



THEME AWARD:

Designing Care Across Systems: Integration, Equity & Population Health

Organization	Initiative	Contact Information
City of Lakes Family Health Team	Advancing Geriatric Care Through Integrated, Team-Based Innovation	Meghan Peters Executive Director
Prime Care Family Health Team Prime Care Family Health Team- Gender Affirming Care Team	Beyond Boundaries: Scaling Integrated Gender Affirming Care to Advance Equity and Access Across Regions	Gina Mannella Executive Director
South East Toronto Family Health Team Dr. Kit Shan Lee	Beyond own practice - providing equitable care	Stephen Beckwith CEO
Ancient Rivers Family Health Team	Expanding Access for Unattached Patients: An Equity Focused IHP-Led Care Model	Kate Jones Executive Director
Norfolk Family Health Team	Functional Independence & Power: A New Approach to Healthy Aging	Roxanne Pierssens - Silva Executive Director
Aurora-Newmarket Family Health Team	Hot Topics, Cool Solutions: Menopause Care Without Boundaries	Mary Jane Rodgers Executive Director
Summerville Family Health Team	HPV Self Collection Pilot at Summerville Family Health Team	Andrea Stevens Executive Director
Couchiching Family Health Team Couchiching Palliative Care Team	Integrated Primary Care Led Palliative Care Program across Couchiching Service Area	Lynne Davies CEO

Prince Edward Family Health Team	Partnership in Practice: Designing Care Across Systems	<u>Barinder Gill</u> Executive Director
McMaster Family Health Team and Maternity Centre of Hamilton- PROSPR Clinic	PROSPR: Integrated, Low-Barrier Care for Pregnant People with Substance Use Disorders	<u>Jill Berridge</u> Co-Executive Director <u>Barb Flaherty</u> Co-Executive Director
Southlake Family Health Team and Northern York South Simcoe Ontario Health Team	Segmenting Care, Scaling Equity: A Flexible Primary Care Home in Georgina	<u>Mary Nguyen</u> Executive Director
Dufferin Area Family Health Team	The Dufferin DBT Program - A FHT Led Community Initiative to Provide Access to Team-Based Collaborative Care for Individuals Struggling with Suicidality	<u>Lianne Barbour</u> Executive Director



THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): City of Lakes Family Health Team

ORGANIZATION: City of Lakes Family Health Team

INITIATIVE: Advancing Geriatric Care Through Integrated, Team-Based Innovation

AT A GLANCE

Bringing specialized geriatric care closer to home. City of Lakes Family Health Team built an NP directed (NPs working at full scope), interdisciplinary model that combines comprehensive geriatric assessment with embedded specialist support, strengthening local capacity to care for frail older adults and helping more seniors remain safely in their communities.

THE OPPORTUNITY

City of Lakes identified a growing population of older adults with frailty and increasingly complex medical, functional, cognitive and social needs. At the same time, patients and providers faced long waits and limited access to specialized geriatric services.

Rather than relying primarily on referral outside the organization, the team sought to strengthen its own capacity to assess and manage geriatric complexity. The aim was to provide earlier, more coordinated intervention within the patient's primary care home, while creating a clearer pathway to specialized geriatric expertise for patients requiring additional assessment or consultation.

WHAT WE DID

The team developed an NP-directed geriatric care model, with NPs receiving specialized training in comprehensive geriatric assessment and working to full scope. Assessments consider medical conditions alongside functional status, cognition and social factors, allowing the team to develop a more complete understanding of patient and caregiver needs.

NPs work alongside physicians, nurses, care coordinators, dietitians, pharmacists and other allied health professionals. Depending on identified needs, care may include medication review, chronic disease management, nutrition support, functional and cognitive assessment, care planning, and connection to community-based services.

A key component is the partnership with Northeast Specialized Geriatric Centre. A geriatrician now provides on-site consultations and assessments one day per month, allowing specialist expertise to be integrated directly into the primary care setting. The relationship also supports case-based learning and knowledge transfer between specialized geriatric and primary care providers.

The Model:

1. NP-directed geriatric care model, with NPs receiving specialized training in comprehensive geriatric assessment and working to full scope
2. Partnership for shared care with Northeast Specialized Geriatric Centre

THE IMPACT

The model has increased access to timely geriatric assessment and strengthened coordination for older adults with complex needs. The program has also shown reduced reliance on referrals to specialized geriatric services, while patients requiring specialist input can receive it within their existing primary care environment.

The approach has also increased the capacity and confidence of primary care providers to identify and manage geriatric complexity. Integration with community supports provides an additional mechanism for addressing functional and social needs, with the goal of helping older adults remain safely and independently at home for as long as possible.

SUSTAINING AND ADVANCING THE WORK

City of Lakes is sustaining the model through continued workforce development, interdisciplinary practice and its ongoing partnership with Northeast Specialized Geriatric Centre. The embedded specialist relationship provides both clinical consultation and continuing knowledge transfer to the primary care team.

The program is also using data to monitor referral patterns, access to care and patient experience, providing a foundation for ongoing quality improvement and adaptation as patient needs and service demand evolve.

WHAT OTHERS CAN LEARN

City of Lakes Family Health has developed a highly transferable model of geriatric care that provides other primary care teams with practical tools, processes, and learning opportunities to improve care for seniors. The program includes standardized workflows and digital health tools that support comprehensive geriatric assessments, making it easier for other teams to adopt and integrate these practices into their own settings. In addition, the program offers strong clinical learning through its emphasis on Nurse Practitioner directed care supported by specialized geriatric training. The integration of interdisciplinary team members and wraparound services provides a replicable framework for delivering holistic, patient-centered care. The partnership with Northeast Specialized Geriatric Centre further enhances learning by demonstrating how specialist support can be effectively embedded into primary care, offering a model for collaborative, integrated service delivery. Overall, this achievement provides both the structure and practical resources needed for other organizations to build capacity, improve access, and enhance quality of geriatric care.

SPREAD / KNOWLEDGE SHARING

Achieved Already!

- Actively running implementation support program for FHT's across the Northeast to scale and spread
- Mentorship, in-person training and virtual support

City of Lakes Family Health has taken deliberate and proactive steps to spread this model across Northeastern Ontario. The organization has partnered with multiple Family Health Teams to provide mentorship, hands-on training, and in-person learning opportunities for Nurse Practitioners and interdisciplinary providers across our region. These efforts focus on building local capacity so that teams can implement similar geriatric care programs within their own communities. The team has also shared its digital tools, workflows, and clinical approaches, enabling other organizations to adopt and adapt the

model more efficiently. Additionally, the partnership with Northeast Specialized Geriatric Centre has created a two-way learning environment.

FOR MORE INFORMATION

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THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Prime Care Family Health Team- Gender Affirming Care Team

ORGANIZATION: Prime Care Family Health Team

INITIATIVE: Beyond Boundaries: Scaling Integrated Gender Affirming Care to Advance Equity and Access Across Regions

AT A GLANCE

Gender-affirming care without geographic boundaries. Prime Care Family Health Team created an NP-directed, interprofessional program that combines clinical care, mental health support, navigation and education through virtual and in-person access, reaching thousands of people across and beyond the GTA.

THE OPPORTUNITY

In July 2024, Prime Care Family Health Team (PCFHT) launched and scaled an interprofessional Gender Affirming Care Clinic (GAC) to improve equitable access to timely, affirming, and integrated care for transgender, non-binary, and gender-diverse people. The initiative began in response to a critical gap in Halton Region, where no established gender-affirming clinic existed, and has grown into a broader regional access model that supports patients across geographic boundaries. The model integrates hormone therapy, mental health support, service navigation, surgical readiness and assessment support, peer and group supports, injection support, results review, and education through an interprofessional team. This aligns closely with the Bright Lights theme of designing care across systems because the clinic connects primary care, mental health, social supports, pharmacy, quality improvement, community referrals, and Ontario Health accountability into one coordinated approach.

The clinic's hybrid access model also demonstrates how integrated primary care can reach beyond local boundaries:

- 11,876 total visits captured by visit type,
 - 10,195 were virtual (85.8%) and
 - 1,379 were in person (11.6%).

This flexible model reduces travel burden, supports patients who do not have local gender-affirming care options, and helps the clinic respond to growing demand across regions.

