

Connected Care Ontario Health Team: Our Operational Plan Impact 2024-2025

A Word from our Executive Director Zoë Dawe



June 2025

This year, the Connected Care Ontario Health Team (OHT) made significant impact in improving the experiences of both patients and providers. It began with a collective energy in our Operating Plan Development which brought together in person patients, caregivers, Physicians and our OHT partner organizations back on August 20th. The result was a collaboratively developed operating plan to guide our work for the year ahead.

To support our collective goals, I conducted a thorough environmental scan of other OHT structures. This informed team optimization and strategic advancements for the CCHOHT, resulting in:

- A dedicated Communications and Engagement Coordinator role to enhance partner member relations to develop a communications and interaction strategy for the CCHOHT/PCN;
- Two new lead roles: Health System Advancement and Evaluation and Integrated Population Health;
- Three PCN Physician Clinical Leads: PCN Advancement, Digital Projects, and Social Prescribing all made possible through one-time funding initiatives from Ontario Health. These Roles will continue for 2025-26 to support the advancement of an established Primary Care Network (PCN).



Our Year-end report was successfully submitted to Ontario Health in April and I am proud to share back that we achieved and surpassed what we set out to accomplish.

I would like to extend a sincere thank you to our patients, family members, and caregivers who bring courage and a compassionate voice to our work. To all our CCHOHT workstream leads for Palliative Care, Mental Health and Addictions, Home and Community Care, and Digital and Analytics in leading our workstream members in focus groups and engagement capable environment sessions, your time, energy and talents made an impact.

To the Halton Physician Association and Primary Care Network working group; what has been achieved over the past 8 months has made for a solid foundation for a future thriving PCN, feel proud!

Finally, a sincere thank you to our Collaborative Committee for their time and strategic oversight for ensuring our efforts had an impact at the point of care for our patients/families and caregivers and for the providers who care for them.

We now begin the focused work ahead with our 2025-26 mandate focused on access, attachment and enablement for achieving 100% attachment to Primary Care. Given many of our providers have regional accountabilities, the CCHOHT and BOHT leadership is actively pursuing opportunities for alignment on initiatives where it makes sense for all Halton residents and we will continue to engage our communities to plan with you for achieving progress over the next year and into the future.

Stay well and stay engaged!

Zoë Dawe

Snapshot 2024-25 Operating Plan Achievements

Integrated Care through Population Health Management and Equity Approaches

CCHOHT Community-Integrated Social Prescription Model



100 social prescriptions were issued by 14 providers at Halton Hills Family Health Team, referring individuals to Hillsvie programs in both Acton and Georgetown



198 ParX Prescriptions were given to patients by their Primary Care Provider



11 walk with a Doc® Events held

5 Participating Physicians

90+ unique individuals



37 registered in **Small Steps Big Changes**® a type 2 Diabetes prevention group through the YMCA



70 attendees from across sectors attended webinars organized by Dr. Nivedita Patel as our Clinical Lead for social prescribing as a valuable tool for patient care and a proactive approach to improving patient outcomes



Community Wellness Hubs:

2 hubs with 2 Spokes

106 Seniors as hub members.

- ✓ 31% Lower Rate of Hospitalizations for ACSCs²
- ✓ 14% Fewer Less/Non-Urgent ED³ Visits⁴

Support House in Collaboration with CCHOHT and BOHT Launched the Mobile Community Wellness Centre Van on June 12th 2025

- ✓ 370+ unique individuals supported
- ✓ 146 referrals made.



Seamless Care Optimizing The Patient Experience (SCOPE)

Onboarded 61 additional Primary Care Providers number bringing the number to 320 as of March 31st 2025.



Truth with Reconciliation -Indigenous knowledge and Cultural Safety Training
4 CCHOHT Team members, 3 Physician leads and 2 PFAC members participated.



System Navigation



Navigation Line Key Achievements:

 11,515 contacts, addressed 4,206 identified needs with an 85% resolution rate

People were asking About?

