



Photo by Marcin Skelton on Unsplash

PRIMARY HEALTH CARE ACTION PLAN REPORT

OCTOBER 2025

Taking Action to Improve Primary Health Care in Halton Hills, Milton, and Oakville





TABLE OF CONTENTS

Executive Summary	3
Background	5
Planning Approach	7
Planning Context.....	9
Guidance for Decision-Making.....	14
Primary Health Care Action Plan.....	18
Implementation Guidance.....	24
Appendix.....	27

Primary Health Care Action Plan for the Connected Care Halton Ontario Health Team Geography

We want to make sure every person in our community has the care they need, when and where they need it.

This plan is our shared roadmap to get there.



Photo provided by Conservation Halton

Our “Why”

A strong primary health care system is the foundation of a healthy community.

We recognize:

- **Our community is growing and changing.** We have more seniors, more diverse families, and more people with different health needs.
- **More of our neighbours** are managing long-term health issues like diabetes or heart disease.
- **Too many people** don’t have a family doctor and struggle to find one.
- **Finding your way through the health system** can be confusing because different services often don’t connect well with each other.
- **Our dedicated doctors, nurses, and other health professionals** are stretched thin by heavy workloads and too much paperwork.

A Timely Opportunity to Work Together

The good news is there is a strong desire for change. Across our region and the province, there’s a growing focus on improving primary care.

That’s why the Connected Care Halton Ontario Health Team (CCHOHT), Halton Healthcare, and other local health leaders have come together. We’ve created a shared plan to build a primary care system that is stronger, more connected, and works better for everyone.

Guiding our Plan

We will align with the provincial objectives for primary care:

- Province-wide
- Connected
- Convenient
- Inclusive
- Empowered
- Responsive

Our design principles outline how we will work to achieve our vision:

- **Putting People First:** We will design this new system with patients, families, caregivers, and health care providers, not just for them.
- **Fair and Smart:** We will invest resources where they are needed most to ensure everyone has fair access to care.
- **Quick Wins and Lasting Change:** We will focus on making a difference you can feel now, while also building a stronger health care system for the long term.
- **Built to Last and Ready to Adapt:** We will create solutions that are sustainable and flexible enough to evolve as our community’s needs change over time.
- **A Shared Responsibility:** We will foster accountability to our partners and the community, working together to achieve our shared goals.
- **Focused on Real-World Results:** We will use data and evidence to measure our progress and ensure our efforts are leading to better health.

Primary Health Care Action Plan

This Action Plan will serve as a shared roadmap to align efforts to improve primary care over the coming years. It focuses our activities against four goals that define the shared vision and aspiration for the CCHOHT geography in its primary care transformation efforts.

We will prioritize our core goal as the foundation:

Goal 1: Every person in our geography is connected to a primary care provider.

How We'll Do it:

We will establish a formal network of local 'Health Hubs' that are accountable for connecting people to care teams in their area. We'll create clear partnership agreements between these hubs and other local doctors and health care providers to ensure everyone understands their roles and can work together effectively. We will also create a system for these hubs to share successful ideas and resources across the entire region.



Sample initiatives include:

- Taking stock of which local physician offices and clinics have the space to take on new patients.
- Coordinating with health home satellites to connect patients to providers.

While advancing toward a high-performing primary care system:

Goal 2: Everyone across the geography has timely access to an interprofessional team of care providers.



How we'll do it:

To help you get the care you need with less waiting, we will give your family doctor better tools and simpler processes to connect you with specialists and other health services. By having your doctor better connected to a full team of experts—like dietitians or social workers—you'll get more comprehensive support for your overall health.

Sample initiatives include:

- Supporting uptake of eReferral to streamline referral processes
- Establishing a way to provide an up-to-date database of physicians
- Using existing health home satellites as transitional support hubs to fill gaps in access

Goal 3: We work as an agile integrated system in which primary care providers are engaged, empowered, and supported.



How we'll do it:

When your doctor is supported, they can provide you with better care. That's why we're creating a more collaborative environment for our primary care providers, with clear standards and coordinated resources that reduce their paperwork. This allows them to focus on you, which also helps us attract and keep talented health professionals in our community.

Sample initiatives include:

- Establishing a representative Primary Care Network to provide ongoing oversight of transformation work
- Establishing a communications and engagement strategy to bring everyone along in our improvement journey

Goal 4: Health inequities are measurably reduced across our communities.



How we'll do it:

To ensure your care is tailored to your unique needs, we will use population health data to understand what different groups in our community require. By partnering with trusted community organizations, we will strive to make sure that your income, language, or background is not a barrier to receiving excellent, culturally safe care.

Sample initiatives include:

- Deploying dedicated community paramedics to deliver in-home care to vulnerable patients
- Assessing capacities of health home hubs to provide appropriate, accessible care for equity-deserving groups

Bringing this to Life

This plan is just the beginning. It's a living resource that will grow and adapt as our community's needs change. The CCHOHT and our new Primary Care Network will lead this work in close collaboration with Halton Healthcare, coordinating with partners across the region.

We are committed to clear communication, strong leadership, and continuously measuring our progress. Most importantly, we'll keep listening to patients, providers, and partners to make sure we're on the right track. Together, we can build a primary care system that truly cares for everyone in our community.

BACKGROUND

Our Why:

A strong, well-functioning and well-resourced primary care system is integral to the health of our population. The Connected Care Halton Ontario Health Team (CCHOHT) geography faces challenges with system fragmentation, significant disparities and challenges in access, and a high degree of clinical and administrative burden on providers. With a growing, aging and increasingly diverse population and rises in complex and chronic diseases, it is critical to address the foundational issues in our system now to ensure we can meet the needs of our population in the future.

A Timely Opportunity for Change:

Thankfully, this issue has been brought into the spotlight and significant momentum has begun to drive meaningful and lasting change. There is a new sense of energy to improve primary care, supported by:

- A provincial Primary Care Action Team and associated funding opportunities
- The development of a Primary Care Network through the Ontario Health Team
- Increasing regional alignment around primary care thanks to:
 - A Halton Healthcare Clinical Services Plan that depends on a strong regional primary care system; and
 - Deepening relationships and collaboration across the CCHOHT and Burlington OHT (BOHT).

ALIGNING ON A SHARED ACTION PLAN:

Recognizing this unique opportunity to align efforts for greater impact, Halton Healthcare came together with the CCHOHT to develop a Primary Health Care Action Plan for the CCHOHT Geography.

