SGFP
GENERAL & FAMILY PRACTICE

A Primary Care Transformation and Change Approach for Ontario

Discussion Paper

June 2025

The Section on General & Famiy Practice is a section of the Ontario Medical Association representing over 15,000 family physicians.

TABLE OF CONTENTS

Summary & Key Actions for Government	**3**
Case Example	**4**
Introduction	**5**
Change Management Strategy and Transformation Strategy Defined	**7**
Change Management Strategy	**8**
Transformation Strategy	**11**
An Integrated Change and Transformation Plan	**16**
Conclusion	**17**
References	**18**

Authors

The SGFP Policy Team:
Dr. Beth Perrier, Lead
Lori Choma, Co-Lead
Dr. Ali Damji
Dr. Ross Male
Dr. Catherine Yu

This important work is only possible through the contributions of our members, and dedicated colleagues. This advocacy effort has not been funded by the OMA.

The SGFP acknowledges Indigenous health must remain in Indigenous hands. The strategies outlined in this paper are not intended to prescribe solutions for Indigenous populations, but rather focus on primary care transformation within the non-Indigenous healthcare system.

SUMMARY

To achieve meaningful transformation in primary care delivery across Ontario, we must address change at both the micro and macro levels, at the clinic level, where care is delivered, and at the system level, where policies, structures, and culture evolve. Successful reform requires defining new provincial frameworks, shaping the culture of primary care, and ensuring clinics can adopt and sustain the necessary changes.

This paper presents a complementary approach, recognizing the interplay between change management and system-wide transformation. It covers:

- **A clinic-level "change" strategy** focused on frontline change and practice-level improvement.
- **A system-wide "transformation" strategy** designed for province-wide implementation and structural change.

It concludes with a model that integrates previous SGFP policy on system reform including the need for a provincial primary care strategy, the adoption of the Patient's Medical Home as the future of family practice, the need for family physician-led Primary Care Network with change and transformation.

KEY ACTIONS FOR GOVERNMENT:

To achieve meaningful primary care reform*, the government must take deliberate, coordinated action for both the clinic and system levels.

- Define the vision for change: Commit to developing a comprehensive provincial primary care strategy, with the Patient's Medical Home (PMH) model as the foundation for transformation.
- Adopt a clinic-level change approach to bring the PMH vision to life:
  - Leverage quality improvement approaches for province-wide expansion, already widely accepted and utilized in Ontario.
  - Establish a provincial transformation workforce of practice facilitators to support clinic-level implementation.
- Adopt a provincial transformation approach to drive system-wide reform:
  - Define how PMH will be scaled province-wide, guided by the Diffusion of Innovations Theory to support gradual adoption.
  - Position family physician-led PCNs as the primary vehicle for system transformation, ensuring alignment between frontline care and provincial policy.

**While this paper is being produced within the timeline of mandate of the Primary Care Action Team (PCAT), SGFP recognizes that the need for reform extends beyond PCAT's goals and objectives. This paper aligns with PCAT's priorities while also addressing several additional objectives essential to advancing meaningful change and transformation in primary care.*

CASE EXAMPLE: OVERCOMING SKEPTICISM THROUGH PEER-LED ENGAGEMENT

Dr. James, a family physician in a rural town, practices within a Family Health Organization (FHO) but lacks the additional support of a Family Health Team (FHT). Having seen government-funded initiatives come and go, he was skeptical about funding stability for team-based care. He worried that if financial support disappeared, he would be left absorbing costs and managing an unreasonably large panel.

Beyond sustainability concerns, Dr. James struggled to see the practical benefits of team-based care. While he heard discussions about its advantages, his overwhelming workload left little time to explore its impact on efficiency or patient care. Without clear, accessible guidance, he assumed the change would be disruptive rather than beneficial, making him reluctant to engage.

A Purposeful Shift in PCN Leadership

Recently, changes were made to the Primary Care Network (PCN) structure to enhance family physician leadership. In Dr. James' community, PCN leadership now reflects those delivering care in the community, primarily family physicians. The PCN receives stable funding to support team-based care and dedicated change management expertise to facilitate implementation.

Unlike previous system-driven initiatives, this physician-led approach ensured discussions about this change was rooted in real practice experiences —making them far more credible and relatable.

Engaging Physicians Through Peer-Led Support

With newly secured funding, the PCN's mission is clear: help family physician practices integrate team-based care through sustainable supports, not temporary pilot projects. The PCN also recognized the importance of on-the-ground change management, hiring practice facilitators trained in clinic-level change.

Rather than overwhelming Dr. James with formal policy directives, PCN leadership took a peer-led approach. Local family physicians already engaged in team-based care met with him directly, sharing their own clinic experiences: ✓How team-based care eased workloads rather than adding complexity. ✓ How the funding model ensured sustainability, securing ongoing resources. ✓ How changes were manageable, not disruptive.

A Practical, Trust-Building Approach

Days later, the PCN introduced Dr. James to a practice facilitator, ensuring he had a local, trusted individual to help navigate the transition. Rather than pushing predefined solutions, the facilitator took time to observe clinic workflows, identify challenges, and collaborate on adjustments.

