OHT FY 24/25 Agreement

OHT Operating Plan Guidance

May 2024

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Introduction

- Since 2019, all Ontario Health Teams (OHTs) have received implementation funding, through either Implementation or Continued Implementation Funding Transfer Payment Agreements (TPAs), to advance shared priorities.

- As direction for OHTs continues to evolve, for FY 24/25 of the recently issued 3-year OHT Agreement, **six revised priority areas have been identified for all OHTs**, outlined in Figure 1.

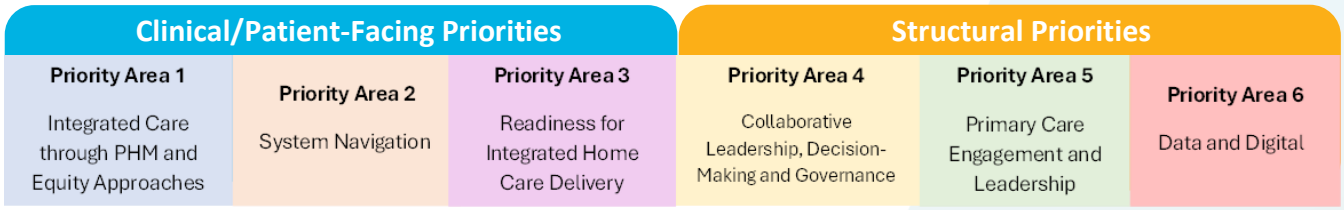

***Figure 1. Refreshed OHT Agreement Priority Areas**. Note: OHTs are expected to ensure equity considerations remain embedded across all Priority Areas.*

- These refreshed priorities build on previous clinical and structural priorities, including those articulated in *Ontario Health Teams – The Path Forward* (2022), which is the most recent all-OHT guidance provided by the Ministry of Health (MOH).

- The Initial 12 OHTs, announced during the *Minister's Update on OHT Acceleration* (September 2023), will advance similar priorities to those outlined in *Figure 1*, with additional clinical and structural expectations.

- As the MOH direction continues to evolve, particularly related to the path to designation and the transfer of home care, OHTs should anticipate that priority areas and deliverables may be further amended in FY 25/26 and FY 26/27 of the 3-year OHT Agreement. Updates will be communicated by the MOH and Ontario Health (OH) as they become available.

- The MOH and OH acknowledge that teams are at varying stages of maturity, with the newest team only having been approved in January 2024. OH is committed to working with all teams to advance towards these common deliverables at an appropriate pace.

What's New in the OHT Agreements?

- The TPA released on May 7, 2024, outlines the deliverables for the first fiscal year of confirmed 3-year funding for all OHTs.
- All OHTs now have the same baseline TPA, as MOH and OH are no longer using a cohort model. Deliverables have been designed to accommodate the diversity of OHT maturity and we acknowledge that teams are at varying stages of development.
- The Transfer Payment Recipient (TPR) acts as the legal recipient of the TPA. This means that the TPR is the official legal fund holder of the funding related to this agreement. The deliverables and reporting requirements apply to the associated OHT and any flow of funding from the TPR to partner organizations within the OHT should adhere to the requirements as set out in "Schedule D" of the agreement.
- As part of this new agreement, OHTs will continue to move towards quantitative reporting and reporting on outcomes, patient impact, and experience, with a focus on advancing local improvements for target populations.
- To support OHTs to track their progress towards completion of TPA deliverables and measure impact, key performance indicators (KPIs) have been identified for each deliverable. OHTs will be expected to report on their progress for these KPIs in addition to any self-selected performance indicators that teams continue to monitor.
- Reporting requirements in the new OHT Agreement have been revised to include an **OHT Operating Plan** (in place of the OHT Plan) and a consolidated **Sustainability Plan & Final Report** (in place of the Year End/12-Month progress report - see *Appendix B* for more information).
- "**System Navigation**" and "**Digital Supports**" have been separated as distinct priorities to acknowledge that work on system navigation extends well beyond provision of digital supports.
- "**Readiness for Integrated Home Care Delivery**" has been added as a distinct priority area, aligned with MOH direction on the role of OHTs in the delivery of home care. Importantly, OHTs are not yet required to advance work in this priority area with the exception of the Initial 12 OHTs and those participating in Home Care Leading Projects.
- "**Data**" has been added and combined with "**Digital**" under a new priority area to reflect critical work required on data sharing and governance to enable OHTs and their members to advance population health management (PHM).

Purpose

- This document, prepared by OH and the MOH, provides guidance to OHTs to support the development and implementation of the **OHT Operating Plan**, the first deliverable of the OHT Agreement for FY 24/25.
- The Operating Plan deliverable is due on **June 28, 2024,** and is intended to allow OHTs to outline how they plan to achieve key deliverables across priority areas within the funding period (April 1, 2024 - March 31, 2025). Subsequent semi-annual reporting (e.g., the Mid-Year Report and Sustainability Plan & Final Report) will provide an opportunity for OHTs to report on progress towards achieving the goals set out in the Operating Plan. Refer to *Appendix A* for a summary of reporting requirements in the OHT Agreement.
- This document identifies **what's new** in each OHT Agreement priority area (outlined in *Figure 1*), articulates **how success will be measured**, and provides tailored **guidance and resources** for each priority area (refer to *Appendix B* for additional resources). It also includes **general guidance** to support the completion of the Operating Plan.
- As part of ongoing work on OHT performance measurement, KPIs have been identified for each of the deliverables within the OHT Agreement and are embedded within this guidance. This is intended to provide additional clarity to OHTs on what is required for deliverable completion. In the subsequent semi-annual reporting, OHTs will be required to report on the KPIs, as well as any self-selected performance indicators.

Update on the OHT Performance Framework

- Development of a performance framework for OHTs was first identified in the 2019 OHT guidance. *Ontario Health Teams – The Path Forward* (2022) and the Minister's Update on OHT Acceleration (2023) renewed the importance of developing a standardized performance framework with the goal of demonstrating how OHTs are collectively improving patient care.
- A working group comprised of OHT, patient and scientific advisors has selected an initial set of validated and developmental performance measures for FY24/25. These measures will be implemented in phases beginning with the Initial 12 OHTs in FY 2024-25 and will be used by OH and OHTs to collaboratively assess progress and support continuous improvement. Planning is also underway to align the framework with the Collaborative Quality Improvement Program (cQIP).
- OHTs beyond the Initial 12 are required to continue reporting on their self-selected indicators as well as the KPIs identified in this guidance document.

