FLA OHT ANNUAL REPORT

2024/2025

April 1, 2024 to March 31, 2025

FLAOHT
Frontenac Lennox & Addington Ontario Health Team

ÉSOFLA
Équipe Santé Ontario de Frontenac, Lennox et Addington

Land **acknowledgement**

With deep respect and humility, we acknowledge that the FLA OHT is located on the traditional territories of the Anishinaabe, and Haudenosaunee Huron-Wendat Nations, as well as the territories of other rural and urban Indigenous community members including Métis, Inuit, and other First Peoples from across the Turtle Island.

We stand upon land that carries the footsteps of Peoples of Indigenous ancestry who have been here for thousands of years. We have an opportunity to learn from each other, improve relationships and promote respect for the past, present and future. We are thankful to share, learn, work, play and grow on these lands as we work together to build a new health-care system that will be inclusive and equal for all.

We are deeply grateful for the collaboration and partnership with Indigenous communities and organizations. Their engagement, willingness to share ideas, insights, and perspectives, as well as their invaluable knowledge, have been instrumental in shaping our approach to health-care delivery in our region. Together, we are building a more inclusive and responsive health-care system that acknowledges, honours and respects Indigenous health and well-being practices. We look forward to continuing this important work together.

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Impact **at a glance**

Together with our partners in 2024-25, we:

Expanded access to primary care

- Connected 13,000+ people to primary care teams across the region
- Opened Midtown Kingston Health Home, set to attach 8,000 people
- Created connections between primary and hospital specialty care to improve access and capacity

Advanced equitable, people-centred care

- Launched the Indigenous Health and Wellness Strategic Advancement initiative
- Expanded French language access and developed a regional translation strategy

Improved health-care quality

- Implemented Integrated Care Pathways for heart failure and chronic obstructive pulmonary disease (COPD), improving care and reducing hospital admissions by 23% for heart failure, and 18% for COPD (based on Q1-3 data)

Supported digital innovation

- Launched Find Services, a 24/7 online health navigation tool with more than 300 local services
- Expanded online appointment booking for 80,000+ people across 103 providers
- Introduced AI scribes for 135 clinicians, saving 800+ hours of clinician time

Helped people stay healthier at home

- Expanded remote care monitoring in partnership with Ontario Health atHome
- Launched *Living Well with Home Care* project aimed at aligning home care services within Health Homes
- Introduced a dedicated Palliative Care Clinical Coach to support care providers deliver more coordinated, compassionate palliative care
- Supported mental health and addiction access through AccessMHA, which saw 4,258 referrals across the South East region this year— 1,551 from primary care and 2,707 self-referrals

Impact at a glance

2024 attachment highlights:

- **CDK Kingston Health Home:** Attached 4,187 people, including all on Health Care Connect in its neighbourhood.
- **Frontenac Doctors:** Attached 300 people — 100 from Health Care Connect and 200 pregnant women and their babies.
- **Greater Napanee Health Home:** Attached 2,000 people, including all on Health Care Connect in its neighbourhood.
- **Greenwood Medical Centre:** Attached 1,700 people, cleared neighbourhood waitlist, expanding into rural east Kingston.
- **Lakelands Family Health Team:** Attached 1,512 people in rural parts of the region.
- **Queens Family Health Team:** Attached 1,500 people through Health Care Connect and target populations (pregnant women, newcomers).
- **Weller Clinic (KCHC):** Attached 354 people from Rideau Heights; provided access to 1,454 additional residents without primary care.
- **Midtown Kingston Health Home:** Newly opened in July 2024; attached 1,211 people and provided access to 1,450 more.

Priority populations

- **Street Health Centre:** Attached 188 people with complex needs including substance use, housing instability, incarceration, or Hepatitis C risk.
- **Well Baby Care Clinic:** Attached 685 pregnant women and newborns; provided well-baby care to 182 without a provider.
- **Tsi Kanonhkhwatsheríyo Indigenous Interprofessional Primary Care Team:** Attached 589 Indigenous community members — 109 in Tyendinaga and 480 in Kingston.

A message from **the Executive Lead**

This past year, our shared work across the Frontenac, Lennox and Addington Ontario Health Team (FLA OHT) has brought us closer to achieving our mission: **ensuring everyone in our region is connected to a primary care team in a People-Centred Health Home.**

Together, we're making real progress toward this goal. More than **13,000 people in our region were connected to a primary care team in 2024**—teams made up of health professionals who work together to support each person's unique needs, close to where they live. And that number continues to grow.

