Ontario Health Teams:

Guidance for Health Care Providers and Organizations

Ontario

Table of Contents

Purpose

This document sets out the process for the Ministry of Health and Long-Term Care's (the "Ministry") **open invitation** to providers across the full continuum of care to come together and demonstrate their readiness to become Ontario Health Teams — groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population**.**

This document is designed to guide groups of health care providers and organizations in becoming Ontario Health Teams. It describes the components of the model, the expectations for Ontario Health Teams at maturity, and readiness criteria to become an Ontario Health Team. There is an assessment process to enable all Ontario's health providers to improve readiness and eventually become an Ontario Health Team.

While the goal is for all health services providers to eventually join or become Ontario Health Teams, how health service providers get there can vary depending on numerous factors, including the readiness of the local health system.

The readiness assessment process set out in this document will allow the Ministry to select Ontario Health Team Candidates, and identify other providers that are '*In Development'* to becoming an Ontario Health Team and those that are still '*In Discovery'*[1], requiring local assistance and other supports to achieve a fully ready state for implementation. The assessment process will be repeated until full provincial coverage of Ontario Health Teams is achieved. This document sets out the operational expectations for Ontario Health Team candidates and lists the supports that will be provided by the Ministry and other partners to assist providers at each stage of their journey to reach Ontario Health Team maturity.

Although the Ontario Health Team model will evolve over time based on learnings from those first implementing the model, the core components of the model are expected to remain in place. At mature state, each Ontario Health Team will:

1. Provide a full and coordinated continuum of care for a defined population within a geographic region;
2. Offer patients 24/7 access to coordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey;
3. Improve performance across a range of outcomes linked to the 'Quadruple Aim': better patient and population health outcomes; better patient, family and

[1] See page 9 for description of these stages.

caregiver experience; better provider experience; and better value[2];
4. Be measured and reported against a standardized performance framework aligned to the Quadruple Aim;
5. Operate within a single, clear accountability framework;
6. Be funded through an integrated[3] funding envelope;
7. Reinvest into front line care; and
8. Take a digital first approach, in alignment with provincial digital health policies and standards, including the provision of digital choices for patients to access care and health information and the use of digital tools to communicate and share information among providers.

The intention is for Ontario Health Teams and teams '*In Development'* to be prioritized for future investments and receive incentives based on performance.

The Ministry encourages all health care providers and organizations from across the full continuum of care to engage and begin to self-organize towards wide scale implementation of Ontario Health Teams. The first Ontario Health Team Candidates and those identified as *'In Development'* will help set the course for system-wide transformation.

Part I: Why does our health care system need change?

Notwithstanding the constraints of the current health care system, there is great work being done across the province. Primary health care attachment is at 94 percent; cancer survival rates are at their highest; and Ontario has one of the best immunization rates in the world. However, Ontario's health care system is complex, and many patients, families, caregivers, and providers find it confusing, inconvenient, and challenging to navigate. In particular, patients experience fragmented care as they transition from one provider to the next. They wait too long for care and find that they have to repeat their health history and fill out duplicate forms when moving from one level of care to the next. Many health care organizations operate beyond their capacity due to ever-increasing health care demands, while others are below capacity.

Individually, many health care programs and providers are performing well and many provide excellent care; however, when taken as a whole, existing services are not

[2] Sikka, Rishi, et. Al. "The Quadruple Aim: care, health, cost and meaning in work", The British Medical Journal (vol. 24, Iss 10). Accessed online: https://qualitysafety.bmj.com/content/24/10/608

[3] Where used within this document, terms like 'integrate', 'integration', 'shared', 'common', 'unified' and 'joint' are used interchangeably to refer to the concept of providing more connected, seamless, and coordinated care, centred on improving patient outcomes and experience, and value. The terms do not refer to legal relationships, or forms of corporate or structural integration (e.g., transfers of services, mergers, amalgamation, starting or ceasing to provide services or operate, etc.).

coordinated, not yielding improvements in quality of care or health outcomes, and not providing the best value for our health care dollars. Fully integrating care is challenging when each provider functions independently and is funded without common accountabilities and performance metrics. Some of the immediate challenges facing the current health care system include:

- Transitions, access, and communication: According to the Patient Ombudsman's Annual Report (2016/17) [link], some of the most common complaints from patients, families and caregivers relate to transitions between care settings, access to the right care, and miscommunication or lack of communication.
- Alternate Level of Care and capacity issues: In its first report, the Premier's Council on Improving Healthcare and Ending Hallway Medicine (2019) [link] identifies that a significant proportion of hospital beds are occupied by patients who should be receiving care in long-term care homes, in supported residential settings, or at home, while many others are being treated in hospital hallways as they wait to be admitted.
- Funding and structural considerations: There are systemic barriers to coordinated and seamless care among 4,500 transfer payment recipients across the province, including fragmented funding and accountability, and duplication of services.

The intent of the Ontario Health Team model is to alleviate constraints and allow providers to deliver better, faster, more coordinated and patient-centred care.

We have heard from patients and providers across the health care system, including the Premier's Council on Improving Healthcare and Ending Hallway Medicine and the Minister's Patient and Family Advisory Council, that the current conditions are not making the most effective use of current resources, given how we fund providers. As a result, our system is not sustainable and the time for transformational change is now – before the many pressures already present across our health care system become even more acute.

Despite these challenges, there are several pockets of innovation throughout the province that support innovative delivery models and improved coordination of care. For example, there are regions in the province where primary care physicians and hospitals are working closely together by ensuring that physicians know when patients are admitted and discharged from hospital or visit the emergency department so that they can quickly provide follow-up care and arrange any supports to keep patients healthy at home. Other parts of Ontario already have hospital, home care, and long-term care home services under unified administration and governance, enabling a high degree of clinical integration and innovation across full care pathways. Innovative partnerships are also emerging between providers to create short term transitional spaces so that people

can leave the hospital sooner, reducing hallway health care pressures.

The Ontario Health Team model will build on this innovation, scale up integration beyond a handful of sectors to include the full continuum of care, and extend the benefits of more integrated and accessible care across the entire province.

The priority is to transform the way health care is provided and funded across Ontario – through an integrated model of care that is focused on improving outcomes and experiences for patients, grounded in the experience and expertise of front line health care providers, and that works for patients across the full continuum of their care journey.

Part II: What will the future look like?

Ontarians expect a health care system that:

- Is designed to ensure patients experience seamless transitions across different care providers and settings;
- Promotes the active involvement and participation of primary care providers throughout a person's care journey;
- Takes care of a person's complete physical and mental health needs, and not just one condition at a time;
- Encourages and enables healthy behaviours and activities, and self-care that promote physical and mental health and well-being;
- Is interconnected, so that patients don't have to repeat their health history over and over again or take the same test multiple times for different providers;
- Is easy to access and provides navigation when patients, families, and caregivers have questions or need assistance;
- Provides the appropriate level of care in the appropriate setting, at the right time;
- Achieves better value by delivering better quality for the same or lower cost; and
- Is built on collaboration, partnership, trust, communication, and mutual respect between patients, families, caregivers, providers, and communities.

