

# EXECUTIVE DIRECTOR

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Ashnoor Rahim  
Executive  
Director





COMMUNITIES AND STAKEHOLDERS WORK

# CULTURALLY RELEVANT APPROACHES WITH FIRST NATIONS, INUIT AND METIS PEOPLES LIVING WITH DIABETES

On **April 10, 2025**, the Diabetes with Indigenous Older Adults Working Group, in partnership with the Indigenous Diabetes Health Circle (IDHC), hosted a virtual workshop for health care providers and educators. The session focused on culturally grounded approaches to supporting First Nations, Inuit, and Métis Peoples living with Type 2 diabetes.

Facilitated by **Crystal Bomberry** (Mohawk Nation - Turtle Clan, Six Nations of the Grand River), IDHC's Training Lead and long-standing advocate for holistic health, the session explored the intersection of historical and cultural factors that shape Indigenous health outcomes. Crystal guided participants through a timeline of policy-driven disruptions to Indigenous ways of life, connecting these shifts to present-day health inequities—especially regarding diabetes.

Participants learned about key characteristics of diabetes in Indigenous populations and how social determinants of health, including colonization, food insecurity, housing, and access to care, affect risk, management, and overall outcomes. The session also introduced IDHC's holistic model of care, which integrates Western and traditional Indigenous knowledge systems.

A highlight of the workshop was guest speaker **Cathy Andrus** (Ojibwa, Turtle Clan, Alderville First Nation). Cathy shared her lived experience as an Indigenous older adult living with diabetes in the Waterloo Wellington region. Through her story, she emphasized the need for culturally respectful care and the role of community support in navigating the health system.

At the core of the session was the message that Indigenous culture and land is not only a source of identity and autonomy, but a critical element of healing and well-being.

## Next Session

The second webinar in this series will take place virtually on May 8. [Register here](#) to continue learning about culturally-rooted approaches to care.

# COMMUNITIES AND STAKEHOLDERS WORK ICT HIGHLIGHTED BY HEALTHCARE EXCELLENCE CANADA

Congratulations to the KW4 OHT Integrated Care Team for Older Adults program on being recognized as a Promising Practice for Enabling Aging in Place by Healthcare Excellence Canada!

This prestigious acknowledgment highlights the team's exceptional dedication to providing comprehensive, person-centered care for older adults with complex health needs. This innovative approach and commitment to excellence have significantly improved patient outcomes and set a high standard in healthcare.

Well done and keep up the outstanding work!

## Model description

The KW4 Ontario Health Team (OHT) Integrated Care Team for Older Adults is an innovative, primary care-based support model that provides older adults with direct access to a specialized geriatric integrated care team in a primary care setting. The integrated care team is led by a nurse practitioner, geriatric psychiatrist, pharmacist and other care professionals who collaborate to offer comprehensive support to older adults and their primary care providers.

The motivation for this innovation was to provide integrated and geriatric health and social care to older adults with complex care needs in a person-centred and efficient way. The co-location and interprofessional philosophy that care is coordinated, with the patient's goals and wishes known to all, avoid duplication and mistakes are avoided.

The purpose of the KW4 OHT's integrated care team is to develop interventions in collaboration with the primary care provider, the older adult and their family. The goal is to identify older adults early in their frailty journey and support their care needs, thereby avoiding urgent specialist intervention or hospitalization.

The KW4 OHT integrated care team was designed to:

- embed into primary care the capacity to perform an interprofessional geriatric assessment for higher-risk older adults, and develop an associated person-centred plan of care
- embed a palliative approach for older adults in a primary care setting
- optimize the self-management capacity of older adults and their family
- provide ongoing case management
- reduce the burden on older adults and caregivers of attending multiple appointments
- expedite and ensure referrals to community service programs
- reduce the primary care burden through a shared care model
- optimize the time of geriatric specialists through shared care

The KW4 OHT integrated care team meets weekly to review referrals suitable for the KW4 OHT integrated care team. The team ensures the appropriate resources. Once an older adult is accepted, a nurse practitioner, with support from additional team members as needed, provides person-centred support for older adults with complex health needs by personal goals, managing symptoms, and supporting advanced care



## Enabling Aging in Place Promising Practices: KW4 Ontario Health Team Integrated Care Team for Older Adults

Following this visit, older adults continue to work with the integrated care team in a model through clinic visits, home visits and telephone consultations.

**Communication** – Finally, the care plan and assessment information are sent to the older adult's primary care provider along with the team's contact information for questions.

This process typically occurs within three to four weeks, accelerating older adults' access to geriatric assessment and referral to appropriate community resources.

The OHT integrated care team expanded to three additional organizations in 2023: Westside Family Medicine Centre, Waterloo Region Family Health (Frederick Street Medical Clinic). This expansion added 25 new family health physicians to the region and now serves 5,277 adults age 65+ (as of August 2024).

