Alliance for Healthier Communities
Alliance pour des communautés en santé

500-970 Lawrence Ave. W.
Toronto, ON M6A 3B6
416-236-2539
www.AllianceON.org

Aligning Ontario Health Teams and Primary Care Networks to Advance Primary Health Care
Executive Summary

Ontario Health Teams (OHTs) were established to advance integrated, people-centred care by improving coordination across local health and social services. Evidence from Ontario and internationally demonstrates that a strong, engaged primary care sector is essential to achieving this goal. The introduction of Primary Care Networks (PCNs) in 2025 provides a critical opportunity to strengthen primary care leadership, coordination, and participation in system decision-making. However, the relationship between OHTs and PCNs currently varies across the province, limiting consistency and impact. In addition, there is variance in the roles and functions of the OHTs and PCNs. As Ontario continues to shift care from hospitals to communities and from treatment to prevention, clearer definition and alignment between OHTs and PCNs is necessary to improve access, attachment, population health, and health equity.

This paper outlines a shared vision in which OHTs act as convenors of integrated care—bringing together health and social service partners, patients, caregivers, and communities—while PCNs serve as expert implementers responsible for planning and delivering improved health care, ensuring better health outcomes for the population they serve. This vision emphasizes streamlined governance, strong local partnerships, meaningful patient and caregiver engagement, and clear provincial guidance and mandates paired with local flexibility. Strengthening alignment and defining clear roles between OHTs, PCNs and Patient and Family/Caregivers Council (PFACs), will accelerate system transformation, reduce fragmentation, and enable more coordinated, community-based care that delivers better outcomes for Ontarians.

Introduction

Ontario Health Teams (OHTs) were introduced in 2019 to provide a new way of organizing and integrating local care delivery. The overarching goal is to ensure that everyone in Ontario benefits from more connected, coordinated, and convenient care. Evidence and experience from health systems around the world consistently demonstrate that a strong, engaged primary care sector is foundational to successful care integration and improved health outcomes. In 2025, Ontario enacted the *Primary Care Act*, establishing primary care as the foundation of the health system. The time is now for system implementers—Ontario Health Teams (OHTs) and Primary Care Networks (PCNs)—to shift their practices to support this transformation. It is therefore essential that OHTs work in close partnership with primary care and PCNs to advance population health, prevention, health equity, patient attachment, and, ultimately, truly

integrated care. Primary Care Networks were introduced in 2025 to bring primary care practitioners – family physicians, nurse practitioners and others together - to support coordinated care, shared resources, and meaningful participation in decision-making. Each PCN is organized within an OHT; however, the strength of the relationship between OHTs and PCNs varies significantly across the province. In some regions, these entities are tightly aligned, while in others they remain disconnected, limiting their collective impact.

The purpose of this guidance paper is to articulate a clear vision, objectives, and a common set of functions for OHTs and PCNs to develop over time, ensuring that they are complementary, aligned, and mutually reinforcing.

This paper draws on international best practices and highlights exemplary OHTs and PCNs that demonstrate the desired future state. While we recognize that OHTs encompass more than primary care, primary care is the focus of this paper given its critical role in system transformation and the current system priorities. Health systems globally are shifting from hospital-based care to community-based care, and from a focus on sickness to prevention. Ontario is no exception, particularly with its increasing emphasis on patient attachment and access to primary health care. These shifts are both welcome and necessary if Ontario is to achieve meaningful progress toward people- and community-centred integrated care and improved population health.

For meaningful change to occur, the voices of those involved—providers, patients, caregivers, and communities—must be heard. This is where OHTs and PCNs play a vital role. Together, they can serve as convenors of integrated care, ensuring that primary care voices within PCNs, as well as patients and communities, are active partners in system transformation.

