All-OHT Webinar

FY 2026/27 Integrated OHT TPA Amendment Guidance

June 9, 2026 8:00 - 9:00am

Ontario Health

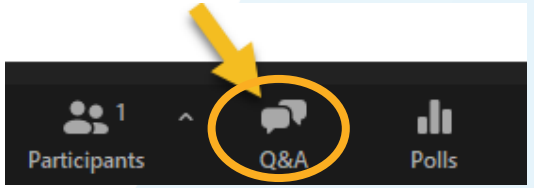
Welcome

Meaghan Cunningham, *Director, OHT Implementation, Ontario Health*

Webinar Logistics

- This session will be recorded and a link to the recording will be circulated, via OH regions, as soon as it is available post meeting.

- Please submit your questions via the Q&A box.
  - Questions will be answered during the Q&A portion of the webinar
  - Due to limited time, unanswered questions should be advanced to your OH regional point of contact.



Agenda

TIME	TOPIC	SPEAKER
8:00am	Welcome and webinar logistics	**Meaghan Cunningham** Director, OHT Implementation, Ontario Health
8:02am	Land Acknowledgement	**Isabella Calderon Uribe** Lead, OHT Strategic Planning, Ontario Health
8:05am	Opening Remarks	**Dr. Brian McKenna** Provincial Primary Care Clinical Lead, Ontario Health
8:10am	2026/27 Integrated OHT TPA Amendment Principles and Operational Updates	**Meaghan Cunningham** Director, OHT Implementation, Ontario Health
8:20am	2026/27 Integrated OHT TPA Amendment Guidance	**Ian Cummins** Director, OHT Strategy, Ontario Health
8:40am	OHT Performance and Improvement Program Updates	**Ian Cummins** Director, OHT Strategy, Ontario Health
8:45am	Facilitated Q&A	***Facilitator:*** **Meaghan Cunningham** Director, OHT Implementation, Ontario Health
8:55am	Closing Remarks	**Meaghan Cunningham** Director, OHT Implementation, Ontario Health

Land Acknowledgement

Opening Remarks

Dr. Brian McKenna, *Provincial Primary Care Clinical Lead, Ontario Health*

OHTs and their PCNs: Priorities for 2026/27

This year's amendment largely maintains existing priorities, with targeted updates to improve focus, alignment, and impact.

- Primary care attachment remains a top priority
- Stronger expectations for PCN clinician engagement
- Focused role for provincial digital priorities (eReferral, Central Intake)
- Deepen partnerships with Regional Cancer Programs
- New CDPM program expectations introduced
- Focus on data-driven improvement

Overview of 2026/27 Integrated OHT Agreement Amendment

Meaghan Cunningham, *Director, OHT Implementation, Ontario Health*

OHT TPA Amendment Principles

- **Maintain continuity to support transformation:**
  - Minimize deliverable changes to support continuity and performance measurement
  - Continue focus on clinical rather than structural or operational deliverables
- **Prioritize primary care access, attachment and enablement:**
  - Continue to prioritize clinical priorities related to primary care attachment, access and enablement, in alignment with MOH/PCAT direction
  - Continue focus on Primary Care Network (PCN) development
- **Focus on performance and improvement:**
  - Ensure there is a clear and transparent measurement approach for all deliverables
  - Unified performance and quality improvement efforts through integration (OHT Performance and Improvement Program)
- **Reduce reporting burden**
  - OHT reporting focuses on collecting only what helps teams stay connected, track progress, and support decision-making, and submission dates have been aligned where possible

Overview of 2026/27 OHT Funding Allocation

Funding for All OHTs		
OHT Implementation Funding	Ongoing implementation of OHT priorities and deliverables	$750,000 / OHT
Primary Care: Access & Attachment	Funding to support OHTs and PCNs to advance local access and attachment, aligned with Ontario's Primary Care Action Plan. *This funding stream continues to be eligible for spend on clinical services.*	$312,862 / OHT
Primary Care: Supported Attachment	Funding to support OHTs and PCNs as they continue to implement supported attachment models. *This funding stream continues to be eligible for spend on clinical services.*	Consistent with the 2025/26 allocation ($125,000 / OHT) + needs-based top-up for select OHTs
Funding for Select OHTs		
Chronic Disease Prevention and Management	Funding to support improved chronic disease prevention and management in primary and community care settings and supporting peer leadership and capacity building activities for other OHTs. *This funding stream is eligible for spend on clinical services.*	$227,000 / OHT
Funding for LLP ICPs (Note that for some OHTs, LLP ICP funding will be flowed via a standalone TPA)		
Lower Limb Preservation Integrated Clinical Pathways	Funding to support continued advancement of LLP ICPs. *This funding stream is eligible for spend on clinical services.*	$225,000 / pathway

