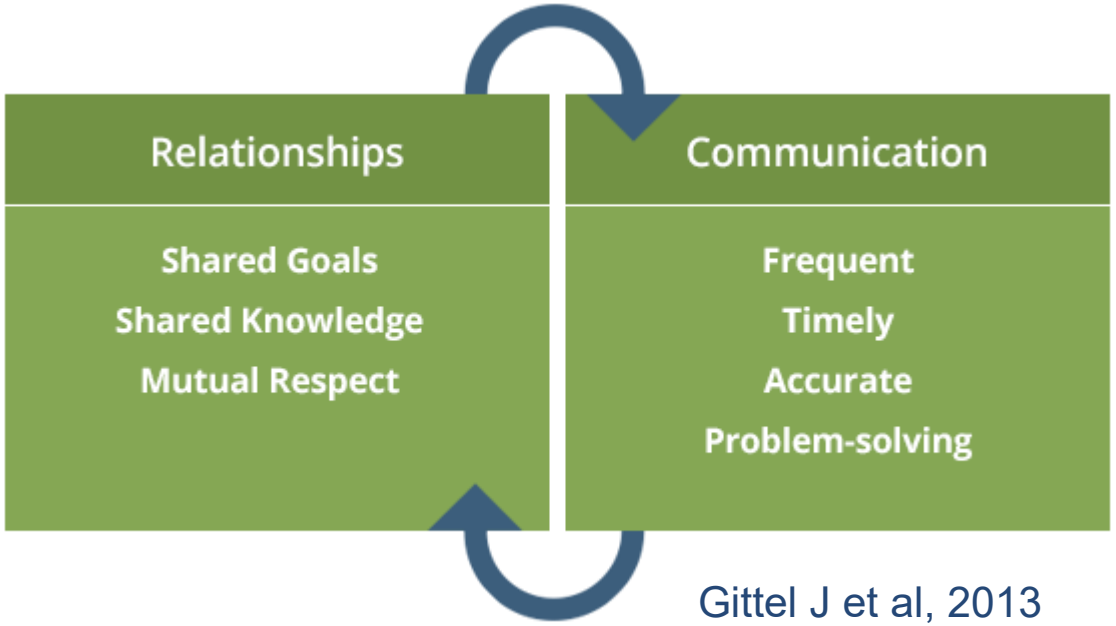
- Teams are more than just groups of individuals. Composed of people with complementary skills working collectively towards same goals
- Built on foundations of trust and mutual respect
- Effective primary care teams are relational and highly interdependent. Team members develop shared knowledge about 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

A Day in the Life of a Primary Care Team

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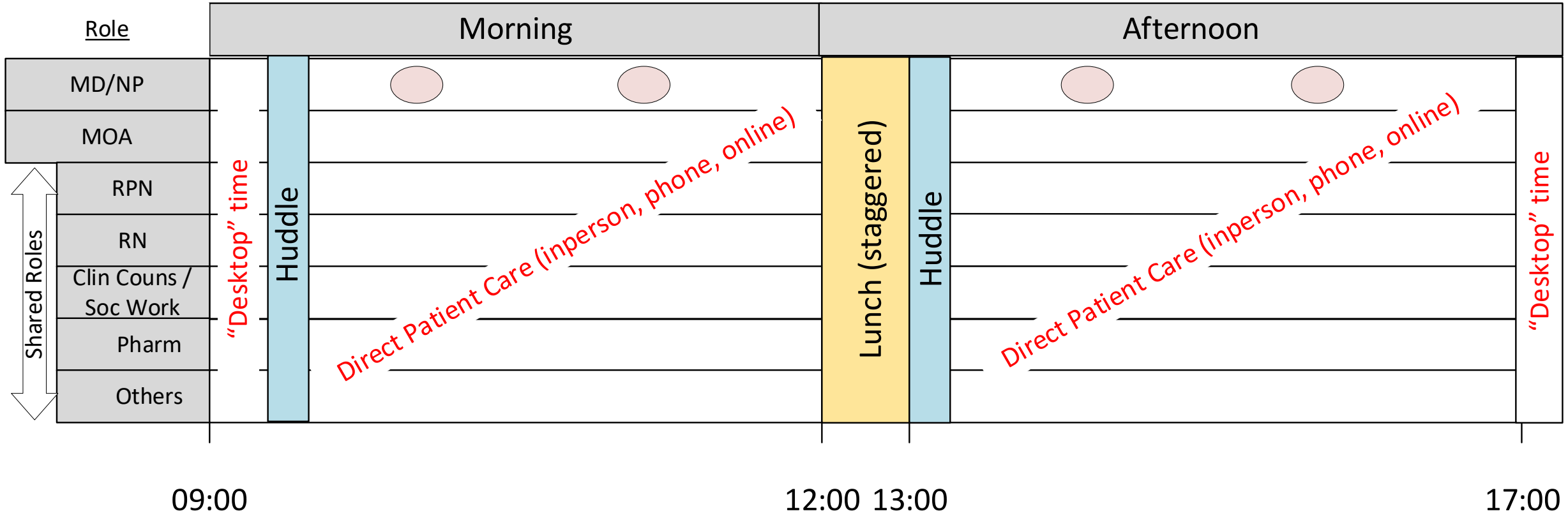

