Central West
ONTARIO HEALTH TEAM

ANNUAL REPORT
2025 - 2026

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15,984
patients attached through OHT efforts

80
practitioners in primary care attachment network

LOWER LIMB PRESERVATION (LLP) PROGRAM

1,148
patients helped

43
LLP screening events

CARE PROGRAM

51.2%
drop in emergency dept. visits after intake

100%
patient-reported confidence in managing health

CANCER SCREENING

605
people reached

14
community outreach and education sessions

SCOPE PROGRAM

95.5%
emergency dept. diversion rate

673
patients helped

5/5
Interprofessional Primary Care Team proposals accepted by province

1,158
patients participated in OHT community-based interventions

27K+
unique website visits

1
new partner organization added

100%
of CW OHT staff completed EIDA-R training

100%
of CW OHT staff completed Indigenous Cultural Safety training

78,852
patients reached with Online Appt. Booking (OAB)

288
family doctors and nurse practitioners engaged

CW OHT HEALTH CARE SYSTEM AT A GLANCE

Second-largest OHT in province (6% of Ontario's population or ~900K attributed individuals).

Lowest acute care beds per capita in Ontario.

Lowest primary care physicians per capita and **lowest specialty physicians** per capita in Ontario.

William Osler Health System sees the **most ED/UCC visits in the province.**

Over 66% of all ambulatory care sensitive condition admissions to Osler were attributed to diabetes.

CW OHT POPULATION AT A GLANCE

13% of geographic population **does not have access to a regular primary care provider.**

22% in lowest income, compared to 20% in Ontario.

Average age of **42** years.

52% of residents are born outside of Canada.

43% living with 5+ health conditions, compared to 35% in Ontario.

43% live **in low or very low income neighbourhoods**, impacting health in multiple ways.

76%+ of residents identify as **visible minorities**, compared to 34% in Ontario.

54% speak languages other than English or French, compared to 26% in Ontario.

One of the **highest rates of diabetes** per capita (82.2 per 1000, compared to 76.4 per 1000 in Ontario).

Historically one of the fastest growing regions, with **30% population growth between 2016-2024** compared to 20% for Ontario.

131K+ unattached patients.

Senior population expected to grow by 46% by 2041 (~112,000 residents), one of the fastest rates in province.

