Great RIVER ONTARIO HEALTH TEAM

ÉQUIPE SANTÉ ONTARIO DU Grand FLEUVE

Kaniatarowanénhne Kaniatarí:io Ata'karitéhtshera Raotinèn:ra

Annual Report

Where everyone's health and well-being matter!

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Message from the Steering Committee Co-Chairs

The Great River Ontario Health Team (GR OHT) continues to advance its shared vision of a more connected, equitable, and people-centred health system.

Over the past year, partners across the region have worked together to strengthen primary care access, expand team-based care, and improve how people navigate services across hospitals, primary care, community health, mental health and addictions, and social supports. This work is grounded in collaboration for improving the health and well-being of approximately:

125,000 **RESIDENTS**

(across our region, including urban, rural, and Indigenous communities).

We are proud not only of the progress made, but of how it was achieved — through trust, partnership, and a collective commitment to improving care experiences for patients, families, caregivers, and providers. Partners advanced numerous initiatives focused on improving access, coordination, digital transformation, chronic disease management, caregiver inclusion, health equity, and workforce recruitment.

This progress reflects the strength of our partnerships and the dedication of organizations, providers, staff, and lived experience partners across the region.

Together, we are building a future where everyone's health and well-being matter, guided by the following priorities:

- Expanding primary care access, attachment and enablement, including strengthening supported attachment services and team-based care
- Supporting integrated clinical priorities
- Strengthening OHT capacity building and partnerships
- Supporting a sustainable health workforce through a robust health human resources recruitment plan

Joanne Ledoux-Moshonas

Ann Zeran

Collaborative Structure

The GR OHT brings together more than:

50 **HEALTH AND SOCIAL SERVICE PARTNERS**

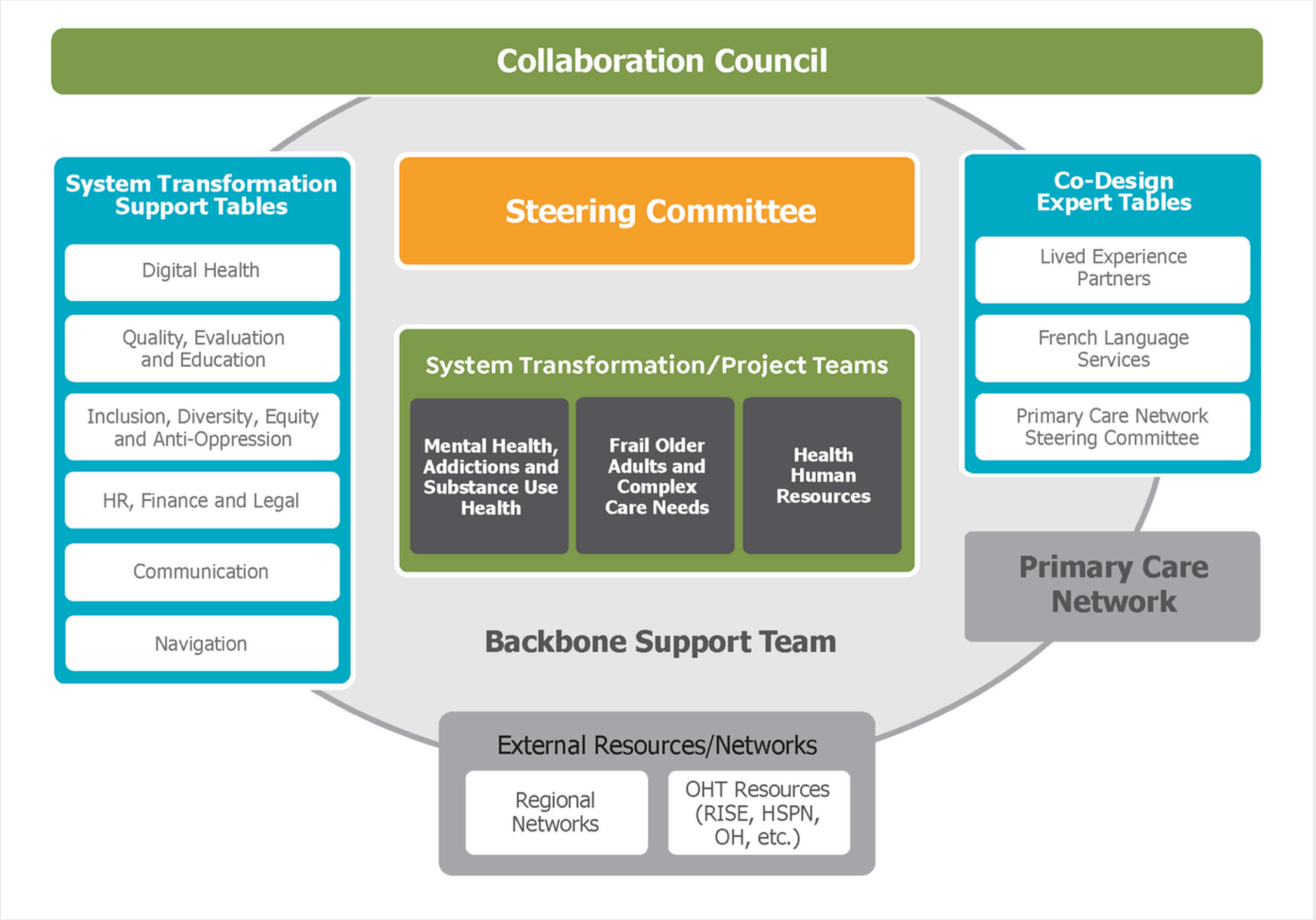
(across hospitals, primary care, community health centres, mental health and addictions services, home care, Indigenous health partners, and community organizations).

Together, these partners serve a geography of approximately:

4,046 **SQUARE KILOMETRES**

(spanning the City of Cornwall, Stormont, Dundas and Glengarry, Akwesasne, and parts of Southeast Ottawa and Russell Township).