A Patient's Journey with their Primary Care Team

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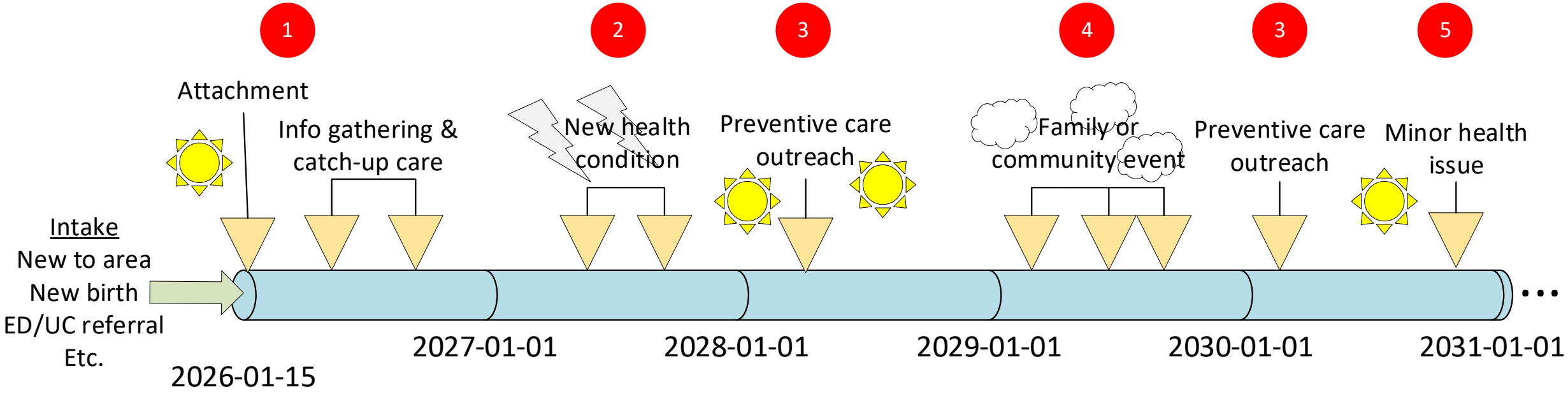

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Ontario Midwifery by the Numbers

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As of **May 2025**, there are:

- **1050** Registered Midwives in Ontario
- **18** Indigenous midwives practicing under the ***Midwifery Act*** **exception clause**
- Midwives work across a variety of settings, including:
  - **89** Midwifery Practice Groups
  - **33** Expanded Midwifery Care Models (located in hospitals, CHCs, FHTs, and
  - other not-for-profits)
  - **14** Indigenous Midwifery Programs serving First Nation communities
  - **3** birth centres (Toronto, Ottawa and Tsi Nón:we Ionnakerátstha / Six Nations)

Association of Ontario Midwives

Midwives in Interprofessional Primary Care Teams

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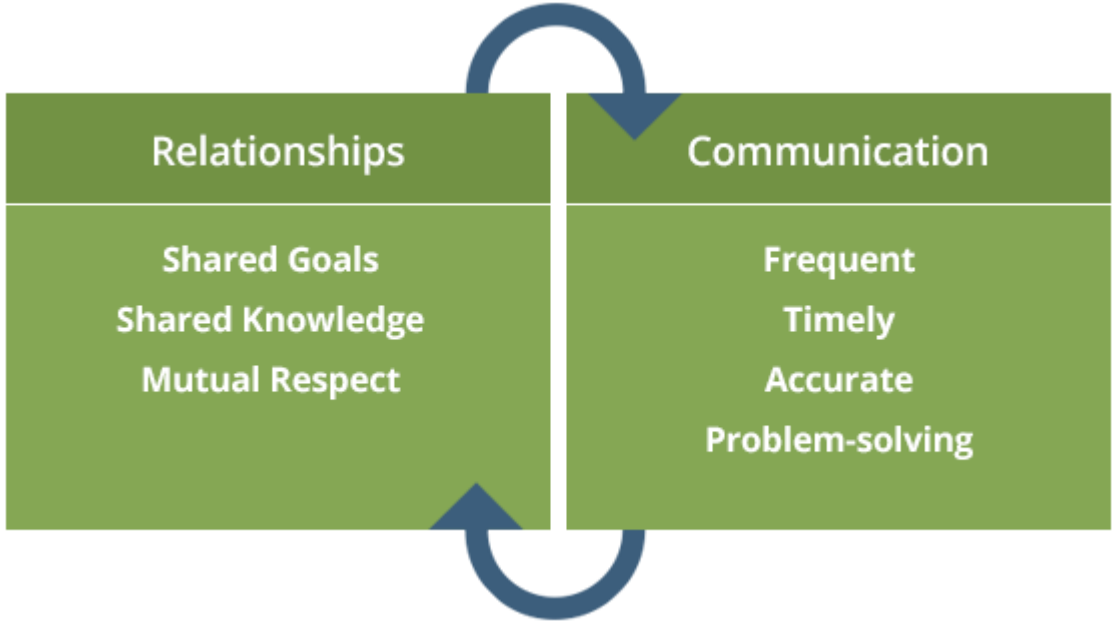
As primary care providers, midwives are already working in interprofessional teams across the province funded through the **Ministry of Health and Ontario Health (ie:** FHTs, Aboriginal Health Access Centres, NPLCs and CHCs).