A Shared Vision for OHTs and PCNs

We envision OHTs and PCNs working in close alignment to advance primary care and support integrated care. OHTs should act as convenors, bringing together health and social care organizations to develop shared priorities and integrated care plans. PCNs (consisting of physicians, nurse practitioners, interprofessional team members and primary care executive leaders), in turn, should serve as expert implementers, leading the planning and delivery of primary care.

In this model, each OHT would receive clear guidance, mandates and oversight from Ontario Health (corporate) and implement locally. There is no need for each OHT to design structures and processes from scratch; stronger and more consistent provincial guidance would enable greater alignment and efficiency. That guidance should include clear expectations on the structure, expected participants, community involvement, and key priorities. Local implementation would then be driven collaboratively by the OHT executive

(leadership/executive committee, consisting of leaders from OH funded health service providers), the PCN, and Patient and Family/Caregiver representatives.

Ontario Health Teams

OHTs are the primary vehicle for integrated care and should serve as the convenor of partnerships and relationship-building at the local level. They should provide flexibility for local partners to tailor service delivery, while maintaining a clear focus on shared outcomes. Partnerships are the golden thread that runs through OHTs, creating opportunities for organizations to work together to improve outcomes for local populations.

The needs and aspirations of people and communities must remain at the heart of integrated care. These perspectives must be actively sought, listened to, and represented across the system so that communities are involved in all key decisions. Importantly, OHTs should not create additional administrative bureaucracy; rather, they should act as enablers of integration, streamlining decision-making by the partners and ensuring that all relevant decision-makers are at the table. OHTs should foster, not constrain, innovation. Finally, OHTs should not act as funders, given the inherent conflicts of interest, but rather as convenors of effective partnerships.

> *"Our OHT feels like a true collaborative versus a corporate entity"*
>
> *OHT, Executive Director*

> *"OHTs have been very helpful with some foundational things like population health data and data sharing agreements – this support has removed barriers so we can do the integrated care work we want to do"*
>
> *Primary Care, Executive Leader*

Incorporation is not required for effective collaboration. For some high-performing OHTs, choosing not to incorporate has enabled them to focus on care integration rather than building new organizational structures. In this model, the steering committee - specifically the leadership or executive table - is responsible for strategic planning, decision-making, and oversight. OHT staff support the steering committee(s) to work together better. This includes convening and strengthening partnerships, facilitating decision-making, providing population health data to improve health outcomes and reduce health disparities, and sharing best practices.

It is important to recognize that the OHT leadership/executive table from OH funded health service providers, the Primary Care Network, and the Patient and Caregiver Council each bring distinct strengths. These bodies should not compete with one another but instead work collaboratively. All three should have equal input into decision making. OHT staff play a critical support role for these groups but are not decision-makers.

Steering Committee and Working Groups

The **OHT Leadership/Executive Table** (steering committee) brings together leaders and governors from OH funded health service providers/organizations. It should include representation from the Primary Care Network and the Patient and Caregiver Council. This group has a collective responsibility to collaborate, understand local population health needs, set priorities, and agree on strategies to improve population health within their communities. Decision-making authority should rest with local partnerships that work directly with communities to design and deliver efficient services that meet local needs and reduce duplication. This group holds voting rights and is accountable for system-level decisions. While it would not have the authority to dictate how individual organizations operate, it would set the conditions that enable meaningful participation by all partners.

> *"OHT and PCN are a 'we' - there is a high degree of ownership. We are the OHT"*
> *Primary Care, Executive Leader*

The **OHT Primary Care Network** brings together primary care providers, including physicians, nurse practitioners, interprofessional team members, and primary care executive leaders from OH funded health service organizations. The PCN is responsible for informing, planning, delivering, and transforming primary care and serves as a collaborative planning partner with the OHT Leadership/Executive Table. The PCN should not evolve into the role of funder or performance manager.

The **OHT Patient, Family/Caregiver Council** represents a critical voice within the OHT. This council should represent the diversity within the community as well have a strong and equal voice and be supported to ensure that they are enabled to be a true collaborator. This will ensure that lived experience informs planning and decision-making and serves as a collaborative planning partner with the OHT Leadership/Executive Table.