The GR OHT collaborative structure allows organizations to jointly plan services, identify gaps, improve care transitions, and respond more effectively to local population health needs while ensuring patients experience more connected care across the system.



Backbone Support Team

The Backbone Support Team continues to play an essential role in coordinating collaboration across the GR OHT and supporting the advancement of strategic priorities, project work, communications, engagement, and system integration activities.

Throughout the year, the **Backbone Team** supported the work of our two Steering Committees (OHT and PCN), tables, project teams, working groups, and partner organizations by facilitating collaboration, advancing communications, coordinating engagement activities, and helping drive implementation of key initiatives across the region.

This fiscal year also marked the introduction of the **Ontario Health Team Ambassador initiative**, created to recognize and celebrate outstanding collaboration and the meaningful collective impact being achieved. The GR OHT now has two Ambassadors, *Amik* and *Tsianì:to*, who can be shared with partners to acknowledge exceptional collaborative efforts and innovative work that demonstrate the value of partnership in improving care and outcomes across our communities.

As the scope and complexity of OHT initiatives continue to grow, the **Backbone Team** remains central to supporting coordination, communication, and system-wide collaboration.

Diane Plourde
Executive Transformation Lead

Marilyn Crabtree
Clinical Lead

Munro Ross
Digital Health Lead

Carilyne Hébert
Engagement & Navigation Lead

Tracy Crowder
Project Manager

Sophie Cadorette
Communication & Administrative Agent

Angela Martin
Integrated Care Manager

Josephine Pham
Quality & Decision Support Specialist

Amik
Collective Impact Ambassador

Tsianì:to
Collective Impact Ambassador

Evolving Priorities:

Primary Care Attachment, Health Care Connect, and Supported Attachment

Improving access to primary care remains a top priority across the region. In 2025-2026, Ontario Health and the Ministry of Health reinforced expectations for OHTs and Primary Care Networks (PCNs) to strengthen attachment pathways and reduce the number of unattached patients.

In response, GR OHT partners enhanced coordinated efforts to connect individuals on the Health Care Connect (HCC) waitlist to primary care more quickly and efficiently. A key enabler was the implementation of Supported Attachment funding, distributed to **two Community Health Centres**, **one Nurse Practitioner-Led Clinic**, and **one Family Health Organization** in Q4. These resources increased administrative and clinical capacity, enabling providers to attach more patients efficiently.

As of March 2026:

25 **PRIMARY CARE CLINICIANS** and

4 **PRIMARY CARE TEAMS** were actively using supported attachment workflows.

Impact:

902 **PATIENTS REFERRED FROM HCC WAITLIST AND CONNECTED TO PRIMARY CARE PROVIDERS** (January–March 2026)

+ another 990 patients *continue to be referred and onboarded to primary care during April-June.*

Goal:

1,900 **PATIENTS ATTACHED** (by June 20, 2026)

These efforts advance the provincial goal of connecting every Ontarian to primary care while improving continuity and access across the region.

In addition:

- All identified Francophone patients on the Health Care Connect (HCC) waitlist were successfully connected to primary care through Francophone services
- Partners expanded attachment pathways through emergency department transitions, mental health and addictions services, newborn attachment pathways, and Francophone-specific matching
- Collaboration continues to enhance digital referral pathways, including Ocean eReferral, to support more efficient and equitable attachment

Interprofessional Primary Care Team (IPCT) Update

The Interprofessional Primary Care Team (IPCT) continues to play a key role in expanding access to team-based primary care across the Great River Ontario Health Team region. To date:

4 **TEAM-BASED PRIMARY CARE PARTNERS INVOLVED**

13,000+ **PATIENTS ATTACHED AND/OR ACCESSING SERVICES**

Over the past year, the four partners — Seaway Valley Community Health Centre, Rideau St. Lawrence Family Health Team, Glengarry Nurse Practitioner-Led Clinic, and Centre de santé communautaire de l'Estrie — have continued to strengthen their collective impact by expanding access to coordinated, multidisciplinary care.

Key highlights:

- Association of Family Health Teams of Ontario's *Bright Lights* Award recognition for innovation in team-based care
- Ontario Health "bright spot" designation for improved access and equity
- Participation in University of Toronto–led primary care research
- Health Equity Impact Assessment completed to guide planning
- Expansion of team-based services across primary care models

Together, IPCT partners continue to strengthen team-based care models and expand access to services for patients, particularly for those who may otherwise face challenges connecting to consistent primary care.

Primary Care Network (PCN) Steering Committee

The PCN Steering Committee continues to serve as a central forum for advancing primary care transformation across the region. This work focuses on strengthening collaboration among primary care providers and improving access to coordinated, team-based care.

PCN Events and Digital Health Transformation

Two major engagement events were held this year, bringing together family physicians, nurse practitioners, and interdisciplinary partners from across the region.

In April 2025:

45 **FAMILY PHYSICIANS, NURSE PRACTITIONERS, AND CLINICAL PROFESSIONALS**

A regional co-design session brought together partners to strengthen **diabetes and heart failure care pathways**, identifying opportunities to improve centralized intake, enhance communication between programs, and expand supports for primary care practices. The event concluded with networking opportunities and a keynote presentation by Dr. Dominik Nowak on optimism and leadership in medicine.

In October 2025:

45 **CLINICIANS, PROVIDERS, AND DIGITAL HEALTH LEADERS**

The PCN hosted a **Digital Health Transformation Event** focused on AI, automation, and workflow optimization, bringing primary care teams together to explore practical ways technology can reduce administrative burden, improve efficiency, and enhance the use of digital tools such as EMRs, eReferral systems, Ocean platforms, and online appointment booking.

