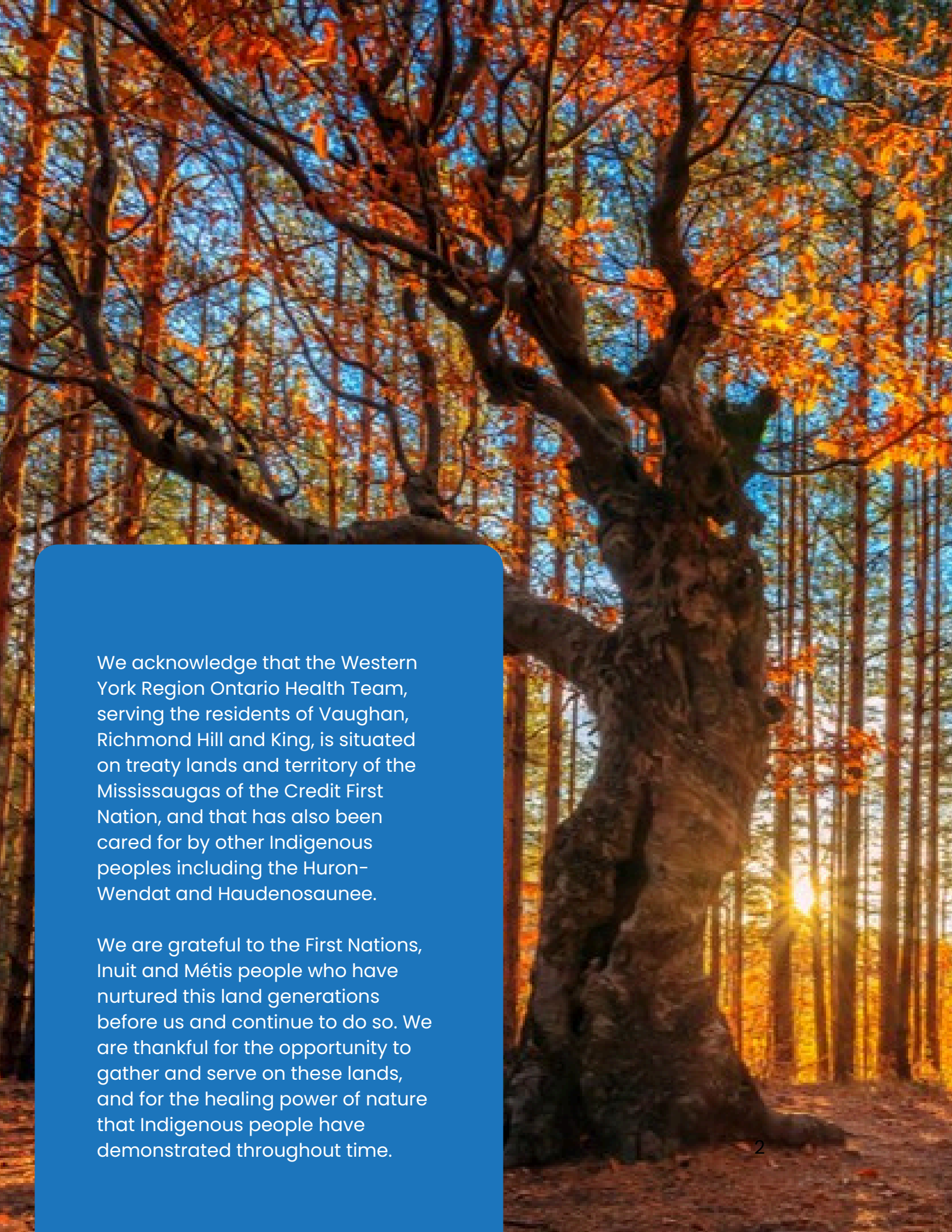
Western York Region
ONTARIO HEALTH TEAM

Impact Report

2025/2026





We acknowledge that the Western York Region Ontario Health Team, serving the residents of Vaughan, Richmond Hill and King, is situated on treaty lands and territory of the Mississaugas of the Credit First Nation, and that has also been cared for by other Indigenous peoples including the Huron-Wendat and Haudenosaunee.

We are grateful to the First Nations, Inuit and Métis people who have nurtured this land generations before us and continue to do so. We are thankful for the opportunity to gather and serve on these lands, and for the healing power of nature that Indigenous people have demonstrated throughout time.

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A message from our Co-Chairs

It is an honour to share the Western York Region Ontario Health Team's annual report. This past year has been a remarkable period of learning, collaboration and meaningful progress. Together, we have taken important steps to improve access to care and support the creation of an integrated system across our communities.

We are especially proud of the new programs and initiatives launched this year, including SCOPE (Seamless Care Optimizing the Patient Experience), Primary Care Attachment and the Integrated Care Pathway for Stroke. These initiatives reflect our commitment to strengthening care in our communities and expanding the supports available to patients and providers. Equally important are the relationships we have built with patients, caregivers, primary care providers, community organizations and many others. These partnerships are the foundation of our work and essential to designing a connected system that truly works for everyone.

Looking ahead, we remain focused on advancing an integrated, equitable and connected health system across the region. Our plan positions the Western York Region OHT as a connector and integrator, bringing partners together to collaborate, communicate and innovate in support of better experiences and health outcomes for patients and caregivers.

Thank you to all our partners, staff and community members who have contributed to our progress. We look forward to building on this momentum together.

