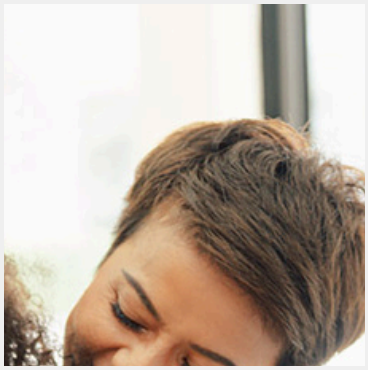
Great RIVER ONTARIO HEALTH TEAM

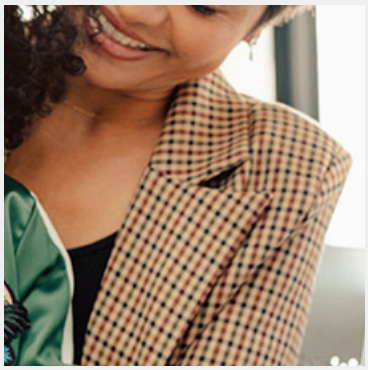
ÉQUIPE SANTÉ ONTARIO DU Grand FLEUVE

Kaniatarowanénhne Kaniatarí:io Ata'karitéhtshera Raotinèn:ra

Annual Report 2024-2025

Where everyone's health and well-being matter!





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Message from the Steering Committee Co-Chairs

This past year has been one of meaningful collaboration, growth, and transformation for the Great River Ontario Health Team (GR OHT). Guided by the belief that we are stronger together, our OHT has continued to strengthen, build, and facilitate connections across the local and regional health system—bringing together primary care providers, hospitals, home and community care, mental health and addictions services, and community support organizations.

OHTs exist to create a more connected, patient-centered health care system—one that is easier to navigate, more equitable, and responsive to community needs. At the Great River OHT, we are proud to play an active role in advancing that vision by supporting better access, coordination, and delivery of care. While the health system has long been criticized for working in silos, our collective efforts are helping to change that narrative. Thanks to the dedication of our partners and the insight and collaboration of patients, caregivers, and families, we are aligning exceptional programs and services, raising their profile, and enhancing their impact.

Our team has grown considerably, with a significant increase in active work groups and project tables focused on integrated care. These efforts reflect a shared commitment to delivering the right care, at the right time, in the right place—and to achieving better health outcomes across the region.

Transformation is ongoing, and we recognize that lasting change takes time, trust, and collaboration. This report highlights just some of the important milestones we've reached this year—progress made possible by the energy, vision, and leadership of everyone involved.

Thank you to all who have contributed to this year's successes—together, we are shaping a stronger, more connected system!