Among 6,644 GAC intakes, 211 registrants were identified as not attached to any primary care provider and not rostered. This means approximately 3.2% of all GAC intakes represented patients with no established primary care attachment. For this population, the clinic is not only a specialized gender-affirming service; it is a critical bridge to care, trust, navigation, and continuity within the health system.

The initiative advances equity by providing culturally safer access for an underserved population that experiences stigma, travel barriers, long waits, and gaps in provider knowledge.

This model advances scalability by offering a practical model that other primary care teams can adapt for communities without local gender-affirming care access.

WHAT WE DID

PCFHT recognized the need for GAC through patient experience, community consultation, regional service gaps, and evidence from the implementation plan. The plan identified that transgender, non-binary, and gender-diverse people in Halton faced limited local access, long wait lists at existing clinics, travel outside their home communities, insufficient primary care capacity, and fragmented pathways across medical, mental health, and social care.

PCFHT also recognized that disrupted community navigation supports and gaps between youth and adult systems created additional barriers for patients. To address these needs, PCFHT established an NP run Gender Affirming Care Clinic embedded within PCFHT and designed as an interprofessional primary care service rather than a stand-alone specialty program. The team created accessible referral pathways, including community referrals and self-referrals, to reduce entry barriers and support people who may not have an attached provider. Together, the team built an integrated service model that includes support for social, medical, and legal transition; hormone therapy; injection support; mental health care; surgical assessments and support; sexual health and screening; peer/group support; education; and service navigation. The clinic integrated mental health and system navigation into the care model to address social determinants of health and reduce fragmentation between primary care, community supports, and mental health services. The team uses shared care, case conferencing, team communication, EMR-supported documentation, and digital tools to support continuity and coordination.

Ongoing quality improvement is implemented through PDSA cycles, supported by a Quality Improvement Decision Support Specialist (QIDSS), with monthly reporting to Ontario Health. The clinic offers a hybrid care model, providing both virtual and in-person assessment and follow-up options to reduce travel barriers and reach patients across regions.

THE IMPACT

The Gender Affirming Care initiative has grown rapidly, demonstrating substantial demand for accessible, integrated gender-affirming care. Since launching in 2024, the clinic has recorded **more than 11,000 visits and 6,644 GAC intakes**, with quarterly visits increasing from **226 in Q3 2024 to 2,685 in Q2 2026**. The identification of 211 unattached or non-rostered patients further demonstrates that the clinic is reaching people who face both gender-affirming care barriers and broader primary care attachment barriers.

The clinic is also reaching well beyond its local Halton population. Among patients with a known location, **44% live outside the GTA**, with patients represented across **175 communities**. Virtual care has been an important enabler of this reach, accounting for approximately **86% of visits**, while in-person care remains available when clinically appropriate or preferred by patients.

Utilization also demonstrates that patients need more than access to hormone therapy. The clinic's highest-volume services include **hormone therapy, mental health care and service navigation**, alongside surgical support, peer and group programming, injection support, sexual and preventive health, medication review and family support. This breadth reinforces the value of an interdisciplinary model that can address medical, psychosocial and navigation needs together.

The model provides patients with a more coordinated and affirming point of access while reducing the need to navigate multiple disconnected services. Defined workflows, shared documentation and interdisciplinary care planning also support coordination across the care team. Client experience surveys and ongoing feedback from the Gender Journeys Group are being used to inform continued improvement.

SUSTAINING AND ADVANCING THE WORK

PCFHT is sustaining the GAC initiative through clear governance, interprofessional staffing, Ontario Health-supported accountability, quality improvement infrastructure, and ongoing capacity planning. The clinic is not built around a single provider or isolated intervention; it is supported by a team-based model and embedded within PCFHT operations. A stable interprofessional model includes a Nurse Practitioner, Registered Nurse, Social Worker, Case Worker/Manager, Pharmacist, and two Registered Practical Nurses. Ontario Health support and monthly reporting provide accountability, visibility, and structured monitoring of program performance. Executive Director and Finance Manager supervision support operational oversight, financial stewardship, risk management, and sustainability. QIDSS

support enables ongoing measurement, data interpretation, reporting, and continuous quality improvement. The team uses ongoing PDSA cycles to refine referral processes, scheduling, documentation, patient flow, access, and equity-focused service design. Visit, intake, visit type, and appointment-reason trends are used to identify capacity pressures, adjust workflows, and plan future growth. Hybrid delivery is also a sustainability strategy: virtual visits account for 85.8% of visit-type activity, helping the team manage volume, reduce travel-related access barriers, and extend specialized gender-affirming care beyond the immediate local clinic geography. Team-based meetings and case conferencing support coordinated care, shared problem-solving, and continuity for patients with complex needs. Sustainability is also supported by the clinic's alignment with PCFHT's mission to provide patient-centred, dynamic, and compassionate care.

WHAT OTHERS CAN LEARN

This achievement offers significant and practical learning for other primary care teams. The model demonstrates that gender-affirming care can be embedded in interprofessional primary care and delivered through a coordinated pathway that addresses access, attachment, equity, mental health, social needs, medication management, and system navigation together. Transferable components include a replicable intake and triage process that captures demand, identifies unattached/unrostered patients, and supports prioritization; an interprofessional staffing model that clarifies how NP, RN, RPN, social work, case management/navigation, and pharmacy roles can work together; a shared-care workflow using team communication, case conferencing, documentation standards, and coordinated follow-up; and a hybrid access model that shows how virtual assessments and follow-ups can extend reach across regions while preserving in-person pathways for clinical needs that require face-to-face support. Other transferable components include an equity-focused access model that treats lack of attachment, stigma, travel burden, mental health needs, and navigation barriers as system design issues; a quality improvement approach using PDSA cycles, QIDSS support, and monthly reporting to improve access and patient experience; a population health measurement approach that uses visit type, visit reason, growth trends, intake volume, geography, and attachment status to guide decision-making; and a scalable template for communities that do not have dedicated gender-affirming care services and need to build local capacity within primary care. SPREAD / KNOWLEDGE SHARING

PCFHT has spread the reach and learning of the GAC initiative through regional collaboration, referral pathways, partnership development, virtual access, and structured reporting. The clinic accepts referrals beyond the immediate PCFHT roster, including community and provider referrals, allowing GAC to serve patients across geographic boundaries. It has used virtual care at scale, with 10,195 virtual visits representing 85.8% of visit-type activity, to extend access beyond immediate local geography and reduce travel-related barriers. The team consulted with clinical and academic advisors to support evidence-informed program design and safe gender-affirming care practices, and it uses

Ontario Health monthly reporting to share performance information, identify service pressures, and support accountability for spread and sustainability. The clinic's spread 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. PCFHT has built internal capacity across the interprofessional team through ongoing learning, case discussion, PDSA cycles, and workflow refinement. The model is positioned for spread because it includes transferable operational components: intake pathways, provider roles, service categories, hybrid visit options, QI processes, attachment tracking, patient feedback mechanisms, and equity-focused measurement. Further spread opportunities include mentoring other primary care teams, presenting the model through AFHTO or Ontario Health Team forums, sharing de-identified data and lessons learned, developing an implementation toolkit, and publishing a short practice case study on how interprofessional primary care can advance gender-affirming care, attachment, hybrid access, equity, and regional reach.

FOR MORE INFORMATION





THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Dr. Kit Shan Lee

ORGANIZATION: South East Toronto Family Health Team

INITIATIVE: Beyond own practice - providing equitable care.

AT A GLANCE

Primary care that goes where patients are. Dr. Kit Shan Lee extends care beyond traditional practice walls through outreach to underserved communities, combining preventive care, medical support and advocacy to address both clinical needs and the conditions affecting health.

THE OPPORTUNITY

Dr. Kit Shan has a patient panel at SETFHT, but recognizes health care systems does not fit all people. She uses her connections to bring additional care and opportunities to our outreach patients living in social housing and facing inequitable care. She has utilized residents in our residency program to support preventative care through offering vaccines, cervical cancer screening catch up, DM visits and/or bone density screening. As an MD, Kit Shan is passionate about the effects of climate change. She is an advocate for patients in housing buildings without AC units and directs the team towards resources that can provide cooling devices. Giving underserved and marginalized communities resources and bringing concerns to change systems is at the forefront of her mind.