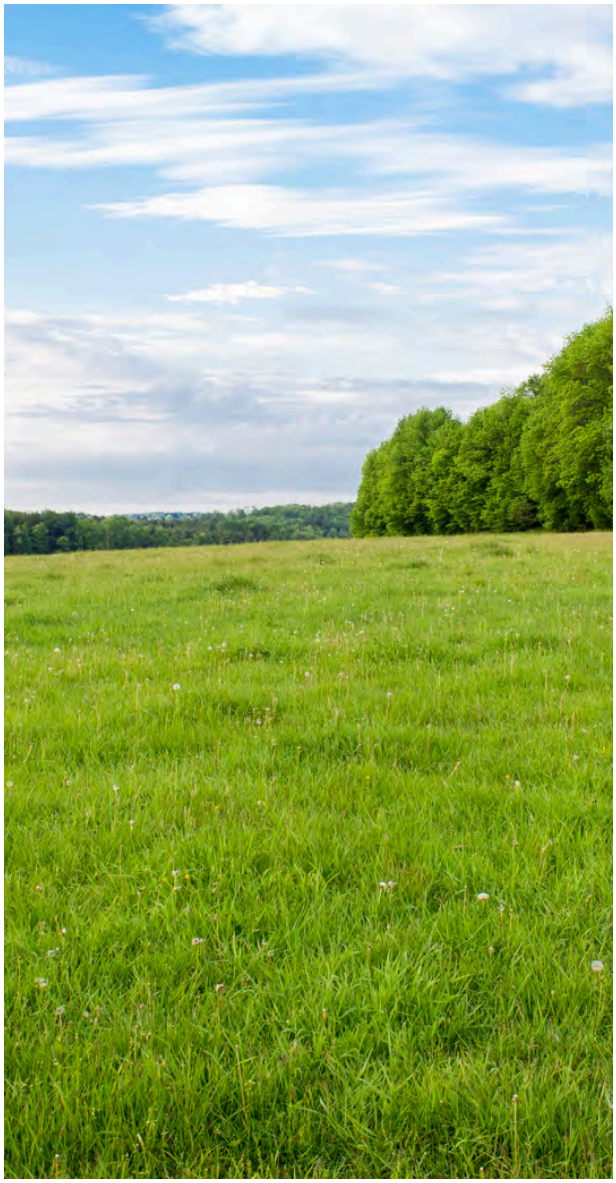
LAND ACKNOWLEDGEMENT

We acknowledge that we work on a land which is part of the Treaty Lands and Territory of the Mississaugas of the Credit, the territory of the Anishinabek, Huron-Wendat, Haudenosaunee and Ojibway-Chippewa peoples.

As visitors and settlers in this Territory, we express our gratitude to the Mississaugas of the Credit First Nation and the descendants of the Credit First Nation.

We are grateful to have the opportunity to work and serve the people who now inhabit this land, and by doing so, give our respect to its first inhabitants.

The Central West Ontario Health Team is committed to our ongoing role in reconciliation through meaningful action rooted in truth, justice and respect. We recognize that meaningful reconciliation requires listening, learning, and action.



MESSAGE FROM OUR LEADERSHIP

RISHIKA THAKUR MALHI
EXECUTIVE LEAD

DR. SHANE TEPER
COLLABORATION COUNCIL CO-CHAIR

DAVID SMITH
COLLABORATION COUNCIL CO-CHAIR

As we reflect on 2025-2026, we are proud of the progress made through collaboration, innovation, and a shared commitment to improving care across our region. Together with patients, caregivers, providers, and community partners, the Central West Ontario Health Team (CW OHT) continued to strengthen the foundations of a more connected, equitable, and person-centred health system.

With the Central West area having the highest unattached patient rate in the region, this year, a major focus was on improving access to primary care. Through the launch of the Access Primary Care initiative, we worked alongside partners to build a coordinated infrastructure to help residents connect with a family doctor or nurse practitioner, which required a collaborative startegy built around neighbourhood network models. This initiative included the creation of a dedicated regional webpage, a coordinated communications and marketing campaign, and support for the launch of five Interprofessional Primary Care Team (IPCT) partner sites. We look forward o building on this momentum and continuing expansion in the coming year, as access to primary care remains a critical priority.

We also continued to advance chronic disease prevention and management by leveraging data, provider expertise, and patient experiences to ensure programs and services are responsive to the needs of our growing and diverse communities. We placed a specific focus on solutions and care for chronic diseases that impact our region in particular. With the CW region having one of the highest rates of diabetes per capita, an emphasis was placed on the Lower Limb Preservation Program, which helped 1,146 patients.

The patient voice remained central to our work. Through the leadership of our Patient and Family Advisory Council (PFAC), patients and caregivers helped shape programs and priorities while also supporting the community through initiatives like the CW OHT Caregiver Event, which had 62 attendees. At the same time, we began evolving our governance structures to strengthen collaboration, accountability, and long-term sustainability.

This year also marked an important evolution in how we define our role within the health system. Guided by our purpose of achieving collective impact for integration by supporting our OHT partners, the CW OHT is uniquely positioned to align efforts across the health system, and support partners in addressing shared challenges and opportunities. This renewed focus will help guide our work in the years ahead.

Thank you to our patients, caregivers, providers, community organizations, and partners for your continued dedication and collaboration. The accomplishments highlighted in this report reflect what we can achieve together, and we look forward to continuing this work in 2026/27 and beyond.

ORGANIZATION OVERVIEW

PURPOSE Achieving collective impact for integration by supporting our OHT partners.

VISION People-first health with trust and compassion.

MISSION Collaborative partners building a healthier community.