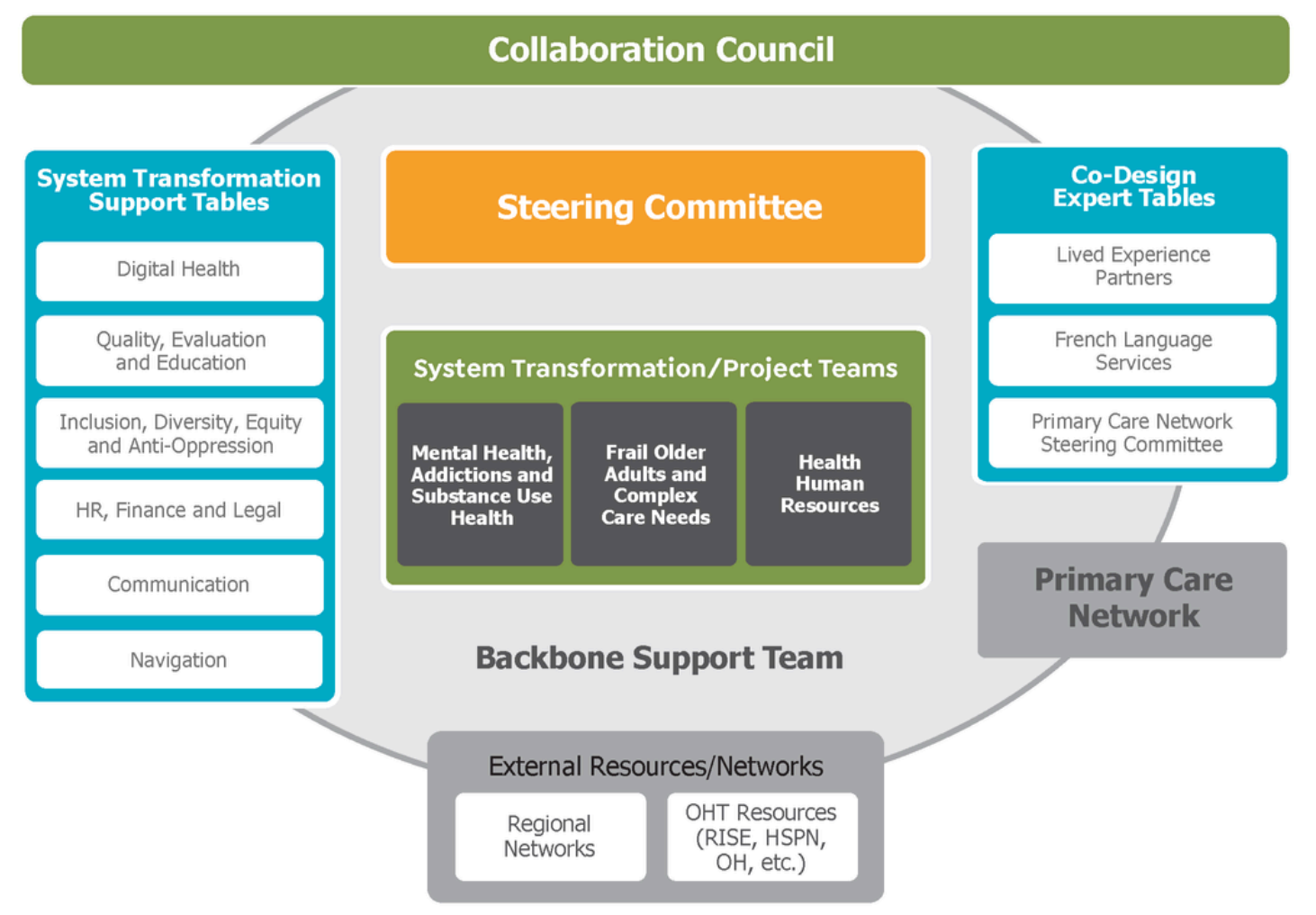
Joanne Ledoux-Moshonas

Marc Bisson

The Great River Ontario Health Team is a collective of health and social service providers who plan and work together, as one coordinated team, to provide integrated services and supports to meet the health needs of people who seek care in the City of Cornwall, Stormont, Dundas & Glengarry, Akwesasne and parts of rural Southeast Ottawa and Russell Township. Our goal is to provide a new way of coordinating and delivering care that is better connected to patients and providers in their communities to improve patient outcomes. As a collective, we will become accountable for the care experiences, population-health outcomes and costs of care for the people and communities we serve. Through our work together, we value collaboration, innovation, person-centeredness and equity and remain mindful of our vision:

Where everyone's health and well-being matter!

Collaborative Structure



Meet the Backbone Support Team

At the heart of the Great River Ontario Health Team's success is its Backbone Support Team—a committed group that provides strategic, operational, and administrative leadership across the region. From managing projects and coordinating partner efforts to facilitating education, community engagement, and alignment with Ontario Health priorities, the Backbone Team plays a vital role in driving GR OHT's collective impact and sustaining its momentum.

Diane Plourde
Executive Transformation Lead

Dr. Marilyn Crabtree
Clinical Lead

Munro Ross
Digital Health Lead

Carilyne Hébert
Engagement and Navigation Lead

Tracy Crowder
Project Manager

Sophie Cadorette
Communication and Administrative Agent

Angela Martin
Integrated Care Manager

Sarah Good
Engagement and Population Health Specialist

Brenda Toonders
Navigation Specialist

Reflect. Align. Advance.

The Great River Ontario Health Team continues to anchor its work in a shared Strategic Plan that outlines our vision, values, and long-term goals. While the current plan continues to guide our collective work, we are actively reviewing our activities for the 2025–2026 fiscal year in anticipation of updated guidance from Ontario Health. This pause for reflection allows us to assess alignment with provincial priorities and local needs, ensuring our work remains responsive, effective, and future-focused.

