



BOARD AWARD: TEAM OF THE YEAR

Team	Contact Information
Couchiching Family Health Team	Lynne Davies CEO l.davies@cfht.ca https://www.cfht.ca
Prime Care Family Health Team Gender Affirming Clinic (GAC) Initiative	Gina Manella Executive Director ginamannella@primecarefht.ca https://primecarefht.ca/
Queen Square Doctors & Family Health Team	Steve Sheldrick CEO ssheldrick@queensquarefht.ca https://www.queensquarehealth.ca/
Health for All Family Health Team Together We Built Capacity: A Collective Journey Across Roles to Redefine Booking to Grow Attachment Without Breaking Continuity	Zabi Nassery Executive Director znassery@healthforallfht.ca https://healthforallfht.ca/





BOARD AWARD: TEAM OF THE YEAR

NOMINEE(S): Couchiching Family Health Team

TANGIBLE IMPACT

Our Chief Executive Officer, Lynne Davies, is among the pioneering Executive Directors in the Family Health Team sector and continues to lead by example. Through decades of leadership, mentorship, and advocacy, she has helped shape not only our organization but also the broader primary care landscape. Her example has fostered a culture of trust, accountability, collaboration, and excellence that permeates every level of our organization.

A key strength of the CFHT team is its commitment to actively involve patients and community voices in shaping care. Through an embedded Patient and Family Caregiver Network, patients and caregivers are engaged as partners within working groups and strategic planning processes. This ensures that programs and services are co-designed with those they serve, strengthening relevance, accessibility, and overall patient experience. The team's ongoing focus on supporting both patients and caregivers reflects a deep understanding of the importance of inclusive, person- and family-centred care.

DEMONSTRATING EFFECTIVE INTERPROFESSIONAL COLLABORATION & LEADERSHIP

Our Family Health Team exemplifies what it means to be a truly team-based, patient-centred organization. Team-based care is not simply a model of service delivery it is the foundation of how we care for patients, support one another, and partner with our community. We believe the best outcomes occur when patients, families, physicians, nurses, allied health professionals, administrative staff, and community partners work together toward shared goals. Every member of our team contributes unique expertise, and we have intentionally

built a culture where collaboration, communication, and mutual respect enable each individual to work to their full scope in service of patient care.

This approach extends beyond co-location or interdisciplinary practice. We share responsibility for patient outcomes, collaborate on complex care needs, and coordinate services across programs and sectors to ensure patients experience seamless, person-centred care. Through true team-based care, patients gain access not only to an individual provider, but to the collective knowledge, skills, and compassion of an entire healthcare team.

ENGAGING PATIENTS AND COMMUNITY MEMBER TO SHAPE AND DELIVER CARE

As a highly connected organization within our community, we have consistently stepped forward to address emerging healthcare needs and strengthen integrated care across the region. We proudly serve as the lead organization for the Couchiching Ontario Health Team, bringing partners together to improve coordination, access, and outcomes for patients. Our leadership and commitment to transformation were further recognized when we were selected as one of the province's i12 teams, reflecting our ability to drive innovation and system improvement.

This team-first approach was clearly reflected through their engagement with a local “Loonie Lunch” program—a welcoming, low-cost weekly meal that supports individuals in need. Recognizing an opportunity to extend care beyond traditional settings, the System Navigation Team, Dietitians, and Unattached Care Clinic came together with a unified purpose. Each team contributed their expertise on-site, sharing information, connecting individuals to services, and facilitating access to care. This coordinated effort ensured that individuals were not only supported in the moment but also connected to ongoing care. The response from program organizers was deeply moving and highlighted the meaningful impact of this collective effort.

The strength of our team was further demonstrated during the 2025 Ice Storm, when staff rapidly mobilized to support the Emergency Response Centre. Working seamlessly across roles, the team ensured patients received timely clinical care. Patients without a primary care provider were registered in the Unattached Care Clinic, seen the same day, and supported with transportation through community partnerships. Mental Health and System Navigation teams collaborated closely to provide immediate on-site support and coordinated follow-up care, ensuring continuity beyond the crisis.

Our team consistently demonstrates a willingness to take on complex challenges when it is the right thing to do for patients. Over the years, we have been entrusted to lead and deliver numerous programs, including Trans Health, Rapid Access Clinics, Ontario Structured Psychotherapy (OSP), CARE, and Congestive Heart Failure (CHF) programs. Each initiative

involved unique partnerships, funding models, reporting requirements, and operational demands. Despite the significant workload, our response has always been the same: if it benefits our patients and community, we will find a way to make it happen.

INNOVATION & QUALITY IMPROVEMENT

Our achievements are possible because of the strength of our team-based model. Across programs, disciplines, and organizations, our providers work together to coordinate care, share expertise, and ensure patients receive the right care at the right time. Whether supporting individuals with complex chronic disease, improving access to mental health services, or creating inclusive pathways for underserved populations, our teams approach every challenge collaboratively. We recognize that no single profession or provider can meet all patient needs; it is through our collective efforts that we achieve the greatest impact.

One example is our Trans Gender program.

Where our specialized care absorbing complex gender-affirming care needs of patients and community members decreases utilization of emergency services.