VALUES Innovative, Compassionate, Accountable, Responsive and Equitable

The CW OHT serves patients who seek care in the Brampton, Malton, West Woodbridge, and North Etobicoke area.

We are a dedicated group of health and community care partners working together to create a healthier, more connected system of care for the people in our region.

Our team brings together primary care providers, hospitals, home and community care services, mental health and addictions supports, long-term care homes, municipalities, social service agencies, and patients, families, and caregivers.

As one of the largest OHTs in the province, we serve **more than 900,000 people,** and are the largest OHT by geographic location. Together, **more than 275 partners** including home and community care, acute care, specialty care, primary care, long-term care, mental health and addictions services, patients/clients, community support services, are coming together with the goal of providing better coordinated care for the community.

29 organizational partners from a variety of sectors

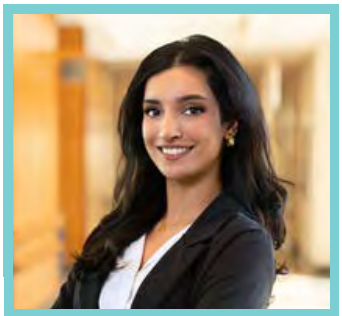
11 patient partners

275+ partners that provide care

OUR TEAM

RISHIKA THAKUR MALHI
EXECUTIVE LEAD

EMILY CICHONSKI
MANAGER



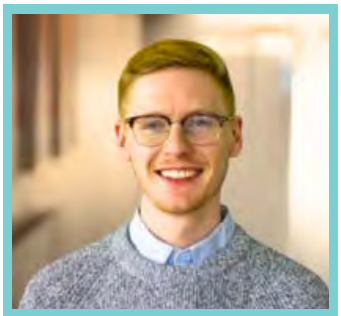
CAMILLA BAINS
COMMUNICATIONS SPECIALIST

SAMANTHA DITLOF
PROJECT MANAGER

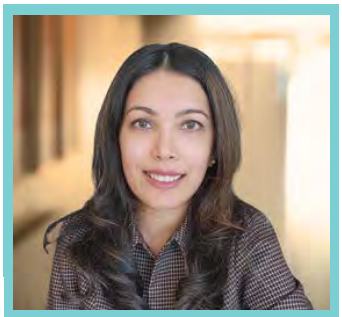
REBECCA HILLIS
COORDINATOR

RICHARD MORRISON
DIGITAL LEAD

ANDREEA POPESCU
PERFORMANCE LEAD



SAMUEL SEE
COODINATOR



AISHA TEHSEEN
PROJECT MANAGER

This page highlights the people behind the work — their dedication, collaboration, and drive to make a difference across the Central West region.

At the heart of the Central West Ontario Health Team is a passionate and diverse group of individuals who are committed to transforming care in our communities.

OUR PARTNERS

We are thrilled to have expanded our partnerships this year, allowing the OHT to further strengthen its integration efforts.

✦ Indicates partner organization added this year

Canadian Addiction Treatment Centres
Canadian Mental Health Association Peel Dufferin
Canadian Red Cross
CANES Community Care
Central Brampton Family Health Team
Ontario Health atHome
The Dorothy Ley Hospice
ESS Support Services Etobicoke
Friends & Advocates Peel and Surrounding Areas ✦
Hospice Mississauga
Holland Christian Homes
Humber College
North Peel Family Health Team
Peel Addiction Assessment and Referral Centre
Peel Senior Link
Punjabi Community Health Services
Queen Square Family Health Team
Region of Peel
Rexdale Community Health Centre
Richview Community Care Services Corporation
Roots Community Services
Services and Housing in the Province
Sienna Senior Living
St. Leonard's Place Peel
Toronto Metropolitan University
WellFort Community Health Services
West Park Healthcare Centre
William Osler Health System
Woodbine Family Health Team

Interested in becoming a partner? Scan here!

