



Équipe Santé Ontario de
WINDSOR
 ESSEX
Ontario Health Team

Partnership Council Meeting
June 2026

Welcoming Remarks

Margo Reilly and Leigh Vachon
Partnership Council Co-Chairs



Land Acknowledgement

Barb Colaizzi

WEOHT Indigenous Engagement Lead



WEOHT 2025 – 2026 Year In Review Report

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Meeting Our FY 2025/26 Deliverables

OHTs received FY 2025/26 Integrated TPA Amendment Guidance in July 2025 to support achieving a set of deliverables prescribed by Ontario Health. OHTs were asked to focus on a common set of clinical and digital priorities that align with three areas:

1. Primary Care Access, Attachment, and Enablement
2. Integrated Clinical Priorities
3. OHT Capacity Building

Across these 3 priority areas, there were 16 total deliverables. Most deliverables had a set of minimum expectations and success measures that OHTs strive to achieve. Additionally, because WEOHT has a funded In-Flight Integrated Clinical Pathway (ICP) (Lower Limb Preservation Project), there was another set of deliverables to mature their ICP.

A deliverables tracker was created by the WEOHT staff team to track progress on meeting each deliverable's minimum requirements and success measures. The WEOHT met 100% of minimum expectations and success measures for all but two deliverables.



Meeting Our FY 2025/26 Deliverables

Priority Area	#	Deliverable	Progress - Minimum Expectations	Progress - Success Measures	Notes
Primary Care Enablement	1	In alignment with provincial direction, continue to advance a PCN that organizes the local primary care sector and engages interprofessional primary care providers (i.e. family physicians, nurse practitioners and other primary care clinicians) in OHT planning, decision-making, and implementation of clinical priorities.	▶ 100%	▶ 100%	
Primary Care Enablement	2	Continue to fund a PCN Clinical Lead/Leads to advance the OHT's PCN, participate in OHT decision-making and local and regional PCN leadership tables, support OHT/PCN clinical initiatives and participate in fall/winter surge planning.	▶ 100%	▶ 100%	
Primary Care Enablement	3	Develop and implement a plan to facilitate primary care matching and attachment , including navigation and access to primary care services, aligned to provincial direction.	n/a	▶ 100%	
Primary Care Enablement	4	Curate information about local services , with a focus on primary care services and resources and services for unattached patients, across Health811, OHT, and member organization websites, and collect analytics about user behaviour across OHT digital assets.	▶ 100%	▶ 100%	
Primary Care Enablement	5	Increase participation in cancer screening (e.g., cervical, colorectal and breast), including support for unattached participants accessing screening (e.g., provision of HPV testing) and follow-up services for abnormal test results (e.g., provision of Fecal Immunochemical Test positive (FIT+) colonoscopy referrals), in collaboration with the Regional Cancer Program.	▶ 100%	▶ 100%	
Primary Care Enablement	6	Report on progress expanding access to Online Appointment Booking (OAB) in primary care settings.	▶ 100%	▶ 100%	
Primary Care Enablement	7	Facilitate the adoption and report on progress of e-Referral solutions by primary care and specialist providers participating in the OHT, including those involved in enabling chronic disease Integrated Clinical Pathways, in support of the Patients Before Paperwork Strategy.	▶ 100%	▶ 80%	<ul style="list-style-type: none">•in process of seeking out "success stories" for e-referral adoption•all other expectations met
Integrated Clinical Priorities	8	Chronic Disease Prevention and Management (CDPM) : Develop and implement a plan to advance community-based care for individuals at risk or living with chronic disease to support primary care and reduce hospital use.	▶ 60%	▶ 75%	<ul style="list-style-type: none">•progressing in a phased approach•current focus is on establishing governance, population identification, data infrastructure, and integration with IPCTs•outcome measurement related to hospital utilization will be reported once sufficient implementation scale and data maturity are achieved•aligned with Access and Flow (ALC) and coordinated services across care continuum, and using community mapping
Integrated Clinical Priorities	9	ALC Prevention and Reduction : Develop and implement an ALC action plan aligned to OH regional ALC planning that identifies the greatest opportunities for ALC prevention and management.	▶ 100%	▶ 100%	