1. Trans and gender diverse people in Ontario are more likely to access emergency or acute care due to unmet mental health needs. Our services focuses on proactive gender-affirming care by providing access to medical care, counselling, and systems navigation. Our approach supports mental health earlier, improving client well-being, and helps reduce crisis and hospital use.
2. We support our own PCPs who may lack training or confidence.
3. Working to build capacity in our local region by working with and educating other service providers, including community based PCPs.
 - Regionally important (North Simcoe Muskoka – large catchment)
 - Reduces need for travel to urban centres
 - Improves equity in a semi-rural/rural region
 - Offering telephone, virtual and in person appts to decrease barriers

This commitment is only possible because of the extraordinary dedication of our interdisciplinary team. Every day, physicians, nurse practitioners, nurses, allied health professionals, administrative staff, and leaders work together as a coordinated care team, sharing knowledge, solving problems collectively, and supporting patients across their healthcare journeys. Team members are empowered to work to their full scope, recognizing that each discipline brings valuable expertise that strengthens patient care. The trust, respect, and psychological safety that define our culture enable innovation, open communication, and a shared accountability for outcomes. Rather than working in parallel, we work together ensuring patients experience truly integrated, person-centred care.

ROLE AS INFLUENCER IN BROADER SYSTEM IMPROVEMENTS FOR OPPORTUNITY TO SCALE AND SPREAD

What truly distinguishes our organization is our people. From our Primary Care Lead to our Senior Executive Team, leadership is grounded in a culture-first philosophy. Our leaders understand that exceptional patient care begins with supporting the individuals who provide it. Staff and physician well-being are not simply organizational values they are reflected in daily actions, decisions, and workplace practices. We have built an environment that genuinely supports work-life balance, fostering engagement, resilience, and long-term sustainability.





BOARD AWARD: TEAM OF THE YEAR

NOMINEE(S): Gender Affirming Clinic (GAC) Initiative

ORGANIZATION: Prime Care Family Health Team

TANGIBLE IMPACT SNAPSHOT

The GAC team has achieved measurable outcomes across access, equity, integration, patient experience, provider/team workflows, and system efficiency. The clinic's data show substantial demand, rapid growth, strong use of virtual care, preservation of in-person access, and a comprehensive service mix. The clinic is also reaching people who may otherwise remain disconnected from care, including 211 unattached or unrostered patients, representing approximately 3.2% of all intakes.

The client testimonial captures the impact in the patient's own words: "After some difficulty finding available support and access to gender affirmative care, I was immediately welcomed and given every resource needed at Prime Care Family Health Team's Gender Clinic. Meeting with a team of specialists all there to assist me on my journey allowed me to move forward with confidence. I appreciate having direct access to my health care provider. It's been a life changing experience to have landed here."

Overall, the team merits recognition because it demonstrates the best of interprofessional primary care: shared leadership, equity-driven access, patient-informed improvement, measurable impact, and a scalable model that can help transform care delivery. The GAC team is not simply providing appointments; it has built a specialized, trained, and coordinated care pathway for a population that has historically faced stigma, travel barriers, long waits, lack of provider knowledge, and fragmented services.

DEMONSTRATING EFFECTIVE INTERPROFESSIONAL COLLABORATION & LEADERSHIP

Prime Care Family Health Team's Gender Affirming Care Clinic (GAC), launched in July 2024, demonstrates effective interprofessional collaboration by delivering specialized gender-affirming care through a cohesive primary care team rather than a single-provider or stand-alone specialty model. The clinic is NP-led and supported by a Nurse Practitioner, Registered Nurse, Social Worker, Case Worker/Manager, Pharmacist, two Registered Practical Nurses, QIDSS support, Ontario Health accountability, and operational oversight from leadership. This structure allows the team to respond to hormone therapy, mental health support, service navigation, injection support, surgical-readiness and assessment support, results review, education, peer/group programming, and broader primary care needs.

Shared leadership is evident in how each role contributes to the patient journey. The Nurse Practitioner leads clinical assessment, hormone therapy, medical follow-up, surgical-readiness support, and clinical leadership. Registered Nurses and RPNs support injections, patient flow, education, follow-up, screening, and in-person clinical needs. Social work supports mental health, coping, counselling-related care, and social determinants of health. The Case Worker/Manager supports service navigation, referrals, forms, community resources, and system coordination. The Pharmacist supports medication review, medication safety, patient education, and team consultation. QIDSS support enables data tracking, reporting, PDSA cycles, quality improvement, and population health measurement. Leadership and operations support sustainability, staffing, accountability, financial oversight, and risk management.

The team collaborates through shared workflows, EMR-supported documentation, team communication, interdisciplinary problem-solving, and case conferencing. This reduces fragmentation for patients and prevents patients from repeatedly explaining their needs across disconnected services. The result is a dedicated, trained, specialized team that wraps care around the patient and uses each discipline's strengths to improve access, safety, equity, and continuity.

ENGAGING PATIENTS AND COMMUNITY MEMBER TO SHAPE AND DELIVER CARE

The clinic was developed in response to patient experience, community consultation, regional service gaps, and implementation-planning evidence. The team recognized that transgender, non-binary, and gender-diverse people in Halton and surrounding regions faced limited local access, long wait lists, travel outside their communities, insufficient provider capacity, and fragmented pathways across medical, mental health, and social care. The

team also recognized that some patients were unattached to primary care, making navigation and continuity even more difficult.

Patient and community engagement are embedded in the access model. The clinic accepts community referrals and self-referrals to reduce entry barriers, including for people without an attached primary care provider. The clinic also accepts referrals beyond the immediate PCFHT roster, allowing the team to respond to broader regional need and support patients across geographic boundaries. Regional access itself functions as an engagement strategy by allowing the clinic to hear from and respond to patients who would otherwise have limited local options.