Over the following months, small, incremental improvements were implemented—focusing on building trust, minimizing disruptions, and allowing Dr. James to experience team-based care in action before fully committing to broader changes.

INTRODUCTION

In today's rapidly evolving healthcare landscape, the need for effective change management and transformational strategies has never been more crucial. The primary care system in Ontario faces numerous challenges, including uncoordinated care, lack of equity, inconsistent quality of care, and barriers to access. These issues are not merely administrative or procedural, they directly impact the health and well-being of millions of Ontarians.

The Section on General and Family Practice (SGFP) is advocating for a provincial primary care strategy with the major focus of transforming family practices into Patient Medical Homes. This vision emphasizes coordinated, continuous, proactive, evidence-based, and accessible attachment to team-based care that integrates family physicians and their clinic support teams, allied healthcare professionals, patients, and communities to optimize health. However, achieving this ambitious vision requires more than just policy directives and/or funding allocations. It necessitates a fundamental shift in how change and transformation are approached and managed at both the micro (clinic) and macro (system-wide) levels.

This discussion paper will begin by reiterating the SGFP vision for primary care and the future of family practice, then focus on the change and transformation approaches, structures and supports needed at both the clinic and system levels. All approaches outlined in this paper are grounded in evidence-based practices, ensuring that the proposed strategies are informed by the best available research and data.

By understanding and embracing the principles of both change management and transformational strategies, Ontario can build a resilient and responsive primary care system that will be adaptable and effective into the future.

What are we Changing? Structuring Ontario's Vision for Family Medicine and Primary Care

The SGFP is strongly advocating for the development of a provincial primary care strategy, with a clear, structured vision for the future of family medicine clinics, grounded in evidence-based principles that enable sustainable, high-functioning primary care. The Patient's Medical Home (PMH) serves as a well-researched framework, however, the focus need not be on any single model, but rather on ensuring that Ontario establishes the necessary infrastructure, policies, and supports to achieve lasting transformation through a framework such as the PMH.

To be effective, this strategy must include key system enablers such as:

✓ Education and training for family physicians and allied health professionals
✓ Appropriate remuneration for both family physicians and allied health professionals
✓ Physical infrastructure to support evolving care models
✓ Coordinated technology systems for improved integration
✓Transformational change and change management to enable effective implementation

Ontario's Primary Care Action Plan KPIs—while important—are not enough to drive lasting, sustainable change. Without structural supports, funding mechanisms, and meaningful engagement with family physicians, these targets remain fragile. SGFP continues to push for a broader, well-coordinated vision that ensures team-based care is achievable, effective, and sustainable.

With these foundational elements of a strategy in place, the focus can shift to high-impact and visible improvements, such as access, attachment, team-based care, person-centred interactions, digital health integration, and seamless care coordination. These priorities align with PMH and other evidence-based approaches, ensuring that change is purposeful, strategic, and scalable.

For nearly 15 years, PMH has informed the College of Family Physicians of Canada's vision for family medicine, but **achieving truly high-functioning, sustainable clinic models requires more than endorsing a framework, it demands deliberate, well-coordinated change efforts at both the clinic and system levels.** A successful strategy will prioritize clinic-level transformation while ensuring broader system shifts that create alignment and long-term sustainability. Without this unified and intentional effort, Ontario's primary care system risks continued fragmentation, limiting its ability to fully support family physicians and their patients.

Figure 1: The College of Family Physicians of Canada Patient's Medical Home Vision, 2019.

While PMH remains one of the most studied and supported models of effective (i.e., cost, outcomes, satisfaction) primary care delivery, the ultimate goal is not about terminology—it's about establishing a framework that provides direction and structure for reform.

The implementation of team-based care is a high priority of the Ontario Government, however, funding alone will not guarantee success. The approach to integrating team resources must be strategic and carefully planned.

Lessons from the UK show that simply expanding multidisciplinary teams (MDTs) does not automatically improve patient care or reduce physician workload. A review of Scotland's 2018 General Practitioner (GP) contract found that, despite significant investment, MDTs did not achieve their intended benefits. Many GPs reported that poorly structured implementation increased their workload, requiring ongoing supervision and training while costing significantly more to deliver fewer services than GPs directly (Audit Scotland 2025).

This reinforces the need for a thoughtful, system-wide strategy—one that ensures team-based care is implemented in a way that truly supports physicians, enhances patient access, and drives long-term transformation.

Change Management Strategy and Transformation Strategy Defined

It is crucial to the understanding of the content that follows that we define two distinct and interrelated concepts, change management strategy and transformation strategy. Both are critical to achieving lasting reform in primary care and establishing a framework that enables future innovations and system improvements.

Change Management Strategy

This will be the approach for change at the micro level, specifically at the clinic level or the level of care delivery. It draws on evidence-based theories and practices to guide how individuals and groups shift their behaviors, adopt new practices, and sustain improvements.