These are hallmarks of a system that is **connected**. To meet these expectations, the Government of Ontario, through the Ministry, is introducing a new model to integrate care delivery and funding, which will enable patients, families, communities, providers, and system leaders to better work together, innovate, and build on what is best in Ontario's health care system. The goal is to provide better, more connected care across the province. We call this new model of care Ontario Health Teams.

Ontario Health Teams are groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population.

Under the Ontario Health Team model, we envision that patients, families, caregivers, and health care providers will more actively shape how local health care services are delivered and managed. The approach will make it easier for local health care providers to partner and deliver high-quality, coordinated care for their patients and their communities.

Through this model, many health care providers will work together as a team to deliver a full continuum of care, even if they're not in the same organization or physical location. As a team, they will work towards common goals related to improved health outcomes, patient and provider experience, and value.

The Ontario Health Team model will encourage providers to improve the health of an entire population, reducing disparities among different population groups. As part of this approach, Ontario Health Teams will be enabled to locally redesign care in ways that best meet the needs of the diverse communities they serve. This includes creating opportunities to improve care for Indigenous populations, Francophones, and other population groups in Ontario which may have distinct health service needs, such as inner-city urban areas and northern and rural communities.

In particular, Ontario Health Teams must demonstrate that they respect the role of Indigenous peoples and Francophones in the planning, design, delivery and evaluation of services for these communities. Furthermore, Ontario Health Teams must demonstrate that they are able to provide culturally safe care for Indigenous people in their proposed population. This could be achieved through partnership with Indigenous-governed organizations, especially where these organizations are providing integrated care to their community. In the case of First Nations communities on reserve, where a prospective team is proposing to be responsible for a region or geography that includes one or more First Nation communities, endorsement from those communities is required.

Integrated funding and accountability will create the optimal conditions for Ontario Health Teams to innovate, be more aware of their own performance to drive quality improvement, and be fully accountable for the health care dollars they spend.

Strengthening our relationship with patients, families, and caregivers

Improvements in integrated care through Ontario Health Teams will fundamentally change how patients, families, and caregivers experience the health care system. They will be able to more easily access and navigate the system and be better supported as they transition from one health care provider or setting to another.

Patients, families, and caregivers will be recognized and supported as active partners in their care according to their preference. Patients will have easier access to their health care records and will have options for accessing care virtually. Patients, families, and caregivers will be partners in their care decisions and will be included as part of transition planning processes. The role and involvement of families and caregivers as valuable contributors to the health care team will be supported and respected. Caregivers will be connected to learn and share best practices, as well as access supports for addressing distress and burnout.

It is critical to emphasize that the new model will not interfere with patients' choice of health care providers or disrupt the continuity of any patient's care with their current health care providers.

Patient experience and outcomes will be at the centre of health care delivery and improvement efforts; Ontario Health Teams will assess patient experience in a standardized way to ensure patients are at the forefront of care design and delivery in every part of Ontario.

The Patient Declaration of Values for Ontario [link] articulates some of the fundamental principles and values that will guide the culture of Ontario Health Teams.

Supporting providers to work better together

One of the areas of greatest opportunity within our system is to enable and encourage providers to work better together and, in particular, better involve and include primary care providers throughout the health care journey. The intent of the model is to promote the adoption of safe, effective, and innovative practices. Providers should not have to contend with administrative or bureaucratic hurdles that do not add value and which prevent them from delivering better, more coordinated care for patients.

In the Ontario Health Team model, common standards and target outcomes will be established, and Ontario Health Teams will be able to determine how best to self-organize to meet standards and targets. Lines of accountability and funding will be

focused and simplified. The secure sharing of necessary information among Ontario Health Team members will be prioritized. Innovation, reduction of waste, and elimination of duplication will be encouraged. Providers in Ontario Health Teams will champion their own culture change, moving from siloed, sector-based care, towards coordinated teams.

Ontario Health Teams will be responsible for providing a full and coordinated continuum of care for all but the most specialized conditions and procedures, such as transplant or neurosurgery. Services like these are currently delivered by a few specialized providers as they require an exceptional degree of clinical skill and oversight. These services will continue to be delivered by existing specialized providers and will be provincially coordinated. In some cases providers might offer care within an Ontario Health Team, as well as provide provincially coordinated specialized services. In the future, each Ontario Health Team will work with specialized service providers so that their patients can access these services in a timely fashion and be supported to transition back to their local Ontario Health Team in a coordinated way.

Part III: How will we get there?

Leverage existing strengths and partnerships, scale, and spread quickly

The Ministry is confident that there are many groups of providers and organizations across the province that are eager to lead the early implementation of the Ontario Health Team model. The path toward a fully operational Ontario Health Team is a continuum of maturity, along which all providers will progress. There are groups of providers and organizations in Ontario who have already partnered and collectively demonstrate key capabilities, positioning them to begin implementation of the model. These groups will be identified through a rigorous assessment process to become Ontario Health Team Candidates.

Ontario Health Teams are not a pilot project. Through a readiness assessment process, groups of providers and organizations will be confirmed as Ontario Health Team Candidates and will begin implementation. Other teams may discover through the assessment process that, while not yet equipped to begin implementation, with tailored supports and over time they will achieve full readiness. These groups will be identified as *'In Development'* and be supported to progress towards readiness. The first Ontario Health Team Candidates and those *'In Development'* will help demonstrate the impact of the model on quality of care, patient and provider experience, and cost, and will provide important lessons for implementing the model across the rest of the province.

Both Ontario Health Team Candidates and teams *'In Development'* will benefit from access to tailored supports to advance their progression towards maturity and will be prioritized to receive provincial digital health services to help them meet their specific needs. To enable rapid cycle learning, the first Ontario Health Team Candidates will be monitored and evaluated by a third-party to generate learnings that will enable and guide other groups on the path to becoming Ontario Health Teams.

This kind of system transformation will take time; it will require ongoing support and adaptive learning to reach full maturity. The Ministry recognizes that the process to establish and support the development of Ontario Health Teams will contribute to the identification of further policy, regulatory and legislative reforms that will enable high performing Ontario Health Teams. The Ministry is committed to minimizing barriers for the first Ontario Health Teams Candidates and those that come after.

The path to becoming an Ontario Health Team

The Ontario Health Team model sets a high bar for a new standard of care across the province. At maturity, every patient whose care needs span across different providers and settings will receive integrated, connected care provided by their local Ontario Health Team.

The Ministry is taking a deliberate and rigorous approach to the implementation of Ontario Health Teams that seeks to ensure that:

- All providers and organizations who are interested in participating in the model can come forward to participate;
- At each level of readiness, providers receive the supports they need to move along the path to become an Ontario Health Team;
- Groups demonstrate they are able to meet basic requirements before beginning to operate in the model; and
- Scale and spread takes place quickly and is informed by evidence and rapid cycle learning.