Our very best,



Mario Longo

Vice President, Quality and Strategic Initiatives, CHATS (Community & Home Assistance to Seniors)



Bryan Keshen

CEO, Reena

About us

Your care. Your team.

The Western York Region Ontario Health Team (OHT) is committed to working with community partners to better coordinate care across Vaughan, Richmond Hill and King. Our goal is to deliver more connected, accessible and patient centred services by breaking down silos and ensuring individuals receive the right care, at the right time, in the right place.

Our team brings together **16 partner organizations**, along with Patient and Family Advisors, spanning acute and primary care, home and community support services, mental health services, seniors care, long-term care and palliative care. Through collaboration and innovation, we are building a more responsive, inclusive and integrated health system for patients, providers and caregivers in our communities.

Our values

Community – we are dedicated health and social service providers in the King, Vaughan and Richmond Hill communities.

Compassionate care – we provide compassionate and care services for all people in Western York Region.

Collaboration – we collaborate to deliver co-ordinated services and a pathway to better living.

Change – we see a better future for health care in our region, and with the right changes, we know it's possible.

Our community

The Western York Region OHT supports a vibrant, fast-growing community of 675,026 people across Vaughan, Richmond Hill and King. By 2051, that number is expected to surge past 960,000, with all three municipalities experiencing significant growth.

Across our region, one challenge rises above the rest: access to primary care. **The 2024 OurCare Primary Care Needs report** shows that 1 in 5 Canadians lack a primary care provider. In Western York Region, early data from Ontario Health suggests that roughly 69,452 residents are navigating the system without the support they need. It's a clear signal that better system navigation and more accessible entry points are urgently required.

As our population grows and needs evolve, the case for integrated, person-centred care becomes even stronger. In the Western York Region OHT, care is designed with our community, and for our community, at every step.

Data sources: *PCAT Data Package (OHTAM 2024), 2022 Regional Official Plan, Primary Care Needs OurCare: The final report of the largest pan-Canadian conversation about primary care.*



Our staff team



Andra Duff-Woskosky
Associate Vice President



Pawan Khullar
Program Director



Dr. Loredana Di Santo
Primary Care Lead



Stefania Piazza
System Planner



Abira Jeyakumar
System Planner



Maria Grant
System Planner



Drew Torresan
Communications Specialist

Our strategic plan

Building a connected, equitable and innovative health system

Enabler pillar



Equity and diversity
Ensuring equitable access, inclusive care and culturally responsive services for all communities.

Key enablers
- Eliminate barriers
- Advance health equity
- Reflect diverse voices
- Measure and act on disparities

Outcomes
- Improved access and experience
- Better health outcomes
- Stronger community trust

Primary care enablement



Strengthening access, attachment and experience in primary care for all patients.

Key priorities
- Attach more people to primary care
- Improve access and team-based care
- Enhance patient and provider experience
- Leverage digital tools and data

Outcomes
More people attached, better access, stronger primary care experience.

Integrated care priorities

Delivering coordinated, person-centered care across the continuum.



Key priorities
- Advance chronic disease prevention and management
- Enhance care transitions and coordination
- Expand palliative care, community paramedicine and remote care
- Strengthen partnerships (e.g., RCPs)

Outcomes
Better coordinated care, improved health outcomes and reduced unnecessary use of the system.

OHT capacity building



Building strong, sustainable OHTs that enable innovation and continuous improvement.

Key priorities
- Strengthen governance and collaboration
- Engage providers, partners and communities
- Build data, digital and analytical capabilities
- Drive performance and quality improvement

Outcomes
Stronger OHTs, better decisions and a culture of improvement and innovation.

Enabler pillar



Education and research
Building knowledge, capability and evidence to drive better care and inform innovation.

Key enablers
- Build a learning health system
- Support clinician development
- Partner on research and innovation
- Translate evidence into practice

Outcomes
- More evidence-informed care
- Stronger workforce capability
- Innovation that improves outcomes

An outstanding event: The Western York Region OHT Collaboration Council Retreat



The Western York Region OHT Collaboration Council Retreat was held on April 27, 2026, bringing together Council members and participants from across the organization's committees and working groups. The retreat provided an opportunity to celebrate accomplishments achieved over the past year, strengthen shared understanding of progress made toward the Strategic Plan, and collaboratively shape and refine the 2026–2029 Western York Region OHT Strategic Plan.

Highlights of the day included opening the day with a patient story, presentations from the Western York Region Primary Care Leads on primary care enablement from the provider perspective, active participation from several Patient and Family Advisory Council (PFAC) members, discussions on the Integrated Care Priorities roadmap, and collaborative planning activities to further refine strategic priorities and directions for the next three years.





Looking ahead

Strategic plan and priorities ahead for the next fiscal

The 2026–2029 Western York Region OHT Strategic Plan focuses on strengthening an integrated, equitable and connected health system across the region. The plan positions the Western York Region OHT as a connector that brings partners together to collaborate, communicate and innovate in support of better patient and caregiver experiences.

The strategy is built around five key priorities:

1. **Primary care enablement:** Improve access to primary care so every resident is connected to a provider or care team, with a focus on priority populations and reducing wait times through initiatives such as primary care teaching clinics, attachment proposals and care dashboards.
2. **Integrated care priorities:** Advance integrated care pathways for conditions such as diabetes, CHF and stroke to improve transitions, standardize care, reduce avoidable hospital use and strengthen community-based supports including navigation and surge escalation services.
3. **Western York Region OHT capacity building:** Strengthen governance, accountability and partner collaboration by maturing organizational structures, enhancing partner engagement, refreshing committees and establishing the PFAC and Primary Care Network.
4. **Equity and diversity:** Embed equity across all initiatives through a comprehensive equity strategy, measurement approaches and ongoing education and engagement with staff, partners and patient/family advisors.
5. **Education and Research:** Build stronger academic and research infrastructure through partnerships with York University, learner placements, primary care teaching clinics, collaborative research opportunities and formalized education processes.