WHAT WE DID

Explained above. In addition, Kit Shan also provides medical consultation to the NPs who staff our primary care out reach program.

THE IMPACT

The number of patients/community members who were eligible, and then accepted preventative care.

24 seniors eligible for shingrix/prevnar 20.

- 8 declined
- 6 unable to contact
- 6 pending but ultimately did not confirm
- 4 successful vaccination

These numbers reflect the challenge of providing preventative care in marginalized and underserved populations with history of vaccine mistrust/hesitancy.

SUSTAINING AND ADVANCING THE WORK

Kit Shan continues to offer preventative care resources with her resident when they become available or expand.

WHAT OTHERS CAN LEARN

At this point, these efforts are isolated to the outreach program.

SPREAD / KNOWLEDGE SHARING

Involving residents of primary care in spaces that bring low barrier health care to people who don't fit into the system broadens their practice experience and builds an understanding to develop future doctors who will take part in this kind of clinical care in non-conventional spaces.

FOR MORE INFORMATION





THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Primary Care Outreach Team

ORGANIZATION: South East Toronto Family Health Team

INITIATIVE: Designing Care Across Systems: Integration, Equity & Population Health. Providing care to cognitively declining seniors living in community.

AT A GLANCE

For vulnerable seniors, staying safely at home often requires much more than a medical visit. South East Toronto Family Health Team's Primary Care Outreach Team brings clinical and social care directly into community housing, coordinating across sectors for older adults facing cognitive decline, isolation and complex health and social needs.

THE OPPORTUNITY

As we work in communities with an aging population without familial support or reliable friends and community members, integration of care systems become increasingly essential to patient care. The primary care outreach teams provides clinical and social services in independent social housing buildings. Tenants living in these buildings are low income (ODSP, OW, GIS), isolated, lack social supports, low education, experienced trauma, struggles with mental health and addictions. In these buildings, seniors with cognitive decline are struggling to remain independent and often resisting additional supports beyond our team.

The outreach team consists of 1 NP and 2 RNs is anchor in the care of these patients. They initiate integrated tables, bringing housing, Ontario Health, public guardian and trustee, and other service providers to discuss how to manage care of seniors who are being taken

advantage of financially, poor unit conditions (unhygienic and unsafe), diagnosed with a life limiting illness needing massive coordination of for appointment and transportation support. When it is clear palliative and long-term care is needed, this team is the trusted provide to patiently explain, waiting for the patient's readiness and setting up friendly hand overs to ensure services are connected. They spend countless hours calling providers, running up against walls of the system, offer their limited best because the care they have to provide dignity and humanity to these seniors trump the work, effort, tears, and sweat. When a patient is transferred to hospital, palliative care they are still advocating for the end of life wishes, never stopping until patient centered care is considered and achieved.

WHAT WE DID

As seniors' health and care needs evolve, the team proactively engages patients and families in advance care planning and helps them navigate longer-term care options. Where appropriate, this includes supporting long-term care applications and wait-list placement, particularly for seniors with limited social supports or few alternatives.

The team also works creatively to identify available housekeeping and community resources, including potential funding supports, so that seniors who are no longer physically or cognitively able to manage these tasks can continue to live safely and with dignity in their homes.

By engaging community resources and partners early, the team aims to support seniors to remain safely in the community for as long as possible. They also work with seniors' networks to provide education and workshops on healthy aging, preventive care, caregiver support, advance care planning, mental health and other issues important to seniors and their families.

THE IMPACT

Patient stories of dignified end-of-life care demonstrate the impact this team has had in the community. Over the past year, the team supported three seniors with life-limiting illnesses to transition to palliative or long-term care after significant coordination and sustained engagement. In one case, this followed months of conversations and support with the application process. In another, the team intervened when a senior was found on the floor of his apartment but was reluctant to go to hospital. A third patient had been declining over a two-year period, and the team was ultimately able to coordinate long-term care placement through the collective efforts of multiple partners.

While the team does not yet have robust data to fully capture these outcomes, the human impact is significant. Their persistence and ability to support patients through complex circumstances has helped build trust and credibility in communities where there can be considerable mistrust of the health care system. That trust, in turn, creates opportunities to reach and support other marginalized patients who may otherwise remain disconnected from care.

SUSTAINING AND ADVANCING THE WORK

Conducting more robust senior assessments early on to identify areas of support and bridging gaps.

Forming case conferencing tables at buildings that have other partners to bring care on the same page.

WHAT OTHERS CAN LEARN

Caring for seniors with complex needs and working persistently to identify and coordinate available resources builds significant experiential knowledge that can be shared with others working in similar settings. Just as importantly, this work develops the practical skills needed to navigate system constraints, build partnerships and find creative solutions when traditional pathways do not meet a patient's needs.

FOR MORE INFORMATION





THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Ancient Rivers Family Health Team

ORGANIZATION: Ancient Rivers Family Health Team

INITIATIVE: Expanding Access for Unattached Patients: An Equity Focused IHP-Led Care Model

AT A GLANCE

What if patients did not have to be attached to a practice to benefit from the team? Ancient Rivers Family Health Team opened many interprofessional services to unattached patients, using self-referral, standardized intake and expanded nursing scope to improve access to preventive, chronic disease and other primary care supports.

THE OPPORTUNITY

In September of 2025, our team implemented a redesigned model for accessing IHP-led primary care services within our Family Health Team. As a newly established team (with our first staff joining in September 2024), improving access for unattached patients was a core part of our original vision, recognizing early on the significant unmet need in our community. We introduced a low-barrier, front-door entry point through self-referral (online, phone, or in person).

We also implemented online booking for services that require minimal screening or triage, enabling patients to directly book many RPN services. In addition, we began accepting

By removing attachment-based eligibility criteria, the model improves equity, enables earlier access to preventive and supportive care, and strengthens system integration.

referrals from non-physician care providers and physicians external to our team. By removing attachment-based eligibility criteria, the model improves equity, enables earlier access to preventive and supportive care, and strengthens system integration. This is particularly important in our region, where a significant portion of the population lives with low income, access to privately funded allied health services is often cost-prohibitive, and geographic and transportation barriers further limit access.

WHAT WE DID

Our team identified that historic access requirements (attachment to a FHO MD or FHT NP and a referral from that PCP) were excluding key populations, including unattached patients, those connected to non-team-based primary care providers, and individuals facing geographic barriers. Requiring a physician referral also, at times, was delaying access to service for patients with an affiliated provider.

- Introduced self-referral pathways, allowing patients to initiate access independently
- Enabled referrals from external providers (hospital, specialists, community agencies, non-affiliated PCPs)
- Implemented online booking for selected services to improve timeliness of access
- Established standardized intake processes to ensure consistent and equitable access.

This increased service breadth for unattached patients. These actions were designed to align services with community need rather than organizational attachment, improving access for underserved populations and simplifying navigation across the broader care system.

THE IMPACT

Between September 23, 2025 when we first implemented these changes and March 31, 2026, 6% of patients accessing individual services and 29% of those participating in workshops or groups were not attached to our team, representing a meaningful expansion of access for individuals who would not previously have been eligible.

Patients accessed the full range of IHP-led services, including mental health counselling, kinesiology, nutrition counselling, and RPN-led care such as immunizations, breastfeeding support, cervical cancer screening, basic preventive footcare, ear flushing, and suture/staple removal.

Patient Story from Blair Wilson

(consent to share obtained): I have a family doctor far away from our community. When I was diagnosed in December 2025 with high cholesterol, my doctor suggested statins. ARFHT is ideal as you can self-refer if you are not a patient at the clinic; I found it easy to book an appointment with the dietitian and didn't experience any barriers to

A practical example of system integration is our collaboration with the local Emergency Department (ED). Patients who receive sutures or staples and do not have a primary care provider or cannot easily access timely follow up have traditionally been advised to return to the ED for removal. Through this initiative, the ED now provides patients with information on how to book follow up care with the FHT, creating an appropriate and accessible care pathway that better aligns with patient needs and reduces avoidable ED visits.

Overall, the initiative has increased access for unattached and underserved populations, supported earlier intervention and prevention, reduced reliance on acute care for non-urgent needs, and strengthened integration between primary care, hospital, and community services.