We've also expanded **tools that help people take charge of their health and wellness**. One highlight is the launch of Find Services—a 24/7 online tool that makes it easier for people to locate local and provincial health and wellness services and resources—anytime, from anywhere.

This year, we've seen the impact of our Integrated Care Pathways for chronic conditions like chronic obstructive pulmonary disease (COPD) and heart failure, which help guide people from early diagnosis through treatment and follow-up—reducing hospital stays and supporting better care at home.

These are only a few examples. Through innovation, collaboration, and a shared commitment to care that puts people first, we're building a more connected, accessible health system—one that works better for everyone, people and providers alike.

Thank you to all of our partners, providers, and community members who have helped bring this vision to life. We look forward to continuing this important work—together.

Dr. Kim Morrison
Executive Lead, FLA OHT

A message from the **Community Council Co-Chairs**

We are proud to reflect on a successful year of progress toward building a health-care system that reflects the voices and needs of the people of Frontenac, Lennox and Addington counties.

Throughout the past year, we've seen the power of involving our community and how it can drive genuine change. We've met with a diversity of community members and heard their ideas and opinions. These included Indigenous Peoples, Francophone community members, people with lived and living experience, seniors, youth, people with disabilities, and many other equity-deserving voices. They have all helped shape the direction of our local health-care system.

We met with many community partners and worked with them to make care better connected and more responsive to the whole person. We're proud to see that this work is making a difference!

The FLA OHT has enhanced support for people with chronic conditions and created a tool to help people find care more easily. We've also worked hard to increase stronger collaboration across providers and begun new initiatives in trauma-informed care. And that's not all!

It has also been a key focus this year to continue to ensure people are heard and that their voices help shape decisions. We're proud to be part of an Ontario Health Team that is committed to doing just that.

The momentum we've built is exciting. We look forward to our continuing work with communities, partners, and providers to build a system that truly works for everyone.

Thank you to all of you who shared their experiences or contributed in other ways. You have helped us work towards a healthier future. We couldn't do it without you!

FLA OHT Community Council Co-Chairs

Dorothyanne Brown

Allan Katz

About the **FLA OHT**

The Frontenac, Lennox & Addington Ontario Health Team (FLA OHT) is a collective of health-care providers, community and social service organizations, and community members working together to make health-care delivery more efficient, integrated and equitable for individuals and families improving access to the full spectrum of care they need, where and when they need it.

The FLA OHT includes:

- 85+ health and wellness organizations
- 160+ family physicians, including all primary care groups in our region
- 25+ Community Council members

… working together to meet the health and wellness needs of 210,000+ people.

Our team supports residents and providers in the area spanning Deseronto, Napanee, Kingston and Gananoque in the south; Denbigh, Sharbot Lake and Cloyne in the north; and surrounding communities in between.

Our mission

A People-Centred Health Home for everyone in Frontenac, Lennox & Addington.

Our vision

A healthier community where we all have equitable access to high-quality care, services and supports that empower us toward *Achieving our best health.*

Co-designing a new framework of care: **People-Centred Health Homes**

A Health Home is a person's front door to the health-care system, where they are connected to a primary care team close to their home, as well as a network of health professionals and services that are tailored to their unique health and wellness needs. A Health Home is where people receive the care they need throughout all stages of life to support them in achieving their best health. This means easier access to care, shorter wait times to see a provider, and better communication between providers, so people get the support they need to stay healthy.

Key features of Health Homes:

1. Care centred on a person's unique health and wellness needs (people-centred care)

Care is tailored to each person's unique needs, values, and preferences — supporting their physical, emotional, mental, social, cultural, and spiritual well-being.

2. Care delivered by a team of health-care professionals (team-based care)

Care is delivered by a coordinated team of health and social care providers. People get support from the most appropriate providers for their needs—not just their family doctor.

3. Care close to a person's home or neighbourhood (care close to home)

Care is tailored to each person's unique needs, values, and preferences — supporting their physical, emotional, mental, social, cultural, and spiritual well-being.

Learn more about People-Centred Health Homes.

