Cohort 3 Ontario Health Teams
TPA Deliverable Guidance

June 2023

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Introduction & Purpose

This document provides guidance to Cohort 3 Ontario Health Teams (OHTs) to support the development and implementation of the **OHT Plan,** the key deliverable of the Continued Implementation Funding Transfer Payment Agreement (TPA).

Specifically, this document offers recommendations related to each of the OHT Plan priority areas (Figure 1) and provides a summary list of resources for consideration when developing the plan (refer to Appendix C). The guidance was prepared by Ontario Health (OH) in consultation with the Ministry of Health (MOH).

OHT Plan Priority Areas

Figure 1: *OHT Plan Priority Areas. OHTs are expected to ensure equity considerations are embedded across all Priority Areas.*

The four priority areas form the foundation of the OHT Plan, and build on existing clinical, digital and virtual, and organizational OHT priorities, including those articulated by MOH's latest policy direction (*Ontario Health Teams – The Path Forward*). These priorities are intended to continue enabling OHT maturity.

The OHT Plan should outline how deliverables across the priority areas will be achieved. Understanding that many Cohort 3 OHTs have made substantial progress against many of these deliverables, references to existing initiatives and/or workstreams are encouraged. For example, an OHT's efforts to advance an **Integrated Clinical Pathway** or to increase preventative screening rates as outlined within the **Collaborative Quality Improvement Plan (cQIP)** align with the priorities of this TPA and can be referenced in the OHT Plan. OHTs are also encouraged to provide details about any work underway to advance locally defined priorities, which may fall outside of the four priority areas, in the **Other Implementation Updates** section of the **OHT Plan Template.**

Prior to submission, the OHT Plan should be reviewed and approved by the OHT through processes prescribed by your **Collaborative Decision-Making Arrangement (CDMA)**. Once the OHT Plan is finalized and submitted, semi-annual reporting (i.e., a nine-month and final report) will provide an opportunity to highlight progress.

For additional accessibility and transparency, Cohort 3 OHTs are encouraged to share the TPA with all member organizations and primary care providers on the OHT website. If a website is not available, the TPA should be shared with OHT physician leaders.

Embedding Equity Considerations & Education Requirements across the OHT Plan

To support OHTs, OH's **data and analytics** team, in collaboration with the MOH, has released the OHT Data Dashboard – a suite of interactive, map-based reports to support OHTs in understanding and planning for the populations and communities they serve. These reports enable equity stratifications and the ability to drill down into attributed populations and geographical locations. Throughout FY 2023-24, OH will launch new reports of the OHT Data Dashboard and additional analytic supports for OHTs to segment populations, identify areas of concern and support ongoing planning.

When completing the OHT Plan, OHTs should ensure equity considerations are embedded across all priority areas. To support these efforts, the following guidelines have been prepared.

When developing the OHT Plan, OHTs should:

- Leverage existing equity frameworks and local/regional resources. Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework (EIDA-R Framework), and Black Health Plan (page 20) are available as resources. In 23/24, OH's First Nations, Métis, Inuit, and Urban Indigenous (FNIMUI) Health Framework will be released and available for teams later this year to help guide their work.
- Ensure member organizations comply with the requirements of French Language Services Act (FLSA) as applicable and working with the appropriate French Language Health Planning Entity or Entities for its priority patient population(s).
- Reach out to OH regional equity teams for support (contact information in appendix D).
- Review equity plans from partner organizations.
- Recognize the role of FNIMUI communities and organizations in the planning, design, delivery and evaluation of health services in their communities.
- Engage with patients, families and caregivers, FNIMUI populations, Francophone populations and other equity deserving communities (including Black and racialized communities; 2SLGBTQIA+ communities; and people with disabilities) with a goal of:
    - Building and sustaining productive relationships
    - Reducing inequities in access, experience, and outcomes for underserved populations

- Supporting co-design/re-design in OHT population health management

In addition, within the OHT Plan template, Cohort 3 OHTs are required to articulate a plan that outlines equity training, education or learning for OHT staff* to be completed by the end of the TPA period including:

- Indigenous cultural awareness and safety
- Heath equity
- French language services/Active offer

*For the purposes of this OHT Plan, OHT staff are defined as those whose positions are funded through OHT Implementation Funding.

In future reports, teams will be asked to report on progress on this deliverable. Refer to **Appendix C** (pages 19-21) for links to courses that can be accessed.

Priority Area 1: Integrated Care Through Population Health Management and Equity Approaches

The MOH and OH recognize that OHTs are the foundation for health system transformation and the vehicle for integrated care in Ontario. Improving population health outcomes for an OHT's attributed population using an equity-centred population health management (PHM) approach is one of the primary objectives of all OHTs.

Building on OHT accomplishments to date with initial target populations, a continuing area of focus is planning and delivering more equitable, culturally competent care. This includes identifying specific strategies, including engaging/partnering with community-based organizations, as an example, to ensure improved access to care for equity-deserving populations.

In *Ontario Health Teams – The Path Forward*, the phased introduction of integrated clinical pathways for OHTs to help deliver proactive, evidence-based care for patients with specific conditions was announced. OHTs working on the development and implementation of integrated care pathways for chronic diseases can report on this as part of TPA deliverables related to priority area 1.

Deliverables

Develop, implement, and measure a plan using population health management and equity approaches to:

- Continue to improve the coordination and integration of programs and services for initial target population(s).

