INTEGRATED CARE ACTION SUMMIT

What We Heard About Strengthening Integrated Care Across Ontario

2025 Integrated Care Action Summit

DAVIS PIER

Report Prepared by Davis Pier Consulting


IN A GENTLE WAY
YOU CAN SHAKE
THE WORLD
MAHATMA GANDHI


THE WESTIN
TORONTO AIRPORT

Table of Contents

A Note from the Planning Committee

Dear colleagues and partners,

In late summer 2025, an opportunity emerged to bring together the Ontario Health Teams (OHTs), Primary Care Networks (PCNs), Patient and Family Advisory Councils (PFACs), and their partners for the first time. In collaboration with Davis Pier Consulting, a Planning Committee came together to define objectives, develop programming, and plan logistics.

This collective effort led to the inaugural Integrated Care Action Summit in November 2025, a gathering of more than 300 leaders and partners across OHTs. We were particularly pleased to have colleagues from the Ministry of Health and Ontario Health join us, creating an opportunity to discuss key priorities and engage in shared planning and problem-solving.

The Summit was intended to create space for shared learnings, strengthen relationships, and build shared momentum toward a more coordinated, person-centred health system that advances both provincial and local priorities. From the beginning, we saw that there was a strong appetite for our partners to gather – an enthusiasm that we shared and that reinforced the value of this event. From speaker proposals and sponsorship support to registration demand beyond venue capacity, we are grateful for the support and interest.

As a Planning Committee, we sincerely thank everyone who dedicated their time, attention, and trust to this ambitious effort. A special thank you to all speakers and session presenters for the thoughtfulness you brought to the Summit.

We are inspired by the conversations throughout the Summit and to hear that many of the connections made have continued to flourish, leading to new initiatives. Above all, we were encouraged to hear a shared commitment to building a more connected and mutually supportive system that builds upon each other's successes and meaningfully supports the communities we serve.

This "What We Heard" report captures key themes and reflections from Summit sessions and the informal conversations in-between. While it is not a comprehensive record of everything shared, it's meant to be a reference for us to revisit our shared commitments, stay connected to what we learned together, and carry forward the momentum built over those two days.

Thank you again for the openness, candour, and commitment you brought to the Summit; and for the work you do every day to improve health outcomes in your communities. This Summit was one step on a shared journey to amplify our collective impact across Ontario. It reaffirms that we are not alone – and that together, we can go far.

With appreciation,

The Integrated Care Action Summit
Planning Committee

INTEGRATED CARE
ACTION SUMMIT

A Reflection on Language

Integrated care is a widely used term used in health system transformation and was central to the framing of the Action Summit. In this report, the term reflects the provincial vision of OHTs as regional facilitators of coordinated care, as set out in the Connected Care Act.

Here, "integrated care" aligns with common usage in international literature, where it refers to organizing and coordinating services across providers and settings to ensure that people experience seamless, person-centred support across the continuum of care.

Canada's colonial history and the ongoing harms of colonial policies and institutions continue to affect Indigenous Peoples. During the Summit, participants noted that the term "integrated" can carry colonial associations with assimilation; alternatives such as connected care, harmonized networks, or inclusive collaboration were suggested to better reflect the intent, honouring Indigenous histories and the impacts of colonial harm.

While the term "integrated care" is used throughout this report for consistency with provincial language, we recognize the importance of language. OHTs will continue to reflect on how they communicate their role and their approach to system building. This includes ongoing engagement and learning, facilitating co-design with Indigenous community members, and ensuring Indigenous voices, perspectives, and priorities are represented in OHT work.

About the Integrated Care Action Summit

The Integrated Care Action Summit (November 24 – 25, 2025) was initiated by members of the Ontario Health Team (OHT) Community of Practice – representing leads from 58 OHTs across the province – in response to a shared desire to connect in person and collaborate more meaningfully.

More than 300 participants (including OHTs, Primary Care Networks [PCNs], Patient and Family Advisory Council [PFAC] members, government, as well as partners across primary care, acute care, home care, community support services, patients, caregivers, and private sector collaborators) came together to explore a guiding question: **"How will we continue to strengthen integrated care in Ontario – together?"**

The gathering was designed to emphasize collective action and to drive practical next steps and shared commitments. It aimed to advance provincial priorities and accelerate integrated care across Ontario. Over two days, speakers and participants exchanged local successes and challenges, strengthened relationships, aligned around priorities, and workshopped ways to accelerate progress toward a more connected and person-centred health system.

Programming included concurrent panels, presentations, and workshops – selected through an open call for proposals and largely led by OHT and PCN representatives – alongside main-stage keynote and panel discussions featuring health system leaders across Ontario. Throughout, the Summit prioritized OHT, PCN, and PFAC voices, lived experiences, and innovations to support knowledge sharing and meaningful collaboration.

