Proof in the Progress

How Connected Care is Changing Our Community

ANNUAL REPORT 2024-2025

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Cover art by BBNOHT, Sheridan Illustration Student, Sophie Riches

Welcome!

Highlighting how connected care is transforming the health and well-being of our communities.

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Welcome to the fourth annual report of the Brantford Brant Norfolk Ontario Health Team!

As local health system leaders, we are proud to share the 2024-25 Annual Report for the Brantford Brant Norfolk Ontario Health Team, which highlights how connected care is transforming the health and well-being of our communities.

Over the past year, we have deepened our commitment to integrated, person-centred care by strengthening partnerships across primary care, community support services, hospitals, mental health and addictions services, and public health. At the heart of this work is a shared belief: that everyone deserves equitable, timely, and culturally safe care – delivered by a connected team of providers who put people and communities first.

This report highlights some of the many tangible impacts of our collective efforts. More patients now have access to team-based primary care. New integrated care pathways are supporting smoother transitions between hospital and home. Our innovative work in digital health, such as expanding virtual care, remote patient monitoring, and allowing more people the convenience of online appointment booking is helping people receive the right care, at the right time, in the right place. We are also addressing the needs of underserved and equity-deserving populations—including people who speak different languages, older adults, and those without a regular primary care provider—through more inclusive and coordinated approaches.

We know there is still much to do. Brantford, Brant, and Norfolk continue to face complex health challenges—from high rates of chronic disease and mental health concerns to growing numbers of people without access to primary care. Through our shared leadership and unwavering focus on collaboration, we are creating the conditions for a healthier, more connected future.

To our partners, providers, patients, caregivers, and community leaders: thank you. Your voices and your commitment drive this work forward every day.

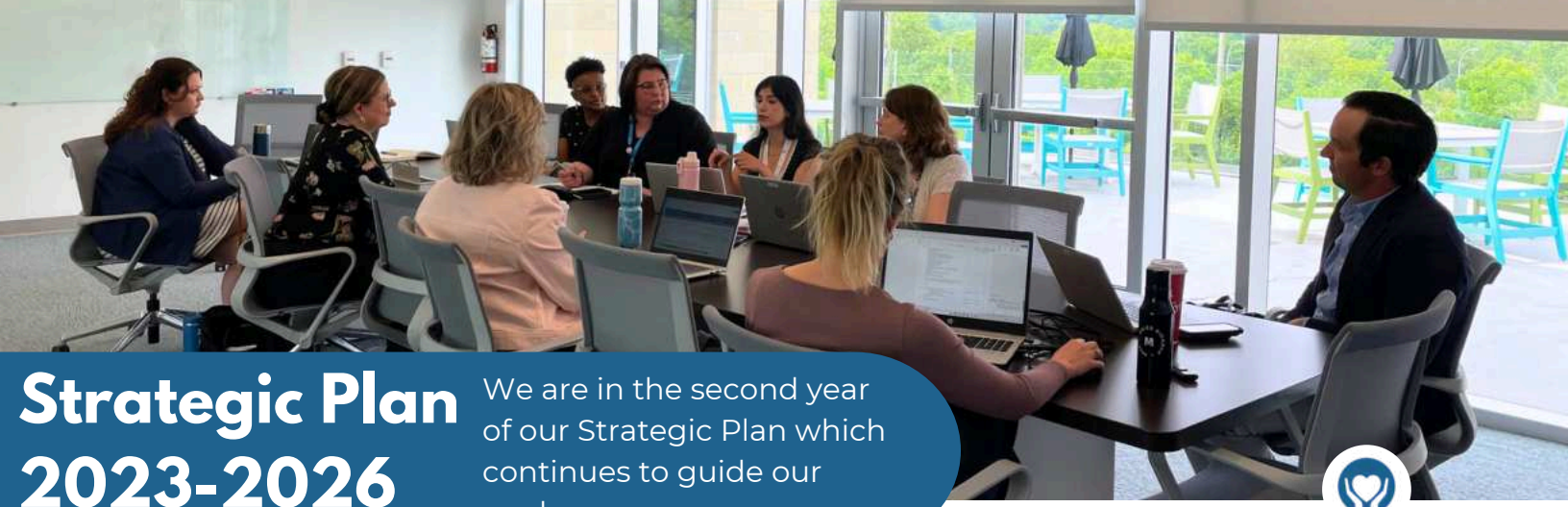
Together, we are building a more integrated, equitable, and responsive health system—one that reflects the needs of our community and delivers on the promise of connected care.
Sincerely,

