

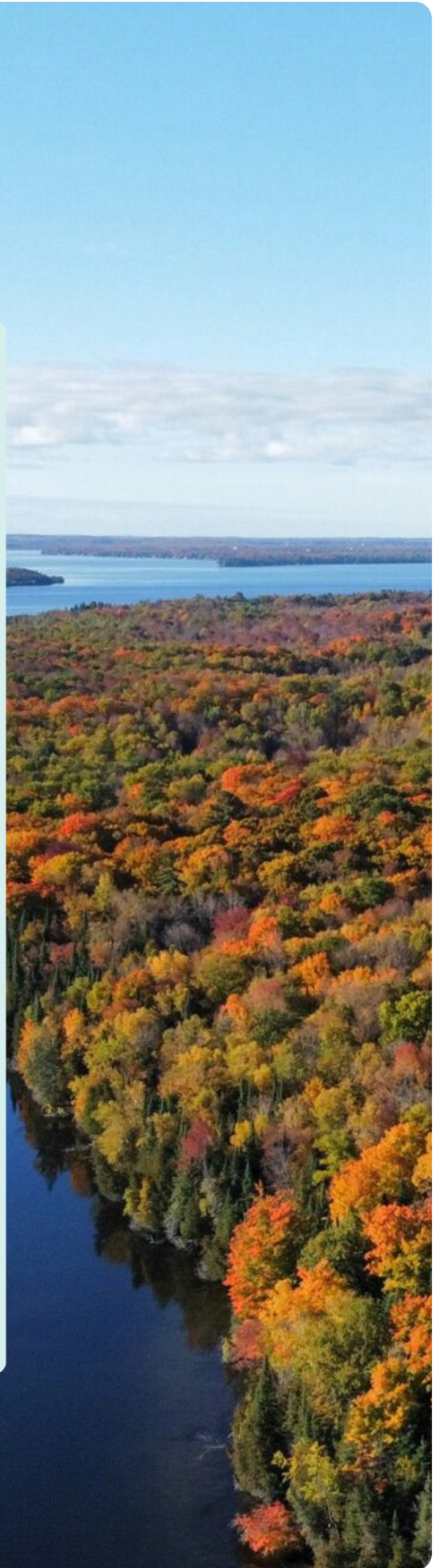


Kawartha Lakes Haliburton  
Ontario Health Team

# Impact Report

## 2025/26

Building Connected  
Care Across  
**Kawartha Lakes and  
Haliburton County**



# Land Acknowledgement

We respectfully acknowledge that the work of the Kawartha Lakes Haliburton Ontario Health Team takes place on Treaty 20 Michi Saagiig territory, and in the traditional lands of the Michi Saagiig and Chippewa Nations, collectively known as the Williams Treaties First Nations: Curve Lake, Rama, Hiawatha, Alderville, Scugog Island, Beausoleil, and Georgina Island First Nations. We recognize a shared presence of Indigenous nations throughout this region and honour the original stewards of these lands and waters, who have cared for them since time immemorial.

We are grateful to live and work on these lands, and we acknowledge the deep and enduring connection that First Nations, Inuit, and Métis peoples have to this place, connections grounded in responsibility, relationship, and respect.

As partners within the health system, we also acknowledge the harms caused by colonial systems, including the legacy of residential schools and the ongoing inequities experienced by Indigenous peoples within healthcare.

This acknowledgement calls on us to reflect on our role and our progress. While we have taken important steps this year, we recognize that this work is ongoing and requires sustained commitment.

Over the past year, we have taken steps toward advancing truth and reconciliation, building relationships, increasing awareness, and beginning to embed equity considerations into our work. There is more to do to ensure that care is culturally safe, that Indigenous voices meaningfully shape our decisions, and that barriers to care are reduced in tangible ways.

In a largely rural and interconnected community like Kawartha Lakes and Haliburton County, relationships matter deeply. Reconciliation is not a single initiative, it is ongoing, grounded in trust, listening, and accountability. We are committed to continuing this work alongside Indigenous partners, guided by humility and a willingness to learn, unlearn, and do better.

As we look ahead, we remain committed to advancing health equity, strengthening partnerships with Indigenous communities, and ensuring our actions reflect the principles of truth, respect, and reconciliation not only in words, but in measurable and meaningful change.



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# Key Impact Metrics

This year, the Kawartha Lakes Haliburton Ontario Health Team (KLH-OHT) focused on strengthening the foundations of a more connected, accessible, and community-based health system. Through collaboration with primary care, hospitals, community agencies, patients, and caregivers, significant progress was made in improving attachment to care, advancing integrated chronic disease management, enhancing digital health infrastructure, and supporting equitable access to services across our rural region.



## Primary Care Access

**96.6%**

of pre-Jan 2025  
**Health Care Connect**  
waitlist cleared

**2,038**

**patients attached**  
to primary care

**3**

**new IPCT clinics**  
underway in underserved  
communities



## Digital Innovation

**7,940**

**clinical hours saved**  
through AI Scribe  
implementation

**5,543**

**referrals** coordinated  
through navigation  
platform

**2,448**

**appointments** booked  
online



## Community Based Care

**152**

**social prescriptions**  
connecting residents to  
community supports

**93%**

**increase** in  
Ontario Structured  
Psychotherapy referrals

**66**

**partners trained** in  
trauma and violence  
informed care



# Connecting More People to Primary Care

The KLH-OHT continued to advance a coordinated regional strategy to improve access to primary care, reduce barriers for unattached patients, and strengthen the capacity of local providers and teams.