Partner Spotlight:
CDK Family Medicine and Walk-In Clinic

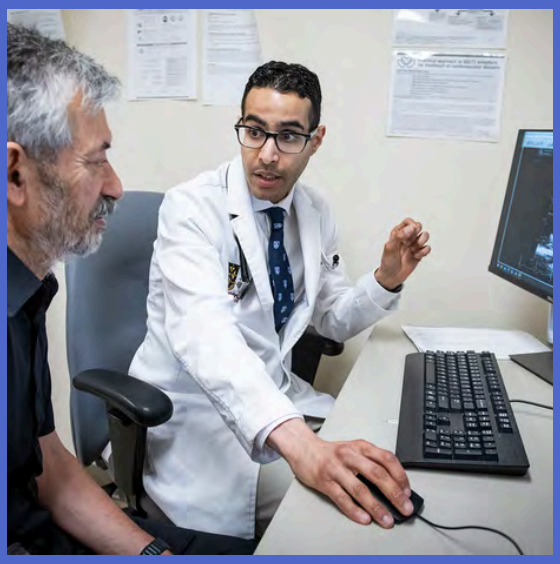
CDK Family Medicine and Walk-In Clinic is playing a leading role in transforming primary care in our region through its evolution into a People-Centred Health Home. Under the co-leadership of Dr. Ziny Yen, the clinic has expanded services, welcomed new team members, and successfully attached thousands of individuals to primary care—all without additional funding. This transformation reflects the strength of collaboration and a shared commitment to improving community health.

The CDK Central Kingston Health Home operates across three key sites: the CDK Princess Street Walk-In Clinic, the CDK Sutherland Clinic, and the Princess Street Medical Centre. Together, these clinics are helping to connect people to timely, appropriate care, whether they need urgent support or ongoing primary care.

As part of the Health Home framework, CDK has embraced team-based care, bringing together a range of health professionals to provide more comprehensive support. Their team includes a physiotherapist, psychotherapist, mental health worker, and Certified Diabetes Educators, with plans to welcome a social worker and dietitian—ensuring care that meets people's full spectrum of health and wellness needs.

Read more.

Progress towards our **Strategic Plan**



Promote equitable **health and wellness**

This strategic priority is about making sure everyone can access safe, inclusive, and appropriate care, with a specific focus on meeting the needs of Indigenous, Francophone, and equity-deserving communities.

Launched Indigenous Health and Wellness Strategic Advancement initiative with Kingston Community Health Centres (KCHC) and Three Things Consulting to support culturally safe care through Indigenous-led artwork in health-care spaces, policy and process development, and cultural learning and capacity building sessions for nearly 300 staff across 19 partner organizations.

Trauma-informed care training

Delivered accredited trauma-informed care training to 48 primary care providers and community workers in partnership with Teach Resilience (Pathways to Education), with further offerings for 90-100 practitioners planned in 2025–26.

Palliative Care Partnerships subgroup

Advanced work through this subgroup to improve early identification and palliative support for unhoused and vulnerable populations at In From the Cold shelter, the Integrated Care Hub, and Assertive Community Treatment Teams in Kingston, where 40% of clients identify as Indigenous.

DEIA training

All FLA OHT backbone team staff members completed Indigenous cultural awareness, Active Offer, and Equity, Inclusion, Diversity, and Anti-Racism education, including training in culturally and linguistically sensitive care, 2SLGBTQIA+ health, and general health equity.

Traditional Healing Mentorship Program

Partnered with Tsi Kanonhkhwatsheríyo Indigenous Interprofessional Primary Care Team to advance this mentorship program (2024–26), improving access to culturally informed care for individuals living with chronic disease.

French language services

Continued work to improve access to French language services across all Health Homes, including hiring a French-speaking physician at Midtown to support French-speaking patients.

Winning Strategies for Francophone communities

Supported *Winning Strategies*, a project aimed at improving services for Francophone communities in Eastern Ontario, with 15% of FLA OHT partners attending information sessions and five completing self-assessments.

Training licenses

Provided more than 50 training licenses to primary care teams to build skills in equity, diversity, inclusion, and cultural safety, helping clinics offer more welcoming, respectful care and supporting their quality improvement work.