This Action Plan:

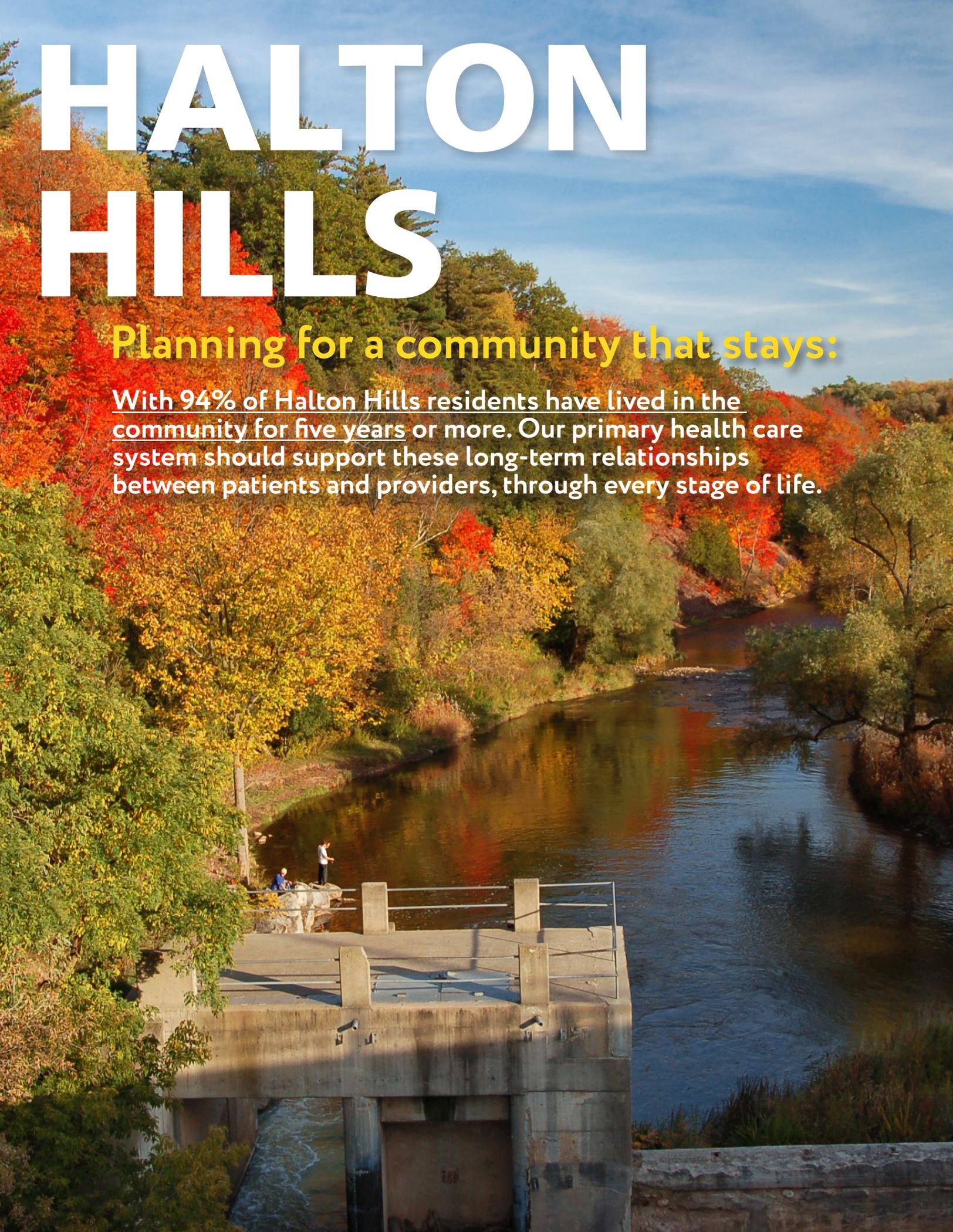
- Articulates a clear vision for primary care in the CCHOHT geographies within Halton.
- Outlines a coordinated strategy to achieve this vision through prioritized, actionable, high-impact initiatives.



HALTON HILLS

Planning for a community that stays:

With 94% of Halton Hills residents have lived in the community for five years or more. Our primary health care system should support these long-term relationships between patients and providers, through every stage of life.



PLANNING APPROACH

Process Initiation and Work Plan

Halton Healthcare and CCHOHT began collaborating on this work in early 2025. Supported by Santis Health and IQVIA, as well as two physician advisors, the core project team advanced phases 1 and 2 of this work to establish a strong foundation for developing an Action Plan in collaboration with key leaders, partners, providers, and patient/community representatives in the CCHOHT geography.

Phase 1: Project Initiation	Phase 2: Current and Future Supply and Demand: Quantitative Analysis	Phase 3: Engagement & Committee Development	Phase 4: Action Plan Development
January - February	February – June	July - August	August - September
<ul style="list-style-type: none"> • Planning discussions with Halton Healthcare, CCHOHT, and primary care leadership • Alignment on goals and objectives for action plan • Project work plan • Key document request and review 	<ul style="list-style-type: none"> • Understanding the number of family doctors delivering primary care in the OHT geography • Analyzing current and projected supply and demand for primary care in the CCHOHT • Better understanding how to maximize existing and future resourcing through Regional Action Planning 	<ul style="list-style-type: none"> • Engagement planning • Engagement with local primary care providers • Establishment and initiation of multi-partner advisory committee 	<ul style="list-style-type: none"> • Facilitation of multi-partner committee planning discussions • Priority testing and alignment with ongoing work • Community and key partner validation • Development of Action Plan

Action Planning Committee

Following this foundational work, an Action Planning Committee was established to act as an advisory group for the development of the Action Plan. The membership of the Action Planning Committee was designed to provide representation from key audiences across the region who will play a role in the plan’s eventual implementation.

Action Planning Committee Membership:

Dr. Nadia Alam, *PMD, Community Integration & Primary Health Care, Halton Healthcare*

Dr. Arieg Badawi, *Family Physician*
Shannon Bettridge, *Interim Project Lead, Strategy, Halton Healthcare*

Heather Burnett, *Physician Engagement Specialist, Halton Region*

Zoe Dawe, *Executive Director, CCHOHT*

Mike Dickin, *CEO, Dorval Medical Associates Family Health Team*

Melissa Farrell, *President & CEO, Halton Healthcare*

Meghann Foley, *Primary Care Nurse Practitioner, Prime Care FHT*

Elma Hrapovich, *Program Director, Community Integration & Primary Health Care, Halton Healthcare*

Mary Rose van Kesteren, *Member, CCHOHT Patient Family Advisory Committee*

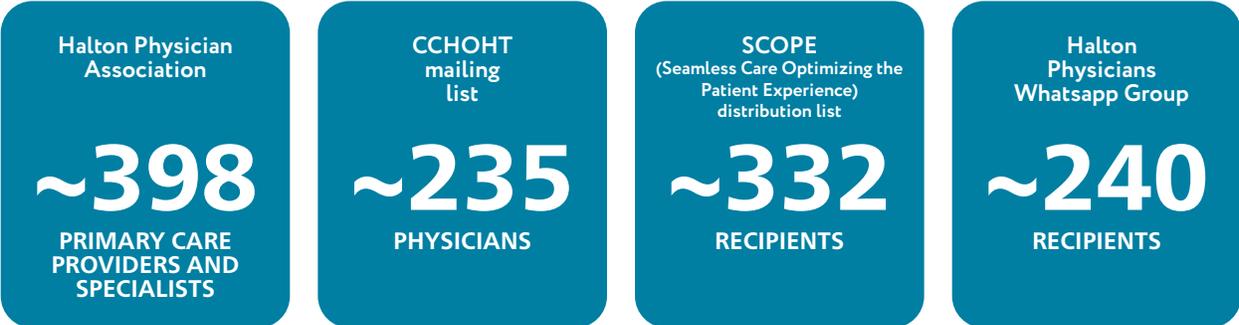
Dr. Kristianna Martiniuk, *Family Physician*