The maturation of Ontario Health Teams

The path to becoming a designated Ontario Health Team consists of four steps[4]:

1. **Self-Assessing Readiness – 2. Validating Provider Readiness – 3. Becoming an Ontario Health Team *Candidate* – 4. Becoming a Designated[4] Ontario Health Team**

1. Self-Assessing Readiness	Interested groups of providers and organizations assess their readiness and begin working to meet key readiness criteria for implementation.
2. Validating Provider Readiness	Based on Self-Assessments, groups of providers are identified as being *In Discovery* or *In Development* stages of readiness.
3. Becoming an Ontario Health Team *Candidate*	Groups of providers that demonstrate, through an invitational, full application, that they meet key readiness criteria are selected to begin implementation of the Ontario Health Team model.
4. Becoming a Designated Ontario Health Team	Ontario Health Teams Candidates that are ready to receive an integrated funding envelope and enter into an Ontario Health Team accountability agreement with the funder can be **designated[5]** as an Ontario Health Team

Ontario Health Team: Assessment Process

To onboard interested groups of providers and organizations on this path, the Ministry is launching a readiness assessment process[6] to:

- Determine which groups currently (or with some assistance) meet the key readiness criteria to begin implementation of the Ontario Health Team model, i.e., those who will be Ontario Health Team Candidates
- Identify groups who are not yet ready to begin implementation but who can be actively supported to work towards readiness, i.e., those who are *'In Development'* or *'In Discovery'*.

[4] This process is not intended to be a formal legally binding offer to enter into a contract, and does not constitute a commitment by the Ministry to enter into a funding or accountability agreement with any person or organization.
[5] If passed, Bill 74, *The People's Health Care Act, 2019*, would allow the designation of integrated care delivery systems (Ontario Health Teams). See s.29 of the Connecting Care Act, 2019 – Schedule 1 of Bill 74.
[6] This process is not intended to be a formal legally binding offer to enter into a contract, and does not constitute a commitment by the Ministry to enter into a funding or accountability agreement with any person or organization.

The readiness assessment process has three components:

1. **Self-Assessment:** Interested providers or groups of providers are invited to complete a Self-Assessment guided by an *Ontario Health Team Self-Assessment Form.* This stage allows teams to familiarize themselves with the model and required components, and work through together how they would meet the minimum criteria.
    - Self-Assessment submissions will be reviewed and those deemed to be in the beginning stage of readiness will receive access to supports to continue working towards further readiness. These teams will be considered as *'In Discovery'*.
    - Those teams that demonstrate a higher degree of readiness to become Ontario Health Teams (i.e., *'In Development'*) will be invited to prepare and submit a Full Application.
    - *Note: Where appropriate, groups may be asked to collaborate with additional providers to re-submit a joint Self-Assessment.*

2. **Full Application:** Invited providers or groups will submit a Full Application to demonstrate, with evidence, their ability to meet the Ontario Health Team Candidate readiness criteria set out in Appendix B. The *Ontario Health Team Full Application Form* will be provided to those proceeding to this stage.
    - Full Applications will be reviewed and evaluated and those that demonstrate a higher degree of readiness for implementation will be invited to participate in an In-Person Visit.

3. **In-Person Visit**: Invited providers or groups of providers will be assessed through a final in-person visit in order to identify those who are demonstrably ready to continue to become Ontario Health Team Candidates.
    - During this visit, providers will be expected to present a comprehensive current state assessment of their system and a vision for the future of patient care in the near and longer-terms. Groups may be required to provide supplementary documentation to support this visit, such as information about digital and information management capacity. Further details will be provided to groups selected for an in-person visit.
    - Following the in-person visits, providers that demonstrate full readiness for implementation will be categorized as 'Ontario Health Team Candidates' and will go on to implement the Ontario Health Team model. Remaining providers will remain '*In Development*' and will continue working towards full readiness.

The assessment process will be repeated until full provincial coverage is achieved. Providers or groups of providers who are not ready to participate in the first round will have further opportunities to participate, with additional dates to be announced. All providers and organizations who participate in the assessment process will have access to supports that will help improve readiness and eventual implementation.

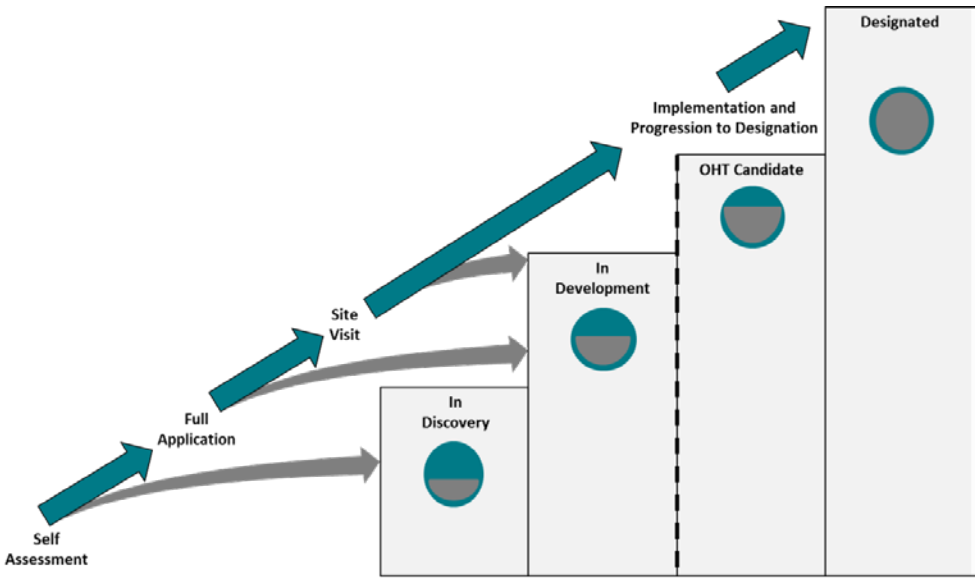

Figure 1: Readiness Assessment and Ontario Health Team Designation Process

Part IV: How interested providers will be supported

For Ontario Health Teams to succeed, they will need supports from partners across the broader health system, including the Ministry, Ontario Health, and Ontario's world class research assets. To support **all** providers who come forward through the readiness assessment process, a suite of resources will be developed to help them improve their readiness and to support their implementation. Supports and enablers will include the following:

Tools and templates. Providing access to optional provincial templates, tools, and services; tools for patient, family, and caregiver engagement and partnership; tools for provider and patient identification; and tools for digitally and securely sharing information.

Data and analytics. Providing data and analytical support to groups as appropriate and supporting Ontario Health Team Candidates with regular access to their performance measurement data as well as population and financial analytics (e.g., data on costing, health service utilization, referral patterns and market sharing mapping) so that they can take a population health approach to re-designing care.

Digital health supports. Working with Ontario Health Teams to identify approaches for improving their suite of digital tools in order to improve access, share information with providers and patients, and measure performance. This will include providing clear policies and standards for digital health solutions and a commitment to a collaborative approach whereby Ontario Health Team Candidates and those '*In Development'*, as appropriate and required, are enabled to redesign their digital health and information management practices. At the same time, the province's digital health delivery partners will prioritize their efforts to focus on delivering the necessary digital health services and change management supports to enable the work of Ontario Health Teams.

Support to grow and share best practices. Offering a range of centralized supports such as a peer collaborative learning platform to share learnings and experiences; governance (board) training; expert resources on implementing integration; patient engagement tools; resources for understanding and managing financial drivers associated with population health management; and a central repository of best-practice evidence for integrated care delivery and improving population health.