Meeting Our FY 2025/26 Deliverables

Priority Area	#	Deliverable	Progress - Minumum Expectations	Progress - Success Measures	Notes
OHT Capacity Building	10	Demonstrate targeted outreach efforts and report on progress to continue to expand OHT membership to mandatory and optional membership groups described in 'Ontario Health Teams: The Path Forward', including Indigenous communities and organizations and patients, families and caregivers, and to continue to expand the OHT's PCN membership aligned to the Ministry's PCN guidance document.	▶ 100%	▶ 100%	
OHT Capacity Building	11	Implement the OHT's action plan developed as part of the 2024/25 (Year 1) deliverables, identify priority areas of focus within the plan to support the goal of OHTs advancing to a minimum of 'Level 2: Learning and Developing' as outlined in the Creating Engagement Capable Environments in Ontario Health Teams Framework.	▶ 100%	▶ 100%	
OHT Capacity Building	12	Demonstrate that OHT staff have completed the following education : <ul style="list-style-type: none">•Indigenous cultural awareness and safety training•EIDA-R education and training•Active Offer•Patient, Family and caregiver engagement training	▶ 100%	▶ 100%	
Clinical Spending: Primary Care Access & Attachment Funds	13	Develop and implement a plan to facilitate matching and attachment of patients on the Health Care Connect (HCC) waitlist (as of January 1st, 2025) by spring of 2026.	n/a	n/a	•Attachment plan submitted to OH
Clinical Spending: Primary Care Access & Attachment Funds	14	Develop an initial plan to support 100% attachment of local population by 2029, based on identified primary care attachment and access gaps and aligned to provincial direction.	▶ 100%	▶ 100%	
Clinical Spending: Primary Care Access & Attachment Funds	15	Lead and/or coordinate submissions for new/expanded Interprofessional Primary Care Teams (IPCT) investment from primary care partners.	n/a	n/a	•IPCT submissions coordinated and successful
Clinical Spending: Primary Care Access & Attachment Funds	16	Implement collaborative initiatives to provide clinical services to unattached patients while they await matching and attachment to family physicians or nurse practitioners.	▶ 100%	▶ 100%	



Year at a Glance

2025–2026 Highlights

- ✓ **6,056 residents** attached to primary care, including **1,609** from Health Care Connect
- ✓ **Health Care Connect waitlist cleared**
- ✓ **\$4.77 million** secured through Interprofessional Primary Care Team funding applications
- ✓ **Comprehensive regional primary care provider inventory developed**
- ✓ **13 Indigenous Cultural Safety training sessions** delivered
 - ✓ **468 participants** trained across **32 organizations**
- ✓ **56 sector table and collaborative planning meetings**
- ✓ **17 PFAC meetings** held; **6 new members** recruited
- ✓ **70 Online Appointment Booking licenses** sustained; **5 new implemented**
- ✓ **2 new organizations** joined the WEOHT



Strategic Priority 1: Integrated Care & Clinical Excellence

Objective: Deliver seamless, team based, evidence-informed care for priority populations.

What We Did

- Cleared the Health Care Connect waitlist
- Supported primary care attachment through outreach and navigation
- Developed regional primary care provider inventory
- Advanced integrated initiatives (ED GEM, MH/IDD pathways, complex navigation)
- Shifted beyond traditional numerical targets toward pathway optimization, focusing on how care is coordinated and delivered across teams to improve effectiveness and continuity
- Implemented Warm Hand-Off Protocol between adult mental health & addictions providers

Impact

- Improved access to primary care
- Stronger coordination across sectors
- Strengthened system flow and continuity of care



Strategic Priority 2: Quality Improvement & Performance Analytics

Objective: Drive continuous improvement through data informed and equity-informed decision-making.

What We Did

- Expanded eReferral adoption across sectors
- Advanced digital readiness, including mental health and addictions
- Sustained 70 online booking licenses; implemented 5 new
- Supported data-informed planning and reporting
- Attended workshop on First Nations OCAP® (Ownership, Control, Access, and Possession) and First Nations data sovereignty*

Impact

- Improved access and coordination
- Enhanced patient experience through digital tools
- Stronger foundation for continuous improvement

*presented by the First Nations Information Governance Centre (FNIGC)



Strategic Priority 3: Strategic & System Partnerships

Objective: Strengthen cross-sector collaboration to align resources and improve system coordination.