OHT Scorecard Data

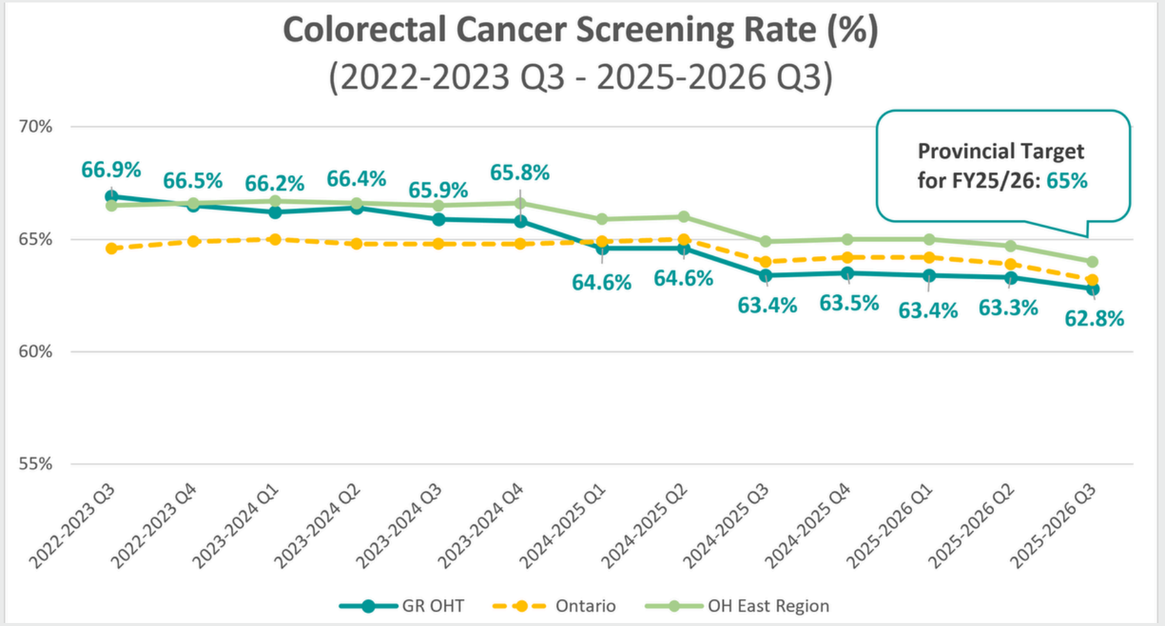
Performance measurement remains an important part of understanding system impact and identifying opportunities for improvement.

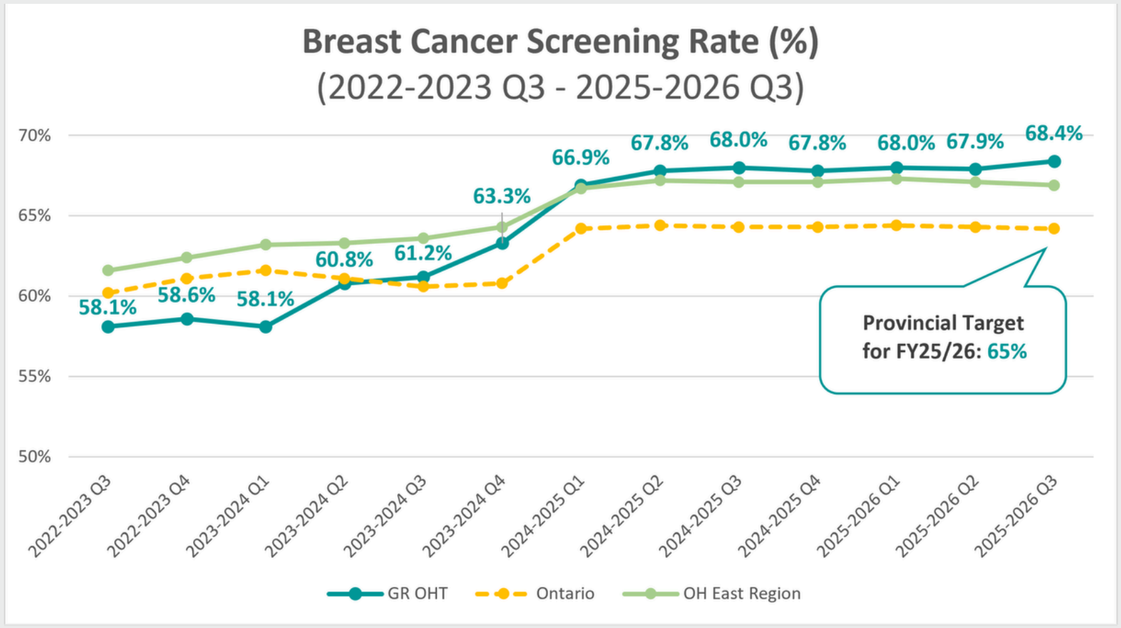
This year's scorecard highlights progress across key areas of chronic disease management and avoidable hospital utilization, including **heart failure**, **chronic obstructive pulmonary disease (COPD)**, and **ambulatory care sensitive conditions (ACSCs)** across Q1 (April to June 2025), Q2 (June to September 2025), and Q3 (October to December 2025).