- Design and implement improvements to care coordination and integration for additional target populations.
- Measure and evaluate OHT improvements using the Quintuple-AIM framework.
- Ensure engagement with the following groups:
    - Patients, family and caregivers
    - First Nations, Inuit, Métis, and Urban Indigenous (FNIMUI) populations,
    - Francophone populations,
    - Equity deserving communities, including Black and racialized communities; 2SLGBTQIA+ communities; and people with disabilities.
- Advance Indigenous Cultural Awareness and Safety
- Advance EIDA-R knowledge and capacity
- Advance the provision of health services in French

Guidelines

Leveraging the OHT Plan template, teams are asked to:

- Explain how local and provincial data sources are being used to identify and segment your population. The OHT Data Dashboard provided by OH is available as a resource.
- Outline planned improvements for your initial target population(s) that will be implemented by March 31, 2024, using an equity-centred population health management approach.
    - When describing the planned improvements, articulate the specific role the OHT has in advancing implementation and how the improvements are being funded.
- Indicate if your OHT is implementing an integrated clinical pathway for chronic conditions.
- Describe the rationale for selecting additional target population(s) and planned improvements that will be implemented by March 31, 2024, using an equity-centred population health management approach.
- Describe how your team has engaged with, and how your planned improvements will meet the needs of FNIMUI populations, Francophone populations and other equity deserving communities (including Black and racialized communities; 2SLGBTQIA+ communities; and people with disabilities) to improve access or receipt of services, including upstream, in-reach and outreach approaches. OHTs should describe their plan for engagement in the development, implementation and evaluation stages of the OHT plan.
- Describe your team's plan to build productive and sustainable relationships with FNIMUI populations.
- Ensure member organizations comply with the requirements of French Language Services Act (FLSA) as applicable and working with the appropriate French Language Health Planning Entity or Entities for its priority patient population(s).
- Demonstrate how your OHT is integrating and coordinating existing system resources.
- Provide information about how your OHT will measure and evaluate the impact of your improvements on patient experience and outcomes, including indicators that align to the Quintuple-Aim Framework.
- Consider sharing or linking to your OHT's Strategic Plan outlining locally defined priorities (if available).

- Leverage local/regional guidance and resources in the completion of these deliverables and/or reach out to OH regional equity teams for further support/resources.

Priority Area 2: Patient Navigation and Digital Access

Another OHT objective that supports an equity-centred population health management approach is improving patient access and experience by re-designing processes and leveraging digital and virtual care offerings. The following priority areas align with Ontario's *Digital First for Health* Strategy and represent areas where many OHTs have already made significant progress.

In addition to these priority areas, OHTs are encouraged to highlight other digital and virtual health initiatives that are planned or underway and identify areas where provincial support or guidance may be required.

Note that in this section, guidance is provided separately for each deliverable.

Note on Cybersecurity:

OH will be releasing new direction on a provincial approach to cybersecurity that applies to all health service providers. OHTs are encouraged to work with their member organizations to ensure this new provincial direction is implemented at the HSP level. Please contact your OH Regional Digital Lead (RDL) for more information.

Deliverables

1. Design and implement patient navigation supports aligned to provincial guidance and measure impact on patient experience.
2. Report on progress expanding access to Online Appointment Booking (OAB) in primary care settings.
3. Complete an assessment of virtual care services across OHT member organizations.

Deliverable 1: Design and implement patient navigation supports aligned to provincial guidance and measure impact on patient experience.

A key priority for OHTs is to improve access, transitions, and coordination by designing and implementing 24/7 coordination and navigation services in alignment with Health811. Within this deliverable, OHTs are expected to advance two distinct but related activities:

1. **Implement initial OHT navigation improvement, accessible to patients, by January 1, 2024**.
2. **Engage with Regional Digital Leads (RDLs) to support OHT integration into Health811.**

The following section provides guidance for both activities mentioned above.

Activity 1: Implement an initial OHT navigation improvement, accessible to patients, by January 1, 2024

Context
Navigation is defined as a service that assists the public/clients/patients with:

- Needs assessment/screening for eligibility (in some cases);
- Finding available health and social services to meet individual needs;
- Assisting with access to those services (warm transfers).

It may be provided on the internet (e.g., virtual care, chat, potential for mature AI algorithms to be leveraged), through live phone services, or in-person. Services can be provided anonymously or non-anonymously and can involve on-going support and follow-up in some cases.

At a minimum, OHTs should aim to provide OHT-level support seven days per week, ensuring daytime and evening coverage. After hours and holidays, Health811 may be used to supplement the OHT-level navigation support. In these cases, there should be a mechanism in place for the Health811 service to link to the OHT-level navigation support (i.e., ability for Health811 to book a call for the patient with the OHT-level navigation supports). This mechanism will be co-designed over time with OHTs.

A warm transfer/handoff ensures that both the patient and providers understand the next step in the patient journey before ending an interaction (i.e., transferring the patient to the next care provider on the telephone while the patient is on the line, assisting the patient with booking an appointment with the next care provider, etc.), and that the patient's story follows them (i.e., does not need to be retold).

Digital Navigation
Digital navigation applications can complement traditional navigation services. They can provide one place for patients to find information about OHT programs and services and access their health information, among other helpful features. However, on their own, digital navigation applications are not considered a comprehensive 24/7 navigation service because they do not yet support a needs assessment or warm transfers.

