

Primary Care Networks in Ontario Health Teams: **Guidance Document**

January 2024

Introduction

The Ontario government is building a connected health care system centred around patients, families, and caregivers. Ontario Health Teams (OHTs) were introduced in 2019 to provide a new way of organizing and integrating local care delivery. The goal is to ensure that everyone in Ontario can benefit from better connected and convenient care.

OHTs have been working to achieve this vision, bringing together an array of local providers, including family physicians, nurse practitioners and others. Since 2019, significant progress has also been made engaging and organizing primary care within OHTs, with many family physicians, nurse practitioners and others partnering with their local OHT and building better connections with one another.

Evidence and experience from around the world show that an engaged primary care sector is foundational to successfully improving and integrating care. It is therefore essential that OHTs organize and connect with primary care to advance population health through integrated and equitable approaches to care.

In *OHTs: The Path Forward*, the valuable role that primary care providers play in OHTs was re-emphasized and the ministry and Ontario Health committed to supporting their involvement in OHTs. *Your Health: A Plan for Connected and Convenient Care* noted that every OHT will include primary care providers organized in a Primary Care Network (PCN) to be part of decision-making and to improve access to care for patients.

The purpose of this guidance is to outline a vision, objectives and a common set of functions for PCNs to develop over time. By establishing a robust local PCN, OHTs can leverage this expertise and knowledge to more effectively co-design system changes and improve outcomes for their attributed population.

How to Use this Document:

Throughout the province, many OHTs have already established local approaches to involving primary care in OHTs. Over time, OHTs will be asked to align their PCN to the guiding principles, vision, objectives and functions outlined in this document. For teams in earlier development, this guidance will be foundational to improving primary care involvement in OHTs.

Additional information about OHT governance and the role and structure of PCNs in OHT decision-making is forthcoming. This information can be used to complement PCN implementation when available.

Vision and Objectives

Prior to the release of *Your Health: A Plan for Connected and Convenient Care*, patients and primary care providers called for changes in how care was planned and delivered. Primary care providers have shared they are experiencing increasing challenges helping patients navigate the health care system and connecting to the clinical supports that they need. The vision and objectives for PCNs set out below were developed with this context in mind.

Vision

PCNs will connect, integrate, and support primary care providers within OHTs to improve the delivery and coordination of care for patients.

Objectives

Within the OHT, PCNs will have two core objectives:

1. To organize the local primary care sector in OHT planning and provide a voice in OHT decision-making;
2. To serve as a vehicle to support OHTs in the implementation of local and provincial priorities.

Over time, every family physician, nurse practitioner and other primary care provider will have the opportunity to be involved in a PCN so the local primary care sector has a collective voice at OHT decision-making tables.

Through its collective voice, the PCN can help break down health system barriers, address inequities in health outcomes and access in local communities and lead primary care planning activities that will improve patient experiences.

Initial Clinical Priorities

OHTs and PCNs will focus on an initial core set of urgent clinical priorities, as identified below. Over time it is expected that these initial clinical priorities will change to continue to meet the needs of patients, families and communities.

1. Improve access and attachment to comprehensive primary care, with a focus on equity-deserving populations (e.g. Indigenous, Black, Francophone, etc.).
2. Implement integrated chronic disease prevention and management strategies, with a focus on equity-deserving populations, as above.
3. Implement additional local priorities as defined by the OHT and PCN.

OHTs and their PCNs will work with Ontario Health to identify specific initiatives and outcomes that will positively impact patient care and experience related to these priorities.

Guiding Principles

The following key principles provide a frame for the vision, objectives and common functions set out in this document.

- Joining a PCN is voluntary, but strongly encouraged. Participation should be driven by a strong value proposition and be built on local relationships to implement a quintuple aim approach that will improve patient care, primary care provider experiences, and enable system transformation.
- PCNs will build and enable clinical leadership with the capacity to deliver on its core functions. PCNs should work to ensure that clinical leadership represents primary care providers broadly, but at a minimum includes family physicians and nurse practitioners.
- PCNs will adopt a health equity lens including in its clinical priorities, with a focus on the needs of equity-deserving populations including First Nations, Inuit,

Métis and urban Indigenous, Francophone, Black and other racialized communities, 2SLGBTQIA+, and other underserved and underrepresented communities in alignment with Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework and the Patient, Family and Caregiver Declaration of Values for Ontario.