Indigenous art In health-care spaces

Promoted Indigenous representation in health spaces by commissioning “The Circle of Life and Wellness” by Indigenous artists Jaylene and Dakota of W.C. Creatives, distributing 80 prints to primary care offices, and coordinating permanent art installations at seven partner sites through the Indigenous Health and Wellness Strategic Advancement initiative, with unveiling ceremonies planned for July 2025.

Health service planning

Partnered with the Réseau des services de santé en français de l’Est de l’Ontario and the Comité des Citoyens to involve Francophone community voices in health service planning.

French translation strategy

Developed a translation strategy to increase FLA OHT information available in French, in partnership with Francophone health leaders.

The Circle of Life and Wellness

Partner Spotight:
Indigenous Health and Wellness Council

The Indigenous Health and Wellness Council (IHWC) is a valued partner of the FLA OHT, playing a vital role in advancing culturally safe, inclusive care for Indigenous Peoples across the region. Co-chaired by Lynn Brant and Mireille LaPointe, the IHWC brings together Indigenous health leaders to share knowledge, strengthen relationships, and promote mutual support across care settings. Their leadership helps ensure Indigenous voices, experiences, and practices are reflected in health system planning and service delivery.

From shaping the creation of Cedar Lodge at Napanee Area Community Health Centre to advising on culturally inclusive spaces at AB Smith Homestead House, Providence Care's new hospice residence, the IHWC is helping to create environments where Indigenous cultural practices are recognized and respected. Their efforts reflect a broader vision: a health-care system where Indigenous and Western health approaches are integrated, and where all individuals can receive care that aligns with their values and worldviews.

Through this partnership, the FLA OHT and the IHWC are working together to build a more inclusive, responsive, and culturally grounded health system—supporting better outcomes for Indigenous communities and, ultimately, for all.

"This dual representation helps institutions understand the importance of culturally appropriate care for Indigenous clients. It also helps Indigenous health providers not feel isolated within their institutions. Sitting with other Indigenous practitioners, they can exchange ideas and encourage one another."

- Mireille LaPointe

Read more.

Improve health-care quality

This strategic priority is about improving the quality and coordination of care by expanding access to team-based Health Homes, supporting people through all stages of life, and helping them stay healthy and well at home and in their communities.

Supported Health Homes connect more than 13,000 people to primary care teams across the region in 2024.

Heart Function Clinic at KHSC

Partnered with Kingston Health Sciences Centre's (KHSC) Heart Function Clinic to expand integrated heart failure care—boosting clinic capacity by 25%, cutting wait times by over 50%, launching a rapid-access clinic, and reducing heart failure hospital admissions by 23%.

Chronic disease educators

Placed two specialized educators in seven Health Homes who have supported 193 people with lung disease across 10 sites, increasing access to diagnostic testing, optimizing medications, providing disease specific education and action plans to people—bringing our region's lung function testing rate to its highest in five years.

Promoting primary care attachments

Partnered with Health Homes across the region to promote awareness of primary care attachment opportunities through traditional media, social media, websites, and community outreach.

Community paramedic training

Partnered with KHSC and local paramedics to deliver specialized training for community paramedics on heart failure care and create clear protocols with the Heart Function Clinic, helping people manage their condition at home and access faster, coordinated care.

Home care modernization

Led and supported home care modernization by expanding digital coordination tools and launching the Living Well with Home Care Project to integrate home care in primary care teams—reducing hospital visits, improving provider communication, and helping people stay healthy at home.

Culturally safe palliative care strategies

Working with Indigenous communities to co-develop culturally safe palliative care strategies, beginning with relationship-building and the planning of community-led talking circles to better understand local strengths and needs.

Palliative care clinical coach

Introduced a dedicated Palliative Care Clinical Coach to support care providers with guidance, training, and resources—helping teams deliver more coordinated, compassionate palliative care across the region.

Unattached Patients Initiative

Launched this to identify emergency department visitors with lung and heart conditions who lack a primary care provider (family doctor or nurse practitioner), connecting 49 people to ongoing primary care this year to reduce hospital visits and improve long-term outcomes.

Enhanced palliative care access

Improved access to palliative care for people facing housing insecurity by creating a direct referral pathway from shelter and housing staff to the palliative outreach team, and offering training to frontline workers on how to support clients with serious illness.

Remote Care Monitoring

Supported the rollout of Remote Care Monitoring in partnership with hospitals, paramedics, and home care providers, helping to reduce hospital stays, improve care satisfaction, and provide faster, more coordinated care.

