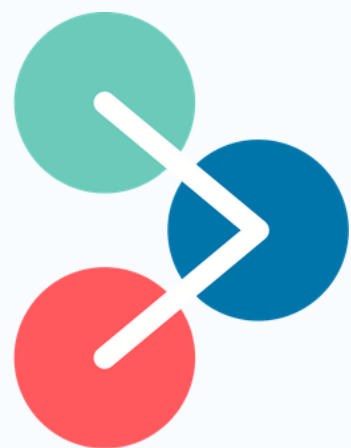


ANNUAL BUSINESS PLAN

*BUILDING COMMUNITY
HEALTH TOGETHER*

Greater
Hamilton
Health
Network
ONTARIO HEALTH TEAM



2026/27



MISSION

*Building Community
Health Together*

VISION

A healthier community that provides an equitable and seamless continuum of care that actively improves population health and meets the individual needs of our community.

VALUES

- Equity & Engagement
- Accountability
- Respect & Dignity
- Empathy & Compassion
- Transparency

PRINCIPLES

Our four overarching principles are key to all the work we do across the GHHN.

Equitable Healthcare Approaches

Commit to health equity-informed approaches to planning with a focus on those who experience the greatest barriers to health.

Patient & Community Engagement

Engage people with lived experience including patients, families, carepartners, and the community to co-design an equitable and culturally safe health care system.

Collaboration

Bring together health, social, community, primary care partners and people with lived experience to re-imagine how we deliver a more integrated and coordinated system of care.

Impact

Make a collective impact to the communities we serve enabled by strong measurement, evaluation and shared accountability.

Building Community Health Together



The Greater Hamilton Health Network (GHHN) is a not-for-profit organization and one of the first Ontario Health Teams across the province, with a purpose of transforming local healthcare.

The organization is a network of more than 150 local health and social service organizations serving over 600,000 citizens spanning the geographies of Hamilton, Haldimand and Niagara Northwest.

We are a dedicated group of professionals, organizations and people with lived experience working to co-design a person-centered health system.

Who We Are

We are committed to authentic engagement with partners, patients, families, carepartners, and our communities.

We are committed to co-designing and building a connected healthcare system centered in health equity, population health, and collective impact through measurement and evaluation.

We are committed to people receiving the right care, at the right time, in the right place.

Our Commitment

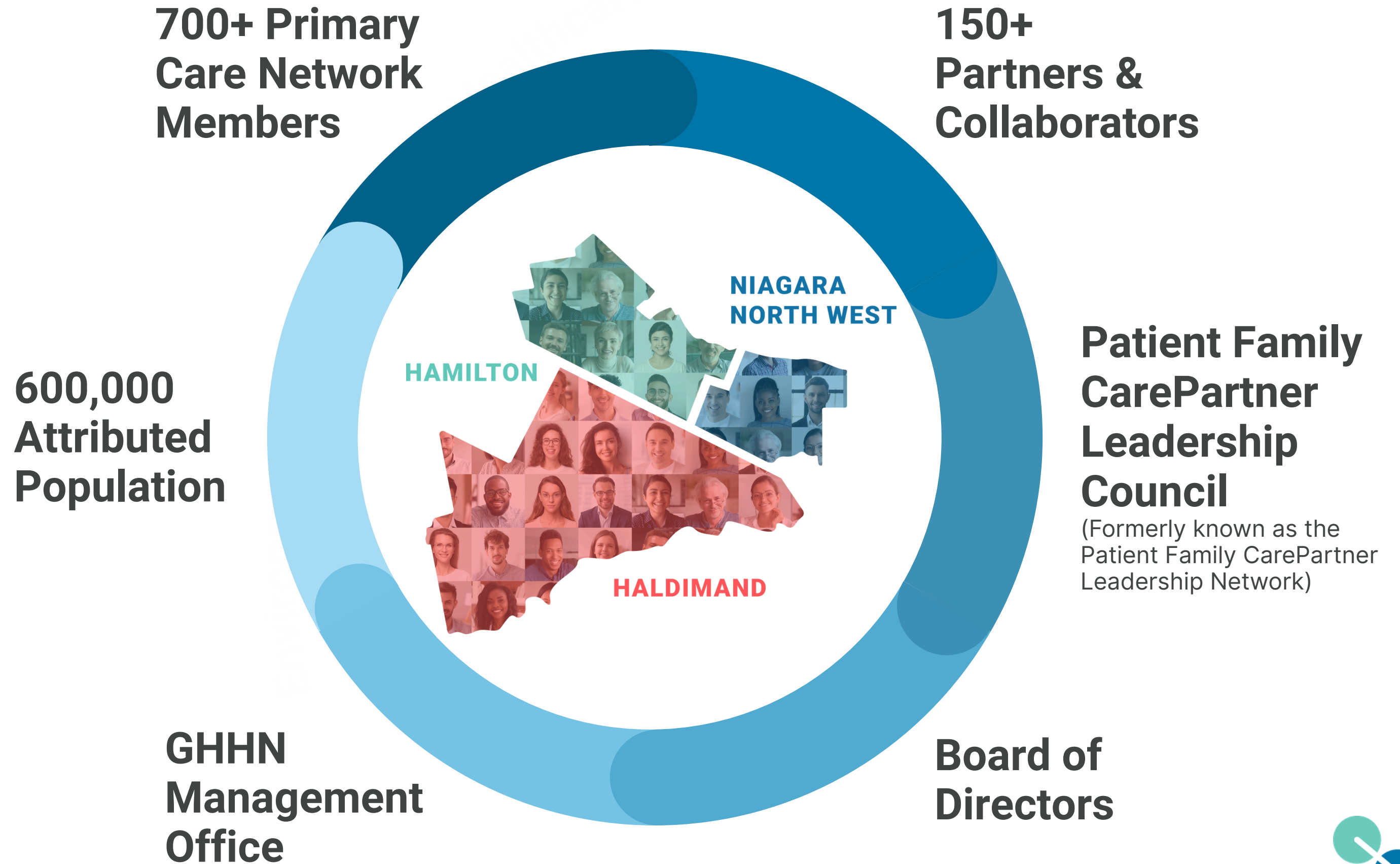
The Greater Hamilton Health Network's is committed to creating impactful and sustainable changes that create a healthier community.