CW OHT PROGRAMS

PRIMARY CARE ATTACHMENT

The OHT successfully launched the centralized patient attachment intake, advancing coordinated access to primary care services across the region We implemented a large-scale, multi-channel community awareness campaign, Access Primary Care, in alignment with neighbouring OHTs to promote navigation and attachment opportunities for residents. The overall advertisement campaign garnered well over 1 million impressions. Additionally, the Health Care Connect waitlist was cleared, finding all 1,763 patients pa family doctor or nurse practitioner.

15,984
patients attached through OHT efforts

1M+
advertisement impressions

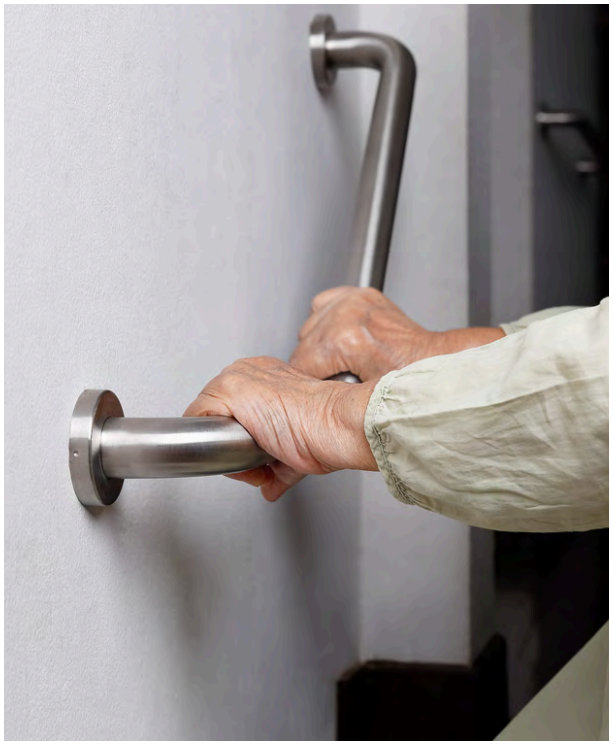
LOWER LIMB PRESERVATION (LLP) PROGRAM

The LLP Program helped 1,148 patients across Central West. This is an important initiative given the vascular conditions and diabetes prevalence in our community, with the Central West region having one of the highest rates of diabetes per capita. A key win was the acute care dialysis program's official launch, which has supported expansion of foot screenings and leveraging the escalated wound clinic referral process as required.

1,148
patients helped

43
screening events

CW OHT PROGRAMS

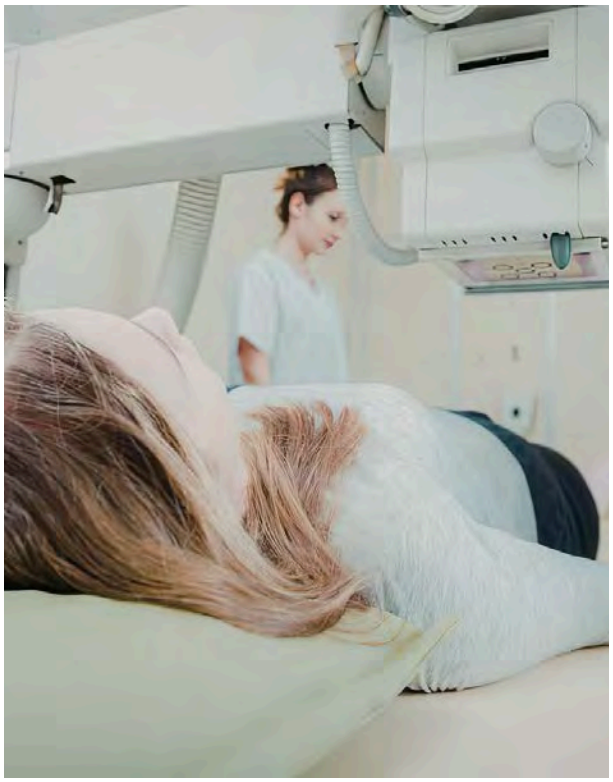


CARE PROGRAM

The CARE (Coordinated, Accessible, Respectful, Equitable) Program supported 210 older adults living with frailty, a major increase from last year's 86. This wrap-around service for home-bound frail elders helped keep people at home and out of hospital, with a 51.2% drop in emergency department visits after intake. 100% of patients asked reported reported involvement in planning their care.