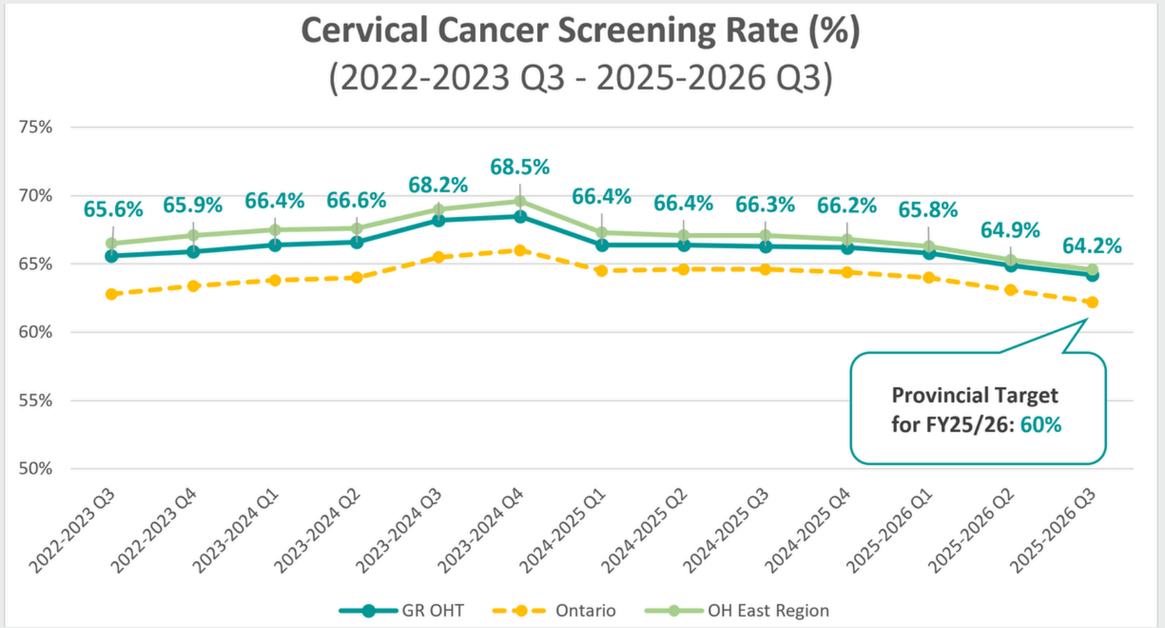
Across these indicators, partners continue to work collaboratively to strengthen early intervention, improve chronic disease management, increase **breast/cervical/colorectal cancer screening** participation rates in the community, and reduce unnecessary emergency department visits. While results vary across indicators compared to Q1-Q3 results from last year, the overall direction continues to support more proactive, community-based care and improved coordination between primary care and hospital services.

Collaborations with OHT East partners (Archipel OHT, Ottawa OHT, Ottawa West Four Rivers OHT, Lanark, Leeds and Grenville OHT, and more) are currently exploring how to use neighbourhood-based data to inform cancer screening participation and health promotion programs among attached and unattached patients.

CANCER SCREENING DATA







Cancer Screening

The Champlain Regional Cancer Program convened a multi-OHT working group to identify priority cancer screening areas and strengthen screening uptake and access across the region.

Digital Redesign of Clinic Workflows

A key success this fiscal was the digital redesign of clinic workflows to support improved efficiency and patient access for cancer screening, using Ocean-based screening tools across primary care clinics. EMR-enabled searches allowed clinics to proactively identify patients overdue for cancer screening and deliver targeted outreach through direct reminders and integrated online booking.

While significantly reducing the administrative burden associated with manual follow-up and phone-based outreach, this approach supported approximately:

25 **CLINICIANS** and

+32,000 **PRIMARY CARE PATIENTS**

By embedding cancer screening processes within existing digital systems, clinics were able to streamline operations, improve screening uptake, and establish a more proactive, sustainable approach to population health management.

Partnership for Better Screening Access

Another innovative initiative this fiscal was a partnership between the **Eastern Ontario Health Unit** and the **Champlain Regional Cancer Program**.

Together they held:

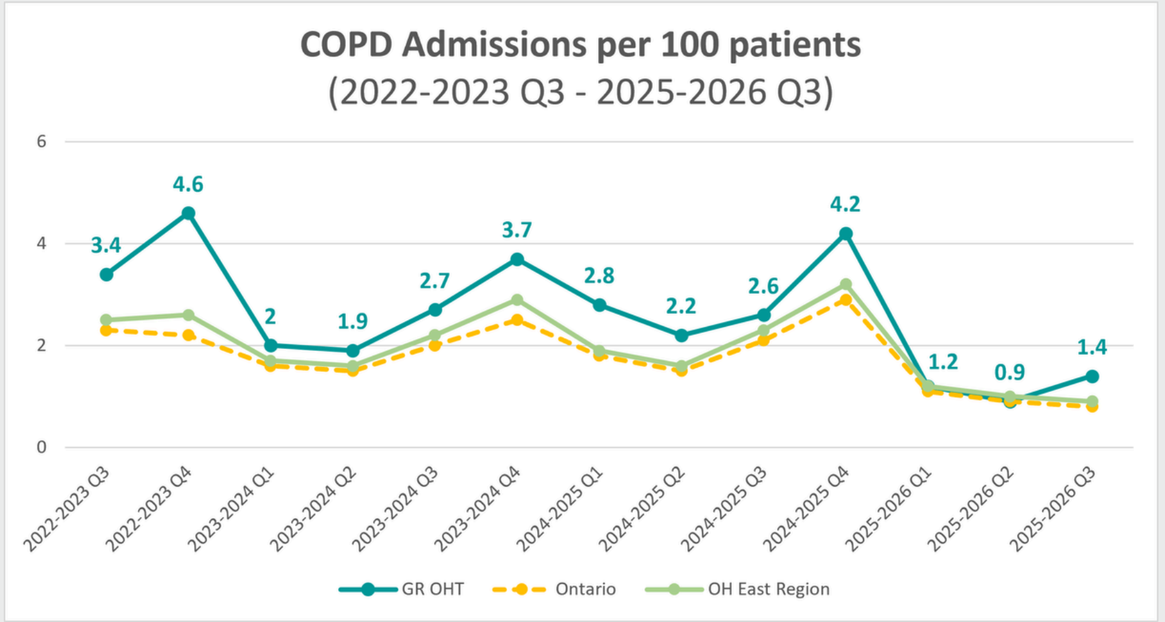
11 **CERVICAL SCREENING CLINICS**

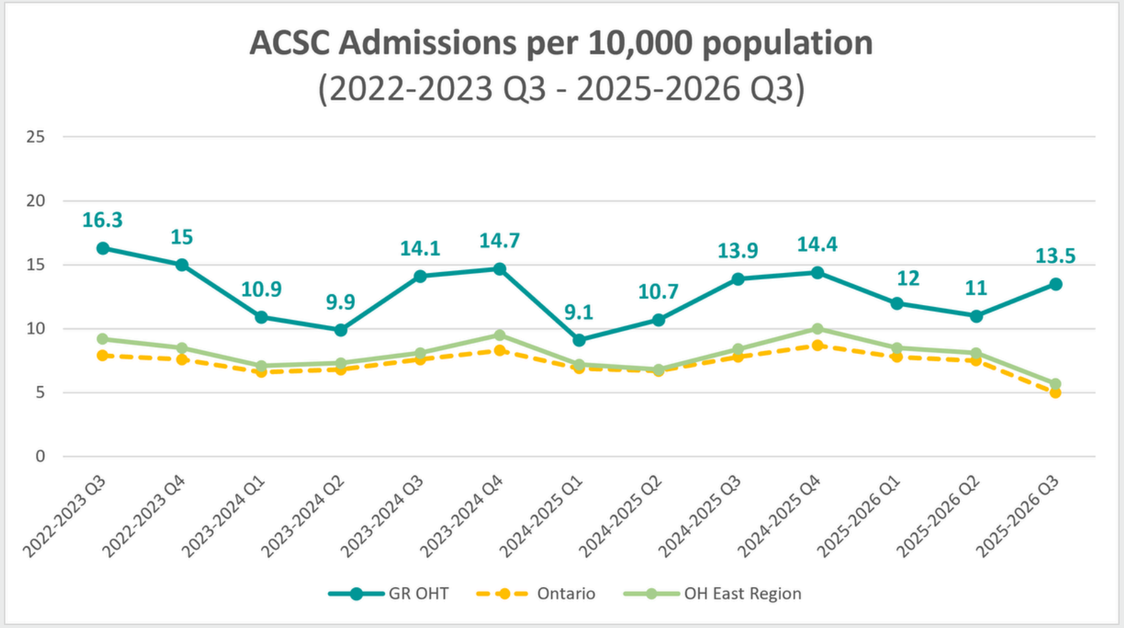
and supported:

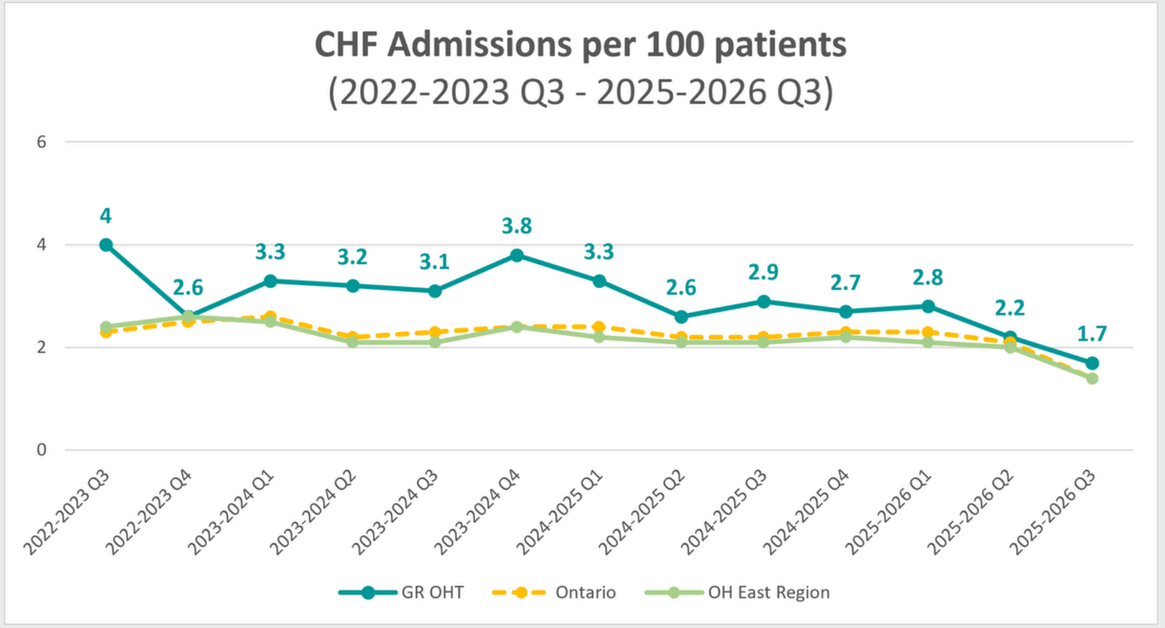
88 **UNATTACHED PATIENTS**

CHRONIC DISEASE MANAGEMENT DATA

COPD: Chronic Obstructive Pulmonary Disease
ACSC: Ambulatory Care Sensitive Conditions
CHF: Congestive Heart Failure







Chronic Disease Management

PCN Nurse

43 CLINIC DAYS

574 PATIENTS

5 PRIMARY CARE PROVIDERS

The PCN Nurse program supported clinics without team-based resources, improving access for patients with diabetes and easing clinician workload. Patients received education, preventive care, foot care, vaccinations, referrals, and self-management support, all documented in EMRs.

Diabetes Days

Diabetes Days improved coordination between primary care and diabetes education programs by strengthening communication and introducing shared standardized flowsheets to support continuity of care.

Best Care

The Best Care program expanded support for patients with heart failure, COPD, and asthma by embedding clinical support directly into primary care settings.

29 UNIQUE PATIENTS SUPPORTED THIS YEAR

(including 19 heart failure patients through 25 visits, 9 COPD patients, 1 asthma patient, and 8 spirometry assessments)

INTERCONNECTOME
COEUR-CERVEAU
BRAIN-HEART
INTERCONNECTOME

The Brain-Heart Interconnectome (BHI) project is in its second year and is studying how heart failure relates to mental health challenges. Working with several OHT partners and patient groups, it aims to understand these combined needs and improve how care systems respond. To date, approximately:

130 PATIENT SURVEYS HAVE BEEN COMPLETED

With a goal of 300 completed surveys, this initiative will establish a strong baseline of data to inform future improvements in integrated care delivery.