Programming and discussions were organized around four guiding themes:

- **Planning with People**: Putting people at the centre of care
- **Stronger Together**: Collaboration and partnership across health and social care
- **Powering Care**: People, teams, and digital innovation
- **From Insight to Impact**: Using data, evaluation, and shared learning to turn ideas into measurable change

Session topics ranged from primary care access and attachment; performance measurement; digital health planning; home care integration; integrated pathways and chronic disease and prevention management; and population health, equity, and social impact.

This ***What We Heard*** report aims to capture standout themes, lessons, and insights from the Summit serving as inspiration and fuel to continue the work ahead. It is not intended to be a comprehensive playback of the Summit.

Three questions guided the Summit:

1

How will we continue to strengthen integrated care in Ontario – together?

2

What more is possible in Ontario when we work as an integrated health system?

3

How will we make what is possible a reality? **What** is needed?

Summit Agenda

8:00 – 9:00 Registration and Breakfast

9:00 – 10:30 Dr. Jane Philpott | Keynote

Primary Care Action Plan Updates and the Important Role of Ontario Health Teams

Sutton Hall (Main Stage)

10:30 – 10:45 Break

10:45 – 12:00 Concurrent Sessions

Evolution of E-nangaabe-jig Health Services: A Journey of Collaboration and Trust	Essential Building Blocks for Rural Primary Care Network Development in Ontario	Health Neighbourhoods: Applying a Collaborative Health Neighbourhood Approach to Facilitate Access and Attachment to Primary Care	Improving Care and Increasing Attachment through Digital and Data Solutions	Integrating Housing, Health, and Social Services: Collaborative Models for Supporting Aging Adults	Community Health Integrated Care (CHIC): Embedding CP in Mental Health & Addictions Care in Sarnia-Lambton
Sutton Hall (Main Stage)	Carlyle	Balmoral	Windsor	Bristol A	Bristol B
Panel and Discussion	Panel and Discussion	Workshop	Lighting Talks and Discussion	Lighting Talks and Discussion	Panel and Discussion

See Summit App for speakers and additional session details

12:00 – 1:00 Lunch

1:00 – 3:00 Concurrent Sessions

Learning from Home Care Leading Projects: Recommendations for Advancing the Integration of Home Care and Primary Care	Digital Tools for Integrated Care	Integrated Care Pathways for Chronic Conditions and Frailty	Building Resilient Integrated Systems that Focus on Population Health, Equity, and Social Impact	Accelerating Performance Management within Ontario Health Teams	Success Stories: Health System Transformation Through Authentic Co-Design with Primary Care
Carlyle	Balmoral	Bristol A	Windsor	Bristol B	Sutton Hall (Main Stage)
Workshop	Lighting Talks and Discussion	Lightning Talk and Workshop	Lighting Talks and Discussion	Workshop	Interactive Panel

See Summit App for speakers and additional session details

3:00 – 3:15 Break

3:15 – 4:15 Panel

Advancing Health Equity Through Integrated Care

Sutton Hall (Main Stage)

4:15 – 4:30 Closing Remarks

Sutton Hall (Main Stage)

7:45 - 8:30 Registration and Breakfast

8:30 – 10:30 Jodeme Goldhar | Workshop

Accelerating Integrated Care: Harnessing Our Collective Potential

Sutton Hall (Main Stage)

10:30 – 10:45 Break

10:45 – 12:00 Concurrent Workshops

Our Untapped Leadership Potential: Connection as the Correction, Collective Action as the Path	PCN Clinical Leads Workshop: Strengthening Our Ecosystem (PCN Clinical Leads Only)	OHTs in Focus: Defining Value and Aligning Priorities (OHT Leads Only)
Sutton Hall (Main Stage)	Carlyle & Balmoral	Bristol A & B
		Runs 10:45AM - 1:00PM (includes working lunch)

12:00 – 1:00 Lunch

1:00 – 2:00 Panel

Leadership in Action: Hospital Partnerships Strengthening Integrated Care

Sutton Hall (Main Stage)

2:00 – 2:15 Break

2:15 – 3:00 ***Guided Discussion and Reflection on Collective Impact and Commitments***

Sutton Hall (Main Stage)

3:00 – 4:00 ***Summit Reflections and Shared Learnings***

Sutton Hall (Main Stage)

Ontario Health Teams

Ontario Health Teams were established through Ontario's Connecting Care Act (2019). At maturity, OHTs are intended to be a fully integrated delivery system that enables the delivery of local health and social care centred around patients, families and caregivers. There are 58 OHTs across the province, each bringing together local health care providers and organizations and shaped by the needs and strengths of their community.

OHTs aim to bring providers across the continuum together as one team, working to deliver more coordinated care for the people they serve. OHTs also bring partners across the continuum – such as primary care, hospitals, home and community care, mental health and addictions services, and community supports – together to improve access and attachment, strengthen transitions, and improve outcomes and experiences for the people and communities they serve.

Currently, the 58 OHTs are at various stages of development, offering an opportunity for ongoing learning and knowledge sharing.

SECTION ONE

Why strengthen integrated care in Ontario?

