RISE
Rapid-Improvement Support and Exchange

Data sharing supports for OHTs

RISE brief 38: Supporting data sharing by OHTs with an agreement template and four tools

Context

The member organizations in Ontario Health Teams (OHTs) – primary-care practices and teams, home and community care organizations, and hospitals, among others – need to be able to share data, particularly personal health information (PHI), among themselves. Effective data sharing is foundational to advancing integrated care, enabling coordinated clinical pathways, implementing programs, monitoring performance across OHTs/PCNs and their member organizations, and responding directly to challenges identified by OHTs as barriers to integrated-care delivery.

Data sharing needs to become the 'new normal' and to be actively supported among OHT member organizations by OHTs and Primary Care Networks (PCNs). The potential benefits of data sharing have long been clear; now we have an opportunity to ramp up efforts to support this transition, to ensure the benefits are realized for both clients and for clinicians, and to minimize the risks for clinicians and organizations. (We use the term 'clients' to mean patients, families and caregivers, residents of long-term care homes, and other recipients of healthcare services.) 'Playing it safe' has – until now – often meant not sharing data. In future, 'playing it safe' should mean safely and efficiently sharing data in a way that complies with existing legislation (Personal Health Information Protection Act, or PHIPA, 2009) and regulations (e.g., pertaining to privacy and information management), adheres to policy and contractual obligations (e.g., Ontario Health atHome contracts prohibit storing data on servers outside Canada), respects Indigenous data sovereignty and governance, meets Ontarians' rising expectations for integrated care, adds clinical and operational value, and mitigates risk appropriately.

Box 1: Coverage of OHT priorities

This RISE brief addresses a cross-cutting OHT priority – data sharing to support integrated care – and one specifically connected to OHT building block 5 (digital health and data analytics). It also addresses OHT clinical priorities, including chronic disease prevention and management and increasing primary-care access and attachment, given that data sharing is essential for OHTs and PCNs to address these clinical priorities in an integrated manner.

Box 2: Process followed

We followed a three-feature process to create the data-sharing supports:

1) convened an advisory panel on four occasions – 28 November 2025, 22 and 27 January 2026, and 9 February 2026 -- to bring diverse OHT, PCN and other partner perspectives to framing what was needed, to providing feedback on drafts of the template and tools, and to identifying implementation considerations, including issues unique to Indigenous data and primary-care enablement
2) issued a call to OHTs to share examples of data-sharing templates and related tools that they have found helpful, what they found helpful about them, and what could have been improved to address challenges (with a particular focus on supports addressing Indigenous data sovereignty and on primary-care enablement)
3) procured the services of Borden Ladner Gervais LLP (BLG) to participate in advisory panel meetings, review the submitted materials (18 documents from 8 different OHTs), draft the data-sharing supports, and revise them based on feedback from the advisory panel.

The advisory panel was co-chair by an experienced lawyer (Lauren Black from VHA Home Healthcare) and a RISE co-lead (John Lavis) and comprised of:

1) 18 members from OHTs who were identified through a nominations process, including from sectors like primary care, home and community care and hospitals, and roles like clinicians, managers and privacy leads
2) 12 members from Ontario Health (one from each of five regions and three from central office), Ontario Health atHome (one member), and the Ministry of Health (three members).

The ex-officio members included BLG staff leading the work (Daniel Michaluk and Krystin Chung) and RISE staff supporting it (Ileana Ciurea and Kaelan Moat).

Data sharing contributes to a number of current OHT and PCN priorities (see Box 1). It will contribute to many other priorities in future. Data sharing will underpin much of what OHTs and PCNs are seeking to improve about Ontario's health system.

To accelerate data sharing, RISE was asked to develop and implement a process (described in Box 2) for co-creating with OHT and PCN representatives a data-sharing agreement (DSA) template, as well as four tools that can help to operationalize the use of the template and enable the practical implementation of data sharing in OHTs. RISE was asked to give particular attention to Indigenous data sovereignty and to primary-care enablement (and these are the focus of dedicated sections later in this RISE brief).

