Provincial Hybrid Model of Care Guideline

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Contents

1. Purpose

This Hybrid Model of Care (HMOC) Guideline provides wise practice considerations for regional health authorities exploring and/or implementing HMOC, where virtual physicians work alongside on-site teams to deliver integrated care. The purpose of this guideline is to support the integration of virtual care into health care settings to reduce unnecessary and avoidable service interruptions (i.e. emergency department closures, inpatient unit diversions and/or acute care bed reductions).

While in-person care is recommended to remain the primary mode of care delivery in all healthcare settings, ongoing health human resource challenges highlight the need for standardized hybrid care to support continuity of services and prevent disruptions. Hybrid care is a complementary tool alongside existing mitigation strategies, such as recruitment and retention efforts, incentives, and locum programs. It offers a structured approach to purposefully integrate virtual and in-person clinical services.

HMOC enables equitable access, clinical consistency, and long-term sustainability, and aligns with provincial healthcare priorities to enhance workforce resilience, optimize workforce utilization, and enable high-quality care for all communities. HMOC services are designed to follow a wise practice approach that upholds the Province's commitments to align with HSO 75000 Cultural Safety Standards intended to work towards the eradication of Indigenous-specific racism from healthcare settings for First Nations, Metis as well as urban and away Indigenous Peoples in this project.

The guideline draws on key best practice sources, including the Virtual Care Clinical Reference Group Final Report (2023), the Canadian Association of Emergency Physicians (CAEP) Position Statement on Virtual Care in Emergency Medicine (2025), and lessons learned from HMOC initiatives across British Columbia (B.C.). These efforts are informed by research and partnerships with experienced teams across Canada. As CAEP (2025) highlights, virtual emergency care should be driven by current evidence on patient outcomes, clinical performance, operational efficiency and best practices. Guidelines should be regularly updated, supported by standardized data across the system to enable real-time monitoring, inform policy, and improve hybrid care delivery. By aligning HMOC with the Indigenous Cultural Safety and Humility Standard (HSO 75000), BC Accessibility Act, Anti-racism Data Act , BC Indigenous Language Legislation, Ownership, Control, Access and Possession (OCAP) and other related legal obligations there is a commitment to the eradication of Indigenous-specific racism within healthcare settings that is paramount to best practice standards.

This guideline aims to set clear boundaries for HMOC use, ensuring consistent, province-aligned implementation and embedding a quality framework to support patient safety and clinical operational excellence.

2. Scope

This guideline applies to the integration of a virtual provider as the Most Responsible Provider (MRP) within an in-person care team. It is intended for hospitals and health centres across B.C., with a particular focus on rural and remote settings. The guideline supports emergency and inpatient care services in small to mid-sized hospitals, as well as health authority urgent primary care services. Virtual care delivered in large or urban centres is out of scope of this guideline, as are home-based virtual care

and peer-to-peer virtual consultations. Health authorities are expected to adapt the development and implementation of hybrid care models to meet the needs of their patient populations and clinical services.

3. Strategic Oversight and Partnerships

Ministry of Health (MoH): Sets strategic direction, policy oversight, and funding priorities.

Provincial HMOC Advisory Committee: This provincial governance group has representation from the Ministry of Health, all health authorities and key partner organizations including Rural Coordination Center of BC, Doctors of BC, and the University of British Columbia. The group provides guidance on model development, supports alignment across health authorities, and recommends standardized approaches to ensure consistency, quality, and equity in care delivery across the province. It serves as a collaborative forum for sharing insights, addressing challenges, and advising on policy and operational decisions related to the HMOC.

Regional Health Authorities (HAs): Accountable for planning and implementation of services within geographical region, regional contracts, and site-specific integration.

PHSA Provincial Virtual Health (PVH): Supports provincial coordination and collaboration across regional health authorities to develop provincial standards and ensures consistency in service model development, implementation and monitoring.

4. Defining Hybrid and Virtual Care

Virtual Care is defined as any interaction between patients and/or members of their circle of care with their care team, occurring remotely, using any form of communication information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care (CIHI, 2025).