Change management support. Providing structured resources, if needed and/or requested, to enable effective change management to transition into the Ontario Health Team model of care.

Incentives. Prioritizing Ontario Health Teams and providers who are actively working towards implementation for future investments that enhance health service capacity, quality and performance. Designated Ontario Health Teams will also be rewarded based on performance through shared savings. Shared savings must be used to improve patient care.

Legislative, regulatory, and policy or other enablers. Inviting input from providers regarding aspects of applicable legislation, regulations, funding agreements or government policies which could impede their participation in this transformative model and prevent Ontario Health Teams from realizing their full potential to deliver innovative, efficient, high quality, and coordinated care. This input will be considered in the development of proposals for any additional changes or reforms that may be required to support the implementation of the Ontario Health Team model.

Conclusion

Ontario has some of the world's best health care providers and world class health care services. However, urgent changes are required to redesign relationships, accountabilities, and incentives to put patients at the centre of how services are delivered, and to truly deliver seamless care to all Ontarians.

The Ontario Health Teams model represents a fundamental shift in the way health care will be delivered and funded across our province. This is the beginning of our transformation towards a sustainable and connected health care system that will ensure patients get the care they need. Although this scale of transformation is complex and will take time to reach maturity, maintaining the status quo is not an option. Real implementation will require continuous hard work across Ontario over a number of years.

All Ontarians deserve a health system that serves them better and implementation will not stop with early adopters. Additional Ontario Health Teams will be established across the province in phases over the next several years. Rapid cycle learning approaches and a comprehensive, ongoing evaluation will be used to translate lessons learned from early implementation into best practices.

We know that Ontario's health care providers and organizations are ready and capable of engaging in this transformation. We share in providers' and patients' desire to improve Ontario's publicly funded health care system and deliver fully integrated care to achieve better outcomes, better experience, and better value for all Ontarians, and we are ready to embark on this journey with them.

Appendix A – Ontario Health Team Model: From Readiness to Maturity Summary

	Readiness Criteria for Ontario Health Team Candidates	Year 1 Expectations for Ontario Health Team Candidates	Ontario Health Teams at Maturity
Patient Care & Experience	Plans in place to improve access, transitions and coordination, key measures of integration, patient self-management and health literacy, and digital access to health information. Existing capacity to coordinate care. Commitment to measure and improve patient experience and to offer 24/7 coordination and navigation services and virtual care.	Care has been redesigned. Access, transitions and coordination, and integration have improved. Zero cold handoffs. 24/7 coordination and navigation services, self-management plans, health literacy supports, and public information about the Team's services are in place. Expanded virtual care offerings and availability of digital access to health information.	Teams will offer patients, families and caregivers the highest quality care and best experience possible. 24/7 coordination and system navigation services will be available to patients who need them. Patients will be able to access care and their own health information when and where they need it, including digitally, and transitions will be seamless.
Patient Partnership & Community Engagement	Demonstrated history of meaningful patient, family, and caregiver (P/F/C) engagement, and support from First Nations communities[7] where applicable. Plan in place to include P/F/C in governance structure(s) and put in place patient leadership. Commitment to develop an integrated patient engagement framework, and patient relations process. Adherence to the *French Language Services Act,* as applicable.	Patient Declaration of Values in place. P/F/C included in governance structure(s) and patient leadership established. Patient engagement framework, patient relations process, and community engagement plan are in place.	Teams will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage and partner with - and be driven by the needs of - patients, families, caregivers, and the communities they serve.
Defined Patient Population	Identified population and geography at maturity and target population for year 1. Process in place for building sustained care relationships with patients. High-volume service delivery target for year 1.	Patient access and service delivery target met. Number of patients with sustained care relationship reported. Plan in place for expanding target population.	Teams will be responsible for the health outcomes of a population within a geographic area that is defined based on local factors and how patients typically access care.
In-Scope Services	Existing capacity to deliver coordinated services across at least three sectors of care (especially hospital, home care, community care, and primary care). Plan in place to phase in full continuum of care and include or expand primary care services.	Additional partners identified for inclusion. Plan in place for expanding range and volume of services provided. Primary care coverage for a significant proportion of the population.	Teams will provide a full and coordinated continuum of care for all but the most highly-specialized conditions to achieve better patient and population health outcomes.
Leadership, Accountability, and Governance	Team members are identified and some can demonstrate history of working together to provide integrated care. Plan in place for physician and clinical engagement and inclusion in leadership and/or governance structure(s). Commitment to the Ontario Health Team vision and goals, developing a strategic plan for team, reflecting a central brand, and where applicable, putting in place formal agreements between team members.	Agreements with Ministry and between Team members (where applicable) in place. Existing accountabilities continue to be met. Strategic plan for the Team and central brand in place. Physician and clinical engagement plan implemented.	Teams will determine their own governance structure(s). Each team will operate through a single clinical and fiscal accountability framework, which will include appropriate financial management and controls.
Performance Measurement, Quality Improvement, & Continuous Learning	Demonstrated understanding of baseline performance on key integration measures and history of quality and performance improvement. Identified opportunities for reducing inappropriate variation and implementing clinical standards and best evidence. Commitment to collect data, pursue joint quality improvement activities, engage in continuous learning, and champion integrated care.	Integrated Quality Improvement Plan in place for following fiscal year. Progress made to reduce variation and implement clinical standards/best evidence. Complete and accurate reporting on required indicators. Participation in central learning collaborative.	Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators aligned with the Quadruple Aim will measure performance and evaluate the extent to which Teams are providing integrated care, and performance will be reported.
Funding and Incentive Structure	Demonstrated track record of responsible financial management and understanding of population costs and cost drivers. Commitment to working towards integrated funding envelope, identifying a single fund holder, and reinvesting savings to improve patient care.	Individual funding envelopes remain in place. Single fund holder identified. Improved understanding of cost data.	Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations.
Digital Health	Demonstrated ability to digitally record and share information with one another and to adopt/provide digital options for decision support, operational insights, population health management, and tracking/reporting key indicators. Single point of contact for digital health activities. Digital health gaps identified and plans in place to address gaps and share information across partners.	Harmonized Information Management plan in place. Increased adoption of digital health tools. Plans in place to streamline and integrate point of service systems and use data to support patient care and population health management.	Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.

[7] For a map of First Nations communities and reserves, please refer to the following link: https://www.ontario.ca/page/ontario-first-nations-maps [link]

Appendix B – Ontario Health Teams in Detail

The following appendix specifies the Ontario Health Team model in detail, including:

- Minimum readiness criteria that groups must demonstrate over the course of the readiness assessment process[8] in order to be considered for Ontario Health Team Candidate selection;
- Expectations for Ontario Health Team Candidates at the end of their first year of operations; and
- Expectations for an Ontario Health Team at maturity.

Groups of providers and organizations who are invited to the Full Application stage will be expected to demonstrate with evidence how they meet the readiness criteria for each of the Ontario Health Team model components.

