About These Practical Guides

Building Capacity in Ontario Interprofessional Primary Care Teams (IPCTs)

Department of Family and Community Medicine (DFCM), University of Toronto, in partnership with Ontario Health and the Primary Care Collaborative (PCC)

Why These Guides Were Created

Many Ontarians do not have an ongoing relationship with a primary care clinician. Ontario has responded with a historic investment in primary care through the Primary Care Action Plan to establish and grow Interprofessional Primary Care Teams (IPCTs) across the province. The goal is that every Ontarian will be attached to primary care by 2029.

Achieving this goal will depend not only on establishing more teams, but on how effectively those teams work.The teams making the most progress on patient attachment are the ones that have figured out how to work well together, how to organize their tasks effectively, how to engage their communities, and how to adapt their roles iteratively.

Who These Guides Are For

These practical guides are written for the executive directors, managers, clinician leaders, and frontline staff who are doing this work right now, trying to overcome constraints and manage uncertainty while under significant pressure. The aim is not to prescribe a solution, but to offer evidence-informed options that each team can adapt to its own context, community, and workforce.

Definitions and Key Concepts

Interprofessional Primary Care Team (IPCT)

Interprofessional primary care teams are made up of a family physician or nurse practitioner working together with other health care professionals such as nurses, pharmacists, social workers, dietitians, physician assistants, administrative professionals, and more. Ontario's IPCTs include Family Health Teams [FHTs], Community Health Centres [CHCs], Indigenous Primary Health Care Organizations [IPHCOs], and Nurse Practitioner-Led Clinics [NPLCs].

Primary Care Attachment

Primary care attachment is defined as a documented and ongoing relationship with an individual physician, physician group, or a nurse practitioner working in a publicly funded system. The documentation could be through formal registration or signed enrolment and consent form.

While this definition supports consistent measurement and reporting, attachment may also be understood more broadly as a relationship-based process that develops over time through trust, continuity, cultural safety, respect and individual choice.

A Broader Understanding of Attachment

Throughout these guides, attachment is understood from two complementary perspectives. From a health systems perspective, attachment is typically defined as a documented and ongoing relationship with a physician, physician group or nurse practitioner. This definition supports consistent measurement, planning, and reporting across the health system.

At the same time, attachment is more than an administrative designation. Informed by perspectives shared by the Indigenous Primary Health Care Council (IPHCC), these guides recognize meaningful attachment as a relationship-based process that develops over time and is strengthened through trust, continuity, cultural safety, respect for individual choice, and self-determination.

This broader understanding recognizes that attachment is not a single event or administrative step, but an ongoing journey that supports meaningful connections to care. Effective attachment may include navigation supports, connection to community resources, and, where desired, access to culturally grounded care, traditional healing, Elders, Knowledge Holders, and other supports.

What the Guides Are Based On

These guides draw primarily on two bodies of work conducted by a research team based at Office of Health System Partnerships (OHSP) at the Department of Family and Community Medicine (DFCM), University of Toronto, in partnership with Office of Spread and Scale (OSS) at Women's College Hospital (WCH).

- **The Primary Care Bright Spots Qualitative Evaluation (conducted in collaboration with Ontario Health, 2025-2026)**[1] examined a set of high-performing IPCTs from across Ontario, selected because they had demonstrated progress on patient attachment. Researchers conducted site-visits, in-depth interviews, and focus groups with clinical staff, administrative leaders, and managers at each site. Participants spoke openly about what they had tried, what had failed, and what had made a difference. Their insights are shared in de-identified form.

[1] Jennifer Shuldiner, Sydney Pearce, Khalida Nasir, Rebecca Starkman, Hina Ansari, Emma Wedekind, Umair Majid, and Noah Ivers, *The Primary Care Bright Spots Qualitative Evaluation Report: A Qualitative Case-Study Approach to Understanding How Teams Responded to Expansion Funding.*

- **A Rapid Realist Review of How and Why Interprofessional Teams Increase Capacity (Pearce et al., 2026)**[2] synthesized the international evidence on this question: under what conditions does adding interprofessional team members actually increase the number of patients a family physician or nurse practitioner can serve? Realist synthesis is a method designed to go beyond asking whether something works to ask how and why it works, and for whom. This review identified the key mechanisms through which team-based primary care can expand capacity, and the contextual conditions that enable or block those mechanisms. It forms the theoretical backbone of the recommendations offered across these guides.

The guides also draw on a range of complementary sources, including the Compendium of Roles in Team-Based Primary Care (Team Primary Care/Health Human Resources, 2025), policy analyses from the Section on General and Family Practice (SGFP), resources from the Association of Family Health Teams of Ontario (AFHTO), the Full Scope Toolkit for Primary Care RNs and RPNs, and broader published literature on team-based primary care, practice facilitation, and health system change.

Using these sources, the Guides are drafted by Dr. Noah Ivers, Tara Kiran and OHSP team members prior to being prepared for online posting.

How the Guides Are Organized

Each guide addresses a distinct theme identified as important for IPCT capacity and functioning. Each guide is organized around key themes and practical actions to consider. They are not checklists or directives. The Bright Spots teams were effective not because they followed a standardized model but because they were thoughtful, adaptive, and honest about what their communities needed and what their teams could realistically deliver.

A Note on Peer Learning

These guides were developed alongside the Ontario's Interprofessional Primary Care (IPCT) Community of Practice (CoP), convened by Ontario Health and the Primary Care Collaborative (PCC) with DFCM serving as secretariat. The CoP brings together IPCT leaders from across the province to share what has worked and to spread practical ideas that others can test in their own contexts. Readers are encouraged to get involved in the CoP and to meet with peers to share ideas and solve problems. Please bring the ideas and examples in these Guides to your own teams, and consider them as material meant to inspire reflection and discussion.

[2] Sydney Pearce, Meghan Gilfoyle, Daphne To, Amber Khan, Alison Scholes, Meredith Vanstone, Lyn Sibley, Hina Ansari, Susan Beazley, Jennifer Shuldiner, Nathasha Kithulegoda, and Noah Ivers, *A Rapid Realist Review on How and Why Interprofessional Teams Increase Capacity* (work in progress).