Hybrid Models of Care (HMOC) combines both virtual and in-person healthcare services to provide a flexible, integrated, and patient-centered approach to care delivery. For the purpose of this guideline, Hybrid Models of Care incorporate a virtual “Most Responsible Provider” (MRP) into clinical service design and in-person care teams to manage patient care on-site in hospitals and health centers. The virtual providers serve as the MRP for allocated patients and works as part of the care team in close collaboration with on-site nurses, allied health and staff. Using remote technology, the virtual MRP supports all aspects of care delivery - including assessment, diagnosis, referrals, treatment, discharge. Escalation options are recommended to remain in place for rapid in-person assessment, when required.

Hybrid On-Site Service Model: Virtual physician is working alongside an in-person physician and an in-person team. This model is intended to support workload by dividing MRP responsibilities between providers based on acuity and physician capacity.

Hybrid On-Call Service Model: Virtual physician works alongside an in-person care team, with back up for in person assessment/intervention from an onsite resting or available community physician as needed.

Fully Virtual Service Model: A virtual physician is the sole physician delivering care alongside an in-person team, with escalations to hands on physician care to another hospital with in-person physician coverage. This model requires an airway protection and/or management escalation plan via nursing rural/remote cert, advanced care paramedic, respiratory therapist and/or ambulance bypass for high acuity cases

5. Guiding Principles

Hybrid Models of Care adopt a principles-based approach to the design, implementation, and integration of equitable, high-quality care. The core principles guiding hybrid models of care are consistent with the British Columbia Health Quality Matrix (BCPSQC, 2020) and recommendations of the Virtual Care Clinical Reference Group (VCCRG) and CAEP Position Statement on Optimizing the Role of Virtual Care in Emergency Medicine (2025).

- **Quality and Safety:** Ensure virtual care is delivered safely with appropriate clinical oversight and follow-up mechanisms. The same quality assurance processes that apply to in-person hospital care should also be applied to virtual providers to maintain quality standards.
- **Integration**: Virtual care is intended to complement and enable in-person care, not replace it: virtual care should be integrated into in-person services and workflows should be co-designed with in-person clinical staff.
- **Effectiveness:** Virtual care should be evidence-based and continuously evaluated for efficiency and impact.
- **Accessibility & Equity:** Virtual care should enhance patient access without creating additional barriers, this includes but is not limited to addressing digital literacy and infrastructure gaps, and language access, to ensure fair access to hybrid care services.
- **Person-Centred Care & Relationship Building:** Engage providers, care teams, system experts and patients in planning and implementing virtual care and promote trust and communication.
- **Efficiency and sustainability:** Optimize financial, human, and technological resources for sustainable healthcare delivery utilizing data driven insights. Ensure virtual services and funding strengthens long-term system capacity without compromising necessary resources from in-person services.
- **Appropriateness:** Virtual care should be based on clinical appropriateness, patient needs, and the context of service delivery. Service design and care planning should define patient conditions and contexts that are best suited for virtual emergency consultations to ensure virtual services are used only when safe, effective, and suitable. Transitions/escalations to in-person care should remain available when needed