Dr. Ian Preyra, *Vice President, Medical & Academic Affairs, Halton Healthcare*

Adrienne Spafford, *Vice President, Strategy & Partnerships, Halton Healthcare*

Engaging Key Audiences

With guidance from the Action Planning Committee, a series of engagement activities (four focus groups and a survey) were conducted through August 2025 to provide information on the work underway and gather input from interested parties across the CCHOHT geography to help shape the Action Plan. Information about the focus groups and survey were distributed to the following:



The focus of and participation in the various engagement activities are summarized below.

Activity	Participation	Focus
<p>Round 1 Focus Groups August 5 and 7 (Two 90-min Sessions)</p>	15 Attendees	Sharing the work underway and facilitating an open discussion to understand provider perspectives.
<p>Round 2 Focus Groups August 20 and 21 (Two 90-min Sessions)</p>	21 Attendees	Socializing draft plan elements and gathering feedback for further iteration.
<p>Virtual Survey August 13 – 22</p>	13 Responses	Input from broader audiences on the opportunities, challenges, and needs to improve primary care in the CCHOHT Geography.

With acknowledgement of the historical issues in the region, participants were largely enthusiastic about the opportunity presented through this exercise. Valuable input was provided to inform both the overall approach for planning and implementation as well as the priority areas for action. It also served to set the tone for the implementation of this Action Plan with a focus on strong co-design, engagement and ongoing collaboration.

A summary of key takeaways from engagement is provided in the Planning Context section, and specific feedback on priorities and potential initiatives has directly shaped the Action Plan itself.

Based on input from the engagement activities, the Action Planning Committee supported the development of this Action Plan.

PLANNING CONTEXT

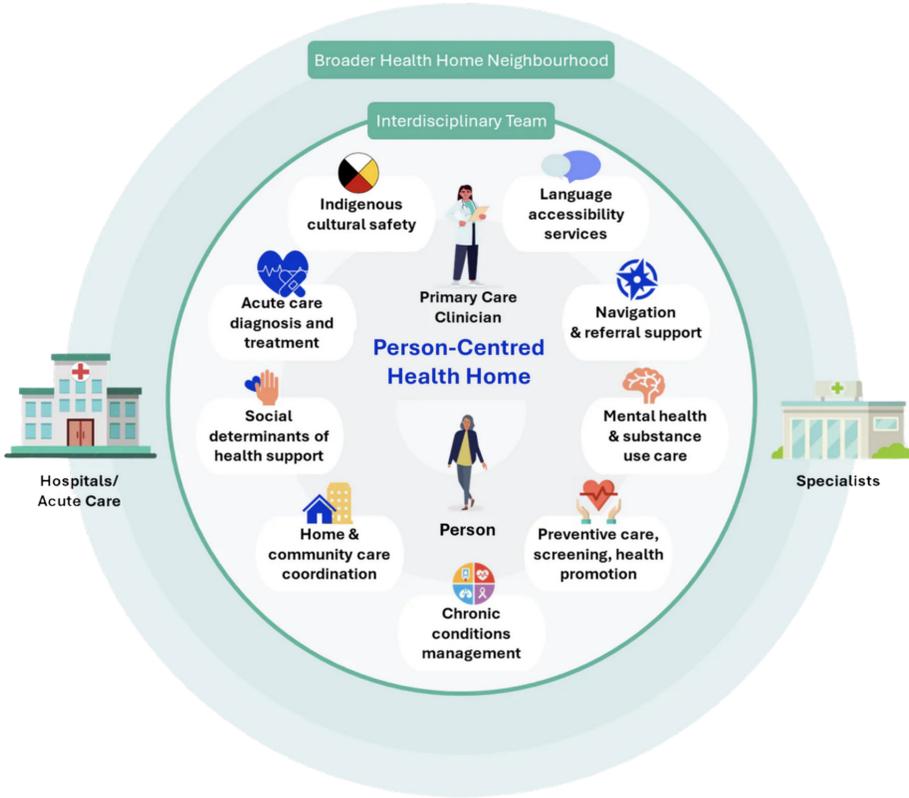
Provincial Primary Care Landscape and Vision

Primary care has been a major area of focus for Ontario Health and the Ministry of Health, including through the advancement of Primary Care Networks across the province and the ongoing work of the Primary Care Action Team (led by Dr. Jane Philpott) aiming to attach 100% of people to a “Patient Health Home” in their community by 2029.¹

In the province’s vision, Health Homes support the wellbeing of the whole person by:

- Serving as the primary access point for care where each person has a primary care provider (MD or NP)
- Supporting access to a broader network of health professionals and wellness services (either onsite or nearby)

This Action Plan was initiated due to an identified need in the CCHOHT geography for better coordination and alignment to improve primary care in the region. The work being driven by the province (including the Interprofessional Primary Care Team (IPCT) funding opportunities and OHT Primary Care Access and Attachment Planning work) is highly aligned and reinforces the value and importance of the development of this Action Plan to provide leaders and partners in the CCHOHT geography with a clear shared plan to advance the vision outlined by the province recognizing the unique needs and considerations within our community.



¹Ontario’s Primary Care Action Plan, January 2025. Ontario Ministry of Health. <https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025>

MILTON

Growing Together:

With a population projected to grow 24% between 2025 and 2030, Milton is one of Canada's fastest-growing communities. We want to create a primary health care system designed for the families of today and tomorrow.



Demographic Information

The three municipalities in Halton Region—Oakville, Milton, and Halton Hills—each present distinct demographic, cultural, and healthcare access characteristics. While over half of the current population lives in Oakville, Milton is seeing rapid growth with an influx of new, young residents. Simultaneously, populations in Oakville and Halton Hills are older, and Halton Hills is characterized by a greater rural-urban mix.

Municipality	2025 Population	2030 Projection	% Growth	Key Demographic Notes
Oakville	241,964	261,313	8%	Older, affluent, more stable housing
Milton	152,709	189,712	24%	Youngest, fastest-growing, high newcomer density
Halton Hills	70,880	74,273	5%	Rural-urban mix, aging population

See Appendix for additional data on Social Determinants of Health.

Chronic Illness & Cancer Screening

Halton Region overall appears to outperform the Ontario average in several chronic disease indicators, but localized disparities remain.

Higher rates of Heart Failure and Chronic Obstructive Pulmonary Disease (COPD), and lower cancer screening rates are evident in Milton with a high proportion of residents with uncertain or no primary care attachment. A similar profile with localized disparities exists in Halton Hills.