Box 3: Acronyms used in this RISE brief

DSA = data-sharing agreement
HIC = health information custodian
HIC-agent = agent acting on behalf of a health information custodian
(note that HIC-agent is not a legal term under PHIPA; it is used here for brevity)
HINP = health information network provider
IPC = Information and Privacy Commissioner of Ontario
OCAP® = ownership, control, access, and possession (Indigenous data principles)
PHI = personal health information
PHIPA = Personal Health Information Protection Act, 2004

This RISE brief provides context for and tips for the use of the DSA template and tools, including links to additional resources (e.g., OCAP®). The DSA template was designed to be adapted (as needed) and used by all OHTs and their member organizations. The tools were designed to be helpful in particular situations and for organizations that may be less familiar with data-sharing requirements, expectations and best practices, including the primary-care practices and teams and community organizations that are increasingly assuming some of the OHT-related responsibilities previously taken on by hospitals and other large organizations. The tools need to be accompanied by a doubling-down on commitments to interoperable systems, capacity building, and appropriate resourcing. Several acronyms are used in this brief (see Box 3), and we describe what they mean later in the brief.

Data-sharing agreement (DSA) template

The DSA template is an editable and adaptable template for use by all OHTs and their member organizations. The eight-page template includes seven articles:

1) definitions of terms
2) foundation for data sharing, including good data governance
3) **five 'means' of data sharing** (which we return to in tool 2, a decision tree to help select an appropriate 'lane')
   a. three 'lanes' for sharing personal health information
      i. within the 'circle of care' (i.e., to provide or assist in the provision of healthcare) for health information custodians, or HICs, and their service providers (which we return to in 4b below)
      ii. with express consent
      iii. to prevent harm
   b. one 'lane' for sharing de-identified data (which we return to later in this RISE brief when addressing Indigenous data and the OCAP® principles, as well as by Inuit Qaujimajatuqangit and the Principles of Ethical Métis Research where applicable
   c. one 'lane' for sharing confidential business information
4) **two approaches to electronic data sharing**
   a. via a service provider (which can be documented in schedule C) that handles personal health information on behalf of another member for that member's purposes (which could be a HINP and which we return to in tool 4)
   b. via access to an information system (e.g., CHRIS for sharing home care data)
5) collaboration necessary for data sharing, including an OHT collaboration council or equivalent
6) approach to liability and indemnification, including requirements for cyber insurance or equivalent
7) general provisions such as amendment.

The DSA has highlighted fields in which to add the effective date, name of the OHT, region where the OHT is based, list of OHT members, dollar value of insurance requirement, duration of termination notice, and prompts to list the names, titles and signatures of parties. The DSA can also be edited to provide additional adaptations for a given context.

The DSA template includes five schedules:

A. a **minimum privacy and security standard** that provides the expectations for the organizations (HICs such as primary-care physicians or teams) involved in data sharing
   i. a privacy contact person
   ii. four types of policies and procedures: confidentiality policy, 'acceptable use of technology' policy, 'records retention and destruction' policy, and 'privacy breach response' policy or plan
   iii. seven types of safeguards (e.g., access controls)
   iv. training of staff
B. **consent form** for a client to permit a HIC to disclose their personal health information under the terms of 'lane 2' (with express consent) to other HICs and their service providers (e.g., HINPs), and the consent form has highlighted fields in which to add
   i. client name
   ii. name of the party (a HIC) disclosing the personal health information (PHI)
   iii. purpose of the disclosure (e.g., to provide or assist in the provision of healthcare, particularly more integrated care)
   iv. types of personal health information being disclosed (e.g., diagnoses, test results, and treatment plans including prescribed medications)
   v. receiving party (e.g., other HICs, agents acting on behalf of HICs (which we call HIC-agents for brevity), or HINPs)
   vi. name of the privacy officer for the party closing the PHI
C. schedule of **services provided by service provider** (e.g., HINP)
D. provisions for **data protection** (e.g., compliance with privacy legislation, access requests, data security program, and data incidents)
E. **adhesion agreement** that binds the signing parties to the DSA.