- As the OHT matures, its PCN will be critical to supporting the local primary care sector, including through connecting primary care providers to information and clinical tools that are useful and supportive to a primary care provider in the network.
- PCNs will work within OHT collaborative governance structures to ensure a strong primary care clinical voice and perspective is a critical part of local OHT decision-making.
- Over time, every OHT across the province will be required to have a PCN that organizes family physicians, nurse practitioners and other primary care providers to the common vision, objectives and functions outlined in this document.

Building a Strong Value Proposition for PCNs

To realize the vision and objectives of PCNs in Ontario, a strong value proposition is required that puts primary care providers and patients, families and communities at the centre.

Through PCNs, primary care providers will:

- 1) Have collective “voice” – unified, strong, and effective input from primary care providers in OHTs.**

The current primary care landscape is composed of various payment models and ways of accessing interdisciplinary health care. By working across existing primary care models, local PCNs will support the coordination of equitable access to inter-professional health care providers and plan for the needs of their attributed

population.

2) Benefit from improved connections between the primary care sector and specialists, home care services and other community providers to improve patient care and primary care provider experience.

The primary care sector will experience more timely and accessible patient referrals that ensure patients are getting the care they need when they need it. Primary care providers will receive information about patients they are caring for from providers across the OHT to improve outcomes for patients.

3) Lead access to integrated clinical and digital solutions for primary care providers and co-design integrated care (e.g. digital solutions, Health Human Resource planning, and wellness supports).

Through the PCN, family physicians, nurse practitioners and other primary care providers will access the tools and supports they need to ease their day-to-day practices (e.g. access to wellness supports, clinical support tools and training, easier connections to locum coverage for physicians). Through the PCN, primary care providers will also co-design models of integrated care by bringing resources together across providers to make meaningful impact for patients. PCNs may proactively work with the ministry and Ontario Health to identify and plan for Health Human Resource needs.

Core Functions

To support the vision, objectives and clinical priorities set out above, the following functions have been identified for PCNs.

Functions

1. The PCN connects primary care within the OHT.
2. The PCN serves as a vehicle for providing the local primary care sector's voice in OHT decision-making.
3. The PCN supports OHT clinical change management and population health management approaches.
4. The PCN facilitates access to clinical and digital supports and improvements for primary care.
5. The PCN supports local primary care Health Human Resource planning within the OHT.

Minimum and advanced state characteristics have been outlined for each function to support OHT implementation.

Many OHTs are already advancing these functions. Over time, PCNs will move from minimum characteristics, set out below, to more advanced characteristics.

Function 1: PCN connects primary care within the OHT

Value for Patients, Families and Communities

Most family physicians, nurse practitioners (NP) and other primary care providers in Ontario work alone or with a small group and are not well connected to one another in the same way as providers in other settings. By connecting primary care within an OHT, it will be easier for them to work together to improve patient access to primary care and respond to communities' local needs.

Value for Primary Care

Primary care providers have reported isolation and burnout. By connecting primary care providers within an OHT, they can work together to address common clinical and administrative challenges and access supports they need.

Value for OHTs

It can be challenging to generate partnerships across many separate primary care practices that can exist within each OHT. PCNs create a "one door" approach for other partners within an OHT to work with primary care to improve and integrate care.

Minimum Characteristics

- Joining a PCN is voluntary, but strongly encouraged.
- PCNs are open to all primary care providers (e.g. family physicians, primary care pediatricians, primary care NP and primary care Indigenous / Traditional Healers, registered nurses, registered practical nurses, occupational therapists, social workers, pharmacists, midwives).
- Processes are established to recruit family physicians, NPs and other primary care providers to become involved through effective communications.
- Equity-centered communication is led by the PCN to a variety of local primary care providers (e.g. fee-for-service, Indigenous providers).

Advanced Characteristics

- There is significant inclusion of local primary care providers (those examples captured in minimum state) supporting the delivery of comprehensive primary care to the OHT's attributed population.
- The PCN is the hub for local primary care communication, connections and information.

Function 2: PCN serves as a vehicle for providing the primary care voice in OHT decision-making

Value for Patients, Families and Communities

OHT decision-making includes family physicians, NPs and other primary care providers that work frequently with the OHT patient population. Primary care providers co-design better ways to integrate care with patients, families and communities and improve access to primary care by being a part of local decisions within their OHT.

Value for Primary Care

Family physicians, NPs and other primary care providers are heard. They can identify and articulate the needs of their patients and common challenges, and work with the OHT to address these and improve their daily primary care practice.

Value for OHTs

Family physicians, NPs and other primary care providers build trusting relationships within the OHT that are essential to improving and transforming care. A strong clinical primary care perspective is embedded across the OHT that enables improvements to care.