What We Did

- Engaged partners across primary care, hospitals, community services, and municipalities
- Leveraged Partnership Council, sector tables, and working groups

Impact

- Improved coordination and communication
- Reduced duplication of efforts
- Stronger alignment on shared priorities



Strategic Priority 3 Spotlight ★

Primary Care Network

- **Key Contributions**

- Developed comprehensive primary care inventory
- Strengthened communication with providers
- Supported primary care attachment initiatives
- Advanced digital health priorities

- **Impact**

- Increased primary care engagement
- Stronger collaboration with physicians and nurse practitioners
- Laid the foundation for improved system planning and coordination



Strategic Priority 4: Patient, Family & Caregiver Engagement

Objective: Embed lived experience in governance, design, and evaluation.

What We Did

- Engaged PFAC across governance and system initiatives
- Supported co-design of programs and services
- Strengthened PFAC capacity and representation
- Advanced engagement and evaluation strategy

Impact

- More patient-centred planning and decision-making
- Improved alignment with community needs
- Stronger engagement across the system



Strategic Priority 4 Spotlight ★

PFAC Visioning Conference

- **Highlights**

- Brought together patients, caregivers, and system partners
- Explored future of engagement in Windsor-Essex
- Identified priorities and opportunities for improvement

- **Key Themes**

- Accessibility and communication
- Caregiver inclusion
- Navigation support
- Culturally safe care



Strategic Priority 5: Health Equity & Population Health

Key Focus: Advancing equity and improving outcomes for priority populations

What We Did

- Delivered Indigenous Cultural Safety training (468 participants, 32 organizations)
- Strengthened partnerships with Indigenous communities
- Advanced EIDA-R education and resource development
- Supported population health and preventative care initiatives

Impact

- Increased awareness of culturally safe care
- Improved access and reduced barriers
- Stronger focus on equity in system planning

WEOHT Staffing Overview and Sector Tables and Working Groups Structure

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WEOHT: Meet the Staff



Joyce Zuk

Executive Director

Supports SteerCo, PFAC, Partnership,
and all tables!



Amanda Willms

Primary Care Attachment Lead

Supports PCN and PC Sector Table
Seconded from ESHC



Barb Colaizzi

Indigenous Engagement Lead

Supports EIDA-R Working Group
Seconded from ESHC



Erica Bassakos

Mental Health & Addictions Lead

Supports MHA and CSS Sector Tables
Seconded from HDGH



Jenniffer Clifford

ALC Lead

Supports CSS Sector Table and all things ALC
Seconded from HDGH



Dr. Jennifer Bertram

Primary Care Clinical Lead

Practicing family physician



Darcie Renaud

Data and Performance Lead

Joint position with WECHU

New!