The team uses feedback as a quality improvement tool. A Client Experience Survey was administered multiple times in the first year to understand how patients experienced the clinic and to identify opportunities for improvement. The team also administers regular surveys at the end of the online 8-week Gender Journeys Group sessions to gather participant feedback and refine group content, delivery, and supports. These feedback loops support continuous improvement and ensure patient voices shape care delivery, communication, education, and service design.

Patient voice also demonstrates the value of the model. One client shared: “After some difficulty finding available support and access to gender affirmative care, I was immediately welcomed and given every resource needed at Prime Care Family Health Team’s Gender Clinic. Meeting with a team of specialists all there to assist me on my journey allowed me to move forward with confidence. I appreciate having direct access to my health care provider. It’s been a life changing experience to have landed here.”

INNOVATION & QUALITY IMPROVEMENT

The team’s core innovation is a hybrid, interprofessional, primary-care-based Gender Affirming Care Clinic that brings together services that are often fragmented across multiple settings. Instead of requiring patients to navigate separate medical, mental health, pharmacy, surgical-readiness, and navigation pathways, the clinic coordinates these supports through one trained team. This approach was developed in response to a documented local gap in gender-affirming care access and to patient/community needs related to travel burden, long waits, provider knowledge gaps, and fragmented navigation.

The model reflects disciplined quality improvement. The team uses EMR-supported documentation, Ontario Health monthly reporting, PDSA cycles, QIDSS-supported measurement, and regular review of intake, visit type, appointment reason, attachment status, patient feedback, and geography. These data are used to identify demand, adjust workflows, refine scheduling, improve referral processes, monitor access, and plan future capacity. The Client Experience Survey and Gender Journeys Group surveys add qualitative and patient-experience feedback to the team’s improvement cycle.

Evidence supports the effectiveness of this approach. The clinic has recorded 6,644 intakes and 11,876 visits captured by visit type. Virtual care accounts for 10,195 visits, or 85.8% of visit-type activity, demonstrating that the model reduces travel burden and extends access beyond local geography. In-person care remains available for clinical needs, with 1,379 in-person visits, or 11.6% of visit-type activity. The service mix also confirms the need for integrated care: GAC Hormone Therapy accounted for 1,606 visits, GAC Mental Health for 1,370 visits, GAC Service Navigation for 862 visits, GAC Gender Journey Program for 324 visits, GAC Surgical for 261 visits, GAC Group Peer Support for 191 visits, GAC Injection for 130 visits, GAC Results for 101 visits, and other needs such as education, family support, medication review, Pap/HPV, preventative care, forms, and sexual health for 196 visits. These volumes show that patients require more than isolated medical visits; they require integrated, coordinated, equity-focused care.

ROLE AS INFLUENCER IN BROADER SYSTEM IMPROVEMENTS FOR OPPORTUNITY TO SCALE AND SPREAD

The GAC team has influenced broader system improvement by proving that gender-affirming care can be delivered safely, compassionately, and comprehensively within interprofessional primary care. This is important because many patients experience gender-affirming care as fragmented, hard to access, and dependent on limited specialized services. PCFHT's model demonstrates that a trained primary care team can create a coordinated pathway that includes clinical care, mental health, medication support, social work, service navigation, peer/group programming, surgical-readiness assessment, and quality improvement.

The model has strong replication potential because its core components are transferable: accessible referral and self-referral pathways, intake and triage processes, clearly defined interprofessional roles, shared documentation, case conferencing, hybrid access, patient feedback mechanisms, appointment-reason tracking, attachment-status tracking, population-health measurement, and QI support. Other primary care teams could adapt the model for communities that have limited or no local gender-affirming care access.

The team's regional reach also shows system-level relevance. Patient location data include 175 known city locations. Among patients with known city data, 548 patients, or 55.9%, were from the GTA and 433 patients, or 44.1%, were from outside the GTA. The map-ready dataset of cities with 10 or more patients includes 19 cities and 685 patients, with high-volume locations including Ottawa, Mississauga, Toronto, Oakville, Milton, Brampton, Burlington, and London. Across the full dataset, 1,244 records were reviewed, including 263 blank city records; 981 patients had a known city that could be classified as GTA or outside GTA. This reach demonstrates that the clinic is not only filling a local Halton gap; it is functioning as a broader regional access model.

The clinic's broader system impact is also reflected in the range of organizations that refer patients to the GAC team, demonstrating trust in the model and the need for a specialized primary care pathway across sectors. Referrals have come from community health, hospital, pediatric, family health team, mental health, and peer/community support partners, including Centretown Community Health Centre, Planned Parenthood Ottawa, SickKids Hospital, Children's Hospital of Eastern Ontario, McMaster Children's Hospital Gender Clinic, Queen Square FHT, CMHA York-Durham, Couchiching FHT, PFLAG, and CMHA Halton. This referral network shows that the clinic is not functioning in isolation; it is part of a broader care ecosystem helping patients move from fragmented access points into coordinated, affirming, interprofessional primary care.

TANGIBLE IMPACT CONTINUED

Visit type data demonstrate the strength of the hybrid model. Of 11,876 total visits captured by visit type, 437 were in-person assessments, representing 3.7%; 6,906 were virtual assessments, representing 58.2%; 942 were in-person follow-ups, representing 7.9%; 3,289 were virtual follow-ups, representing 27.7%; and 302 were unspecified or blank, representing 2.5%. The predominance of virtual assessments and follow-ups supports access across regions, reduces travel burden, and helps the team respond to high demand. At the same time, in-person visits remain available for clinical needs requiring direct assessment, injections, or face-to-face support.