Operational Updates

Ineligible Spend

- **Expanded clause:** Acquiring goods or services, including equipment, consulting services and clinical services, that are supported by other funding sources (e.g., other Ministry/Regional funding).
- **Expanded clause:** Duplication of service provided by Ontario Health atHome Care Connectors, Community Paramedicine services, and local Diabetes Education Programs.
- **New clause:** Expenses associated with travel outside the province of Ontario, including travel to the United States and any other international destination, including travel, accommodation, meals, and related costs.

Accountability

- **New clause:** Adherence with BPSA Act, if applicable
- **New clause**: The Recipient may be asked to resubmit any of the reports or provide supplementary materials following initial submission at OH's request for performance monitoring and management.

Performance & Improvement

- **Updated language:** Participation in the implementation of the *OHT Performance and Improvement Program.*
  - *Sharing quarterly and annual performance reports with OHT and PCN Leadership, OHT Leadership Councils (or equivalent) and the Patient Family and Caregiver Advisory Council.*
  - *Performance review process with OH to collaboratively review quarterly performance data.*
  - *Target setting for select clinical priorities using standardized measures.*
  - *Collection of select implementation measures.*

EIDA-R Engagement and Capacity Building

- **Expanded Scope of Equity Deserving Groups:** Ensure continued involvement and engagement with the following groups in the design, implementation, and measurement/evaluation of OHT programs, services, and improvements: FNIMUI populations, Francophone populations, and equity deserving communities, including Black and other racialized communities, 2SLGBTQIA+ communities, *people living with disabilities*, *people living with mental health and substance use challenges,* newcomers, refugees, and people experiencing homelessness.
- Staff, leadership and decision-maker training and capacity building related to EIDA-R added as a **Program Expectation** (no longer a deliverable).

French Translation Services

- **New:** Regional Translation Network Program as primary avenue for French translation.

Reporting Requirements

Reporting Requirement (All OHTs)	Due Date
2026-27 Operating Plan and Budget	June 26, 2026
Interim Report* & Membership Report	October 30, 2026
2026-27 Year-End Report	April 30, 2027

Additionally, all OHTs are required to submit bi-monthly Supported Attachment data as per the Supported Attachment Data Submission Guide.

Reporting Requirement (Select OHTs)	Due Date
CDPM section of 2026-27 Operating Plan and Budget	June 26, 2026
CDPM section of Interim Report* & Unique Patient Reporting	October 30, 2026
CDPM section of 2026-27 Year-End Report & Unique Patient Reporting	April 30, 2027

Reporting Requirement (Select OHTs)	Due Date
LLP section of 2026-27 Operating Plan and Budget	June 26, 2026
LLP section of Interim Report* & Unique Patient Reporting	October 30, 2026
LLP section of 2026-27 Year-End Report & Unique Patient Reporting	April 30, 2027

**Where an OHT is assessed by the OH Region as meeting or exceeding expected performance, the OHT may be exempt from submitting select components of the Interim Report. Further details regarding eligibility for exemption and the associated process will be communicated through the distribution of the interim reporting template.*

2026/27 Integrated OHT TPA Amendment Guidance

Ian Cummins, *Director, OHT Strategy, Ontario Health*

Priority Area 1
Primary Care Access, Attachment, and Enablement

Primary Care Access, Attachment, and Enablement Deliverables

1. Continue to advance a PCN.
2. Continue to fund a PCN Clinical Lead/Leads to advance the OHT's PCN.
3. Communicate and engage with primary care providers to advance provincial priorities.
4. Increase participation in cancer screening (e.g., cervical, colorectal and breast), in collaboration with the Regional Cancer Program.
9. Continue to implement the plan to support 100% attachment of local population by 2029, including facilitating matching and attachment of registrants from the Health Care Connect (HCC) waitlist (as of January 1, 2025) by spring of 2026 as the priority, and the broader unattached population thereafter, including those on the post-January 1, 2025 HCC waitlist.
10. Lead and/or coordinate submissions for new/expanded interprofessional primary care team (IPCT) investment.
11. Implementation of collaborative initiatives to provide clinical and non-clinical services to unattached patients.
12. Continue to implement supported attachment services and continue to evaluate and report on its impact.