Across Ontario – and in many parts of Canada – the health system is at a critical moment. A 2025 survey conducted on behalf of the Ontario Medical Association (OMA) found that most Ontarians believe the health care crisis is worse than it was a year ago, alongside rising concern about wait times and access across the system.

In conversations throughout the Summit, we heard participants point to a set of challenges that are increasingly interconnected: persistent workforce shortages, long waits, care that often feels reactive rather than preventative, and a system that can be difficult to navigate – especially for individuals with complex needs or those who rely on multiple services.

Access and attachment are essential, but not enough on their own

The Summit started with a keynote address by Dr. Jane Philpott, Chair, Primary Care Action Team, who emphasized the urgency of primary care access and attachment. The Ontario Primary Care Action Plan, which sets the goal of connecting every person in Ontario to primary care by 2029, was referenced as a bold commitment from the government to making this a reality.

The keynote address reinforced the scale of work that is underway to achieve this goal. In response to the over 2.2M Ontarians currently lacking a regular primary care provider, recent provincial investments rely on the important work of OHTs and PCNs to be successful. These efforts include funding to support over 130 new and expanded primary care teams that will connect 300,000 people to primary care, as well as a call for proposals for approximately 75 more teams to attach an additional 500,000 people. Celebrating the hard work that many across Ontario are undertaking to expand primary care teams, Dr. Philpott urged OHTs and PCNs to continue this important work.

That said, we were also reminded that "name only" attachment is not enough. In other words, attachment needs to translate into timely access and continuity. This needs to be supported by pathways that connect to all parts of the system – primary care to hospitals, specialists, home and community care, mental health and addictions services, community supports, and more.

Integrated care helps us work differently, together

We heard that the system cannot hire or fund its way out of today's pressures. Further, as patient complexity increases, there is recognition that no single provider can serve the comprehensive needs of patients. Instead, we heard a similar message across speakers: to successfully increase system capacity, our solutions must also involve reorganizing care to work better together – whether within teams through team-based models, or, across organizations through clearer coordination and shared ways of working.

We heard integrated care described as the practical route to making that happen: finding efficiencies through provider-to-provider collaboration, improving navigation towards a "no wrong door" approach, and streamlining referrals to ensure people do not fall through gaps between services. In this framing, integrated care is not just a concept – it is an operating model that makes limited capacity go further by improving how the system functions as a whole.

Why OHTs and partners are essential to the "local" reality of integration

When it comes to operationalizing integrated care across the province, we heard that connected care looks different depending on community context. Population needs, geography, available services, and trusting relationships between partners all determine how system partners collaborate with one another.

Successful integrated care needs a regional coordinating structure to bring partners together around shared purpose, ways of working, and collective impact. Since OHTs were created to support locally organized and connected health services, throughout the Summit, they were often described as a key vehicle for strengthening integrated care. OHT membership consists of the system partners who are positioned close to communities, and best positioned to design integrated pathways and creative solutions that truly reflect local needs and realities.

Whether partnering alongside PCNs to advance the Primary Care Action Plan or bringing hospitals, home and community care, and primary care together, OHTs help partners see their role within a larger system.

Across the two days, many examples of integrated care in action were shared. Examples include the following:

- Coordinated hospital to home pathways,
- Neighbourhood or community hubs offering multiple services coordinated across different partners
- Integrated home and primary care models
- Central referral and intake approaches, and many others.

These stories reinforced a shared belief that integration is built through trust, relationships, and practical mechanisms for joint planning and delivery – and that OHTs play a unique role in enabling that work.

Why strengthen integrated care in Ontario?

Returning to the core question, we heard two messages emphasized: the system cannot hire or spend its way out of today's challenges, and progress depends on working differently together.

Integrated care creates the coordination and efficiency needed to deliver seamless support, preventing patients from falling through the cracks. It is most effective when built locally through OHT-led collaboration and grounded in trusting relationships.

> **We heard two messages emphasized: the system cannot hire or spend its way out of today's challenges, and progress depends on working differently together.**


Workforce Capacity and
Capability

SECTION TWO

What more is possible in Ontario when we work as an integrated health system?

One of the guiding questions we explored throughout the Summit was: ***What more is possible in Ontario when we work as an integrated health system?*** Organized around the Summit's four themes, this section highlights examples of integrated care that were shared throughout the Summit and their impact.

Theme One: **Planning with People**–Putting people at the centre of integrated care

A clear message across Summit discussions was that integrated care is most meaningful when it results in tangible improvements in the lives of patients, families, and caregivers – not simply new structures, strategies, or plans. In this theme, speakers often returned to the idea that OHTs – as integrated care systems – are accountable for population health outcomes. In Jodeme Goldhar's workshop, we heard that the most mature expression of integrated care focuses on population-based outcomes rather than condition-based priorities, emphasizing the importance of system design around the needs of communities.