Our strategic priorities guide us in our collaborative efforts:

- Strengthen Primary Care as the System's Foundation
- Enable Collaboration for Connected, Coordinated Care
- Simplify Navigation and Improve Access
- Co-Design Care with Communities and People with Lived Experience
- Build Strong Partnerships, Governance and Capacity

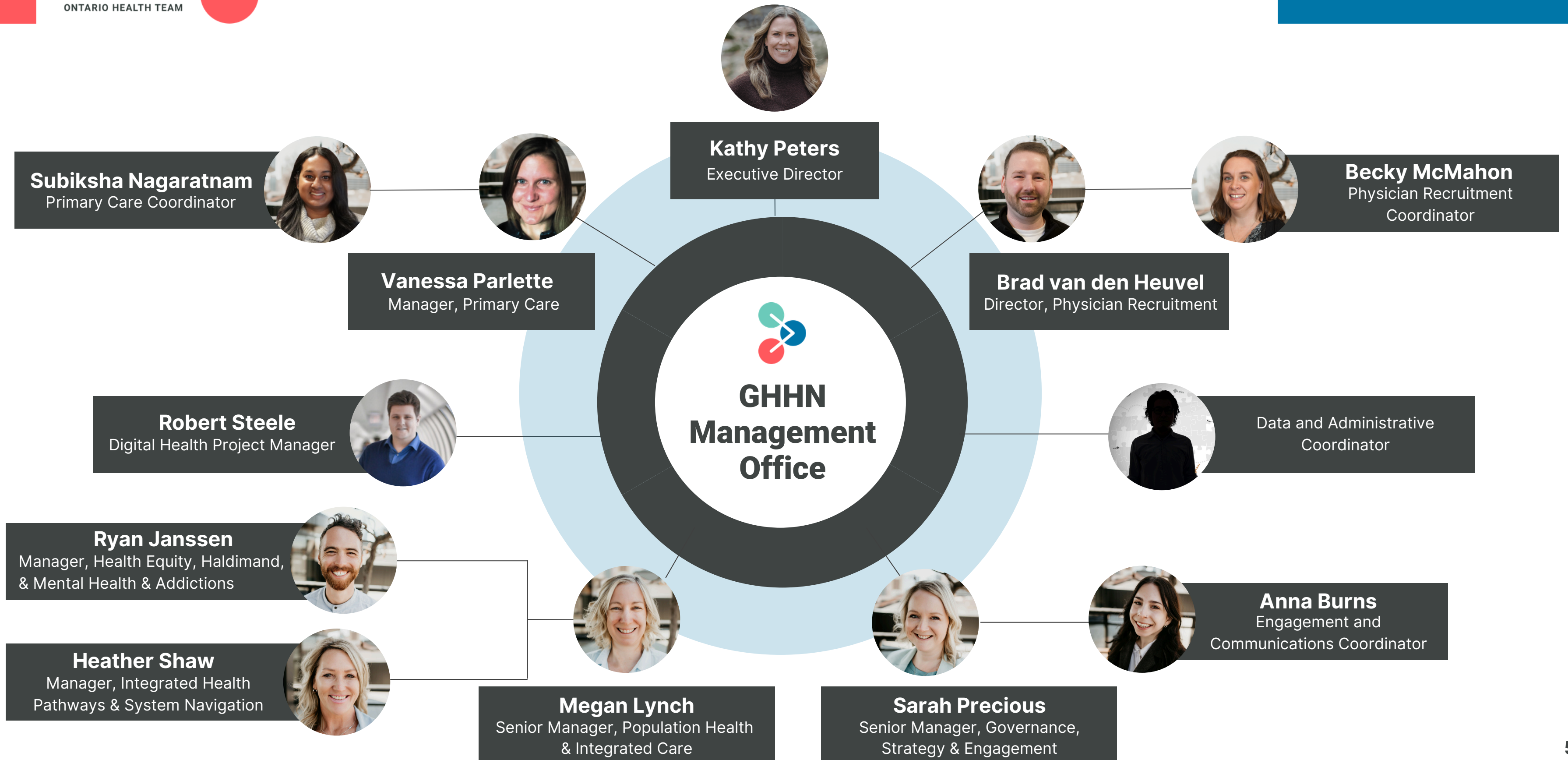
Our Plan

Greater Hamilton Health Network



MEET THE TEAM

*Building Community
Health Together.*



2026/27 Annual Business Plan

FISCAL YEAR: APRIL 1, 2026 TO MARCH 31, 2027