Indigenous Health Recommendations

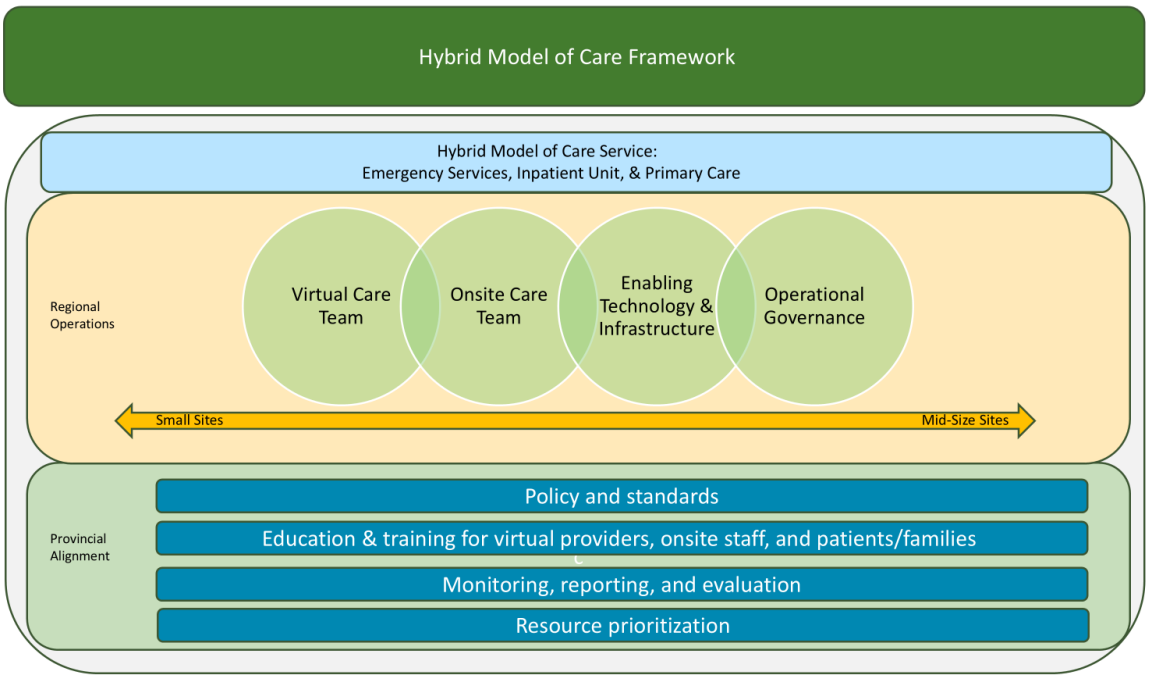
Indigenous Specific Anti-Racism (ISAR) modality is central to ensuring that safety and accessibility of hybrid models of care are attained by Host Nations as well as First Nations, Metis and Urban & Away

Indigenous Peoples. It is incumbent of all health authorities to embed the Indigenous Cultural Safety and Humility Standard (HSO 75000), BC Accessibility Act, Anti-racism Data Act, BC Indigenous Language Legislation, Ownership, Control, Access and Possession (OCAP) Standards, and other legal obligations across the engagement and evaluation frameworks.

6. Framework and Service Models

Provincial Hybrid Model of Care Framework

The Provincial Hybrid Model of Care Framework provides a flexible structure for delivering consistent, high-quality hybrid care across B.C., while allowing communities to adapt models to local realities and patient needs. It balances regional flexibility with provincial consistency, strengthening system-wide resilience and sustainability.



***Informed by MoH Mandate Letter*

Hybrid Model of Care Core Components

The Hybrid Model of Care is structured around four foundational and integrated concepts that ensure safe, effective, and locally adaptable care delivery, which are managed at the regional level, and underpinned by provincially aligned policy & standards. These elements must work cohesively to create a disciplined and resilient hybrid care system that can meet diverse community needs while maintaining provincial consistency in standards and outcomes:

1. **Virtual Team – Clinical & Operations:** Virtual physicians deliver remote clinical care in partnership with the on-site team. These direct patient interactions are supported by a virtual operations team (nursing and clerical support) to ensure virtual patient assessment and treatment orders are transferred and actioned by the in-person care team according to the care plan.
2. **Enabling Technology & Infrastructure:** Secure, reliable technology platforms that support the full integration of virtual and in-person care, including video conferencing, electronic health record (EHR) access (site dependent, but is highly recommended), remote diagnostic tools (e.g.,

e-stethoscopes), structured communication tools for clinical handovers, and contingency systems for managing technology failures or service interruptions.

3. **On-site Care Team Optimization:** Workflow mapping, role clarification, escalation pathways (including airway and resuscitation protocols), and service redesign to support seamless collaboration between on-site and virtual providers.
4. **Operational Governance:** Clearly defined local, regional, and provincial structures that oversee strategic, logistical, and quality assurance functions, ensuring accountability, standardization, and continuous evaluation across all hybrid care models.