Ben Deignan, Director, Brantford Brant Norfolk OHT

Sherri Dockree, Co-Chair, Brantford Brant Norfolk OHT Joint Board

Todd Stepanuik, Co-Chair, Brantford Brant Norfolk OHT Executive Leadership Group

Lynn Hinds , Co-Chair, Brantford Brant Norfolk OHT Executive Leadership Group



Strategic Plan 2023-2026

We are in the second year of our Strategic Plan which continues to guide our work

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Vision, Mission, Values

Mission

Together we deliver and advance integrated, equitable, and person centered care.

Vision

Partnering for a healthier tomorrow for everyone.

Values

Person centred, collaborative, equitable, excellent, accountable.

Our Strategic Direction

[Click here to read the complete BBNOHT 2023 - 2026 Strategic Plan]

From Planning to Action

Advancing Integrated Equitable and Person-Centred Care.

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Current Health Care Landscape in Brantford Brant Norfolk

In Brantford, Brant, and Norfolk, only 18% of residents have access to interprofessional primary care teams—groups of healthcare providers such as doctors, nurse practitioners, and other specialists working together. This is well below the provincial average.

18%
Percent of residents in Brantford Brant Norfolk residents have access to inter-professional primary care teams

Our region is experiencing several ongoing pressures:

- A growing number of people do not have a regular family doctor or primary care provider.
- Many residents are living with risk factors for chronic diseases.
- A significant amount of care is being provided in hospitals, even when it could be more appropriately delivered at home or in the community.

26, 000
The estimated number of people without primary care in Brantford, Brant, Norfolk

Overview of How We're Helping

In 2024, BBNOHT made meaningful strides in improving access to connected care across Brantford, Brant, and Norfolk. Our coordinated efforts are helping people get timely, appropriate care that meets their needs. Highlights from this work include:

- Developing coordinated care pathways to better connect services across Brantford, Brant, and Norfolk
- Local physicians and nurse practitioners - launching shared back office supports such as in procurement and technologies to reduce costs, reinvest in services, and better connect services
- Expanding access to care through Remote Monitoring
- Growing Interprofessional Primary Care Teams to reach more people
- Strengthening operational processes across our network
- Empowering patients through digital health tools
- Engaging People with Lived Experience to guide real-world improvements
- Partnering with the Primary Care Council to align efforts with local physicians
- Creating dedicated communities of practice for priority populations and system-wide working groups
- Launching shared procurement of learning management systems, administrative software, and other tools to reduce costs, improve consistency, and connect services across our Ontario Health Team
- Connecting provider to providers through digital support and enhancing communication
- Supporting patients through virtual care

From Planning to Action

Spotlight on Remote Patient Monitors

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Expanding Remote Care Through Community Paramedicine

The BBNOHT supported the expansion of Remote Patient Monitoring (RPM) by funding the purchase of 15 additional home monitoring kits for use by Community Paramedicine programs across Brantford, Brant, and Norfolk. RPM allows patients—particularly those with chronic or complex health condition such as COPD or diabetes—to monitor vital signs such as blood pressure, oxygen levels, weight, and glucose from home using Bluetooth-enabled devices, where results .

Remote Home Monitoring Facts

All data is automatically and instantly transmitted to the paramedics through a connected tablet.

Using the SPO2 sensor on their finger all data is automatically and instantly transmitted to the paramedics through a connected tablet.

The program is especially helpful for seniors, those without regular access to a family doctor, or individuals with difficulty managing complex care plans.

If patients do not have internet access, a SIM card is provided and installed in the tablet free of charge.

Patient Q& A on Remote Patient Monitoring

How did you feel when you were first offered the RPM?

Patient: It made me feel a lot safer knowing my vitals were being monitored from home.

When do you use your monitor?

Patient: I normally take it around lunch time. I can get anxious seeing what my numbers are so when it's done, I have some piece of mind throughout the day."

Do you feel more in control of your health since starting with RPM ?

