Team-Based Care to Expand Attachment: SGFP Perspectives

Family physicians attach most Ontarians. Here's what it will take for us expand attachment.

Family physicians are central to solving Ontario's primary care access and attachment crisis. Patients and the system rely on the comprehensive, longitudinal care that only family physicians provide. When supported by well-integrated teams, family physician-led care is cost-effective, preferred by patients, and delivers better outcomes. If designed intentionally, team-based models expand capacity for attachment.

The SGFP affirms that every Ontarian should have access to the care of a family physician supported by a team. This does not mean that family physicians are gatekeepers of care, but rather that their expertise is embedded within the team, available to patients when needed, and shared with colleagues to support high-quality care.

This brief paper outlines three key enablers that expand family physician capacity to attach patients:

1. Generalist/core team supports
2. Integration and co-location of core team members
3. Change supports, including practice facilitation

This paper builds on the OMA's 2025 Policy paper, *Building Capacity to Attach all Ontarians to Primary Care: The Patient Core Team*. The SGFP supports the core team concept and is expanding on some of its critical elements in this paper.

These recommendations are grounded in evidence and experience, including insights into how teams function across a spectrum and how cognitive load is distributed in complex care. We conclude with funding recommendations to support these enablers.

What's Needed to Expand Family Physician Capacity for Attachment

1 Generalist Team Supports

Family physicians need team members who can take on a wide range of clinical and administrative tasks. These generalist roles, such as primary care nurses and medical office assistants, help extend the physician's capacity and allow more patients to be attached.

- The exact mix of team supports will vary across practices, depending on patient needs, team member skills, and clinic workflows.
- Generalist roles differ from targeted allied health care resources, such as a diabetic foot nurse or respiratory educator. While these services are valuable, they tend to enhance care for specific patients rather than increase overall capacity.
- Developing training programs and competencies tailored to generalist roles in primary care may further enhance capacity.
- Contracts for teams must be redesigned to prioritize generalist supports that enable patient attachment, rather than emphasizing access to community programs.

2 Integration and Co-location of Core Team Members

For teams to work effectively, they need to be integrated and, ideally, co-located.

- When team members share space, they build trust, collaborate more easily, and provide more consistent care.
- Centralized models, where physicians refer patients to offsite team resources, often don't support the level of collaboration needed to share work meaningfully.
- Where co-location isn't possible, purposeful integration must be prioritized. This includes shared technology and workflows that support real-time communication.
- Integration looks different across settings. In Northern Ontario, for example, team supports often travel to patients and/or provide virtual care to make care more accessible.
- Team members can unintentionally increase a physician's workload if roles are not clearly defined. Shared care models must support physicians can practicing to optimal scope, and avoid family physicians absorbing additional tasks.

3 Change Supports

Shifting to team-based care requires resources plus changing how care is delivered. This type of change requires support.

- Information alone does not lead to behaviour change. The evidence is clear that teams need dedicated, trusted practice facilitators to help them evolve their practices.
- Internationally, successful transformation is happening through "mass customization", or tailored support that reflects each clinic's unique context rather than one-size-fits-all approaches.
- Practice facilitators can guide teams through this change, helping them build new workflows, clarify roles, and adopt team-based models that truly increase capacity.

Why These Recommendations Matter: Team Functioning and Cognitive Load

- Team-based care works only when team members are truly integrated. Research shows that primary care teams operate along a spectrum, from loosely connected to fully collaborative. Most clinics will not automatically shift to high-functioning models. In fact, only about 15% of clinics evolve on their own. The other 85% need support to get there. This is well-documented reality of how human behaviour change works. (It is described in detail in this SGFP Discussion Paper.)

- At the heart of this shift is how work and thinking are shared. Family physicians carry a heavy cognitive load: making decisions, coordinating care, managing uncertainty, while providing compassion. These high-level mental tasks are called macrocognitive functions. This is the deep thinking that happens in complex settings like primary care.

- When teams are well-integrated, these functions can be shared to increase capacity, not just adding people, but by distributing the thinking, problem solving and responsibility across the team. Co-location and trust are key to this happening.

- Without the right team supports, integration, and practice change facilitation, family physicians remain the sole decision-makers. Capacity is unchanged, attachment remains limited, and the system strained.

Team Mental Models and the Distribution of Macrocognitive Functions

The previous section introduced the idea that team-based care only increases capacity when cognitive work is shared. This section offers a deeper look at how teams function and why most clinics need support to evolve.