Data sharing with government entities, such as Ontario Health atHome, does not require them to be parties to the DSA and their policy is typically not to be party to each OHT agreement. A key implementation challenge related to the consent form will be how to share data about which clients have given consent to whom efficiently and in (near) 'real time.'

As noted in the DSA template, it was developed based on legislation existing as of February 2026 and input from the advisory panel. It is provided for general information purposes and does not constitute legal or other professional advice or a legal opinion of any kind.

As one advisory-panel member noted: "If used well, this agreement can help [OHTs] move from: 'We could share, but it feels risky and unclear' to 'We are expected to share for care, and we know the legal boundaries." The DSA template provides all obligations related to delivering integrated care in a single agreement. It does not address:

- research, such as the use of de-identified primary-care EMR data for research via POPLAR
- marketing and other business purposes separate from the delivery of integrated care (and hence does not speak to Canada's Anti-Spam Legislation).

The data-sharing template is complemented by four tools (see Table 1). As was periodically noted during the advisory-panel discussions, 20% of the challenge is 'legal' (and handled through the DSA template) and 80% of the challenge is about implementation, change management, and risk management (which are handled through the tools).

Table 1: Four tools to support data sharing

Tools	Purpose	Description & related links
1) Frequently asked questions (FAQ)	Answers questions about how data sharing works under the DSA template (and PHIPA)	4 pages in a clickable format with 18 questions & answers (primarily for use by OHTs and PCNs) Guidelines: De-identifying data
2) Decision tree	Helps to select a 'lane' for sharing data under the DSA: 1) sharing PHI within the 'circle of care' 2) sharing PHI with express consent 3) sharing PHI to prevent harm 4) sharing de-identified data, including Indigenous data 5) sharing confidential business information	1 page printable flow chart, as well as a version that 'zooms in' on particular sections of the flow chart (primarily for use by HICs)
3) Roadmap for 'new project' data sharing and governance	Helps to operationalize data sharing – under the DSA template – with any 'new project' (e.g., improving chronic disease prevention and management, increasing primary-care access and attachment) in five phases: 1) project foundation and governance alignment (initial project scoping and executive leadership engagement) 2) technical and legal architecture design (system architecture decision, organizational roles and responsibilities, and legal framework development) 3) risk assessment (identification, risk treatment / mitigation planning, appropriate additional assurance) 4) implementation (stakeholder engagement, including respecting Indigenous data sovereignty, and training and competency program) 5) 'go live' (pilot implementation, full rollout)	11-page document in a clickable format (primarily for use by OHTs and PCNs)
4) Data sharing 'role' decision framework	Helps to assess organizational readiness and other considerations for serving as an agent or HINP for other HICs (or overseeing a HINP) under PHIPA: 1) HIC-agent (which is the most common model now being used and which involves one organization serving as an agent for one or more other HICs) 2) Health Information Network Provider (HINP, such as Ontario Health being a HINP for CHRIS) 3) managing member (who oversees an external organization that serves as a HINP)	5-page document in a clickable format listing questions to spur reflection before a decision and appropriate next steps (primarily for use by OHTs and PCNs supporting OHT members in taking on any of these three key roles) Tips about providing electronic services

Some additional resources were identified by advisory-panel members but not vetted by BLG in the same way as the other resources that were built upon in creating the DSA template and tools. We provide links to these resources below.

Additional tool-related considerations

Four phases or sub-phases in the 'new project' data sharing and governance guidance (tool 2) warrant particular attention:

- project foundation and governance alignment in phase 1, which is where privacy and IT security experts can be engaged in a steering committee and where the OHT collaboration council and other governance and related bodies can be leveraged to ensure executive leadership alignment
- 'system architecture decision' in phase 2.1 of the roadmap, which is where one of system expansion, new technology purchase or interoperability are selected to provide the (near) real-time data needed for integrated care (i.e., this is not about handing off information in a sequential manner as has long been the norm)
- 'roles and responsibilities' definition in phase 2.2 of the roadmap, which is where a plan is made about whether to use a HIC-agent or HINP model and for how information will flow to and be managed by non-HICs (e.g., community-based organizations) providing their own healthcare services as part of integrated-care delivery
- 'training' in phase 4.2 of the roadmap, which is where training will be provided, particularly to non-HICs, to provide reassurance to the HIC that staff – for whom it has no direct oversight – know how to handle the data with which they have been entrusted.