General Guidance

Tips for Completing the Operating Plan:

- OHTs have already made substantial progress on many of the deliverables included in the new OHT Agreement. To recognize these efforts, OHTs are encouraged to reference existing initiatives and/or workstreams in the Operating Plan (and in subsequent semi-annual reporting).
    - For example, an OHT's efforts to advance an **Integrated Clinical Pathway (ICP)** or to increase **preventative screening rates**, as outlined within the **cQIP**, align with the priorities of this TPA and can be referenced in the OHT Operating Plan.
- To support local planning, OHTs can access the OHT Data Dashboard (developed by OH's data and analytics team, in collaboration with the MOH). The OHT Data Dashboard includes a suite of interactive, map-based reports to support OHTs to understand and plan for the populations and communities they serve, including equity stratifications and the ability to focus on attributed populations and geographical locations. OHTs can also access data through IntelliHealth, a knowledge repository that contains clinical and administrative data collected from various sectors of the Ontario healthcare system.
    - Note: Login to the **OHT Data Dashboard** is required via OneID. Contact OHTanalytics@ontariohealth.ca for OneID registration support.
    - To register for **IntelliHealth**, please email IMsupport@ontario.ca with the subject line "IntelliHealth User Registration."
- The **OHT Central Program of Supports** provides OHTs at all stages of implementation with coaching, training, resources, tools, and access to a coordinated network of partners with expertise in integrated care delivery and population health management. **OHT supports partners** provide targeted supports across the 8 OHT building blocks to support teams to build OHT capacity and successfully implement and advance the OHT model.
    - OHTs are encouraged to leverage resources available through OHT support partners available on the OHT resources hub and reach out directly to support partners for assistance in advancing OHT implementation. Please see Appendix C for a list of OHT Supports Partners' areas of supports focus, and sign up for updates on OHT learning opportunities via the OHT Supports Events Calendar.
- OHTs are encouraged to use the Operating Plan to provide details about **any work underway to advance locally defined priorities** (including addressing system-level or regional challenges such as Alternate Level of Care, or fall preparedness/surge planning), which may fall outside of the six priority areas in the OHT Agreement.
- The Operating Plan should be developed in **collaboration with OHT member organizations, physicians and other clinicians, and patients, families and caregivers**. Prior to submission, it should be reviewed and approved through processes prescribed by the OHT's Collaborative Decision-Making Arrangement (CDMA).

- For additional accessibility and transparency, OHTs are encouraged to share the OHT Agreement and the completed Operating Plan with all member organizations (including primary care providers and physicians) on their OHT website (or through other mechanisms if a website is unavailable).
- OHTs are encouraged to engage with their OH Regional OHT Point of Contact for additional guidance or support for developing the Operating Plan (see *Appendix C*).
- OHTs can refer to previous guidance documents prepared by OH and the MOH for additional guidance and resources.

Equity Considerations

- OHTs continue to advance initiatives to engage and support equity-deserving populations. Although "equity" is explicitly referenced within Priority Area 1 of the OHT Agreement (Integrated Care through PHM and Equity Approaches), OHTs should work to ensure **equity considerations are embedded across the Operating Plan and subsequently, across all OHT activities**.
- To achieve this aim, when developing the Operating Plan, OHTs should:
    - Leverage existing equity frameworks and local/regional resources. OH's Equity, Inclusion, Diversity and Anti-Racism (EIDA-R) Framework, Black Health Plan, First Nations, Métis, Inuit, and Urban Indigenous (FNIMUI) Health Framework (FY 23/24) and Social Determinants of Health Framework, as well as the Patient, Family and Caregiver Declaration of Values for Ontario are available to OHTs to guide their work.
    - OHTs can also learn from and support equity plans developed or equity initiatives undertaken by partner organizations to develop locally driven population health models (e.g., Locally Driven Population Health Models formerly known as the High Priority Communities Strategy).
        - Consider the following guiding principles for locally driven population health models:
            - Working with partners and the community to assess and identify barriers to accessing existing services;
            - Developing culturally responsive health supports to enable communicating health information to diverse populations (e.g., translated materials tailored to community needs);
            - Enhancing population specific wellness models to improve access to primary health care and mental health and addictions supports;
            - Providing in-community engagement, outreach and navigation supports to meet local needs (e.g., community ambassadors);
            - Providing supports for integrating mobile or pop-up capacity into service delivery to improve access to health services in non-traditional places of care;
            - Developing community partnerships, including with non-health organizations (e.g., social service agencies) to address social determinants of health.
    - Ensure member organizations comply with the requirements of French Language Services Act (FLSA) as applicable and work with their appropriate OH Regional French Language Services (FLS) Lead.

- Recognize the role of FNIMUI and Francophone communities and organizations in the planning, design, delivery and evaluation of health services in their communities.
- **Considerations for OHT Indigenous-focused work:** It is recommended that an Indigenous expert lead the process for OHT engagements with local and regional Indigenous partners. As an Indigenous expert, this person should possess extensive experience, knowledge and skills in Indigenous health, including in developing and maintaining relationships with Indigenous partners and will have established credibility with the Indigenous communities they would be working with. It is preferable that Indigenous experts are Indigenous, but due to challenges recruiting Indigenous individuals to these types of positions, non-Indigenous persons who possesses the skills outlined should be considered to support the OHT Indigenous-focused work.
- Engage with patients, families and caregivers, FNIMUI populations, Francophone populations and other equity deserving communities (including Black and racialized communities; 2SLGBTQIA+ communities; people with disabilities; newcomers, refugees; and people experiencing homelessness) in the development of the OHT Operating Plan 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 PHM

- OHTs are encouraged to engage with their OH Regional Equity Teams on embedding equity considerations and OH Regional FLS Leads for additional guidance on embedded Francophone lens within the Operating Plan (see *Appendix C* for key contacts).

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

Background

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 using an equity-centred PHM approach is one of the primary objectives for all OHTs.