Service Model Development

Local and regional service model development should be informed by engagement with local physicians, interdisciplinary care teams, digital and virtual care system experts, and patients, alongside a thorough needs analysis of local data, patient needs, and clinical service requirements within the community. Typically, these service models assume one virtual physician is working at one site in a shift, except in cases which are discussed in the maximizing physician capacity section.
As a project team, at minimum, the following data needs to be considered:

- Healthcare service required (ED, inpatient, or primary care)
- Number of diversions or service interruptions in the past 12-24 months
- Root causes of service disruptions (e.g. physician shortages, infrastructure, staff burnout, etc.)
- Site visit volumes (daytime, evening, overnight)
- Onsite staffing model
- Patient acuity levels and common reasons for care visits
- Understanding of Host Nations cultural protocol as well as the cultural needs of Metis, Urban and Away Indigenous Peoples on Host Nation land.

The following service models can be considered:

Service Model	Description	Driver/Problem to be Solved	Data Indicators	Escalation
Hybrid On-Site	Virtual physician is working alongside an in-person physician and an in-person team. This model is intended to support workload by dividing MRP responsibilities between providers based on acuity and physician capacity.	Long waitlists Patients leaving without being seen Service interruptions due to physician shortages or reduced capacity of existing on-site physician	ED wait times % of patients waiting beyond target wait times Stratified ED volumes based on CTAS triage categorization LWBS rate Time to physician assessment ED occupancy level Patient /provider satisfaction	On-site physician
Hybrid On-Call	Virtual physician works alongside an in-person care team, with back up for in	Service interruptions due to physician shortage	Physician FTE availability vs. service demand	Resting in-person physician

Service Model	Description	Driver/Problem to be Solved	Data Indicators	Escalation
	person assessment/intervention from an onsite resting or community physician as needed.	Proactive overnight coverage (alignment with Corridors of Care) Allow limited community physicians to rest	# of shifts unfilled ED closure hours Provider burnout rates Patient /provider satisfaction	
Fully Virtual	A virtual physician is the sole physician delivering care alongside an in-person team, with escalations to hands on physician care to another hospital with in-person physician coverage. This model requires an airway protection and/or management escalation plan via nursing rural/remote cert, advanced care paramedic, respiratory therapist and/or ambulance bypass for high acuity cases.	Service interruptions due to physician shortage Proactive overnight coverage (alignment with Corridors of Care)	Physician FTE availability vs. service demand # of shifts unfilled ED closure hours Provider burnout rates or satisfaction	On-site airway protection provided by non-physician, as per description

Note: Clear communication of available services should be provided to the public. Refer to CAEP statement for recommendations on how to communicate the designation of emergency departments that operate with virtual physician support only (Kernick et al., 2025).

7. Use and Optimization of Virtual Care Services

Determining Appropriateness for Virtual Care

When designing virtual care and hybrid care service models, it is essential to determine if the site is ready to integrate this model of care; and if they are, clearly define which patients and clinical scenarios are suitable for virtual management.

Key factors include:

- **Clinical and Site Readiness:** Staff competency, availability of on-site or community support, and technology infrastructure.
- **Patient Assignment for Virtual Care:** Clear triage protocols for identifying patients appropriate for virtual care (e.g., patient assignment criteria for Emergency Department, Inpatient Unit, and Primary Care can be found in the **HMOC Implementation Playbook**).
- **Escalation Pathways**: Robust systems to ensure timely access to in-person physician support when needed.

- **High-Acuity Preparedness:** Strategies such as upskilling nurses, ensuring RTs or ACPs are available, ambulance bypass protocols, and/or engaging on-call physicians as a back up.
- **Equity and Accessibility Considerations:** accessibility features (e.g., screen readers, captioning, multilingual support) are essential. Supporting equitable access through targeted investments and inclusive policies.
- **Indigenous-specific Recommendations:** Virtual platforms must be designed to respect and integrate cultural values, especially for Indigenous populations. For Indigenous communities, control over health data is a critical equity issue.