Transformation Strategy

At the macro level, the Transformation Strategy addresses system-wide change. It is about creating a fundamental shift in primary care's structure, culture, and operations, ensuring alignment with a vision of the future for primary care. Using proven change frameworks, this strategy defines how transformation will occur at scale, embedding lasting reforms across the entire healthcare system.

With this foundation in place, let's begin with the Change Management Strategy, the approach to change at the micro level: clinic, practice, care-delivery.

CHANGE MANAGEMENT STRATEGY

The proposed clinic level approach to changing family practices toward a vision such as the PMH is widely supported in the literature, successfully implemented in leading primary care systems, and already in practice in select areas across Ontario. To ensure province-wide adoption, the SGFP outlines the following key elements for a comprehensive change management strategy:

- ***Create a broad and explicit commitment to ongoing QI in primary care.***
- ***Support practices to build their QI capacity.***
- ***Develop a QI infrastructure including local teams of practice facilitators that are supported provincially.***

OntarioMD's Peer Leader program is a strong example of how local support can be effectively integrated into a provincial infrastructure. Peer Leaders are deployed within their communities, providing direct, hands-on guidance while being backed by OntarioMD at a provincial level. Additionally, the Peer Leaders are connected through a broad provincial network, ensuring continuous collaboration, shared best practices, and coordinated support. This made-in-Ontario model demonstrates the value of having local facilitators with a structured provincial system behind them.

Create a Broad and Explicit Commitment to Primary Care Quality Improvement

Quality improvement has long been a requirement in Ontario's healthcare system. In 2010, the Excellent Care for All Act mandated the development and publication of QI plans, but this requirement applies to hospitals and only small numbers of primary care groups, however, no similar province-wide standard exists across all of primary care. Despite this gap, several organizations supporting primary care have developed QI programs and initiatives, including but not limited to AFHTO (Association of Family Health Teams of Ontario), CEP (Centre for Effective Practice), Amplify Care [formerly eHCE (e-Health Centre of Excellence)], HQO (Health Quality Ontario), and AHC (Alliance for Healthier Communities).

Note on Terminology: *Physicians may respond differently to the terms 'quality improvement' and 'innovation.' While innovation emphasizes new ideas and transformation, quality improvement focuses on systematic enhancements and efficiency. While both are required, this paper will maintain the language of 'quality improvement' for consistency in discussion.*

Effective QI work requires dedicated financial support for both infrastructure and staff remuneration. Practices often struggle to prioritize QI amid clinical and administrative demands without structured financial backing. Funding should support not only facilitation—such as coaching and data analysis—but also essential components like technology, staffing, and workflow redesign. This financial support should be tied to broader QI initiatives while remaining distinct from formal QI plans, ensuring flexibility for meaningful implementation.

To establish a lasting culture of quality improvement, QI education must be introduced early and reinforced throughout family physician training. Embedding QI principles in medical education ensures that future family physicians develop the competencies needed to engage in continuous improvement from the start of their careers. As they advance through training, deeper integration of QI prepares them to drive practice-level improvements long-term. For those family physicians already in practice, they must be supported to learn and apply QI to their practices. Whether introduced in training or learned on the job, engaging with QI fosters a fundamental shift in mindset—one that drives continuous improvement and strengthens the delivery of high-quality patient care.

The SGFP advocates for a more equitable, systematic approach to QI, ensuring that all family physicians and their teams have equal access to QI supports, much like hospital-based physicians. **Access should not depend on whether a physician belongs to a Family Health Team (FHT), practices in a Community Health Clinic, or proactively seeks out individual programs.**

While existing programs like CEP offer valuable opportunities, low engagement levels suggest that many family physicians still face barriers to participation—not just in terms of knowing what to do, but also having the time to do it while managing overwhelming clinical workloads. To ensure broader adoption, QI initiatives must be embedded within clinical workflows, rather than relying solely on individual outreach efforts.

However, it must be recognized that at the initial stages, physicians need protected time to engage in QI efforts. Early investment in dedicated time allows physicians to integrate QI meaningfully into their practice, fostering efficiencies that gradually free up time and enable the process to become self-sustaining in the long run.

Just as patients experience better health outcomes when they have a continuous relationship with their family physician, the same principle applies to clinics and their QI support teams. Clinics thrive when they have consistent engagement with the same QI facilitators, fostering trust, long-term collaboration, and higher rates of innovation uptake.

Support Practices to Build their Quality Improvement Capacity

Quality improvement (QI) capacity goes beyond individual projects, it requires a deep understanding of and commitment to continuous improvement. The goal is to embed QI as a core function of primary care, creating a sustainable framework and culture that enables practices to adapt to challenges and consistently deliver high-quality care. In other words, practices become learning organizations.

To be effective, QI must be practical and tailored to the realities of clinical practice. Physicians already face immense demands, and QI efforts should complement, not complicate, their workflow. Simple, well-integrated approaches that align with practice priorities that are appropriated supported ensure that improvement initiatives are meaningful rather than burdensome. When structured this way, QI enhances patient care without adding unnecessary workload.

