

Peer sharing & learning session (third Thursday of each month, 12-1:30 pm)
15 January 2026 – Team-based care: Role definition and scope of practice
 (Summary last updated on 19 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/256>
 - Recording
 - Slides
 - Supplementary handout: A day in the life of team-based care (by Dean R. Roehl)

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 defining roles and working to full scope of practice, including understanding the unrealized contributions of each cadre of personnel in a team-based setting.

Context for defining roles and working to full scope of practice

- Components of the primary-care team (e.g., multidisciplinary team working in ‘teamlets’ and teams, defined ‘practice population’ or a geographic community being served, proactive chronic disease and multimorbidity management, and focus on equity and addressing the social determinants of health)
- Personnel that can make up a primary-care team (e.g., physician, nurse practitioner, registered nurse, registered practical nurse, and medical office assistant)
- Primary-care models that can be in use within an OHT (and engaged in resource sharing), including enhanced fee-for-service models (e.g., Comprehensive Care Model, Family Health Group), capitation models (e.g., Family Health Organizations and Networks), and interprofessional team models (e.g., Family Health Teams, Aboriginal Health Access Centres, Nurse Practitioner-Led Clinics, and Community Health Centres)
- Trust needed for good team-based care is built through relationships and communication

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

- Relations and communication are supported through:
 - ‘structures’ like: 1) shared protocols, directives and standard work templates; 2) shared meetings, huddles and opportunities to reflect, learn and plan; and 3) 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, including and boundary-spanning roles.

Two examples of defining roles and working to full scope of practice

- Dean Roehl described ‘a day in the life’ of team-based care based on his experiences as a family physician in both Canada and the US, including (as captured in the four-page handout linked to above):
 - context, with a ‘teamlet,’ clinical team, and shared resources
 - preparatory time before seeing patients (e.g., reviewing lab results, ‘mining the schedule,’ answering calls, and participating in a team huddle)
 - direct patient care time (e.g., what each of the medical office assistant, physician or nurse practitioner, and a shared RPN or RN do)

- a 'life in the system' from the perspective of a patient receiving team-based care (e.g., becoming 'attached,' dealing with a major health condition, being the focus of 'outreach' if they hadn't been seen in some time, being supported through a family or community event, and getting help with a minor health issue)
- concluding thoughts about the benefits of team-based care (e.g., higher quality and more professionally rewarding care, greater patient satisfaction, and greater team-member satisfaction).
- Kirsty Bourret and Jenni Huntley described what team-based care can look like from the perspective of a midwife
 - context, both in primary care (e.g., with expanded midwifery care models in Family Health Teams and Community Health Centres) and in midwifery practice (e.g., birth centres, midwifery practice groups, and Indigenous midwifery programs serving First Nations communities)
 - 'structures' like medical directives, which are written orders from one healthcare provider to another for the performance of treatments, interventions or procedures on particular patients when specific conditions and circumstances are met (with the authorizer remaining the most responsible practitioner and the delegate implementing the authorizer's order)
 - table that compared what midwives can do under their regulated scope of practice with what they can do in one clinic under medical directives
 - experiences of midwifery care embedded in NorWest CHC in Thunder Bay
 - services include pre- and post-natal care, sexual and reproductive health services, STI testing, contraception (IUD and implants), menstrual health, unplanned pregnancy care, cervical screening, well baby care up to 18 months, and gender affirming care
 - working to full scope and beyond with medical directives, as well as clinical rounds (and case reviews), are both essential.

Discussion

- RISE asked six questions to get OHT and PCN representatives thinking about what they can start testing:
 - 1) what do the current compositions of primary-care teams look like in your OHT or PCN? How are these different compositions spread across OHT? *Tip:* OH regions may have some data to help you
 - 2) how are you thinking about developing teams (e.g., team building events, information systems, and communication mechanisms)?
 - 3) what models are being used (e.g., single clinician and a medical office assistant, or five clinicians and an MOA)?
 - 4) how are you thinking about best leveraging existing skillsets on the team (e.g., new roles and responsibilities of clinicians, especially RNs/RPNs and MOAs)?
 - 5) How will existing information systems be optimized to enhance the team's work?
 - 6) What specific strategies could you use to enhance team function (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)?
- Additional insights that emerged during the discussion included:
 - encouraging whoever sees the EMR prompt to take action
 - distinguishing scope (what a healthcare provider can do) and role (what they are asked to do)
 - building a team culture through meetings and other activities
 - building relationships among cadres of personnel doing similar things
 - building teams with equity, diversity and inclusion principles in mind.