Wise Practice Considerations:

- **Team Confidence:** Nurses should be trained to perform quality physical exams using electronic tools; physicians should trust virtual assessments and collaboration with the on-site team.
- **Hands-On Assessment Capacity:** Sites should determine whether hands-on care is provided by the virtual MRP or deferred to a backup physician (onsite, in community, or transported to another facility).
- **Continuity of Care:** Rotating virtual physicians may impact patient familiarity and longitudinal care.
- **Privacy:** Ensure virtual consultations maintain patient privacy, especially in busy environments (e.g., using headsets or handheld phones).
- **Patient Engagement:** Some patients may need education and reassurance to feel comfortable with virtual care

Maximizing Physician Capacity: Utilizing One Physician Across Multiple Sites

For optimal use of physician capacity, a region may consider leveraging the capacity of one physician across multiple sites in a virtual capacity.

To determine if this model is appropriate, the region should consider the following:

- **Site readiness:** Select sites which are familiar with a virtual physician support model with one physician assigned to one site prior to starting a multi-site model.
- **Site volumes:** this physician resource model is appropriate for low volume sites
- **Aggregate Volumes**: Consider total patient load across all sites.
- **Triage alignment**: Establish a consistent patient triage system across sites.
- **Patient sorting across sites:** Agree on sorting protocols to manage physician capacity fairly (e.g., prioritization when patients have equal triage ratings).
- **Nursing triage:** Nurses should assess whether patients require in-person, virtual, or alternative care. When selecting a technology solution for a hybrid model of care service model, the following criteria is recommended:
- **Workflows consistency:** Consistent virtual physician workflows across all participating sites.
- **Nursing capacity:** Adequate nursing capacity at each site to support virtual care.
- **Cross-site communication**: Implement tools (e.g., dashboard, virtual coordinator, triage nurse) to connect physicians with the right site and patient at the right time.
- **Patient information sharing and order processing:**

- If using a shared EHR, physicians can review charts and place orders directly.
- Without a shared EHR, establish workflows & determine support needed (e.g., virtual coordinator) to securely transfer patient data and orders.
- Ensure treatment orders and results are sent to and actioned by the correct site, with physician follow-up.

Technology Considerations

- **Visual & audio quality**: High-definition screen and camera with zoom; electronic peripherals (e.g., e-stethoscope, e-otoscope) are strongly recommended for inpatient and ED settings.
- **Privacy & Security**: Must safeguard patient information in compliance with health authority privacy standards.
- **Connectivity**: Supports both wired and wireless operation.
- **Usability**: Reliable and intuitive for clinicians, support staff, and patients/families.
- **Training**: Includes comprehensive training for all users.
- **Backup plan**: Provides alternative devices (e.g., tablet or phone) in case of technical failure.
- **System integration**: Compatible with electronic health records or adaptable to paper-based workflows.
- **Technical support**: Offers robust support pathways for clinical staff.

A full list of clinical and technical requirements can be found in the ***HMOC Implementation Playbook***.

Privacy Considerations

To support clinicians and staff in protecting patient privacy and effectively communicating hybrid model of care services to patients and families, teams should follow their health authority or site's virtual care policies and guidelines.

Inform Patients:

- What to expect from their virtual physician encounter.
- How their personal health information will be stored and in accordance with privacy laws.

Patient Consent:

- Obtain and document informed consent for virtual care
- As advised by the Canadian Medical Protective Association (CMPA), the consent process should include:
  - A clear explanation of the clinical and technological capabilities and limitations of virtual care, including when in-person assessments may be required.
  - Information about privacy and confidentiality, including potential risks and the measures in place to mitigate them.

Technology privacy considerations:

The CMPA recommends the following for technology in virtual care:

- Screening by regional privacy (complete Privacy Impact Assessment or health authority equivalent)
- Screen by security teams (complete Security Threat and Risk Assessment or health authority equivalent)
- Secure platform features such as encryption, authentication, and compliant data storage.
- Vendor contracts that align with Canadian health privacy laws.

- Data minimization: collect only essential personal health information required for care and avoid unnecessary sharing or storage of data
- Use of private settings for virtual consultations.
- Audit trails to monitor access and changes to patient records, with regular reviews of privacy policies and security protocols.

Interprofessional Collaboration – Hybrid Teamwork

Trust and rapport between physicians, nursing, and the other members of a patient's care journey is well documented to enhance care outcomes, improve efficiency, and is the foundation of a quality care experience. This takes some time to be established for in-person teams; however, can take longer for a virtual physician as they are not in the physical location as the rest of the team. It is critical to pay attention and create an environment where trust can grow.