Building Community
Health Together.

Vision

A healthier community that provides an equitable and seamless continuum of care that actively improves population health and meets the individual needs of our community.

Mission

Building Community Health Together

Principles

- Equitable Healthcare Approaches
- Patient & Community Engagement
- Collaboration
- Impact

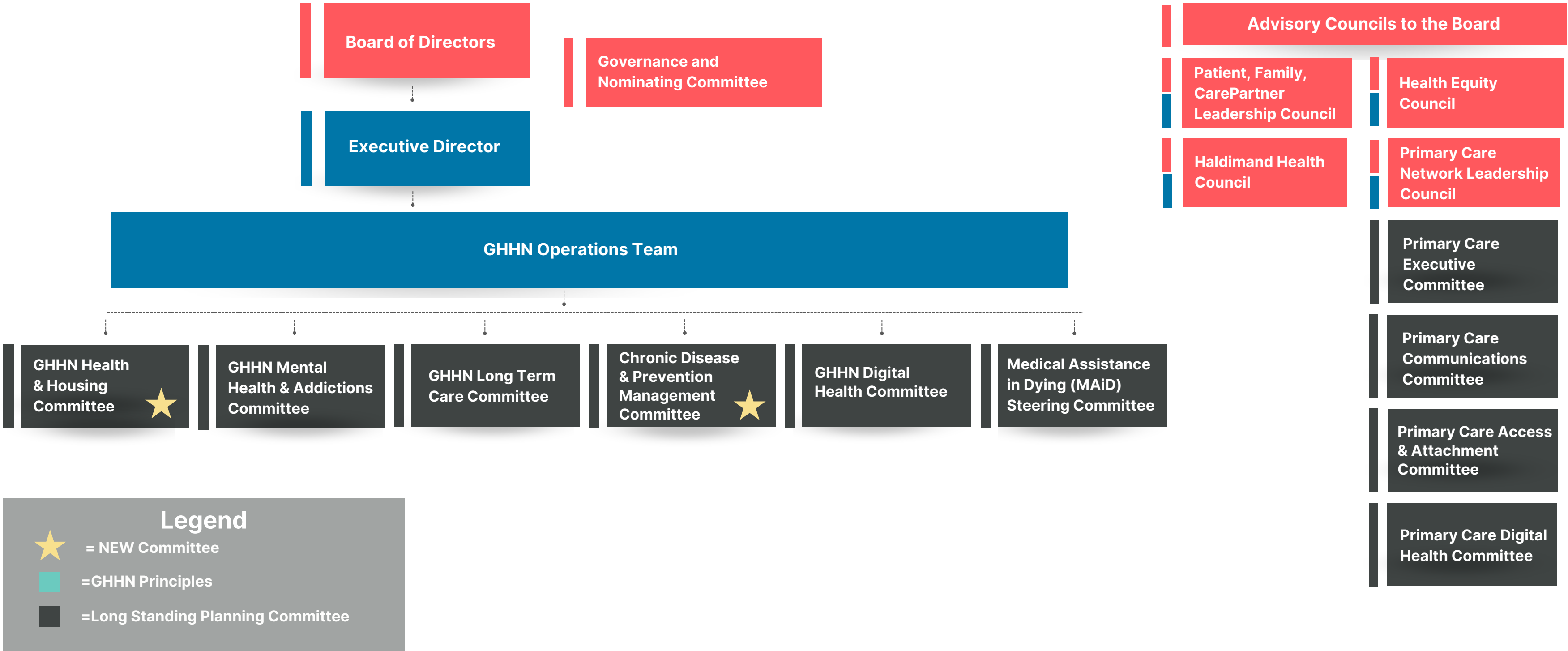
Values

- Accountability
- Empathy & Compassion
- Transparency
- Equity & Engagement
- Respect & Dignity