Note: *Numbering of deliverables is reflective of how they are numbered in the TPA Agreement and Guidance documents*

Primary Care Access & Attachment, and Enablement: PCN

1. In alignment with provincial direction, continue to advance a PCN that organizes the local primary care sector and engages interprofessional primary care providers (i.e., family physicians, nurse practitioners, and other primary care clinicians) in OHT planning, decision-making, and implementation of clinical priorities.
2. Continue to fund a PCN Clinical Lead/Leads to advance the OHT's PCN, participate in OHT decision-making and regional PCN leadership tables, support OHT and PCN clinical initiatives, and lead communication and engagement with PCN members on local and provincial initiatives.

PRIMARY CARE NETWORKS (PCNs)

PCNs are the mechanism through which primary care clinicians within an OHT connect, coordinate and act collectively to plan, support, and implement provincial and local priorities. Advanced PCNs not only support planning and implementation but also ensure that primary care clinicians experience value from their participation.

2026/27 Key Message

There is increased emphasis on both the reach of PCN participation and the depth of engagement

PCN CLINICAL LEADS

- ✓ Inform planning and decision making
- ✓ Enable bi-directional flow of insights and feedback
- ✓ Lead communication and engagement
- ✓ Support implementation of OHT and PCN priorities

Minimum Expectations

- ❑ PCN Clinical Lead(s) and operational supports in place to advance PCN functions and priorities
- ❑ Strategy in place to reach and engage the local primary care sector, including:
  - ❑ Reaching clinicians who are not currently participating in the PCN
  - ❑ Engaging with local primary care clinical leaders
  - ❑ Maintaining an accurate and up-to-date PCN email distribution list
  - ❑ Disseminating and promoting OH's annual OHT Standardized Provider Experience Survey

How will Success be Measured?

- ✓ Number of clinicians (by role) and administrators who are on the PCN's email distribution list and receiving PCN communications will be used to assess reach
- ✓ Efforts to increase participation and engagement of primary care clinicians in the PCN, supported by an ongoing engagement strategy
- ✓ Review of results from the standardized OHT Provider Experience Survey
- ✓ Active PCN Clinical Lead engagement in OHT decision-making and relevant local and/or regional PCN leadership tables

Primary Care Access & Attachment, and Enablement: HCC Waitlist & Unattached Patients

9. Via collaboration between PCN Clinical Lead(s), OHT staff, and OHT members continue to implement the plan to support 100% attachment of local population by 2029, including facilitating matching and attachment of patients from the January 1, 2025 Health Care Connect (HCC) waitlist by spring of 2026 as the priority, and the broader unattached population thereafter, including those on the post-January 1, 2025 HCC waitlist.
10. Lead and/or coordinate submissions for new/expanded interprofessional primary care team (IPCT) investment.
11. Via a collaboration between PCN Clinical Lead(s), OHT staff, and OHT members, implement collaborative initiatives to provide clinical and non-clinical services to unattached patients while they await matching and attachment to primary care, including navigation and access to interim primary care services where feasible, in alignment with the government's Primary Care Action Plan.

PRIMARY CARE ATTACHMENT

In 2025/26, OHTs and their PCNs played a pivotal role in supporting the objectives of the Primary Care Action Plan.

- This included making substantial progress in the government's goal of attaching everyone on the HCC waitlist as of January 1, 2025, to primary care by spring of 2026, via collaboration with OH atHome Care Connectors.

2026/27 Key Message

Primary care access, attachment, and enablement remains a primary priority. Once each OHT's HCC (as of January 1st, 2025) list has been cleared, OHTs will focus on attaching their broader unattached population to primary care, including registrants on the HCC list post January 1, 2025.

Note: *More information to follow on OHTs and their PCNs' expectations for the 2027/28 IPCT Expansion Process*

Minimum Expectations

- ❑ Continue to build relationships and identify local gaps and opportunities for attachment
- ❑ Consider collaboration with local Departments of Family Medicine
- ❑ Monitor ongoing primary care capacity to support attachment
- ❑ Review HCC waitlist data (aligned to the OHT) to inform planning
- ❑ Once the HCC waitlist (as of Jan 1, 2025) has been cleared, continue to support attaching registrants on the post Jan 1, 2025, HCC waitlist to primary care, as well as facilitate matching for other unattached patients.
- ❑ Advance previously identified OHT and PCN actions that work toward 100% population attachment by 2029, aligned with provincial direction

How will Success be Measured?