Patient: Yeah, I feel safer, I don't know if I feel more in control, but I never knew if I was doing things right or wrong before, this makes me feel like I know what's going on more."

Have there been any moments where the kit helped catch a problem early or avoid a hospital trip?

Patient: Yes, I would get calls quite often after seeing numbers that were wrong. One time the gentleman working came to the house because of it, and he sent me to the hospital. They shocked my heart when I got there because it was too fast. It brings me peace of mind knowing those issues will not go unnoticed. "

From Planning to Action

Seniors and Dementia

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

The DREAM Team

The Integrated Dementia Resource (D.R.E.A.M) Team, works to divert non-acute dementia patients from emergency departments across Ontario. This team, including a Dementia Resource Consultant, Hospital Navigator, and Home and Community Care Coordinator, provides education, support, and information to dementia patients and their caregivers. In 2023, funding from Ontario Health West expanded the program to over 15 hospitals.

Outcomes

- Increased ER Capacity
- Connection to Community Resources
- Admission Diversion
- Substantial savings to healthcare system
- Reduced ER visits due to caregiver burn out
- Reduced alternate level care

359

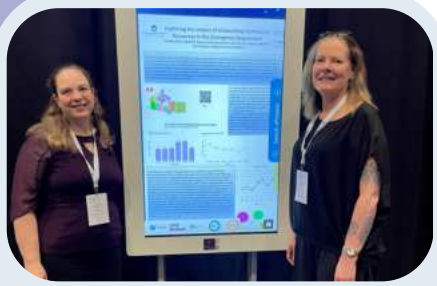
Annual admission diversions for Brantford and Norfolk General Hospitals

22 Days

Average length of stay at BCHSYS for people living with dementia

$37,840

The cost of a 22 day stay at BGH for a dementia patient



ICIC

The BBNOHT was internationally recognized, and invited to participate in the 24th International Conference on Integrated Care in Belfast, Ireland, to share the initiatives underway aimed at enhancing care for individuals living with dementia!

Keeping Seniors Safely at Home: Community Integrated Resource Team Launches in Brantford- Brant-Norfolk

Helping vulnerable seniors remain safely in their homes for longer. At the core of this work is the Community Integrated Resource Team

The Grand River Community Health Centre, in partnership with BBNOHT and local support services, has launched the Community Integrated Resource Team (CIRT) to help vulnerable seniors stay safely at home longer. This mobile team—a Care of the Elderly Physician, Registered Nurse, and Occupational Therapist—provides in-home geriatric assessments for seniors facing mobility, cognitive, or transportation barriers.

Working with partners like Community Paramedicine, the Alzheimer Society, Participation Support Services – LeGHO, the Adult Recreation Therapy Centre, and the John Noble Home Day and Stay Program, CIRT delivers personalized, coordinated care. This proactive approach helps prevent hospital visits, supports independence, and improves quality of life.

$13.5 Million

Amount of money saved this year at BGH in dementia diversions because of DREAM

From Planning to Action

Expanding Primary Care

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Partnering with the Regional Cancer Program to bring the Mobile Cancer Screening Coach to Brantford and Simcoe

This past May marks the one year anniversary of our partnership with Cancer Care Ontario, bringing the Mobile Coach to Brantford and Simcoe.

The state-of-the-art bus is equipped with a mammography machine, a private room for cervical cancer screening and all female staff who offer knowledgeable and compassionate care.

Since its inception, the coach identified multiple abnormal test results—demonstrating its critical role in early detection and intervention.

To ensure no one falls through the cracks, our Primary Care Council—made up of local physicians—developed a dedicated care pathway for individuals without a family doctor who receive an abnormal result. Through this pathway, patients are connected to a specialist for follow-up, helping to ensure timely care and improved outcomes.

Click here to learn more about the Coach and for upcoming dates

12

Number of combined visits to Brantford and Simcoe

267

Number of cancer assessments done in those 12 visits

Expanding Access Through Interprofessional Primary Care Teams

The Brantford Brant Norfolk Ontario Health Team (BBNOHT) supported the expansion of interprofessional primary care services through its collaboration with the Grand River Community Health Centre (GRCHC).

