OMA Ontario Medical Association

Building Capacity to Attach All Ontarians to Primary Care: The Patient Core Team

July 2025

Background

Ontario's primary care system is braced with a supply and demand problem. There is an ever-increasing number of patients without a family doctor, which is expected to rise to 4.4 million Ontarians by 2026. At the same time, there is a declining number of family physicians available to take on these patients, with family physicians retiring earlier or practicing less comprehensive care and fewer new graduates choosing to stay in comprehensive family medicine. Of the remaining family physicians, their capacity to take on additional patients is limited. These issues only exacerbated with the COVID-19 pandemic, prompting the need for significant reform.

With the establishment of the Primary Care Action Team (PCAT), led by Dr. Jane Philpott, Ontario is poised to make substantial improvements in its primary care system. PCAT is working on a mandate to attach 100% of Ontarians to a family doctor, nurse practitioner or primary care team by 2029, where they receive ongoing, comprehensive, and convenient care. This mandate is supported by a $2.1 billion Primary Care Action Plan.

The Ontario Medical Association (OMA) strongly supports PCAT's objective of attaching all Ontarians to physicians practicing comprehensive, longitudinal primary care. Physicians, who are responsible for attachment, play a vital role in achieving this mandate through working with team members to enable attachment. We are keen to work together to create a system that empowers physicians and provides necessary supports to attach more patients with timely access to quality primary care.

As part of its Primary Care Action Plan, PCAT has made substantial investments in developing and expanding primary care teams. In the recent call for proposals, existing models of teams such as Family Health Teams (FHTs) and Community Health Centres (CHCs) were eligible to apply for funding. Notably, physicians were not eligible to apply for funding aside from the option to join or create a FHT. Given the limitations of this option for physicians, including the time-consuming and cumbersome process to join or create a FHT as well as the lack of decision-making power in many current FHT structures, this funding option was not feasible for many physicians. This further limited the opportunity for physicians to apply for funding to attach more patients.

While team-based care models such as FHTs have demonstrated success in improving patient access to allied health professionals and quality of care, interestingly, physicians' roster sizes are slightly lower when working with these government-funded team models than without. This is very surprising given the significant investment of PCAT in these team models to achieve their mandate of full attachment.

The lower roster size in FHTs can be explained by the fact that FHTs were not designed with the objective of supporting physicians to attach patients to comprehensive, longitudinal care. As such, many physicians in FHTs lack the ability to direct resources, including utilizing team members to support their capacity to attach. Instead, most FHTs focus on improving patient access to specific aspects of care through dedicated programs and services such as diabetes

education. While access to better quality of care is a fundamental element of care, it is not directed to the current goal of attachment.

How should primary care teams be designed to achieve PCAT's goal of attaching all Ontarians?

To achieve the shared goal of increased attachment to comprehensive, longitudinal primary care, it is essential to enhance the capacity of those who attach, such as family physicians and primary care pediatricians. To free up capacity to attach more patients, physicians need to be able to offload and share tasks with other team members. This means we need to build team models that have the objective of enabling those who attach (e.g. physicians) to direct resources to expand their capacity to attach patients with timely access to quality primary care.

This can be achieved through building and funding patient core teams.

The Patient Core Team

A patient core team is comprised of a physician and other health care professionals who work to their optimal scope to provide comprehensive, longitudinal primary care to the patient. The entire team is focused on the objective of attaching patients with timely access to quality primary care. This includes providing routine and acute care visits, chronic and preventive services, and coordinating care with outside services.

Physicians, who are responsible for attachment, direct and share clinical and administrative tasks with their patient core team members. This frees up the physician's capacity to attach more patients, and focus on care decisions with the patient.

Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physician Assistants (PAs), and practice support staff (e.g., patient navigators, Medical Office Assistants) are highly effective in expanding physician capacity to attach.

Clinical team members can support a broad range of primary care tasks, including triaging new issues, managing care plans for chronic diseases, performing routine and preventive care screenings, conducting patient follow-up calls, and providing patient education.

Practice support staff play a vital role in alleviating much of the administrative burden for physicians that takes time away from seeing patients. Patient navigators can help connect patients with health system and community resources. Medical Office Assistants can handle patient appointment bookings and check-in patients, manage office administration tasks such as ordering equipment, and complete basic sections of forms.

Each patient core team composition would depend on the unique practice needs and goals for patient attachment in different communities.