51.2%
drop in ED visits post-intake

100%
patient-reported confidence in managing health



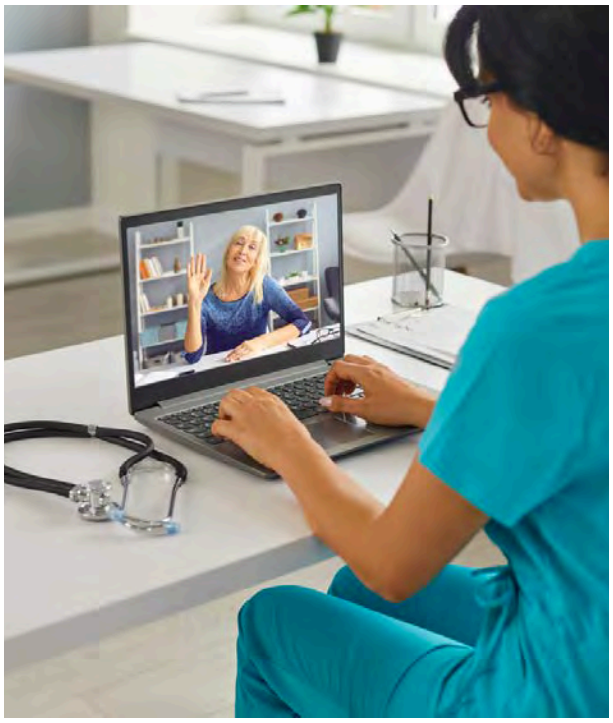
CANCER SCREENING

The CW OHT launched a targeted cancer screening initiative in partnership with Rexdale Community Health Centre, with a focus on improving access for unattached patients and facilitating connections to primary care. Key accomplishments included the delivery of 14 community outreach and education sessions, surpassing the target of one session per week. The initiative resulted in 43 mammograms, 88 HPV tests, and 17 colorectal cancer screening tests completed. In total, 605 residents were reached, with 40 individuals successfully attached to primary care.

605
people reached

14
community outreach & education sessions

CW OHT PROGRAMS

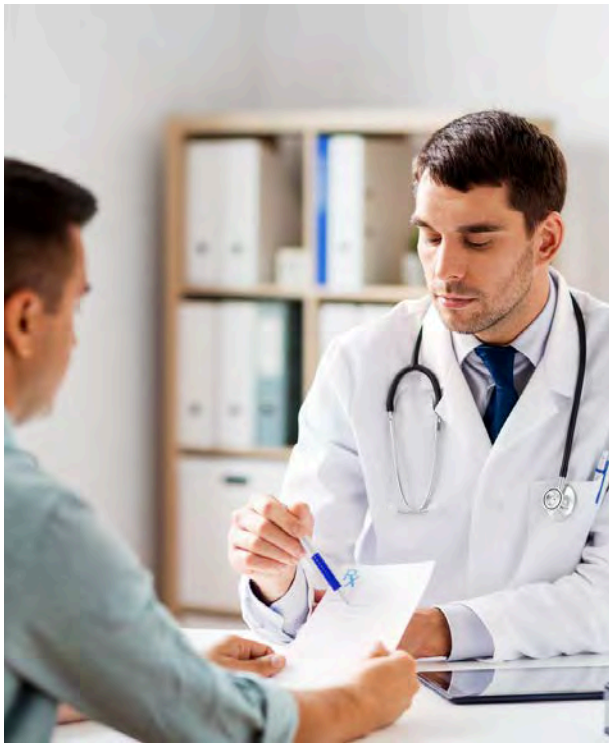


SCOPE PROGRAM

The SCOPE (Seamless Care Optimizing the Patient Experience) Program connected primary care providers to urgent help, with 673 calls and a 95.5% emergency department diversion rate, up 1.5% from last year. There were 303 active users, showing strong provider engagement.