Our ongoing planning process remains grounded in the needs of our communities and informed by the voices of our partners, patients, and caregivers. As we await the release of the 2025-2026 Transfer Payment Agreement (TPA) deliverables and guidance document, our focus remains on optimizing current initiatives while preparing for the next phase of integrated, equitable care.

Amik
Collective Impact Ambassador

Tsianì:to
Collective Impact Ambassador

New Ambassadors

In 2024–2025, GR OHT proudly introduced Collective Impact Ambassadors—symbolized by the beaver, an animal revered in many First Nations cultures for its perseverance, cooperation, and dedication to community well-being. Following a public naming campaign, the chosen names were **Amik** (beaver in Algonquin) and **Tsianì:to** (beaver in Mohawk). In the coming fiscal year, our ambassadors will visit our partner organizations to celebrate collaborative initiatives and highlight the power of our shared efforts.

Newsletter Launch

To enhance communication and transparency, GR OHT launched its public-facing newsletter in 2024–2025. This newsletter provides partners, patients, and community members with regular updates on initiatives, project progress, upcoming events, and system improvements. It also highlights and celebrates the collective achievements of our Ontario Health Team. We encourage everyone to subscribe and share the newsletter to help keep our region informed and connected to the evolving health landscape.

Click here to subscribe to the GR OHT newsletter.

Collaboration and Engagement Initiatives

Interprofessional Primary Care Team (IPCT)

A major achievement this year was the innovative collaboration between four team-based primary care models—Seaway Valley CHC, Glengarry NPLC, Rideau St. Lawrence FHT, and CSC de l'Estrie—to co-design a proposal under Ontario Health's *Expanding and Enhancing Interprofessional Primary Care Teams* initiative. Their joint efforts, grounded in transparency and a shared commitment to care, led to the successful award of $4.07 million—one of the largest funding envelopes in the province. This accomplishment sets a powerful precedent for future collaboration across our Ontario Health Team.

With this funding, the four teams are hiring 26.5 FTE staff to expand access to care. Already, over 3,500 patients have been newly attached to primary care, and an additional 11,800 now benefit from enhanced team-based services. The project supports the quintuple aim, with a strong focus on equity—reflected in a Health Equity Impact Assessment being completed. Recognized as a "Bright Spot" project by Ontario Health, the initiative has also sparked academic interest through a research partnership with the University of Toronto.

Next Steps

In spring 2025, GR OHT submitted a major proposal under Ontario's $1.8 billion expansion of Interprofessional Primary Care Teams. In collaboration with Seaway Valley CHC, Glengarry NPLC, Rideau St. Lawrence FHT, CSC de l'Estrie, and the Mohawk Council of Akwesasne's Department of Health, GR OHT requested $11.7 million to attach an additional 13,000+ people to a primary care provider—focusing on underserved postal codes K6H, K0C and K0A. This new proposal includes hiring nurse practitioners and physicians, a wide range of allied health professionals, and administrative staff. This initiative builds on the 2023–2024 IPCT funding and reflects GR OHT's commitment to culturally safe, community-driven care.

Interprofessional Primary Care Team (IPCT)

Collaboration and Engagement Initiatives

Primary Care Network (PCN)

In alignment with Ontario Health's directive to establish Primary Care Networks (PCNs), GR OHT created the Primary Care Network Steering Committee (PCN SC) by merging three key working groups: the Primary Health Care Clinicians Table, the Primary Care Project Team, and the Interprofessional Primary Care Team. This integration promotes stronger collaboration and eliminates redundancy, while centering decision-making on population health and equity.

The PCN SC now leads strategic planning and implementation of all primary care-related projects. With representation from clinicians and lived experience partners, the committee has already launched several priority initiatives, including an **AI Scribe pilot**, **PCN Nurse program**, and a **practice facilitation project**. The group is also preparing to roll out an integrated Heart Failure program, expanded digital tools like Online Appointment Booking (OAB), and community-focused strategies for enhanced cancer screening and chronic disease management.

On June 14, 2024, Dr. Vikas Bhagirath presented on AI Scribes at the event Primary Care Vision 2027: Your Practice, Your Future.