SUSTAINING AND ADVANCING THE WORK

The model was designed for sustainability by leveraging existing infrastructure and continuously reinforcing awareness. Core sustainment strategies include online self-referral and booking tools to reduce administrative burden, standardized workflows to ensure consistent triage and intake, and ongoing monitoring of service use and demand to guide adjustments. These efforts support appropriate uptake of services and improve system efficiency, as increased awareness reduces the need for patients and partners to contact the organization to confirm eligibility prior to self-referring.

WHAT OTHERS CAN LEARN

This initiative provides a practical, experience-informed model for improving access and equity using existing resources. Our experience demonstrates that removing attachment criteria can safely expand access when supported by clear triage processes and appropriate medical directives. Digital tools played an important role in enabling this approach with Ocean webforms functioning effectively as a self-referral pathway, improving access while reducing system friction. Uptake improved through consistent engagement with healthcare partners, community organizations, and the broader community. Group programming supported sustained engagement, with participants often sharing information about available services with family and friends or returning later to access individual care, reinforcing ongoing connection to the model.

SPREAD / KNOWLEDGE SHARING

This model is transferable; expanding access by removing attachment-based eligibility criteria can be achieved using existing team structures and workflows. In our setting, the initiative was implemented within current team capacity, and to date, the impact on service wait times has remained manageable. Our team has actively supported the spread and adoption of this approach through ongoing collaboration with hospital partners, our OHT, and community providers, direct communication with local organizations such as community paramedics, mental health agencies, retirement homes, and recreation departments, and public facing promotion through social media, print materials, and community outreach.

FOR MORE INFORMATION



THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Norfolk Family Health Team

ORGANIZATION: Norfolk Family Health Team

INITIATIVE: Functional Independence & Power: A New Approach to Healthy Aging

AT A GLANCE

A fall can be the beginning of a much larger decline, unless the right supports arrive early. Norfolk Family Health Team's Functional Independence & Power Program connects assessment, exercise, rehabilitation and falls prevention into a coordinated pathway designed to preserve mobility, independence and healthy aging.

THE OPPORTUNITY

Norfolk County has an older population, with approximately 26% of residents aged 65+, and even higher proportions in communities such as Port Rowan and Port Dover. The team identified a growing need among seniors experiencing declines in strength, balance, mobility and confidence, alongside limited local rehabilitation and falls-prevention options.

Registered Kinesiologist Michelle recognized an opportunity to intervene earlier, before a fall resulted in injury, loss of independence or increased healthcare use. Working with Norfolk Community Paramedics and the Rehabilitative Care Alliance, the team developed a community-based approach focused not only on responding to falls, but on maintaining function and preventing them.

WHAT WE DID

The program combines individualized assessment, post-fall intervention, exercise, education and community-based supports. Patients can be referred by physicians, NPs, allied health providers, the visiting geriatric specialist and community paramedics.

Assessments are offered in clinic and at home, with nearly half of initial assessments occurring in patients' homes. This allows the kinesiologist to assess mobility and function while also identifying environmental hazards and opportunities to improve home safety.

A key innovation is the **Post-Fall Pathway with Norfolk Community Paramedics**. Patients seen by paramedics following a fall are automatically referred to the program for follow-up assessment, rehabilitation support and education.

The broader **10-week Functional Independence & Power Program** combines weekly physical activity with interdisciplinary education on factors affecting healthy aging. Sessions include strength, balance, stretching and chair yoga, alongside topics such as medication-related fall risk, mental health, social isolation and other aspects of healthy aging. Programming has also expanded into local seniors' centres, with some community sessions attracting up to 36 participants.

THE IMPACT

The program has created a more systematic approach to supporting seniors following a fall. Previously, community paramedic assessments focused primarily on immediate injury, with limited referral options and no standardized pathway for rehabilitation or prevention. The new pathway assesses factors including mobility, balance, cognition, frailty, home safety, nutrition, mood, medications, vision and hearing, with findings shared back with primary care.

Nearly all patients assessed through the pathway have been referred to appropriate rehabilitation, falls-prevention or in-home supports. Participants report improvements in mobility, confidence, self-care and pain management, while patient satisfaction averaged 7 out of 7, with participants indicating they would recommend the service to others.

The model has also gained regional and provincial attention and is informing broader frailty and falls-prevention work within the Brantford Brant Norfolk Ontario Health Team and elsewhere in Ontario.

SUSTAINING & ADVANCING THE WORK

The program is supported through ongoing base funding for both Norfolk Family Health Team and Norfolk Community Paramedics, as well as strong relationships with community organizations and seniors' centres that provide space and other supports.

Transportation remains an important barrier for seniors in rural Norfolk. The team is exploring partnerships with service clubs and community organizations to improve transportation and access to programming.

Looking ahead, the team envisions expanding the model into a broader community wellness hub, combining exercise and falls prevention with social connection and preventive services such as foot care, blood pressure monitoring and diabetes education. This would allow seniors to access multiple supports in one community setting.

WHAT OTHERS CAN LEARN / SPREAD

The program provides a transferable model for integrating kinesiology, primary care, community paramedicine and community-based seniors' services. Particularly adaptable components include the structured Post-Fall Pathway, automatic referral following a paramedic-attended fall, home-based assessment, interdisciplinary education and an emphasis on intervention before significant functional decline occurs.

The approach is already informing work beyond Norfolk. Kinesiology-supported falls-prevention strategies have been adopted by partners in Brantford, and the team's experience is contributing to development of a broader Frailty Care Pathway through the Brantford Brant Norfolk OHT.

The Post-Fall Pathway has also been shared through the Ontario Community Paramedicine Knowledge Exchange Expo and with OHT frailty and executive leadership groups. The team continues to share referral processes, program materials and lessons learned with primary care, community paramedicine and senior-serving organizations interested in adapting the approach.

FOR MORE INFORMATION





THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Aurora-Newmarket Family Health Team

ORGANIZATION: Aurora-Newmarket Family Health Team

INITIATIVE: Hot Topics, Cool Solutions: Menopause Care Without Boundaries

AT A GLANCE

Menopause care is moving out of the margins. Aurora-Newmarket Family Health Team developed an NP designed program that combines individualized assessment and treatment with broad education, expanding access to evidence-based menopause care for patients and communities that may otherwise struggle to find it.

THE OPPORTUNITY

The Nurse Practitioner designed and executed Menopause program addresses a significant population health need at the community level by providing accessible, evidence-based care for attached patients and valuable health education for unattached patients experiencing perimenopause and menopause. Through integrated, collaborative care, this program supports symptom management, chronic disease prevention, screening, and referral coordination across systems. This model strengthens primary care capacity, reduces health disparities, improves quality of life and functional health outcomes, and responds to the growing community demand for comprehensive midlife women's health services.

WHAT WE DID

The ANFHT recognized a significant gap in access to evidence-based menopause care for complex, underserved, and unattached patients within the local community. In response, they established an innovative, coordinated menopause program model that integrates specialized assessment, treatment, education, and connections to primary care and

community services. To improve access and reduce barriers, they developed virtual education programs for patients, unattached individuals, healthcare staff experiencing menopause-related workplace challenges at the York Region District School Board, and participants in the Southlake Hospital Cardiac Rehabilitation Program.

THE IMPACT

Recognizing a widespread lack of knowledge about menopause, our Nurse Practitioner developed a Group Workshop and one-on-one counselling program. Multiple partnerships have been established to share this information beyond our immediate patient population. Our Nurse Practitioner has partnered with the YRDSB to present on menopause and its impact in the workplace. She also presented to residents of Georgina through a collaboration with the NYSS OHT and the Town of Georgina.

Additionally, representatives from the Government of Nova Scotia's Department of Health and Wellness - who have successfully developed the province's first-of-its-kind Menopause Centre of Excellence (MCoE), reached out for guidance and we have met and discussed the approach we have taken with this program. **Our Nurse Practitioner has facilitated multiple sessions, with a cumulative attendance of over 310 individuals** -many of whom went on to book one-on-one appointments with her.

As of March 2026, 95% of patients reported timely access to assessment, 89% reported increased knowledge and 92% reported satisfaction with follow up care and assessment.