Oakville shows better-than-average outcomes on COPD and diabetes; North Central Oakville and Acton show significantly lower screening rates for chronic conditions, indicating potential underdiagnosis or access issues.

See Appendix for additional data on Regional Disease Burden.

Attached Populations

Currently, 8.6% of people in the CCHOHT are not attached to a primary care provider (although the specific proportion varies across subregions).

Without change, this number is expected to grow in the coming 5 years.

FSA	Primary Subregion	Total Population	Unattached (Number)	Unattached (%)
L9E, L9T	Milton	153,530	12,545	8.3%
L6H, L6J, L6K, L6L, L6M	Oakville	248,317	23,313	9.7%
L7J, L7G, L0P	Halton Hills	77,448	5,147	7.1%
All CCHOHT	—	479,295	41,005	8.6%



Primary Care Capacity

Primary Care Providers & Team Based Care

At present, the CCHOHT geography has an estimated 419 primary care practitioners across the region (275 in Oakville, 87 in Milton, 52 in Georgetown, and 5 in Acton). Of these, approximately 50 physicians are delivering care in multidisciplinary team-based settings, equating to ~12% of our total physician workforce.² Based on previous years data, the CCHOHT region attracts on average 10 new family physicians per year to the region who then provide primary care services.

See Appendix for additional data on Provider Distribution

Coverage / Capacity Forecast

Supported by IQVIA, a comprehensive analysis was conducted to better understand the CCHOHT's current "supply" of primary care providers within the geography and compare this capacity against demand in the region both now and forecasted into the future. This process relied on available data with the aim of supporting directional planning. These insights are best understood as part of an evolving, iterative planning process rather than definitive statistics about the region.

Overall, the modeling work considered the contingent of primary care providers delivering care in the region and aimed to adjust for various factors including capacity, projected retirement, etc. With the 419 identified providers of primary care in the catchment, modelling found that Halton has a **strong primary care provider supply overall** (though there is sub-regional variation). In particular, modelling suggested that Halton at present may have sufficient capacity to attach most (if not all) of its currently unattached patients to care*. However, the current pace of attracting on average 10 new family physicians per year to the region will not be sufficient to keep up with population growth in the years to come. Without change, Halton would see a **significant primary shortage emerge in the future (e.g. the next ~5 years) due to rapid population growth** (the pace of which varies across the CCHOHT geography).

*This is a general estimate based on limited generalized data not accounting for the unique context of individual patients and providers.

See Appendix for additional data on Capacity Forecasting

419
primary care
practitioners
across the
region

CCHOHT
region attracts
on average
10
new family
physicians per
year

Without
change,
Halton
would see a
significant
primary
shortage
emerge in the
future

This plan
will help us
better meet
the needs of
the today and
tomorrow's
population

²Data Source: Halton Physician Association, July 2025. Of the 50 physicians identified working in team-based settings, 49 are in Family Health Teams (FHTs), and 1 is contracted with the mobile Community Health Centre (CHC).

Core Findings from Engagement

The engagement process provided a rich and insightful foundation for developing this Action Plan. While participants acknowledged a history of fragmentation and challenges, there was widespread enthusiasm for the opportunity to come together and co-design a better path forward. The feedback confirmed key assumptions about the state of primary care in our geography while also highlighting crucial nuances and priorities from those providing primary care.

The insights gathered can be grouped into the following key themes, which directly informed the design of our Action Plan:



A Call for a Cohesive System

Participants consistently expressed a desire to move from a fragmented system to a more cohesive model of care. This included addressing the significant administrative burden associated with care coordination and the challenges experienced when there is a lack of clear information. The feedback underscored the need for better system navigation, efficient pathways, and improved communication between providers and across the healthcare system.



Addressing Gaps in Access and Resources

The feedback highlighted critical gaps in timely access to specialists and allied health services. Participants noted that these challenges disproportionately affect certain communities and geographies, leading to long wait times and additional burden on primary care providers. This input emphasized the need for targeted solutions that improve access, particularly in underserved areas, and ensure a more equitable distribution of resources.



Building Trust and Fostering Collaboration

A central and recurring theme was the importance of building trust among all. Participants called for a transparent approach rooted in co-design with patients, families, community members, and providers. The feedback also stressed the importance of ensuring new initiatives are seen as building upon, rather than undermining, existing efforts and resources. This includes a “whole system” perspective, considering a breadth of partners from physicians and allied health to home care and learners. This desire for shared ownership and a collaborative approach served as a foundational principle for our implementation strategy.



Ensuring Foundational Requirements for Success are In Place

Participants provided specific, actionable guidance on how to advance the plan. They stressed the need for clear governance structures with cross-regional representation and dedicated working groups to ensure accountability and focus. A strong emphasis was also placed on improving communication and information sharing through better resources, directories, and regular updates. The feedback highlighted that physician engagement is crucial and requires dedicated support for networking, leadership roles, and educational opportunities.

This valuable input served to both set the tone for implementation—with a focus on co-design and ongoing collaboration—and directly shape the Action Plan itself. The priorities outlined in this document were crafted as a direct response to these core findings, ensuring our strategy is grounded in what we heard from our community and those who work within it.

GUIDANCE FOR DECISION-MAKING

Provincial Direction

Description: These objectives constitute the foundation of Ontario’s statutory vision for primary care. Funding proposals will need to align with these objectives to maximize the likelihood of success. They are aligned with the provincial Primary Care Act³ and Primary Care Action Team direction.



PROVINCE-WIDE: Every insured person has the opportunity to have a documented ongoing relationship with a primary care clinician or interprofessional care team.



CONNECTED: Seamless patient journeys across all settings via consistent information flow and integrated planning.



CONVENIENT: Every resident has timely, convenient, and comprehensive access to a primary care team, fostering continuous and trusted relationships.



INCLUSIVE: Care designed in partnership with patients/families, respecting preferences, fostering shared decision-making.



EMPOWERED: Residents receive care from interdisciplinary teams working to their maximum scope, with family physicians leading coordinated care.



RESPONSIVE: Services are tailored to the specific needs of different communities, reducing health inequities and addressing social determinants of health.

Action Plan Design Principles

Description: These design principles, co-designed through our discussions with regional representatives, define how we will work to achieve the vision. These collaborative and operational strategies will inform the implementation approach and help guide decisions as the plan evolves over time.