Purchased Services

Supporting the Work of the WEOHT



HÔTEL-DIEU GRACE
ESTD HEALTHCARE 1888

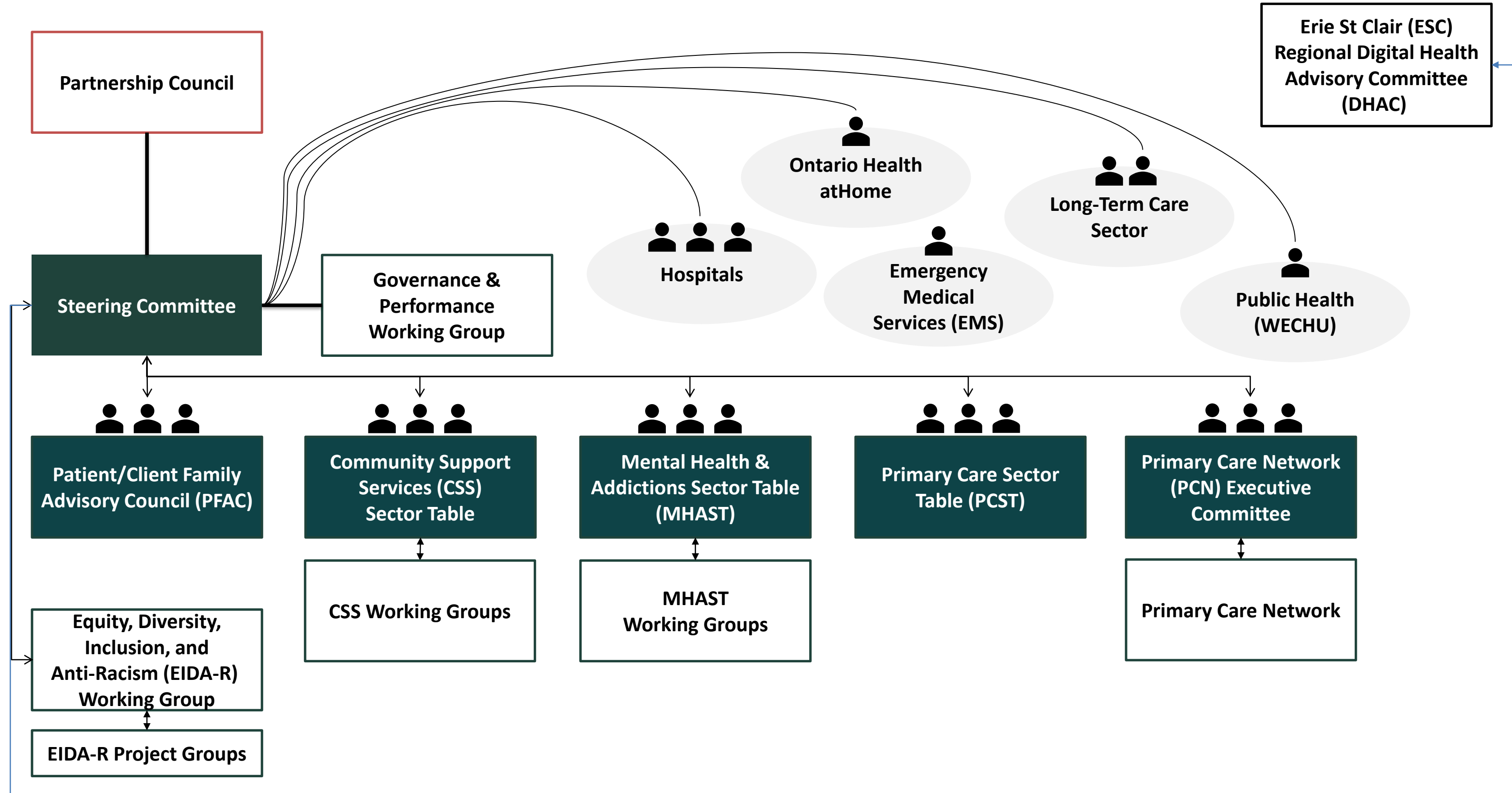
Providing Digital Support and Leadership

- OH Digital Health Representation and Advocacy:
Attend West Region Digital Health Advisory Committee (DHAC) meetings
- Local Regional Digital Health Advisory Committee:
Co-facilitate the Erie-St. Clair DHAC
- Subject Matter Expertise: AI Scribe
- Digital Health Projects and Initiatives:
Assisting with the roll out of Ocean eReferral,
Online Appointment Booking (OAB)

Providing Communications Support

- social media content development and posting
- graphic design
- website maintenance and user tracking
- newsletter development and circulation
- maintenance of a contact list

WEOHT Structure



as outlined in the Collaborative Decision-Making Agreement (CDMA) and Sector Table and Working Groups' Terms of Reference (TOR)

OHT Deliverables for 2026 – 2027

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Deliverables Overview

Deliverables are either the same as FY 25-26
or advance deliverables and initiatives from last year

Additional foundational program expectations outlined for

- Indigenous Health Equity & Partnerships
- Health Equity & Community Partnership

14 Deliverables Total

1 is n/a
(for 112
OHTs)

12 for all OHTs

+1 for ICP

8 for
OHT Implementation
Funding

4 for
Clinical Spending
(Primary Care Access
& Supported
Attachment)

Specific to
Lower Limb
Preservation Pathway

Note: We are in the last year of a 3-year funding cycle and have not yet received information about future funding



Implementation Funding Deliverables (8)

3 Priority Areas:

Primary Care Access, Attachment and Enablement

1. Continue to advance a PCN
2. Continue to fund a PCN Clinical Lead(s)
3. Engage with primary care providers to advance provincial priorities
4. Increase participation in cancer screening

Integrated Clinical Priorities

5. Advance Chronic Disease Prevention and Management (CDPM) activities
6. Support ALC prevention and discharge management

OHT Capacity Building

7. Continue to expand OHT membership, including FNMIUI communities and patients, families and caregivers
8. Continue to implement activities to advance to a minimum 'Level 2: Learning and Developing' as outlined in the Creating Engagement Capable Environments