Patient core teams have proven effective in helping family physicians see more patients. In the Netherlands, where over 95% of people have a family doctor, practice assistants play a key role. They handle tasks like wound care, immunizations, and pap tests, along with triaging patients and managing administrative work, which increases physician capacity.

In the United States, clinics using patient core teams with nurses or medical assistants have increased capacity for physicians to see more patients, while also improving access to care, quality of care, and satisfaction for patients, physicians, and staff.

The Ministry of Health (MOH) has had a history of successful programs that have placed team supports in physician offices with a commitment to attach more patients. For example, in 2008, a bilateral agreement was established between the OMA and MOH that placed nurses in physician offices: the Inter-Professional Shared Care - 500 Nurses Initiative. The patient core team builds off that model by providing physicians with the direct resources they need in their practice to attach more patients.

With patient core teams, more people can be seen and attached to comprehensive, longitudinal primary care and help achieve PCAT's goal of ensuring all Ontarians have a family doctor.

Recommendations to Implement Patient Core Teams

To fully implement patient core teams in Ontario, the OMA recommends:

Recommendation 1: Funding

In the next and future rounds of the PCAT investments in primary care teams, eligibility needs to be opened to physicians to apply for funding to build patient core teams. Funding and resources need to be made available to all family physicians in all practice models – including non-Patient Enrollment Models - as well as different levels of size and organizational sophistication. Funding also needs to be made available to primary care pediatricians who provide comprehensive primary care to children.

Physicians need to have decision-making power over funding and the ability to direct resources to expand their capacity. This will lead to increased attachment.

We recommend a variety of mechanisms to make funding available. This will allow for the most suitable funding mechanism to be utilized according to the geographical and organizational situation.

Funding Mechanisms for Patient Core Team

Funding Mechanism	Considerations
i. Explore mechanisms to enable funding to flow directly to physicians to hire patient core team members (physicians remain fundholder)	This option builds off the successful 500 Nurses Initiative. It is a simple and inclusive option, and may help to attract increased participation from smaller physician groups.
ii. Flow funding to FHT and then from FHT to physicians to hire patient core team members (physicians become fundholder)	This option may require overcoming existing hesitancy/challenges some physicians have with FHTs.
iii. Flow funding to FHT (FHT remains fundholder) and then the FHT enters into a contract with the physicians to: a) use budget line to hire patient core team members; or b) provide the services of a FHT employee(s) to carry out responsibilities directed by the physicians	This option would require modifying the objective of the FHT to enable physicians to direct patient core team members to expand their capacity to attach patients with timely access to care. The OMA is consulting with members to help inform recommendations on this.

Recommendation 2: Change Management

Family physicians and other professionals need to be provided with change management supports to become an effective patient core team that increases capacity to attach. This includes help in understanding and defining roles and responsibilities, and fostering a team culture which is focused on sharing the care of patients through each member working to their optimal scope.

Physicians need to be equipped with education, training, and practice facilitation support to effectively optimize their clinic workflow and team functioning to increase their capacity to attach. This includes providing physicians with best practices on how to optimize their practice with patient core team members, as well as education on delegation and scope optimization.

Recommendation 3: Workforce

System investments need to be made to increase the workforce required to fill these patient core team roles. This includes the health human resources for nurses, PAs, and practice support staff – and family physicians.

A host of systemic issues has made family medicine a less desirable and sustainable specialty. To recruit and retain more family doctors, we need broad solutions that address systemic problems and bring joy back to family medicine.

This includes reducing the overwhelming administrative burden faced by family physicians, with administrative tasks taking on average 40 per cent of their work week. Implementation of digital tools, such as AI scribe and a centralized referral system, can help alleviate some of the burden.

It also requires updating family medicine compensation models. Progress on this front is imminent with the new FHO+ model culminating from negotiations between the Ontario Medical Association and Ministry of Health. The Arbitration Board has a few issues to decide on. This updated compensation model will address many long-standing issues identified by family physicians, including administrative burden, increasing complexity, the gender pay gap, and lagging compensation.

Further, investing in patient core teams for all family physicians is essential to provide them with the supportive team-based resources they need to effectively practice and care for patients. Pay parity for other patient core team members across all models (i.e. between hospital and community-based teams) is needed to attract and retain these professionals in primary care teams.

Conclusion

Patient core teams are a highly effective model of care to attach more people with timely access to comprehensive, longitudinal primary care. As the province works towards attaching all Ontarians to primary care, it's time to reimagine how we build teams to support this new objective. Let's start at the core.