- 1 PUTTING PEOPLE FIRST:**
Co-Designed with Providers, Patients, Families and Caregivers, and System Partners
We will design this new system with patients, families, caregivers, and health care providers, not just for them. Your voice matters.
We will work together with providers, patients, families, and system partners to plan, carry out, and review our work. By working as a team, we build trust and make sure our solutions reflect everyone's real experiences.
- 2 SMART AND FAIR:**
Strategic and Equitable Investments and Resourcing
We will invest resources where they are needed most to ensure everyone has fair access to care.
We will use our resources carefully and will focus funding, staff, and technology where they can help the most, especially in areas with the greatest need. We will build on what already works and make sure new efforts support, not replace, existing good practices.
- 3 QUICK WINS AND LASTING CHANGE:**
Balance Impact and Momentum Generation
We will focus on making a difference you can feel now, while also building a stronger health care system for the long term.
We will work toward big goals while also taking smaller steps that show quick results. This helps build trust, keeps everyone motivated, and shows we are making progress. We will solve tough problems and celebrate small wins to keep everyone engaged.
- 4 BUILT TO LAST AND READY TO ADAPT:**
Adaptable and Sustainable
We will create solutions that are sustainable and flexible enough to evolve as our community's needs change over time.
We will stay flexible and focus on actions that matter. We will learn from what works and what doesn't and adjust as needed. By sharing our results, we can grow successful ideas and make sure our efforts last, not just one-time fixes.
- 5 A SHARED RESPONSIBILITY:**
Accountable
We will foster accountability to our partners and the community, working together to achieve our shared goals.
We will clearly say who does what and how things are managed, so everyone knows what to expect. We will track and share our progress and learn from any challenges.
- 6 FOCUSED ON REAL-WORLD RESULTS:**
Data-Informed and Outcomes-Focused
We will use data and evidence to measure our progress and ensure our efforts are leading to better health for you and your family.
Our success will be measured by real impacts aligned with the quintuple aim (patient experience, provider experience, population health, value, and health equity). We will use facts and feedback to make choices. We will check if we are helping patients, providers, communities, saving money, and being fair. We will set clear goals and review often to see if we are making a real difference.

Vision of Success for Primary Health Care in the CCHOHT Geography

While we are guided by the provincial vision for primary care and our local design principles, these collective goals define the shared vision and aspiration for the CCHOHT geography in its primary care transformation efforts. Although this Action Plan alone will not be able to achieve these goals in full, it will help us advance closer to this future state we want to achieve.

We will prioritize our core goal as the foundation:



Goal 1:
Every person in our geography is connected to a primary care provider.

We will ensure everyone in the CCHOHT geography has a documented, ongoing relationship with a primary care provider by implementing a coordinated matching process that connects people on the Health Care Connect waitlist and those without a provider into the One Halton Health Home System.

While advancing toward a high-performing primary care system:



Goal 2:
Everyone across the CCHOHT geography has timely access to an interprofessional team of care providers.

We will improve access to interprofessional providers either within teams or via regional networks of resources, focusing on the most prevalent areas of need for our population.



Goal 3:
We work as an agile integrated system in which primary care providers are engaged, empowered, and supported.

We will create a primary care network that supports providers to work collaboratively to deliver high-quality, comprehensive care and enables agility to adapt to changing dynamics and population needs.



Goal 4:
Health inequities are measurably reduced across our communities.

We will work to actively address health inequities that exist in the delivery of primary care across our geographies. Our success will be defined by an improvement in health outcomes and equity across all our subregions.

OAKVILLE

Care as diverse as our community:

With over 150 ethnic and cultural origins represented, Oakville is a truly global community. We want to build an inclusive primary health care system where everyone feels they belong.



PRIMARY HEALTH CARE ACTION PLAN

This Action Plan will serve as a shared roadmap to align efforts to improve primary care over the coming years.

The Action Plan outlined below includes:

HOW WE WILL ACHIEVE THIS GOAL:

Describes the approach we will take to make progress toward our vision.

POTENTIAL INITIATIVES:

Describe some early wins and potential future initiatives that would advance us toward the goals. This includes:

- **Initiatives to be Advanced:** These are the initiatives identified throughout this process that can be advanced in the short-medium term (starting this year) without significant additional resources.
- **Other Priority Initiatives Requiring Additional Resources:** These initiatives have been identified as valuable to the CCHOHT geography and within scope for this Action Plan but require additional resources. Leaders will explore opportunities that emerge over the coming year(s) to advance these initiatives.

USING THE PLAN

This Action Plan will not be a static product – rather, it is intended to be a living resource that will evolve over time. The CCHOHT and Primary Care Network (PCN) will coordinate across all supporting partners in the region to advance this plan. It will leverage the Design Principles and Priorities to provide guidance in prioritizing new initiatives to advance toward our Vision for Success. The Action Plan will be reviewed on a regular basis to consider any potential adaptation needed to ensure it continues to serve us as a region. (See *Implementation Guidance for additional information*).

ALIGNMENT WITH ONGOING WORK:

Interprofessional Primary Care Team (IPCT) Funding Opportunity (2025-2026): The current IPCT efforts present a timely opportunity in alignment with this plan. Planning efforts for an initial round of submissions in Spring 2025 as well as feedback following that process have helped to shape the contents of this plan. Across all initiatives noted, an has also been added to **indicate initiatives that may be relevant for consideration for submissions to the next round of IPCT funding (at the time of this report the most recent round is due Nov 14th)**. Most initiatives in this group are contingent on additional resources; some may be advanced partially using current resources but could only be scaled through additional resources. This assessment is based on current guidance and assumptions about funding parameters relying on information shared at the time of plan development in early September 2025. It will need to be reviewed and revised as needed as additional information is shared by the province with the CCHOHT.

Goal #1: Every person in our geography is connected to a primary care provider.



We will work to provide everyone in the CCHOHT geography with a documented, ongoing relationship with a primary care provider, focusing on connecting people to a Patient Health Home that includes timely access to a team of interprofessional providers who can support a wider range of health needs.

CCHOHT Primary Care Access and Attachment Plan: CCHOHT's work to advance deliverables related to primary care access and attachment has also been coordinated with the planning efforts for this Action Plan. Relevant components of the Access and Attachment Plan (a deliverable for all OHTs to Ontario Health with a draft plan completed July 20th 2025) have been incorporated and ongoing alignment around this shared plan will be a top priority

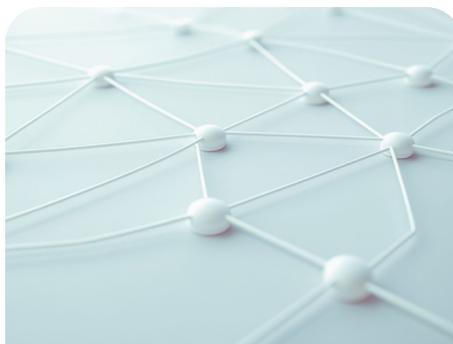
TO ACHIEVE THIS, WE WILL:

Identify Health Home Hubs as leads in the three sub-regions who will be accountable to:

- Ensure all rostered patients in a health home model have access to a primary care provider and allied health clinicians when needed.
- Engage and collaborate with other providers to understand needs, identify priorities and align resources and programming.

Establish and sustain collaborative agreements between Hub leads and other providers to:

- Clarify relationships, roles, and responsibilities to support alignment and accountability.