SUSTAINING AND ADVANCING THE WORK

To sustain the achievement of developing a menopause program that improves patient experience across care boundaries, the ANFHT has implemented several long-term strategies focused on integration, education, and capacity building: This includes:

- Our Nurse Practitioner being a certified Menopause Society Certified Practitioner (MSCP)
- Our Social Worker has completed Counselling Women Through Menopause training to support patients from a mental health perspective.
- This program model has been embedded into existing primary care and community health pathways to ensure continuity beyond initial referral.
- Standardized care protocols and virtual care platforms have been established to support consistent access for both attached and unattached patients.
- Ongoing inter-professional collaboration with primary care, cardiology rehabilitation programs, and community partners ensures shared responsibility for menopause care delivery.

A key sustainability strategy includes continuous education through ongoing education sessions for clinicians, patients, and community organizations, strengthening self-management and reducing system fragmentation. In addition, the team has supported

knowledge transfer by mentoring clinicians and embedding menopause competencies into routine practice.

WHAT OTHERS CAN LEARN

The program offers a high degree of transferable learning, new processes, and reusable resources that can drive improvement across multiple teams and settings. It introduces a coordinated, interdisciplinary care model that other teams can adopt to better integrate menopause care across primary care, specialty services, and community programs. The use of standardized assessment tools, virtual education platforms, and structured referral pathways provides practical processes that reduce variation in care and improve access, particularly for underserved or unattached patients. Other teams benefit from shared educational resources, including virtual learning sessions and clinical guidance materials, which enhance provider confidence and consistency in menopause management. The program also demonstrates how virtual care can be effectively used to bridge geographic and system access gaps, offering a scalable model for other regions. SPREAD / KNOWLEDGE SHARING

To spread the achievement broadly, the ANFHT has actively engaged in knowledge translation, mentorship, and program development support across multiple sectors and regions. The team has delivered structured education and mentorship to diverse organizations, including:

- the York Region District School Board,
- the Town of Georgina, and
- Southlake Hospital's cardiac rehabilitation program

In addition, the ANFHT provided direct consultation and advisory support to the Menopause Centre of Excellence in Nova Scotia, assisting with program design, startup planning, and clinical workflow development. This included guidance on integrated care pathways, service structure, and education models to ensure consistency and scalability.

Through these activities, the program has been disseminated beyond its original setting, supporting system-wide improvement by equipping external teams with practical tools, frameworks, and confidence to implement or enhance menopause care within their own environments.

FOR MORE INFORMATION



THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Summerville Family Health Team

ORGANIZATION: Summerville Family Health Team

INITIATIVE: HPV Self Collection Pilot at Summerville Family Health Team

AT A GLANCE

A different way to screen can reach people traditional screening misses. Summerville Family Health Team's HPV self-collection pilot paired staff training, targeted outreach and new testing options to substantially increase cervical screening activity and give patients greater choice in how they participate.

THE OPPORTUNITY

Family physicians, nurse practitioners, nurses, and the leadership team at Summerville Family Health Team collaborated to be one of the few organizations in the province to offer HPV self-collection to patients. Starting in March 2025, the team was involved in the development, implementation, and evaluation of the provincial HPV Self Collection Pilot Program for Cervical Cancer Screening.

WHAT WE DID

Improving access to cancer screening across populations and promoting equal opportunity for preventative health care is a priority for Summerville Family Health Team. We aimed to improve access to cervical cancer screening by offering different methods for HPV collection including patient self-collection. We worked to educate patients about the different HPV collection options via patient email notifications, updating our organization's website and posters in the waiting and exam rooms. In addition, we ran a query to identify patients that

had not had cervical cancer testing for the past five years. These patients were contacted by our administrative and nursing staff to encourage cervical cancer screening and explore reasons for declining testing.

THE IMPACT

This initiative has helped to improve access to cervical cancer screening. At the onset of this project in Q1 of 2025 we had 257 patients complete provider HPV tests and 20 patients complete self HPV tests. After one year of this initiative, our testing rates improved to 790 provider HPV tests and 85 self-tests in Q2 of 2026. Furthermore, patient satisfaction scores have demonstrated patients are very satisfied with having different cervical cancer testing options available with multiple patients reporting to participate in screening only after learning there was a self-test option.

SUSTAINING AND ADVANCING THE WORK

Summerville Family Health Teams continues to run queries to identify patients due for cervical cancer screening. These patients are emailed and called to encourage cervical cancer screening. Recently, we have started to explore reasons for patients' declining screening and work with patients to overcome some of these potential barriers. This includes running HPV screening clinics after hours on weekends and evenings to improve access and opportunities for screening.

WHAT OTHERS CAN LEARN

This initiative demonstrates that patients value choice in their preventative health care screening. Providing patient choice allows for improved autonomy for healthcare options and expanded access to screening across patient populations. In the future, continuing to offer educational materials in even more languages can further improve patient education on this and other pertinent health topics, expanding patient knowledge on important healthcare options.

The patient report below demonstrates the strong impact this work has had on patients.

Jane, a 36-year-old mom of two, was due for her cervical screening. Due to negative past experiences with speculum exams, she had been declining her next screen for several years. When the clinic began the Ontario Health self-collected HPV testing pilot, her family physician thought she would be a perfect candidate. Her doctor asked the registered nurse leading the study at the clinic to call her, explain the study to her and offer an appointment to do the self-collection as opposed to a speculum exam. The RN called Jane, explained the study and the procedure for self-collection and Jane agreed.

SPREAD / KNOWLEDGE SHARING

This pilot originally started at four of Summerville Family Health Teams five sites in March 2025. Due to its success, we expanded the project to our fifth site to further improve access across our patient populations.

FOR MORE INFORMATION





THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Couchiching Palliative Care Program

ORGANIZATION: Couchiching Family Health Team

INITIATIVE: Integrated Primary Care Led Palliative Care Program across Couchiching Service Area

AT A GLANCE

Palliative care built around primary care, not around organizational boundaries. Couchiching Family Health Team helped create an integrated regional model with nurse navigation, shared-care supports and after-hours physician coverage, enabling more patients to receive coordinated palliative care closer to home.

THE OPPORTUNITY

Designing integrated models that connect primary care, acute care, home care, long term care and community services. Couchiching Family Health Team (CFHT) applied for Palliative Care Clinical Coach OH funding and was successful in 2025-26. By engaging OHT partners, we created a program structure with distributed leadership from key sectors that was socialized, approved and implemented within the fiscal year.

We have demonstrated that by leveraging the expertise of the Family Health Team in delivery of complex community care plans that require intense collaboration, partners gained confidence and were able to commit to the cross organizational vision of the Program and how OHTs can support innovation in care without formal governance and accountability agreements.

WHAT WE DID

In February 2025, partners gathered for two Mapping Days to establish willingness to work on priorities for palliative care delivery across sectors. A Program Steering Committee is now in place to advance the Ontario Palliative Care Network (OPCN) Models of Palliative Care. Working Groups will address:

- Clinical Practice & Quality;
- Education, Capacity Building & Provider Wellbeing;
- and Operations Integration.

Annual workplans have recently been approved for 2026-27 which include multiple deliverables to be actioned.

THE IMPACT

New program status for Palliative Care across OHT service area. Over 500 patients annualized (on service every year), Over 150 new referrals per year for CFHT Palliative Nurse Navigation and Family Physician support. Attachment for 20% of palliative referrals (28 attached in 2025)

Over 70% of people dying in preferred place of death.

The CFHT Nurse Navigator provides clinical and system liaison for patients, families and caregivers to bridge gaps in physician capacity.

The CFHT has a philosophy that no palliative patient will remain unattached. A group of FPs in two FHOs absorb these patients in a rotation, supported by the Nurse Navigator

The CFHT has a philosophy that no palliative patient will remain unattached, and a group of FPs in two FHOs absorb these patients in a rotation, supported by the Nurse Navigator. In 2025-26 we were able to put in place:

1. A multi-FHO after hours response MD call group using hospital switchboard to assist callers, home care and Hospice with 24 x 7 access.
2. CFHT Palliative Nurse Navigator support for 147 new palliative referrals, 20% of which were unattached and were assigned to participating FPs.
3. An Integrated Palliative Patient Pathway adopted across partners in our service area.
4. Awareness of available resource for provider wellbeing services.