The model has been informed by Ontario's past experience with integrated care initiatives and research[9] that demonstrates that successful integrated health systems universally share a set of key features:

- ✓ Comprehensive, coordinated services that span the continuum of care
- ✓ Standardized care delivered by inter-professional teams
- ✓ Patient-centred care responsive to population need
- ✓ Systematic geographic coverage (and rostering) to minimize duplication and maximize access
- ✓ Performance measurement, management and continuous quality improvement for better outcomes
- ✓ Integrated digital health ecosystem to manage patient health information and financial data
- ✓ Visionary, committed leadership that instills cohesive culture across the system
- ✓ Physicians integrated throughout the system and engaged in co-design
- ✓ Strong governance with diverse membership
- ✓ Funding levels aligned with population need, flowed using mechanisms that support improved patient outcomes

There are multiple components to the Ontario Health Team model:

1. Patient Care & Experience

[8] This process is not intended to be a formal legally binding offer to enter into a contract, and does not constitute a commitment by the Ministry to enter into a funding or accountability agreement with any person or organization.

[9] Suter, E., Oelke, N. D., Adair, C. E., & Armitage, G. D. (2009). Ten Key Principles for Successful Health Systems Integration. *Healthcare Quarterly (Toronto, Ont.)*, *13*(Spec No), 16–23. For additional resources about integrated care, please see the '*Essential Reading List – Integrated Care Delivery Systems' [link: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/reading.aspx]*

2. Patient Partnership & Community Engagement
3. Defined Patient Population
4. In-Scope Services
5. Leadership, Accountability, & Governance
6. Performance Measurement, Quality Improvement, & Continuous Learning
7. Funding and Incentive Structure
8. Digital Health

For each component of the model, Ontario Health Teams will be expected to meet certain commitments and service delivery expectations for their population after their first year of operations through to maturity.

1. Patient Care & Experience

At Maturity

Ontario Health Teams will offer patients, families, and caregivers the highest quality care and best experience possible. This will require Ontario Health Teams to challenge the status quo and re-engineer the care they deliver according to best evidence and available standards, with attention to inclusive approaches to care and a relentless focus on quality improvement and rapid learning at all levels of operations. The following statements will hold true for patients who receive care from an Ontario Health Team:

- *Access* – I can access care when and where I need it. I have many ways to access my care, including digital choices (e.g., in-person, home visits, virtual care, online appointment bookings, a phone call to my care coordinator or doctor).

- *Coordination & Transitions* – My providers work together as a team and know my medical history. My care is seamless, and each step in my care journey is planned. I know who I can go to when I need help navigating my care or when things go wrong. I only interact with the health care system when I need or want to.

- *Communication & Information* – I can access my health record digitally. I am provided information about my condition and know how to be an active partner in managing my own health and health conditions. My providers tell me what to expect in each step of my care journey. I know what services are available to me from my Ontario Health Team and how to access services outside of my Team.

Readiness Criteria for Ontario Health Team Candidates

- Opportunities and proposed Year 1 targets for improvement have been identified and a plan has been proposed to improve:
    - Access to services provided by partners (e.g., wait times, availability of services),
    - Transitions and coordination of care between care settings and providers (e.g., assessment of care needs, care planning, information sharing), and
    - Key measures of integration (e.g., alternate level of care, avoidable emergency department visits, readmission rates, hallway bed use)
- A plan has been proposed for enhancing patient self-management and/or health literacy for at least a specifically defined segment of Year 1 patients, based on diagnoses
- Confirmed commitment to measure and report patient experience according to standardized metrics and to relentlessly improve care based on findings
- Demonstrated existing ability and capacity to coordinate care across multiple providers and settings for Year 1 patients
- Confirmed commitment to put in place 24/7 coordination of care and system navigation services for Year 1 patients
- Confirmed commitment to offer one or more virtual care services to patients, such as: email, secure messaging, phone or video visits; online appointment booking offered by providers within the Ontario Health Team; or digital self-care supports for chronic disease management – *further details on relevant policies and standards will be provided to groups invited to complete a Full Application*
- A plan has been proposed to provide patients with some digital access to their health information (e.g., patient portal for digital access to records from hospitals within the Ontario Health Team) – *further details on relevant policies and standards will be provided to groups invited to complete a Full Application*

Year 1 Expectations for Ontario Health Team Candidates

- ✓ Care has been re-designed for Year 1 patients
- ✓ Improved performance against access, transition, coordination of care, and integration targets determined in consultation with the Ministry
- ✓ Every Year 1 patient who received care across multiple providers or settings experienced coordinated care; zero cold handoffs
- ✓ Any Year 1 patient can access 24/7 coordination and system navigation services from their Ontario Health Team (e.g., someone with access to their health information who can help with system navigation, when something goes wrong with their care, or when they have a complaint)
- ✓ The majority of Year 1 patients who received a self-management plan and/or access to health literacy supports understood that plan, as appropriate, and/or

used those supports
- ✓ 10-15% of Year 1 patients who received care from the Ontario Health Team digitally accessed their health information
- ✓ Expanded virtual care offerings from baseline, and 2-5% of Year 1 patients who received care from the Ontario Health Team had a virtual encounter in Year 1
- ✓ Information about Ontario Health Team's service offerings is readily available and accessible to the public (e.g., through a website)

2. Patient Partnership & Community Engagement

At Maturity

Ontario Health Teams will uphold the principles of patient partnership, community engagement, and system co-design.

Ontario Health Teams will be driven based on the needs of patients and communities. They will meaningfully engage and partner with patients, families, caregivers, and communities, based on a robust patient partnership model and community engagement strategy.

Readiness Criteria for Ontario Health Team Candidates

- Demonstrated track record of meaningful patient, family, and caregiver engagement and partnership activities
- A plan has been proposed to incorporate patients, families, and/or caregivers in the team's governance structure(s) (e.g., patient advisor role) and put in place patient leadership
- Confirmed commitment to developing a patient engagement framework for the team
- Confirmed commitment to developing a team-wide transparent and accessible patient relations process for addressing patient feedback and complaints, and a mechanism for using this feedback for continuous quality improvement
- Indication of whether patients, families, and caregivers have been involved in the design and planning of the application
- Indication of whether there is community support for the application
- Demonstrated support or permission of communities where team is proposing to be responsible for a region or geography that includes one or more First Nation[10] communities.

[10] For a map of First Nations communities and reserves, please refer to the following link: https://www.ontario.ca/page/ontario-first-nations-maps [link]

- Adherence to the requirements of the *French Language Services Act,* as applicable, in serving Ontario's French language communities

Year 1 Expectations for Ontario Health Team Candidates

- ✓ The Ontario Health Team has a Patient Declaration of Values in place, aligned in principle with the *Patient Declaration of Values for Ontario.*
- ✓ Patient(s), families, and/or caregiver(s) are members of governance structure(s) and patient leadership established
- ✓ Well-defined patient engagement, consultation, and partnership strategy/framework and patient relations process are in place, developed in partnership with patients, families, and caregivers
- ✓ Community engagement plan is in place to inform continued implementation and out-year planning

3. Defined Patient Population

At Maturity

Apart from certain highly specialized, lower volume services, each Ontario Health Team will be responsible for meeting all health care needs of a population within a geographic area that is defined based on local factors and how patients typically access care.