Leverage a cross-region governance model to:

- Enable sharing of best practices and solutions across leads;
- Support resource sharing and limit duplication;
- Invest in leadership capacity; and
- Support evaluation and quality improvement.



POTENTIAL INITIATIVES

Initiatives to be Advanced:

INITIATIVE	DESCRIPTION
Scope roster expansion capacity of providers in region	Engage current providers and facilitate broader peer-to-peer dialogue to understand interest and capacity for attachment.
Coordinate with health home satellites to connect patients to providers	Support matching patients by neighborhood and FSA proximity to the primary care practice with capacity closest to the patient's home.

Other Priority Initiatives Requiring Additional Funding Resources:

INITIATIVE	DESCRIPTION
Scale "Take 5" intake approach*	Expand attachment volumes through a focused campaign for family physicians to "take 5" new patients, supported by engagement and trust building with providers.
Spoke and satellite clinics*	Services that travel to under-resourced areas to provide equitable access to care (e.g. nurse practitioners, allied health professionals).
Expand allied health capacity*	Invest in shared allied health professionals (e.g., nurse practitioners, occupational therapists, physiotherapists, pharmacists, dietitians, social workers, palliative care, obstetricians, lactation supports, mental health) who can serve multiple "community hubs".

Goal #2: Everyone across the CCHOHT geography has timely access to an interprofessional team of care providers.



We will improve access to interprofessional providers either within teams or via regional networks of resources, focusing on the most prevalent areas of need for our population.

TO ACHIEVE THIS, WE WILL:

- Leverage tools that help providers connect their patients to the right people and resources across the system.
- Implement targeted solutions to improve timely access to high-demand services.

POTENTIAL INITIATIVES:

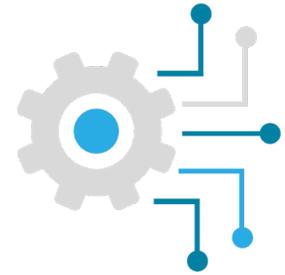
Initiatives to be Advanced:

INITIATIVE	DESCRIPTION
Scale accessible database of physicians (including specialties)	Coordinate across primary care providers and specialists to build out and provide access to an up-to-date database of physicians (e.g., by updating and scaling Doc Search or another similar tool).
Support uptake of e-Referral	Support uptake of e-Referral tool being advanced by regional hubs to streamline referral process.
Extend SCOPE to include obstetrics and gynecology (OBGYN)	Enable primary care providers to refer patients to OBGYN providers via SCOPE work led by Halton Healthcare.
Health home satellites as transitional support hubs	Utilize existing community health centres to provide clinical and psychosocial support for complex, un-rostered or marginalized unattached patients in interim before attachment.
Expand after-hours clinics (in-person and virtual)	Work with providers across region to leverage existing clinics for expanded access.

Other Priority Initiatives Requiring Additional Funding Resources:

INITIATIVE	DESCRIPTION
Extend Specialist Navigation thru SCOPE	Enable primary care providers to refer patients to specialists providers via SCOPE work led by Halton Healthcare (ie: Neurology)
Public education resources	Establish regularly updated resources outlining available services, information on how to access care, and more.

Goal #3: We work as an agile integrated system in which primary care providers are engaged, empowered, and supported.



We will create a primary care network that supports providers to work collaboratively to deliver high-quality, comprehensive care.

TO ACHIEVE THIS, WE WILL:

- Establish the structures, standards and processes to foster a collaborative and accountable environment.
- Coordinate and connect resources to support provider capacity and care quality.

POTENTIAL INITIATIVES:

Initiatives to be Advanced:

INITIATIVE	DESCRIPTION
Establish a Primary Care Network	With oversight from a leadership council inclusive of providers, patients and caregivers, and specialists, across subregions – to provide ongoing input to primary care transformation efforts.
Advance coordinated coverage plans	Explore solutions for more coordinated locum and after-hours care.
Create a provider resources repository and supporting education	Establish a shared resource for providers and learners with health home information including academic resources, teaching and research/quality improvement work, etc.
Establish a communications and engagement strategy	Develop a communications and interaction strategy ensuring all providers in the region will be appropriately engaged in ongoing change efforts and informed of relevant updates.

Other Priority Initiatives Requiring Additional Funding Resources:

INITIATIVE	DESCRIPTION
Health Pathways*	Leveraging what has been developed for Burlington OHT, provide CCHOHT geography providers with access to locally relevant, evidence-based guidelines and resources. *requires significant funding.

Goal #4: Health inequities are measurably reduced across our communities.



We will work to actively address health inequities that exist in the delivery of primary care across our geographies. Our success will be defined by an improvement in health outcomes and equity across all our subregions.

TO ACHIEVE THIS, WE WILL:

- Leverage data to better understand the needs of our population; and
- Work in partnership with community organizations to support outreach and culturally safe care

POTENTIAL INITIATIVES:

Initiatives to be Advanced:

INITIATIVE	DESCRIPTION
Community paramedicine for homebound patients	Deploy dedicated community paramedics across FSAs with highest unattachment rates to deliver in-home primary care, facilitate virtual visits, conduct assessments and coordinate access.
Strengthen connection with local cultural leaders and urban Indigenous representatives in the community.	Develop pathways and connect to primary care that is inclusive of Indigenous healing and other culturally-competent care best practices.
Analyze IPCT capacities for providing appropriate, accessible, culturally safe care for equity-deserving groups.	Create repository of the cultural competence, linguistic capabilities, or established community organization partnerships of IPCTs with capacity for attachment to support connection with appropriate segmented patient groups.

Other Priority Initiatives Requiring Additional Funding Resources:

INITIATIVE	DESCRIPTION
Mobile community / system navigators and access resources*	Establish roles focused on helping vulnerable residents, including newcomers, navigate and access the healthcare system and social supports.

IMPLEMENTATION GUIDANCE

The successful implementation of this Action Plan is as critical as its design. As a living document, it is intended to guide our collective efforts and adapt as we learn. Our Design Principles serve as the foundational values for how we will work together, and they directly inform our approach to implementation. To bring these principles to life, we must focus on four key areas: clear governance and management of the plan, strong communications, ongoing change management, and a rigorous approach to measurement and evaluation.



Plan Governance and Management

Establishing clear governance is the essential backbone for ensuring the Action Plan remains on track, adaptable, and accountable. Our Plan will be managed by the Connected Care Halton OHT and its Primary Care Network and overseen by a Pan Halton Health Homes Steering Committee, and will focus on:

FORMALIZING ROLES AND ACCOUNTABILITIES: The Primary Care Network (supported by the CCHOHT) will be the main body responsible for advancing the strategic direction of the Plan, including the process of ongoing monitoring and adaptation as required, reviewing progress against key milestones and working to remove barriers. A Pan Halton Health Homes Steering Committee is being established with leaders from across various regional partners to oversee the plan, including its ongoing review and refresh. Specific leads will be assigned for each initiative – those leads will be responsible for the tangible implementation of initiatives and ongoing coordination with the Primary Care Networks between the BOHT and the CCHOHT to ensure transparency and alignment with the Plan.