Considerations specific to Indigenous data

In the DSA template, Indigenous data are defined as de-identified personal health information that is about Indigenous Peoples, communities, Nations, lands and resources. The term Indigenous refers to the collective and diverse groups and Nations that include constitutionally recognized Indigenous Peoples in Canada: First Nations, Inuit, and Métis. The DSA template commits signatories to be guided by and aligned with the OCAP® (ownership, control, access and possession) principles for First Nations data (see section 3.4d), as well as by Inuit Qaujimajatuqangit and the Principles of Ethical Métis Research where applicable. They shall also be guided by and aligned with the principles of Collective benefit, Authority to control, Responsibility and Ethics (the "CARE Principles") created by the Global Indigenous Data Alliance to ensure the principles of Findable, Accessible, Interoperable and Reusable (the "FAIR" Principles) are applied in a manner that is consistent with, and does not override, Indigenous data governance principles. The DSA template also commits signatories to follow three steps prior to initiating any sharing of Indigenous data with each other for the purpose of any project:

1) identify the impacted Indigenous community(ies) and appropriate governing or authorized body(ies)
2) engage in early, ongoing, and good-faith engagement
3) obtain all necessary community approvals, in each case on terms acceptable to the Indigenous community(ies).

Indigenous data are referred to in several tools:

1) in question 3 in the FAQ document
2) as a key 'branch' in the lower-right corner of the decision tree
3) in phases 1.1 (initial project scoping and executive leadership engagement), 2.2 (organizational roles and responsibilities, with key role 4 addressing Indigenous governing authority), 3.1 (comprehensive risk identification, in this case the risk of doing harm to Indigenous peoples), 4.1 (stakeholder engagement strategy, in this case with Indigenous communities and leaders), 5.2 (roll-out readiness checklist, in this case with whether Indigenous data governance requirements met), and conclusion (where respect for Indigenous data sovereignty is noted as a critical success factor).

Additional data-sharing considerations can emerge with Indigenous health organizations, which will often have their own data governance policies and ways to respect Indigenous data sovereignty, comply with PHIPA and other relevant legislation (e.g., federal), and address the unique issues that emerge with, for example, Indigenous Services Canada data.

Advisory-panel members brought to our attention additional resources that may be helpful:

- resources related to OCAP® prepared by the First Nations Information Governance Centre
- resources from the Indigenous Primary Health Care Council
  - proposed working definitions of Indigenous data sovereignty and Indigenous data governance

  - handbooks on data privacy and security, data governance indicators, and data governance policy
  - application guide for the above resources
- a report on Indigenous data sovereignty for the City of Vancouver that includes some useful resources.

Considerations specific to primary care

Family physicians, nurse practitioners and primary-care team leaders may want to consider the following:

- confirm whether individual family physicians or nurse practitioners in the practice are each a HIC or whether they have established the practice or team as the HIC
- for individual clinicians in particular, identify the lightest-touch approach that you can make work within your risk tolerance (e.g., identifying the manager as your HIC, identifying a staff member as the privacy officer, and asking colleagues for sample policies – like the four described in the schedule A description on page 2 – and adapt them as needed, putting in place the seven types of safeguards described in schedule A, and pointing your manager or staff to an appropriate training opportunity)
- seek support from your PCN, particularly for current PCN priorities, including sharing data in support of:
  - 'attaching' new clients
  - 'catching up' newly attached patients with chronic disease prevention and management, including cancer screening and immunizations.
- seek advice from your PCN about how to make the most you can with what little time you have with the array of reports you are sent (e.g., MyPractice Report, Screening Activity Report, OntarioMD reports), have access to (e.g., EMR dashboards), and that are likely to arrive with the influx of AI tools, and to speed up the movement away from phone calls and faxes and towards interoperable systems and single sign-ons that provide a much more integrated reporting system for primary care.