The Primary Care Network

Exploring its significant impact

Over the past year, the Family Practice Network transitioned into the Primary Care Network (PCN), reflecting the network's evolving role and responsibilities within Western York Region. The Primary Care Network is a coordinated network of primary care providers working in partnership with the Western York Region OHT to strengthen, integrate and represent primary care across the region. The Primary Care Network helps ensure that primary care has a clear and collective voice in system planning and decision-making, while supporting providers in delivering high-quality, accessible and coordinated care to the residents of the Western York Region. In the past year, the Primary Care Network membership continued to grow, reaching 234 members, representing a net increase of 97 providers this fiscal year.

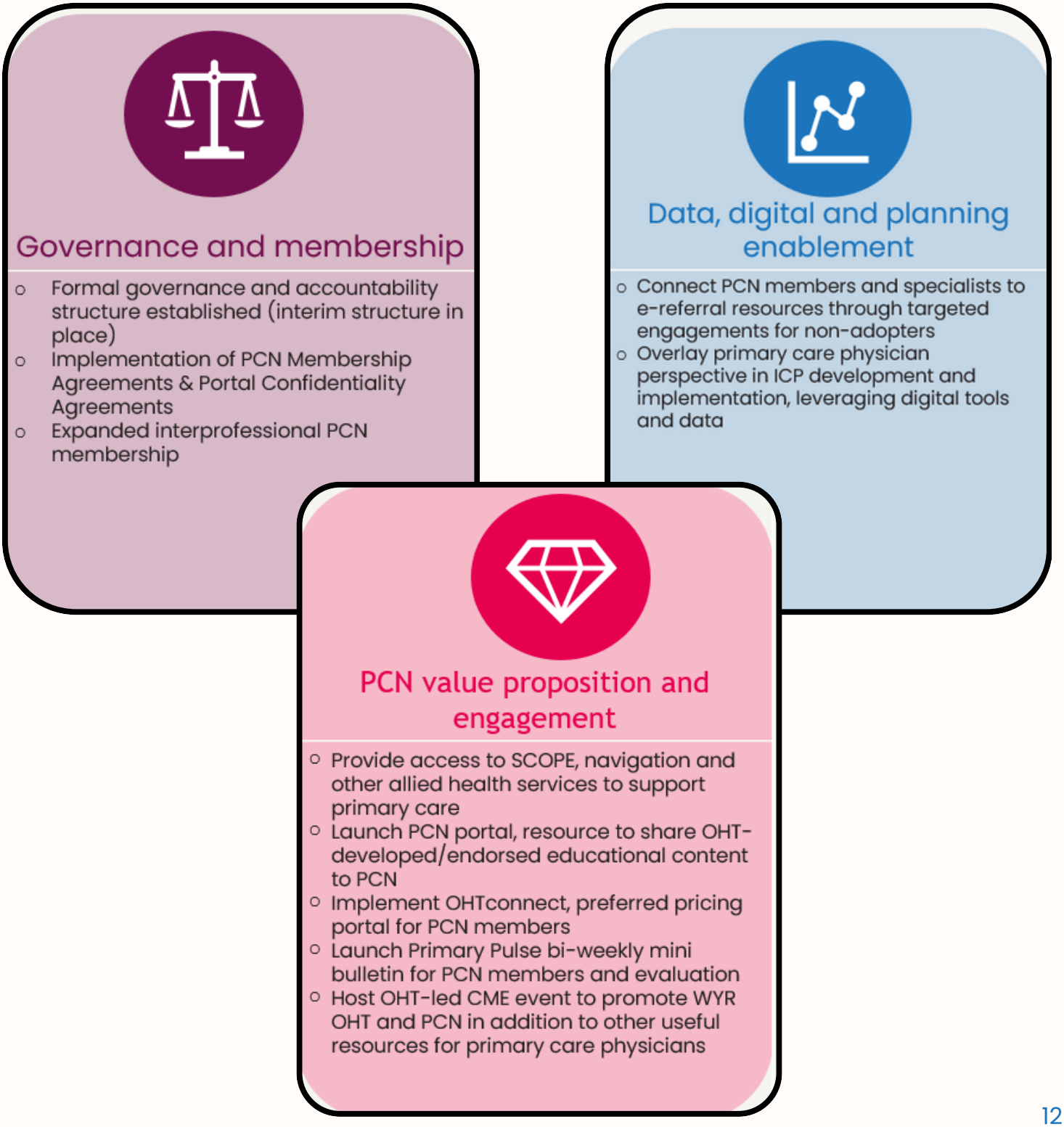
The Primary Care Network experienced significant growth over the past year, increasing to 234 members, with a net gain of 97 providers during the fiscal year.

Communication and engagement have strengthened significantly through the introduction of Primary Pulse, a monthly newsletter launched earlier this year to support regular communication with Primary Care Network members and primary care partners across the region. The Western York Region OHT will continue to use the Primary Pulse as a key communication tool to strengthen connection, information-sharing and engagement across the primary care community.