This clinic provides connected, barrier free inclusive, non-urgent health services for individuals in Brantford, Brant, and Norfolk who do not currently have a primary care provider. The model ensures patients receive timely, team-based care, aligning with the goals of Ontario's Primary Care Act.

The team delivering care includes a diverse group of professionals such as:

- Physician, Nurse Practitioners
- Registered Nurse and Registered Practical Nurse
- Registered Dietitian
- Social worker
- Social Prescriber
- Outreach worker and peer worker

Through this initiative, BBNOHT and GRCHC are helping to bridge gaps in access to care and promote equitable health outcomes across our communities.

Click here to learn more about this clinic and for the self referral form.

Enhancing Operational Effectiveness

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Online Appointment Booking

Since the start of the Online Appointment Booking program, 62 physicians across Brantford, Brant, and Norfolk have adopted the service—giving over 64,000 patients the ability to skip long phone waits and book appointments with their family doctor online.

On the administrative side, 45% of office administrators reported that OAB has reduced time spent on phone calls, allowing staff to focus on other important tasks.

A recent survey of 2,000 patients found that:

87% of survey takers said the system was easy to use

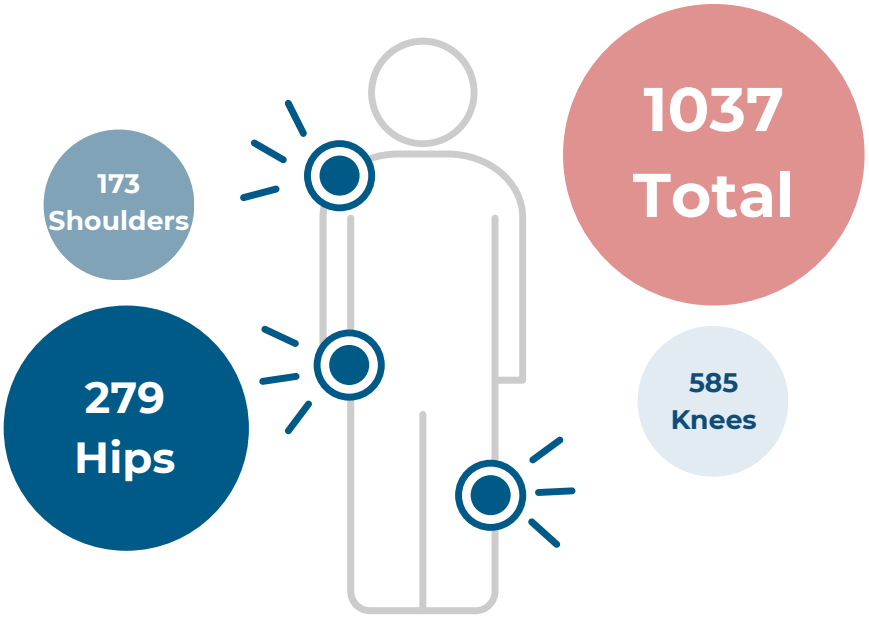
85% of survey takers said They were satisfied with the service.

Seamless MD

The SeamlessMD digital patient engagement platform continues to demonstrate strong impact in supporting patients through their surgical journey at BCHS. In the 2024–2025 fiscal year, a total of 1,037 patients undergoing shoulder, hip, and knee surgery were successfully enrolled in the program SeamlessMD provides patients with real-time access to education, reminders, and self-monitoring tools throughout their pre- and post-operative care. This has contributed to improved patient experience, better adherence to care protocols, and enhanced communication between patients and the care team.

The success of this initiative reflects the commitment of our surgical teams to innovation, patient-centered care, and continuous improvement in surgical outcomes.
97.9 % of patients felt SeamlessMD helped them feel more confident before surgery and **93%** of pateints would recommend the Seamless MD app..

Enrollment Stats from April 1st, 2024 - March 31st, 2025 for all programs:



The Primary Care Council

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

The Brantford Brant Norfolk Primary Care Council is a largely self-organized group that has been actively engaged as a Brantford Brant Norfolk Ontario Health Team partner since 2019. With high levels of engagement and participation, this group of physicians have committed to collaborating with one another to provide the best level of care to the people of Brantford brant Norfolk. As they wrap up their strategic plan for 2022-2025, we reflect on the work that has been done.