Coordinated Access for Mental Health and Addictions
The Mental Health and Addictions Centre of Excellence (MHA CoE) at Ontario Health is leading the implementation of provincial coordinated access for mental health and addictions services

(MHA). MHA CoE will work with partners and OH Regional Leadership to establish, plan and implement minimum standards that must be in place to ensure standardization of Provincial Coordinated Access (PCA) at the regional level. A key foundational principle for MHA PCA is to leverage and align existing assets, including but not limited to, Health811 and OHTs 24/7 Navigation. As OHTs plan for, and implement, their 24/7 navigation plans, it is important that they collaborate with their OH Regional Leadership to avoid duplication and streamline access to care for clients and families requiring MHA supports.

Further guidance will be provided to OHTs on more specific navigation expectations and future standardization of navigation models.

Guidelines
Leveraging the OHT Plan template, teams are asked to:

- Describe how your OHT will implement an initial navigation improvement, accessible to patients, by **January 1, 2024.**
- Specifically, articulate how your OHT will achieve the three key navigation criteria:
    1. Introduce a navigation improvement that is patient facing for the full attributed population or an initial target population (with a plan to expand to the full population).
        a. Demonstrate process improvements to service intake, access and referral.
        b. As articulated above, a digital navigation application alone is not considered sufficient to achieve these criteria. This includes website enhancements.
    2. Improve coordination of existing navigation services.
        a. OHTs should also demonstrate that they have engaged Home and Community Care Support Services (HCCSS) to explore opportunities to improve coordination with HCCSS's information and referral services.
    3. Ensure that local processes are in place to measure and evaluate improvements in patient access and experience.

Activity 2: Engage with Regional Digital Leads (RDLs) to support OHT integration into Health811.

Context
Ontario Health has launched Health811 – a free digital, secure and confidential service available 24 hours a day, seven days a week – which Ontarians can access to receive health advice from qualified health professionals, such as registered nurses, locate health services and find trusted health information. The service can also be a helpful resource for those unsure where to seek care and can prevent unnecessary visits to the emergency department. OHTs will be expected to work with Ontario Health, their RDLs, and SSPDI teams to provide information and collaborate on processes and services to allow patients to be served local-level content and service information, as well as access to their digital health data. Health811 aims to be

recognized as a trusted 'contact point' for assistance with health system navigation, guidance and access to health care advice, health resources and as an evidence-based source for health information.

Ontario Health is currently working with OHTs to onboard on the Health811 platform. OHTs will be expected to work with Ontario Health and their RDLs to complete specific requirements, allowing for patients to be served local-level content and service information, as well as access to their digital health data.

Guidelines
Leveraging the OHT Plan template, teams are asked to:

- Describe how your OHT has provided information about local programs and services that will be featured on Health811.
- Engage with OH Provincial and Regional teams to support the design and phased implementation of warm transfers from Health811 to OHTs.

Deliverable 2: Report on progress expanding access to OAB in primary care settings.

OAB solutions improve patient access and convenience by providing patients and caregivers the ability to book an appointment online. OAB solutions also provide appointment confirmations and reminders, which can reduce missed appointments, improve administrative capacity, and increase office efficiency.

In FY 2023-24, OH has a one-time funding opportunity to support new and sustainable OAB implementations. OHTs should contact their OH Regional Digital Lead for more information (refer to Key Contacts in Appendix D).

Guidelines

Leveraging the OHT Plan template, teams are asked to:

- Describe planned or existing activities intended to facilitate OAB implementation by primary care and other providers participating in the OHT.
- Describe how many primary care providers have been onboarded onto OAB, and targets for expanded implementation during the TPA reporting period.
- Describe how primary care engagement structures, such as primary care networks, are being utilized to promote OAB implementation and if relevant, current uptake of OAB.
- Describe how OAB solutions align with OH's Online Appointment Booking Standard.

Deliverable 3: Complete an assessment of virtual care services across OHT member organizations.

Virtual care can improve patient access and experience by enabling services to be delivered more conveniently, when clinically appropriate. OHTs should aim to ensure virtual care services

are available to patients as an option, when appropriate, by member organizations and providers.

OHTs should focus efforts on completing an assessment of the availability and maturity of virtual care services across their member organizations and if possible, use the assessment to identify any opportunities for improvement using OH's Virtual Care Maturity Model as a reference. OHTs are also strongly encouraged to consider how virtual care can be embedded in equity-centred population health management and patient navigation plans. In FY 2023-24, OH has one-time funding opportunities to support OHTs with specific integrated virtual care models, including remote care management, surgical transitions, and episodic access to virtual care. OHTs are encouraged to consult with OH Regional Digital Leads for more information.

Guidelines

Leveraging the OHT Plan template, teams are asked to:

- Describe how your OHT will assess existing virtual care offerings across OHT member organizations and virtual care maturity across OHT member organizations, aligned to the Quintuple AIM framework. OH's Virtual Care Maturity Model can be used as a resource.
    - If assessment is already complete, describe outcomes and processes underway to use the assessment to inform future planning for expanding access to care using virtual means as appropriate.
    - If applicable, describe how OHT member organizations, providers and patients were engaged to identify virtual care priorities, including health equity disparities.
    - Highlight any existing or planned innovative virtual care models that are transforming how care is delivered, with a specific focus on how you are measuring patient experience and outcomes.
- Describe any virtual care supports/programs that the OHT will be offering directly, including ensuring member organizations and providers are using safe, secure and interoperable virtual visit solutions that meet the requirements of OH's Verification Program.
- Consider how virtual care can be embedded in equity-centred population health management and patient navigation plans.