The project brings together partners from Centre de santé communautaire de l'Estrie, Seaway Valley CHC, and Winchester District Memorial Hospital.

Practice Facilitation

The Primary Care Practice Facilitator continues to play a critical role in supporting digital transformation and workflow optimization across primary care practices.

12 **PRIMARY CARE CLINICS**

70 **CLINICIANS ACROSS THE REGION**

Over the past year, primary care practices were supported in implementing and optimizing digital tools, including online appointment booking, eReferral, Ocean forms, secure messaging, and workflow improvements to enhance practice efficiency and patient access. Key initiatives included cancer screening workflow enhancements and expanded use of the Evidence2Practice (E2P) EMR toolbar to support standardized, guideline-informed documentation.

Together, these efforts helped reduce administrative burden, improve care quality and clinic efficiency, and better align digital health tools with the realities of primary care practice.

Primary Care Integration

This year, OHT partners and Lived Experience members came together to explore opportunities to improve coordination between primary care and community-based services including:

- **Remote Care Monitoring (RCM)** – St. Joseph's Continuing Care Centre and Ontario Health atHome
- **Primary Care Outreach (PCO)** – South East Ottawa CHC (with Seaway Valley CHC)
- **Regional Integrated Care (RIC)** – South East Ottawa CHC
- **Community Paramedicine Program (CPP)** – Cornwall SDG Paramedic Services

Key highlights:

- Planning for a coordinated intake model to improve patient attachment and reduce system fragmentation
- Challenges identified with inconsistent referral pathways (fax, Ocean eReferral, Caredove) and limited program awareness
- Commitment to a "one door" coordinated intake via Ocean eReferral to streamline access and improve provider and patient experience
- Environmental scans of existing services and referral volumes to support implementation planning

Tables and Teams

Lived Experience Partners Table (LEPT)

12 **ACTIVE MEMBERS**

12 **GR OHT TEAMS, TABLES, AND WORKING GROUPS BENEFITING FROM THEIR PERSPECTIVES**

The LEPT continues to play a vital role in embedding patient, family, and caregiver voices across GR OHT work, ensuring lived experience perspectives inform planning and decision-making. This year, the group focused on strengthening engagement through **Engagement Capable Environments**, including enhanced onboarding, mentorship, and participation of lived experience partners across OHT initiatives. A key achievement was the development of the **Sharing Your Story for System Change** toolkit, supporting safe, meaningful, and respectful storytelling. The table also advanced recruitment and outreach efforts, informed by community engagement activities that helped shape the idea for the development of a **Community Voices Collective** to broaden representation in system planning.

Navigation Table

The Navigation Table continues to improve how people access information and services across the system.

A **Navigation Services Pathways resource** was developed and broadly shared through partner organizations, public locations, and the OHT website to help individuals and caregivers more easily connect to health and social services.

The **AI Working Group** initially explored an AI-supported navigation assistant for the Great River Ontario Health Team website. Following testing and concerns related to the quality of results, the Navigation Table ended the pilot and shifted its focus toward enhancing the **Explore Supports webpage** to provide a more user-friendly and comprehensive resource.

The table also developed a **monthly webinar series** to spotlight navigation services and improve awareness of available supports across the region beginning in 2026–2027.

Tables and Teams

Inclusion, Diversity, Equity and Anti-Oppression (IDEA) Table

The IDEA Table continued its work to advance equity across the health system. This year began with an engagement activity with Collaboration Council members to explore what was working well across organizations and identify challenges related to implementing inclusion, diversity, equity, and anti-oppression (IDEA) work.

Building on those discussions, an **IDEA Baseline Survey** was completed by:

32 **MEMBER ORGANIZATIONS**

This survey was conducted to better understand current strengths, gaps, and priority areas related to inclusion, diversity, equity, and anti-oppression. Findings from both the engagement activities and survey informed the development of an IDEA work plan and identified a need for shared tools and practical resources.

In response, the table began developing a regional **IDEA Resource Directory** featuring:

100+ **CURATED RESOURCES**
including frameworks, toolkits, trainings, reports, and policy resources

This work is helping build a stronger shared foundation for equity practice across the OHT and supporting more inclusive and culturally responsive care.

French Language Services (FLS) Table

This year, partner organizations completed a **Francophone Client Identification Survey** led by the FLS Table, with findings showing that

74% **OF PARTNER ORGANIZATIONS**

currently collect information related to patients' preferred language, most commonly during intake or registration processes.

The FLS Table also continued to promote the regional **Winning Strategies** initiative among partner organizations, resulting in the following progress to date:

40% **COMPLETED THE ORGANIZATIONAL ASSESSMENT**

48% **IDENTIFIED A CHAMPION**

43% **COMPLETED CHAMPION TRAINING**

Collaboration with Indigenous Partners

The GR OHT continues to strengthen relationships with Indigenous partners, including the Mohawk Council of Akwesasne's Department of Health.

This year included several cultural learning opportunities focused on Indigenous perspectives, reconciliation, and culturally safe care.

In October 2025:

15 **GR OHT MEMBERS AND BACKBONE STAFF IN ATTENDANCE**

The group participated in a guided tour and cultural conversation at the **Native North American Travelling College**, learning more about Haudenosaunee culture, history, and worldviews.

In November 2025:

25 **MEMBERS IN ATTENDANCE**

The GR OHT also hosted a two-part workshop series on **Indigenous Perspectives on Truth and Reconciliation in Healthcare** led by Nova Cook. Participants explored topics including residential schools, colonization, intergenerational trauma, traditional medicine, and culturally safe care.

These initiatives continue to strengthen relationships, support reconciliation efforts, and deepen understanding of Indigenous histories and experiences within healthcare systems.