95.5%
emergency department diversion rate

673
patients helped



ALTERNATE LEVEL OF CARE CQIP

The Alternate Level of Care (ALC) initiative focused on improving transitions from hospital to home. The CW OHT continued supporting ALC-focused educational webinars, engaging 47 participants across two Q4 sessions and received consistently positive feedback.

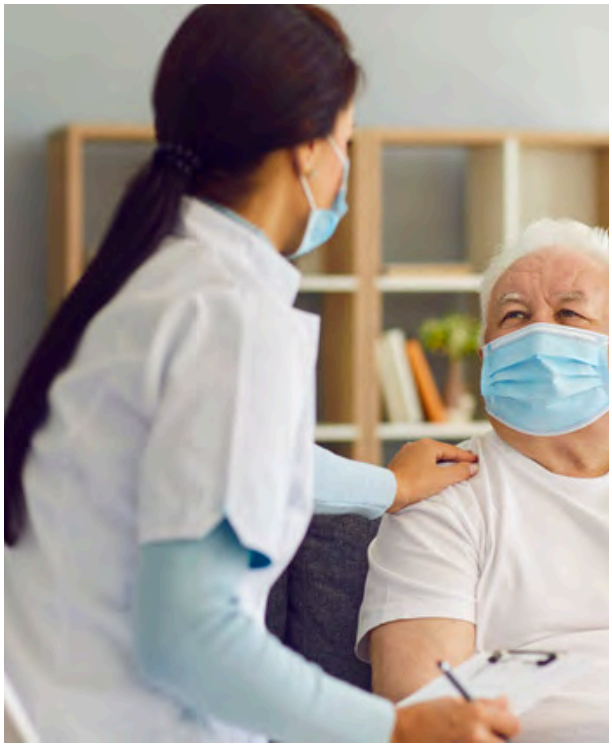
47
ALC webinar attendees

CW OHT SUPPORTING SUCCESS FACTORS

SYSTEM NAVIGATION

The CW OHT improved navigation through a well-attended Navigation Conference and added digital navigation tools to the OHT website, including the launch of an interactive clinic map where residents can geo-locate local walk-ins, pharmacies, urgent care and more. The OHT website saw 29,669 website sessions, and launched the Access Primary Care webpage, in efforts to increase local attachment to primary care.

29K
website sessions



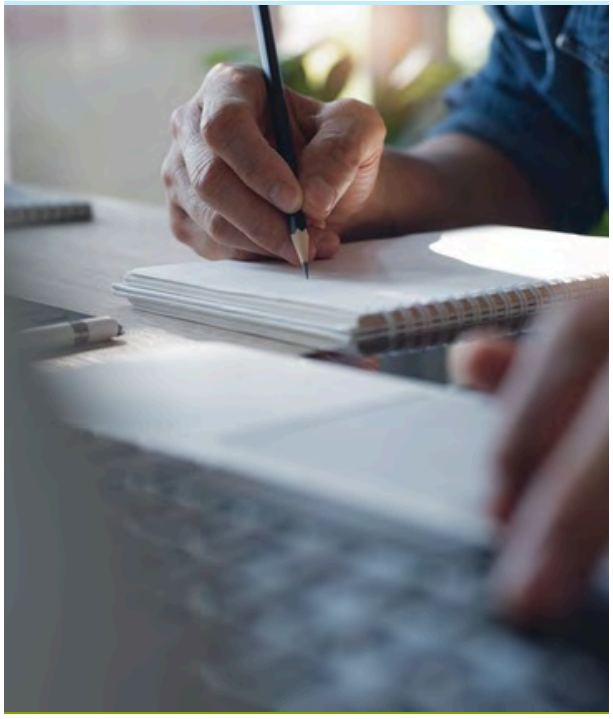
PRIMARY CARE ENGAGEMENT

The CW OHT engaged 271 family doctors and 17 nurse practitioners as part our PCN, and the physician WhatsApp group exanded to 103 members. There was a strong uptake of Online Appointment Booking (OAB), resulting in 78,852 patients reached with OAB.