Priority Area 3: Collaborative Leadership, Decision-Making and Governance

In 2019 and 2020, the MOH released guidance to the system which established OHT governance arrangements as self-determined and fit-for-purpose. This flexibility supported locally driven coordination of care and empowered organizations to determine CDMAs that work best for OHTs, patients, family and caregivers, and local communities.

In *Ontario Health Teams – The Path Forward*, the MOH identified a standard OHT model that will support the future-state vision of integrated clinical and fiscal accountability: a new not-for profit corporation created for the purpose of managing and coordinating OHT activities.

OHTs should await MOH and OH guidance and supports before incorporating.

Note that in this section, guidance is provided separately for each deliverable.

Deliverables

1. Implement governance requirements relating to OHT membership and operational supports, aligned to provincial guidance (when available).
2. Report on progress implementing Patient, Family and Caregiver (PFC) Partnership and Engagement Strategy.

Deliverable 1: Develop and implement an enhanced governance model and processes that align with provincial direction (when available)

Guidelines

Leveraging the OHT Plan template, teams are asked to:

- Optionally provide a brief description of their existing membership categories and governance structures, including the composition of their decision-making tables.
    - Describe how patients, families, caregivers, First Nations, Inuit, Métis, Urban Indigenous, Black, racialized, Francophone and other equity deserving communities are being included in the OHT's collaborative decision-making structure and governance model.
    - If applicable, describe how municipalities and public health units are engaged within the OHT.
- Optionally self-assess how their current membership composition aligns with MOH direction.
- Highlight any questions or issues relating to incorporation that they would like to see addressed in the forthcoming guidance for consideration.

- Additional guidance, tools and resources will be provided to OHTs to support implementation of an enhanced governance model that aligns with provincial direction.

Deliverable 2: Report on progress implementing Patient, Family and Caregiver Partnership and Engagement Strategy

As OHTs continue to evolve, the role of patients, families and caregivers (PFC) as partners, leaders and key participants in decision making should be advanced and maintained. For this deliverable, please include information that demonstrates how processes and structures have been established that support effective partnerships developed with patients, families, and caregivers to address the needs of the communities served. When developing the OHT Plan, demonstrate how the OHT engages with patients, families and caregivers at all levels, and how the OHT is building a culture around PFC partnership, engagement and inclusion.

Guidelines

Leveraging the OHT Plan template, teams are asked to:

- Describe how processes and structures for the implementation of the OHT's Patient, Family and Caregiver Partnership and Engagement Strategy will be established in alignment with the OHT identified domains and approaches for engagement.
- Conduct a self-evaluation of patient, family, caregiver and community engagement and partnership activities within the OHT and ensure key findings are used to inform strengthened patient, family and caregiver engagement and partnership including PHM planning and care delivery.
    - Demonstrate how patients, families and caregivers were involved in the completion of the self-evaluation and reporting.
- Demonstrate action towards ongoing learning and training for clinicians, leaders and patient, family and caregiver partners within the OHT to advance safe and meaningful engagement and partnership practices.

Priority Area 4: Primary Care Engagement and Leadership

The involvement of the primary care sector in all aspects of OHTs remains foundational to OHT success and should be a driver of OHT planning. Efforts to continuously improve engagement and leadership of primary care providers (primary care physicians and other clinicians) in OHTs is necessary to increase provider satisfaction and improve connections across the continuum of care. OHTs can support models and structures that enable primary care providers (primary care physicians and other clinicians) to organize and have a collective voice at OHT planning and decision-making tables.

In *Ontario Health Teams – The Path Forward*, MOH and OH confirmed that they will work to support greater primary care involvement in OHTs, including more consistency in how they are involved in OHT decision-making.

Deliverables

- Develop and implement a model and process to enable primary care providers (primary care physicians and other clinicians) to have a collective voice in OHT planning and decision-making tables to advance local and provincial primary care priorities.
- Develop and implement a plan to connect additional primary care providers (primary care physicians and other clinicians) to the OHT.

Guidelines

Leveraging the OHT Plan template, teams are asked to:

- Provide a current state assessment of primary care provider representation in the OHT and involvement in OHT leadership, planning and decision making (i.e. leadership roles, associated responsibilities, and any selection process that may be in place for determining primary care leadership).
- Describe any existing or planned approaches / work to engage with all primary care providers in your community (e.g., primary care network, physician association, other structures). If applicable, include a brief description of:
    - The functions that the structure performs (e.g., communication to sector, delivering clinical programs, providing clinical supports, etc.)
    - The membership criteria (i.e., which professions/disciplines are eligible to join, which professions/disciplines have joined thus far)
    - How this work supports your OHT's clinical priorities and implementation of Primary Care Communications Protocol
    - If/how this approach supports a primary care voice in OHT planning and decision-making
- Describe how your OHT is tracking the level of primary care provider participation in your OHT, and how your OHT defines such participation.

- Describe any existing or planned model and processes for involving primary care providers in clinical pathway redesign and supporting clinical care planning, planning, including in integrated clinical pathways as well as other primary care priorities (e.g. access, unattached patients, preventative screening).
- Describe if/how your OHT is facilitating access to clinical supports for primary care providers.
- If relevant, refer to and share your OHT's primary care plan/strategy and/or any priorities that have been identified by your primary care sector partners.

Appendix A: OHT Continued Implementation Funding TPA Reporting Timelines

Table 1 below summarizes key deadlines for Reports that OHTs will use to report updates on the OHT Plan. Please refer to **Schedule "C"** in the TPA for the full list of Reporting Requirements.