What's New in this Section?

- Compared to previous TPAs, OH has removed references to advancing improvements for initial and additional target populations. OH will require OHTs to advance improvements across at least two target populations and are expected to demonstrate how they are expanding their impact both within and across selected target populations.
- While OHTs should continue to make local decisions about their target populations, all OHTs are encouraged to begin advancing improvements for one or more of the clinical priorities outlined in *Ontario Health Teams: The Path Forward* (chronic disease, mental health and addictions and palliative).
- OHTs will no longer be expected to advance virtual care as a separate deliverable. Instead, OHTs should identify opportunities to use virtual care modalities as part of their clinical improvements.

Deliverables

Develop, implement, and measure initiatives that use PHM and equity approaches to:

1. Co-design with OHT members and partners and implement integrated programs and services for target population(s) (e.g., integrated clinical pathways), aligned to the Social Determinants of Health Framework and integrate with cQIP (where applicable).
2. Measure and evaluate OHT improvements using the Quintuple Aim framework.
3. Ensure continued involvement and engagement in the aforementioned deliverables with the following groups in the design, implementation and measurement/evaluation of OHT programs, services and improvements to coordination and integration:
    - Patients, families and caregivers,
    - FNIMUI communities,
    - Francophone populations,

- Equity deserving communities, including Black and racialized communities, 2SLGBTQIA+ communities, people with disabilities, newcomers, refugees, and people experiencing homelessness.

4. Advance Indigenous cultural awareness and safety knowledge and capacity.
5. Advance Equity, Inclusion, Diversity, and Anti-Racism (EIDA-R) knowledge and capacity.
6. Advance the provision of health services in French through application of the principles of Active Offer.

How Will Success Be Measured?

- OHTs will be asked to:
    - Demonstrate how they are expanding the number of patients impacted by OHT-led clinical improvements within and across target populations using an equity-centred population health management approach;
    - Report on the number of patients impacted by local clinical improvements;
    - Report on how locally defined indicators are being used to monitor OHT performance;
    - Describe successes, challenges and/or barriers to Patient, Family and Caregiver engagements across programs and initiatives; and
    - Describe successes, challenges and/or barriers to engagement with FNIMUI populations, Francophone populations and other equity deserving communities (including Black and racialized communities; 2SLGBTQIA+ communities; people with disabilities; newcomers and refugees; and people experiencing homelessness) across programs and initiatives.

Guidance

In this section of the OHT Operating Plan, OHTs should:

- Outline operational and planned improvements for target population(s) that will be implemented by March 31, 2025.
    - OHTs are expected to continue to advance improvements for at least **two target populations,** with efforts to expand reach and impact for these populations as well as consider expanding to additional target populations.
    - OHTs are encouraged, where relevant to local priorities, to consider selecting the clinical priorities outlined in *The Path Forward,* including Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Lower Limb Preservation (LLP), mental health and addictions and palliative care, informed by clinical best practice and evidence.
        - Note: At this time, OHTs choosing to implement Integrated Clinical Pathways as a local priority will not receive separate provincial funding for this work. OHTs who have previously held a TPA to implement ICPs as a demonstration team through FY 23/24, inclusive of the Initial 12, will continue to receive funding in FY 24/25, as previously communicated.

- If OHTs are interested in advancing local work on Mental Health and Addictions, the Mental Health and Addictions Centre of Excellence is focused on key provincial priorities, such as Provincial Coordinated Access, the MHA Data and Digital Initiative (DDI) and four clinical areas which include depression and anxiety-related disorders (includes Ontario Structured Psychotherapy and Neurostimulation Procedures), substance use disorders (includes pathways for clients presenting to emergency departments and transitioning into the community), schizophrenia, and psychosis (Early Psychosis Intervention), and eating disorders. OHTs who are interested in learning more or aligning their local work with these provincial initiatives, please email the MHA CoE (contact Dielle Miranda at MHACoE@OntarioHealth.ca) and include your Regional OHT Point of Contact
- To support OHTs with integrating palliative care into their service-delivery planning, the Ontario Palliative Care Network (OPCN) is a health-system partnership with palliative-care expertise, resources and data.
    - In particular, the OPCN has developed the Palliative Care Health Services Delivery Framework, Focus Area 1: Adults Receiving Care in Community Settings, that outlines a model of care to optimize the way OHTs deliver care. In collaboration with the Ontario Health Regions, there is work under way to support implementation of the community model of care.
    - Clinical Coaches and Regional Implementation Teams will work with community organizations to support system navigation and to create an organized system. OHTs who are interested in learning more or aligning their local work with provincial priorities for palliative care, please email the Provincial Palliative Care Program at Ontario Health that supports the OPCN (Contact ProvincialPalliativeCareProgram@ontariohealth.ca)
- Where appropriate and feasible, OHTs and their member organizations should consider how to use virtual care modalities to deliver programs, services and improvements, referring to OH's Clinically Appropriate Use of Virtual Care in Primary Care for guidance.
    - OHTs may work with their OH Regional OHT and Digital Leads to arrange consultations with the OH Provincial Clinical Transformation team for support to align goals for priority populations with provincial virtual care and Remote Care Management strategies and initiatives.
- OHTs are encouraged to establish and leverage local primary care structures in OHTs to design and implement clinical priorities for the OHT in alignment with PCN in OHT Guidance.

- Outline how the operational and planned improvements will be measured and evaluated to assess the impact on patient experience and outcomes, including indicators that align to the Quintuple Aim Framework.
- Describe how the OHT will continue integrating and coordinating existing system resources.
- Describe how the OHT has engaged with, and how planned improvements will meet the needs of, patients, families and caregivers, FNIMUI populations, Francophone populations and other equity deserving communities (including Black and racialized communities; 2SLGBTQIA+ communities; people with disabilities; newcomers and refugees; and people experiencing homelessness) to improve access or receipt of services, including upstream, in-reach and outreach approaches.

- Describe how the OHT will continue to build productive and sustainable relationships with FNIMUI populations.
- Outline, if applicable, how the OHT will ensure they are advancing Francophone cultural awareness and that member organizations comply with the requirements of FLSA as applicable and working with the appropriate OH Regional FLS Lead.
- Refer to the *General Guidance* section for more information and *Appendix C* for additional resources.