Improving Provider-to-Provider Communication

The Primary Care Council (PCC) supports communication across the region by sending out a monthly newsletter to local Primary Care Providers.

These updates include:

- New processes and protocols
- Learning opportunities
- Urgent alerts from Grand Erie Public Health, hospitals, and care teams
- Information on services that benefit patients
- For time-sensitive updates, the PCC also distributes a weekly email to ensure providers stay informed between newsletters.

Currently, The Primary Care Council meets monthly and continues to look for opportunities to educate, inform and move Primary Care forward with physicians and hospitalists in Brantford Brant, Norfolk.

Click here to learn more about the Primary Care Council

Collaborating to Expand Primary Care

BBNOHT is actively collaborating with McMaster University to support the expansion of primary care across Brantford, Brant, and Norfolk training opportunities for new clinicians across Brantford, Brant and Norfolk.

Your Health at Your Finger Tips - Digital Health and Navigation

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

ConnectMyHealth

The BBN OHT supports the promotion and awareness of ConnectmyHealth to patients in Brantford, Brant & Norfolk. This secure digital health solution provides patients with an online, single access point to review health records from participating hospitals in Southwestern Ontario including, Brant Community Healthcare System & Norfolk General Hospital.
To learn more and register today, **visit info.ConnectMyHealth.ca**

1123 **ConnectMyHealth registrations in Brantford, Brant and Norfolk in 2024**

Access Virtual Urgent Care

A virtual Urgent Care Appointment may be right for you if you or a loved one has a medical issue that is not life-threatening but requires urgent medical attention.

In the event of an emergency, please dial 911 immediately.

Health811

(Previously Telehealth Ontario) is for non-urgent health concerns, available 24/7 online and by phone. You can get safe, high-quality health advice from qualified health professional and avoid unnecessary visits to the emergency room. This service is free to use and you do not need to provide a healthcard number.

For Health Advice:
Connect with Health811 by dialing: 811 or (TTY:1866-797-0007).

You can chat live online or access resources at ontario.ca/health811.

BBNOHT Health Navigator App

This app was designed to help patients and caregivers in Brantford, Brant and Norfolk explore local and provincial health services and to more seamlessly access personal health information in one convenient location!

The app is free to use and available in both Apple and Google Play stores by searching “BBN OHT Health Navigator.”

BBN OHT
FIND THE BBN OHT HEALTH NAVIGATOR IN YOUR APP STORE

App Store

Google Play

Mental Health and Addictions

Current State and Looking Forward

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Strengthening Mental Health and Substance Use Services in Brantford Brant and Norfolk

Brantford Brant and Norfolk are facing urgent challenges in mental health, substance use, and homelessness—especially among people affected by poverty, housing instability, and systemic barriers.

Opioid-related deaths and overdose-related ER visits remain significantly above the provincial average

217 Suspected Opioid-Related Fatal and Non-Fatal Incidents, City of Brantford, 2024

23 Suspected Opioid-Related Fatal Incidents, City of Brantford, 2024

38 Suspected Opioid-Related Fatal Incidents, City of Brantford, 2023

What's Ahead for Mental Health & Addictions in 2025

An equity gap analysis to better understand and address barriers to care for equity-deserving groups such as Black, Indigenous, racialized, 2SLGBTQIA+ people, people with disabilities, and others.

Anti-stigma videos and psychoeducational posts to help raise awareness and reduce stigma around mental health and addictions on our various social media platforms.

An advocacy document focused on improving care and support for people living with anxiety and depressive disorders.

A patient-oriented discharge summary (PODS), which will be piloted in our emergency departments for individuals admitted for mental health and addictions concerns, to ensure smoother and more supportive transitions from hospital to home.

Mental Health and Addictions 2024

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Brant-Brantford Norfolk Ontario Health Team (BBNOHT) has continued to strengthen how mental health and addictions care is delivered in our region, making it more connected, responsive, and inclusive.

Here are some of the ways we are addressing mental health.

Cross-Sector Screening Tool Project

Created in response to local providers who saw that many people—especially those facing poverty, discrimination, or stigma—weren't getting help early enough. By giving housing, justice, and primary care providers an easy way to flag concerns and connect people to support, we're helping more individuals access care before crisis.