Growth data show rapid scale-up. The clinic recorded 897 visits in 2024, including 226 in Q3 and 671 in Q4. In 2025, visit volume increased to 5,872 visits, with 965 in Q1, 1,545 in Q2, 1,489 in Q3, and 1,873 in Q4. In 2026 year-to-date, 6,011 visits were reported, including 2,422 in Q1 and 2,685 in Q2. The increase from 226 visits in 2024 Q3 to 2,685 visits in 2026 Q2 demonstrates that the team is meeting a real population need and has developed a model that can expand beyond launch capacity.

Observable outcomes include a more welcoming, affirming, and coordinated point of access for patients; identification and support for patients without an attached provider; clearer workflows and role clarity for providers; shared documentation and interdisciplinary problem-solving; and a replicable primary care model that reduces avoidable fragmentation and expands access across geography.





BOARD AWARD: TEAM OF THE YEAR

NOMINEE(S): Queen Square Doctors & Family Health Team

ORGANIZATION: Queen Square Family Health Team

TANGIBLE IMPACT SNAPSHOT

At Queen Square FHT, we routinely collect and implement feedback from various sources, including quantitative data and lived experience, to drive quality improvement. This commitment has led to tangible changes in care delivery. For example, feedback from 2SLGBTQI+ patients informed the creation of our Care Navigator role - a position designed to gather ongoing lived-experience insights, reduce barriers to care, and help create a more welcoming and affirming environment.

To promote equitable access, we provide taxi vouchers to patients with complex medical needs who are experiencing financial hardship, are unable to use public/accessible transit, do not drive, and lack supports who can drive them to appointments.

In 2025, Dr. Chris Veenema was recognized by the Ontario College of Family Physicians for his outstanding, coordinated care of a patient following a catastrophic motor vehicle collision, an example of the compassionate care that defines Queen Square. The article is found here:

<https://ontariofamilyphysicians.ca/news/brampton-family-physician-quarterbacks-care-after-catastrophic-car-accident/>

DEMONSTRATING EFFECTIVE INTERPROFESSIONAL COLLABORATION & LEADERSHIP

Our team demonstrates effective interprofessional collaboration and shared leadership through an organizational culture that values collective decision-making, role clarity, innovation, and mutual respect across all disciplines. Over the past three years, a conscious effort has strengthened collaboration between the FHT and the FHO, ensuring both groups work closely together across all aspects of care delivery, operations, strategic planning, and team-building activities. This integration was first reflected in the appointment of one CEO overseeing both the FHO and the FHT. This was further strengthened by establishing a Senior Leadership Team (SLT) consisting of leaders from both the FHT and FHO. As a result of our efforts, we have seen a 14% increase in our team's satisfaction with this collaboration in 2025-26.

Our SLT reflects interprofessional collaboration by including leaders who come from clinical backgrounds and who also maintain their clinical roles. In addition, the Medical Director provides physician oversight, and the CEO, Manager, and Director of Operations support operational and organizational effectiveness. This offers a strong balance of clinical and administrative perspectives. Our SLT meets regularly, plans events, discusses staff training and team-building opportunities, and advances strategic priorities while actively incorporating input from staff. Examples of events include our annual general meeting, summer BBQ, year-end event, privacy training, provider in-services and patient-facing promotional booths, and recognition days such as Administrative Assistants' Day, Mental Health Week, Nursing Week, etc., to name a few. To strengthen effective collaboration, clear organizational charts, staff list and roles, and FHT program and service descriptions in a regularly revised manual, have enabled all members of Queen Square to learn more about the organization.

A special characteristic of Queen Square's culture is our horizontal operating model. We minimize hierarchical barriers, empower decision-making at every level, and foster cross-functional collaboration, allowing us to respond quickly and execute with agility. An example of how we effectively collaborate across teams is through our annual reflections on service and program data to celebrate successes, identify gaps, review and revise Schedule A indicators and key performance metrics to maintain high-quality team-based care that is accessible and responsive, and keep patient experience at the center. Shared leadership and team empowerment are further embedded through our Quality Improvement Team, which includes diverse representation from both the FHT and FHO to further enable collective decision-making, shared accountability, and coordinated actions towards our strategic priorities.

Queen Square encourages staff from all backgrounds to propose innovative ideas and lead initiatives aligned with their interests and skills. For example, our green healthcare initiatives are led by our Dietitians (RD), while our Medical Office Assistants, Social Workers, and Project Manager lead community outreach activities for patient attachment, Peel Pride, Coldest Night of the Year, and volunteering for community events. In addition, our IHPs have co-developed health and wellness workshops, self-paced videos, system navigation tools, and tip sheets for patients and community members. Examples include an OT-led Seniors' Social Club at a local church, RD-led cooking classes and staff trainings on managing diabetic emergencies.

Queen Square FHT continues to be a place for progressive growth with many examples where clinical and administrative staff have moved into formal leadership positions over the years. Our Nursing team embodies shared leadership through a rotating "Lead Nurse" model. Every three months, nurses take on leadership responsibilities, from scheduling and coverage coordination, to quality improvement and team communication, while mentoring the next lead. This approach builds leadership capacity within the team, strengthens accountability and collaboration. Physicians and team members have reported better communication, seamless coverage, and more coordinated patient care as successful outcomes.