In the keynote, Dr. Jane Philpott called for a shift to "stop building for systems" and instead "build for people". The ***Advancing Health Equity Through Integrated Care*** panel reinforced that improving access must be grounded in equity. Across examples shared, the starting point is the same: understand who lives in a community, the barriers they face, and the supports that will make the greatest difference.

What might be possible when we plan with people?

We heard that planning with people shifts the health system from a reactive to a preventive system. Not only will it ensure that patients and caregivers experience clear entry points and pathways that help them find the right care, at the right time, from the right provider; but it also allows us to use population-level insights to invest in preventive measures that address conditions most prevalent locally.

This kind of system design shifts care upstream, ensuring that concerns get identified earlier, supports are available before needs escalate, and fewer patients reach a crisis point that could have been prevented with timely, coordinated care.

When the system is designed to prioritize the people it serves, the resulting benefits also lead to a more efficient system. Fewer patients reach the point of needing an emergency visit or taking up an ALC bed, transitions across settings are smoother, and patients are less likely to fall through the cracks or shoulder the burden of coordinating information across providers. Providers spend less time working around disconnected processes and spend more time delivering care, and equity moves from principle to practice as services are designed for everyone in a community, including those who have historically been missed or overlooked.

In short, better experiences and outcomes go hand in hand with reduced duplication and avoidable high-cost use – strengthening trust while making the system work better overall.

What "Planning with People" looks like in practice

While planning with people may seem straightforward in principle, its effectiveness depends on whether the approach is genuinely person-centred. This means starting from humility rather than assumptions, looking beyond one-dimensional definitions of need, and designing with communities in ways that reflect the diversity of Ontario's populations. The goal is for integrated care to improve outcomes for everyone, not only those who are easiest to reach.

A few examples of how presentations demonstrated the "Planning with People" theme:

- In ***Success Stories: Health System Transformation Through Authentic Co-Design with Primary Care***, Great River OHT co-designed programs that fit community and workforce needs based on primary care input, including patient self-management education and dedicated support roles that work alongside primary care teams.
- In ***Essential Building Blocks for Non-Urban Primary Care Network Development*** session, we looked at approaches taken to understand physician needs through formal and informal engagement efforts, including short surveys, roadshows, and individual reach-outs.

CASE STUDY

East Toronto Health Partners

The **Health Neighbourhood** is a model that organizes health and social supports around a shared geography to provide patients and caregivers with appropriate and timely care across the health continuum. The East Toronto Health Partners (ETHP) is developing this model across 21 neighbourhoods to serve 350,000–400,000 residents, with priority given to five equity-deserving neighbourhoods where access and equity challenges have been longstanding.

ETHP's model focuses on "Health Access" hubs that co-locate two or more primary care and community partners, providing "no wrong door" entry points to the system. This is enabled by mechanisms such as a shared Electronic Medical Record System (EMR), integrated governance and funding models, coordinated pathways to specialty care, and Holistic Intake Navigators who connect patients and caregivers to community supports.

Theme Two: **Stronger Together**–Building resilient systems through collaboration and partnership

A consistent message was that connected care is not possible without collaboration. Speakers emphasized that the work moves fastest when it is relationship-based and grounded in trust between partners. Many returned to a shared sentiment that integration moves at the speed of trust – built through consistent engagement, transparency, and shared decision-making.

When these conditions are in place, collaboration helps teams leverage one another's strengths, reduce burden and duplication, improve efficiency, and better support patients with the right care at the right time.

"Stronger Together" showed up in two ways: within OHTs and between OHTs:

- Within OHTs, we noted that collaboration is strongest when no single organization or provider is positioned as "the anchor" and all partners are treated as essential; meaningful integration relies on shared vision, shared accountability, and demonstrated commitment across all partners. One practical example shared on the Hospital CEO Panel was aligning board-level priorities with OHT priorities through strategic planning.

- Between OHTs, we highlighted collaboration that helps spread what works – sharing tools, scaling proven approaches, and in some cases, pooling resources to design and deliver programs together.

What might be possible when we work together?

When collaboration is working well, it changes what the day-to-day feels like for providers, patients, and caregivers. Clinicians who are used to solving problems within the four walls of their own practice gain a wider network to lean on for advice, mentorship, and shared clinical learning. We heard that this support can be especially important in rural and remote settings, where professional isolation is common and access to specialty input can be limited.

As partners align around shared goals and build consistent routines, teams coordinate more smoothly across organizations, share resources, and bring complementary strengths and knowledge to the table – expanding local service options and strengthening team-based care.

Over time, these connections also create practical system capacity. More integrated processes – such as e-referrals, clearer pathways, and more consistent information sharing – help reduce delays and ensure people aren't left behind. Partnerships across disciplines can also improve communication and awareness of available programs, making it easier for patients to access timely and appropriate health and social services.

Collaboration across practices and OHTs supports approaches that are better tailored to local needs and helps proven interventions spread faster, without requiring every community to reinvent the wheel. The result is a stronger, more resilient system that enables every team member to contribute at their highest level.