Clinical Spending Deliverables (4)



Primary Care Access & Attachment

9. Continue to implement the plan to support 100% attachment of local population by 2029
10. Lead and/or coordinate submissions for new/expanded interprofessional primary care team (IPCT) investment from primary care partners (following further direction from OH and MOH)

Primary Care Supported Attachment

11. Implement collaborative initiatives to provide clinical and non-clinical services to unattached patients while they await matching and attachment to primary care
12. Continue to implement supported attachment services, and evaluate and report on impact

Integrated Clinical Pathway (ICP) Deliverable



Specific to Lower Limb Preservation Pathway Funding

14. Build on existing LLP ICPs by supporting the following activities to mature ICPs in key areas:

- Collaborate with community and acute care clinical leadership in place to jointly lead
- Continue to identify patients served by pathways and report these unique patients to Ontario Health
- Mobilize continued pathway improvements in key areas to strengthen program impact, and improve outcomes for patients at highest-risk of lower-limb amputation
- Ensure that all patients served by pathways are attached and/or have ongoing access to primary care

WEOHT Workplan with **Key Performance Indicators (KPIs)**

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Goal	2026-2027 WEOHT WORKPLAN An integrated, equitable and high-performing local health system where residents receive seamless, timely, culturally safe, and evidence-informed care across the continuum.			
Quintuple Aim	Our work advances the following system outcomes: Improved Population Health Enhanced Patient & Care Partner Experience Improved Provider Experience & Well-Being Better Value & Cost Stewardship Health Equity & Reduced Disparities			
Strategic Priorities (impact is achieved through 5 interconnected pillars)	Objective	Activities	Outcomes	KPIs / Scorecard (examples)
Integrated Care & Clinical Excellence	Deliver seamless, team-based, evidence-informed care for priority populations.	<ul style="list-style-type: none"> - Standardized Integrated Care Pathways (Seniors, MHA, Chronic Disease) - Centralized Intake and coordinated navigation - Improved hospital to community transitions - Increase primary care attachment 	<ul style="list-style-type: none"> - Reduced ALC days and avoidable hospitalizations - Improved continuity of care and reduced duplication - Increased primary care attachment 	% reduction in ALC days % reduction in unattached patients % of MHA providers receiving Ocean referrals % of discharges with 7-day primary care follow-up 30-day readmission rate (%) 30-day ED revisit rate for MHA (%) % receiving home care within 48 hours
Quality Improvement & Performance Analytics	Drive continuous improvement through data-informed and equity-informed decision-making	<ul style="list-style-type: none"> - System-wide KPI dashboard and scorecard - minimum four Q1 cycles on priority initiatives - equity stratification embedded in reporting 	<ul style="list-style-type: none"> - Real-time performance visibility - Measurable improvement in priority indicators - Improved operational effectiveness 	% increase in referral senders % of partners completing QI training % of indicators with equity stratification % of required data sharing agreements executed % of KPIs updated on schedule (dashboard timeliness)
Strategic & System Partnerships	Strengthen cross-sector collaboration to align resources and improve system coordination.	<ul style="list-style-type: none"> - Updates MOUs with key partners - cross-sector planning tables - joint funding proposals - conflict resolution and escalation framework 	<ul style="list-style-type: none"> - Improved coordination across health and social sectors - Enhanced shared accountability and resource alignment - Increased partner satisfaction and engagement 	% of funding requests coordinated through OHT % of MOUs signed/updated % of partners sharing data % of partners participating in ≥75% of planning tables Partner satisfaction score (survey-based)
Patient, Family & Care Partner Engagement	Embed lived experience in governance, design, and evaluation	<ul style="list-style-type: none"> - Sustain PFAC - Embed advisors in pathway design - Annual engagement reporting 	<ul style="list-style-type: none"> - Co-designed care pathways - Increased patient satisfaction - Strengthened patient voice in decision-making 	% of care pathways co-designed with patients % of partner PFACs engaged with WEOHT PFAC Quality of engagement score % of patients reporting involvement in care decisions % of advisors from priority populations
Health Equity & Population Health	Reduce disparities and improve outcomes for equity-deserving populations	<ul style="list-style-type: none"> - Implement Equity Framework across all pillars - Cultural safety and anti-racism training - Identify priority underserved populations - Disparity gap measurement and reporting 	<ul style="list-style-type: none"> - Increased culturally safe care delivery - Reduced disparities in access and outcomes - Improved population health indicators 	Disparities (Rate Ratios, RR) Primary care attachment RR, Cancer screening RR, Mental health ED visit RR, ED visits for primary-care-treatable conditions RR, ACSC admission RR, Premature mortality RR,



KPI Framework Overview



Grounded in a logic model linking structures → activities → outcomes.