Project Teams

Frail Older Adults and Complex Care Needs

Over the past year, the GR OHT has made significant progress in advancing the **Essential Caregiver Program**, recognizing caregivers as key members of the care team.

In 2025–2026, the program expanded through Phase 2, focusing on growth, consistency, and sustainability. Key achievements included the development of bilingual, standardized training materials and onboarding of new referral partners.

136 **CAREGIVERS COMPLETED THE ESSENTIAL CAREGIVER PROGRAM TRAINING**

Strong cross-sector collaboration was a key driver of success, fostering alignment across organizations and demonstrating the value of integrated, system-wide approaches to supporting caregivers.

The program has been recognized provincially as a leading example of cross-sector collaboration, and tools such as implementation checklists have positioned the ECP for continued spread and long-term success.

Mental Health, Addictions and Substance Use Health

A key highlight was the continued implementation of **Solution-Focused Therapy** across organizations that provide therapy services. To date, **seven organizations** have implemented the model. The partners held an additional staff training session to ensure sustainability of the therapy offering and implemented a **Community of Practice**, where they come together to learn from one another, share knowledge, and improve their practice.

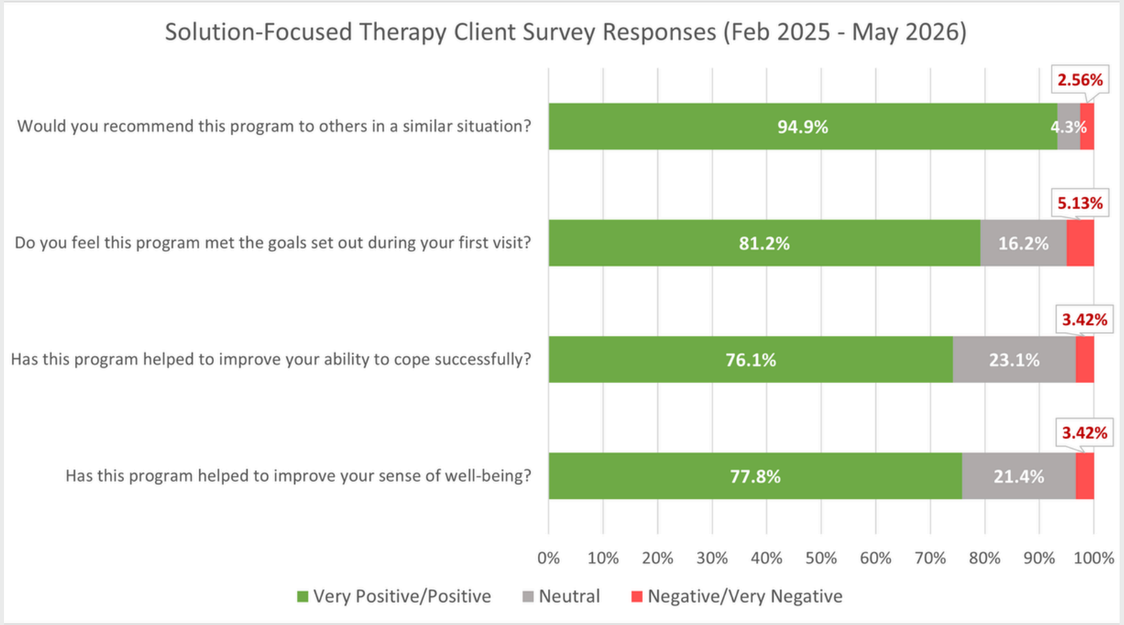
Early survey results showed very positive feedback:

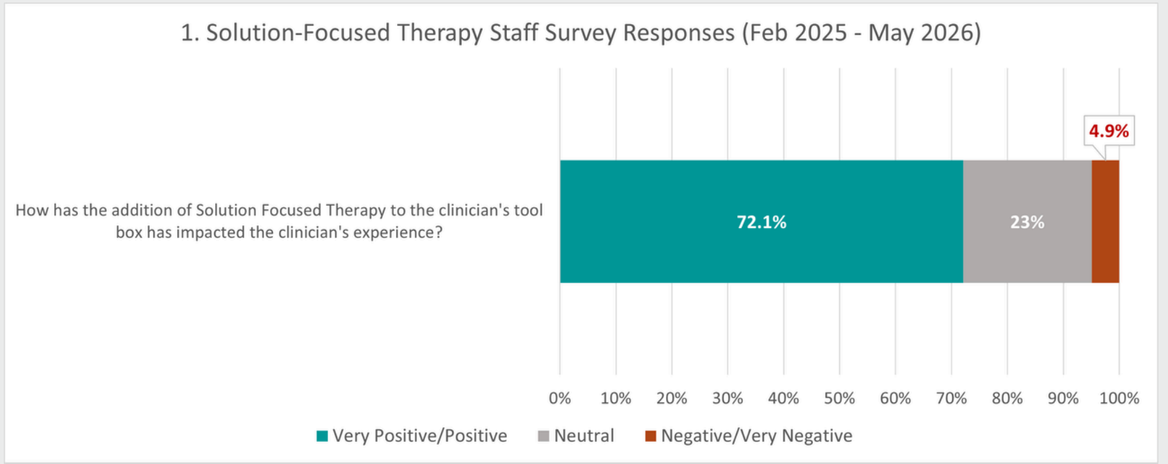
94.9% **OF CLIENTS WOULD RECOMMEND THE THERAPY APPROACH TO OTHERS**

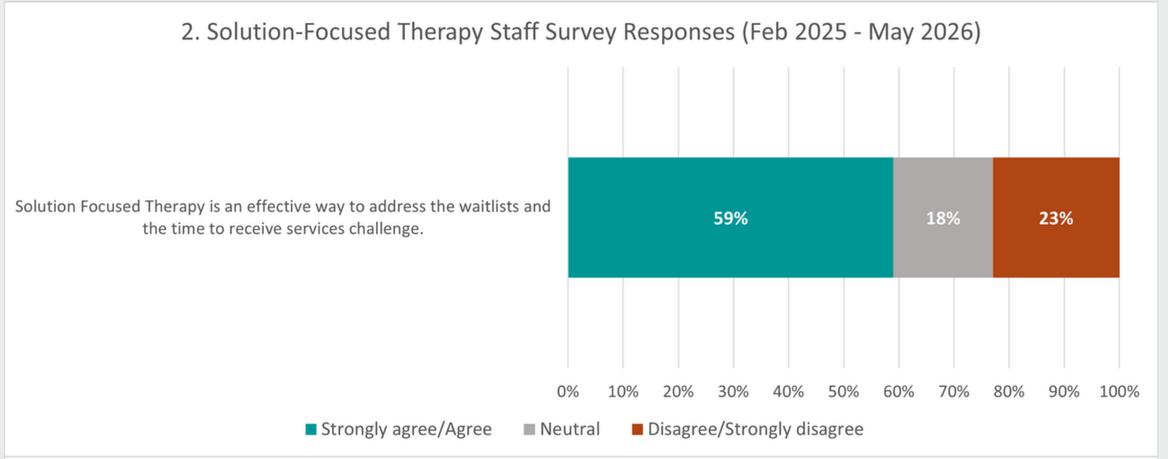
22% **REDUCTION IN MHA WAIT TIMES WAS REPORTED DURING EARLY IMPLEMENTATION**

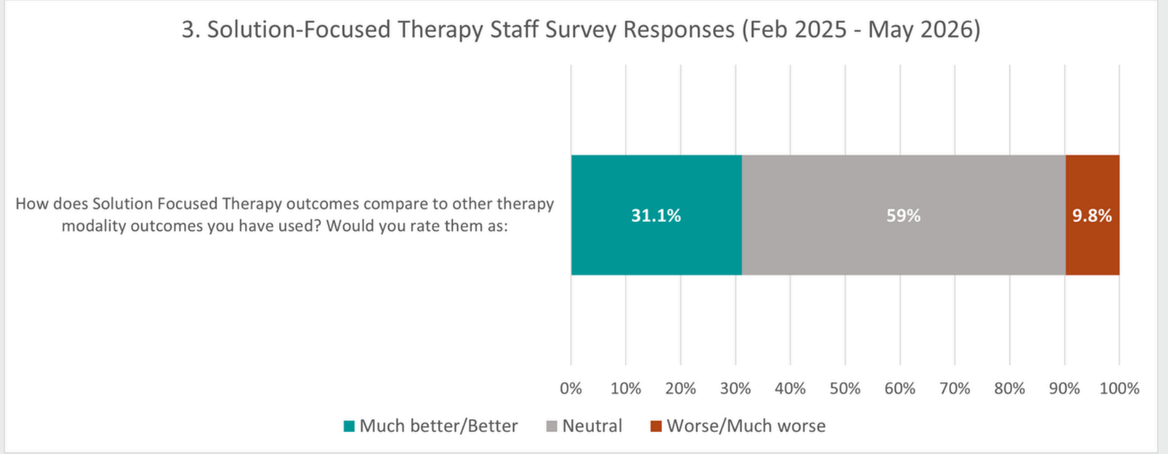
The **Substance Use Health Working Group** also advanced work on reducing stigma through the **“Safer Language: Compassionate and Stigma-Free”** initiative, promoting person-centred and non-stigmatizing communication practices across member organizations. A comprehensive package to support organizations was developed.

SOLUTION FOCUS THERAPY DATA









Project Teams

Health Human Resources (HHR)

Through the HHR Project Team and related working groups, partner organizations continue to demonstrate a strong regional commitment to collectively addressing healthcare workforce challenges.

GREAT RIVER
GREAT FUTURE
Work. Live. Belong.
In the Heart of Eastern Ontario.

+23
PARTNERS INVOLVED

A major milestone this year was the launch of the regional recruitment campaign, **“Great River, Great Future”**, featuring a shared brand, promotional materials, and recruitment video highlighting the region’s strengths.

The HHR team also advanced collaborative recruitment efforts with municipalities, healthcare organizations, and community partners, while exploring opportunities to attract healthcare professionals from Quebec, the United States, and internationally. Discussions were also initiated with the Mohawk Council of Akwesasne’s Department of Health to explore workforce planning and recruitment collaboration.

Learning Opportunities

This year, the GR OHT continued to invest in shared learning and capacity building across the system.

Key initiatives included trauma-informed care training, Indigenous cultural learning opportunities, and promotion of the Ontario Health Team Engagement Learning Series focused on empathy, co-design, equity, and trauma-informed engagement.

The Great River OHT also participated in the **Integrated Care Action Summit** held in Toronto in November 2025, joining representatives from Ontario Health Teams and Primary Care Networks across the province to share lessons learned and explore opportunities related to integrated, people-centred care.

Next Steps

Looking ahead, the Great River OHT will continue to focus on the following 2026-2027 priorities:

- Strengthening our Primary Care Network (PCN) engagement and communications
- Expanding primary care access, attachment and enablement, including strengthening supported attachment services and team-based care to work towards the goal of 100% attachment by 2029
- Supporting integrated clinical priorities (cancer screening, chronic disease management)
- Advancing provincial digital priorities
- Strengthening OHT capacity building and partnerships including our collaboration with Akwesasne
- Supporting a sustainable health workforce through a robust health human resources recruitment plan

Emerging initiatives will continue to evolve in areas such as in-home chronic disease support, digital navigation tools, integrated referral coordination, and health equity planning.

These priorities reflect both provincial direction and local community needs and will continue guiding collaboration across partners as the Great River OHT works toward a more connected, accessible, and equitable health system for all.

Great RIVER ONTARIO HEALTH TEAM

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Thank you to everyone—partners, patients, caregivers, and communities—for another wonderful year. We value your time and commitment and look forward to what can be accomplished in the upcoming fiscal year.

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