Quality improvement in primary care isn't just about individual projects—it's about creating a sustainable culture of continuous learning and adaptation. By developing QI skills, clinics can tackle new challenges efficiently, improving care across multiple areas, from chronic disease management to opioid safety and risk screening. The goal is to build lasting QI capacity that enhances teamwork, optimizes data use, and fosters innovation, ensuring high-quality care for diverse patient needs.

For example, a clinic's initial QI project might focus on improving care for a specific chronic condition. The team would train staff to use community-level data, mine and optimize EMR systems, and explore new ways to leverage clinic resources. They would redesign team workflows, integrate evidence-based care protocols, and implement clinical practice guidelines effectively.

Regular QI team meetings provide a platform for collaborative problem-solving, enabling the clinic to refine and sustain improvements over time. However, this effort doesn't stop with one improvement area. By building strong QI foundations, clinics strengthen their ability to apply these strategies to new areas, whether improving opioid overdose prevention, enhancing preventive care and screening protocols, or expanding patient access to care. The QI skills they develop become transferable tools for ongoing improvement, ensuring adaptability and long-term success.

Develop a Quality Improvement Infrastructure

Building a provincial QI structure requires careful planning. This paper highlights four key areas: practice facilitation, clinical change priorities, access to data, and collaborative networks.

Practice Facilitation

Practice facilitators are experts in primary care context, provincial priorities, and quality improvement. Evidence shows they enhance clinical outcomes, support chronic disease management, improve preventative care, and strengthen team collaboration.

Their role is to make QI meaningful and actionable for family physicians and their teams. By understanding clinic needs and patient populations, facilitators align improvements with clinic priorities, ensuring real value. The local, personalized nature of this support is essential, what works for the clinic in Temiskaming is likely to differ greatly from a clinic in Toronto's west end. A trusted, skilled practice facilitator helps clinics optimize processes in ways that are practical, efficient, and beneficial to both physicians and patients.

A U.S. study found that practice facilitation costs range between $9,670 and $15,098 per practice annually and could be cost-neutral if it prevents two hospitalizations per practice per year. While practice facilitation exists in Ontario, access for family physicians is limited by funding models or programs. The SGFP calls for equitable access for all family physicians to this crucial resource.

Clinical Change Priorities

Clinical QI priorities focus on improving patient care and practice management, guided by identified needs, evidence-based practices, and system-wide goals. While this work is well-established within the Centre for Effective Practice, further alignment with provincial priorities and the expansion of practical tools would enhance its impact and drive meaningful primary care transformation. To ensure long-term success, primary care requires a clearly defined strategic direction—a ‘north star’—that aligns local improvement efforts with a broader, system-wide vision for sustainable change.

Access to Data

Beyond EMR data, practice teams need provincial, regional, and local datasets to inform QI projects, benchmark progress, and track improvements. Individual family physician and practice-level data are essential —not only for informing clinical decisions, but also for measuring the true impact of change efforts. Data-driven decision-making can motivate teams and accelerate transformation, but only if the right metrics are used. To drive meaningful improvements in patient care, measures must be clinically relevant, rather than selected purely for ease of measurement.

Communities of Practice, Networks, and Learning Collaboratives

A provincial QI infrastructure will foster peer-to-peer learning and system-wide collaboration.

- Communities of Practice connect healthcare professionals to exchange best practices.
- Networks promote collaboration across organizations, breaking down silos.
- Learning Collaboratives provide structured environments to test, refine, and scale innovations.

Together, these elements strengthen Ontario’s capacity for continuous QI, ensuring equity, shared knowledge, and sustainable improvements in primary care.

Other considerations—such as patient involvement, QI leadership development, and digital health QI, remain important but are beyond the scope of this paper.

TRANSFORMATION STRATEGY

While the Change Management Strategy focuses on individual and localized behavior shifts crucial for successful adoption of change at the clinic level, the Transformation Strategy provides the overarching framework to ensure these changes happen at scale across the entire primary care system.

Even with adequate financial resources, widespread QI adoption is not guaranteed, evidence suggests uptake is often limited and inconsistent. Embedding QI practices requires more than communications, workshops, and toolkits. It demands a structured approach that ensures:

- Every clinic is aware of the new ways of working.
- A desire for change is cultivated.
- Front-line professionals have the knowledge, skills, and attitudes to drive meaningful improvements.
- For lasting impact, this approach must be sustainable and adaptable for future innovations, supported by structural reinforcements that ensure QI practices remain embedded at both the clinic and system levels.

Ontario has an embarrassment of resources to support primary care transformation, yet widespread transformation remains elusive. The 2015 landmark report, “Unleashing Innovation: Excellent Healthcare for Canada” report authored by the Advisory Panel on Healthcare Innovation chaired by David Naylor discusses the challenges in scaling up successful demonstration projects to systemic practice as one of the central problems that Canadian health care faces today. This scale problem is solvable.