The Primary Care Network's strategic plan

The Primary Care Network continues to build momentum as a platform for primary care engagement, collaboration and leadership in system planning. Growth in membership, the establishment of primary care leads, the launch of the Primary Care Network portal and strong engagement with communication platforms all demonstrate meaningful progress in building a more connected, informed and collaborative primary care community.



Access and attachment



Ontario's Primary Care Action Plan aims to improve access to team-based primary care and connect every Ontarian to a primary care provider. To address this focus, the Western York Region OHT launched a coordinated Access and Attachment Initiative, beginning with a system-wide assessment of primary care capacity across the region. Through a community-wide survey, an estimated 43,000 available patient spots were identified across nearly 100 primary care providers in Vaughan, King and Richmond Hill. This newly identified capacity created a strong foundation for regional planning and for attaching patients to primary care.

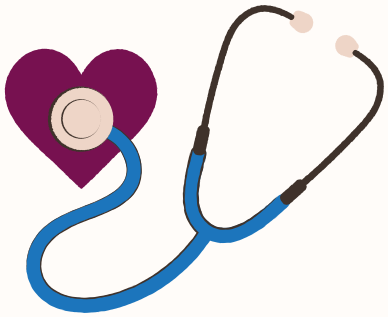
Program impact and key performance indications:



- The Western York Region OHT advanced its supported-attachment efforts by screening almost **1,100 people**, ultimately securing **369 confirmed connections.**



- 12,000 postcards distributed across community partners and 13 Vaughan library sites to promote access.



- Through joint efforts of Health Care Connect (HCC) Connectors, Western York Region OHT primary care navigator and partners, a total of 7,226 individuals have been referred to the ICPT leads for primary care attachment within our region. Of the 7,226 total, 1,186 referrals were cleared off the Health Care Connect pre-2025 (referrals from 2024 and prior) within four months (Q3 2025) per OH guidance.



- In October 2026, the Western York Region OHT began supporting the Mackenzie Health Family Health Navigation Clinic to attach patients to a primary care provider. Since this transition the following achievements have been made:
  - Attachment rate sustained in the high 80s, with an overall average of 85%
  - 304 patients scheduled with a community PCP (Oct. 29, 2026 – March 31, 2026)

Access and attachment, continued



Key achievements and lessons learned include:



- We helped design a single regional system to connect patients without a primary care provider.
- Strengthened collaboration across the Western York Region OHT, Health Care Connect and community partners.
- Leverage key partnerships, specifically York Region's Community Paramedicine and Vaughan's Welcome Centre to effectively target vulnerable populations including seniors, new commers and marginally housed individuals.
- Launched an urgent pathway for complex high-risk individuals.

- Implemented a triage system to identify community members with Social Determinants of Health needs.
- Co-designed the creation and implementation of a collaborative partnership between Blue Door and Carefirst's Mobile Health Clinic to target unattached vulnerable individuals.
- Championed attachment efforts for families in emergency housing by improving access to primary care and preventative health supports.
- Collaborated with neighboring OHTs, including the North York South Simcoe and the Eastern York Region North Durham OHTs, to align and implement a consistent primary care attachment process across York Region, ensuring continuity for shared partners and improved accessibility for patients.

Team based care implementation

Through strategic investments from PCAT and strong partnerships, we are increasing capacity for attachmentand improving access to team-based care through a coordinated approach in Western York Region.

ROUND 1: CAPACITY INCREASE

Received funding to increase attachment capacity for

~39,000

additional people

ROUND 2: ADDITIONAL CAPACITY

Additional capacity for

~19,000

additional people

Includes the creation of **2 net new primary care teams**

The OHT will support coordination of attachment across our region through **collaboration with our primary care partners.**

Expand access to team-based care

Provide access to services while people wait for attachment

Strengthen primary care to build a more connected, resilient health system



Unpacking our programs and initiatives

SCOPE (Seamless Care Optimizing the Patient Experience) officially launched in May 2025 with the support of Mackenzie Health, to support primary care providers through integrated navigation, timely access to clinical and community services and enhanced care coordination. In its first year, the program established a strong foundation for improving access to care, strengthening provider support, facilitating coordinated patient centered care and reducing avoidable Emergency Department visits through timely intervention and connection to appropriate services.

As of July 2026, 55% of primary care providers across Western York Region are actively accessing SCOPE, reflecting strong engagement and growing adoption of the program.

As of July 2026, 55% of primary care providers across Western York Region are actively accessing SCOPE, reflecting strong engagement and growing adoption of the program. This is a significant milestone that demonstrates the value SCOPE is providing to providers and patients, and we are excited to build on this momentum in the months ahead.
We have also collaborated with internal and external partners to implement eight clinical and community pathways, helping to streamline access to specialized services and community-based supports. The pathways include:

- Nurse navigator



- Diagnostic imaging – deep vein thrombosis



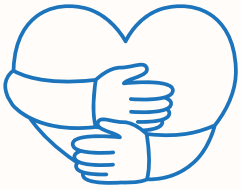
- Mental health



- Center of Behavior Health Sciences



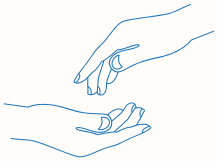
- Community palliative



- Seniors Wellness Clinic/Geriatric Outreach Team



- The Compassionate Care Clinic



- Ontario Health atHome



Key achievements: SCOPE



- Implemented eight clinical and community pathways with both internal and external partners to improve access to specialized services and community supports.
- Welcomed and onboarded more than 175 primary care providers across Western York Region within the first year of operation.
- Successfully implemented Healthy Planet Link (HPL), the community arm of our electronic health record software, for SCOPE.
- Developed and launched SCOPE Newsletter, e-blast, SCOPE calendar and a marketing campaign to increase awareness, engagement and uptake of SCOPE services across the region.