Heart Failure and Diabetes Initiatives

Chronic disease management remains a key priority for GR OHT. In 2024–2025, the team laid the groundwork for an integrated **Heart Failure Pathway** in partnership with **Best Care** and brought together the **Diabetes Education Programs (DEP)** in our area to develop a Stepped Care Model. These projects are part of the PCN Steering Committee's broader efforts to standardize care and improve access to clinical and allied health supports.

Using population health data and collaborative input from clinicians and patients, these initiatives are poised to enhance care coordination, reduce emergency department visits, and improve quality of life for patients living with chronic conditions.

On October 2, 2024, the Great River OHT held three training sessions on Evidence2Practice's EMR-Integrated Management Tool for Chronic Conditions.

More Collaboration and Engagement Initiatives

East Region
VIRTUAL CARE CLINIC

The East Region Virtual Care Clinic (ERVCC) continued to grow in 2024–2025, providing timely, same day access to virtual care to residents across the East Region. This year, GR OHT launched a **Collective Impact Challenge** to promote the ERVCC—resulting in a tripling of new users in our area within a three-month period. The challenge saw **45%** of GR OHT partner organizations participate, promoting the service through posters, staff communications, and outreach events. The clinic surpassed its annual target of 12,375 appointments with 18,700 completed across the region. Integration with Health811 has further streamlined patient access.

HEALTHY SPROUTS

The Healthy Sprouts program, offered through **Seaway Valley Community Health Centre**, provides early childhood health support for children aged 0–5 without a family doctor or nurse practitioner. The program helps monitor child development, provides immunizations, and connects families to early intervention and community services. Initially launched as a pilot, the program will become full-time starting June 2025, marking a significant investment in the health of children during their early years. The program also supports caregivers with parenting guidance and referrals—addressing both medical and social determinants of health.

CANCER SCREENING SAVES **LIVES**

In response to cancer screening gaps among residents without a primary care provider, the GR OHT hosted two successful cancer screening campaigns that led to the **Eastern Ontario Health Unit (EOHU)** adopting the initiative as part of its partnership with **Champlain Regional Cancer Program**. This collaborative expansion ensures continuity of access to essential screening services across the region. By connecting people to life-saving cancer screening tests, this work contributes to early detection, better health outcomes, and reduced disparities in access to preventive care.

INTERCONNECTOME
COEUR-CERVEAU
BRAIN-HEART
INTERCONNECTOME

In collaboration with **Bruyère Health**, **GR OHT** and **Archipel OHT** have partnered to advance a Brain-Heart Interconnectome Research Project. This research project aims to improve care delivery systems in two OHT regions for people with heart failure who are at risk of, or experiencing, mental health challenges such as depression, anxiety, and stress. Year 1 focused on the completion of asset mapping, community consultations and a scoping review. Year 2 will include the co-design of intervention guides, system mapping and a plan to pilot test and evaluate the intervention in various settings.

Lived Experience Partners Table (LEPT)

The LEPT continues to be at the heart of GR OHT's engagement and co-design work. This year, LEPT members played pivotal roles in developing the Engagement Capable Environments Self-Assessment and Action Plan, co-designing client tools for mental health programs, and participating in system navigation reviews. LEPT membership expanded significantly, with more individuals joining various OHT groups, contributing to meeting discussions, and advising on planning processes.

Public Engagement Session

In May 2024, GR OHT shared results from its Patient Experience Survey through a webinar and a public engagement session at the Cornwall Public Library. Overwhelmingly, respondents valued respectful, person-centered care but raised concerns about **accessibility and navigation challenges**.

These insights are helping shape GR OHT's current and future initiatives, including enhancements to the navigation system, increased health equity efforts, and targeted improvements in digital and virtual care. The survey's findings reaffirm GR OHT's commitment to listening, learning, and taking action based on real patient voices.

Self-Assessment and Action Plan

In alignment with Ontario Health's guidance, GR OHT undertook a comprehensive **Engagement Capable Environments Self-Assessment** and developed an **Action Plan** in collaboration with the LEPT, Steering Committee members, and Backbone Team. This process helped the team evaluate current engagement practices and identify concrete steps to reach **Level 2: Learning and Developing** by March 2026. Key actions that will take place in the upcoming fiscal year include expanding LEPT representation, launching a mentorship program for new partners, improving onboarding and evaluation tools, and updating the Engagement Checklist. With implementation underway, GR OHT is embedding meaningful engagement into every level of its operations and planning.