Experience from other health care systems that feature integration and shared accountability suggest that population sizes must reach a critical mass of people in order for integrated funding and accountability structures to function well and optimize value. At maturity, the size of each Ontario Health Team's population will be sufficient to fully optimize clinical and financial outcomes and will account for unique regional variations and the needs across our rural, urban, and northern communities. Regardless of size, care delivery will be tailored according to the needs of the patients and communities served.

Geographic delineations will be determined over time, based on patient access patterns and collaboration between the Ministry, Ontario Health Teams, and their communities. Ontario Health Teams will be expected to 're-patriate' patients where appropriate (for example, if a patient requires urgent care outside of their Ontario Health Team, they will receive that care and experience a warm handoff back to their local Ontario Health Team).

In order to hold Ontario Health Teams clinically and fiscally accountable for the total costs and health outcomes of their population, each Team will have an "attributed population" – the population that the Ontario Health Team is responsible for and on

which outcomes and costs will be calculated. Attribution methods will be determined by the Ministry based on lessons learned from the first Ontario Health Team Candidates and may be based on a number of factors, including patient proximity to the care providers within an Ontario Health Team, existing referral patterns, the care needs of the population, and the specific mix of providers within an Ontario Health Team. Attribution methods may evolve over time.

Patients will **retain full choice** in who they see for their care – even if a patient has been attributed to an Ontario Health Team, they may still choose to receive care from providers outside that group.

Readiness Criteria for Ontario Health Team Candidates

- A proposed population and geography (i.e., community) whose outcomes and costs of care the team envisions being accountable for at a mature state have been identified. The geography must be informed by existing access/referral patterns.
- A target population that the team would focus on in the first year has been identified for focus on improvement and outcomes. The intent is for Ontario Health Teams to move quickly towards a population health approach (i.e., where an Ontario Health Team is responsible and held accountable for caring for an entire population).
- A well-defined mechanism/process is in place for creating a sustained care relationship with patients who receive care in Year 1 (e.g., formal patient registration/ enrolment/ membership/ rostering).
- A relatively high-volume service delivery target has been proposed for Year 1 as a proportion of the overall Year 1 target population (i.e., of the Year 1 target population, applicants must provide an estimate of how many patients would actually receive integrated care from the Ontario Health Team in the first year of operations).

Year 1 Expectations for Ontario Health Team Candidates

- ✓ Patient access and service delivery target met (finalized target to be determined in consultation with the Ministry)
- ✓ Number of patients who identify as having a sustained care relationship with the Ontario Health Team has been reported
- ✓ Plan in place for expanding target population

4. In-Scope Services

At Maturity

Ontario Health Teams will offer a full and coordinated continuum of services to achieve target outcomes, including but not limited to:

- primary care (including inter-professional primary care[11] and physicians);
- secondary care (e.g., in-patient and ambulatory medical and surgical services (includes specialist services));
- home care;
- community support services;
- mental health and addictions;
- health promotion and disease prevention;
- rehabilitation and complex care;
- palliative care (e.g., hospice);
- residential care and short-term transitional care (e.g., in supportive housing, long-term care homes, retirement homes);
- long-term care home placement;
- emergency health services;
- laboratory and diagnostic services;
- midwifery services; and
- other social and community services and other services, as needed by the population.

Coordination of Care

Coordination of care within and across the full continuum of care and system navigation[12] will be integral to the effective functioning of Ontario Health Teams, and services and supports to achieve these ends must be provided by each Team. Ontario Health Teams will aim to ensure seamless and continuous transitions between individual providers, across the health system, and throughout a person's life span. They may involve the coordination of specialist appointments and referrals to a range of medical and community-based care, facilitation of medication management through partnerships with community pharmacies, and broader supports to address issues affecting a patient's health outcomes.

[11] Including Nurse Practitioners

[12] Care coordination and system navigation are related concepts. Generally, care coordination refers "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient" (Care Coordination. Agency for Healthcare Research and Quality (2018) [link]. System navigation activities can include helping people understand where to go for certain types of care and facilitating access to health and social services.

At maturity, it is envisioned that home care coordination and long-term care home placement services would be delivered by Ontario Health Teams. Potential legislative, regulatory and policy changes to enable and support such a model will be explored. Measures will be taken to prevent any disruptions to the continuity of these services.

Role of Physicians

While physician participation is voluntary, physicians are key to the success of Ontario Health Teams. The vision for Ontario Health Teams is not only for physicians to play leadership roles and function as core members of Ontario Health Teams, but also that they have access to more robust digital tools, data, and analytics and feel better supported by being part of an inter-professional, integrated team that shares accountability for patients. Because Ontario Health Teams are responsible for providing a full continuum of coordinated care and improving health outcomes for an entire population, strong physician participation and leadership (both primary care and specialist) are essential cornerstones of the model. Experience from other jurisdictions reinforces this point – systems that feature strong physician leadership and participation, particularly of primary care providers, yield better success. Unequivocally, physicians will have an important and distinct role to play in Ontario Health Teams, from the early stages of implementation to the long-term expansion of the model. Successful Ontario Health Teams can be built on existing physician remuneration models.

Readiness Criteria for Ontario Health Team Candidates

- The team is able to deliver coordinated services across at least three sectors of care in Year 1 and has adequate service delivery capacity to serve the care needs of the proposed Year 1 target population
    - *Note: As part of the readiness assessment process, submissions that include a minimum of hospital, home care, community care and primary care (inter-professional primary care models and physicians) will be prioritized*
- A plan/process has been proposed to phase in the full continuum of care
- Where primary care is not proposed as a Year 1 in-scope offering, there is a demonstrated history of primary care engagement and a proposed plan for eventual inclusion
- Where primary care is an immediate in-scope offering, there is a proposed plan for expansion to meet population need at maturity

Year 1 Expectations for Ontario Health Team Candidates

- ✓ Additional partners identified and engaged for inclusion in Year 2
- ✓ Plan in place for expanding range and volume of services provided in Year 2

- ✓ Primary care coverage for a significant proportion of the Ontario Health Team population.

5. Leadership, Accountability, & Governance

At Maturity

The providers that form Ontario Health Teams will be free to determine the governance model that works best for them, their patients, and their communities. Regardless of what governance model an Ontario Health Team adopts, it must be conducive to coordinated care delivery for patients, support achievement of performance targets, and enable the achievement of accountability objectives. Teams will also be expected to demonstrate strong financial management and controllership to appropriately oversee its integrated funding envelope.

- *Leadership* – Each Ontario Health Team must have a strong leadership structure to provide a unifying vision and strategy, drive integration of care and change management, and bring providers and patients, families, and caregivers together to rethink how care is delivered, while using data and analytics to create a culture of learning, performance measurement, and continuous quality improvement.

- *Accountability* – Every Ontario Health Team will operate under a single clinical and fiscal accountability framework. A portion of funding will be linked to achieving improvement against a standard performance measurement framework.

- *Governance* – Ontario Health Team governance arrangements will be self-determined and fit-for-purpose. Governance structures will include patients.

The Ministry encourages all providers and organizations to organize themselves in a way that truly works best for patients and communities.

For Ontario Health Teams that are comprised of multiple, separate organizations, building shared governance and accountability relationships requires trust and may take time to establish. Governance arrangements may evolve as each Ontario Health Team matures, and Ontario Health Teams may establish transitional governance structures as they adapt to new ways of working together.