We recognize that strong collaboration and high-quality team-based care depend on a healthy workplace culture. We prioritize staff wellbeing through flexible work arrangements, team-building activities and celebrations, and professional development. We continue to see high rates of autonomy, collaboration, and overall satisfaction in staff experience surveys. Queen Square's reputation has led to former students; healthcare and administrative professionals reach out proactively to inquire about job opportunities, in addition to maintaining above 85% staff retention rates.

ENGAGING PATIENTS AND COMMUNITY MEMBER TO SHAPE AND DELIVER CARE

As a founding member and the largest FHT in the Central West Ontario Health Team (CWOHT), we play a leadership role in advancing integrated, community-centred care and supporting patient attachment across the region. Our team collaborates with patients, caregivers, and community partners to ensure services are responsive, inclusive, and aligned with evolving community needs.

A cornerstone of our engagement approach is the Queen Square Patient Voices (QSPV) Advisory Committee, which is a patient-led body supported by our leadership team and FHT Board. QSPV members provide direct input into care experiences, program planning, communication strategies, and quality improvement initiatives, including guiding the rollout

of our health equity survey. The FHT Board also includes two community members who ensure organizational decisions remain grounded in lived experience and community needs.

We use multiple feedback mechanisms to continuously improve and adapt care delivery. Collection methods are intentionally varied to reflect patient experiences, preferences and the program or service sensitivity: OCEAN questionnaires and food logs are completed prior to interprofessional appointments to support tailored, efficient care; FAMCARE uses mailed surveys to provide confidential feedback; and digital tools (Google/Microsoft Forms) capture timely program-specific input. We note consistently high rates (above 85-95%) across most of our programs and services on patient and caregiver surveys on their perception of skills, confidence, and knowledge in managing their health. These surveys were developed based on standards from Health Quality Ontario and literature based on the Patient Activation Measure (PAM). Our post-workshop feedback from our pharmacist-led Gender Affirming Care hormone therapy sessions drove meaningful revisions to content and delivery, improving participant satisfaction and experience. Our Care Navigator, a champion of the 2SLGBTQI+ community, gathers lived-experience data to identify barriers and opportunities within care pathways. The FHT adopted CHIME, a kiosk-style check-in system that is EMR-integrated, one of the first FHTs in Ontario to do this! This addition was well received by our patients, “It is very easy to use which from my experience has sped up wait times”

We have built meaningful partnerships that expand access and improve transitions in care. We are the only FHT in the CWOHT offering a community-and self-referral-based Gender Affirming Care Program. Other examples - Step 2 CBT groups for anxiety and depression with William Osler Health System (WOHS); the CBT Affirm Program with AYSP and Pflag Canada Peel Region; the Ontario Structured Psychotherapy Program with CarePoint Health; and collaborative Geriatrician-Nurse Practitioner joint consultations to provide timely access to a specialist within primary care.

A simple example of our culture of listening and action occurred recently when a patient expressed appreciation for a Medical Office Assistant wearing a Pride allyship shirt. Recognizing the positive impact this had on the patient's sense of inclusion and belonging, the leadership team quickly responded by providing additional allyship shirts for staff to wear regularly. This small but meaningful change demonstrates how feedback is acted upon in real time to foster a more welcoming environment for patients and staff alike.

Our community partnerships span a broad network: Regeneration Brampton, a local organization for those experiencing homelessness, Brampton Public Library, Seva Food Bank, Peel 2SLGBTQI+ Collaborative, Moyo Health and Community Services, Canadian Mental Health Association, Centre for Addiction and Mental Health, Brampton HART Hub, William Osler Health System (WOHS), and Pflag Canada Peel Region. Our team actively attends events like the CWOHT System Navigation Fair, and Peel District School Board Mental Health Fair. Staff contribute to the Peel Collaborative for Pride and sit on the Peel District School Board Mental Health Advisory Committee. This reflects deliberate efforts

taken to increase physical presence and bring services directly into community spaces such as libraries, churches, schools, cultural festivals, etc., meeting people where they are, and addressing broader determinants of health. These ongoing connections have built trust, raised awareness of Queen Square and its offerings, and ensured that community voices continue to shape what we do.

We are fortunate to have staff members who deliver care in other languages, and we regularly use interpretation services. We strive to match patients with physicians based on their preferences for gender and language whenever possible. We also partner with various universities to offer student placements and residencies to foster the growth of next-generation healthcare professionals.

INNOVATION & QUALITY IMPROVEMENT

An impactful quality improvement initiative at Queen Square FHT has been the redesign of our Nurse Assist Service, a deliberate, team-driven effort to restructure nursing workflows and deliver more proactive, coordinated team-based care.

Physicians were managing dense, information-heavy appointments with limited time to address upstream education, preventive care, and patient activation. Nursing capacity existed within the team independently but was not deployed in tandem with physician visits. There was a clear opportunity to restructure how nurses and physicians worked together to deliver more comprehensive, efficient, and patient-centred care.

The redesign was collaborative from the outset. Nursing and physician leads engaged in structured planning discussions, workflow mapping, and feedback gathering to identify where care gaps existed and how nursing assessments could meaningfully complement physician visits. The process was iterative, built on frontline expertise, provider input, and a shared commitment to improving outcomes rather than simply redistributing tasks. The team started with a prioritized list of nursing services and eventually scaled up to best suit the needs of the physicians and the patient populations they were serving.