Conclusion

The success of Ontario Health Teams as the vehicle for integrated care depends on strong, deliberate alignment with Primary Care Networks. Primary care is foundational to population health, prevention, access, and equity, and PCNs provide a critical mechanism for engaging and mobilizing this sector. Ensuring that Patient and Family/ Caregiver Council have an equal voice will ensure that the decisions that are being made will reflect patient and community need, thus enabling a patient centred health system, rather than the historical provider driven system. By positioning OHTs as convenors of integrated care and PCNs as expert implementers, supported by clear provincial guidance and mandates as well as streamlined local governance, Ontario can reduce fragmentation and accelerate system transformation. Meaningful partnership with patients, families/caregivers, and communities must remain central to this work. With clear roles, shared accountability, and sustained collaboration, OHTs and PCNs can

together deliver more connected, community-based care and improved outcomes for people across Ontario.

We have provided a summary of recommendations in the appendix.

Appendix A: Summary of Recommendations

Entity	In Scope	Out of Scope
Ontario Health Teams (OHTs)	Act as **convenors of integrated care**, bringing together health, social service, community, patient, and caregiver partners	Deliver or manage primary care services directly
	Focus on **system-level integration**, shared priorities, and population health outcomes	Micromanage clinical operations or dictate how primary care practices operate
	Create space for **collaborative decision-making** with PCNs and Patient & Caregiver Councils	Make unilateral decisions without meaningful primary care or patient input
	Enable **local flexibility** while aligning with provincial direction	Require every OHT to reinvent governance structures or processes
	Streamline decision-making and **reduce duplication and bureaucracy**	Create additional administrative layers or parallel structures
	Ensure patient, caregiver, and community voices are **actively embedded** in planning and oversight	Treat patient engagement as symbolic or advisory-only
	Maintain a **clear focus on shared outcomes** (access, attachment, equity, prevention)	Prioritize organizational interests over population needs
	Support partnerships without requiring incorporation	Assume incorporation is necessary for effectiveness
	Provide staff support functions (e.g., coordination, facilitation, analytics, reporting)	Position OHT staff as decision-makers rather than enablers
	Share decision-making authority with PCNs and Patient and Family/Caregiver Councils	Compete with PCNs or Councils for influence or control

Entity	In Scope	Out of Scope
Primary Care Networks (PCNs)	Serve as **clinical experts** of primary care planning, delivery	Act as a funding body or system purchaser
	Facilitate **primary care transformation**, including access, attachment, prevention, and equity	Take on system integration roles better suited to OHTs
	Represent the collective voice of primary care in OHT decision-making	Function in isolation from the OHT or broader system partners
	Engage physicians, nurse practitioners, interprofessional teams, and primary care leaders	Operate as a physician-only or siloed structure
	Partner with OHT leadership as a **co-equal planning partner**	Defer entirely to hospital or OHT-driven priorities
	Provide clinical guidance and address clinical barriers to advance provincial mandates	Accountability/performance management
	Translate OHT priorities into **practical, practice-level implementation**	Be responsible for convening non–primary care partners
	Drive improvements in quality, coordination, and continuity of primary care	Duplicate OHT governance or system planning structures
	Support shared accountability for population outcomes	Focus solely on individual practice interests

Shared "Red Lines" for Both OHTs and PCNs

In Scope	Out of Scope
Work collaboratively with patients, caregivers, and communities	Treat engagement as optional or after-the-fact
Respect distinct but complementary roles	Compete for authority, visibility, or control
Align around population health, equity, and prevention	Reinforce fragmentation or sector-based silos
Use governance to enable care, not slow it down	Overbuild committees, working groups, or reporting requirements
Share accountability for outcomes	Shift responsibility when challenges arise

Appendix B: OHT Governance Structure