Early palliative care

Expanded access to early palliative care in primary care clinics, with over 40 patients referred and supported through their Health Home—many reporting greater comfort, clarity about their condition, and improved connections to home care.

Community Paramedic training for heart failure management

Partner Spotight:

KHSC Heart Function Clinic – Improving Heart Failure Care

The Heart Function Clinic at Kingston Health Sciences Centre is helping transform care for people with heart failure across our region. As part of the FLA OHT's Integrated Care Pathways, the clinic works closely with primary care, hospital, and community partners to guide patients from diagnosis to recovery and long-term management.

In the past year, the clinic increased capacity by 25%, cut wait times for care from 92 to 43 days, and introduced faster echocardiogram access for high-risk patients. With support from community paramedics and Ontario Health at Home, the clinic has also expanded remote care monitoring to help people manage their condition at home and avoid unnecessary hospital visits. This strong collaboration is creating a more connected, person-centred system for people living with chronic conditions like heart failure.

Read more.

Dr. Aws Almufleh with a patient at the Heart Function Clinic

Empower people to achieve their best **health and wellness**

This strategic priority is about giving people the tools, support, and information they need to stay healthy, prevent illness, manage chronic conditions, and easily access care and services.

Launched Find Services, an online navigation tool available in English and French to help people easily locate health and wellness services and resources across the region.

Resources for unattached people

Created and widely promoted a new resource to help people without a primary care provider access care and get connected.

East Region Virtual Care Clinic

Supported the East Region Virtual Care Clinic by promoting the service, helping callers connect to local in-person services, and creating pathways for people without a primary care provider (family doctor or nurse practitioner) to be matched with a care team close to home.

Cervical cancer screening

Increased cervical cancer screening rates by 8.1%, while maintaining mammogram and colorectal screening rates above the provincial average (7.4% higher and 4% higher, respectively).

Cancer screening awareness

Strengthened community awareness and access to cancer screening through partnerships with the Regional Cancer Centre and Indigenous health initiatives.

AccessMHA

Continued to promote AccessMHA, a free service that connects people to mental health, substance use, and addiction support, which saw 4,258 referrals across the South East region this year—1,551 from primary care and 2,707 self-referrals.

Cancer screening reminders

Piloted PoppyBot in three primary care clinics to test automated cancer screening reminders and improve preventative care follow-up.

Community Council Spotight: **Gerhard Wendt**

With more than 35 years of international experience in health-care systems and services, Gerhard Wendt brings deep insight and a strong commitment to improving access and coordination through digital innovation. As a long-standing member of the FLA OHT Community Council and one of the first members of the Digital Support Structure, Gerhard has helped shape initiatives that make health care more intuitive and connected for people across our region.

A passionate advocate for digital health, Gerhard champions tools like online appointment booking and shared health records to reduce fragmentation and empower individuals to take a more active role in their care. At the same time, he emphasizes the importance of ensuring digital tools are accessible, inclusive, and supported by traditional options for those less comfortable with technology.

For Gerhard, the future of health care lies in collaboration—between providers, community members, and systems. “Our health-care system includes everyone,” he says. “The more we work together, the better outcomes we’ll achieve.”

Read more.

Gerhard Wendt

Support provider **wellbeing**

This strategic priority is about supporting the well-being of providers by building strong teams, reducing workload, improving digital tools, and creating a healthier, more sustainable work environment.

Expanded the use of digital tools, including AI scribes, online appointment booking, and electronic referral systems, to reduce paperwork and make appointment scheduling and referrals easier, improving efficiency and clinic workflows and reducing stress for providers.

Online appointment booking

Expanded online appointment booking from 33 to 103 providers across 18 clinics in nine Health Homes, making it available to more than 80,000 people— with 400+ community member surveys showing high satisfaction and strong likelihood of recommending the service.

AI scribes

Led, funded, and evaluated the rollout of AI scribe technology in local Health Homes, implementing 135 licenses that supported 84% of primary care providers (family doctor or nurse practitioner), generated over 50,000 clinical notes, and saved an estimated 800 hours of clinician time.

Lumeo

Partnered with regional hospitals to launch Lumeo, a new health information system that connects health-care providers across 33 sites, giving providers secure access to a person's medical history in real time, reducing duplicate tests and paperwork, improving care coordination, and enabling providers to spend more time on care.