Equity Deserving Groups

Strengthening Relationships

French Language Services Table

To support the implementation of the **Winning Strategies** initiative, GR OHT has engaged its Collaboration Council members through multiple channels to encourage participation in the Organizational Self-Assessment and identification of local champions. Reminders included links to resources such as **Active Offer** training.

Thanks to these efforts, GR OHT is leading among the nine participating OHTs, with **45%** of partner organizations engaged in at least one **Winning Strategies** action.

The French Language Services Table is finalizing a new survey to be distributed to all member organizations this spring. Building on the 2023 version, it falls under the **Winning Strategies** theme “Identifying Francophone Clients.” The 2025 survey will provide insight into how member organizations collect data on French-speaking clients, helping identify current practices, gaps, and supports needed to strengthen service delivery and data harmonization across the GR OHT.

Collaboration with Indigenous Communities

GR OHT has made steady progress in building respectful, meaningful relationships with Indigenous partners, especially the Mohawk Council of Akwesasne's Department of Health. In 2024–2025, the team:

- Hosted two tours of the **Native North American Travelling College**
- Participated in the **Akwesasne Health Fair**
- Organized an **Ownership, Control, Access, and Possession (OCAP®)** information session and workshop
- Collaborated on the **IPCT funding proposal**
- Welcomed more **Indigenous representation** on GR OHT tables and initiatives

Furthermore, while jurisdictional barriers still limit access for Quebec-based Akwesasne residents, GR OHT continues to advocate for equitable care and welcomes all opportunities to include Indigenous perspectives in regional health planning.

Learning Opportunities

Inclusion, Diversity and Anti-Oppression (IDEA) Table

The IDEA Table continued to drive efforts to build a more inclusive, equitable, and anti-oppressive health system. In 2024–2025, the table coordinated:

- The **CAPSA "Stigma Ends With Me"** training on substance use and stigma (October 2024)
- A powerful **Black History Month Presentation** by César Ndéma-Moussa (February 2025)
- Completion of **Rainbow Health Ontario Training** by Backbone staff
- Participation in the **IDEA Community Coalition**, a regional hub for shared learning

These initiatives are transforming awareness into action and embedding equity in GR OHT's culture and operations.

Additional Events and Training Highlights

GR OHT hosted and promoted a wide range of events and learning sessions this year, fostering continuous improvement and shared learning. Highlights included:

- **Regional Integrated Care Program Presentation**, clarifying referral pathways for complex care clients (November 2024)
- **Zayna Khayat's "The Future of Health(Care)" Presentation**, which sparked discussions about innovation, partnerships, and systems thinking (December 2024)
- **Optimizing Heart Failure Management Webinar**, building clinical capacity for chronic disease care (January 2025)
- **Prosci ADKAR® Change Management Coaching Sessions**, attended by over 40 partner organizations (March 2025)

Navigation in Action

A major milestone this year was the official launch of the Navigation Table in March 2025. This collaborative table brings together navigation experts, leaders, and frontline providers from across the Great River Ontario Health Team to improve access to, and understanding of, the local health and social system. The table is designed to assist and advise the Steering Committee on all matters related to navigation, while supporting and guiding other tables, project teams, and working groups. Its role is to ensure that navigation supports and philosophies are embedded across all OHT development and implementation efforts.

The inaugural meeting of the Navigation Table was marked by great energy and a highly productive discussion. The group will continue to meet bi-weekly throughout the year to maintain momentum and drive progress.

AI Project Working Group

The AI Project Working Group is developing an innovative tool for the Great River OHT website. This **AI-powered assistant** is being designed to help the public, care providers, and primary care clinicians more easily find local programs and services. With support from an AI developer and a web designer, the group is working to create a user-friendly digital solution that enhances access to care and community resources.

The working group is responsible for drafting a project charter, setting clear steps and timelines, and ensuring robust testing throughout the development process. This project exemplifies the Navigation Table's commitment to practical, user-centered innovation that supports the OHT's broader goals of integration and improved patient experience.