All TPA deliverables should be submitted centrally to ontariohealthteams@ontariohealth.ca with the appropriate OH Regional OHT Point of Contact copied. Please ensure the OHT name is included in the file name.

Table 1: OHT Plan Reporting Timelines

Deliverable	Deadline	Notes
The OHT Plan	September 29, 2023	• Must be completed using the OHT Plan Template issued by OH. • Includes the OHT's Equity Education Plan
Six-Month Financial Expenditure Statement	October 27, 2023	• Must be completed using template issued by OH; will cover first two quarters of the TPA.
Nine-Month Narrative Progress Report	February 2, 2024	• The purpose of progress report is to provide OH with status updates on completion of the deliverables outlined in the OHT Plan, including performance or evaluation data demonstrating how OHT programs and services are benefiting patients, families, caregivers and communities. • Initial OHT navigation improvement should be implemented by January 1, 2024. • Within the progress report, OHTs are invited to **provide feedback or suggestions** on how OH can support OHTs • Includes TPA Performance Indicator Report (template to be issued by OH)
Collaborative Quality Improvement Plan (cQIP) (FY 24/25)	March 29, 2024	• Guidance for cQIP program will be provided separately.
Final Report	May 17, 2024	• Document progress across priority areas and deliverables during the duration of the TPA. • Includes TPA Performance Indicator report • Includes financial expenditure statement (will cover last two quarters of the TPA) • Includes progress report on the OHT's Equity Education Plan.

Appendix B: Information on Performance Indicator Reporting

The OHT performance measurement framework has been critical in providing insights into improvements in population health outcomes as a result of increased integration.

Going forward, MOH and OH are working collaboratively to streamline a set of standardized, system-level indicators that will align with health system priorities and support a more consistent approach to performance measurement. These new standardized indicators will eventually replace the self-selected indicators that OHTs have used to support early implementation efforts and will be included as part of future reporting. **Teams are required to continue reporting on their self-selected indicators in the interim.**

For the purposes of the OHT Plan, OHTs are asked to describe their intentions to measure progress against each priority area. Identified measurement approaches may include the use of metrics that OHTs are already tracking, including self-selected indicators and cQIP indicators.

Appendix C: OHT Resources

This appendix provides a list of key resources related to each priority area in the OHT Plan. Please note, this is not an exhaustive list of resources available to support OHTs in planning and implementation activities.

OHTs are encouraged to visit the OHT Supports Events Calendar, the RISE Website, and the MOH OHT Supports Page to find the most comprehensive and up-to-date information on OHT supports, activities and resources to support the completion of the OHT Plan.

General OHT Resources

- Visit the OHT Shared Space* to create an account and join "Learning Collaboratives and Communities of Practice (CoP)". These groups provide the opportunity for OHTs to share information, resources and experiences across teams. Groups include:
    - OHT Patients, Families and Caregivers CoP
    - Communications and Community Engagement CoP
    - cQIP CoP
    - Digital Health OHT CoP
    - Evaluation and Performance Improvement for OHTs CoP
    - OHT Planning Leads CoP

**The OHT Shared Space is supported by a partnership between RISE and OH.*

Resources by Priority Area

Priority Area 1: Integrated Care through PHM and Equity Approaches

Building blocks and population-health management (PHM) overviews

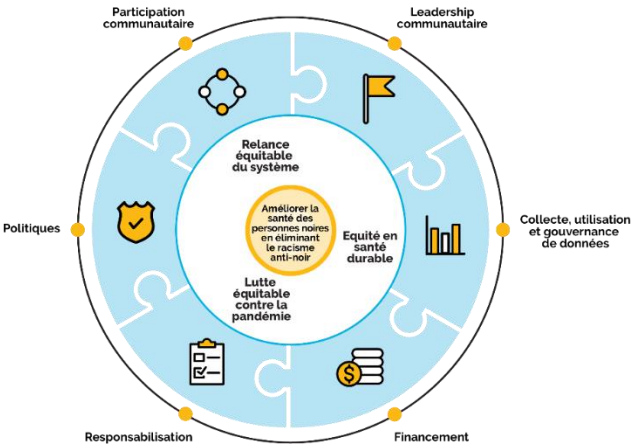
- Brief 1 on OHT Building Blocks (RISE)
- Brief 6 on Population Health Management (RISE)
- RISE building block and PHM infographic (RISE)

Equity-Centred PHM resources

- Applying an equity lens when caring for your population - webinar and PDF (RISE)
- Social Determinants of Health Snapshot (Public Health Ontario)
- Equity in Engagement Framework (Ontario Health)
- Indigenous Primary Health Care Council (IPHCC)
    - Guidance for creating safer environments for Indigenous Communities
- Brief 25 on Ontario's French-language health planning entities and how they can support OHTs as a health system partner (RISE)

- French language services supports for Ontario Health Teams (French Language Health Planning Entities [FLHPEs]) (RISE)
- Health Indicators Project (Alliance for Healthier Communities)
- High Priority Communities Strategy (Government of Ontario)
    - Backgrounder - Ontario Supporting High Priority Communities (Government of Ontario)
- Advancing the Black Health Strategy in Ontario (The Black Health Committee)
- Black Health Plan/Plan de santé Noir:

Plan de santé Noir



Black Health Plan

Population identification and segmentation

- Ontario Health Teams: Data Supports Guidance Document (Government of Ontario)
- Tool on unpacking an attributed population (Health Commons Solutions Lab)
- RISE one page summary on stratifying priority populations (RISE)
- Using Segmentation to support quality improvement (HSPN & RISE)
- This map identifies approximate locations of Indigenous communities, as well as regional cancer centres and other Indigenous healthcare and service providers in Ontario: www.cancercareontario.ca/en/iccumap
- Native Land is a resource to learn more about Indigenous territories, languages, lands, and ways of life. This map does not represent or intend to represent official or legal boundaries of any Indigenous nations. To learn about definitive boundaries, contact the nations in question.