- ✓ Success will be measured by the OHT's ability to demonstrate progress towards clearing the HCC waitlist (as of Jan 1, 2025) by spring 2026 and advancing attachment to primary care, including through HCC
- ✓ Achievement will be assessed using provincial attachment data complemented by OHT reporting on local strategies and actions

Primary Care Access & Attachment, and Enablement: Communication & Engagement

3. Communicate and engage with primary care providers to advance provincial priorities, including eReferral, Central Intake, Mental Health and Addictions Provincial Coordinated Access, and Online Appointment Booking, to increase adoption and utilization.

COMMUNICATION & ENGAGEMENT

- **eReferral** and **Central Intake** enable primary care clinicians and specialists to complete electronic referrals and access regionalized central intake hubs for priority pathways (including Diagnostic Imaging [initial focus on MRI/CT)], Cataract, Orthopedics, and MHA).
- **OAB** offers patients the ability to self-book appointments. Collectively, these tools reduce reliance on paper-based and fax-based processes.

2026/27 Key Message

OHTs and their PCNs are expected to focus efforts on **communicating and engaging** with family physicians, nurse practitioners and other primary care clinicians about eReferral, Central and OAB

Many OHTs and their PCNs have led **mental health and addictions** planning and coordination efforts across primary care and other community partners

- Building on this momentum, Central Intake Ontario MHA is a key upcoming opportunity for OHT and PCN engagement and collaboration in 2026/27.

Minimum Expectations

- ❑ In alignment with regional planning, support **communications and engagement** with a focus on primary care clinicians.
  - ❑ Cascade targeted communications through existing channels
  - ❑ Conduct engagements to raise awareness and encourage adoption and utilization.
- ❑ Participate in relevant regional governance structures and planning processes as directed by the OH Regional teams.
- ❑ **PCN Clinical Lead:** Act as peer champions for OAB, eReferral and Central Intake.

How will Success be Measured?

- ✓ Success will be measured using local data on the OHT and their PCNs' ability to demonstrate effective awareness-building, engagement and clinical champion support for provincial digital solutions.

Primary Care Access & Attachment, and Enablement: Cancer Screening

4. Increase participation in cancer screening (i.e., cervical, colorectal and breast) and increase availability of supports for unattached participants accessing screening (e.g., provision of Human Papillomavirus (HPV) testing) and follow-up services (e.g., provision of Fecal Immunochemical Test positive (FIT+) colonoscopy referrals), in collaboration with the Regional Cancer Program(s) (RCPs).

CANCER SCREENING

- Cancer screening and follow-up remain a priority, with strong primary care attachment driving higher participation, timely follow-up, and more equitable access
  - Canadian evidence also demonstrates **that targeted screening and follow-up pathways for unattached populations** can improve access to screening while serving as an effective interim entry point to primary care when paired with navigation and attachment strategies (Wilkinson et al., 2026; Canadian Partnership Against Cancer, 2023).

2026/27 Key Message

OHTs and their PCNs are expected to continue focusing on the following three priorities

1. **Primary care engagement via the PCNs**
2. **Strengthening processes to support unattached participants in accessing screening and follow-up after an abnormal result**
3. **Outreach for underserved populations**

In addition, having a shared governance structure with RCPs is critical to advance increase screening participation and timely follow-up after abnormal results

Minimum Expectations

- ❑ Expected to have a governance working structure in place with their RCP that supports joint planning, decision-making, and performance reviews
- ❑ Expected to demonstrate improved communication and engagement with primary care providers
- ❑ Implement processes developed in 2025/26 to better support unattached participants.
- ❑ Leverage provincial and regional resources to provide outreach services to under-screened or never-screened populations in their local communities

How will Success be Measured?