Substance Use Navigation Working Group

We listened to community voices to better understand gaps and needs in substance use care. A report was generated that lays out clear next steps and recommendations that will guide how we improve services in the future.

Partner with Lighthouse Community Strategy and the Harm Reduction Action Team.

In early 2024, this partnership with over 70 people and organizations, helped lead to a community-wide commitment to a new Substance Use Strategy for Haldimand and Norfolk. BBNOHT is supporting several key actions, including leading substance use treatment efforts through upcoming community consultations.

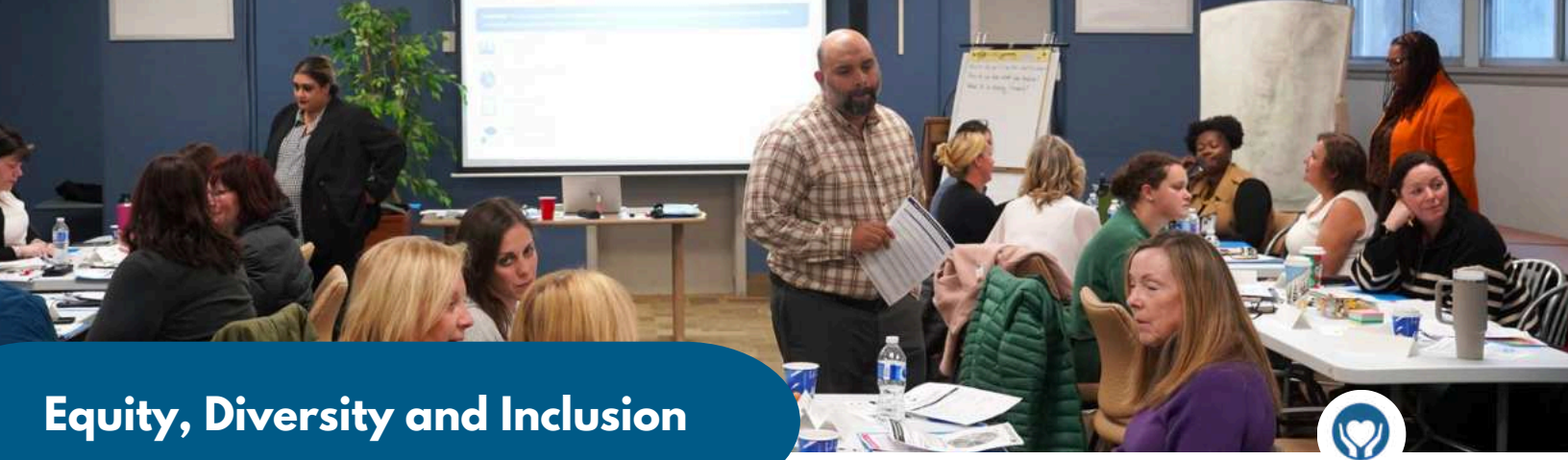
Understanding and Supporting the Mental Health of Caregivers

Understanding the mental health of those helping to care for others. Collaborated with Laurier University to support caregivers experiencing stress related to caring for an ill family member. This collaboration focused on providing information and resources to help caregivers maintain their well-being and reduce the risk of burnout.

Advancing through Community Partnerships with Colleges and Universities

The cover art, title, and mental health section of this year's Annual Report were created through a valuable partnership with Sheridan College and the University of Windsor. Sophie, an Illustration student at Sheridan, and Emily, a Master of Social Work and Law student at Windsor, brought creativity and insight to the project.
Partnering with colleges and universities helps BBNOHT support student learning, build future workforce capacity, and bring fresh perspectives to our work.

Thank you, Sophie and Emily, for all the work you do!



Equity, Diversity and Inclusion

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Equity, Diversity, and Inclusion (EDI)

The BBNOHT, serving over 200,000 residents, identified health equity as a strategic priority based on local data and community feedback from over 500 residents. In 2024–2025, the EDI Committee launched a system-wide strategy to scale the Brant Community Healthcare System's (BCHS) leading EDI work across all OHT partners. This aligns with Ontario Health's EID-AR Framework and the BBNOHT Strategic Plan (2023–2026).