To enable primary care to evolve and scale change over time, the SGFP outlines three essential elements for a provincial transformation strategy:

- **Build understanding among policymakers and leaders on how transformation happens.**
- **Adopt approaches that mitigate the “valley of death”, where most healthcare innovations fail to scale.**
- **Establish the right structures to support a successful and sustained transformation.**

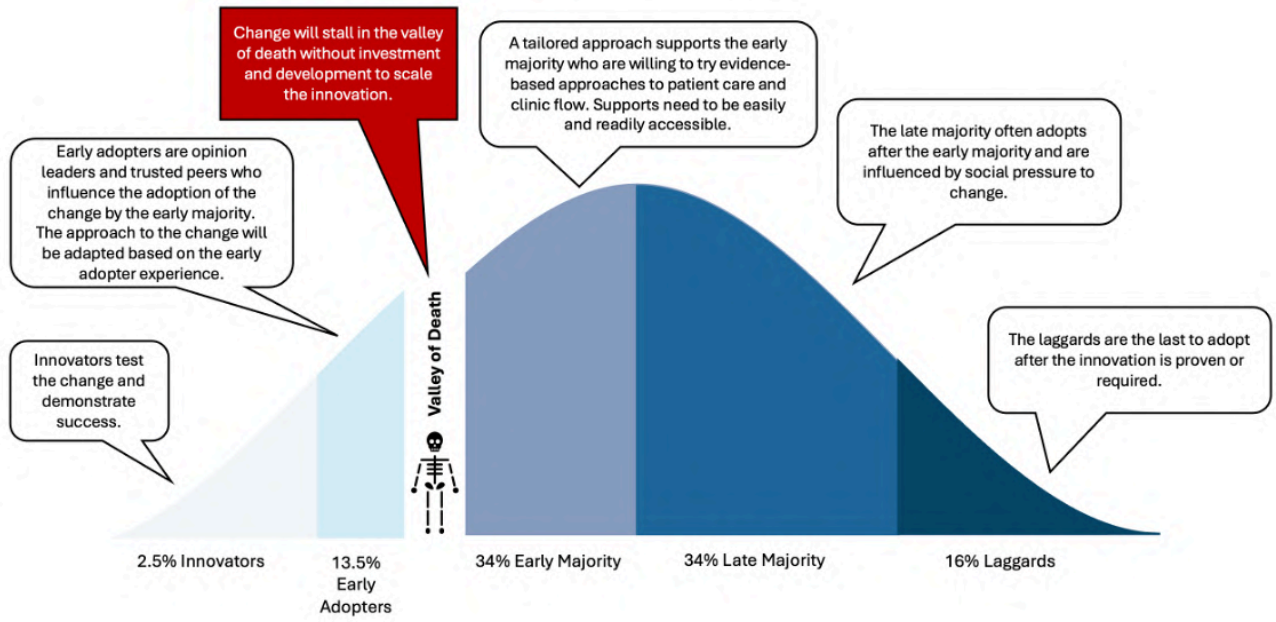
How Transformation Happens: The Diffusion of Innovations Theory

Rogers’ Diffusion of Innovations Theory explains how new ideas, behaviors, or technologies spread through populations gradually rather than being universally adopted all at once. Originally developed in agriculture to study how farmers adopted new practices, the framework highlights the role of social systems, communication channels, and time in influencing the spread of innovations.

This pattern applies widely from cars and smartphones to recycling and genetically modified seeds, each following a predictable adoption curve. A crucial challenge in scaling innovation is crossing the “Valley of Death”, the point where many promising innovations fail to gain traction. To achieve widespread adoption, the transition must reach the tipping point, where steady progress suddenly accelerates into widespread adoption, driving meaningful societal or business change.

Successfully bridging the Valley of Death requires strategic engagement with the early majority, who adopt change differently than innovators and early adopters. While early adopters demonstrate success, the early majority seeks proven, scalable solutions before committing, making their involvement critical to system-wide transformation.

Rogers' Diffusion of Innovations



Many initiatives aimed at scaling innovation operate under the assumption that collaborating with early adopters will naturally lead to the development of standardized solutions and best practices that can be economically extended to the broader audience. In practice, however, this expectation usually runs counter to real-world dynamics—an observation echoed across various sectors, including healthcare.

Addressing the Valley of Death: Think Like the Early Majority

Early adopters and the early majority approach innovation differently. The factors that motivate early adopters often do not appeal to the early majority, who require more structured facilitation and change management support.

A 2018 study on scaling the PMH identified several defining characteristics of early majority physicians when adopting new work:

- Prefer incremental change rather than sweeping transformations.
- Open to change, but will not "swim upstream" against major barriers.
- Need innovations introduced by trusted peers rather than external sources.
- Willing to try evidence-based improvements with clear patient care or operational benefits.
- Require accessible, on-demand support rather than complex processes.
- Often struggle to see how an individual improvement connects to broader primary care transformation.

Recognizing and addressing these characteristics is essential to ensuring the early majority is not left behind, or put another way, that the innovation does not fall into the "Valley of Death" and fail to scale. A transformation strategy must be designed to actively support their adoption process, providing tailored facilitation, accessible resources, and peer-driven engagement to create the conditions for meaningful and sustained change.