ESTABLISHING A PREDICTABLE PLAN REVIEW AND REFRESH CYCLE: The Action Plan will be formally reviewed and refreshed on an annual basis. This process will be led by the Primary Care Network and will be overseen and supported by the Steering Committee. The review will include a comprehensive analysis of progress against key performance indicators (KPIs), a scan of the external environment, and the identification of new, high-impact initiatives based on learnings from the previous year.

ADOPTING AN AGILE “TEST AND LEARN” APPROACH: We will pilot initiatives in small, manageable phases before scaling. We will establish clear feedback loops and a process for rapid course correction, ensuring that we learn from what works and what doesn’t before committing to a full-scale rollout.



Communications and Interaction Strategy

A robust and transparent communication strategy is vital for maintaining momentum and engagement by bridging the gap between leaders and the broader community of providers, patients, and partners. We will execute this through a deliberate, multi-channel approach that prioritizes consistency, clarity, and two-way dialogue, which includes:

A MULTI-CHANNEL COMMUNICATION CADENCE IMPLEMENTED THROUGH THE CCHOHT AND THE PCN: A clear and predictable communication schedule will be established and maintained:

Quarterly Town Halls: A virtual town hall will be held quarterly to provide a strategic overview of the plan's progress, discuss challenges, and allow for live Q&A.

Quarterly Newsletter: A concise email newsletter will be sent in alignment with the Town Hall to provide quick updates on progress, celebrate wins, and highlight key resources.

Timely Updates/Notices (As-Needed): Additional communications will be sent to ensure timely updates and awareness of relevant activities, resources, etc., between quarterly cycles.

TAILORING MESSAGING AND CHANNELS: We will develop distinct communication plans for each key audience, customizing messaging to highlight the specific benefits and impacts relevant to each group (e.g., focusing on reduced administrative burden for providers, and improved access for patient groups).

FACILITATING PEER-TO-PEER ENGAGEMENT: We will create and support structured opportunities for providers to connect and share knowledge. This may include in-person networking events, topic-specific working groups, or dedicated forums for best practice sharing.



Photo provided by Conservation Halton



Change Management

Implementing lasting change is a strategic process that focuses on building understanding and commitment from every person involved. Rather than simply rolling out new initiatives, we will proactively navigate the human side of the transition to ensure buy-in, adoption, and long-term sustainability. This will be accomplished by:

PROACTIVELY MANAGING ISSUES: We recognize that change will bring about disruption and concerns will emerge through the transition process. We will do our best to proactively identify potential issues that may emerge—such as clinical workflow disruption or concerns about administrative burden—through ongoing dialogue and feedback loops and mitigate these as much as possible. By addressing these concerns directly and transparently, we can turn potential barriers into opportunities for co-design and create a more resilient plan.

BUILDING CAPACITY TO SUSTAIN CHANGE: We will focus on building the skills and confidence necessary for providers and partners to not just adopt new practices but to sustain them over time. This includes targeted, practical support for each initiative, such as hands-on training for new technologies or mentorship programs for providers transitioning to new team-based models. This ensures that new practices become integrated into daily operations rather than being temporary add-ons.

ESTABLISHING A COALITION OF CHAMPIONS: We will identify interested primary care leaders from across the CCHOHT geography to be equipped with the necessary knowledge and tools to act as key advocates for the plan. We will provide dedicated support and protected time for them to facilitate peer-to-peer engagement, address concerns, and champion the vision for change within their local networks.



Measurement and Impact Assessment

Success will be measured not just by the completion of initiatives but by their tangible impact on the system and the people it serves. This rigorous, data-driven approach is essential for proving the plan's value, securing continued investment, and course-correcting along the way. Our approach will include:

DEFINING KEY PERFORMANCE INDICATORS (KPIs): For each priority and initiative, we will establish clear, measurable, and achievable KPIs (both qualitative and quantitative). These will be aligned with the Quintuple Aim (patient experience, provider experience, population health, value, and health equity).

DATA COLLECTION, REPORTING AND EVALUATION: The CCHOHT will work with partners (in particular, those leading initiatives across the plan) to establish a consistent process for collecting and analyzing relevant data. A dashboard will be developed to track progress against KPIs and will be reviewed at the designated governance meetings. This will be updated on an ongoing basis and will serve as the primary tool to inform decision-making, resource allocation, and strategic adjustments based on data, including via the plan PDSA cycle.

APPENDIX: PLANNING CONTEXT

Social Determinants of Health

Social Determinants of Health (SDOH)

Determinant	Oakville	Milton	Halton Hills
Income Inequality	Higher	Moderate	Moderate
Housing Stability	Higher	Lower	Variable (rural gaps)
Language Barriers	Moderate	Significant (newcomers)	Low
Transportation	Well-developed	Limited in new suburbs	Sparse in rural areas
Mental Health Access	Better resourced	Limited	Underserved

Demographic & SDOH Data Source: Ontario Health/Stats Canada/Registered Persons Database (RPDB). Sub-regional population growth forecasting provided by Preyra Solutions Group (Commissioned by Halton Healthcare).

Regional Disease Burden Overview

Chronic Disease Rate Comparison

Chronic Disease	Oakville	Milton	Halton Hills
COPD	Lower than Ontario avg.	Highest in CCHOHT	Similar to Milton (high)
Heart Failure	Moderate	Highest in CCHOHT	Similar to Milton (high)
Diabetes	Lower than Ontario avg.	Moderate	Moderate

Cancer Screening Results

Cancer Screening Results	Provincial	Oakville	Milton	Halton Hills
Mammogram	60.8%	64.3%	59.7%	58.6%
Cervical	52.4%	58.4%	57.8%	52.9%
Colorectal	64.2%	73.7%	62.0%	62.7%

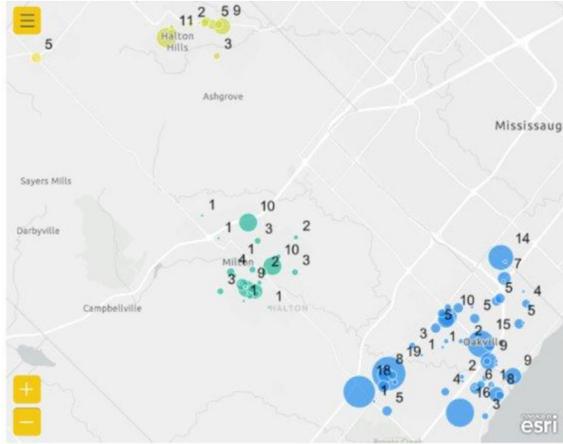
Further analysis shows discrepancies in rates by FSA