While reporting immunizations is a client responsibility, clinicians can play an important role by advising all patients to update their immunization status via tools such as CANImmunize app (which allows for data sharing with a client's local public-health agency), ICON (Immunization Connect Ontario, which provides the data to local public-health agencies), or portals maintained by select local public-health agencies.

Considerations specific to the North

Clinicians and teams in the North have shared a particular concern about how practice-level electronic medical record (EMR) analyses can't capture the complexity of how patients access care, which in turn, can look like poor performance by those clinicians or team. For example, cancer screening is sometimes completed in hospital labs or mobile settings, which is not recorded in provincial reporting systems or most-responsible providers' (MRP's) EMRs. Sometimes follow-up is done in a different province, which is also not captured in the MRP's EMR (or it may be added through scanned notes later).

Clinicians and teams in the North may also have unique populations, models of care, and specific, contextualized ways to interpret imperfect data, and hence may need more adaptations to the DSA template and in their use of the tools. There are strong histories and legacies of collaborations across organizations in the North – to coordinate patient care, which often includes data sharing for example – some practical implementation challenges might arise given the vast geographies covered by collaborating organizations. For example, coordinating electronic data transfer or sharing data personnel across organizations or practices might seem impractical given large distances between the physical locations.

Conclusion

OHTs can now freely use the DSA template and the four tools, knowing that they have been co-created by a diverse group and reviewed and approved by Ontario Health. Each time you use the template or a tool, consider whether you would benefit from legal advice to adapt the template and tools to that particular context.

RISE will pursue the following next steps:

1) implement a plan for the dissemination of the DSA templates and related tools with OHTs, PCNs and other relevant stakeholders, which will include
   a. posting them on RISE website
   b. profiling them in the monthly RISE newsletter
   c. introducing them in a launch webinar to be co-organized with Ontario Health
   d. profiling them in the RISE coaches-led peer sharing and learning sessions
   e. presenting them to the OHT Supports Central Coordination Committee
   f. offering to present them to other groups, including the Ontario Primary Care Council
2) develop a self-assessment tool for data-sharing and privacy capabilities based on the DSA template and tools
3) explore opportunities for maintaining 'living' (regularly updated) versions of tools like the FAQ, developing additional data-sharing tools, and creating a complementary privacy toolkit
4) organizing a workshop series from August through November
5) supporting an online community of practice related to data sharing and privacy on Quorum from September through October.

In addition, Ontario Health may want to consider the following activities to raise awareness about the DSA templates and related tools:

1) disseminate them through its listserv and newsletter 'OHT Update' to OH regions and to all OHTs the RISE brief and the link to the RISE website section where the resources are available
2) posting on its website the link to the RISE web section where the DSA resources are available
3) running an article in the 'News and Updates' section of its website
4) posting on OH social media (e.g., LinkedIn, Facebook, X).

Please send any feedback on needed correction to this RISE brief, the DSA template and related tools to rise@mcmaster.ca. As the tools in particular note, the information contained therein is of a general nature and is not intended to constitute legal advice, a complete statement of the law, or an opinion on any subject. No one should act upon it or refrain from acting without a thorough examination of the law after the facts of a specific situation are considered. You are urged to consult your legal adviser in cases of specific questions or concerns.

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RISE prepares both its own resources (like this RISE brief) that can support rapid learning and improvement, as well as provides a structured 'way in' to resources prepared by other partners and by the ministry. RISE is supported by a grant from the Ontario Ministry of Health to the McMaster Health Forum. The opinions, results and conclusions are those of RISE and are independent of the ministry and Ontario Health. No endorsement by the ministry or Ontario Health is intended or should be inferred.

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