Program impact and key performance indicators

Volume and utilization:

- Received and completed 985 requests during program's first year demonstrating strong adoption and utilization of SCOPE services.

Timely access to care:

- 74% of requests were completed within 24 hours.

Reduction in Emergency Department visits:

- 95% of patients actively managed through SCOPE avoided an Emergency Department visit, highlighting the program's role in providing timely interventions and supporting care in the community.

Accessibility to pathways:

- 76% of all requests involved Nurse Navigation services.

The first year of SCOPE demonstrated the value of integrated navigation and coordinated care pathways in supporting primary care providers and improving patient access to services. As the program continues to grow, SCOPE remains committed to strengthening partnerships, expanding pathways and enhancing equitable access to care across the Western York Region.

Palliative care: Compassion in action

In 2025/26, the Western York Region OHT continued to advance a more integrated, person-centred approach to palliative care by establishing the Palliative Clinical Coach role. Building on Ministry of Health recommendations through the community model of care, the Palliative Clinical Coach supported provider capacity-building, promoted advance care planning and provided training and coaching to front-line staff to encourage earlier identification tools. This work helped lay the groundwork for more consistent and integrated palliative care practices across sectors.

Working closely with multiple health sectors including primary care, hospice, paramedic services and specialized geriatric teams, the Palliative Clinical Coach supported organizations through education, mentorship, collaboration and quality improvement initiatives. Five organizations formally participated in the Adult Community Model of Care initiative, with the Palliative Clinical Coach facilitating completion of the Community Organization Assessment Tool (COAT) and supporting the development of tailored action plans to advance organizational readiness and implementation goals. The organizations were:

Vaughan Community Health Centre

York Region Paramedics

Hospice Vaughan

Alzheimer Society of York Region

Mackenzie Health Geriatric Outreach Team

Key achievements: Palliative care



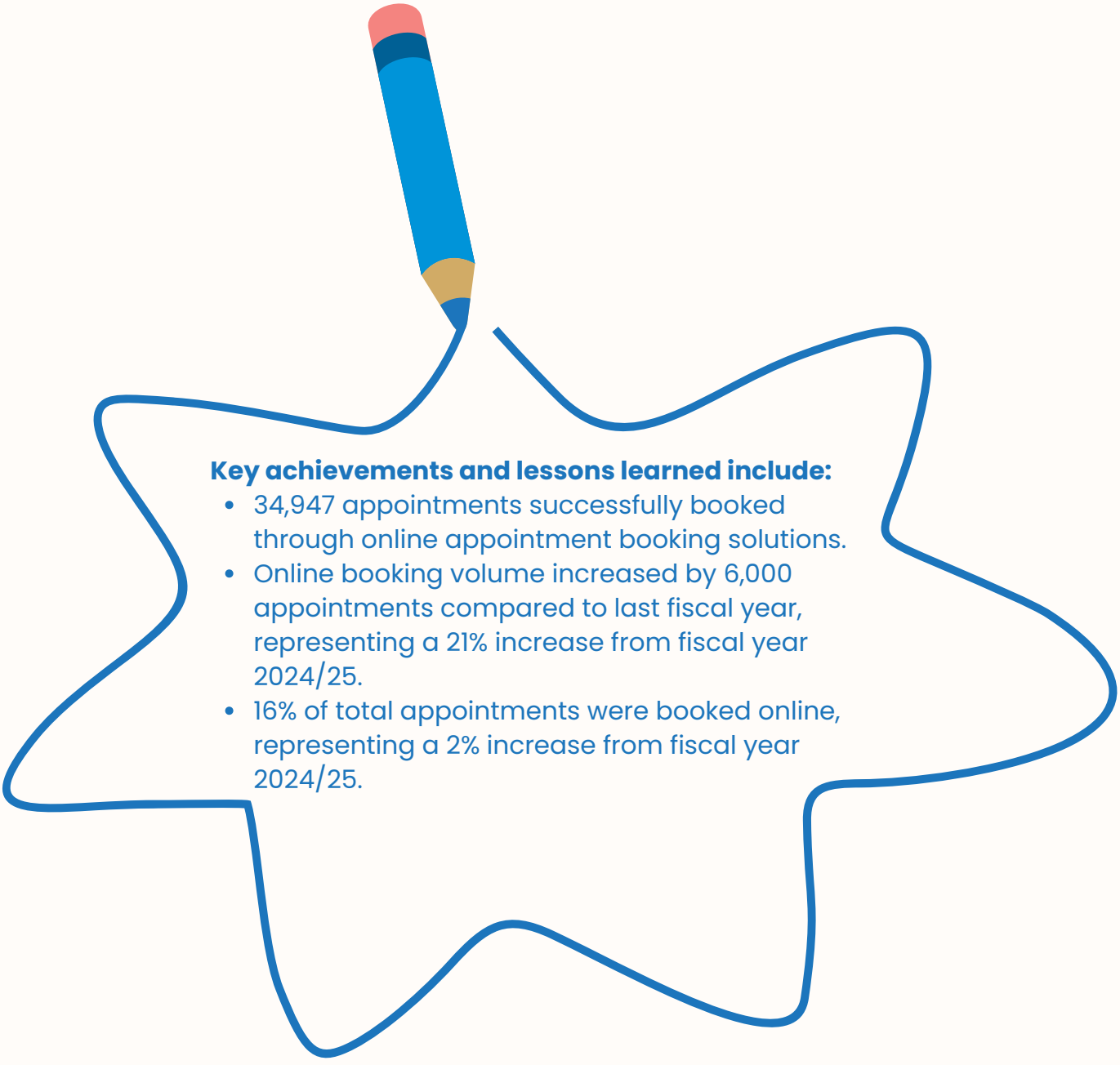


- 13+ community partners present in our Palliative Care Steering and Advisory Committee.
- 14 interdisciplinary education sessions and workshops delivered.
- 200 + staff trained across partner organizations.
- 111 staff members enrolled in external course including LEAP, Serious Illness Conversations through partnerships with Pallium Canada and PALcare.