Organized around WEOHT's five strategic priorities.



Includes structure, process, and outcome indicators for balanced measurement.



Embeds equity-informed monitoring across all priority areas.



Designed for practical implementation, real-time visibility, and continuous improvement.



Priority 1: Integrated Care & Clinical Excellence

Objective: Deliver seamless, team-based, evidence-informed care for priority populations.

Activities:

Standardized Integrated Care Pathways (Seniors, MHA, Chronic Disease)	Centralized intake and coordinated navigation	Improved hospital-to-community transitions	Increase primary care attachment
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Outcomes:

Reduced ALC days and avoidable hospitalizations	Improved continuity and reduced duplication	Increased primary care attachment
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Indicators:

- % reduction in ALC days
- % reduction in unattached patients
- % of MHA providers receiving Ocean referrals
- % of discharges with 7-day primary care follow-up
- 30-day readmission rate
- 30-day ED revisit rate for MHA
- % receiving home care within 48 hours
- % of eligible patients enrolled in care pathways
- % of MHA discharges with physician follow-up in 7 days
- ED visit rate for primary-care-treatable conditions (per 1,000)
- % reporting unmet healthcare needs
- % of patients confident in discharge information
- % of discharges with medication reconciliation

Priority 2: Quality Improvement & Performance Analytics



Objective: Drive continuous improvement through data-informed and equity-informed decision-making.

Activities:

System-wide KPI dashboard

Minimum four QI cycles

Equity stratification embedded in reporting

Outcomes:

Real-time performance visibility

Measurable improvement in priority indicators

Improved operational effectiveness

Indicators:

- Quarterly performance reports
- % Increase in eReferral senders
- % Partner participation in QI training
- % indicators with equity stratification
- % required DSAs executed
- % of KPIs updated on schedule (dashboard timeliness)



Priority 3: Strategic & System Partnerships

Objective: Strengthen cross-sector collaboration.

Activities:

Standardized
Update MOUs

Cross-sector
planning tables

Joint funding
proposals

Conflict resolution
framework

Outcomes:

Improved coordination

Enhanced shared
accountability

Increased partner
satisfaction

Indicators:

- % of funding requests coordinated through OHT
- % of MOUs signed/updated
- % of partners sharing data
- % of partners participating in $\geq 75\%$ of planning table meetings
- Partner satisfaction score (survey-based)



Priority 4: Patient, Family & Care Partner Engagement

Objective: Embed lived experience in governance, design, and evaluation.



Activities:

Sustain PFAC

Embed advisors in pathway design

Annual engagement reporting



Outcomes:

Co-designed care pathways

Increased patient satisfaction

Strengthened patient voice in decision-making

Indicators:

- of active patient/family advisors
- % of care pathways co-designed with patients
- % of partner PFACs engaged with WEOHT PFAC
- Patient satisfaction score
- Quality of engagement score (% meaningful involvement)
- % of patients reporting involvement in care decisions
- % of advisors from priority populations
- % of hospital patients reporting involvement in decisions



Priority 5: Health Equity & Population Health

Objective: Reduce disparities and improve outcomes for equity-deserving populations.

Activities:

Implement Equity Framework

Cultural safety & anti-racism training

Identify priority underserved populations

Disparity gap measurement & reporting

Outcomes:

Increased culturally safe care

Reduced disparities

Improved population health

Equity Capacity & Engagement

- % of staff completing cultural safety & anti-racism training
- % of partner organizations participating in equity training
- % of indicators stratified by equity variables

Access & Prevention

- % of eligible population up-to-date on cancer screening

Disparities (Rate Ratios, RR)

- Primary care attachment RR
- Cancer screening RR
- Mental health ED visit RR
- ED visits for primary-care-treatable conditions RR
- ACSC admission RR
- Premature mortality RR
- Avoidable mortality RR

Population Outcomes

- Premature mortality rate (per 100,000)
- Avoidable mortality rate (per 100,000)

Accreditation Survey

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Accreditation Survey

It was brought forward at Mental Health & Addictions Sector Table (MHAST) meeting to share resources around accreditation so that partners could support one another through successful accreditation.