- ✓ Improve performance on three validated measures within the OHT Performance and Improvement Program
- ✓ Demonstrate how the partnership between the OHT, PCN, and RCP have matured
- ✓ Strengthened screening access and follow-up process

Priority Area 2
Integrated Clinical Priorities

Integrated Clinical Priorities Deliverables

5. Advance CDPM activities, as planned and/or initiated in FY 2025/26, to strengthen proactive management of select chronic conditions in primary/community care settings, with a primary focus on patient populations living with Heart Failure and/or COPD to improve patient outcomes and access to care.
6. Support the implementation of activities aligned with OH Regional ALC Planning that identify the greatest opportunities for ALC prevention and discharge management.

   Note: Select OHTs will continue to advance additional expectations related to chronic disease prevention and management.

Note: *Numbering of deliverables is reflective to how they are numbered in the TPA Agreement and Guidance documents*

Chronic Disease Prevention and Management

5. Advance CDPM activities, as planned and/or initiated in FY 2025/26, to strengthen proactive management of select chronic conditions in primary/community care settings, with a primary focus on patient populations living with Heart Failure and/or COPD to improve patient outcomes and access to care.

CHRONIC DISEASE PREVENTION AND MANAGEMENT (CDPM)

OHTs and PCNs will advance supports for populations with chronic disease while enabling broader OHT primary care priorities. This involves:

- ✓ Identifying patients with HF/COPD who would benefit from structured CDPM supports
- ✓ Connecting patients to ongoing access and/or attachment to primary care, enabled by IPCT, community, and specialty supports
- ✓ Strengthening proactive and timely follow-up, navigation, self management, and escalation across settings

CDPM helps translate attachment into ongoing, proactive care for people with chronic conditions.

2026/27 Key Message

- Build on CDPM work planned or already underway to strengthen local access to care, with focus on supporting patients with HF and/or COPD.
- Strengthen alignment with broader provincial supports, such as palliative care, Community Paramedicine (CP), OH atHome/RCM, and existing regional supports where relevant/available
- Improve outcomes, access, and avoidable acute-care use

Minimum Expectations

- ❑ **Primary care anchoring:** Co-designed with PCNs, activities will be embedded in and promote ongoing access and/or attachment to primary care
- ❑ **HF and/or COPD as a core focus:** in addition, other local CD priorities may be advanced (i.e. diabetes)
- ❑ **Improved coordination:** within and across settings, with strengthened transitions in care supported by structured referral pathways
- ❑ **Use of existing supports:** OHTs and PCNs should leverage local, regional, and provincial supports — including palliative care, CP, Ontario Health atHome and regionally available programs

How will Success be Measured?

Provincial data will support reviewing:

- HF/COPD hospital admissions
- ACSC admissions
- ED visits/hospital use related to Chronic Disease

Local reporting will help demonstrate:

- Patients served through CDPM activities
- How CDPM supports proactive management and coordination
- Connections to ongoing primary care access/attachment
- Progress on reduced avoidable acute-care use

OHTs with existing HF or COPD ICPs, and I12 CDPM are expected to continue to work with partners to continue to report unique patients served.

Priority Area 3

OHT Capacity Building

OHT Capacity Building

7. Demonstrate targeted outreach efforts and report on progress to continue to expand OHT membership to mandatory and optional membership groups described in the 'Ontario Health Teams: The Path Forward', including FNIMUI communities/organizations and patients, families and caregivers.

8. Continue to implement activities identified in the OHT's action plan developed in 2024/25 to advance to a minimum of 'Level 2: Learning and Developing' as outlined in the Creating Engagement Capable Environments in OHTs Framework and demonstrate completion of Level 2 by the end of the 2026/27.

Note: *Numbering of deliverables is reflective to how they are numbered in the TPA Agreement and Guidance documents*

OHT Capacity Building

Strengthening equity-centred approaches is a foundational expectation for OHTs

- This includes embedding health equity, Indigenous cultural safety, anti-racism, French Language Services, and community engagement into care planning and delivery.
- Efforts should address social determinants of health and align with population health management principles. Actions should be guided by lived experience and local population needs, with a focus on reducing inequities in access, experience, and outcomes.

Expanding and engaging OHT membership

- OHTs have made strong progress expanding cross-sector membership and primary care participation through PCNs.
- As OHTs mature, deepening engagement and broadening membership present opportunities to advance a more integrated, connected system.
- Diverse partnerships enable collaboration, collective problem-solving, and more coordinated primary care aligned with broader health and social services. This positions OHTs to better address local needs, close gaps in care, and deliver more seamless, person-centred services.