Looking ahead, the Palliative Clinical Coach will play a pivotal role in supporting Long Term Care, The Mackenzie Helps Hospital to Home program and advancing the integration of palliative care within Integrated Care Pathway design and delivery. This will help strengthen early identification, improve coordination across sectors, and ensure patients and families receive timely, compassionate support throughout their care journey.

Digital: Online appointment booking

Online appointment booking (OAB) in the Western York Region OHT continues to show sustained uptake with nearly 35,000 appointments booked online and 16% of completed appointments occurring through an online appointment booking solution. In the 2025/26 fiscal year, established users increased by 64%, rising from 36 to 59. While new users decreased from 23 to 14, this shift suggests that adoption is maturing, with greater uptake and continued engagement among sustained users.



Key achievements and lessons learned include:

- 34,947 appointments successfully booked through online appointment booking solutions.
- Online booking volume increased by 6,000 appointments compared to last fiscal year, representing a 21% increase from fiscal year 2024/25.
- 16% of total appointments were booked online, representing a 2% increase from fiscal year 2024/25.

The outcomes highlight the important role of digital health tools in improving patient access, enhancing provider capacity, and supporting improved coordinated care. As the Western York Region OHT continues to expand health capabilities, solutions such as OAB, eReferral and other integrated tools will be key enablers in creating a more seamless journey across the Western York Region.

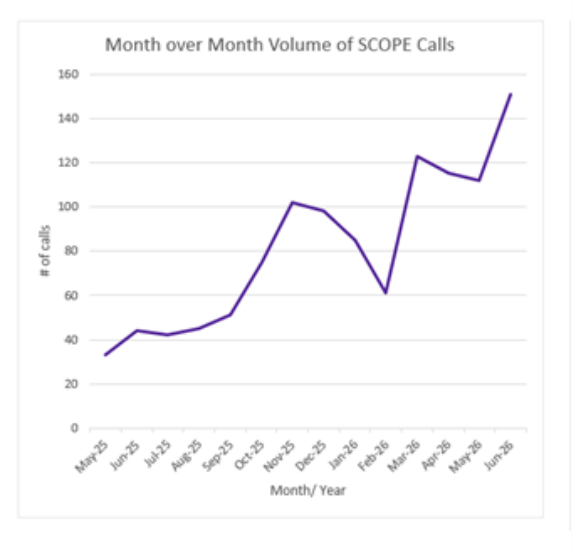
EPIC Healthy Planet Link (HPL) as a digital enabler

Epic Healthy Planet and Healthy Planet Link (HPL) continued to serve as key digital enablers supporting integrated care coordination across the region. During the year, HPL was successfully implemented within the SCOPE pathway to enhance connectivity and information sharing with primary care providers, improving access to coordinated patient care information and strengthening transitions between hospital and community settings.

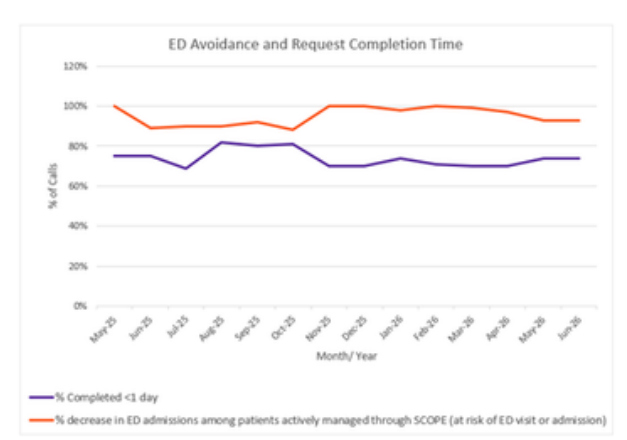
The use of HPL was also expanded within the MackenzieHelps program through the development of a new operational dashboard and activation of additional modules to support enhanced care coordination, population health management and tracking of patient needs. Enhancements within the shared care plan include the integration of Social Drivers of Health indicators such as alcohol use, physical activity and transportation needs that further support equity-informed and person-centered care delivery.

Dashboards

This year, significant progress was made in advancing digital enablement and data integration to support coordinated care, system planning and population health management across the Western York Region OHT. A key achievement was the development and implementation of multiple shared dashboards and digital tools designed to enhance visibility, collaboration and decision-making across sectors.



Through MackenzieHelps, a shared dashboard was successfully developed, implemented and expanded to community partners, enabling improved coordination of referrals, access to services and shared understanding of patient and community needs. This work has strengthened cross-sector collaboration and enhanced the ability to proactively connect individuals to appropriate supports.



Additional digital transformation efforts included the development and implementation of the SCOPE Dashboard, aligned to the Quintuple Aim framework. The dashboard supports performance monitoring and system-level insights related to patient experience, provider experience, population health, value and health equity, enabling more informed decision-making and continuous quality improvement across the system.