Readiness Criteria for Ontario Health Team Candidates

- Providers/organizations comprising the team have been identified

- A plan has been proposed for physician and clinical engagement and ensuring inclusion of physician and clinical leadership as part of the team's leadership and/or governance structure(s)
- Confirmed commitment to the vision and goals of the Ontario Health Team model
- Confirmed commitment to putting in place a strategic plan or strategic direction for the team, consistent with the Ontario Health Team vision
- Confirmed commitment to reflect key components of a central brand
- Confirmed commitment to work towards a single clinical and fiscal accountability framework
- Where a team consists of multiple, separate providers/organizations, confirmed commitment to formalize their relationships though agreements, written governance arrangements, and/or other instruments addressing matters including decision making, conflict resolution, performance management, information sharing, and resource allocation
- Where a team consists of multiple, separate providers/organizations, at least some of the participating providers/organizations have a demonstrated history of formally working with one another to advance integrated care, e.g., development of shared care delivery or shared clinical pathways, participation in Health Links, Bundled Care, Rural Health Hubs, Solo Practitioners in Need (SPiN), etc.

Year 1 Expectations for Ontario Health Team Candidates

- ✓ Ontario Health Team ratifies agreement with Ministry, outlining service delivery and performance obligations
- ✓ Where an Ontario Health Team consists of multiple, separate providers/organizations, formal agreement(s) are in place between providers/organizations, specifying roles and responsibilities
- ✓ Each provider's/organization's existing funding or service accountability agreement or service contract will remain in place, and reporting and other obligations set out in those agreements must continue to be met
    - *Note: The Ministry will examine obligations under current funding or service accountability agreements to determine what obligations may continue or could be revisited based on new obligations of the Ontario Health Team, and will seek to reduce reporting and reporting burdens where possible*
- ✓ Strategic plan or strategic direction in place for the Ontario Health Team, consistent with the central vision and target outcomes of the Ontario Health Team model
- ✓ Physician and clinical engagement plan has been implemented
- ✓ Central brand reflected

6. Performance Measurement, Quality Improvement, & Continuous Learning

At Maturity

Ontario Health Teams will provide high quality care that is informed by the best available evidence and clinical standards, with an ongoing focus on the best possible outcomes through continuous quality improvement at all levels.

Ontario Health Teams will be measured and evaluated on the extent to which they are providing integrated care. Provincial and local targets and benchmarks will be set to track progress and support Ontario Health Teams on their path to maturity. In the first phase, all Ontario Health Teams will be required to collect and report data on key integration indicators, aligned with the principles of the Quadruple Aim.

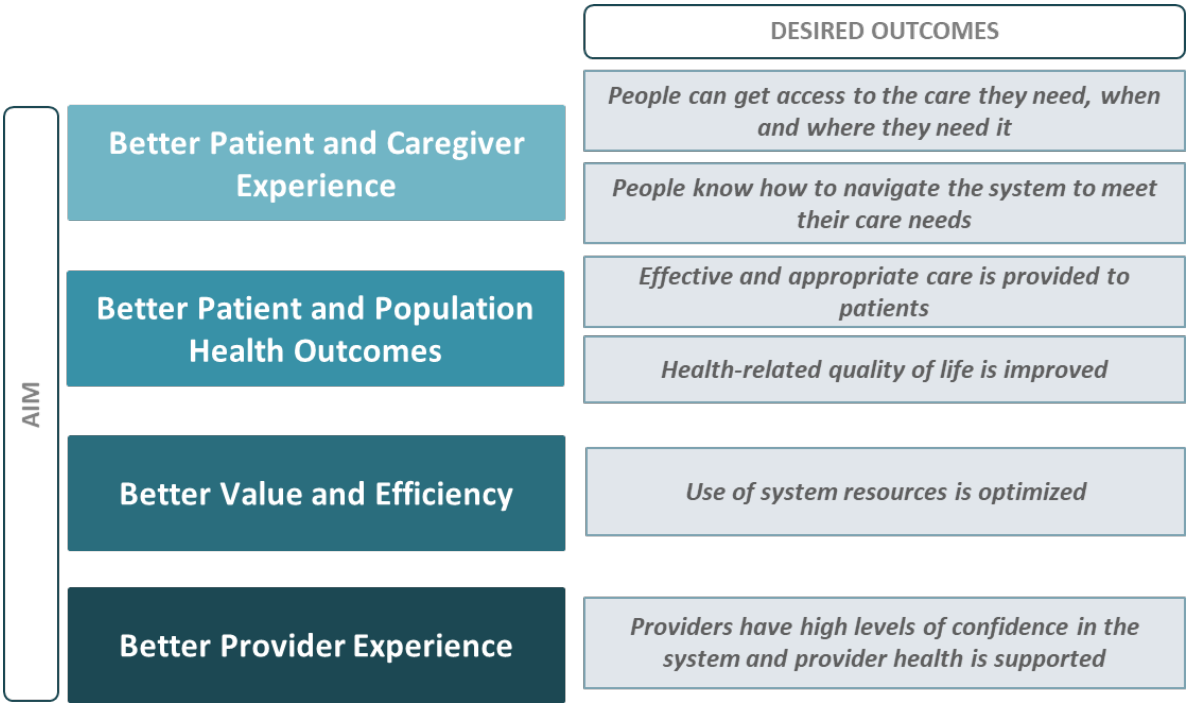

Figure 2: Quadruple Aim and Desired Outcomes

To ensure all aspects of the Quadruple Aim are reflected in the Ontario Health Team performance measurement framework, the Ministry will develop pan-sectoral/multi-sector Patient Reported Experience Measures (PREMs), Patient Reported Outcome Measures (PROMs), and provider experience surveys. These tools will be valuable mechanisms for monitoring Ontarians' perceptions of care, access, and transitions, as well as provider experiences and satisfaction.

Further details on the required indicators, including technical specifications and improvement tools and resources, will be provided to groups who come forward through the assessment process.

Ontario Health Team Reporting

Reporting on Ontario Health Team performance will be established over time to provide Ontarians with easily understandable information on health system improvements and ensure patients have access to information about their choices of providers. Reporting of Ontario Health Teams' key performance measures will also make clear opportunities for quality and performance improvement, promoting a culture of continuous quality improvement, knowledge sharing, and innovation. It will also ensure Ontario Health Teams are being fully responsible for their health care funding.

Each Ontario Health Team will need the ability to analyze data to plan and mobilize resources for its patient population and community. Ontario Health Teams will be assisted with data sharing tools and analytical supports, such as local dashboards and other information to improve care such as the *Primary Care Capacity Assessment Framework,* to inform care planning.