Recommended activities to support interprofessional collaboration:

1. **Establish clear roles and responsibilities:** define roles explicitly in the virtual care setting
2. **Schedule regular communication touch points:** team huddles, structured communication tools, user-friendly communication platforms
3. **Build virtual team cohesion and trust:** encourage informal meet and greets and check ins between team members beyond clinical discussions.
4. **Address conflict proactively:** establish clear protocols for decision making and resolving conflict virtually.
5. **Engage patients and families effectively**: in person teams should prepare patients for their virtual encounter and support them as appropriate.
6. **Leverage technology competently:** ensure all team members are trained on the technology and can navigate technical failures
7. **Continuous learning and improvement:** engage hybrid teams regular feedback and problem-solving sessions

Resources to support interprofessional collaboration can be found in the ***HMOC Implementation Playbook***.

Education and Training

Education and training plans are required for all personnel who interact with the patient journey, as well as the patients themselves. A level of readiness to understand what hybrid care is and ability to provide informed consent on this new service model is essential for patients. For staff, a level of readiness to implement services and collaborate virtually is required, but also to support the patient through their hybrid care experience with confidence.

The following learning domains and related topics are recommended at a minimum:

- Organizational & Operational
- Clinical Practice
- Regulatory, Ethical, Legal
- Technology & Digital Literacy

- Interprofessional Collaboration
- Communication & Continuous Learning
- Indigenous Responsibilities
- Accessibility & Equity

The provincial education framework aims to support virtual providers, onsite staff (including nursing, allied health, admin, and leadership), and patients & families can be found in the ***HMOC Implementation Playbook.*** Learning domains are highlighted above, and content is available to be used as a guide to create health authority specific education materials.

8. Virtual Physicians in British Columbia

Virtual Physician Compensation

- Compensation for virtual physicians is to be negotiated through health authority medical affairs.

Virtual Physician Credentialling

- Virtual physicians are to be credentialled per the College of Physicians & Surgeons of British Columbia, linked: PSG-Virtual-Care.pdf

9. Indigenous Responsibilities

Collaborative Indigenous approach using A Wise Practice Lens

A Wise Practice lens requires people to work from a collaborative approach. Engagement is to be fully engaged in a holistic way, drawing on experience, knowledge, and deep understanding of a given situation to make decisions based on wisdom. Wise practices, in other words, are about the people, their insights, intuition, lived experience, nuance, time, ethics, knowledge of their values and priorities.

Wise practices in technology involve digital literacy, ethical use, and cultural relevance, promoting healthy engagement with digital tools by focusing on real-world application, critical thinking, and co-development with Host First Nations, Metis and Urban and Away Indigenous Peoples. Ensuring equitable access and representation in tech and integrating Indigenous knowledge and reflecting that the service will be offered on the Host Nations lands, but many Indigenous Peoples, not from the host Nation will also be using the services.

Consultation and Co-Design: Health Authorities and virtual health program teams benefit from engaging early with Host Indigenous Nations, Metis and Urban and Away Indigenous health representatives. This may include co-designing services, identifying cultural protocols, and ensuring local perspectives inform all stages of service development and implementation.

10. Language, Equity, and Access

To ensure equitable access to virtual and hybrid care services, language accessibility should be prioritized in the design.

On-demand and Scheduled Interpretation Access: Virtual care platforms and workflows should support 24/7 access to qualified interpreters by phone, video, or integrated digital tools, at no cost to patients or their families.

Two-Way Communication: Effective and safe virtual care requires two-way communication in a language patients understand. Language services should be seamlessly integrated into virtual visits to support accurate, patient-centered care.

Training and Awareness: Providers, patients, and families should be supported through education and training to understand how to access and use language services in a virtual environment. Materials should be available in multiple languages and be culturally appropriate.

11. Rural and Remote Considerations

RSA Level A sites are defined as small hospital sites in communities with less that 7 physicians (BC Government, 2025). Hybrid model of care for these sites is often required to enable care to remain within the community and reduce hospital transfers to larger communities and has been implemented in various forms for many years. These sites have unique challenges and further considerations when looking to introduce this model.