Drivers for success in **well-integrated IPCTs with midwives** include:

- Integration of midwives at **an early phase** of the development of the
- program and team
- Midwives working to their **full scope** as **primary care providers**
- Removal of **unnecessary barriers/restrictions** to midwifery work
- **Adequate remuneration** of midwifery work and services
- Midwives' involvement in **decision-making**

Association of Ontario Midwives

**Remember: Effective primary care teams are relational and highly interdependent.
Team members develop shared knowledge about each other's roles & responsibilities



Key structures assist with team development, including:

- **Shared protocols, directives & standard work templates**
- **Requires understanding of our roles (scope, clinical directives)**
- **In team structures, scope and medical directives improve shared goals and problem-solving with patient care.**

Determining and Designing Role Structuring in a Team

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Scope of Practice

- Authorized decisions and procedures.
- Ontario: the scope of practice scheme is set out in the *Regulated Health Professions Act, 1991* (RHPA)[2]
- Act has two elements: **a scope of practice statement** and the **controlled acts** authorized to each profession.
- Delegation can occur when the patient/client's condition falls outside the legislative scope of practice for the professional.

Medical Directives

- Written orders from healthcare providers for the performance of treatments, interventions or procedures on particular patients when specific conditions and circumstances are met.
- Rely on the collaboration between regulated health professionals and administrators.
- Intended to optimize patient care (timely, effective, efficient, and of the highest quality).
- Order the performance of the treatments, interventions or procedures that are specified in them.
- Implementers of medical directives are not ordering a treatment - they are implementing an authorizer's order for a treatment. physicians (MDs) and nurse practitioners (NPs) remain the most responsible practitioners (MRPs) for the patient care provided pursuant to medical directives.

College of Midwives of Ontario
HIROC **(Health Insurance Reciprocal of Canada)**

Example of Team Based Care and Medical Directive to Optimize Patient/Client Care

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NorWest CHC Midwives

Midwives at **NorWest Community Health Centres** service the CHC located in **Thunder Bay**, and serve Ontarians who live in catchment areas of CHC's satellite clinics in **Armstrong** (252 km distance) and **Longlac**(305 km)

Services address current gaps in perinatal care impacting marginalized and vulnerable populations in Northwestern Ontario

Services:

- Prenatal and postnatal care, sexual and reproductive health services
- STI testing and treatment, contraception (IUD and implants)
- Menstrual health, unplanned pregnancy care
- Cervical screening, lactation consultant services
- Well baby care up to 18 months, education for clients and families
- Gender affirming care for clients

https://norwestchc.org/programs-services/midwifery-program/

Medical Directives optimizing team-based care at Norwest

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Scope of Practice	Medical Directives
Cervical screening for pregnant/postpartum people	Well person cervical screening and contraception (includes STI testing and treatment) includes GAC
Mifegymiso and management of first trimester loss	Mifegymiso for medical abortion
Well baby care for under 8 weeks of age	Well baby care to 18 months of age (vaccinations)
Intra-uterine system insertion up to 8 weeks postpartum	Intra-uterine system insertion/removal and preceptorship for any eligible person
Contraception up to 8 weeks postpartum	Nexplanon insertion/removal any eligible person
Immunization for pregnant and postpartum people	Adult immunization

How does this impact team care? How does this impact client care?

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

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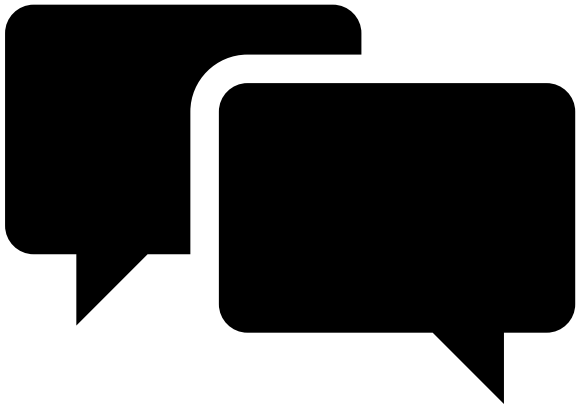
1. **What do the current compositions of PC teams look like in your OHT** (including complements of other staff outside of MD/NP)**?**
   - How are these different compositions spread across OHT?
   - ***Tip:*** OH regions may have some data to help you understand this
2. **How are you thinking about 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.

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



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

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

Next RISE OHT peer sharing & learning session will focus on the mechanics of building a team

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