The resulting model embedded a comprehensive nursing assessment upstream of physician visits for patients with chronic conditions. For diabetic patients specifically, nurses now conduct pre-visit assessments that address key clinical indicators, patient education, medication review, foot screening, and preventive care measures including immunizations, ensuring that by the time a patient sees their physician, foundational work has already been completed. This freed physicians to focus visits on complex clinical decision-making, care planning, and relationship-building. Diabetic patients now receive more consistent, structured assessments, contributing to improved continuity and quality of care.

This model has had a significant downstream effect not only enabling more coordinated, efficient care delivery, but allowing physicians to take on new patients, supporting Queen Square's patient attachment goals. It is a successful example that shows quality

improvement in care delivery and expansion of access are not competing priorities; when care is redesigned thoughtfully, both can be achieved simultaneously.

The team has also implemented various advanced medical directives, accompanied by the necessary nursing training and certification to further support integrated comprehensive care. Providers have reported greater satisfaction with the flow and productivity of clinical visits, and nursing staff have experienced expanded scope and professional growth within their roles. The initiative has influenced how we approach training new staff, setting a higher organizational standard for what coordinated, team-based chronic disease care looks like in practice.

The Nurse Assist Service is one example of Queen Square's broader organizational commitment to innovation and quality improvement. Other examples include 1) WaiveTheWait AI intelligently triages clinical tasks and reduces physician administrative burden. 2) Seniors' Wellness Program is currently undertaking a formal project to assess the effectiveness of team-based older adult care to reduce ED utilization and is supported by a Healthcare Excellence Canada (HEC) grant in partnership with the Canadian Institute of Health Research. 3) Our Gender Affirming Care Program is actively undergoing capacity-building efforts to streamline processes, improve collaboration and provider competency to be able to reduce waitlists and serve more patients who lack access to affirming care. 4) Cancer Screening Program has onboarded 13 physicians, partnered with the local hospital to provide direct mammogram booking for eligible patients, maximized nursing capabilities, partnered with the regional Cancer Care Ontario branch, and utilized digital tools to build capacity in screening over 4000 overdue patients. 5) Through the Leading Safety Differently Action Series by HEC, we have added new safety-related questions to our staff experience survey to capture our team's sense of physical and psychological safety. 6) In 2025, the leadership team led an EMR standardization project to strengthen data quality for Board and Ministry reporting. This not only reduced errors and inconsistencies with EMR tracking in schedules but also provided clarity to teams to meaningfully capture their work. 7) We have developed a Learning Hub for patient and staff education. 8) We are advancing an innovative patient attachment model that has already met over 50% of its target.

These initiatives reflect a team that does not innovate in isolation; quality improvement is embedded in how we plan, deliver, and continuously evolve care across the organization.

ROLE AS INFLUENCER IN BROADER SYSTEM IMPROVEMENTS FOR OPPORTUNITY TO SCALE AND SPREAD

Our team's work has driven broader system improvements through scalable, partnership-driven models, standardized operational frameworks, active knowledge exchange, and

meaningful participation in regional system-building, each designed with replication and equity in mind.

We wish to highlight our innovative patient attachment model, which moves beyond traditional physician recruitment into the Family Health Organization (FHO). By building structured partnerships with existing Family Health Groups (FHGs), we enable patients to remain within familiar clinical environments and community spaces while gaining access to enhanced interprofessional supports through the FHT. This approach preserves continuity of care, strengthens existing primary care infrastructure, and offers flexible partnership agreements that allow physician groups to attach new patients while drawing on the FHT's administrative and allied health resources. This hybrid attachment model is directly replicable across communities facing primary care access challenges and limited physician capacity, offering a practical alternative to building new infrastructure from the ground up.

Our organization has invested in system-level scalability by developing standardized protocols and guidance documents co-designed with staff and embedded into onboarding, clinical workflows, and operational processes. These resources promote consistency, safety, and efficiency, and serve as a replicable framework that other organizations can adapt during periods of growth or workforce transition. Examples include policies governing the safe and effective use of AI technologies, home visits, electronic communications, and professional development. Our Code of Ethics & Professionalism is rooted in our tagline "Compassion. Commitment. Care." and reflects our commitment to building environments where patients, community members, and staff alike feel supported to thrive.

Queen Square's openness and collaborative spirit are further demonstrated through the versatile ways we show up for our community and system partners. Through our partnership with Regeneration Brampton and Seva Food Bank, our IHPs deliver care directly to community members who may not otherwise access primary care supports. As an integral member of the Peel 2SLGBTQI+ Collaborative, we ensure Queen Square remains present and responsive to the needs of the 2SLGBTQI+ community. As founding members of the Central West OHT, our FHT sits on the Palliative Care Planning table. Queen Square also serves as the operational hub for the CWOHT CARE Program for Frail Older Adults, an award-winning initiative that brings physician-RN service to the homes of homebound older adults who are unable to seek care from traditional settings. As of March 2026, this program demonstrates over 50% reduction in ED visits after 6 months of being in the program, and 50% reduction in inpatient admissions after 1 year of being in the program. Altogether, these examples position Queen Square as a trusted thought and implementation partner in shaping system-wide priorities.

We are contributing to broader system improvement through direct collaboration with tertiary care by integrating specialist geriatrician consultations into our Seniors' Wellness Program alongside our Nurse Practitioners (NPs). This model enables timely access to diagnostic clarification, preventative care, and early intervention, while also helping to

reduce pressures on outpatient geriatric services. It strengthens collaboration between primary and tertiary care, while supporting NPs in expanding their expertise and competencies in older adult care. Currently, wait times for outpatient geriatric services at William Osler Health System range from 12-18 months, whereas joint geriatrician-NP consultations at our FHT are typically available within 2-3 months of referral alongside strong team support from occupational therapists and pharmacists.