PFC engagement

- PFC engagement is a core pillar of the OHT model, with OHTs continuing to advance this work through the Creating Engagement Capable Environments Framework and existing action plans.
- Strengthened partnerships help improve primary care access and attachment by aligning care with the needs and experiences of the populations served.

OHT Performance and Improvement Program

Ian Cummins, *Director, OHT Strategy, Ontario Health*

OHT Performance and Improvement Program

Standardized Performance Measures

Note: Some measures are considered "developmental" and require additional time to test and validate.

- ✓ System-Level Measures
- ✓ Patient and Provider Experience
- ✓ Process Measures (locally collected)

Enabling Processes

Structured reporting and collaborative reviews transform data into insights that guide decisions.

- ✓ Quarterly OHT level Performance Reports
- ✓ Quarterly Performance Review (QPR)
- ✓ Quality Improvement Plans

The OHT Performance and Improvement Program combines standardized measures with enabling processes to support continuous performance improvement

OHT Performance Measure Refresh – Survey

This year, OH worked with scientific and clinical advisors to recommend performance measures for FY26/27

This process was informed by feedback from 25 OHTs who completed an optional survey regarding the value and ease of interpretation of existing performance measures

75+%
Respondents agreed that current performance measures are useful

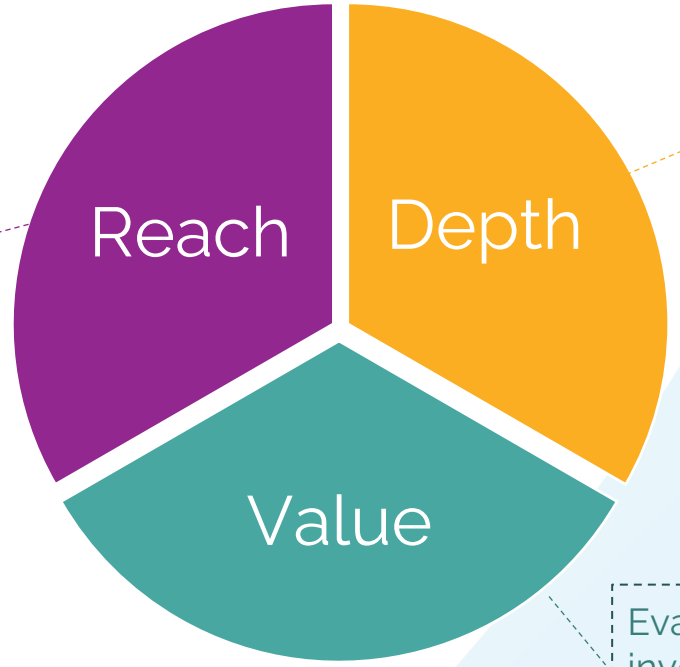
Key Directions

- To support year-over-year continuity, performance measures will remain largely unchanged this year. However, OH will focus on implementing a number of data and reporting enhancements
- Provider experience complements traditional system-level indicators by measuring Primary Care Network engagement, interprofessional collaboration and care coordination

Strengthening PCN Measurement

This year, strengthening Primary Care Network (PCN) measurement will be a key priority of the OHT Performance and Improvement Program:

Measures the spread of participation across the PCN: how many primary care providers are connected to PCN activities (Operating Plan Report)



Assesses the level of PCP involvement in PCN activities (OHT Provider Experience Survey)

Evaluates the PCP perceived impact of PCN involvement (OHT Provider Experience Survey)

TPA Guidance in a glance

- OHTs to report the number clinicians (by role) and administrators who are on the PCN's email distribution list and receiving PCN communications.
- OHTs/PCNs must take steps to ensure those receiving PCN communications are aware of the PCN and its role with the goal of 100% awareness.