288
family doctors and nurse practitioners engaged

78,852
patients reached with OAB

CW OHT SUPPORTING SUCCESS FACTORS



DIGITAL TOOL IMPLEMENTATION

New tools supported care delivery and reduced workload. There was a strong uptake of Online Appointment Booking (OAB) across the region, with 100% of sustainment licenses (112) fully utilized. 22 of 37 newly allocated licenses were also successfully implemented. The OHT actively promoted the adoption of e-Referral across the PCN through multiple channels, increasing awareness and engagement among prioviders.

100%
of sustainment OAB licenses fully utilized

EQUITY AND INCLUSION

The CW OHT staff completed key training: 100% completed training in Equity, Inclusion, Diversity and Anti-Racism (EIDA-R) and 100% completed training in Indigenous cultural awareness and safety.

100%
of CW OHT staff completed EIDA-R training

100%
of CW OHT staff completed Indigenous cultural awareness and safety training

HIGHLIGHT: Access Primary Care

BRAMPTON, NORTH ETOBICOKE, WEST WOODBRIDGE & MALTON

DELIVERED BY WellFort

Access Primary Care Brampton, North Etobicoke, West Woodbridge & Malton is a coordinated, community-wide access point that connects unattached residents in the listed areas to local family physicians and teams. The program is led by the Central West Ontario Health Team, and establishes a single, trusted "front door" to team-based care in the community, making it easier for residents to connect with family doctors and interprofessional care teams.

Ontario has committed to attaching every resident to a primary care team by 2029; Brampton, North Etobicoke, West Woodbridge, and Malton face one of the most significant attachment challenges in the province, with an unattachment rate of 13%, representing over 130,000 residents without a primary care provider.

The program:

- Streamlines intake and attachment.
- Reduces administrative burden for primary care offices.
- Prioritizes patients with urgent or complex health needs to team-based care.
- Improves system efficiency and patient experience.

By establishing a single, trusted "front door" to primary care, the program makes it easier for residents to understand how to access care and navigate the health system. A coordinated communications and marketing campaign generated more than one million impressions, directing residents to one centralized source of information and support for connecting to a local primary care team.

FUTURE OUTLOOK

The CW OHT remains committed to building a more connected, integrated, and person-centred health system that responds to the needs of our communities. Guided by our renewed strategic identity and purpose, we will continue to work alongside partners to align priorities, strengthen coordination across the health system, and advance initiatives that improve access, experiences, and outcomes for residents.

Supporting the provincial goal of connecting every Ontarian to a primary care team by 2029 remains a key priority. We will continue to work alongside primary care teams, Ontario Health, and community partners to expand attachment opportunities, improve access to team-based care, and strengthen coordinated approaches that help residents connect to the right care at the right time.

Building on our work to improve health outcomes and reduce system pressures, we will advance initiatives focused on chronic disease prevention and management. Through coordinated care pathways, strengthened partnerships, and a focus on early intervention, we aim to improve experiences and outcomes for individuals living with or at risk of chronic disease while supporting more sustainable use of health system resources.

As the health system continues to evolve, the CW OHT is evolving its governance to ensure it remains aligned with our purpose and supports effective decision-making, collaboration, and accountability. This work will reinforce our role as a system alignment facilitator, coordinator of service pathways, and system advocate, enabling us to better convene partners, align priorities, and influence improvements that benefit our communities.

Through collaboration, innovation, and a shared commitment to integration, we will continue to strengthen partnerships and advance a more connected health system that meets the needs of the people and communities we serve.

Learn more about our Annual Business Plan (26/27) goals here.