Looking ahead, our Health Equity Survey has the potential to meaningfully inform broader decision-making and drive system improvements across programs and services, ensuring more equitable care delivery is embedded into how our organization and its partners evolve.

Our team has also become a recognized learning site within the region. Other FHTs and health system partners regularly visit to learn from our programs, digital innovations, and care models, with particular interest in our Gender Affirming Care program, interprofessional collaborative care approaches, and digital transformation initiatives such as CHIME-enabled workflows and technology-supported care coordination tools. These exchanges reflect a culture of reciprocal learning: our presence and collaboration across tables and partnerships allow us to continuously learn while sharing our innovations and expertise with the broader system.

TANGIBLE IMPACT CONTINUED

A patient story that demonstrates the collaborative effort of our Seniors' Wellness Program to support a vulnerable older adult living alone: following a home assessment, the need for a lockbox was identified to allow the patient to lock her home while ensuring access for personal support workers and emergency responders when needed. When the patient shared that she could not afford the device, leadership supported the team's request to fund and order it. The patient expressed heartfelt gratitude to the team for going above and beyond, highlighting how simple, creative interventions can significantly enhance safety and compassionate care.

A summary of results on the organization-wide patient experience survey (>600 respondents) include: 95.8% patients felt satisfied or very satisfied with the care received from their visit, 95% reported that their health concern was addressed, 95.3% reported they were able to communicate their health issue, 92.4% reported they had an opportunity to ask questions about recommended treatment, 92.4% felt involved as much as they wanted to be in their care and treatment, 96.3% felt safe (emotionally and physically) during their appointment. Patients report 70% of the time there is appropriate communication between providers. Specific service data where patients were asked if their goals were being addressed or already addressed: Occupational Therapy (81 responses) - 96%, Dietetics (255 responses) - 95%, Chiropractic (178 responses) - 99%.

Patient testimonials that highlight the high-quality care across healthcare professionals:

"In January 2025 I commenced a program with the Queen Square Pain clinic. At that time my pain medications included a daily 75mg Fentanyl patch as well as a daily dose of 5 or 6 Oxycocet pills. This medication was necessary for chronic pain from three major back surgeries and two hip replacements over the last thirty years. With continuous assistance and advice from the program spear-headed by Jaspreet I was slowly able to decrease my medication so that on the 7th August 2025 my fentanyl intake was no longer required. Now in December 2025 my only pain medication is on average 1.5 Oxycocet and 2 acetaminophen (Tylenol) pills daily. I have noticed a great improvement in my mental health and am presently working on increasing my social activities with daily exercising. I really appreciate the encouragement and help Jaspreet and her team have done for me."

"I am very happy that I was able to book a same day appointment. The NP and trainee were friendly, efficient, and knowledgeable. In addition, the NP was able to review my X-ray results within a couple of hours which allowed me to start treatment that day (a Friday) rather than having to wait until Monday"

OT -"Marina was my go-to gal. Easy going, funny yet serious enough to do her work with me. She also gave me an exercise for the next seniors group. I do appreciate how she handles someone with my nature of just being on a funny plane for too long. I look forward to seeing her again. YOU ROCK GIRL!"

"My chiroprapist is incredible. Not only is she professional and addressing my concerns with exceptional results, but she is exceptionally kind and sweet. I'm very happy with the treatment I've received."

RD -"Provided ongoing diet adjustment to target symptoms and overall health. I now have a "toolbox" of steps to take if a flare up occurs. The insight and knowledge was very helpful. Thank you."

From the provider perspective, we have seen an 18% increase in providers feeling that our digital tools improve their job satisfaction, and a 26% increase in providers feeling that these tools improve the quality of care provided to patients.

From a system's perspective, we are honoured to attach an endorsement letter from the Executive Lead of the Central West OHT. Please see in the attachment.





BOARD AWARD: TEAM OF THE YEAR

NOMINEE(S): Together We Built Capacity: A Collective Journey Across Roles to Redefine Booking to Grow Attachment Without Breaking Continuity

ORGANIZATION: Health for All Family Health Team

TANGIBLE IMPACT

The booking workflow redesign initiative has been intentionally designed for replication across primary care, offering a turnkey solution that other teams can adopt and adapt.

Replication elements:

- Turnkey booking tool with 5-level urgency triage, embedded community resources, and clarified admin-clinical handoffs
- Three immediate PDSA tests teams can run without extensive redesign
- Use of Healthcare Excellence Canada's publicly available Primary Care Access Improvement framework
- TNAA and continuity-of-care run-chart methodology for benchmarking and adaptation

DEMONSTRATING EFFECTIVE INTERPROFESSIONAL COLLABORATION & LEADERSHIP

In this 9-month quality improvement initiative, Health For All Family Health Team (16 primary care providers, 11 interprofessional healthcare providers, 18 residents, 10 admin staff) demonstrates the cross-functional operation through co-led governance and clear role integration.

Shared Leadership: The QI Committee is co-led by the Executive Director and QI Program Directors with representation from physicians, medical secretaries, data analyst and decision support staff. This ensures all decisions made throughout this journey are driven by diverse voices.

Collaborative Workflow Design: During the booking tool redesign, 5 iterative cycles included explicit admin-clinical input. Admin staff defined triage realities and clinicians set urgency criteria.

Role-Specific Contributions: The admin team executed 5-level triage, managed slot bookings and routed to community resources. The clinical team co-designed schedule optimization and protected appointment (acute/chronic/preventive) slots.