Key Messages

OHT Performance Reporting & Quality Improvement

- Continued enhancements to quarterly reports based on user feedback
- Increased focus on using report data to support performance improvement discussions

2026/27 OHT Provider Experience Survey

- Successful first year: 100% of OHTs met minimum response rate
- OHT-specific reports will be available by September to support improvement, including PCN measurement

Locally Collected Performance Data

- Continued submission of local process measures to support standardization and system mapping
- Specifications document and regional support available; OHTs to review and flag challenges by June 30, 2026

Note: Information on planned approaches for patient experience measurement approaches will be shared this year

Question and Answers

Moderator: Meaghan Cunningham, *Director, OHT Implementation, Ontario Health*

Panelists:

- ***Dr. Brian McKenna*** *Provincial Primary Care Clinical Lead, Ontario Health*
- ***Ian Cummins*** *Director, OHT Strategy, Ontario Health*
- ***Patrick Kitchen*** *Director, Integrated Care and Value Based Programs, Ontario Health*

Closing Remarks

Meaghan Cunningham, *Director, OHT Implementation, Ontario Health*

Thank you

Appendix

Priority Area 1
Primary Care Access, Attachment, and Enablement

Primary Care Access & Attachment, and Enablement: Supported Attachment

12. Via collaboration between PCN Clinical Lead(s), OHT staff, and OHT members
- Continue to implement supported attachment services in alignment with provincial Guidance and local context
- Continue to evaluate and report on the impact of supported attachment, including patient volumes and the number of clinicians (physicians, nurse practitioners and primary care teams) accessing supported attachment.

PRIMARY CARE SUPPORTED ATTACHMENT (SA)

SA is primarily a clinical service offered prior to attachment, where a dedicated individual or team facilitates patient onboarding to primary care, setting up a successful relationship for future ongoing attachment.

- FY 2026/27 marks the second year of SA investment for OHTs. Last fiscal year, OHTs and their PCNs initiated implementation activities focused on establishing local approaches to SA to onboard patients to primary care.

2026/27 Key Message

This year, OHTs and their PCNs are expected to build on this foundational work to scale effective practices and continue to improve attachment to primary care across their populations.

- **OHTs and their PCNs should continue to refer to Supported Attachment - 2025/26 Guidance for Ontario Health Teams and Primary Care Networks (December 2025)**

Minimum Expectations

- ❑ Sustain and expand SA activities initiated in 2025/26, moving beyond initial implementation and planning, with SA actively contributing to measurable improvements in attachment to primary care.
- ❑ Continue to strengthen primary care partnership in SA, including increased engagement in SA workflows.
- ❑ Integrate SA into broader OHT access and attachment efforts including alignment with mechanisms for identifying unattached patients and connecting them to primary care.

How will Success be Measured?

- ✓ Success will be measured by the OHT's ability to demonstrate ongoing implementation, utilization and resourcing of SA services in alignment with provincial guidance.
- ✓ Achievement will be assessed through required standardized data submissions
  - ✓ OHTs must continue to submit data to OH on a bi-monthly basis (i.e. every two months), beginning May 15, 2026.

Priority Area 2
Integrated Clinical Priorities

Alternate Levels of Care (ALC)

6. Support the implementation of activities aligned with OH Regional ALC Planning that identify the greatest opportunities for ALC prevention and discharge management.

ALC

- OHTs and their PCNs have a mandate to advance preventive care amongst their populations, improve the coordination of health services and support transitions in care across their member organizations
- Efforts made by OHTs on primary care access and attachment, and CDPM both support the prevention of ALC cases.
  - ✓ The goals of ALC prevention and ALC management help improve the hospital flow and patient outcomes by preventing them from entering into the system (preventive)
  - ✓ Reducing the length of stay for patients designated ALC through timely, coordinated, and effective transitions from acute care to community settings.

2026/27 Key Message

All OHTs and their PCNs are expected to continue or initiate activities to reduce new ALC designations (ALC prevention) and support timely discharge to the community for ALC-designated patients (ALC management).

- **OHTs and their PCNs should support their OH Region in planning and implementation of activities that address both the goals of ALC Prevention and Management/ Community Transitions**

Minimum Expectations

- ❑ OHT efforts related to both ALC goals should align with regional guidance and planning approaches
  - ❑ Please note that some OH regions may ask OHTs to submit additional reporting relating to ALC planning activities.
- ❑ Identify and build upon existing OHT activities related to advancing integrated care initiatives for populations at risk of needing ALC (e.g. frail seniors).
- ❑ ALC prevention should be integrated into primary care–led activities where possible. Primary care / IPCT development and CDPM work should support the goal of ALC prevention.

How will Success be Measured?

- ✓ Success will be measured by the OHT's ability to demonstrate progress in advancing local ALC initiatives that align with OH Regional planning priorities, alongside the use of provincial performance data to monitor system-level impact
  - ✓ Number and rate of newly designated ALC cases
  - ✓ Number and rate of discharged ALC cases