

Peer sharing & learning session (third Thursday of each month, 12-1:30 pm)
19 February 2026 – Team-based care: Building teams
(Summary last updated on 26 February 2026)

- Additional resources that will be shared in the private OHT/PCN space:
 - <https://quorum.hqontario.ca/oht-collaboratives/en-us/Home/Groups/Activity/groupid/258>
 - Recording
 - Slides

This session, like all of the peer sharing and learning sessions, aimed to equip OHTs and PCNs with actionable insights about what they need to support and enable at the local primary-care practice level. It addressed one of the primary drivers for local high-performing primary-care teams (and for a provincial high-performing primary-care sector) – team-based care – and focused in particular on building teams (or ‘teamness’).

Context for building teams (or ‘teamness’)

- Teams will make it easier to achieve transfer-payment agreement (TPA) requirements (e.g., CDPM plan, cancer screening, online appointment bookings, and eReferrals) and associated measurement requirements (e.g., CDPM, cancer screening, and provider and patient experiences)
- There are many answers to the question ‘what’s in it for me?’ that is often asked by clinicians, with evidence suggesting that highly functional teams find work more productive and predictable and experience greater job satisfaction
- (Recap from last month) The trust needed for good team-based care – where all members are contributing to the greater good of the team – is built through two things:

Relationships	Communication
Shared goals	Frequent
Shared knowledge	Timely
Mutual respect	Accurate
	Problem-solving

- Relations and communication are supported through:
 - ‘structures’ that enable teamness, such as shared meetings, huddles and opportunities to reflect, learn and plan, as well as shared protocols, directives and standard work templates and shared electronic medical records (EMRs)
 - leadership and management practices such as: 1) selecting and training for teamwork; 2) developing shared accountabilities, performance metrics, QI initiatives, and recognition mechanisms; and 3) designing jobs appropriately for team work, including boundary-spanning roles that can help to make sure team members are contributing in optimal ways, add capacity when needed, and improve efficiencies.

Examples of creating functional teams through team structure, communication and process change

- Dean Roehl, who has worked as a family physician in both Canada and the US, described how they created ‘teamness’ when the ‘patient centered medical home’ concept (sometimes known as the health home) was first introduced in his US practice setting
 - anchoring on vision and core values for a team to deliver continuous, collaborative, accessible, comprehensive and coordinated care
 - creating some rules to start (e.g., what was the ‘standard work’ expected of all team members according to their role) and plan getting-to-know one another activities (as people, not just roles) to build synergies
 - nurturing good leadership and using many communication approaches – including in person and through the electronic medical record (both within and across teams) -- to solve problems and redistribute work among members over the course of a day

- tracking metrics, providing feedback to one another, celebrating successes, reflecting and improving, and recognizing challenges
- having structured 'courageous conversations' among team members when needed as a way to diffuse conflict and seek clarification about work roles, communication and working relationships (and with conversations happening in respectful ways with psychological safety and without fear of retribution, and sometimes with the support of leaders and managers).
- Melissa Harvey described – in four domains – her lessons learned to foster and maintain teamness with the Nipigon District Primary Care Team, which is comprised of the Nipigon District Family Health Team and Nipigon Doctors Group (the latter funded under the Rural and Northern Physicians Group Agreement, or RNPGA)
 - bringing the two organizations together – relationship building among the team members and with managers/leaders is the cornerstone, regular meetings with dates set well in advance, action items with accountability built into meeting agendas and minutes, shared education sessions about work roles and tasks, and scheduled offsite events for team building
 - communication strategies for shared care –meetings and huddles, reliable IT infrastructures for teams to communicate with each other over the course of the day, one EMR for all, FHT clinicians and staff message within the EMR, VPN access for continuity of care and community outreach, and co-location allows for in-person and informal discussion
 - co-designing programs and roles – evidence-based guidelines as the foundation, program-specific procedure documents, support for full scope of practice, training, aligned medical directives, involvement of both the FHT and RNPGA-funded group, and edits based on feedback
 - optimizing the team with members working at the maximum scope of their licensure – medical directives and professional development.
- Mary-Jane Rodgers shared actionable insights – in seven domains – from her role as the executive director of the Aurora-Newmarket Family Health Team (FHT) and co-leadership experiences across both the FHT and their partner Family Health Organization (FHO)
 - single, integrated organization chart that covers both FHT and FHO staff
 - leveraging FHT programs and services and its quality scorecard across both organizations
 - communication (written and oral) as the key to their success (e.g., daily huddle at 8:30 am, weekly meeting of FHT and FHO leads, and monthly team meetings)
 - integration across the team to support each other in day-to-day work (e.g., informal and formal consultation among all providers, shared administrative support, coverage and coordination to support continuity of care, clear roles, and leveraging the support of each organization including IT/EMR support)
 - commitment to and operationalization of team-based care that gets patients what they need as quickly as possible
 - intentional focus on building trust, respect, and positive team culture
 - five things that makes their team work: 1) structure, stability and trust; 2) involvement and collaboration in designing the work; 3) regular use of strong communication systems; 4) trust and mutual respect as core values; and 5) kindness (Mary-Jane's favourite word).

Discussion

- Additional insights that emerged during the discussion included:
 - importance of creating a team environment across practice models, including through resource sharing, while acknowledging that this is probably the biggest challenge that we face in creating 'teamness' locally

- centrality of trust, the relationships and communications that can create and maintain it among team members, the leadership skills needed to nurture and model it, and the memoranda of understanding that help people document their accountabilities to one another
- value of working with the 'early adopters' to jump into team-building activities, learning and improving as you go, and not waiting for everyone to be 'ready'
- helpfulness of sharing medical directives and standard work/role templates so each team doesn't need to 'reinvent the wheel'
- next-best options when a single EMR is not possible and providing EMR access is too costly, including: 1) creating disease/condition registries, exception reports, and recall lists; 2) leveraging platforms like IDS; and 3) awaiting the interoperability that should follow from the federal government's draft Connected Care Act
- possibility of bringing OHTs and PCNs together – through a collaboratives-type approach – to share and learn from each others' experiences in building 'teamness.'
- RISE concluded by recapping the six questions to get OHT and PCN representatives thinking about what they can start testing (see the notes from our last peer sharing and learning session).



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