FSA	FSA Name	Up-to-date with a Mammogram	Up-to-date with Pap Tests	Up-to-date with Colorectal screening
L7J	Acton	51.7%	49.2%	56.9%
L7G	Georgetown	63.7%	54.0%	64.7%
L0P	Halton Boundary North	60.3%	55.4%	66.6%
L9T	Milton	62.2%	58.0%	63.1%
L9E	Milton (South)	57.2%	57.6%	60.9%
L6K	Oakville East	61.2%	56.7%	70.2%
L6H	Oakville North	63.9%	58.6%	72.8%
L6I	Oakville Northeast	68.6%	60.5%	79.1%
L6L	Oakville South	64.3%	58.0%	74.7%
L6M	Oakville West	63.5%	58.2%	71.6%

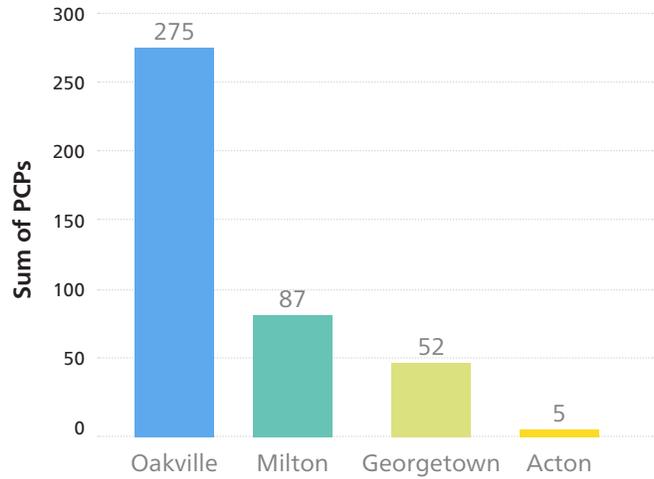
Data Source: Ontario Health e-Reporting Tool, extracted July 2025

Provider Distribution

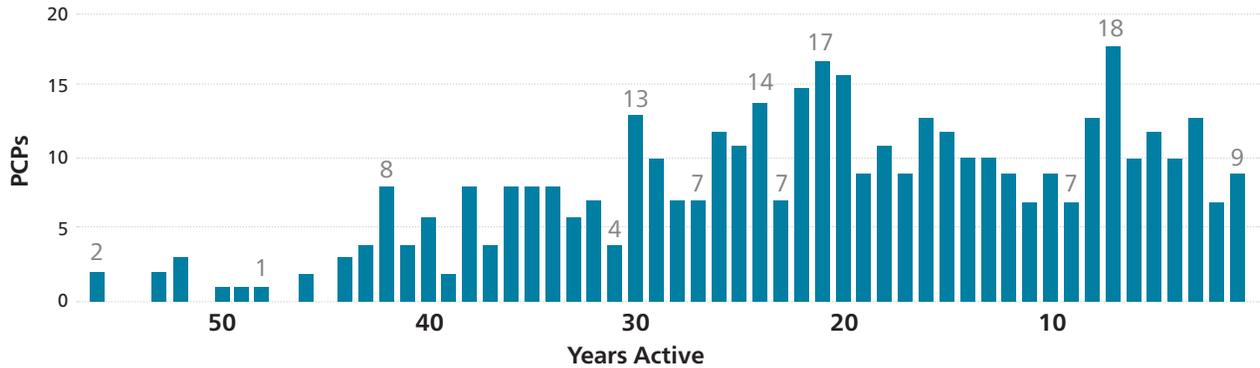
Unique Provider Count by Postal Code and City Name of Practice Location



Unique Provider Count by Postal Code & City Name of Practice Location (IQVIA OneKey Data, July 2025)



CCHOHT PCPs by Number of Years in Practice



CCHOHT PCPs

419

Average Annual Number of New PCPs

10

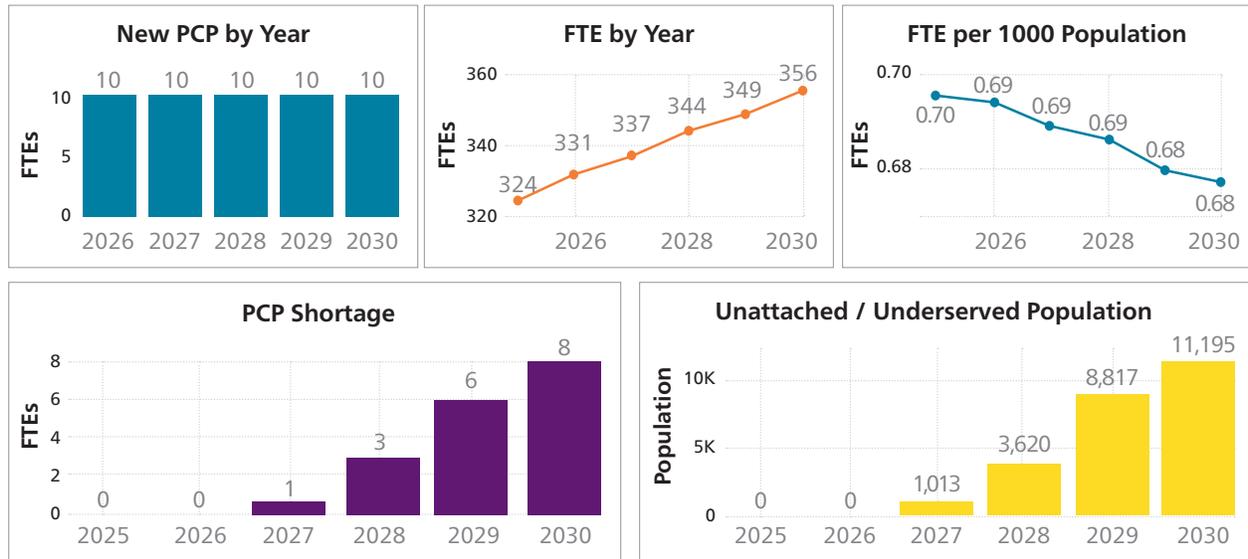
Average of past 3 years

Last updated: May 2, 2025. IQVIA OneKey Data.

Capacity Forecasting

Provider counts reflect different underlying assumptions (e.g., activity-based vs. registration-based), and should be interpreted directionally, not as absolutes.

Assuming PCP recruitment and retention remains the same, and estimating an average panel size of 1400, the model provides the following outlook:



Last updated: May 2, 2025

Notes on Data Inputs:

Population forecasting utilized Preyra Solutions Group (PSG) growth projections, providing more specific population growth forecasting based on the specific catchment area (in alignment with data specificity used for Halton Healthcare’s Clinical Services Planning).

Supply estimates were refined in response to local feedback and stakeholder review.

Note on Model Assumptions:

This scenario assumes a career peak panel size of ~1400 based on research suggesting that average panel sizes for physicians in Canada fall between ~1200-1800. It is recognized that this is not representative of all providers and is intended only to help conceptualize the overall provider supply against the region’s demand.

PRIMARY HEALTH CARE ACTION PLAN REPORT

October 2025



Connected Care Halton
ONTARIO HEALTH TEAM
HALTON HILLS • MILTON • OAKVILLE



**Halton
Healthcare**