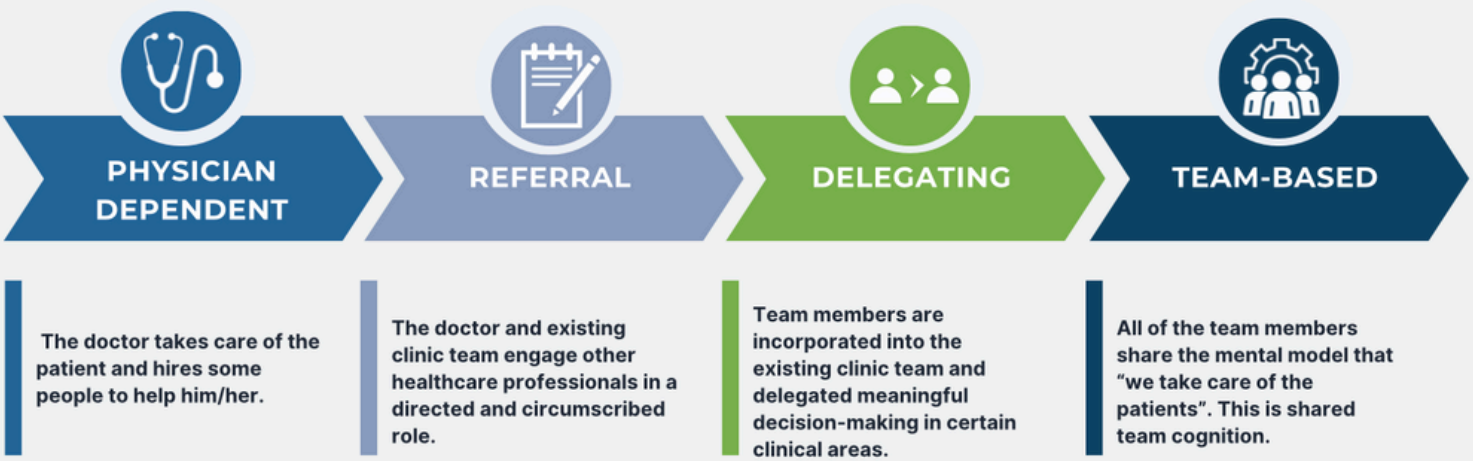
The Spectrum of Team Functioning

Primary care teams operate along a spectrum, from physician-dependent models to fully integrated, collaborative teams. Many studies on team-based care focus on high-performing clinics with strong capacity for innovation. But these are not representative of most practices.

We know what's possible. The challenge is spreading and scaling those optimal models.

Research shows that only about 15% of clinics will self-motivate and self-teach their way to high-functioning team-based care. The other 85% need structured support through practice facilitation, funding reform, and intentional design.

Figure 1. Spectrum of Team Functioning in Primary Care: From Physician-Dependent to Shared Team Cognition



This graphic illustrates how team mental models evolve. At the left end of the spectrum, physicians remain the central decision-makers. At the right, cognitive work is distributed across the team, allowing family physicians to practice to scope and attach more patients. This is shared team cognition and is the gold standard we seek.

The SGFP is advocating for generalist team supports, integration/co-location of team members and change supports so we can move the majority of clinics toward distributed, team-based thinking, or "shared team cognition".

What are Macrocognitive Functions?

Macrocognitive functions are the high-level mental tasks people use to navigate complex, real-world situations. These include decision-making, planning, coordinating, and managing uncertainty, especially under time pressure and multiple competing priorities.

Primary care is full of these moments.

In most clinics, family physicians carry this load alone. In well-integrated teams, these functions are shared, freeing up capacity and improving care.

Macrocognitive Functions in Primary Care:

- Sensemaking and learning
- Decision making
- Planning and replanning
- Monitoring and problem detection
- Managing the unknown
- Coordinating

A Familiar Analogy

It's like asking what's for dinner. The cooking is often the easy part, but deciding what to make, planning around everyone's preferences, and coordinating the ingredients takes substantial, flexible mental effort. In primary care, that kind of cognitive load is constant. Sharing it across the team is what creates more physician capacity and makes increasing attachment possible.

Funding Reform to Support Team-Based Attachment

To scale effective team-based care and increase attachment, Ontario needs funding models that support both family physician compensation and the broader primary care environment. These two areas are distinct but interdependent. Both must reflect the diversity of family practice environments. Some key funding reform elements include:

- Enable flexible hiring options. Family physicians should have the option to:
  - Directly hire team members who meet the specific needs of their practice and patient population.
  - Access locally hired resources managed by other entities, provided those resources are responsive to clinic needs and integrated into workflows.
- Support co-location and integration. Clinics need physical space, shared technology, and workflows that allow teams to collaborate in real time.
- Simplify the funding and governance environment. The current system is administratively complex and difficult to navigate. Radical simplification is needed to reduce leadership fatigue and free up time for patient care.
- Fund change supports. Practice facilitation must be resourced as a core component of team-based care, not an optional add-on.

Summary and Call to Action

- Teams must have high-functioning generalist supports, people who can take on high-cognitive-load tasks and extend family physician capacity.
- Building trust in team members most often happens when the team is co-located and consistent.
- The funding for teams and change supports needs to be reformed for the future.
- Practice facilitation to evolve teams to having "shared team cognition" is essential.

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