Key Resources

Resources for MHA or Palliative Care pathways:

- Depression and Anxiety-Related Concerns
- Clinically Appropriate Use of Virtual Care for Depression and Anxiety-Related Conditions
- Clinically Appropriate Use of Virtual Care for Eating DisordersThe Ontario Palliative Care Quality Standard describes what high-quality palliative care should look like, and provides quality indicators to inform quality measurement
- The Ontario Palliative Care Network's Palliative Care Health Services Delivery Framework, Focus Area 1: Adults Receiving Care in Community Settings, describes the key processes, team structures and roles that are important for the delivery of high-quality palliative care, and includes a patient pathway and is aligned to the Palliative Care Quality Standard
- The Ontario Palliative Care Network's Palliative Care Competency Framework outlines the knowledge to deliver high-quality palliative care in Ontario
- The Ontario Palliative Care Network Tools to Support Earlier Identification provide guidance on preferred identification tools and assessment tools to support providers and system-level leadership in earlier identification of patients who would benefit from palliative care

Priority Area 2: System Navigation

Background

Improving navigation has been a foundational objective for all OHTs since 2019. The overarching goal is to make it simpler for people to find and access the health and social services they need. OHTs have made significant progress implementing a variety of local navigation supports, including access to service information, partnerships with information and referral providers, and process improvements. OHTs should continue their local improvement work and share best practices with other OHTs through regional collaboratives and communities of practice.

Through extensive OHT consultations, OH has identified the following two foundational objectives:

- Ensure Ontarians know who to contact to find and access the services they need, including French language health services. In most cases, this will be health service providers within a person's circle of care. However, this can also be an information and referral service.
- Ensure health or community services providers within an individual's circle of care are aware of how to navigate patients to available services (including available information and referral services).

OHTs should work towards ensuring navigation pathways are defined and, where necessary, make navigation supports available, including navigation in French for Francophone patients (if applicable). This is particularly important for equity deserving groups such as FNIMUI, Francophone and Black populations. There are fewer service providers able to provide culturally and linguistically adapted services to these and other equity-deserving groups, so assisting clients to find service providers with these competencies will be an important function of OHTs.

For the purposes of the Operating Plan, system navigation is defined as a service that assists the public/clients/patients with:

- Needs assessment and/or screening for eligibility (in some cases);
- Finding available health and social services to meet individual needs;
- Assisting with access to those services, e.g., warm transfers/handoffs
    - Note: warm transfer/handoff ensures that both the patient and providers understand the next step in the patient journey before ending an interaction (e.g., 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 (e.g., does not need to be retold).

System navigation may be provided on the internet (e.g., virtual care, chat, potential for mature Artificial Intelligence (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.

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 navigation service because they do not yet support a needs assessment or warm transfers. OHTs should engage their Regional Digital Leads prior to investing in digital navigation solutions to ensure there is no duplication with provincial digital products and services.

Coordinated Access for Mental Health and Addictions

- The Mental Health and Addictions Centre of Excellence (MHA CoE) at OH 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' Navigation resources. As OHTs plan for, and implement, their navigation plans, it is important that they collaborate with OH Regional Leadership to avoid duplication and streamline access to care for clients and families requiring MHA supports. Further direction on alignment between coordinated access for MHA and OHT Navigation will be provided when more information is available.

OHTs should continue to work towards providing OHT-level navigation supports during business hours. 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 with OHTs over time. When available, further guidance will be provided to OHTs on more specific navigation expectations and future standardization of navigation models including the supports that Ontario Health@Home and Ontario211 can offer.

What's New in this Section?

- OHTs should continue to identify opportunities to implement process improvements that make it easier for patients to find and access the health and social services they need. OHTs should also continue to engage their OH Regional Digital Leads prior to making any investments in digital navigation solutions to avoid duplication with provincial assets.
- Note that the expectation for 24/7 navigation has been removed.
- OHTs should consider creating a Community of Practice to engage front line providers that play a navigation role in the identification of process improvements.
- Over time, OHTs will be expected to partner with information and referral service providers operating in their area. OH, in collaboration with MOH, is currently engaging both Home and Community Care Support Services (soon to be Ontario Health@Home) and 211 to clarify what supports they can offer to OHTs, in alignment with what supports OHTs need.
- Curating targeted information about local services across Health811, OHT and member organizations is one part of a comprehensive navigation plan. This year, OHTs should engage communications resources across their member organizations to identify opportunities to raise awareness of critical services, such as cancer screening and chronic disease prevention and management, across multiple channels.

Deliverables

7. Introduce continued system navigation improvements aligned to provincial guidance and measure impact on patient outcomes.
8. Curate information about local services across Health811, OHT and member organization websites, and collect analytics about user behaviour across OHT digital assets.

How Will Success Be Measured?

- OHTs will be asked to:
    - Self-report on the progress and status of implemented system navigation improvements, and whether they have measured the improvements.
    - Optionally survey providers to identify level of confidence navigating patients.
    - Provide analytics on website visits and how many member organizations have featured OHT initiatives on their websites.

Guidelines

***Deliverable 7**:*

In this section of the OHT Operating Plan, OHTs should:

- Outline how they will continue to introduce system navigation improvements to help patients find and access the care they need
    - These navigation improvements should:
        - Demonstrate and improve coordination of process improvements to service intake, access, and referral.
        - Cultivate relationships with local organizations that provide community and health services, including primary care, to identify services and gaps, including French language health services.
        - Build provider and patient awareness of local services and capacity to support patients with navigation.
        - Encourage engagement in existing/new regional groups and or working groups dedicated to system navigation improvements, fostering open communication and shared decision-making among partners.
        - Ensure that local processes are in place to drive continuous improvements.
- Optionally outline if they are considering deploying a survey (regionally or locally) to navigators to understand unmet needs of frontline staff doing navigation work to support continuous improvement initiatives.
    - Describe their continuous improvement process including the insights used to identify navigation gaps, the partnerships involved, and any navigation improvements that have been achieved as a result.