Project Teams

Frail Older Adults and Complex Care Needs

This year, the Frail Older Adults and Complex Care Needs Project Team advanced several key initiatives, including a significant expansion of the **Essential Caregiver Program (ECP)** across hospital, community, and long-term care settings. Between October 2024 and March 2025, 73 caregivers completed training and received ID badges recognized by six GR OHT partners. The **Ontario Caregiver Organization** highlighted this work as a provincial case study. As the successful pilot concludes, phase 2 is underway, aiming to expand education sites and add new referral partners. A caregiver education video is also in development to provide consistent cross-sector information and complement in-person training.

Furthermore, a **Geriatric Think Tank Session** involving 33 participants from 12 organizations led to the formation of a working group focused on developing a centralized intake model for Specialized Geriatric Services, with implementation planning continuing in 2025-2026.

Mental Health, Addictions and Substance Use Health (MHASUH)

A key achievement of the MHASUH Project Team this year was the **Solution Focused Therapy (SFT)** initiative, launched by six partner organizations. In just six months, 221 clients accessed therapy, with early results showing a **22%** reduction in wait times, **40%** fewer clients on MHA waitlists at early adopter sites, and strong overall client satisfaction. Co-design sessions with individuals with lived/living experience shaped key elements of the program.

In addition, the **Substance Use Health Working Group** advanced equity through education and advocacy. During a Collaboration Council meeting, the group delivered a presentation titled **"Safer, More Compassionate, and Non-Stigmatizing Language Related to Substance Use Health."** The session emphasized the importance of person-first, neutral, and medically accurate language, and featured four curated resources to help partner organizations embed equity-focused communication practices across the system.

Project Teams

Health Human Resources

To address staffing challenges across the system, the Health Human Resources (HHR) Project Team focused on workforce capacity building and strategic planning. Towards the end of the fiscal year, an HHR Recruitment Campaign Project Proposal was completed with the goal of establishing three working groups in the next fiscal year to work on community promotion, workforce attraction and recruitment, and community discovery and newcomer orientation.

Building Capacity of Health Care Professionals Through Education

In 2024, the GR OHT partnered with students from St. Lawrence College to conduct a system-wide survey on education needs across 13 member organizations. The **"Building Capacity of Health Care Professionals Through Education"** survey captured insights from 178 respondents and highlighted both strengths and opportunities in workforce development.

Nearly two-thirds of respondents reported receiving training in the past year, with Cultural Competency, Communication, Mental Health, and Leadership topping the list. When asked about future priorities, respondents identified Leadership, Mental Health, and Communication as the most pressing training needs. However, key barriers such as workload constraints, training costs, scheduling issues, and lack of incentives were also noted. Online asynchronous learning and in-person workshops emerged as the most preferred formats for professional development.

These findings are directly informing the development of shared tools and resources to support our partners' learning management systems. By aligning training opportunities with staff needs and preferences, we are helping to build a more skilled, resilient, and responsive health care workforce across the region.

2025-2026 Goals

Fiscal year 2025-2026 marks the second year of a three-year funding agreement for all 58 OHTs. This year, OHTs will continue to grow and mature, with a stronger focus on clinical priorities and measuring impact through the expanded implementation of the OHT Performance Framework.

Priority 1: Primary Care Access, Attachment and Enablement

- Strengthen our PCN by supporting clinical leadership and improving access and attachment to care. Focus on expanding digital tools, supporting unattached patients, and progressing toward full population attachment by 2029.
- Work with PCN Clinical Leads, OHT staff, and partners to connect patients on the Health Care Connect waitlist by spring 2026. Develop a long-term plan for full population attachment by 2029 and support proposals for expanded Interprofessional Primary Care Teams.

Priority 2: Integrated Clinical Priorities

- Develop and implement a plan to advance community-based care for individuals at risk or living with chronic disease to support primary care and reduce hospital use.
- Develop and implement an Alternate Level of Care (ALC) action plan focused on prevention and management, aligned with Ontario Health's regional planning priorities.

Priority 3: OHT Capacity Building

- Continue targeted outreach to grow OHT membership, including Indigenous partners, patients, families, and primary care providers.
- Work toward achieving Level 2 of the Engagement Capable Environments framework and ensure staff complete training in cultural safety, equity, and inclusive practices.




Thank you to everyone—partners, patients, caregivers, and communities—for walking alongside us on this journey. Together, we are building a health system where every person is valued, supported, and well.

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Great River Ontario Health Team is supported by funding from the Government of Ontario.