Example: Applying the Early Majority Characteristics to Team-Based Care Implementation

Characteristics of the Early Majority	Considerations for Team-based Care Implementation and Optimization
Prefer incremental change.	Trust building with new team members takes time before they take on patient care responsibilities.
Are open to change, but will not "swim upstream".	Many family physicians may avoid time-consuming processes like submitting expressions of interest or handling human resource tasks.
Need change brought to them by someone they know and trust.	Scaling team-based care requires physician champions (e.g., peers) who are credible, relatable and persuasive.
Open to evidence-based changes that improve patient care or clinical operations.	Messaging must clearly demonstrate value rather than offering vague benefits. Example: "Team-based care improves diabetic management by X%".
Require easily accessible support.	Many family physicians will not actively seek help; supports need to be proactive and embedded in their workflow.
Struggle to connect individual improvements to broader primary care transformation.	A clear future state vision for family medicine and primary care, such as how team-based care fits into the Patient's Medical Home, is essential.

Early majority physician engagement is essential for scaling innovation beyond individual practices. Without a cohesive provincial transformation strategy, this group is unlikely to be properly engaged risking lack of progress with scattered improvements that lack alignment or lasting impact.

The value of system-wide primary care reform lies in creating a consistent, high-functioning care model—ensuring that innovations are reinforced, standardized, and supported across the province. Without this broader alignment, physicians may invest time in individual improvements that ultimately fail to integrate into a sustainable framework, limiting their long-term effectiveness.

A provincial strategy ensures: ✓ Changes are not isolated, but systematically embedded across all practices. ✓Resources and supports are aligned, preventing duplication and inefficiencies. ✓ Physicians lead transformation, shaping primary care structures rather than adapting to disconnected policies.

To truly avoid the "Valley of Death," primary care reform must not rely solely on early adopters—it must actively engage the early majority, demonstrating why broader transformation is necessary for lasting success.

Structuring for Change: Leveraging Family Physician-Led PCNs

Now that *how transformation happens* is understood and what the early majority needs to adopt change is outlined, the next critical step is building the right support structures to ensure change and transformation success.

For widespread adoption, transformation efforts cannot rely on early adopters alone, the early majority requires trusted leadership, hands-on facilitation, and accessible guidance to integrate new models of care effectively. Physician champions and practice facilitators will play a central role in bridging gaps, reducing barriers, and making innovation scalable across primary care.

Ontario's primary care system remains fragmented, with multiple uncoordinated organizations supporting different aspects of healthcare delivery and transformation. A cohesive provincial strategy has yet to materialize, and one of the most pressing challenges is the lack of family physician engagement in system design and reform.

Despite their critical role, family physicians have not been meaningfully included in shaping and implementing primary care transformation. Without standardized mechanisms for engagement, ensuring consistent family physician involvement across the system remains difficult.

In 2024, SGFP developed two discussion papers outlining strategies to strengthen Primary Care Networks (PCNs) and their potential to drive team-based care implementation and system-wide reform. While no existing primary care structure fully enables province-wide transformation, PCNs are uniquely positioned to serve as the foundation for systemic change.

However, Ontario's healthcare landscape is crowded with administrative structures, including Ontario Health Teams (OHTs) and PCNs, FHTs, CHCs, and FHOs (to name a few), many of which overlap in geography and function. To ensure effective transformation, these structures must be streamlined, strategically aligned, and designed for longevity, avoiding unnecessary duplication while strengthening physician leadership.

The SGFP Advocates for PCNs to Serve as the Foundation for Transformation and Change by:

- Accelerating development of PCNs, elevating their profile, responsibilities, and physician leadership.
- Positioning PCNs as the primary entities overseeing team-based care funding and broader transformation efforts.
- Leading ongoing change management, ensuring effective resource deployment and sustained reform.

Accelerate Development, Elevate Profile, Responsibilities and Family Physician Leadership

PCNs currently lack clear objectives, leadership, and accountability structures, leaving their role in provincial healthcare transformation undefined. However, they present a major opportunity for government to establish front-line engagement, standardized approaches, and measurable outcomes.

In other jurisdictions, PCNs have successfully engaged family physicians, ensuring meaningful leadership in system-wide transformation. Ontario can follow suit by embedding physician-led governance to support clear decision-making, accountability, for the successful implementation of team-based care and future innovations.