SUSTAINING AND ADVANCING THE WORK

To sustain and further strengthen this achievement, the initiative has been transitioned from a time-limited project into a formal, cross-sector palliative care program with shared ownership across the Couchiching Ontario Health Team. A Program Steering Committee with representation from primary care, acute care, Ontario Health at Home, hospice, community partners, and caregivers provides ongoing system-level governance, oversight, and accountability. Three dedicated working groups—Clinical Practice and Quality, Education and Provider Capacity Building, and Operations and System Integration—are actively advancing

approved 2026–2027 workplans, embedding the model into routine practice across the system. In primary care, a shared-care physician model supported by the CFHT Nurse Navigator ensures equitable distribution of workload and sustained access for unattached palliative patients. Continuous improvement is driven through ongoing review of referral data and patient and caregiver feedback, which directly informs service refinement, system navigation improvements, and future planning priorities.

WHAT OTHERS CAN LEARN

This achievement offers a replicable model for integrated palliative care that can be adapted by other teams working to strengthen cross-sector collaboration, particularly in regions without dedicated specialist palliative services. A key learning is the value of a clinical coach–supported, data-driven co-design approach, which enabled partners across primary care, acute care, home and community care, and hospice to rapidly align on system need and implement coordinated action. The Integrated Palliative Patient Pathway provides a practical, transferable tool that standardizes referral processes, clarifies roles, and improves navigation across sectors, reducing fragmentation and improving consistency of care. The shared-care primary care model, supported by a centralized Nurse Navigator, demonstrates a scalable approach for supporting family physicians and nurse practitioners to deliver comprehensive palliative care in resource-limited settings.

SPREAD / KNOWLEDGE SHARING

Program model has been shared with OH Palliative Regional Team and presentations have been delivered to:

- Couchiching OHT Collaborative Table (37 partners)
- Couchiching Annual Partner Summit (47 participants)
- Couchiching Patient, Family Caregiver Network
- Central Region Palliative Coach Collaborative
- Central Region Palliative Care Network
- Couchiching OHT JET-Couchiching Joint Executive Team
- Couchiching FHT Board of Directors
- OSMH-Orillia Soldiers' Memorial Hospital

FOR MORE INFORMATION

WITH SINCERE THANKS TO



Boehringer
Ingelheim

FOR THEIR GENEROUS SUPPORT OF THE
BRIGHT LIGHTS AWARDS

It takes a team.



THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Prince Edward Family Health Team

ORGANIZATION: Prince Edward Family Health Team

INITIATIVE: Partnership in Practice: Designing Care Across Systems

AT A GLANCE

Team-based care does not have to stop at the edge of a Family Health Team. Prince Edward Family Health Team partnered with a non-affiliated Family Health Organization to deploy six nursing positions, testing a practical model for sharing organizational infrastructure and expanding interprofessional care across traditional boundaries.

THE OPPORTUNITY

The Prince Edward Family Health Team (PEFHT), in partnership with the Belleville Physicians Family Health Organization (FHO), has developed an innovative model for expanding access to team-based primary care by leveraging Family Health Team resources beyond traditional organizational boundaries. Through this partnership, PEFHT will recruit, employ, and support six full-time equivalent nursing positions that will be deployed within the Belleville Physicians FHO, increasing interdisciplinary capacity and supporting Ontario's goals for patient attachment, access, and continuity of care. What makes this achievement particularly noteworthy is that the Belleville Physicians FHO is not an affiliated Family Health Team partner.

By demonstrating how resources, expertise, and partnerships can be mobilized to meet community needs, this work reflects the future of primary care and the transformative potential of Ontario Health Team collaboration.

Primary care transformation efforts are further strengthened by PEFHT's Patient in Need Fund, which addresses social determinants of health by providing flexible support to patients facing barriers that impact their ability to access and benefit from care. Together, these initiatives recognize that improving health outcomes requires both strong clinical capacity and targeted supports that address the realities patients face outside the healthcare system. It offers a scalable model for primary care organizations across Ontario seeking to expand attachment, improve access, and create more connected, patient-centred systems of care.

WHAT WE DID

The Prince Edward Family Health Team (PEFHT) recognized several emerging needs within the Hastings Prince Edward region that align with challenges being experienced across Ontario: growing demand for primary care services, increasing complexity of patient needs, pressures on physician capacity, ongoing attachment challenges, and persistent social and economic barriers that prevent some residents from accessing care and achieving optimal health outcomes. Rather than focusing solely on its own rostered population or organizational footprint, PEFHT adopted a population health approach and worked collaboratively with the Belleville Physicians Family Health Organization (FHO) to identify opportunities to expand access to interdisciplinary primary care services across the region.

Rather than focusing solely on its own rostered population or organizational footprint, PEFHT adopted a population health approach and worked collaboratively with the Belleville Physicians Family Health Organization (FHO) to identify opportunities to expand access to interdisciplinary primary care services across the region.

Through this partnership, PEFHT committed to recruiting, employing, and supporting six full-time equivalent nursing positions that will be integrated within the Belleville Physicians FHO. This initiative increases primary care capacity, strengthens chronic disease management, improves access to preventative care, enhances care coordination, and supports the broader goal of attaching more patients to comprehensive team-based primary care.

This work reflects a fundamental shift toward integrated system planning and shared accountability for community health outcomes. By leveraging Family Health Team infrastructure and expertise to support a non-affiliated primary care partner, PEFHT demonstrated leadership in addressing local healthcare needs beyond traditional organizational boundaries. PEFHT also recognized that health outcomes are significantly influenced by factors beyond clinical care.

In response, the organization established the Patient in Need Fund to assist patients experiencing financial and social barriers that impact their ability to engage in care. Increased support for physician practices and enhanced ability to meet growing patient demand. Improved capacity to deliver preventative care, chronic disease management, and

coordinated care services. Strengthened collaboration between organizations within the Hastings Prince Edward Ontario Health Team, creating a model for future system integration. Direct support for patients facing barriers to accessing care through the Patient in Need Fund. Positive feedback from patients, providers, and partners regarding improved access to resources and supports.

Most importantly, these initiatives were developed in direct response to identified community needs and are designed to improve both access to care and health outcomes. By addressing clinical capacity challenges while simultaneously reducing barriers experienced by vulnerable patients, PEFHT has demonstrated a comprehensive, patient-centred approach to meeting the needs of its local population and advancing the goals of primary care transformation.

THE IMPACT

While the full impact of the primary care expansion initiative will continue to be measured as implementation progresses, there is already strong evidence that this achievement will deliver meaningful benefits for patients, providers, and the broader healthcare system.

The initiative has also demonstrated impact through the successful development of a collaborative service delivery model between organizations that do not share a traditional affiliation agreement. By establishing a partnership that leverages Family Health Team infrastructure to support a non-affiliated primary care organization, PEFHT has created a replicable model for system integration and resource optimization.

This approach demonstrates how organizations can work together to address population health needs while maximizing the value of publicly funded healthcare resources.

- Increased interdisciplinary capacity to support primary care physicians and their patients. - Improved provider capacity to manage growing patient demand and increasing complexity of care.
- Improved integration and collaboration among partners within the Hastings Prince Edward Ontario Health Team.
- Reduced duplication of effort through shared infrastructure, recruitment, onboarding, and operational supports.
- The Patient in Need Fund provides additional evidence of impact through its direct support of patients facing barriers that would otherwise limit their ability to access care or follow treatment plans. By assisting with needs such as transportation, medication-related costs, food security, and other social determinants of health, the

fund has enabled patients to access services, maintain continuity of care, and address challenges that contribute to poorer health outcomes.

Feedback from patients and providers consistently demonstrates that relatively small interventions can have a significant impact on an individual's health, wellbeing, and ability to engage with the healthcare system.

It has strengthened relationships among primary care partners, fostered a culture of collaboration and shared accountability, and established a foundation for future innovations in integrated care delivery. As Ontario continues its focus on attachment, team-based care, and health system integration, this work provides tangible evidence that collaborative approaches can expand capacity, improve access, address health inequities, and create sustainable solutions that benefit patients and communities alike.

SUSTAINING & ADVANCING THE WORK

Sustainability was built into the initiative from the outset. Rather than creating a short-term response to workforce pressures, Prince Edward Family Health Team (PEFHT) and the Belleville Physicians Family Health Organization (FHO) established a long-term partnership that uses existing Family Health Team infrastructure, leadership and operational supports to extend team-based care more efficiently.