Minimum Characteristics

- Formalized process is in place for selecting clinical leadership within PCN. Clinical leadership at minimum includes a family physician.
- Process is in place for selecting primary care leaders to participate at OHT decision-making or leadership tables. These leaders are actively involved in OHT decision-making and leadership tables.
- Clinical leadership reflects and can speak to various models of care, clinical settings and equity-deserving populations impacted by decisions.

Advanced Characteristics

- Supports the selection of family physicians, NPs and other primary care providers to OHT working groups / clinical change management projects.
- Primary care leadership is involved in and supports OHT-related decisions on behalf of the PCN at OHT decision-making tables.
- Those involved in the PCN are broadly included in the various OHT working groups and committees.
- The PCN has developed mentoring and learning opportunities to support ongoing leadership.
- Those involved in the PCN feel confident that the clinical voice of primary care is reflected in the decision-making process.

Function 3: The PCN supports OHT clinical change management and population health management approaches

Value for Patients, Families and Communities

Family physicians, NPs and other primary care providers have access to data that help to identify patients at higher risk of poor health outcomes and work together with patients, families and communities to develop care models and pathways that meet their needs.

Value for Primary Care

Family physicians, NPs and other primary care providers are involved from the outset in vision, design implementation of care models and clinical pathways. Pathways are designed focusing on improving patient outcomes and will not increase administration for providers.

Value for OHTs

OHTs advance the quintuple aim with primary care providers and patients are involved in population health approaches to care. The PCN makes it easier to work with primary care providers to implement clinical priorities and novel ways to improve care.

Minimum Characteristics

- The PCN uses data to support planning for the OHT's attributed population.
- PCN leaders support OHT clinical change management activities (e.g. implementation of integrated clinical pathways).
- Primary care related OHT priorities (e.g., access and attachment, local priorities, etc.) are implemented by / through the PCN.

Advanced Characteristics

- Change management to adopt population health management tools and approaches to care delivery and planning are led by the PCN.
- Project and program management support for local primary care programs for the local OHT's attributed population is led by the PCN.
- Patient and provider experience and outcomes data is used to refine and make changes to programs and services.
- Local clinical priorities are identified by the PCN and collective action plans are co-designed for implementation across the OHT.

Function 4: The PCN facilitates access to clinical and digital supports and improvements for primary care

Value for Patients, Families and Communities

Clinical and digital health tools that improve patient access to care, such as easy referrals to specialty care, and patient information are available and to support patients no matter where they are in the province.

Value for Primary Care

Family physicians, NPs and other primary care providers seamlessly access resources in their practices to connect their patients to services they need allowing them to focus on delivering high quality care, not administration.

Value for OHTs

PCNs drive clinical change management efforts with primary care that support the implementation of OHT clinical priorities like integrated clinical pathways. PCNs provide a tangible value to primary care involvement in OHTs by providing easy access to clinical and digital tools.

Minimum Characteristics

- Access is facilitated to tools and resources such as clinical and quality improvement supports, and digital and virtual tools and expertise.
- PCN collaborates with local and provincial partners to encourage and support the implementation of primary care focused digital health tools.

Advanced Characteristics

- Greater access to clinical supports is facilitated for all local family physicians, NPs and other primary care providers.
- PCN co-designs and tests new primary-care focused digital health enablers and other clinical supports to drive OHT maturity.

Function 5: The PCN supports local primary care Health Human Resource planning within the OHT

Value for Patients, Families and Communities

Patients, families, and communities together with family physicians, NPs and other primary care providers are involved in designing and planning how to improve access and attachment to primary care within their OHT.

Value for Primary Care and OHTs

OHTs understand the needs of patients locally, can identify opportunities to integrate care and/or find efficiencies that will positively impact Health Human Resources. The PCN supports effective retention initiatives for primary care.



Minimum Characteristics

- Local primary care Health Human Resource capacity constraints may be identified through the OHT to the ministry / Ontario Health.
- Opportunities for primary care resources to be better coordinated across clinical practice settings are identified.

Advanced Characteristics

- PCN has the ability to lead local primary care Health Human Resource planning for the OHT in coordination with the ministry / Ontario Health.

Conclusion

PCNs will establish a strong foundation for primary care to bring about integrated and population health approaches to care. With this foundation in place, patients will receive better and more connected care and primary care providers will have access to a network of supports and resources that improve their experience.

This guidance is intended to provide a functional roadmap for OHTs to align to over time and with support from the ministry and Ontario Health. Through the success of PCNs and OHTs this guidance may be updated to reflect advancement and continued improvements to patient and primary care provider experiences and outcomes.