***Deliverable 8**:*

In this section of the OHT Operating Plan, OHTs should:

- Outline how they will gather information on key local programs and services from Health811, the OHT, and member organizations to better curate information about local services. This should involve:
    - Conducting a comprehensive audit of existing content across OHT digital assets[1], including Health811, the OHT website, and member organization websites.
    - Identifying and addressing content duplication across channels, while establishing goals for information curation and analytics collection.
    - Facilitating connections among communications representatives from partner organizations within the OHT to consolidate information and consistency across platforms.
    - Collaborating with other OHTs to identify similarities and ensure consistency in information published across all platforms.
    - Collecting analytics and information on user behaviour, including the identification of Francophone users.
        - Utilizing available analytics tools to monitor user behaviour across OHT digital assets, tracking metrics such as page views, time spent on the page, etc.
        - Exploring avenues to access user analytics if not currently available to the OHT.
        - Leveraging user analytics to inform continuous improvement efforts.
        - Periodically share an agreed upon set of OHT website analytics with OH.
    - Participating in engagement sessions with OH's Provincial Health Services Directory (PHSD) team to develop an implementation and data governance model.
    - Engaging local health care providers and organizations to identify local data sources relevant to OHT service delivery.
- OHTs are encouraged to engage with their OH Regional OHT Point of Contact (Regional Digital Leads, Regional FLS Leads, and/or Regional SSPDI Directors) for more resources related to System Navigation (see *Appendix D* for key contacts). Additional navigation guidance will be released to all OHTs when available.

Key Resources

- 211 Ontario®
- Health811

[1] A digital asset is any content or data that exists in digital form and has value to the OHT.

Priority Area 3: Home Care Readiness

Background

In *Ontario Health Teams – The Path Forward* (2022), the MOH outlined a plan for the eventual delivery of home care via OHTs. Direction on the transition will continue to be shared, with the ultimate vision of OHTs delivering home care services in the future.

In FY 24/25, OHTs that are not a part of the Initial 12 group are not required to complete deliverables related to home care readiness. However, all OHTs are encouraged to being building their knowledge and awareness of integrated home care models, including innovative home care models (hospital-to-home) operated by member organizations.

Additional guidance, along with learnings from the Initial 12 related to home care readiness, is expected to be released to all OHTs in future.

Priority Area 4: Collaborative Leadership, Decision-Making and Governance

Background

Since their inception, OHTs have focused on collaborative leadership and decision-making, forming strong and impactful relationships at the local level. As per the original 2019 and 2020 guidance, OHTs have developed and continue to utilize their self-determined and fit-for-purpose CDMAs.

In *Ontario Health Teams – The Path Forward* (2022) the MOH identified a model that would support the future-state vision of integrated clinical and fiscal accountability: a new co-ordinating corporation created for the purpose of managing and coordinating OHT activities.

While other OHTs wait for future direction before creating their co-ordinating corporation, areas related to governance, including expanding OHT membership and PFC engagement, should continue to be advanced.

What's New in this Section?

Reflecting evolving expectations related to OHT governance, deliverables in this section have been modified from the previous OHT TPAs:

- With the exception of Initial 12, OHTs should continue to await MOH and OH guidance and supports before incorporating. However, once incorporation guidance is finalized and released, OHTs are encouraged to review it with their Leadership Councils. OH will also work with the Initial 12 OHTs to document and share best practices and lessons learned.
- OHTs are expected to meet minimum membership requirements and are now expected to conduct targeted outreach to expand OHT membership to include additional sectors (e.g., groups encouraged to be included in decision making within *Ontario Health Teams – The Path Forward*: long-term care homes, municipalities, emergency health services and community paramedicine providers, and public health units).
- OHTs are now expected to adopt and implement the *Creating Engagement Capable Environments in Ontario Health Teams Framework* and continue to advance PFC engagement activities, including the completion of staff training on PFC engagement.

Deliverables

9. Ensure OHT membership and decision-making requirements (including Patient, Family and Caregiver representation) outlined in *Ontario Health Teams: The Path Forward* are met, providing support and resources to facilitate these partnerships and activities.

10. Demonstrate targeted outreach efforts to expand OHT membership to include additional sectors (e.g., optional membership groups described in *Ontario Health Teams: The Path Forward*), aligned to designation and maturity.
11. Adopt and implement the *Creating Engagement Capable Environments in Ontario Health Teams Framework*, including an assessment of the current state and an action plan outlining how the OHT will advance to a minimum of 'Level 2: Learning and Developing'.
12. Demonstrate that OHT staff have completed the following education:
    a. Indigenous Cultural awareness and safety training;
    b. EIDA-R education and training (e.g., anti-racism, anti-Black racism, cultural and linguistic sensitive care training, 2SLGBTQIA+ Rainbow Health Ontario courses, and general health equity); and,
    c. Active Offer.
13. Demonstrate that OHT staff have completed training related to Patient, Family and Caregiver engagement.

How Will Success Be Measured?

- OHTs will be asked to:
  - Self-assess to report on completion of deliverables;
  - Report on the number of new OHT members and indicate outreach efforts taken to expand membership to include additional sectors;
  - Complete and submit the Creating Engagement Capable Environments in Ontario Health Teams self-assessment and action plan to outline how they will advance through levels of the framework;
  - Report on the number of OHT staff and executive leaders that completed training on Indigenous cultural awareness, equity, diversity and inclusion, and active offer;
  - Report on the number of OHT staff and executive leaders that completed training/micro-credential for patient, family and caregiver engagement and partnership.

Guidelines

***Deliverable 9**:*

In this section of the OHT Operating Plan, OHTs should:

- Self-assess if the OHT currently has all **required** groups in their decision making:
  - Primary care providers
  - Home and community care providers (note: OHTs should continue to work with their current home care members, e.g., HCCSS, contracted SPOs until further guidance on home care accountability is available)
  - Community care providers (including Community Support Services, Assisted Living Services, and services for people with Acquired Brain Injury)
  - Public hospitals

    - Mental health and addictions providers
    - Patients, families, and caregivers
    - Physicians and other clinicians
- Outline any gaps and how they will continue to expand their membership of the required groups.