PEFHT provides recruitment, human resources, onboarding, professional development and organizational support for the six nursing positions, creating consistency and stability while avoiding duplication of administrative infrastructure. The partnership is aligned with broader priorities related to patient attachment, access, team-based care and regional integration.

Partners are also monitoring access, provider capacity, interdisciplinary team utilization and patient experience to identify opportunities to refine and expand the model. The Patient in Need Fund is sustained through organizational revenues generated from health record disbursements and provides a flexible mechanism to address barriers related to social determinants of health.

Most importantly, the initiative has created a durable platform for future collaboration. The relationships, governance structures and shared accountability established through this work position the partners to pursue further workforce expansion, integrated service delivery, population health planning and other cross-organizational opportunities.

WHAT OTHERS CAN LEARN / SPREAD

The most transferable feature of this work is the **partnership model itself**. Family Health Team resources have traditionally been deployed within affiliated practices and organizational structures. By partnering with a non-affiliated FHO, PEFHT has demonstrated how existing organizational capacity can be used to extend interdisciplinary care across traditional boundaries without creating a parallel organization or duplicating infrastructure.

The initiative offers practical learning in workforce planning, recruitment, onboarding, governance and operational integration across multiple practice environments. It also demonstrates how relatively small, flexible investments, such as the Patient in Need Fund, can address immediate social and financial barriers that affect patients' ability to access and benefit from care.

Beyond these specific components, the work represents a broader shift in how primary care organizations can think about accountability and community need. Rather than defining responsibility by organizational affiliation, the partners have worked from a shared objective of strengthening access and capacity across the local primary care system.

PEFHT is sharing this experience through regional planning tables, Ontario Health Team discussions and engagement with primary care leaders and organizations across Hastings Prince Edward. The model is informing conversations about attachment, workforce deployment, population health management and how existing primary care resources can be used more collaboratively.

**The central lesson is highly transferable:
primary care transformation does not always require new organizational structures. It
can also come from using existing infrastructure differently, building trusted
partnerships, and creating mechanisms that allow resources and expertise to work**

FOR MORE INFORMATION





THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): McMaster Family Health Team and Maternity Centre of Hamilton- PROSPR Clinic

ORGANIZATION: McMaster Family Health Team

INITIATIVE: PROSPR: Integrated, Low-Barrier Care for Pregnant People with Substance Use Disorders

AT A GLANCE

Pregnancy, substance use, mental health and housing instability rarely arrive one at a time. McMaster's PROSPR program brings obstetrical, addictions, mental health and social supports together in one low-barrier model, helping pregnant patients navigate complex needs while improving access to essential prenatal care.

THE OPPORTUNITY

The PROSPR program delivers integrated, team-based, community-embedded care for pregnant people living with substance use disorders and complex social and medical needs. Patients served by PROSPR face intersecting challenges including substance use, mental health conditions, unstable housing, poverty, and limited access to traditional healthcare. Rather than expecting patients to navigate fragmented systems, PROSPR provides coordinated, compassionate, and flexible care that includes medical treatment, counselling, social support, and system navigation. The program connects care across primary care, acute care, and community services while addressing barriers such as transportation, food insecurity, and stigma.

WHAT WE DID

PROSPR identified the needs of its local population through patient data, chart reviews, and clinical experience. Team-based care involving physicians with expertise in obstetrics and addictions, nursing, system navigation, and administrative coordination

- A system navigator embedded across clinical and community settings (including partnerships such as with the YWCA) to build trust, re-engage patients, and connect them to housing, social, and community supports
- Wrap-around services addressing basic needs (food, transportation, supplies) to remove barriers to care
- Low-barrier, flexible care delivery that meets patients where they are
- Integration of obstetrical care, addictions care, and mental health care within a single coordinated model The program also addressed structural barriers by improving access to testing (e.g., point-of-care testing for HIV and syphilis), enabling same-day diagnosis and treatment, and supporting patients to attend urgent care, imaging, and lab work.

THE IMPACT

Impact is demonstrated through both quantitative and qualitative outcomes:

Quantitative evidence:

- 89% of patients completed routine bloodwork
- 80% completed critical ultrasounds
- Patients had earlier gestational age at first visit and more frequent contact with care providers
- Average delivery occurred at 36 weeks gestation (above typical averages for people living with substance use disorders)
- Reduced complications, including fewer NICU stays and lower rates of neonatal abstinence syndrome
- 100% of patients now interact with the system navigator (up from approximately 50%) Improved patient engagement and attendance, supported by consistent access to transportation and basic needs

Qualitative evidence:

- Patients remain engaged in care due to non-judgmental, relationship-based approaches
- Patients report feeling supported, respected, and part of a community
- Providers report improved collaboration, sustainability, and reduced burnout due to shared care models

WHAT OTHERS CAN LEARN

PROSPR offers a strong model for replication and learning across settings.

- Demonstrating how to integrate obstetrical care, addictions medicine, and mental health into a single coordinated model
- Providing a practical framework for embedding system navigation and community partnerships into healthcare delivery
- Showing how addressing basic needs (e.g., food, transportation) directly improves access and engagement
- Advancing low-barrier, trauma-informed approaches that improve outcomes for complex populations
- Offering innovations such as point-of-care testing and rapid response to emerging public health risks This model illustrates how systems can move from fragmented, crisis-based care to proactive, relationship-based care. Training and mentorship of new physicians and medical residents in integrated perinatal addiction care
- Participation in research initiatives and pilot programs (e.g., point-of-care testing for HIV and syphilis)
- Sharing expertise and clinical guidance with other healthcare providers and organizations
- Supporting system-wide learning by demonstrating effective responses to emerging challenges (e.g., drug supply contaminants)

FOR MORE INFORMATION





THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Southlake Academic Family Health Team & Northern York South Simcoe Ontario Health Team

ORGANIZATION: Southlake Academic Family Health Team

INITIATIVE: Segmenting Care, Scaling Equity: A Flexible Primary Care Home in Georgina

AT A GLANCE

Design the primary care home around the population, not the building. Southlake Academic Family Health Team and the Northern York South Simcoe OHT used population data and community input to create a flexible model for people with different levels of clinical and social complexity, including those experiencing homelessness.

THE OPPORTUNITY

The Southlake Academic Family Health Team (SAFHT), in partnership with Northern York South Simcoe (NYSS) OHT and community organizations, is redefining the primary care home through a segmentation-based model that aligns team-based services to patient complexity. Using a blend of clinic-based, mobile, and virtual care models, this initiative proactively stratifies patients by social and clinical need and configures interdisciplinary care accordingly. It meets patients where they are, literally and figuratively, and delivers equity-focused, flexible care to Georgina's most underserved.

WHAT WE DID

Through geoanalytic mapping and community consultations, SAFHT and partners identified Georgina's high rates of ED usage and unmet primary care needs especially among the unstably housed. A structured literature review of segmentation models informed local adaptation. SAFHT integrated these tools across in-clinic, virtual, and mobile workflows to improve early identification and triage. Marginalized residents also co-developed the service model through surveys and interviews, with 100% expressing interest in receiving care in shelters or encampments.

THE IMPACT

Geoanalytic data revealed over 30,000 "uncertainly attached" residents in the NYSS OHT catchment, with more than 20,000 not having seen a primary care provider in two years. Community Paramedic data identified 442 unique patients experiencing homelessness, with 94% visiting the ED in the last six months. Segmentation tools piloted in Georgina revealed underrecognized needs and informed early care pathways. Qualitative data from clients emphasize barriers like transportation and technology, validating the model's mobile and virtual components. Patient feedback from previous SAFHT-led clinics helped refine workflows.

SUSTAINING AND ADVANCING THE WORK

SAFHT/NYSS OHT is embedding segmentation-informed workflows across its interdisciplinary team: clinic-based, mobile, and virtual, using EMR prompts, shared care plans, and eReferral pathways. Feedback loops, including case reviews and data dashboards, inform ongoing refinement. Partnerships with CMHA, Blue Door, and York Region ensure sustainable delivery through co-location, shared staffing, and mobile infrastructure. A joint QI plan, built with NYSS OHT, ensures the model evolves based on population needs and provider-patient input.