Collectively, these initiatives represent an important step toward a more connected, data-informed and integrated health system that supports improved patient outcomes, enhanced provider collaboration and stronger regional planning capabilities.

MackenzieHelps: Hospital to Home Program

MackenzieHelps is a Hospital to Home program that ensures patients expeditiously and safely transition home while receiving a range of supports they need for a full recovery. The MackenzieHelps team consists of three partners:

SE Health

CHATS

LOFT

In fiscal 2025/26, MackenzieHelps also expanded its focus on population health and health equity through the integration of Social Drivers of Health screening and enhanced interdisciplinary collaboration, helping to build a stronger foundation for proactive, coordinated and connected care delivery across the region.



Key achievements: MackenzieHelps

MackenzieHelps

- Supported a total of 585 individuals to return home with the appropriate care, representing a 12% increase from previous fiscal year.

Successfully implemented the Patient Experience Survey, with year end data indicating:

- 98% of respondents would recommend this program to other patients.
- 98% of respondents were satisfied with MackenzieHelps.
- 93% of respondents felt every member of the MackenzieHelps team listened to them.
- 89% of respondents felt their MackenzieHelps team explained things in a way that was easy to understand.



The program was able to support individuals remain home with the appropriate care:

- 7-Day Emergency Department readmission rate was 7.6%.
- 99% of patients were able to have a home visit within 24 hours of returning home.
- 98% of patients were able to have their prescriptions filled within 48 hours of returning home.

Equity and population health



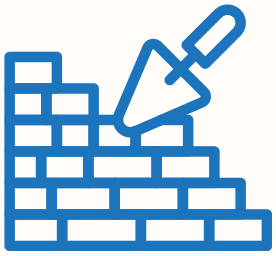
Three Social Drivers of Health: alcohol use, physical activity and transportation needs, were successfully integrated into the MackenzieHelps One Shared Care Plan. This enhancement strengthens the ability of interdisciplinary care teams to identify non-medical factors influencing health outcomes and enables more coordinated, person-centred and equity-informed care.

Embedding Social Drivers of Health within the shared care plan creates a stronger foundation for proactive care planning, risk identification and targeted interventions. By incorporating social and behavioural health insights directly into clinical workflows, providers are better equipped to connect patients to the right community, primary care and wraparound supports at the right time.

Between December 2025 and March 2026, more than 200 program participants were successfully screened for the three integrated Social Drivers of Health, establishing an early foundation for data-informed quality improvement and enhanced care coordination.

In fiscal 2026/27, the MackenzieHelps team will focus on implementing the remaining Social Drivers of Health domains within the shared care plan, while leveraging emerging data to identify targeted quality improvement opportunities, address health inequities and strengthen coordinated regional care planning initiatives.

Partnerships and system integration: cross collaboration in action



Fiscal 2025/26 represented a foundational year for the advancement of our Integrated Care Pathway (ICP) work, with significant focus placed on establishing the core structures, partnerships, governance processes and enabling infrastructure required to support integrated, patient-centered models of care.



Throughout the year, substantial efforts were directed toward defining the vision, scope and operational framework for integrated care pathways, while strengthening collaboration between hospital, primary care, community support services, home and community care, rehabilitation and other regional partners. This work created a shared foundation for how care can be more effectively coordinated across organizations and sectors to improve patient experience and outcomes.



Key activities included the co-design of pathway models, development of interdisciplinary workflows, identification of priority populations, establishment of regional partnerships and advancement of digital enablers, such as shared care planning and data integration capabilities. These foundational elements are critical to enabling more seamless transitions in care, reducing fragmentation, and supporting proactive, coordinated interventions for patients with complex and ongoing care needs.



Fiscal 25/26 also focused on building the organizational readiness necessary to support long-term pathway implementation and sustainability. This included engaging clinical and community partners, aligning strategic priorities, identifying opportunities for quality improvement and developing approaches to measure outcomes and impact across the health system.
As the foundational infrastructure continues to mature, this work positions the Western York Region OHT and its partners to expand integrated care pathways across additional clinical areas and populations, while supporting broader regional objectives related to access, attachment, health equity, population health management and connected care delivery.

Integrated Care Pathways: Stroke



In partnership with **March of Dimes Canada**, Mackenzie Health implemented an Integrated Care Pathway for Stroke to strengthen transitions from hospital to home and improve access to coordinated community-based supports for individuals recovering from stroke. The pathway enhances collaboration across hospital, rehabilitation, primary care, and community partners to support timely follow-up, functional recovery, patient independence, and reduced risk of avoidable hospital utilization.

A key enabler of this initiative is the use of Epic Healthy Planet Healthy Planet Link (HPL) and the One Shared Care Plan, which provide a centralized and coordinated approach to patient care management across organizations. The shared digital care plan enables providers to access real-time patient information, document goals and interventions, improve communication between care teams and ensure continuity of care throughout the recovery journey. This integrated approach supports more seamless transitions, reduces duplication, enhances care coordination, and improves the patient and caregiver experience across the continuum of care.
This new initiative was implemented in December 2025 and by fiscal year end 35 patients were served.