As a follow-up, we are surveying our WEOHT...

Are you accredited?

If yes – who is your accrediting body?



Please fill out the survey now by scanning the QR Code!

We will also follow-up with all WEOHT Partners to share the survey link if they have not yet completed it.

A Scan of the WEOHT Partnership's Websites

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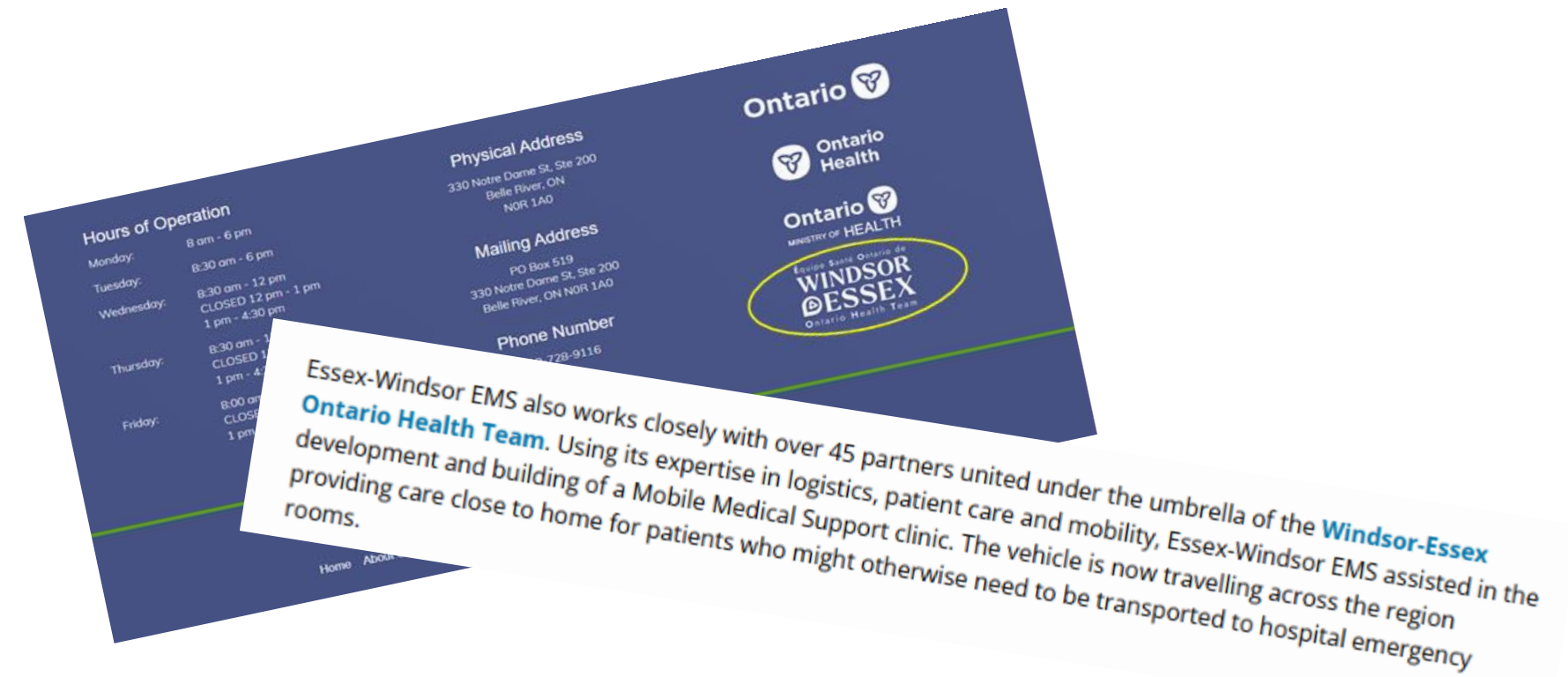
A Scan of the WEOHT Partnership's Websites



As you know, all OHTs receive deliverables from Ontario Health.

One measure of success that we are evaluated on is the number of WEOHT member organizations who feature the WEOHT or WEOHT initiatives on their website.