> **Many returned to a shared sentiment that integration moves at the speed of trust – built through consistent engagement, transparency, and shared decision-making.**

What "Stronger Together" looks like in practice

Across sessions, presenters shared examples of collaboration that becomes stronger over time and delivers more integrated care:

- In ***Building Resilient Integrated Systems that Focus on Population Health, Equity, and Social Impact***, we looked at traits of resilient partnerships, including humility, time invested upfront, and governance aligned around shared purpose.
- In ***Frailty Pathways – An Integrated Model for Older Adult Care*** highlighted how Central East Region OHTs formed a Seniors Care Network to bring together geriatric services across the region and support older adults with complex needs through a cross-sector frailty pathway.
- In ***Success Stories: Health System Transformation Through Authentic Co-Design with Primary Care***, we learned more about shared partnership structures (including PCNs) and co-designing initiatives that aim to move beyond consultation toward shared ownership.

CASE STUDY

E-nangaabe-jig Health Service & Sarnia-Lambton Ontario Health Team

E-nangaabe-jig Health Services is an Indigenous-led approach to health and wellness in Sarnia–Lambton that brings traditional healing and clinical care together, with Indigenous voices setting priorities and shaping design. Working in partnership with the Sarnia-Lambton OHT, E-nangaabe-jig co-designs planning, decision-making, and care delivery across the region. Indigenous leadership is embedded directly into governance through the Indigenous Communities Advisory Council (ICAC).

Voting members include Health Centre leads from Kettle & Stony Point First Nation, Aamjiwnaang First Nation, and Bkejwanong Territory, alongside the Sarnia-Lambton Native Friendship Centre and Bluewater Health's Indigenous Navigator Manager.

Each First Nation and the Friendship Centre holds its own seat, ensuring shared leadership and allowing distinct governance structures and community needs to shape direction. Trust is reinforced through clear, shared processes, including voting on key decisions, transparent sign-off on funding and reporting, and OCAP®-aligned data governance that ensures each Nation retains control over its own community information. This foundation supports coordinated action, guided by a 2025 needs assessment shaped by input from 167 community members.

In practice, the approach focuses on bringing services into community to reduce travel barriers, strengthening Indigenous navigation and outreach, offering Traditional Healer and Cultural Practitioner days, and delivering culturally grounded mental wellness programming (Mino Bimaadiziwin).

Together, these efforts show how collaboration grounded in trust and shared leadership enables partners to work stronger together

Theme Three: **Powering Care**–People, teams, and digital innovation

Integrated care cannot be sustained through strategy alone. To work day-to-day, it needs strong enabling conditions, such as the people, tools, workflows, and existing supports that help teams coordinate care across organizations.

Speakers emphasized that, just as care must be designed around the needs of populations, it must also be designed for the people delivering it. Across sessions, we heard that teams are committed to the work, but they need better supports to do it together.

The need to invest in the "how" was emphasized. We heard this includes change management, shared ways of working, and developing digital foundations that keep pace with evolving privacy, security, and coordination needs. In particular, we were reminded that while technology can reduce burden and improve coordination, it does not replace relationships.

> **Just as care must be designed around the needs of populations, it must also be designed for the people delivering it.**

Digital tools, after all, still rely on trust, clear agreements, and consistent human connection to be successful. Powering care also means investing in people. Several sessions highlighted the importance of supporting primary care teams and strengthening Primary Care Networks (PCNs) to build a positive culture, deepen engagement, and enable collaboration. When teams are set up to succeed, the upside can be significant – reduced administrative burden, stronger morale and connection, improved retention, and more efficient, coordinated care is made possible.

What might be possible when we power care?

When OHTs "power care," the focus shifts from simply having the right strategy to building the enabling conditions that make coordination possible every day. This includes elevating diverse leadership and empowering all professions to use the tools available to work to their full scope.

This means designing workflows, tools, and supports that fit how teams actually work, and creating shared ways of working across organizations so care feels connected rather than fragmented. For example, digital tools and data-sharing can reduce duplication and improve visibility across providers, but only when they are backed by clear agreements and strong change management so adoption is supported and sustained.

Done well, this moves the system from isolated efforts within individual teams to partnerships across teams, disciplines, and geographies. The potential upside is significant: less administrative burden, stronger provider wellness, improved retention, and teams that are better equipped to deliver efficient, coordinated care together.

What "Powering Care" looks like in practice

Presentations offered examples of how teams are strengthening the conditions that make integrated care easier to deliver:

- In ***Accelerating Integrated Care: Harnessing Our Collective Potential***, we reinforced that integration depends not only on structures, but on how people show up, work across boundaries, and lead together.
- In ***From Toolkit to Partnership – Building Data Trust***, we learned about different approaches for establishing information-sharing foundations across partner organizations, including readiness assessments and supports to enable responsible data sharing.
- In ***Moving Beyond Pilot Projects to Build an Integrated Healthcare System***, South Georgian Bay OHT shared efforts to move beyond pilots by building shared digital infrastructure (e.g., a community EMR and e-referrals) to strengthen coordination and access locally.
- In ***Success Stories: Health System Transformation Through Authentic Co-Design with Primary Care***, we looked at how co-design and strong Primary Care Networks can enable clearer representation, better adoption, and more coordinated delivery across the system.