***Deliverable 10**:*

In this section of the OHT Operating Plan, OHTs should:

- Self-assess current membership to identify **additional groups** to engage with and involve in decision making (e.g., groups encouraged to be included in decision making within *Ontario Health Teams – The Path Forward*: long-term care homes, municipalities, emergency health services and community paramedicine providers, public health units, and others based on local OHT context). Ontario Health will also engage OHTs to discuss opportunities and barriers to expand membership.
- Outline planned approaches to expand membership for the identified additional groups.
- Articulate any sectors where they have faced challenges with engagement, if available; seek to understand why other organizations (e.g., HSPs, SPOs, social service providers, community agencies, etc.) may not be participating within the OHT.

***Deliverable 11**:*

In this section of the OHT Operating Plan, OHTs should:

- Identify how they will apply the *Creating Engagement Capable Environments in Ontario Health Teams: A Framework for Action* to their governance and planning and delivery of programs and services
- Use the self-assessment tool (to be provided by Public and Patient Engagement Collaborative (PPEC) from McMaster University) to assess current state and the associated action plan template to develop an action plan in collaboration with PFC partners.
    - OHTs may leverage completed self-assessments to inform the development of operational plans. OHTs may also share self-assessments with OH Regions and OHT Support Partners, including PPEC (ppec@mcmaster.ca), for support in developing their action plan (e.g., coaching, Community of Practice).

***Deliverables 12 & 13**:*

In this section of the OHT Operating Plan, OHTs should:

- Articulate how they will ensure all new and existing OHT staff, including OHT leads and others, receive training on the following equity and education training requirements (refer to *Appendix B* for suggestions for training programs; OHT should note the courses they are taking in their Plans. OHTs are not required to use Implementation Funding on paid programs):
    - Indigenous cultural awareness and safety
    - Health equity

        - Francophone Cultural and Linguistic Sensitive Care Learning Training and/or Active Offer of Services in French
        - Demonstrate that OHT staff, including OHT leads and others, have completed training related to Patient, Family and Caregiver engagement and partnership.
    - Where training is available through the OHT Central Program of Supports, OHTs should leverage existing education and training.
        - Public and Patient Engagement Collaborative, patient, family and caregiver engagement micro credential.
    - Where OHTs have already provided training to their staff, OHTs should note this in their Plans. No further action is required unless new staff are hired.

Key Resources

- Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System (Government of Ontario)
- ALIGN Program - Advancing Leadership and Integrated Governance Networks (formerly the ADVANCE program)
- Ontario Health Teams Patient, Family and Caregiver Partnership and Engagement Strategy: Guidance Document (Government of Ontario)
- The Engage with Impact Toolkit (Public and Patient Engagement Collaborative)
- Public and Patient Engagement Evaluation Tool (PPEET) (Public and Patient Engagement Collaborative)
- Creating Engagement Capable Environments in Ontario Health Teams: A Framework for Action (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)
- 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 Organization)
- Ontario Caregiver Organization
- OHT Patient Family and Caregiver Partnership and Engagement Community of Practice

- Join the online space:
    - Visit the OHT Shared Space and click SIGN UP to create your account.
    - Visit the PFC Engagement and Partnership CoP and click on the JOIN GROUP button.

Equity Education Resources

1) 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

2) 2SLGBTQIA+ Inclusive Health

- Rainbow Health Ontario Courses
- Intro to Gender Diversity

3) Anti-Racism

- Immigrant and Refugee Mental Health
- Building the Foundations of Anti-Oppressive Healthcare

4) Indigenous Cultural Safety and Awareness Education

- OH's Indigenous Relationship and Cultural Awareness Courses (free)
    - 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). Note: these modules underwent a major refresh as of March 31, 2023, and should be completed again if initially completed before this date.
- If the OHT has additional budget for cultural safety training, ensure that the Indigenous Primary Health Care Council's Anishinaabe Mino'Ayaawin – People in Good Health training is completed first, followed by San'Yas' Anti-Racism Indigenous Cultural Safety Program .
- 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.

5) 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
- Wabano Centre for Aboriginal Health's Indigenous Cultural Safety Courses: Wabano-Win

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

- Francophones Cultural and Linguistic Sensitive Care Learning
- https://www.activeoffertraining.ca/
- https://entite3.ca/en/service-providers/active-offer/
- Guide to requirements and obligations relating to French Language Health Services

Priority Area 5: Primary Care Engagement and Leadership

Background

Evidence and experience from around the world show that an engaged primary care sector is foundational to successfully improving and integrating care. It is therefore essential that OHTs organize and connect with primary care to advance population health through integrated and equitable approaches to care.

In *Ontario Health Teams: The Path Forward*, the valuable role that primary care providers play in OHTs was re-emphasized and the MOH and OH committed to supporting their involvement in OHTs. *Your Health: A Plan for Connected and Convenient Care* noted that every OHT will include primary care providers organized in a Primary Care Network (PCN) to be part of decision-making and to improve access to care for patients. In January 2024, the MOH released the *Primary Care Networks in Ontario Health Teams: Guidance Document*, which outlines a vision, objectives and a common set of functions for PCNs to develop over time.

What's New in this Section?

- OHTs should work towards the implementation of a PCN that engages family physicians and interprofessional primary care providers in OHT planning, decision-making and implementation of provincial and local clinical priorities (e.g., attachment and access to primary care), aligned to the provincial PCN Guidance. OH recognizes that this may require some OHTs to adapt existing clinical engagement structures.
- This year, OHTs beyond the Initial 12 may optionally complete and submit a PCN Readiness Assessment to Ontario Health. Doing will help MOH and OH identify targeted opportunities to provide supports.
- PCNs should be actively engaged in selecting and advancing OHT clinical priorities. PCNs may also be positioned to play a leadership role within the OHT for certain priorities and are encouraged to identify local priorities that improve patient and provider experience.
- As part of the upcoming OHT Data Dashboard releases, OH will provide OHTs with a list of physicians (and their business contact information) attributed to their OHT. OHTs will be expected to leverage these lists to support improved outreach and recruitment of primary care physicians into the PCN and OHT.

Deliverables

14. In alignment with the MOH's PCN guidance, advance a primary care structure that organizes and engages interprofessional primary care providers (family physicians, nurse practitioners and other primary care clinicians) in OHT planning, decision-making, and implementation of clinical priorities.
15. Develop, implement, and/or report on progress of plans to connect additional interprofessional primary care providers (family physicians, nurse practitioners and other primary care clinicians) to the OHT's PCN or other similar structure.