After doing a scan of WEOHT member websites, we wanted to take this opportunity to share our updated WEOHT logos and examples of how some WEOHT member organizations highlight being a member of the WEOHT on their website/webpage.



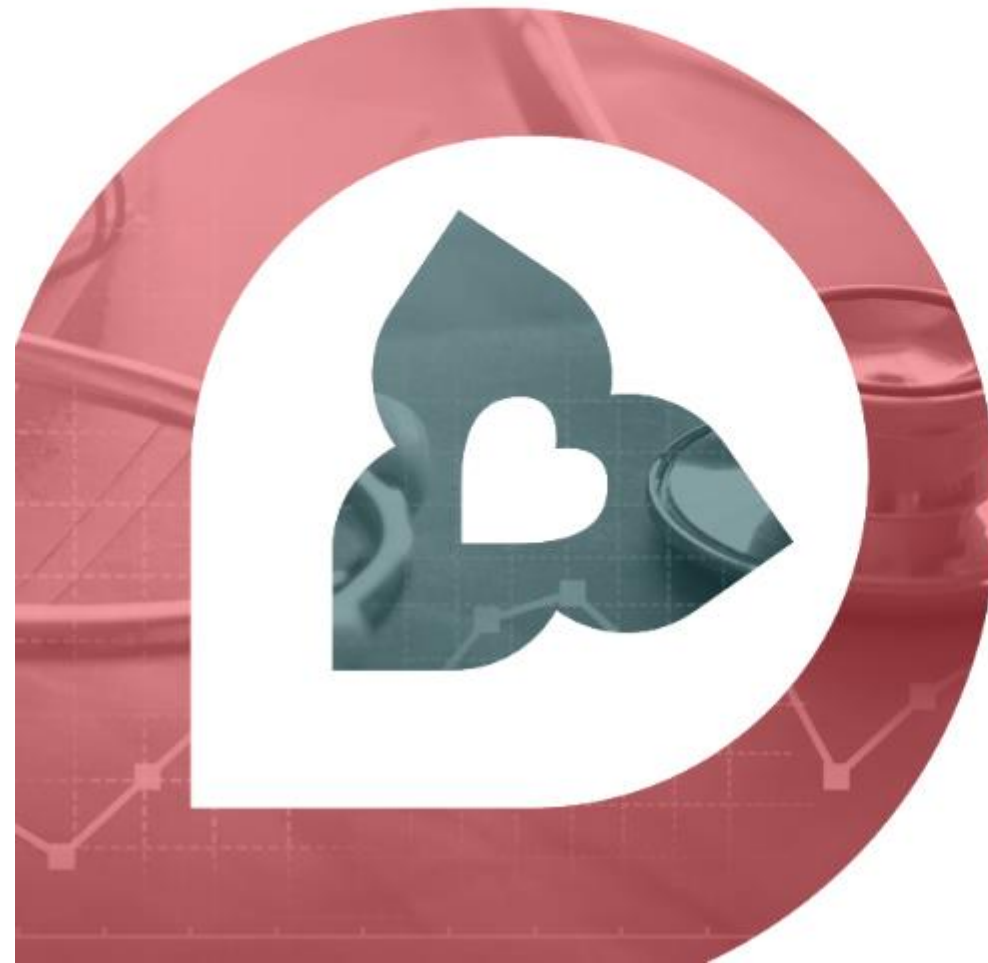
CALL TO ACTION!

Highlight being a WEOHT member on your organization's website

- Let us know if you make any changes to your website to feature being a WEOHT member or WEOHT initiatives
- Reach out to the WEOHT team if you need any support with this / have questions or concerns



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BRANDING GUIDELINES

VISUAL IDENTITY | 2025

We will follow-up with all WEOHT partners to share:

- WEOHT logos and branding
- example document of how you can feature WEOHT membership and initiatives

LOGO USAGE

PRIMARY (VERTICAL)

The primary logo is used in standard brand applications features a wider layout. This main logo serves as the foundation of the brand's identity.

SECONDARY (HORIZONTAL)

The secondary logo is a more compact and stalked version of the primary logo. This version is used where space is limited.

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PRIMARY LOGO - VERTICAL

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SECONDARY LOGO - HORIZONTAL



ICON



Next Meeting

Meeting Dates:

September 24, 2026 (virtual)

December 17, 2026 (in person)