Co-designing person-centred care models

- Redesigning care models through co-design webinar, deck and one page summary (RISE)
- Partnering with patients/families/caregivers in population-health management (RISE)
- Asset mapping overview and examples (Health Commons Solutions Labs)

Data resources

- Primary care data for OHTs (INSPIRE)
- Applied Health Research Questions Requests (ICES)
- HSPN Patient and Provider Surveys: Patient and Provider Experience (HSPN)
- How to Measure OHT Success Evaluation Metrics Using the Quadruple Aim (HSPN)
- OHT Data Dashboard (Ontario Health) – *login required through OneID, contact OHTanalytics@ontariohealth.ca for OneID registration support*
- Indigenous Data Governance-Information and OCAP® training (First Nations Information Governance Centre (FNIGC/CGIPN)

Quality Improvement

- Collaborative Quality Improvement Plan (cQIP) Guidance (Ontario Health)
- Quality Improvement Planning and Implementation for Ontario Health Teams (Ontario Health)

Clinical

- Quality Standards (Ontario Health)
- Practice Guides on Implementing Integrated Care (HSPN)
- Supporting OHTs Toolkit (Centre for Effective Practice)

Equity Education Resources

Note: As part of the OHT Plan, OHT staff are required to complete training in EIDA-R knowledge and capacity, Indigenous Cultural Awareness and Safety, and the provision of health services in French, by March 31, 2024. Below is a list of training programs that staff could complete to meet this requirement. OHTs are not required to use Continued Implementation Funding on paid programs. Please be advised that the list below is not comprehensive of all available training programs, and OHTs are encouraged to explore additional learning opportunities.

EIDA-R Education

- Addressing Anti-Black Racism
  - Black Health Education Collaborative
  - TAHSN Anti-Black Racism e-Module Training
  - Education Modules on Sickle Cell Disease Quality Standard Implementation
- 2SLGBTQIA+ Inclusive Health
  - Rainbow Health Ontario Courses
  - Intro to Gender Diversity
- Anti-Racism
  - Immigrant and Refugee Mental Health
  - Building the Foundations of Anti-Oppressive Healthcare

Indigenous Cultural Safety and Awareness Education
Recommendation:

1. Start with Ontario Health's Indigenous Relationship and Cultural Awareness Courses which are free of cost (*at minimum, 4 foundational courses: First Nations, Inuit and Métis Culture, Colonization and the Determinants of Health; Indigenous History and Political Governance; Cultural Competence in Healthcare; Truth and Reconciliation Commission of Canada (TRC) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*). If Ontario Health's Indigenous Relationship and Cultural Awareness Courses have previously been completed; these modules should be completed again as they have undergone a major refresh as of March 31, 2023.
2. If the health service provider has additional budget for cultural safety training, ensure that the Indigenous Primary Health Care Council's Anishinaabe Mino'Ayaawin – People in Good Health training ($175) is completed first, followed by San'Yas' Anti-Racism Indigenous Cultural Safety Program ($300).
3. If there are local courses or teachings available, these provincial/national trainings do not supersede local teachings. It is encouraged that health service provider staff participate in local courses and teachings when provided.

Additional training is available through the following supplemental courses:

- Indigenous Healthcare and Practice: Applying Digital Teaching and Learning Resources to the TRC's Calls to Action. A Community-led and Community-Informed Collaborative Initiative – Free
- Canadian Virtual Hospice's Indigenous Cultural Safety Training: Advanced illness, palliative care and grief – Free
- Pauktuutit Inuit Women of Canada and the Canadian Cancer Society's Inuusinni Aqqusaaqtara: My journey – Free
- Inuuqatigiit's Bridging the Gap: Inuit Cultural Presentations – $150/hour, $400/half day, $850/full day (in-person options)
- Wabano Centre for Aboriginal Health's Indigenous Cultural Safety Courses: Wabano-Win – $75 (in-person)

French Language Services/Active Offer Education (all free, choose one or more of the following):

1. https://flsonlinetraining.ca/
2. https://www.activeoffertraining.ca/
3. https://entite3.ca/en/service-providers/active-offer/

Additional Resources:

Indigenous Cultural Safety/Awareness

Reports and Government:

- 1996 Royal Commission on Aboriginal Peoples: https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/introduction.aspx
- National Centre for Truth and Reconciliation reports: http://nctr.ca/reports.php
- Track progress of the 94 Calls to Action: https://newsinteractives.cbc.ca/longform-single/beyond-94?&cta=83
- United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP): https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls: https://www.mmiwg-ffada.ca/final-report/
- National Inquiry into Missing and Murdered Indigenous Women and Girls: https://www.mmiwg-ffada.ca/final-report/
- Non-Insured Health Benefits Program: https://www.sac-isc.gc.ca/eng/1572537161086/1572537234517
- Joyce's Principle: https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief___Eng.pdf

Indigenous Cultural Awareness and Safety:

- Cultural Safety – and Why Should I Care About It? https://www.heretohelp.bc.ca/visions/indigenous-people-vol11/what-indigenous-cultural-safety-and-why-should-i-care-about-it.