CASE STUDY

Scarborough Ontario Health Team

Scarborough's Integrated Palliative Care Teams use a centralized intake process to coordinate palliative care across the region. A single phone number, fax line, and common referral form provide access to all palliative care services, reducing the need for patients, families, and referrers to navigate multiple programs or repeat the same information. This integrated model is further supported by one shared EMR and a single pooled group of providers, enabling coordinated care delivery and shared clinical information.

Referrals are managed through a software called Epic that acts as one comprehensive record across hospitals and community partners. To make this work in practice, Scarborough Health Network and Scarborough Centre for Healthy Communities align their workflows within Epic, operating as one department with a shared schedule and record. Key information is standardized and easy to find: advance care planning is embedded directly in the chart, and a shared "Care Coordination" note summarizes essential details such as who is following the patient, key diagnoses, core team members, and active supports. This reduces repeat storytelling and missed handoffs.

The shared record is reinforced with paperless e-Prescribing, secure messaging, and mobile Epic tools, allowing clinicians to review, document, and coordinate care wherever it happens.

Together, these people-centred workflows and digital supports demonstrate how investing in the practical "how" of care – tools, shared ways of working, and team alignment — can power more coordinated care across teams.

Theme Four: **From Insight to Impact**–Turning data, ideas, and collaboration into measurable change

This theme focused on how OHT and community-level data, evaluation, and shared approaches to measurement can support reporting and continuous improvement efforts, helping teams determine what to scale, adapt, or stop. Many noted that while measurement is a difficult undertaking, it is also essential for strengthening accountability, communicating impact, and sustaining momentum. We heard that the innovative work happening across OHTs is only as powerful as the ability to understand it, measure it, and learn from it.

Participants emphasized the need to use data proactively to understand population needs, target interventions, and track outcomes. They noted that hospital-based metrics alone (e.g., emergency admissions) are insufficient; additional measures reflecting integration across primary care, home and community care, mental health, and social supports are essential. Importantly, many noted that some professions data is not being tracked, for example, nurse practitioner attachment.

What might be possible when we measure change?

When teams can back up their work with clear evidence, it becomes easier to tell the story of integrated care. In a province as large and regionally varied as Ontario, OHTs are not only responsible for coordinating care in local contexts, but also for using measurement to make what's working visible to partners and decision-makers beyond their region.

Since funders and system partners are not positioned to see every community's day-to-day pressures or innovations, timely and credible data helps translate local work into a clear case for where investment should go, what should be scaled or sustained, and what needs to change.

Measurement also strengthens accountability in practical ways: it helps us track progress against our intentions, spot what isn't working as expected, and make small adjustments that improve programs beyond their initial design. Just as importantly, shared measures can support collective accountability across the province, creating a clearer picture of progress and gaps over time.

When we can compare results and learn from one another, we can spread what works faster, avoid repeating missteps, and build momentum around the approaches that deliver the greatest impact.

> **Participants emphasized the need to use data proactively to understand population needs, target interventions, and track outcomes.**

What "From Insight to Impact" looks like in practice

Some sessions offered insight into strengthening measurement and using it to guide action:

- In ***Accelerating Performance Management within Ontario Health Teams***, we discussed the challenge of selecting measures that meet both local and provincial needs, and the importance of building a performance approach teams can actually use.
- In ***Learning from Home Care Leading Projects: Recommendations for Advancing the Integration of Home Care and Primary Care***, we looked at how OHTs are testing different integrated home care approaches and using evaluation findings to guide next steps, including where digital tools may help.
- In ***Integrated Care Pathways for Chronic Conditions and Frailty***, we explored how shared, cross-sector pathways can reduce uncertainty about "what happens next" and strengthen coordination across providers to create clearer points of measurement and improvement over time.

CASE STUDY

Burlington Ontario Health Team

The Burlington Ontario Health Team (OHT) has developed the Community Wellness Hub (CWH) model: CWHs are alliances of health, wellness, housing, and social service providers working together as local, integrated care teams to support aging at home.

A core component of the model is rigorous, consistent, and coordinated evaluation across CWHs. BOHT tracks outcomes that reflect community-based integration (not just hospital metrics), including avoidable hospitalizations (ambulatory care sensitive conditions), emergency department use, and patient-reported wellness measures such as general health, pain/discomfort, loneliness, and mental health.

The results make the case for investment: non-members are 1.4x more likely to experience avoidable hospitalizations, CWH members see a 31% lower ACSC hospitalization rate, and members have 14% fewer less/non-urgent ED visits, with ED use that better aligns to appropriate care (6% less/non-urgent vs 20% among Ontario adults 65+). As the model spreads to nine sites and into other OHTs, Burlington ensures shared learning through a CWH Community of Practice, shared evaluation tools, and cross-hub reporting.