Readiness Criteria for Ontario Health Team Candidates

- Demonstrated understanding of baseline performance on key integration metrics (e.g., alternate level of care, avoidable emergency department visits, readmission rates, hallway bed use)
- Confirmed commitment to collect, share and report data as required and in alignment with a standardized performance measurement framework
- Demonstrated history of quality and performance improvement
- Confirmed commitment to pursuing shared quality improvement initiatives that integrate care and improve performance
- Identified opportunities for reducing inappropriate variation and implementing clinical standards and best available evidence
- Confirmed commitment and capacity for continuous learning and improvement including participation in learning collaboratives
- Confirmed commitment to champion integrated care at a system-wide level and mentor other health care provider groups as they ready themselves for the Ontario Health Team model

Year 1 Expectations for Ontario Health Team Candidates

- ✓ Integrated Quality Improvement Plan in place for the following fiscal year
- ✓ Progress made to reduce variation and implement clinical standards or best available evidence

- ✓ Complete and accurate reporting on required indicators
- ✓ Participation in central learning collaborative

7. Funding and Incentive Structure

At Maturity

Integrated funding is an essential component of any shared responsibility model. At maturity, each Ontario Health Team will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient population. Funding must follow patients even if the patient chooses to receive some or all of their care elsewhere. The Ontario Health Team (or the entity within the Team that agrees to act as a fund holder) is responsible for ensuring those services are appropriately funded.

At mature state, budgets will be set according to a blended funding model, which will feature risk-adjusted population-based funding, as well as elements of activity-based funding (i.e., bundled care) for specific episodic conditions. Select low volume, high cost procedures would continue to be overseen and funded provincially. The model will be designed to drive key goals: improving access, better efficiency and effectiveness and improving equity. Ontario Health Teams would have flexibility in how they spend their budget, tied to quality and outcome objectives.

Over time, and in preparation for the mature state, a shared savings incentive structure will be put in place to reward Ontario Health Teams that realize efficiencies and exceed performance targets.[13] For example, if an Ontario Health Team is able to meet quality expectations while delivering care at a cost that is lower than a pre-established benchmark, then it will be able to keep a portion of those savings. Those savings must be used for improvement in direct patient care. Minimum quality and performance targets will need to be met and savings will need to be spent according to prescribed rules (e.g., to fund additional services, quality improvement interventions, etc.). The performance incentive structure will evolve over time as Ontario Health Teams mature. Ontario Health Teams will also be able to engage in risk and gain-sharing amongst participating partners.

[13] **Shared savings and losses** is an approach that allows funders to recoup some of the efficiency gains that providers achieve and disincentivizes overspending. **Risk and gain sharing** is an approach that aligns incentives across different providers and sectors. Each partner in a risk and gain sharing arrangement shares financial gains from efficiencies. For Ontario Health Teams, all savings must be redirected into front line care.

Funding methods and incentive structures will not change for the first Ontario Health Team Candidates. Ontario Health Teams, or those in Candidate and '*In Development*' stages, will be prioritized for any future investments that may become available.

Bundled care has been, and will continue to be, an important tool for advancing integrated care. Through bundled care initiatives to date, providers have been able to forge new partnerships with one another, and have gained important experience executing the principle of "funding follows the patient" and entering into risk and gain-sharing relationships with one another. Providers are encouraged to continue their bundled care implementation activities as they to advance toward implementation of the Ontario Health Team model.

Readiness Criteria for Ontario Health Team Candidates

- All partners have demonstrated a track record of responsible financial management
- Confirmed commitment to work towards an integrated funding envelope and identify a single fund holder
- Confirmed commitment to reinvest savings to improve patient care
- Demonstrated understanding of the costs of their population and associated cost drivers

Year 1 Expectations for Ontario Health Team Candidates

Funding

- ✓ Continued allocation of individual funding envelopes for organizations, calculated using current methods in the near term
- ✓ A better understanding of an integrated funding envelope and analysis of financial data
- ✓ A single identified fund holder by end of Year 1 in anticipation that an integrated funding envelope will be allocated in future years

Incentives

- ✓ Ontario Health Teams will be supported to better understand the health care costs of their population in anticipation that they will be eligible for shared savings received in future years, with any savings achieved to be used for direct patient care

8. Digital Health:

Note: requirements here are in addition to digital health / virtual requirements provided in previous sections (e.g. "Patient Care & Experience").

At Maturity

We envision that at maturity, Ontario Health Teams will offer patients digital access to their health information and a variety of options for virtual encounters, enabling patients to receive care on their own terms. These tools will also significantly improve the operations of health service providers and organizations, enabling improved workflows and reducing common day-to-day challenges that result in provider frustration and burnout.

At a mature state, digital health solutions will be expected to support effective health care delivery, ongoing quality and performance improvements, and better patient experience. We recognize that key digital capabilities for an Ontario Health Team at maturity are interdependent and work together, including:

- *Adoption and adherence* – Ability to adopt provincial digital tools and services and adhere to provincial standards, where applicable

- *Transferability and portability* – Ability to efficiently and effectively communicate and to digitally and securely share information across the network, including shared patient records among all care providers within the system or network

- *Standardization* – Ability to drive performance improvements within and across the network through clinical and data standardization, including common clinician workflows and pathways that are embedded within digital systems to drive quality improvement at scale, and advanced analytics and strong information management practices to enable population health management, quality improvement, and outcomes measurement

- *Virtual care* – Ability to provide patients with digital choices such as virtual care (e.g. telephone, email, electronic booking, remote monitoring, video consult) and full and timely digital access to patient health records that empower patients to better manage their health

To support Ontario Health Teams Candidates to reach this mature state, the Ministry and its partners will prioritize the availability of existing provincial tools (e.g. provincial clinical viewers, eConsult) and services (e.g., ONE ID, provincial client and provider registries) for these groups and will work with them to develop a better understanding of

their long-term needs.

Readiness Criteria for Ontario Health Team Candidates

Because digital tools are a key foundational enabler for the success of the Ontario Health Team model, applications will be prioritized that demonstrate strong existing digital infrastructure and the capacity to expand digital capabilities moving forward.

These success factors include the ability to:

- Demonstrate that the majority of the partners have the ability to digitally record information and have some ability to share information with one another (e.g., a limited number of point-of-service systems are already in place, provincial clinical viewers are used by most providers)
- Demonstrate that at least some partners have the ability to adopt and provide some digital options for decision support (e.g., computerized physician order entry), operational insights, population health management, and track and report on key indicators
- Identify a single point of contact for digital health activities moving forward, with this individual having the ability to represent the team as a whole and to drive digital health activities within the team moving forward
- Identify existing digital health gaps and confirm commitment to develop a plan (with provincial support, if desired) to address them as a priority - *further information on relevant policies and standards as well as provincial tools and services that this plan will be required to meet will be shared prior to implementation*
- Confirm plan to share information across partners for the purposes of integrated care delivery, planning (e.g., pooling information to understand population health needs and cost drivers, population segmentation, integrated care pathway design), and quality improvement - *further information on relevant policies and standards as well as provincial tools and services that this plan will be required to meet will be shared prior to implementation*
    - For proposed teams that consist of multiple providers, plans may include seeking designation as a single Health Information Custodian under the *Personal Health Information Protection Act, 2004*

Year 1 Expectations for Ontario Health Team Candidates

- ✓ Harmonized information management plan in place
- ✓ Increased adoption of relevant digital health tools amongst the Ontario Health Team partners (e.g. ONE-ID, provincial clinical viewers, eConsult)
- ✓ Plan is in place to streamline and integrate point-of-service systems consistent with provincial frameworks (which will be shared prior to the beginning of the

implementation process) and to use data to support enhanced patient care and population health management