- Guidance and Information on referrals: (78%),
- Directory Assistance: (18%)
- Crisis Support: (less than 1%)—hopeful indicator impact of marketing of local and National Crisis lines.

Virtual Urgent Care



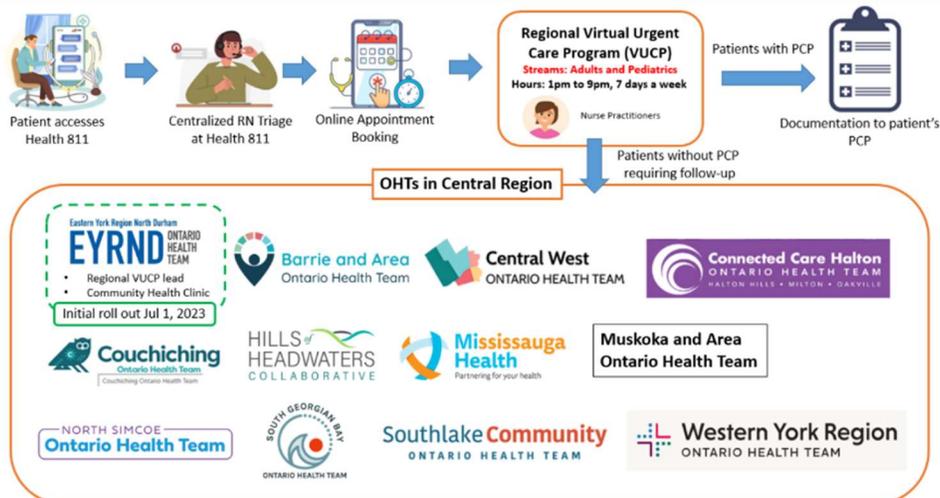
175 patient visits from the CCHOHT population

where 1 in 5 reported not having a family doctor

90% satisfied/very satisfied with Experience

60% noted they would have gone to local ED had VUC not been available

Clinical Model – Episodic Access to Virtual Care – Mature State



Home Care Readiness



11 Partners inclusive of Hospital and Community Support Services reported on progress for **Home First Strategy Submission**



Significant improvement in ALC rate from 13.3% to 9.0% over Winter Surge Season.



Increase in funding and pathways for the **Halton@Home Program** to cover full CCHOHT Geography from both ED and In-patient discharges



Collaboration for ED diversion with CANES Care Bridge, Nucleus Independent Living and Toronto Grace-RCM.

Collaborative Leadership, Decision Making and Governance (Including Patient, Family, Caregiver Strategy)



Full Governance Review Completed with Recommendations and Action Strategies inclusive of an updated Collaborative Decision Making Agreement (CDMA)



Developed a **portal for our Collaborative Committee** to access CCHOHT documents since the designation of becoming an OHT in 2019.

Primary Care Engagement and Leadership

Primary Care Network Advancement **Dr. Kristianna Martiniuk, Clinical Lead CCHOHT**



From January 1 to June 25, 2025, I served as Clinical Lead for PCN Development, contributing significantly to the advancement of primary care within the CCHOHT. I led the submission of IPCT expansion proposals, engaging primary care clinicians—particularly FHO, FHT, and FHG group leads—and represented primary care at the CCHOHT collaborative committee. I facilitated the completion and acceptance of the PCN Working Group Terms of Reference by the Halton Physician Association (HPA), which also agreed to evolve into a broader PCN mandate. In collaboration with the digital lead, I supported primary care physicians in developing proposals for novel digital tools aimed at reducing administrative burden and enhancing care. This included co-hosting an AI Scribe webinar and working with the HHS CIO to eliminate imaging report duplications. I also collaborated with HHS and the OHT to finalize a dataset on primary care physician capacity in the region. Communication with primary care was strengthened through emails, WhatsApp, and a dedicated website, while CME events were hosted, including one featuring Indigenous leaders who will also participate in our fall clinic day. I advocated for primary care at the Halton Crisis Continuum and contributed to the selection of a digital communication solution for palliative care providers. Additionally, I participated in regional and provincial OHT and PCN leadership meetings and coordinated updates to the family physician contact list.

