



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

Strategic Plan 2026-27

The Connected Care Halton Ontario Health Team (CCHOHT) represents a collaborative of healthcare and community service providers along with patients, families, caregivers - in the Halton Hills, Milton, and Oakville communities. Our impact is driven by our purpose: to connect care and to maintain a strong commitment to better health, positive experiences for patients and providers, improved value to the healthcare system, and advancing health equity.

The CCHOHT current Strategic Plan covers 2022 to 2025. In preparation for the next phase, our Collaborative Committee initiated a refresh process to align with the current priorities for all Ontario Health Teams (OHTs) and to focus our strategic initiatives in a balanced way to achieve progress on both Provincial and locally driven initiatives. To build our priorities, we set out to gather many voices through in-person, virtual, and survey options, leveraging our working group memberships (who sits at the planning tables) and broader member reach (partners across the community).

Our 2026-2027 refresh aligns with the end of the 3-year confirmed base funding for all OHTs and has been shaped by input from our members and partners through engagement events during the Fall of 2025. We have identified the strategic initiatives that mattered most to you and described them in plain language for easy understanding. Together, we look forward to continuing advancing connected care with you.

Vision: Healthier Communities in Halton Hills, Milton and Oakville

Purpose: Connecting Care

Mission: Improving the Health of our Community Together

Our Values Aligned to the Patient, Family, Caregiver Declaration of Values for Ontario

01 Accountability

02 Empathy &
Compassion

03 Equity &
Engagement

04 Respect &
Dignity

05 Transparency



www.ConnectedCareHalton.ca



Oakville, Halton Hills and Milton





What is an Ontario Health Team? A group of local health and community care providers including patients, families and caregivers who work together to make it easier for people to get connected, coordinated care.



What is a Strategic Plan? It defines the overarching priorities of our community and outlines the direction and actions required to deliver more connected, high-quality care.



What are Strategic Priorities? They define a focused set of initiatives that guide our efforts toward achieving meaningful impact.



What Are Strategic Initiatives? These initiatives represent the targeted projects and actions that bring our Strategic Plan to life. They include system-wide efforts that benefit the broader community, as well as focused initiatives designed to address specific local needs and areas for improvement within our communities. The initiatives highlighted here are part of a broader body of work and reflect what we heard matters most to you.



What is Primary Care? It is comprehensive health care provided as the first point of contact in the health system, focusing on prevention, diagnosis, treatment and ongoing management of health issues.



What is a Primary Care Network? A Primary Care Network (PCN) is a group of local primary care providers, hospital leadership and community partners working together to improve primary care. PCNs will connect, integrate, and support primary care providers within OHTs to improve the delivery and coordination of care for patients.



What is the Engagement Capable Environments Framework? It is a simple guide that helps organizations create the right conditions—people, processes, and culture—to meaningfully involve patients, families, caregivers, staff, and partners in decisions about care and system planning.

Our Strategic Priorities



Strategic Priority 1: Primary Care Access, Attachment and Enablement

What actions will we take to ensure every person in our region is connected to a primary care provider?

How will these initiatives improve the healthcare experience?

Strategic Initiatives

Attach 100% of our population to a primary care team through implementing our Primary Care Action Plan.

See the full report at: www.connectedcarehalton.ca

We will use data and evidence to measure our progress and ensure our efforts are leading to better health and share these results in a transparent and accessible way.

Develop a Primary Care Network that enables providers to deliver coordinated care through shared digital tools and clinical staff access (e.g., Dietitians, Nurses, Physiotherapists) for wellness and disease prevention.

Providers, patients, families, caregivers will have a simple local health navigation resource that includes digital and human resources to meet healthcare needs and know what steps to take.

Implement the Halton Health Home Model developed in collaboration with the Burlington OHT.

We will create a consistent experience for everyone across our four Halton-based communities to access high quality and accessible primary healthcare.



Our Strategic Priorities



Strategic Priority 2: Integrated Clinical Priorities

What actions will we take to improve care coordination?

How will these initiatives improve the healthcare experience?

Strategic Initiatives

Implement health equity focused approaches and Cross-Sector Partnerships to improve positive health outcomes for people in our communities.

We will collaborate across different sectors to reach vulnerable populations to provide culturally appropriate health information and required supports to access Primary Care to receive preventative screening and chronic disease prevention and management.

Scale access from Hospital based services and Primary Care to high-performing partner-led programs, including: SCOPE (Seamless Care Optimizing the Patient Experience) Remote Care Management (RCM), Halton@Home, Coordinated Access and eReferral, Palliative Care and the Essential Caregivers Program

Patients will receive the right level of support at the right place of care. Impact will be on reducing unnecessary Hospital admissions and Emergency Department avoidance, and empower patients, families, caregivers in their care.

Implement standardized regional care pathways for high-burden conditions (e.g., COPD, CHF, Palliative Care).

This ensures that all patients receive reliable, evidence-based care, regardless of whether they enter the healthcare system through a hospital, primary care provider, or a community service.



Our Strategic Priorities



Strategic Priority 3: OHT Capacity Building

What actions will we take to improve care coordination?

How will these initiatives improve the healthcare experience?

Strategic Initiatives

Develop and implement a communication and interaction strategy with our members.

Patients, caregivers and providers across our geography will know about our Ontario Health Team, PCN and what we are doing to connect care.

Support new agreements between OHT members to intentionally improve how we connect care across our communities and with our neighbouring OHTs.

By working together, we will implement a "Home First" standard where medical and social supports are wrapped around the patient before they leave the hospital, reducing preventable readmissions.

Advance the Engagement Capable Environments Framework to support interest and meaningful involvement for patients, families, caregivers.

Our care design and delivery will incorporate the perspectives of patients, families, caregivers, ensuring their voices shape the healthcare experience.