Health Equity and Indigenous People:

- (Film) Jordan's Principle - Abenaki director Alanis Obomsawin tells the story of Jordan River Anderson who spent all five years of his short life in hospital while the federal and Manitoba governments argued over who was responsible for his care. Jordan's Principle was passed into law in 2007 by the House of Commons to ensure that First Nations children would have equal access to government-funded services as the rest of the Canadian population. Lawyers and activists have continued their fight to ensure that Jordan's Principle is enforced by the federal government: https://www.tvo.org/video/documentaries/jordan-river-anderson-the-messenger
- (Toolkits) Indigenous Primary Health Care Council Resources: https://iphcc.ca/resources/
- (Book and Webinar) Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s. Book by Maureen Katherine Lux: https://www.youtube.com/playlist?list=PLMU8mevc0ompDyuq4N9GDj3MoyHjCSARN
- (Report) Allan B, Smylie J. Toronto: Wellesley Institute; 2015; 1–64. First Peoples, second-class treatment: the role of racism in the health and well-being of Indigenous

peoples in Canada: https://www.wellesleyinstitute.com/publications/first-peoples-second-class-treatment/

- (Report) Cancer Care Ontario Path to Prevention: Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis: https://www.ccohealth.ca/en/report-path-to-prevention
- (Report) National Collaborating Centre for Aboriginal health: Health Inequalities and the Social Determinants of Aboriginal Peoples' Health: https://www.ccnsa-nccah.ca/docs/determinants/RPT-HealthInequalities-Reading-Wien-EN.pdf
- (Article) Margo Greenwood, Academic Leader, National Collaborating Centre for Indigenous Health. We need to address racism directed at Indigenous people as a national health crisis. December 2020 National Collaborating Centre for Indigenous Health Media Statement: https://www.nccih.ca/485/NCCIH_in_the_News.nccih?id=460
- (Article) Kim, Paul. Health Equity, Volume 3.1, 2019. Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System: https://pubmed.ncbi.nlm.nih.gov/31346558/
- (Podcast and Article) https://www.cbc.ca/radio/whitecoat/i-am-a-white-settler-why-that-matters-in-health-care-1.4545454/it-s-the-hardest-conversation-we-can-have-confronting-racism-in-health-care-1.4545477 This also includes a 26 min audio only CBC radio show, from December 17, 2016
- (Inquest Report) Seven Youth Inquest Report Thunder Bay: https://www.thunderbay.ca/en/city-hall/response-to-seven-youth-inquest.aspx
- (Webinars) Indigenous Cultural Safety Learning Collaborative: https://www.icscollaborative.com/

Residential Schools:

- (Interactive on-line) Shingwauk Residential School Centre, Algoma University. Learn where residential schools were located: https://www.cbc.ca/news2/interactives/beyond-94-residential-school-map/
- (Film) Tim Wolochatiuk, National Film Board of Canada (2012). We Were Children *is a powerful Canadian National Film Board documentary with testimony from two survivors of Residentials Schools.* https://www.nfb.ca/film/we_were_children/
- (Film) Gord Downie (2016). Secret Path & Panel Discussion*: A multimedia experience following the story of Chanie Wenjack, a boy who died while fleeing a residential school near Kenora Ontario in 1966*. https://www.youtube.com/watch?v=yGd764YU9yc
- (Article) Erin Hanson (2009). Residential School System: https://indigenousfoundations.arts.ubc.ca/the_residential_school_system/
- (Article) Here to Help: Cheryl Ward, Chelsey Branch, Alycia Fridkin. Visions Journal, 2016.What is Indigenous Cultural Survival. Canada Agrees to Reparations for All Residential School Students. https://www.culturalsurvival.org/news/canada-agrees-reparations-all-residential-school-students
- (Article) The Canadian Encyclopedia. Indian Residential Schools Settlement Agreement. (Last edited January 2020, accessed June 2021).

https://www.thecanadianencyclopedia.ca/en/article/indian-residential-schools-settlement-agreement

- (Interactive on-line) Virtual Tour of the Former Mohawk Institute Residential School: https://woodlandculturalcentre.ca/experience/virtual-tour-of-the-former-mohawk-institute-residential-school-public/

Maps:

- This map identifies approximate locations of Indigenous communities, as well as regional cancer centres and other Indigenous healthcare and service providers in Ontario: www.cancercareontario.ca/en/iccumap
- Native Land is a resource to learn more about Indigenous territories, languages, lands, and ways of life. This map does not represent or intend to represent official or legal boundaries of any Indigenous nations. To learn about definitive boundaries, contact the nations in question: https://native-land.ca/

Equity, Inclusion, Diversity and Anti-Racism Resources to Support Equity Planning and Knowledge

- Health Equity Impact Assessment Tool
- Health Care Standards Recommendations
- Data Standards for the Identification and Monitoring of Systemic Racism
- What is Disability Justice? — Sins Invalid
- Health Equity | IHI - Institute for Healthcare Improvement
- Collecting-Socio-demographic-Data.pdf (wellesleyinstitute.com)
- Black Health Alliance – Resource Hub
- Black Experiences in Health Care Symposium — Health Commons Solutions Lab
- The Health Effects of Anti-Black Racism | The Local
- Resource Library | Rainbow Health Ontario
- Primary Health Care for Trans Patients | Rainbow Health Ontario
- 2SLGBTQ Health Resources | Rainbow Health Ontario
- Ontario Human Rights Commission – Resource List
- Trauma-Informed Care Teaching activities and resources | RNAO
- Trauma-Informed Care Resources - NWAC STBBI
- The Canadian Centre for Diversity and Inclusion
- Key Public Health Resources for Anti-Racism Action – National Collaborating Centre for Determinants of Health
- University of Toronto Faculty of Medicine – Educational Resources on Anti-Racism
- University of Waterloo – Office of Equity, Diversity, Inclusion and Anti-Racism – Anti-Racism Resources
- The Centre for Global Inclusion – Global Diversity and Inclusion Benchmarks