The $100,000 project—supported by $40,000 in partner contributions—focused on three key areas:

- E-Learning Modules – Five interactive modules (Cultural Humility, Understanding Bias, Microaggressions, Inclusive Language, and Allyship) were launched regionally. Organizations without learning platforms received access via Thinkscape (128 seats), including FHTs, CMHA, Southcoast Wellness, ART Centre, and more. Other stakeholders like the PWLE Committee and BCHS Patient Family Advisors also participated. Organizations with their own LMS received the modules for internal use. By May 31, 2025, over 1,200 completions per module were reported.

- DEI-B Maturity Grid – A self-assessment tool launched to help organizations evaluate progress in embedding equity practices. Ten member organizations completed Phase 1 (self-assessment) by March 2025 and Phase 2 (action planning) by April 2025.

- Capacity Building – A dedicated DEI-B Coordinator was hired to support implementation, training, and system-wide learning

This collaborative approach strengthens culturally safe, inclusive care across the OHT.

As of May 31, 2025, these are the completion numbers for the EDI training modules across BBNOHT

1,236
Times Completed

1,306
Times Completed

1,156
Times Completed

1,206
Times Completed

People with Lived Experience and Engagement

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

The People at the Heart of It All

In Brantford, Brant, and Norfolk, our work is guided by the voices of those who live it every day. At the heart of the BBNOHT are the people—patients, caregivers, volunteers, social service providers, and healthcare professionals—who share their lived experiences navigating our local health system.

This network plays a vital role in shaping the work of every Community of Practice and working group within our Ontario Health Team. Their insights ensure that care remains truly person-centered, grounded in the realities our community faces.

This group is ideal for anyone who wants to share their health care experience, students who are interested in learning more about the healthcare system, those with specialized areas and interests within the OHT.

119 **Number of people in our PWLE Network!**

Your Voice Matters

Join our growing network of people with lived experience. With just one monthly email, you can share your story, offer feedback, and stay connected to opportunities to influence real change in our health system.

Click here to learn more and sign up.

People With Lived Experience Member Spotlight

Maggie Gallant

"Health care isn't just about policies and procedures—it's about people."
— Maggie Gallant

As a member of the BBNOHT People With Lived Experience (PWLE) Working Group, Maggie Gallant brings a vital voice shaped by firsthand experience navigating local health systems—particularly from an Indigenous perspective. Her insights help ensure care is more equitable, culturally responsive, and grounded in real-life needs.
Through collaboration with others who have lived experience, health care providers, and partners, Maggie has helped shape more inclusive, patient-centered approaches that reflect the diverse communities BBNOHT serves.

Click here and join Maggie as a member of PWLE

The Brantford Brant Norfolk Ontario Health Team

BRANTFORD BRANT NORFOLK
ONTARIO HEALTH TEAM

Brantford Brant Norfolk Ontario Health Team Partner Organizations

Thank You to Our Partners,

Thank you to all of our partner organizations for your continued collaboration. Your commitment to working together is the foundation of our shared success—and the clearest proof that connected care is truly changing our community.

BRANTFORD BRANT NORFOLK Primary Care Council
Brant Community Healthcare System
GRAND ERIE PUBLIC HEALTH
Grand River Community Health Centre
Norfolk General Hospital
Woodview
Stedman Community Hospice
PARTICIPATION SUPPORT SERVICES
NORFOLK FAMILY HEALTH TEAM
Société Alzheimer Society
CAMHS Community Addiction and Mental Health
PRIMACARE
ARTC
Willowbridge COMMUNITY SERVICES
SOAR Community Services
SENIOR SUPPORT SERVICES
ST. JOSEPH'S Lifecare Centre BRANTFORD
Canadian Mental Health Association Brant-Haldimand-Norfol Mental health for all
JOHN NOBLE HOME LOVE, CARE AND DIGNITY

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https://twitter.com/bbnoht

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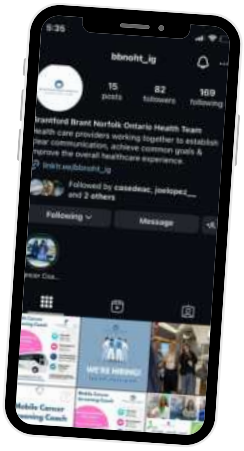

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