Chronic disease educators

Hired two chronic disease educators to support chronic disease management at 10 sites across seven Health Homes, helping providers better manage complex care needs.

Partner Spotight:
Lumeo–connecting People and Health-Care Teams

In December 2024, six health-care organizations across southeastern Ontario launched Lumeo, a single shared health information system designed to improve care by securely connecting providers across 33 sites. Led by FLA OHT partners including Providence Care, Kingston Health Sciences Centre, and Lennox and Addington County General Hospital, Lumeo helps ensure that no matter where people receive care, their health team has timely access to the information they need.

By eliminating repeated tests, streamlining documentation, and improving communication between hospitals, community services, and long-term care, Lumeo is helping reduce paperwork and enhance care experiences. More than 10,000 staff have been trained on the system, which will continue to evolve to meet the needs of both people and providers, including launching a patient portal and exploring new tools like artificial intelligence to further support care teams.

Read more.

Deliver value-based care

This strategic priority is about building a stronger, more integrated health system by empowering care providers to work together, share resources, and co-design solutions that deliver better outcomes and long-term value for people and communities.

Provider and partner engagement

Expanded provider and partner engagement by involving a wide range of care sectors and community voices in decision-making, with new partners including Holy Family Patient Transfer, Kingston Native Centre and Language Nest, United Way KFLA, and Medical Tree clinic.

Engagement and co-design training

Delivered engagement and co-design training to all Working Groups and Support Structures, helping partners understand how to involve community voices meaningfully in planning and decision-making.

Hosted a Primary Care Summit, bringing together 90+ providers to co-create solutions focused on team-based care, equitable access, digital tools, and provider well-being.

Chronic disease training

Provided chronic disease training to 65 primary care providers (family doctor or nurse practitioner)–located at 7 Family Health Teams across the region–to support shared understanding of chronic obstructive pulmonary disease and heart failure care and establishing efficient ways of working with specialist clinics.

Primary care engagement

Engaged the primary care community through the Primary Care Network, which includes strong regional representation from 160 family physicians and 31 nurse practitioners working together to improve care across the region.

Care coordination

Supported providers and community partners to work together across care settings to create better connections for people, reduce gaps in care, and help people stay healthier at home and in their communities.

Community Council

The 22-member Community Council continued to play a strong leadership role in guiding FLA OHT priorities, with Co-Chairs at leadership tables, a new associate member role for flexible involvement, and 2024 survey results showing nearly all members feel respected, engaged, and part of a person-centred culture.

Engagement framework

Adopted Ontario Health's engagement framework and, with partner feedback, developed an action plan to strengthen collaboration and ensure partners stay actively involved in co-designing care.

Social Determinants of Health Community of Practice

The Social Determinants of Health Community of Practice, established in response to a local Health Homes needs assessment to support frontline workers—including community service workers, Indigenous navigators, community support and housing caseworkers—continues to grow and offer a collaborative space for learning, service promotion, warm hand-offs, and system navigation, with participation from over 45 organizations.

86%
of Community Council members felt effectively engaged

92%
of members said the Community Council fosters respect for all voices

86%
of Community Council members felt the time they dedicate to the OHT is valuable

Community Council Spotight: **Micheal Judd**

Michael Judd brings a wealth of experience and a deep passion for community well-being to his role on the FLA OHT Community Council. With a background spanning entrepreneurship, accessibility advocacy, and youth mentorship, Michael is a strong voice for equity and system change.

Motivated by his own health-care journey and a commitment to supporting disadvantaged communities, Michael is focused on reducing barriers to care—particularly for marginalized and equity-deserving groups. His advocacy work includes leading the Kingston Disability Network and supporting organizations like Resolve Counselling Services Canada, where he champions a holistic view of health that integrates both mental and physical wellness.

Through his role on the Community Council, Michael is helping to ensure that lived experience shapes health system planning. “I’ll poke the bear where needed,” he says, “so I can help make changes that will benefit everyone.”

Read more.

Michael Judd

Communications & Engagement **highlights**

We worked hard to improve how we share information and involve people in shaping local health care. Our goal is to make it easier for everyone to learn about services, find care, and be part of the changes happening across our region.