Shared evaluation across hubs informs continuous improvements to the model, supports efforts to standardize and scale the model and its outcomes, and form a clear, collective story on the impacts of the model that support decision-making.

1.4x

Non-members of CWH are **1.4x more likely** to experience avoidable hospitalizations

31%

CWH members see a **31% lower** ACSC hospitalization rate

14%

CWH members have **14% fewer** less/non-urgent ED visits

SECTION THREE

How will we make what is possible a reality? What is needed?

The Summit reinforced that moving from possibility to impact depends on deliberate action and follow-through. Across main stage speakers, workshops, and table discussion, five action-oriented themes emerged: centring equity by sharing power and reaching those left behind; investing in cross-sector relationships; leveraging OHT successes to strengthen impact and demonstrate value; advancing the Primary Care Network; and strengthening evaluation and measurement of impact.

Theme One: Centring Equity

If planning with people is the foundation of integrated care, centring equity is how that commitment is actioned. We heard that even well-designed systems will fall short if they do not reach the full population. Centring equity requires a deliberate focus on who is missing and where barriers persist. It depends on how decisions are made, not just what decisions are made. To do this effectively, we need to involve people with lived experience in shaping priorities, designing services, and defining and measuring success.

> **Centring equity requires a deliberate focus on who is missing and where barriers persist.**

What we heard centring equity looks like

- **Intentional co-design and shared decision-making** - Ask who is at the table and pursue co-design with patients, caregivers, and community partners. Develop clear feedback loops that show how engagement input influenced decisions, helping build trust and accountability over time.
- **Equity-informed use of data** - Understand who lives in the community, and design care and measurement around them and their needs. In parallel, be explicit about who is and is not represented in the data. Further, sharing data back with communities, where appropriate, demonstrates transparency, impact, and accountability.
- **Targeted outreach and relationship building** - Meet people where they are through targeted engagement with equity-deserving groups and sustained relationship-building with community organizations, social service workers, and local champions. Trust develops over time through presence, follow-through, and respect for community dynamics.
- **Culturally safe and inclusive engagement practices** - Honour community context by using a variety of engagement approaches, providing compensation and participation supports, and ensuring engagement is grounded in respect, relationship, and community-led approaches.
- **Explicit focus on who is missing** - Plan deliberately for equity by asking who may be excluded by current approaches and how voices and needs can be better centred.

Commitments we heard

- *"Facilitate community engagement through all partners - to grow the Patient Family Council pool, to share the value of lived experience and to enable community engagement in primary care including communicating the what, why, and how of attachment and access."*
- *"I will look to have conversations about the disparities in our community that we haven't really spoken about these might be uncomfortable conversations, but this Summit has reminded me that it's essential."*
- *"Build trust. Go to the sites and see where the care is happening."*

Theme Two: Investing in cross-sector relationships

If integrated care requires coordination, then strong relationships and effective governance is foundational to it. We heard that achieving alignment and building trust through open, clear communication are essential for coordination and ensuring lasting impact.

This means investing in the systems and processes that make coordination possible across primary care, hospitals, community organizations, public health, and social services. We consistently heard that building and maintaining these relationships and a sense of shared purpose takes time and requires organizational support that extends beyond individual champions.

> **Building trust through open, clear communication are essential for coordinated action and lasting impact.**

What we heard investing in cross-sector relationships looks like

- **Shared purpose and aligned leadership**. Develop a clear, shared vision that partners can see themselves in, supported by board and executive-level engagement.
- **Trust built through presence and follow-through**. Go to partners, learn about their work, and invest in regular connection.

Develop a willingness to "go slow to go fast," particularly in newer partnerships.

- **Structures that make collaboration easier**. Create practical enablers such as shared governance practices, regular cross-sector forums, co-location, shared care planning, clear referral pathways, and roles like navigators and coordinators that bridge organizations.

- **Clear communication and shared tools**. Develop communication strategies that centre patient impact and align with provincial priorities, supported by tools such as shared EMRs that reduce duplication and avoid parallel systems.

- **Workforce capacity for collaboration**. Invest in roles and skills that enable integration, including leadership through uncertainty, relationship-building, and coordination across organizations – "soft skills" are essential to making integration work in practice.

Commitments we heard

"Continue to foster collaboration by recognizing the unique contributions made by each organization, each community partner, and each provider."

"Opportunity to engage partners in conversation of shared goals on strategic plans and shared accountability for metrics"

"It is a we, not an us vs them"

Theme Three: Leveraging OHT successes to strengthen impact and demonstrate value

When progress is underway, making it visible and shareable is essential to scaling impact across the province. We heard that learning from others' successes also requires being open about our own challenges. A culture of openness and learning helps avoid duplication, supports collective progress, and builds confidence in Ontario's integrated care approach.

This calls for better systems to spread effective OHT practices, enhanced organizational readiness to adopt new ideas and approaches, and clear communication of the value we bring as OHTs and partners in leading population health outcomes.