Operations & Service Delivery: Virtual physicians may come from regional pools; however, this may not be sufficient to meet the needs and may need to come from a provincial service provider. Training, recruitment, scheduling, and performance management should be in line with provincial and regional standards. An experienced virtual operations team should support the delivery of virtual physician services.

Relationship-Based Approach: Small sites require a particular focus on relationship building with local teams. Direct site-level engagement to determine specific needs of the community, co-create workflows and evaluations is essential.

Understanding the context: Virtual physicians need to understand the local context, including the community, hospital or health center and cultural context. They need to understand the available resources, expanded roles of clinicians, transfer considerations specific to the location and community expectations to ensure they provide safe, effective, and culturally respectful care

Technology & Information Systems: RSA A sites are typically paper based sites without access to the regional Electronic Medical Record (EMR) system. Any virtual physician should have access to an EMR to ensure privacy standards are maintained, while utilizing site-based fax to transfer information.

HMOC to support clinician recruitment and retention for service stability: Recruitment of clinical staff to rural and remote healthcare service locations is a challenge, retention of those clinicians can also be challenging. Having regularly scheduled HMOC shifts can be protective for a rural and remote healthcare site to give the regular clinician a break, enable regular work/life balance opportunities, foster a team-based environment where a sole provider and/or small team feels supported.

12. Contract Management

Contracts for virtual health services and technology solutions should aim for provincial consistency and, wherever possible, be centralized to maximize economies of scale.
Key considerations for contracts:

- **Standardized Agreements**: Consistent contract templates across health authorities
- **Provider rates & compensation structures** (e.g. hourly, per-service)
- **Service expectations**: Availability, deployment of resources based on contract holder needs and priorities, response times, uptime guarantees
- **Technology integration requirements**: Compatibility with existing systems and EMRs
- **Scope & Service Expectations:** Clearly define deliverables, responsibilities, and performance metrics for virtual care providers and technology vendors.
- **Performance Monitoring & Reporting**: Require regular data sharing, reporting, and evaluation to assess service utilization and patient outcomes.
- **Risk & Issue Management**: Include mechanisms for dispute resolution, contract amendments, and contingency planning to address service disruptions or technology failures.
- **Scalability & Sustainability:** Allow for contract flexibility to support the expansion of HMOC services across different hospital sizes, urban, rural, and remote settings.
- **Privacy:** Compliance with FIPPA for patient information

13. Monitoring and Evaluation

Reporting & Evaluation Framework

Health authorities are responsible for developing an evaluation plan aligned with the Provincial HMOC evaluation framework for quality assurance, enable consistent measurement and reporting across regions and inform data-driven decisions. The evaluation framework is aligned with the Quintuple Aim, Health Quality BC Dimensions of Quality, Ministry of Health reporting requirements, and Indigenous Specific Anti-Racism (ISAR) principles.

To support transparency and build a provincial baseline, sites and health authorities will share data with the province as it becomes available. Data will be aggregated for consistent provincial monitoring. Health authorities will collect both standard provincial metrics and any additional data based on local needs, and are responsible for providing information to the Ministry of Health, or its delegate upon request**.**

Regions are required to map indicators or evaluation questions to both Indigenous Specific Anti-Racism (ISAR) principles and the Indigenous Determinants of Health and be in alignment with the HSO Standard and Accessibility Standards. Evaluation questions may include:

- To what extent do Indigenous patients report culturally safe experiences?
- Are Indigenous communities accessing virtual services at equitable rates? What barriers exist (tech, trust, historical trauma)?
- Have on-site and virtual teams completed Indigenous cultural safety and anti-racism training?

A quality improvement approach drives clinical service improvements through continuous evaluation and adaptation. ***A full evaluation framework can be found in the HMOC Implementation Playbook.***

14. Implementation

Health authorities are recommended to engage with MOH and PVH teams for implementation support and resources. Planning and implementation is supported by the ***HMOC Implementation Playbook*** and includes:

- Site assessment and readiness
- Community and key partner engagement
- Workflow mapping and service design planning
- Implementation support
- Training and education
- Evaluation planning
- Post implementation support

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