Strategic Priorities	Strengthen Primary Care as the System's Foundation	Enable Collaboration for Connected, Coordinated Care	Simplify Navigation and Improve Access	Build Strong Partnerships, Governance and System Capacity	Co-Design Care with Communities and People With Lived Experience
Provincial Deliverables*	• Improve Access and Attachment to Primary Care, including Supported Attachment • Lead Proposal Development for Interprofessional Care Team Expansion • Expand and Improve Primary Care Network member engagement • Improve Cancer Screening Rates for early detection • Support Patients before Paperwork	• Advance & Measure the Chronic Disease Prevention & Management (CDPM) Strategy including pro-active management of chronic conditions of Chronic obstructive pulmonary disease (COPD) and Heart Failure (HF) • Contribute to provincial knowledge development for CDPM • Improve patient outcomes & access to care through integrated care pathways including Diabetes (Lower Limb Preservation) • Support Alternate Level of Care planning for prevention & discharge management	• Support awareness of eReferral and Central Intake for CT, MRI and MHA • Continue in partnership with Regional Cancer Program to improve navigation for screening, follow-up and attachment • Implement new accessible multi-lingual translation services • Support sustainment of Online Appointment Booking	• Maintain and strengthen relationships with existing partners • Ensure representation of equity-deserving communities • Ensure GHHN staff receive required training, including Indigenous Cultural Safety training.	• Advance Patient, Family, Carepartner Engagement Maturity • Build capacity across GHHN partners in co-design and engagement • Meet at minimum level 2 in Creating Engagement Capable Environments in OHTs Framework
Local Deliverables*	• Co-design a multi-year roadmap for primary care access & attachment • Deliver a net increase of family physician capacity (recruitment) • Provide unattached primary care physicians with Quality Improvement & Decision Support services • Support locally-driven health funds for Mobile Primary Care, Gender Affirming Care, Harm Reduction & Women's Health • Support building capacity for Medical Assistance in Dying (MAID)	• Lead collaboration to address Long Term Care (LTC) residents under 65 with Mental Health and Addictions (MHA) • Explore a long-term transition solution for unhoused discharged patients with medical needs • Facilitate health & social care through hub models • Support local ALC efforts including housing ALC patients • Lead collaboration to coordinate Palliative Care in Haldimand	• Create a more coordinated and easily accessible Palliative Care system In Haldimand • Increase service awareness and improve navigation through annual Haldimand Older Adult & Caregiver Health Day • Grow & Evaluate HealthPathways • Conduct a Hamilton-focused Mental Health (MH) Crisis system-level assessment and recommendations to the City of Hamilton	• Enable diverse and balanced Board representation through succession planning • Create and Implement the GHHN Measurement and Evaluation Plan to support delivering community impact • Implement Board education sessions • Led by Indigenous leaders, implement ½ day Indigenous Education session for GHHN and other Hamilton Niagara Haldimand Brant (HNHB) OHTs • Improve GHHN staff operations	• Support Implementation of the Black Health Framework • Enable patients to be empowered partners in their care journey through implementation of Caring for Me Patient Handbook across GHHN • Deliver the Essential CarePartner Project (multit-OHT & hospital partners) • Deliver an inservice to GHHN partners on Co-design with People with Lived Experience (PWLE)
KPI's	Increased Attachment to Primary Care 75% of PCN members report value in being a member	Reduced Alternate Level of Care (ALC) rates	Improved navigation to services as reported by providers	100% of staff meet required training as per the Transfer Payment Agreement (TPA)	Achieve level 2 in Creating Engagement Capable Environments Framework



COMMITTEE STRUCTURE (HIGH LEVEL)



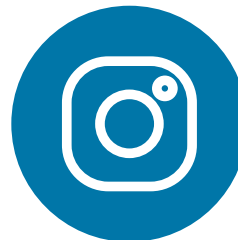
Stay Connected



greaterhamiltonhealthnetwork.ca



info@ghhn.ca



[@greaterhamiltonhealthnetwork](https://www.instagram.com/greaterhamiltonhealthnetwork)



[@greaterhamiltonhealthnetwork](https://www.facebook.com/greaterhamiltonhealthnetwork)



[@GHHN_TheNetwork](https://twitter.com/GHHN_TheNetwork)



<https://www.linkedin.com/company/greater-hamilton-healthnetwork>