Primary Care Network Advancement **Dr. Nivedita Patel, Social Prescribing**

I have worked closely with the team at CCHOHT to advance social prescribing in our community. A pilot project was carried out in Halton Hills, linking primary care at an FHT and FHO with Hillview Seniors Centre programs in Acton and Georgetown. The pilot revealed positive patient experiences alongside key barriers to participation, with



modest uptake in primary care due to workflow constraints. These findings highlighted areas for improvement as we continue to embed social prescribing within our primary care network. In early April, we delivered a webinar introducing social prescribing as a valuable tool for patient care, discussed lifestyle medicine as a proactive approach to improving patient outcomes, and highlighted available programs, including PaRx, Walk With A Doc, and Small Steps for Big Changes. Bite-sized referral information for local programs was developed and shared across the CCHOHT network, with supporting videos currently in progress. On June 17, 2025, we delivered the first of several sessions in the Lifestyle Medicine Series, designed to increase provider comfort with social prescriptions and evidence-based lifestyle approaches to promote healthy aging and reduce the chronic disease burden. The initial session, focused on women's health and PCOS, was very well received.

Primary Care Network Advancement

Dr. Yasar Razvi, Digital Projects

Digital Enablers Survey

Helped develop and disseminate a stakeholder survey to assess current experiences with digital health platforms and identify areas of need.

Evaluation of Digital Platforms

Contributed to the evaluation and selection process between Hypercare and SigMail for a secure provider communication pilot, leveraging knowledge of the current digital health landscape.

Hypercare Pilot – Palliative Care Focus

Helped shape the pilot's focus on palliative care; currently participating in a multidisciplinary working group to support implementation.

AI Scribe Webinar

Co-delivered a presentation to Halton physicians, providing practical guidance and a live demo on how to integrate AI scribes effectively into daily practice.

Ontario Health + Boehringer Ingelheim Digital Health Challenge

Shared funding opportunity with local physicians, supported platform evaluations (Nymble and Own Health), and helped guide Nymble's proposal toward diabetes care—addressing a key gap and increasing the proposal's relevance and impact.

AI Scribe Resource Development

Created a summary of recent AI scribe developments for Halton physicians; currently conducting comparative evaluations of scribes from the Ontario AI Scribe Program VOR list for an upcoming guidance update.

CME Working Group

Active participant in planning future CME events.

Data and Digital

Patients Before Paperwork



67 net new PCPs are online with an OAB solution from April 1, 2024 to March 31, 2025



164,965 patients have access to OAB



Remote Care Management



Supported providing vital sign monitoring equipment to patients in their home for COPD, CHF, COVID and other respiratory conditions to support early discharge, unnecessary emergency department visits and re-admissions.

97% would recommend the program

Patient Feedback:

“I really appreciated the tips and step by step surveys it provided. A major help was they were given systematically to my procedure, which made me feel better prepared. They helped give understanding of what to expect with visuals and text which were easy to understand. Plus, they answered lingering questions I had regarding my condition and the surgery, which calm some of the anxiety I had.”



ED visits of enrolled patients decreased by 58%
hospitalizations decreased by 70%
EMS calls for enrolled patients decreased by 61%.



We successfully delivered an RFQ and subsequent digital project management for the Digital enablers funding in Q4 and engaged our OHT partners and Patient/Family Caregivers on what attributes would be of most interest. This concluded with a recommendation for a digital roadmap for our OHT alongside a pilot with Hypercare for Palliative Care, SCOPE and LTC to be implemented over the 2025-26 fiscal year.

Save the Date
Tuesday September 9th 5:30-7:00pm
2025-26 CCHOHT Operational Plan Development Engagement Session
Location TBC