LEARN MORE & STAY CONNECTED

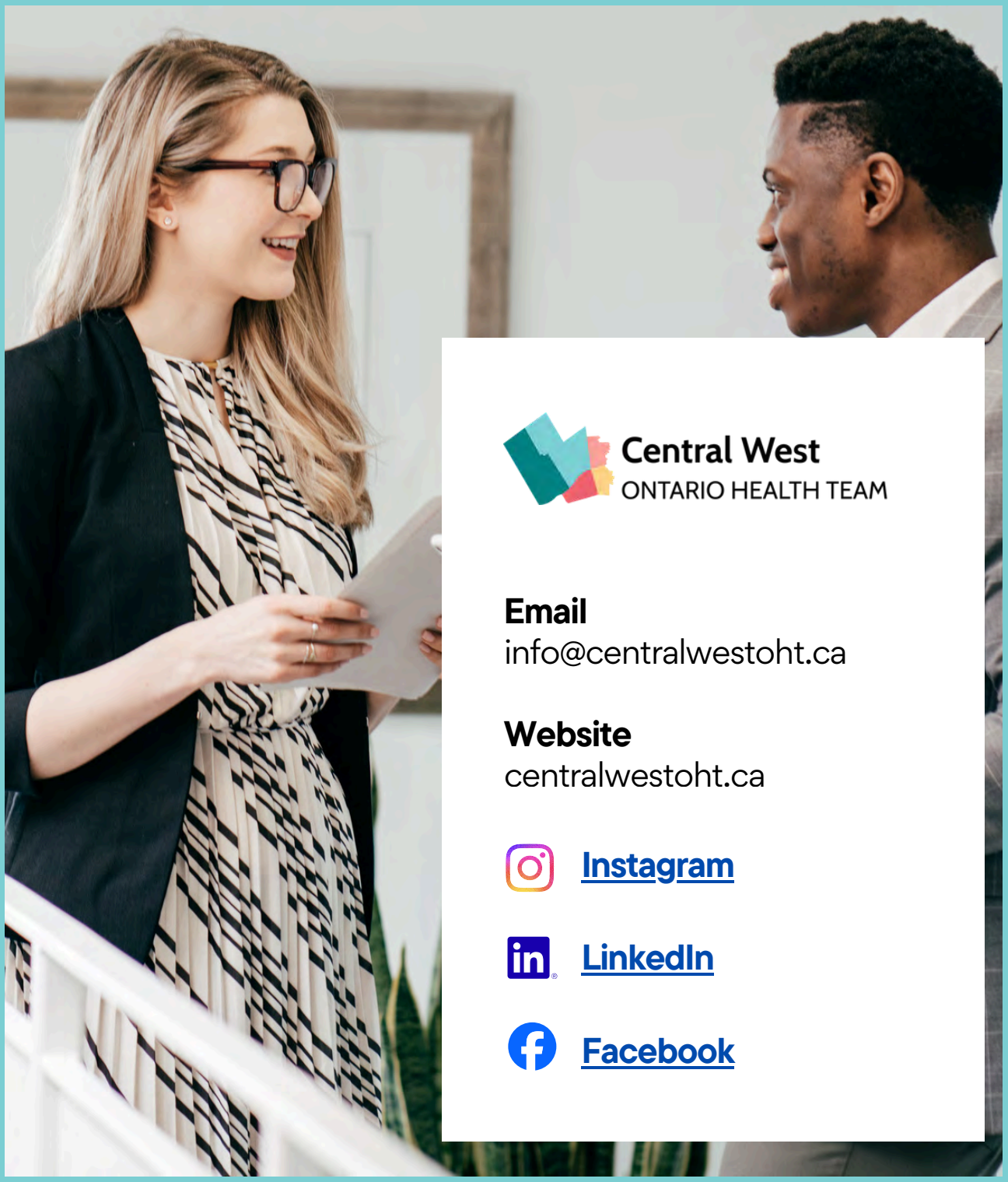
WEBSITE

PARTNERS

STRATEGIC PLAN

PROGRAMS

CONTACT US



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