How Will Success Be Measured?

- OHTs will be asked to:
    - Use the PCN Readiness Assessment criteria to self-assess progress towards implementinga PCN aligned to provincial guidance.
    - Outline efforts taken to connect additional primary care providers to the OHT and PCN, report on the number of new and overall providers.

Guidance

***Deliverable 14*:**
In this section of the OHT Operating Plan, OHTs should:

- Outline how they are aligning with the vision, objectives and functions of PCNs outlined in *Primary Care Networks in Ontario Health Teams: Guidance Document*.
- Work towards establishing a primary care network (or advancing an existing structure) that performs the five functions outlined in the PCN Guidance document.
- Articulate if they plan to submit a PCN Readiness Assessment to OH to:
    - Document achievements to date, as well as areas where additional support from OH may be required
    - Provide the MOH and OH with a better understanding of the state of PCNs across the province

***Deliverable 15*:**
In this section of the OHT Operating Plan, OHTs should:

- 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 how the PCN is leveraging physician business contact information, when available, to engage with physicians.
- Describe how the PCN is identifying clinical leaders and supporting them to work across the PCN and OHT.

- Describe how your OHT is tracking the level of primary care provider participation in your OHT, and how your OHT defines such participation.

Key Resources

Please note that OH will be releasing an iterative PCN Implementation toolkit to all OHTs in FY24/25. The toolkit will include a curated list of documents developed by existing PCNs and sector partners, to support OHTs as they develop PCNs aligned with provincial PCN guidance.

Existing resources include:

- OHT Data Dashboard (OH)
- OHT Primary Care Communications Protocol Guidance (MOH)
- 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) (Indigenous Primary Health Care Council)
- Brief 4: Primary-care leadership and engagement (RISE)
- OHT Handbook for Boards (Association of Family Health Teams of Ontario)
- Tip Sheet for Involving Family Physicians in Health Reform (Ontario College of Family Physicians)

Priority Area 6: Data and Digital

Background

Digital, data and analytics solutions and services are critical enablers to advancing integrated care and equity-centred PHM approaches, including all of the other priorities outlined in this TPA. OHTs will also play a role in advancing certain provincial digital health priorities, such as increasing online appointment booking (OAB) adoption and supporting implementation of the *Patients Before Paperwork* strategy.

To support the Government of Ontario's 'Your Health: A Plan for Connected and Convenient Care Opens in a new window', the MOH and OH are collaborating on a new initiative, 'Patients Before Paperwork' (Pb4P). The Pb4P Strategy works to mobilize digital health tools to improve patient care, enhance health system coordination, strengthen health privacy and reduce the administrative burden faced by health care providers.

Additional guidance will be provided to OHTs in the coming months on specific roles and expectations.

What's New in this Section?

- OHTs should create a digital, data and analytics plan that is integrated within their overarching OHT plan and focused on enabling clinical priorities. OH will not require OHTs to submit separate digital, data and analytics documentation.
- Beginning this year, OHTs will be asked to support the implementation of the provincial Patients Before Paperwork strategy. As a first step, OHTs are encouraged to consult with primary care providers and other providers (e.g. specialists) on local opportunities to reduce the use of fax and improve administrative burden and share their early findings.
- Some OHTs have chosen to fund and license digital solutions, such as provider-to-provider messaging and navigation solutions, to advance their clinical priorities. OHTs will be asked to identify OHT digital solutions and provide a brief update on their adoption and lessons learned to inform provincial planning and potential scale and spread.

Deliverables

16. Report on progress expanding access to Online Appointment Booking (OAB) in primary care settings.
17. Report on progress in supporting the adoption of additional provincial digital services by providers participating in the OHT in support of the Patients Before Paperwork Strategy.
18. Report on progress of adoption of digital health solutions in alignment with priorities and deliverables noted above.

How Will Success Be Measured?

- OHTs will be asked to report on progress of adopting digital health solutions that are aligned to priorities and deliverables across the agreement.

Guidance

Deliverable 16:

In this section of the OHT Operating Plan, OHTs should:

- More guidance will be forthcoming for OAB.
- 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 existing primary care providers are planning to increase the percentage of appointments in their schedules that can be booked via OAB.
- Describe planned communication strategies for building patient awareness of OAB options.
- Describe how provider/clinic OAB data is or will be utilized for quality improvement.
- 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 what enablers would be helpful to ensure full adoption of OAB for all primary care providers.
- Describe how OAB solutions align with OH's Online Appointment Booking Standard.

Deliverable 17:

In this section of the OHT Operating Plan, OHTs should:

- Outline how they will work with their PCN to engage primary care providers and specialists to identify local opportunities to reduce the use of fax and relieve administrative burden in accordance with the Pb4P strategies and supports.
- Report on any adoption of AI and other technologies in use or under consideration that may reduce the use of fax and relieve administrative burden in accordance with the Pb4P strategies and supports.
- Outline the processes that are used to integrate with their OH Regional Digital Team and bridge the digital partnership with primary care within their OHT and the OH Region.
- Outline they connect with their region's clinical areas (i.e., Primary Care), this may include governance structures, assigned leads, etc.

Deliverable 18:

In this section of the OHT Operating Plan, OHTs should:

- Outline any existing or planned implementations of local digital health solutions to support completion of other deliverables in the OHT Agreement. **To clarify: OHTs do not need to report on digital solutions used by individual OHT member organizations or providers or use of provincial digital services.**
- Outline how these planned implementations align with regional and provincial priorities.

Appendix A: OHT Agreement Reporting Requirements

Table 1 below summarizes the reporting requirements outlined in the OHT Agreement for FY 24/25. Please refer to **Schedule "C"** in the TPA for the full list of Reporting Requirements. All reports should be completed using templates issued by OH, unless otherwise noted.