Shared Accountability: All roles review the Third Next Available Appointment (reduced from 18.4 to 9.8 days) and 75% continuity of care metrics together.

Peer-Led Adoption: 2 physician champions worked iteratively with admin staff with a collective goal to spread organically across 14 physicians.

ENGAGING PATIENTS AND COMMUNITY MEMBER TO SHAPE AND DELIVER CARE

HFAFHT engages patients and communities through our Patient Experience Advisory Committee (PEAC). The committee is currently paused to prioritize other high-impact initiatives with a clear plan to reactivate it when resources and timing allow.

The 2026 Patient Experience Survey, in which over 300 patients provided comments, informed the design of this quality improvement journey. From our analysis, 30% of comments highlighted difficulty accessing timely appointments (long waits, phone delays, and limited urgent slots), and 8% emphasized the desire to see their own family physician more often than nurse practitioners, residents, or locums. These insights directly shaped the initiative's focus on reducing Third Next Available Appointment (TNAA) while sustaining current level of continuity of care.

The future approach to engaging patient partners is four-fold:

1. **Core functions:** Patient partners will bring diverse lived-experience perspectives, contribute to quality improvement initiatives, advise on patient-centered care, and help identify opportunities for improvement.
2. **Booking tool input:** They will shape the design of our appointment booking tool, focusing on urgency triage, realistic booking expectations, and access barriers like the 54% who reported being unable to get same-day or next-day urgent-care appointments.

3. **Community resources:** Partners will help embed the most appropriate local and Ontario Health Team–level resources into our workflows to better connect patients to needed services when timely appointments are not available.
4. **Impact assessment:** Patient partners will review real-world experiences with the new appointment triage and booking workflow to guide iterative improvements in access, communication, and overall care experience, including follow-up on comments that 13% of patients felt that the wait time between booking an appointment and receiving actual care was too long.

This structured engagement ensures care delivery is informed by clinical evidence and grounded in the realities, priorities, and values of the patients and communities we serve.

INNOVATION & QUALITY IMPROVEMENT

HFAFHT has implemented a QI-driven triage and booking workflow redesign that turned variable scheduling into a standardized, data-driven system. It reduced the TNAA from 18.4 to 9.8 days while maintaining 75% continuity of care. Using Healthcare Excellence Canada's Primary Care Access Improvement framework, our QI Committee ran PDSA cycles, piloted schedule changes with physician champions, and iteratively built a turnkey booking tool that other teams can adopt.

Key components and innovations:

Root-cause analysis: Conducted a Fishbone review and identified people (triage training), process (no booking standards), technology (underused EMR), and environment (workload) issues.

Iterative design: A standardized booking tool simplifying urgency to five levels, embedding local community resources, and clarifying admin–clinical handoffs.

Pilot & spread: 2 physician champions tested schedule optimization. They incorporated protected same-day/same-week slots and intentionally balancing acute, chronic, and preventive appointment types rather than relying on first-come-first-served.

Data-driven monitoring: Implemented TNAA run charts and continuity-of-care metrics to track impact and tighten control limits, enabling shared and timely decision-making across roles.

Scalability: Produced a turnkey booking tool plus three immediate PDSA tests for rapid local adaptation by other primary care teams.

ROLE AS INFLUENCER IN BROADER SYSTEM IMPROVEMENTS FOR OPPORTUNITY TO SCALE AND SPREAD

Patients: Patients now wait about 9 days for the third next available appointment compared with 18 days previously, markedly reducing delays for urgent needs. Relational continuity is preserved through consistent provider relationships, and the booking tool routes patients to the right provider (MRP, urgent-care physicians, or residents) without unnecessary gatekeeping.

Providers: The new workflow eliminated scheduling chaos and introduced protected slots that balance acute, chronic, and preventive visits, which helps prevent burnout. Changes were adopted peer-to-peer across the 14-physician practice, with physician champions driving practical uptake alongside administrative and allied-health colleagues.

System: The redesign balanced capacity for attaching new patients while protecting access for existing panels, using TNAA and continuity run-charts for data-driven capacity management. Administrative satisfaction improved, and the entire team reported measurable gains in workflow efficiency and team morale, demonstrating improvement across all roles.

Next step: To further strengthen this model, HFAFHT is planning to recruit an administrative/triage RN to support the team with this redesigned appointment booking and triage workflow. This new role will also assist in the development of medical directives and expansion of RN-delivered services and procedures.

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Transferable lessons for system-wide spread:

- Physician champions, iterative admin input, and QI coaching are key success factors
- Clarity between clinical and administrative roles plus data-driven capacity decisions

- The approach surfaced the need for richer metrics and better EMR integration, guiding future enhancements

System-level influence:

- TNAA reduced from 18.4 days to 9.8 days while continuity stabilized at 75%, providing concrete benchmarks for other teams
- Regionally, the model shows how Ontario Health Teams can balance attachment growth with continuity under staffing limits
- Provincially, the story is shared through AFHTO's Power of Primary Care Summit, sparking dialogue about data-driven workflows and replication
- Nationally, alignment with Healthcare Excellence Canada's framework contributes to broader primary care access improvement efforts

Evidence of replication potential:

- Addresses universal primary care barriers, such as scheduling variation, inconsistent triage, and misaligned urgency expectations
- Offers a reproducible team-based model can customize for their own panels and OHTs
- Concrete metrics (47% TNAA improvement, 75% continuity) give other teams realistic targets and a clear improvement path