Evolve PCNs to Hold Funds & Lead Team-Based Care

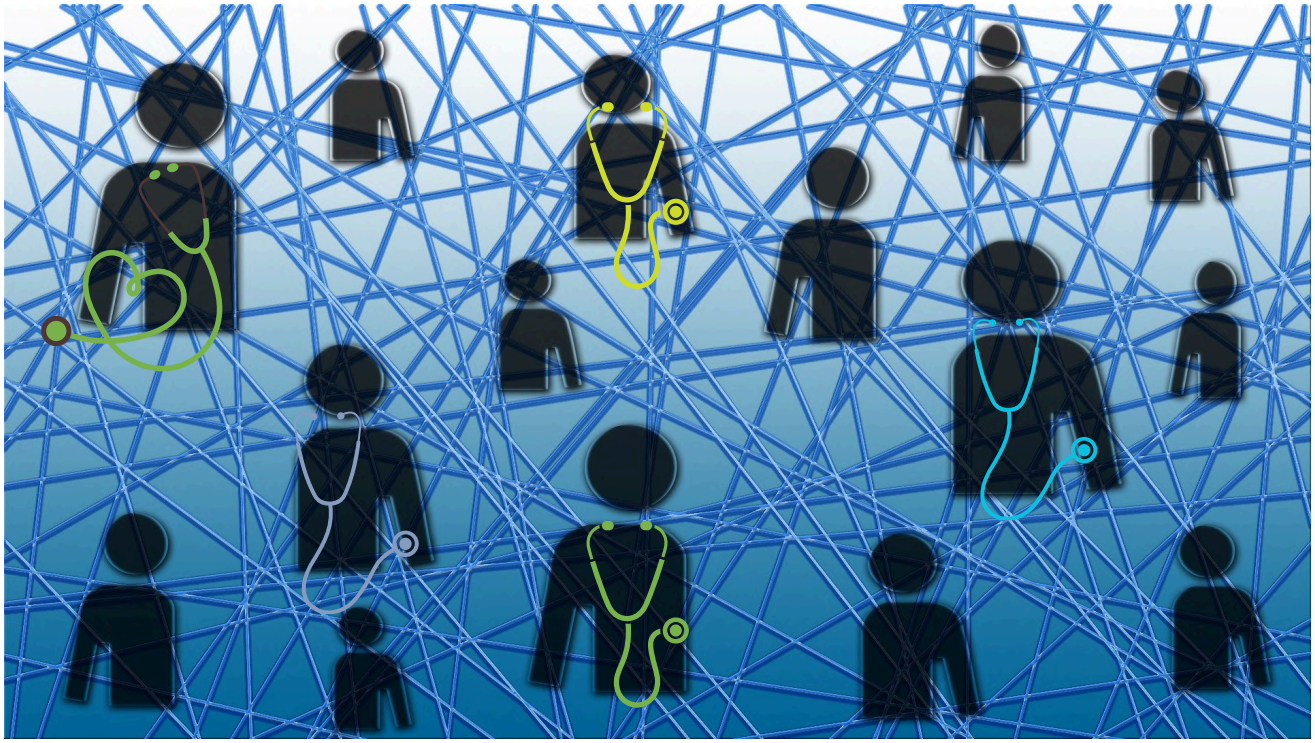
For primary care reform to succeed, PCNs must evolve into central entities, responsible for managing innovation funding and leading system-wide transformation. With province-wide reach, PCNs offer the structured mechanism needed to implement reforms consistently and with accountability.

Despite various organizations working in primary care, no entity has primary care reform and support as its core mandate. If Ontario is serious about strengthening primary care and recognizing its critical role in the health system, it must invest in structures designed specifically to lead and sustain transformation. PCNs provide a physician-led, primary care-focused framework capable of driving meaningful change at scale.

Assign PCNs the Accountability for Change Management

PCNs must lead change management efforts to support primary care transformation. As discussed earlier, early majority physicians adopt change more readily when guided by trusted peers and when support is accessible and practical.

With family physicians leading PCNs, they can set the course for change, ensuring strong peer engagement and buy-in. Embedding change management resources within PCNs will make support more responsive, structured, and integrated into local implementation efforts, creating a smoother transition to team-based care.



AN INTEGRATED CHANGE AND TRANSFORMATION PLAN

This five-step plan depicted below provides an illustrative example of how Ontario could integrate both change management and transformation strategies using the recommendations found throughout this paper, as well as recommendations from other of SGFP's discussion papers, to drive sustainable primary care reform. It demonstrates how clinic-level improvements align with system-wide transformation, ensuring a cohesive, scalable approach to advancing primary care delivery.

1. Develop a Provincial Primary Care Strategy	The transformation of the family medicine clinic and primary care must be informed by a provincial primary care strategy that integrates several important system components including, but not limited to, training and education, compensation, digital health and practice models.
2. Define the Vision for the Future of the Family Medicine Practice	The Patient's Medical Home is a tried and true vision for a family practice. When its elements are realized, the evidence shows health outcomes improve, patients, doctors and clinic teams are more satisfied, and care is cost effective. Although aspects of the model continue to evolve with the times, two decades later, its core principles remain firmly supported by evidence.
3. Create the Structures to Support Change	Primary Care Networks are locally led by family physicians, or those that provide the majority of care in their communities. Embedding the funding for team-based care as well as the change management within these entities brings the oversight and implementation of these two important resources as close as possible to the ground. Family physician peer champions and leaders are embedded in PCNs to further drive change with their colleagues. In addition to the local primary care networks, PCNs are also provincially networked.
4. Establish a Skilled Workforce to Facilitate Change	Transforming to a PMH model requires the support of skilled practice facilitators. These facilitators must be someone the doctors and team members know and trust. They are hired and deployed locally to help with change around local needs, and also networked provincially so they can implement provincial priorities and share best practices. Practice Facilitators are intended to work with clinics over time on various improvement initiatives, enabling clinics to build their "capacity for improvement" and become learning organizations.
5. Go to Scale	Change is realized at the level of care, in the family medicine clinics, all across the province.