## Major Milestones

### Supported Attachment & Health Care Connect

- Developed and implemented a regional attachment strategy aligned with provincial Primary Care Action Team (PCAT) priorities
- Cleared 96.6% of the legacy Health Care Connect (HCC) waitlist
- Attached more than 2,000 residents to ongoing primary care
- Implemented standardized intake and assessment workflows using OCEAN to support coordinated onboarding and equity-informed attachment

### Primary Care Network Development

- Advanced a regional Primary Care Network (PCN) with new governance structures, leadership tables, and clinician engagement strategies
- Launched the KLH-PCN website to support clinical pathways, provider education, and practice supports ([www.klhpcn.ca](http://www.klhpcn.ca))
- Funded and recruited a regional Primary Care Clinical Lead

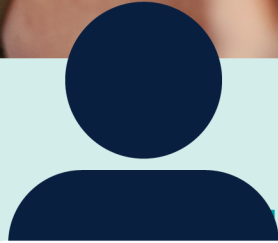
### Reducing Administrative Burden

Implementation of AI Scribe technology supported providers in redirecting time away from documentation and toward patient care:

- 108 users onboarded
- Nearly 8,000 clinical hours saved since January 2025

## The Patient Journey

A Coordinated Pathway to Connected Care



### Unattached Patient

Patient without access to a regular primary care clinician registers with **Health Care Connect**

### Intake & Assessment

Health needs, risks, and priorities are identified through a coordinated intake process

### Navigation Supports

Patient receives guidance connecting them to local health services resources while waiting for attachment

### Primary Care Attachment

Patient gets attached through the Health Care Connect waitlist

### Community Supports

Connections to local wellness, social, and community programs help support long-term health

# Advancing Integrated Community-Based Care

## Chronic Disease Prevention & Management

This year, the KLH-OHT shifted from isolated disease-specific initiatives toward the co-design of an integrated chronic disease prevention and management model across care settings.

Key areas of focus included:

- standardized patient education
- coordinated care planning
- remote care monitoring
- integrated care pathways
- Electronic Medical Record (EMR) optimization and population health tools

### Early Outcomes

- Improvement trends in Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD) admission indicators
- Frailty screening expanded into primary care and community support settings
- 152 social prescriptions issued connecting residents to community-based wellness supports

## Mental Health, Addictions & Homelessness

The KLH-OHT continued to support regional collaboration efforts focused on improving access to mental health, addictions, homelessness, and social support services. This included participation in planning discussions related to the regional Integrated Care Hub and ongoing conversations about service coordination and lived experience engagement.

Highlights:

- 93% increase in psychotherapy referrals
- Regional service provider networking event with 80+ participants across 24 organizations
- Continued development of detox and treatment pathways and transportation supports

## Palliative & Coordinated Care

- Expansion of Shared Health Integrated Information Portal (SHIIP) implementation across hospitals, home care, and community support services
- Increased palliative home care capacity in Haliburton County





# Strengthening System Foundations

## Digital Health & Navigation

The KLH-OHT continued to invest in digital infrastructure to improve access, coordination, and system navigation across the region.

Highlights included:

- 5,543 referrals coordinated through the navigation platform
- Online appointment booking for 48 schedules across participating clinics and 2448 appointments booked online.
- 84% patient satisfaction with online booking experience
- eReferral expansion and integration work across primary care and community services

## Equity & Community Engagement

The KLH-OHT continued to strengthen engagement with equity-deserving populations and lived experience partners through:

- Trans and gender-diverse cancer screening initiatives
- Indigenous outreach and relationship-building activities
- Expansion of lived/living experience participation in planning and working groups
- Broad staff and partner education in trauma-informed, equity-oriented, and culturally responsive care

## Lived Experience Engagement & Partnership

The KLH-OHT continued to strengthen patient and caregiver partnership through the Lived Experience Advisory and Partnership (LEAP) Committee. LEAP members contributed to planning, co-design, and decision-making across multiple initiatives, including:

- Social Determinants of Health (SDOH) project development
- Website redesign and patient-facing communications
- Virtual care and navigation initiatives
- Recruitment and attachment strategies
- Trans and gender-diverse cancer screening pathways
- Representation on OHT working groups and advisory activities

LEAP members also participated in focus groups, onboarding improvements, research collaborations, and recruitment interviews, helping ensure lived and living experience perspectives informed equity-focused system planning and service design.

# Looking Ahead

In 2026/27, the KLH-OHT will continue to:

Advance regional primary care attachment



Implement integrated chronic disease pathways



Strengthen community-based care models



Expand digital health integration



Support equitable and culturally responsive care



Build a more connected regional system grounded in collaboration and patient-centred care





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**Ontario Health Team**

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