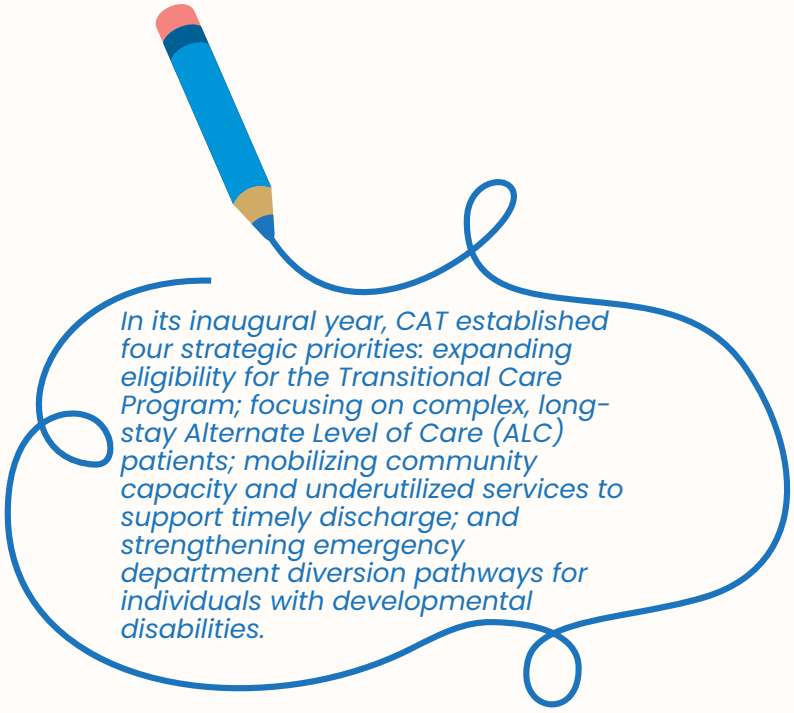
Community Action Table

The Community Action Table (CAT) was established in Fall 2025 to strengthen community-based coordination and address system pressures impacting acute care across the Western York Region. With participation from 16 partner organizations, the table provides a structured forum to identify and advance initiatives that support ED diversion, ALC reduction and improved transitions from hospital to community care.

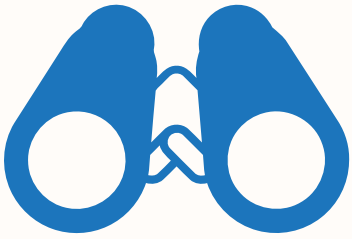
In its foundational year, CAT established four priority areas: expanding criteria for the Transitional Care Program, targeting complex long-stay ALC cases, mobilizing community capacity to support discharge and underutilized services and strengthening ED diversion pathways for individuals with developmental disabilities. Early implementation has demonstrated measurable progress, including increased awareness and utilization of community-based capacity such as the Ontario Health atHome Rapid Response Nurse program (increasing referrals from an average of 14 per month pre-November 2025 to 40 by January 2026) and growth in referrals to Community Paramedicine programs. The table also identified five opportunities to expand Transitional Care Program criteria and supported discharge planning for patients with prolonged ALC stays.

Looking ahead, CAT will focus on scaling transitional care criteria through pilots, expanding community-based capacity utilization and advancing ED diversion pathways for individuals with developmental disabilities to further strengthen system flow and patient outcomes.





In its inaugural year, CAT established four strategic priorities: expanding eligibility for the Transitional Care Program; focusing on complex, long-stay Alternate Level of Care (ALC) patients; mobilizing community capacity and underutilized services to support timely discharge; and strengthening emergency department diversion pathways for individuals with developmental disabilities.



Patient and Family Advisory Council

The Western York Region OHT officially launched its Patient and Family Advisory Council (PFAC) in October 2025 following a successful recruitment campaign conducted during the summer of 2025. Through this process, seven new Patient and Family Advisors joined three existing advisors to establish a diverse and engaged council representing patient, family and caregiver perspectives across the region. An in-person orientation session was held in October 2025 to introduce members to the OHT structure, priorities and engagement approach. Since its launch, the PFAC has collaboratively established team norms, developed terms of reference and integrated members into existing OHT committees to ensure the patient, family and caregiver voice is embedded within ongoing planning and decision-making activities.

From an engagement perspective, our goal is to establish a well-defined and sustainable structure that is supported across the OHT. This includes ensuring that partner organizations are meaningfully represented within OHT governance and working groups, with a minimum of two representatives participating on each committee where appropriate. We also aim to clearly define and regularly review the roles and responsibilities of OHT members, staff and Patient and Family Advisory Council (PFAC) partners to support effective engagement. Equally important is creating strong feedback loops, with OHT staff regularly reporting back to PFAC partners and other stakeholders on how their input and contributions have informed decisions, priorities and initiatives.

In addition, a PFAC Co-Chair role was advertised and successfully recruited to support shared leadership within the council. To further strengthen patient and family partnership practices, new policies and processes were developed and endorsed by the Collaboration Council, including a Patient and Family Advisor Compensation Policy and a PFAC Co-Chair Selection Process.



Governance and leadership

The Western York Region OHT is embarking on a comprehensive review and refresh of its governance structure to ensure it is well-positioned to support the future evolution of the Western York Region OHT and the changing needs of the communities it serves. Through this work, the Western York Region OHT will examine existing Ontario Health Team governance models and leading practices to develop a refreshed governance framework that promotes collaboration, accountability, equitable partner participation and long-term sustainability.

Engagement with OHT partners and community representatives will be a key component of this process, with consultation and feedback sessions taking place throughout the review to help shape the future structure. The refreshed governance model is expected to support stronger collaboration across the health system while enhancing adaptability and decision-making as the OHT continues to mature.

The new governance structure is anticipated to be finalized and implemented by **early 2027.**