CONCLUSION

Achieving meaningful primary care transformation requires coordinated action at both the clinic and system levels. Primary care must evolve in a way that empowers frontline family physicians and other healthcare professionals while driving broader structural reform.

At the clinic level, change happens through incremental improvements, peer-led innovations, and accessible support systems. Embedding quality improvement as a core competency in family medicine, alongside upskilling current physicians, ensures practices can adopt and sustain continuous advancements. Local practice facilitators, who build trust through repeated engagement, serve as essential change agents in guiding clinics through transitions.

At the system level, transformation requires a provincial primary care strategy that clearly defines the future of family medicine. The Patient's Medical Home framework must serve as the foundation for reform, providing physicians with the team-based resources, financial supports, and leadership structures necessary to optimize patient care.

To move beyond isolated efforts, family physician-led Primary Care Networks offer an effective model for managing system-wide change. These networks must evolve to embed team resources and position family physicians at the center of healthcare decision-making. The Diffusion of Innovations Theory reinforces that lasting transformation hinges on supporting early adopters, minimizing barriers, and ensuring alignment between operational improvements and provincial strategies.

By integrating clinic-level strategies with system-wide transformation, Ontario can build a primary care landscape that is sustainable, responsive, and rooted in family physician leadership. The road ahead is complex, but by aligning practice-level innovation, policy development, and structured change management, family physicians can drive real, lasting improvements in primary care delivery.

REFERENCES

Accelerating Change Transformation Team. (2019). Practice facilitation evidence summary. Alberta Medical Association. Retrieved from: https://www.albertadoctors.org/resource-centre/practice-facilitation-resources/pf-evidence-summary/

Agency for Healthcare Research and Quality. (2013). *Building quality improvement capacity in primary care: Supports and resources*. Retrieved from: https://www.ahrq.gov/sites/default/files/publications/files/pcmhqi2.pdf

Baskerville BN, Liddy C, Hogg W. Systematic review and meta-analysis of practice facilitation within primary care settings. *Annals of Family Medicine* 2012;10(1):63-74. Retrieved from: www.annfammed.org/content/10/1/63.full

British Medical Association. (2025). The Value of a GP. Retrieved from https://pexlib.net/?247601

Culler SD, Parchman ML, Lozano-Romero R, Noel PH, Lanham HJ, Leykum LK, et al. Cost estimates for operating a primary care practice facilitation program. *Annals of Family Medicine*. 2013 Jun;11(3):207–11. http://www.annfammed.org/content/11/3/207.full

Excellent Care for All Act. Government of Ontario. 2010. https://www.ontario.ca/laws/statute/10e14

Green, L. A., et al. Scaling Up Primary Care Transformation in Alberta: Insights from Cognitive Science Studies. Edmonton, AB. 2018. Retrieved from: https://www.primarycareresearch.ca/images/scaling_up.pdf

The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. Retrieved from: https://www.ihi.org/library/white-papers/breakthrough-series-ihis-collaborative-model-achieving-breakthrough

Naylor, D.,Girard, F., Mintz, J., Fraser, N., Jenkins, T., & Power, C. (2015) Unleashing Innovation: Excellent Healthcare for Canada: Report of the Advisory Panel on Healthcare Innovation. Health Canada. https://www.canada.ca/en/health-canada/services/publications/health-system-services/report-advisory-panel-healthcare-innovation.html

OntarioMD. (2025). Peer Leader Program. Retrieved from: https://www.ontariomd.ca/products-and-services/peer-leader-program

Ontario Ministry of Health. (2025). Ontario's Primary Care Action Plan. Retrieved from: https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025

Rogers EM. Diffusion of innovations. 5th ed. New York (United States): Free Press; 2003.

Section on General & Family Practice (2024). *Adopting the Patient's Medical Home – The framework to evolve Ontario's family medicine practices.* Toronto, ON: Section on General & Family Practice. https://www.sgfp.ca/policy

Section on General & Family Practice (2024). *Optimizing Primary Care Networks in Ontario: Recommendations to accelerate and advance the evolution of Primary Care Networks.* Toronto, ON: Section on General & Family Practice. https://www.sgfp.ca/policy

Section on General & Family Practice. (2024). *Implementing team-based care in Ontario through primary care networks: A roadmap for equitable, effective and sustainable implementation.* Toronto, ON: Section on General & Family Practice. https://www.sgfp.ca/policy

Section on General & Family Practice. (2025). *The role and value of family physicians in Ontario: The keystone of primary health care.* Toronto, ON: Section on General & Family Practice. https://www.sgfp.ca/policy

Wagner, K., & Austin, J., & Toon, Lynn & Barber, T., & Green, L. (2019). *Differences in Team Mental Models Associated With Medical Home Transformation Success*. *The Annals of Family Medicine.* 17. S50-S56. https://doi.org/10.1370/afm.2380.

SGFP
GENERAL & FAMILY PRACTICE

150 Bloor St W, Suite 900
Toronto, ON M5S 3C1

www.SGFP.ca
ChairLetterSGFP@outlook.com