We strengthened our culture of engagement by training all Working Groups and Support Structures in engagement and co-design, completing an engagement self-assessment using Ontario Health's framework, and hosting community events and town halls to share updates and gather feedback from people across the region.

↑ 189% Social media impressions	150,000 Social media reach
↑ 37% Newsletter subscribers	53% Newsletter open rate
↑ 138% Website traffic	38,000 Website page views
60+ News stories	500,000 Reach from media coverage
10 Community Council meetings	7 New Community Council members

Looking ahead: **2025/2026 priorities**

As we look to 2025-26, we remain focused on advancing our shared vision of a stronger, more connected health system that puts people and communities first.

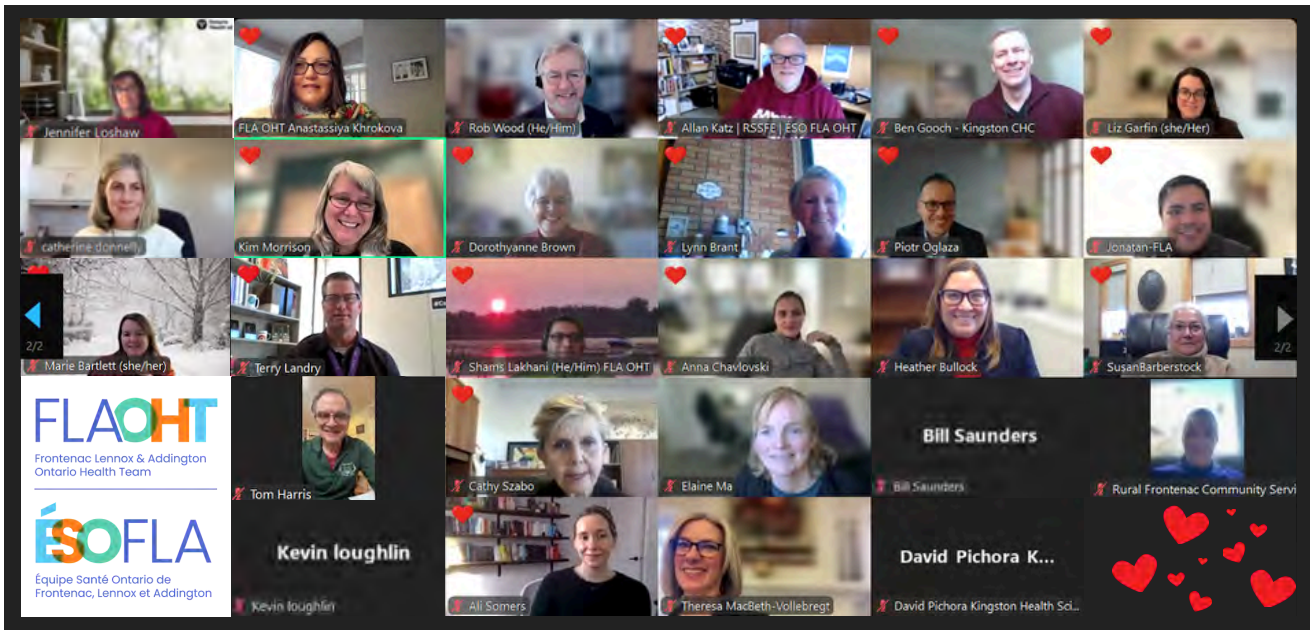
A key priority will be supporting Ontario's Primary Care Action Plan, which aims to ensure every person is connected to a primary care team close to home. We will continue working with our partners to attach everyone in Frontenac, Lennox and Addington to a primary care team in a People-Centred Health Home. This work will help improve access, strengthen relationships between people and care teams, and lead to better long-term health outcomes for our communities.

We will also focus on expanding home care models that are directly embedded within primary care teams, helping people stay healthier at home and reducing hospital visits. We look forward to working with government and community partners to spread this model across our region and explore a more consistent approach to care coordination.

Our work remains guided by our five strategic priorities: promoting equitable health and wellness, improving health-care quality, empowering people to achieve their best health, supporting provider well-being, and delivering value-based care.

Together with our partners, we are committed to building on the successes of the past year and moving closer to the goal of connecting every person in our region to the care and support they need to live healthier lives.

Thank you to our partners for their support, dedication and collaboration in transforming health care in our region.



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