- Engagement, Governance, Access, and Protection (EGAP): A Data Governance Framework for Health Data Collected from Black Communities in Ontario
- Government of Canada – Anti-Racism Resources
- Equity in Engagement
- Measuring Health Equity: Demographic data collection in healthcare
- The Coin Model of Privilege and Critical Allyship: Implications for Health

Priority Area 2: Patient Navigation and Digital Access

Deliverable 1: Implement patient navigation supports and report on patient utilization

- OHT 24/7 Navigation Services Toolkit (Ontario Health)
- OHT 24/7 Navigation Services and Directory Inventory Summary (Ontario Health Team)
- OHT 24/7 Navigation Services Implementation Plan (Ontario Health Team)

To access these resources, please reach out to your identified Ontario Health Regional OHT Point of Contact (Regional SSPDI Directors).

Deliverable 2: Report on progress expanding access to Online Appointment Booking (OAB) in primary care settings

- Online Appointment Booking Standard (Ontario Health)

Deliverable 3: Report on progress enhancing virtual care maturity and access

- Virtual Care Maturity Model (Ontario Health)
- Virtual Visits Standard and Verification Program (Ontario Health)
- Clinically Appropriate Use of Virtual Care – Guidance for Primary Care (Ontario Health)

Priority Area 3: Collaborative Leadership, Decision-making and Governance*

- Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System (Government of Ontario)
- ADVANCE Program - Accountability, Shared Leadership and Governance (HSPN)
- Ontario Health Teams Patient, Family and Caregiver Partnership and Engagement Strategy: Guidance Document (Government of Ontario)
- The Engage with Impact Toolkit - Evaluating the impact of PFAC in Health Systems (Public and Patient Engagement Collaborative)
- Patient, Family and Caregiver Engagement in Ontario Health Teams: Learning from Early Experiences (Public and Patient Engagement Collaborative)
- Patient, Family and Caregiver Declaration of Values Webinar (Minister's Patient and Family Advisory Council)
- Resources to support OHTs' learning and development in PFC partnership and engagement
- OHT Engagement Learning Series (Dr. Kerry Kuluski, Institute for Better Health)

- Patient, family and caregiver engagement evaluation supports for Ontario Health Teams (Public and Patient Engagement Collaborative)
- Supporting Equity-Centred Engagement (Public and Patient Engagement Collaborative)
- Using Culturally Safe Practices to Build Meaningful Relationships with Indigenous Communities (Indigenous Primary Health Care Council)
- Provider and Patient Experience Surveys (HSPN)
- Meaningful Engagement and Co-Design (The Ontario Caregiver Organization)
- Rules of Engagement: 15 recommended approaches to patient and caregiver engagement (The Ontario Caregiver Organization)
- Publications-Ontario Caregiver Organization and Events Archive (The Ontario Caregiver Association)
- Other resources through the Ontario Caregiver Organization website including webinars

** Please see Priority Area 1 above for other supports on engagement, partnership and codesign with patients, families, caregivers and communities that may also support implementation.*

Priority Area 4: Primary Care Engagement and Leadership

- OHT Primary Care Communications Protocol Guidance (Government of Ontario)
- Primary Care Data Reports for OHTs webinar, slides and maps (INSPIRE)
- Tools and Resources to support physician participation and leadership in OHTs (Ontario Medical Association)
- Involving Physicians in OHTs Worksheet (Ontario Medical Association)
- Resources-Indigenous Primary Health Care Council (iphcc.ca) (Primary Health Care Council)
- Brief 4: Primary-care leadership and engagement (RISE)
- OHT Handbook for Boards (Association of Family Health Teams of Ontario)
- Primary Care Maturity Model and Key Enablers for Ontario Health Teams (Ontario Primary Care Council)
- Tip Sheet for Involving Family Physicians in Health Reform (Ontario College of Family Physicians)
- Overview Resource for Family Physicians on OHTs (Ontario College of Family Physicians)

Appendix D: Key Contacts

Ontario Health Regional OHT Leads	For information, resources, and advice on completing TPA deliverables, please reach out to your identified Ontario Health Regional OHT Point of Contact (Regional SSPDI Directors).
Ontario Health Regional Digital Leads	For OHT digital questions and supports, contact the OH Regional Digital Leads: OH-Central_DigitalVirtual@ontariohealth.ca OH-East_DigitalVirtual@ontariohealth.ca OH-North_DigitalVirtual@ontariohealth.ca OH-Toronto_DigitalVirtual@ontariohealth.ca OH-West_DigitalVirtual@ontariohealth.ca
Ontario Health Regional Equity Teams	OH East: Denise.graham@ontariohealth.ca OH West: OH-West-EIDAR@ontariohealth.ca OH Central: Trish.Chatterpaul@ontariohealth.ca
RISE PHM Coaches	RISE population-health management (PHM) coaches provide customized PHM coaching to support OHTs to implement a PHM approach. To connect with PHM coaches, email: RISE@McMaster.ca