### Enabling-in-place principles

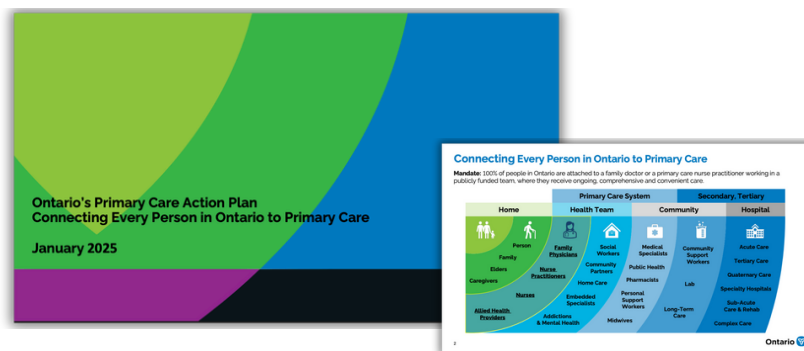
Enabling-in-place is a core philosophy of HEC's Enabling Aging in Place program. All the programs are implemented in a person-centred way and reflect a deep understanding of the needs and wishes of older adults and their care partners.

Specialized services	Access to social and community support	Access to system navigation support
Older adults have access to specialized services living in their homes, including home care, including more and more services and supports.	Programs are built around community assets and partners to improve social connections and reduce loneliness and social isolation of older adults and their caregivers living in the community – complementary to specialized healthcare supports.	Programs optimize the use of health and community assets and improve access to supportive services through personalized navigation and accompaniment to support older adults.

**Adaptive and responsive**  
Programs are tailored to the specific, individualized needs and preferences of older adults living in the community. Programs adapt and respond to emerging needs as they evolve.

# PRIMARY CARE ACTION PLAN – EXPRESSION OF INTEREST

On January 27, 2025, the Government of Ontario announced that it is investing \$1.8 billion to support the Primary Care Action Team's plan to attach every person in Ontario to primary care. The action plan includes a suite of initiatives, including a commitment to establish and expand over 300 additional primary care teams that would attach approximately two million more people to primary care by 2029.



For 2025/26, there will be an investment of \$235 million which will be used in part to establish and expand up to 80 additional primary care teams across the province that would attach 300,000 more people to ongoing primary care. The Government of Ontario is also committing to ensuring that every person on the Health Care Connect waitlist (as of January 1, 2025) is attached to a primary care team by the Spring of 2026.

Round 1 of the Interprofessional Primary Care Team Expansion proposals was released on April 10th and is a targeted call for proposals based on postal codes with the highest number of people not currently attached to a primary care clinician, including those on the Health Care Connect waitlist.

The KW4 OHT has 4 postal codes identified for consideration in this round, including N0B, N2E, N2M, and N2L. A Working Group consisting of leaders from across primary care, and the entire health and wellness system has been convened and is in the process of drafting proposals to capitalize on this incredible opportunity.

Proposals are due May 2, 2025.

## HEALTH SYSTEM UPDATES

# AI SCRIBE

The Health Care Unburdened Grant to support the implementation and evaluation of AutoScribe, a Canadian AI scribe technology for transcribing patient-clinician conversations in real time and enhancing medical record documentation, began the second round of onboarding of KW4 OHT primary care providers in April. The registration form to access the 6-month free AutoScribe solution will be open until May 30, 2025.

At the time of reporting, 27 primary care clinicians had activated the scribe, with 13 additional providers in the pipeline to participate. This initiative aims to explore and accelerate the adoption of AI scribe technology while reducing the administrative burden faced by primary care clinicians, benefiting patients and the Ontario health system.



***The Canadian Medical Association, MD Financial Management Inc. and Scotiabank proudly support this program, one of several initiatives that comprise their \$115 million commitment to supporting the medical profession and advancing health in Canada.***

# HEALTH 811 IDEATION SESSIONS

In April, the KW4 OHT, members and community representatives attended the Health811 Ideation Sessions for 2025. These sessions provide an opportunity for patients, caregivers, clinicians, and administrators to help inform the continued development of Health811. Health811 is the provincial patient platform for accessing health information and services 24/7.

## Session 1:

### **Health811 Supporting Primary Care** (April 23)

This session focused on how Health811 could better support primary care and assist people without a family doctor in accessing care and understanding their options. Attendees participated in a brainstorming exercise centered around seven questions, such as

**“What services would be useful to you while waiting to be attached to a primary care provider or team?”**

**“How can Health811 connect people to primary care?”**

Ideas from attendees included access to prescription renewals where possible, reminders for preventative screening tests, and easy access to self-management resources for chronic diseases.

## Session 2:

### **Health811 Supporting Mental Health & Addictions** (April 24)

This interactive session focused on how Health811 could improve access to mental health and addiction services in Ontario. Attendees provided feedback on how Health811 could support people:

- When they are waiting MH&A services
- How Health811 as a virtual service can help support people to access mental health support from their home
- The types of mental health and substance abuse information and resources would be helpful on Health811

# HEALTH 811 IDEATION SESSIONS

## Session 2:

### **Health811 Supporting Mental Health & Addictions** (April 24)

Ideas from attendees included connecting people with a social worker or peer support while awaiting services, collaborating and utilizing existing services like ConnexOntario, publicly list wait times for mental health services that are relevant to the user, and ensure resources and guidance are culturally safe and sensitive.

The final session, **Improving Health811 Usability & Innovation** (May 8), will focus on how the province can make Health811 easier to use and explore new ideas like AI, access medical records and more.

The Health811 team will compile the results of these ideation sessions, identify key themes, and share this with the attendees in the summer to confirm consensus and prioritize the suggested enhancements. Following this, the Health811 team will assess the feasibility of these enhancements based on attendee consensus and communicate the feasibility and future plans for Health811 in the fall.