WHAT OTHERS CAN LEARN

This model offers a roadmap for how to reimagine the primary care home across care settings. Other teams can adopt its population segmentation framework, validated intake tools, mobile deployment strategies, and integrated governance. EMR workflows and referral tools are already being shared across NYSS OHT. Teams across Ontario can apply this framework to improve attachment, tailor care, and proactively address risk especially in regions facing workforce shortages or high inequity. SPREAD / KNOWLEDGE SHARING

SAFHT and NYSS OHT have actively shared their segmentation work through steering committees, physician councils, and interdisciplinary forums. Team members have mentored partners (e.g., Blue Door, CMHA, Vaughan CHC) in adapting workflows and screening tools to their contexts. Lessons learned are embedded in onboarding for learners and new clinicians. The model's digital assets (intake templates, EMR workflows) are being standardized for replication across other underserved areas.

FOR MORE INFORMATION



THEME AWARD: Designing Care Across Systems: Integration, Equity & Population Health

NOMINEE(S): Dufferin DBT Program (Community Program led by DAFHT)

ORGANIZATION: Dufferin Area Family Health Team

INITIATIVE: The Dufferin DBT Program - A FHT Led Community Initiative to Provide Access to Team-Based Collaborative Care for Individuals Struggling with Suicidality

AT A GLANCE

For people living with suicidality, fragmented mental health care can carry enormous consequences. The Dufferin DBT Program brings five community partners together around an intensive six-month treatment model, with strong improvements reported in emotion regulation, suicidal ideation and self-harm.

THE OPPORTUNITY

For residents of Dufferin-Caledon, participation in specialized mental health programs has often required individuals to travel to other communities – or, more frequently than not, resulted in patients being unable to access such treatment due to transportation or logistical barriers. In recognition of these ongoing challenges for patients and providers, the Dufferin DBT Program was designed, collaboratively resourced, and launched in May 2019 as a ‘community program’. Our vision – led by the Dufferin Area Family Health Team - was to provide evidence-based, intensive, dialectical behaviour therapy for ‘complex’ or ‘difficult to serve’ patients who struggle with impulsivity, pervasive emotion dysregulation, and

substantial risk to life due to suicidality, self-harm, or other behaviours. Over the past eight years, the Dufferin DBT Program has served as an example of what is 'only possible together', as four local mental health services 'harnessed relationships' and collaboratively partnered to respond to a specific community need through supporting a shared program. For the Dufferin Area Family Health Team, the Dufferin DBT Program has extended team-based care outside our roster, enhanced our working relationships with community partners, advanced clinical skills and knowledge for our mental health therapists and team, and increased care coordination. Participants of the Dufferin DBT Program have reported significantly improved mental health (based on self-report and outcome measures), specifically, reduced suicidality, increased emotion regulation skills, as well as reduced hospitalization and ER visits. Given the huge time and resource commitment to providing a DBT Program – involving individual therapy, weekly skills group, phone coaching, and weekly peer consultation to support clinical adherence – we recognize that the remarkable sustainability of the Dufferin DBT Program has been rooted in our investment in relationships and recognizing the real results of integrated care.

WHAT WE DID

See above. The Dufferin DBT Program is now an intensive 6 Month Program developed as a response to recognizing that a number of patients were not able to access specific, effective and targeted treatment for emotional distress resulting in suicidal and other life threatening behaviours. Moreover, many of the patients now supported through the DBT Program are community members who had previously accessed several mental health services with support from various therapists, social workers, case managers. To date, over 70 adults have participated in the Dufferin DBT Program.

THE IMPACT

Outcome data for 2025-2026: Year 7 (November 2025 - April/May 2026)

OUTCOME – Improved Emotion Regulation Skills (based on the DERS)

- Overall, patients demonstrated improvement in 5 of 6 skill areas
- 77% of participants showed significant increase in emotion regulation skills in 3 out of 6 skill areas as measured by the DERS, with 55% reflecting improvement in emotion regulation skills in 5 of 6 skill areas

OUTCOME – Reduced 'Suicidality' as per Patient Questionnaire:

- 89% of participants showed improvement in reduced ideation and/or self-harm behaviours
- Ideation (incl "thoughts about killing self, thoughts about how to work out the details of killing self, doing things to prepare to end your life) reduced, locating experience

on average of active suicidal ideation with specific intention or preparatory planning as more than 4-12 months ago for 89% of participants.

OUTCOME - Reduced ER visits (based on patient self-report)

- 100% (0 reported occurrences in past 2-3 months at follow-up)
- 0% or none reported for duration of program participation Outcome Results for Year 5 (October 2023 - May 2024)

OUTCOME – Improved Emotion Regulation Skills (based on the DERS) showing: 88% increase in emotion regulation skills in 4 out of 6 skill areas measured by the DERS

OUTCOME - ‘Suicidality’ Measure:

- 90% participants showed improvement in reduced ideation and/or self-harm behaviours
- Frequency of ideation (incl “thoughts about killing self, thoughts about how to work out the details of killing self, doing things to prepare to end your life) reduced on average by 38% frequency, locating experience on average of active suicidal ideation with specific intention or preparatory planning as more than 4-12 months ago for 90% (9 /10) of participants.
- Reduced ER visits (based on patient self-report) = 100% (0 reported occurrences in past 0-12 months at follow-up) Summary of Outcome Results for Years 1-4 (2019-2023)

OUTCOME – Improved Regulation Skills (based on the DERS) at 12 month follow-up reflected 91% improvement in at least one skill area and 71% of participants showed improvement in 6 of 6 skill areas related to managing ‘impulsivity’ (33.25%) and increased ‘strategies’ (29.97%) for regulation being skill areas of most improvement

OUTCOME– based on “Ways of Coping” Measure which was also utilized – 100% of participants showed improvement with increased “skills use” and decreased “general dysfunction” at 12 months

OUTCOME - ‘Suicidality’ Measure: showed decreased suicidal ideation and behaviours, as well as self-harm behaviours – on average reflected 13% decrease overall per participant (inclusive of passive ideation to planning and preparatory behaviours as well as non-suicidal self-harm)

- Reduced ER visits (based on patient self-report for past 6 mon) = 98% (93 initial reported occurrences for past 1-6 months initially vs at follow-up 2 occurrences) •
- Reduced hospitalizations (based on patient self-report for past 6 mon) = 100% (51 reported hospitalizations initially for past 1-6 months vs at follow-up 0 reported occurrences)
- Reduced isolation and increased collegial support between inter-agency providers.
- Increased functional knowledge of other community mental health services. • Better adherence to a DBT approach, increased accountability.
- Shared care in working with patients at high risk.
- Shared burden, shared benefit' in supporting patients with challenging mental health who have often accessed multiple services. For patients:
- Decrease in hospitalizations or ER visits for participants

SUSTAINING AND ADVANCING THE WORK

As a community initiative - the Dufferin DBT Program - is an intensive program serving a small number of patients each year - and a 'big ask' for providers, collaborating agencies, and patients. However, as a program and a community team, we have endured and are now entering our 8th year! Some of our efforts for sustainability have included:

- Ongoing investment in training for providers, including 'new-to-the-program' orientation, coaching and skills training, as well as advanced consultation for more experienced therapists
- Highlighting the impact of integrated care through the Dufferin DBT Program with partner organizations and health system decision makers, including sharing patient feedback
- Growing DBT champions among involved providers and across partnering organizations
- Continuing to be rooted in our relationships while working together with respect, openness, trust and partnership – 'without egos' and with vision for 'what is possible'.

WHAT OTHERS CAN LEARN

The 'Pay off' of partnership – when we “all put in a little, it takes some of the pressure off the individual provider or organization”.

- Value of supporting on-going clinical consultation with an DBT expert therapist.
- Shared commitment is essential; through communication, collaboration, coordination, and consensus decision-making over time with 'a vision' for the program's future.

SPREAD / KNOWLEDGE SHARING

Over the past couple of years, DBT Team members have made presentations about the vision and nature of the Dufferin DBT Program, including meeting with other community providers in health care and social service organizations to share the unique delivery of this community program, the shared referral process, and guidance around who the program is intended to serve. Other formal presentations have occurred over the years in different formats, including a Poster Presentation at the virtual AFHTO Conference in Fall 2021.

FOR MORE INFORMATION