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 Agreement FY 24/25 Reporting Requirements

Reporting Requirement	Due Date	Notes
FY 2024-25 Operating Plan and Budget	June 28, 2024	• Opportunity for OHTs to identify how they plan to achieve the OHT Agreement deliverables, and measure success, during the funding period, including a budget for all planned activities.
Mid-Year Progress Report	October 25, 2024	• Opportunity for OHTs to provide status updates on completion of the deliverables outlined in the OHT Operating Plan, including performance or evaluation data demonstrating how OHT programs and services are benefitting patients, families, caregivers and communities. It will cover the first two quarters of the Agreement. • Within the progress report, OHTs are invited to **provide feedback or suggestions** on how OH and OHT support partners can support OHTs. • Includes a financial expenditure statement (will cover first two quarters of the TPA).
Collaborative Quality Improvement Plan (cQIP)	March 31, 2025	• Completion of the cQIP continues to be an expectation for all OHTs. • Guidance for cQIP program will be provided separately.
Sustainability Plan and Final Report	April 25, 2025	• Opportunity for OHTs to report on overall progress to achieve deliverables outlined in the OHT Agreement, including key metrics, as well as document a plan for sustainability of operations moving forward. • Includes a financial expenditure statement (will cover last two quarters of the TPA).

Appendix B: General 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 Engagement and Partnerning 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.*

Additional Resources

Integrated Care through PHM and Equity Approaches	
Equity-Centred PHM resources: • **RISE** • **Public Health Ontario** • **OH** • **IPHCC** • **Alliance for Healthier Communities** • **Government of Ontario** • **The Black Health Committee**	• Applying an equity lens when caring for your population - webinar and PDF • Ontario Health's Social Determinants of Health Framework. Additional resources related to the SDoH Framework, including a set of Resource Guides, will be shared with OHTs when available. • Social Determinants of Health Snapshot • Equity in Engagement Framework • Indigenous Primary Health Care Council • Guidance for creating safer environments for Indigenous Communities • French language services supports for Ontario Health Teams • eQUITY Link: Advancing Health Equity and Accessibility in French • Health Indicators Project • High Priority Communities Strategy • Backgrounder - Ontario Supporting High Priority Communities • Advancing the Black Health Strategy in Ontario • Black Health Plan/Plan de santé Noir **Black Health Plan**  **Plan de santé Noir**  **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
- 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 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
Population identification & segmentation	• Ontario Health Teams: Data Supports Guidance Document • 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) • cQIP Webinar and CoP meetings (Ontario Health) • cQIP CoP group on the OHT Shared Space • QI Tools and Resources (Ontario Health)

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

Appendix C: Key Contacts

Table 2: Key Contacts to Support OHTs with Completion of the OHT Operating Plan

OH Regional OHT Leads	For information, resources, and advice on completing TPA deliverables and reporting requirements, please reach out to your OHT's identified Ontario Health Regional OHT Point of Contact: • OH North West: Kiirsti.Stilla@ontariohealth.ca • OH North East: Philip.Kilbertus@ontariohealth.ca • OH West: Jennifer.Peckitt@ontariohealth.ca • OH Toronto: Madeleine.Morgenstern@ontariohealth.ca • OH Central: Kim.MacDonald@ontariohealth.ca • OH East: Laurel.Hoard@ontariohealth.ca
OH 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
OH Regional Equity Teams	For supports with completion of equity-related deliverables and reporting requirements, contact the OH Equity Leads: • OH East: Denise.Graham@ontariohealth.ca • OH West: OH-West-EIDAR@ontariohealth.ca • OH Central: Trish.Chatterpaul@ontariohealth.ca • OH Toronto: Fatima.ulhaq@ontariohealth.ca • OH North East & North West: Rutendo.Madzima@ontariohealth.ca

OH Regional FLS Leads	For FLS related questions and supports, contact the OH Regional FLS Leads:
	• OH West:
	  • FLS Lead: Marthe.Dumont@ontariohealth.ca
	  • FLS Planner: Suzy.Doucet-simard@ontariohealth.ca
	  • FLS Planner: Leila.Beybouchouika@ontariohealth.ca
	• OH Central FLS Lead: eric.sona@ontariohealth.ca
	• OH Toronto FLS Lead: renee.huntley@ontariohealth.ca
	• OH East FLS Lead: arlynn.belizaire@ontariohealth.ca
	• OH North:
	  • FLS Lead: sophie.lefrancois@ontariohealth.ca
	  • FLS Lead: angele.jean@ontariohealth.ca

OHT Central Program of Supports	• **RISE (Rapid-Improvement Support and Exchange)**
	  ○ https://www.mcmasterforum.org/rise
	  ○ rise@mcmaster.ca

	○ Provides coaching and customized supports for teams to implement a PHM approach; supports for shared learning for OHTs across all 8 OHT building blocks and acceleration priorities; and hosts the OHT Supports Events Calendar and an OHT Resource Hub. • **PPEC (Public and Patient Engagement Collaborative)** ○ https://ppe.mcmaster.ca/research/supports-for-ohts/ ○ ppec@mcmaster.ca ○ Provides OHTs with coaching, training, tools and resources to support patient, family and caregiver engagement and partnership including the evaluation and measurement of patient, family and caregiver engagement to build capacity on key competencies to advance patient, family and caregiver engagement. • **HSPN (Health System Performance Network)** ○ https://hspn.ca/evaluation/oht/ ○ hspn@utoronto.ca ○ Provides OHTs with expertise and resources to build OHT capacity in evaluation, performance measurement, and data interpretation and application. • **ALIGN (Advancing Leadership and Integrated Governance Networks)** (formerly the ADVANCE program) ○ https://hspn.ca/advanceoht/ ○ Align.oht@gmail.com ○ Provides OHT leaders with training and coaching on collaborative leadership and integrated governance networks. • **INSPIRE-PHC (Innovations Strengthening Primary Health Care Research)** ○ https://inspire-phc.org/ ○ info@inspire-phc.org ○ Provide Primary Care Data Reports for all OHTs to support planning and primary care coordination. Provide primary care research and data support on access and attachment of attributed populations. Identification of primary care priorities within each OHT. • **IPHCC (Indigenous Primary Health Care Council)** ○ https://iphcc.ca/ontario-health-teams/ ○ oht@iphcc.ca ○ Provides supports to build OHT capacity to ensure Indigenous inclusion and engagement in the OHT model.

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca.
Document disponible en français en contactant info@ontariohealth.ca