What we heard leveraging OHT successes looks like

- **Invest in your learning**. Engage in networks across the province, especially with others who share similar geographies, populations, and contexts. Communities of practice and regular OHT gatherings provide valuable opportunities for shared learning, but even more connections can be fostered beyond these formal groups.

- **From local wins to scalable approaches for others**. Move beyond presentations to develop practical, replicable tools such as playbooks, toolkits, and shared measurement approaches that others can adapt to local context.

- **Funding structures that support scale**. Seek funding that incentivize collaboration, scale, and spread, including non-competitive funding and support for shared initiatives such as joint procurement or vendor-sharing.

- **Plan for change management and sustained support**. Invest in training, capacity, and ongoing support to embed new ways of working. Sustained change requires continued attention, not one-time implementation.

Commitments we heard

"Find other OHTs working on similar priorities and share with them and CoPs. Think and act on local successes that we might scale and spread"

"Engage more with other OHTs - no need to start from scratch every time!"

"Build on commonalities identified in shared needs throughout the Summit and seek how to advance together to reduce efforts and maximize impacts/outputs."

Theme Four: Advancing the Primary Care Network

For integrated care to function daily, strong Primary Care Networks are essential. Summit participants emphasized that PCNs serve as a vital bridge to connecting patients and caregivers to both community and acute services. As a central point of integration across health and social care, PCNs translate system priorities such as attachment, continuity, access, standardization and team-based care into practice, ensuring health service provision reflects local realities.

What we heard advancing the Primary Care Network looks like

- **Primary care leadership in decision-making**. Embed appropriate levels of primary care leadership within OHT governance to ensure decisions reflect front line realities and patient experience.

- **Aligned funding and workforce stability.** Encourage less siloed ways of working including funding models, salary stabilization, and pay equity to support sustainability and reduce fragmentation.

- **Clear roles, outputs, and accountability**. Define shared objectives including outputs and key performance indicators for PCNs that align with OHT goals and population health outcomes.

- **Collaboration and learning across PCNs**. Strengthen a community of practice that enable PCNs at various stages of maturity to learn from one another and share resources, particularly among those with similar contexts.

- **Membership diversification**. Ensure representation from a range of primary care providers within the Primary Care Network and its decision-making structures, such as Nurse Practitioners.

Commitments we heard

"Define shared outputs for our PCN"

"Really bring in leaders who are further in maturity in their PCN to help us integrate care locally and eventually through our city."

"Support our amazing PCN leads in the incredible work they do"

Theme Five: Strengthening evaluation and impact measurement

If integrated care is to be sustained, its impact must be visible, credible, and meaningful. We heard that measurement directly supports learning and improvement, while also strengthening accountability and confidence in the health care system. Achieving this balance requires consistent, outcome-focused indicators alongside flexibility to reflect local context and lived experience. Measurement is most effective when it informs decisions, rather than serving only as a reporting requirement.

What we heard strengthening evaluation and measurement of impact looks like

- **Focus on a small set of meaningful indicators**. Prioritize a small, meaningful set of indicators that are practical and actionable. Emphasizing common measures across OHTs supports shared learning and enables a more accurate understanding of progress at the provincial level.

- **Equity-informed data and measurement**. Be explicit about data blind spots and expand data collection to better reflect health equity, including Indigenous and other historically excluded experiences. Pair quantitative data with community insight to avoid reinforcing inequities.

- **Population-level insight to guide action**. Use population health and geospatial data to understand needs, identify pressure points, and inform service planning, while recognizing the limits of administrative datasets.

- **Close the accountability loop**. Share findings publicly where appropriate and communicate what was heard, what changed, and what impact resulted. Accountability is relational, not just technical.

- **Embed continuous improvement.** Move beyond compliance-based reporting by integrating routine data monitoring, learning cycles, and performance reviews that enable course correction and adaptation over time.

Commitments we heard

"Find, generate and disseminate stories of our PCN and partner organizations'' collaborative work and clearly tie it to tangible outcomes for patients, staff and/or our system."

"Creative, strength-based storytelling & celebrating wins while in the messy middle"

"Looking at data driven communication to drive home the value add of integrated care"

Thank You

Thank you to everyone who participated in the 2025 Integrated Care Action Summit. Your openness and commitment transformed the Summit from a two-day gathering into a true catalyst for action. Participants affirmed the value of coming together and expressed clear enthusiasm to carry the momentum forward in the year ahead.

The Summit reinforced an important reminder: no one is doing this work alone. Across Ontario, there is a growing community of partners ready to learn from one another, share responsibility, and strengthen the conditions needed to deliver more connected and equitable care.

This report captures a moment in time and shares a snapshot of the insights and ideas that emerged over two days of collective reflection and dialogue. More importantly, it is an invitation forward. The challenge now is not whether integrated care is possible, but how we continue to advance it – within teams, across regions, and alongside communities – together. The vision is for our shared ambition to become sustained action towards better health outcomes for everyone in the province.

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