KW4 ONTARIO HEALTH TEAM

Report to Governance Table

EXECUTIVE DIRECTOR

DECEMBER 2025

Ashnoor Rahim
Executive Director

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MESSAGE FROM THE EXECUTIVE DIRECTOR

As the year comes to a close, I would like to extend warm season's greetings to our community, partners, and health care providers across KW4. This time of reflection allows us to acknowledge the collective effort and collaboration that continue to strengthen health care in our region.

Over the past year, the KW4 Ontario Health Team has made meaningful progress in improving access to care, strengthening system navigation, and advancing equity across the health system. From supporting primary care attachment through Health Care Connect, to launching equity-focused initiatives and strengthening partnerships across community, hospital, and primary care sectors, this work reflects a shared commitment to delivering integrated, patient-centred care.

As we look ahead to the new year, I will be passing the reins of the Executive Director role to Brenda Vollmer, who will serve as Interim Executive Director. Brenda brings deep experience and a strong understanding of our local health system, and I am confident she will continue to guide this work with care and collaboration.

It has been a privilege to serve as the inaugural Executive Director of the KW4 Ontario Health Team. I am deeply grateful to our partners and community members for their trust, dedication, and ongoing commitment to improving care for the people we serve.
Warm regards,

Ashnoor Rahim

GOVERNANCE UPDATES

ONTARIO AUDITOR GENERAL'S REPORT

On December 2, 2025, the Auditor General of Ontario released the 2025 Annual Report.

The report details performance results based on audits focused on:

- Oversight of Access to Primary Care
- Oversight of Medical Education in Family Medicine
- Oversight of Physician Billing
- Supply Ontario: Personal Protective Equipment (PPE)
- Resource Productivity and Recovery Authority
- Operation of the Environmental Bill of Rights, 1993.
- Review of Government Advertising
- The Public Accounts of the Province of Ontario

A summary of some of the key takeaways from each audit in the 2025 Annual Report is available at this link. The full report is available at this link.

COMMUNICATIONS & ENGAGEMENT

VISIT FROM ONTARIO HEALTH PRESIDENT & WEST REGION LEADERSHIP

On December 16, 2025, several KW4 OHT partners hosted Matt Anderson and Nicole Robinson to showcase the wonderful work being done in our community.

- The Waterloo Region Health Network (WRHN) Cancer Centre was delighted to provide a tour of the facility and to have a thoughtful discussion about the hospital's priorities and the positive impact on patients and the broader community with Matt Anderson and Nicole Robinson.

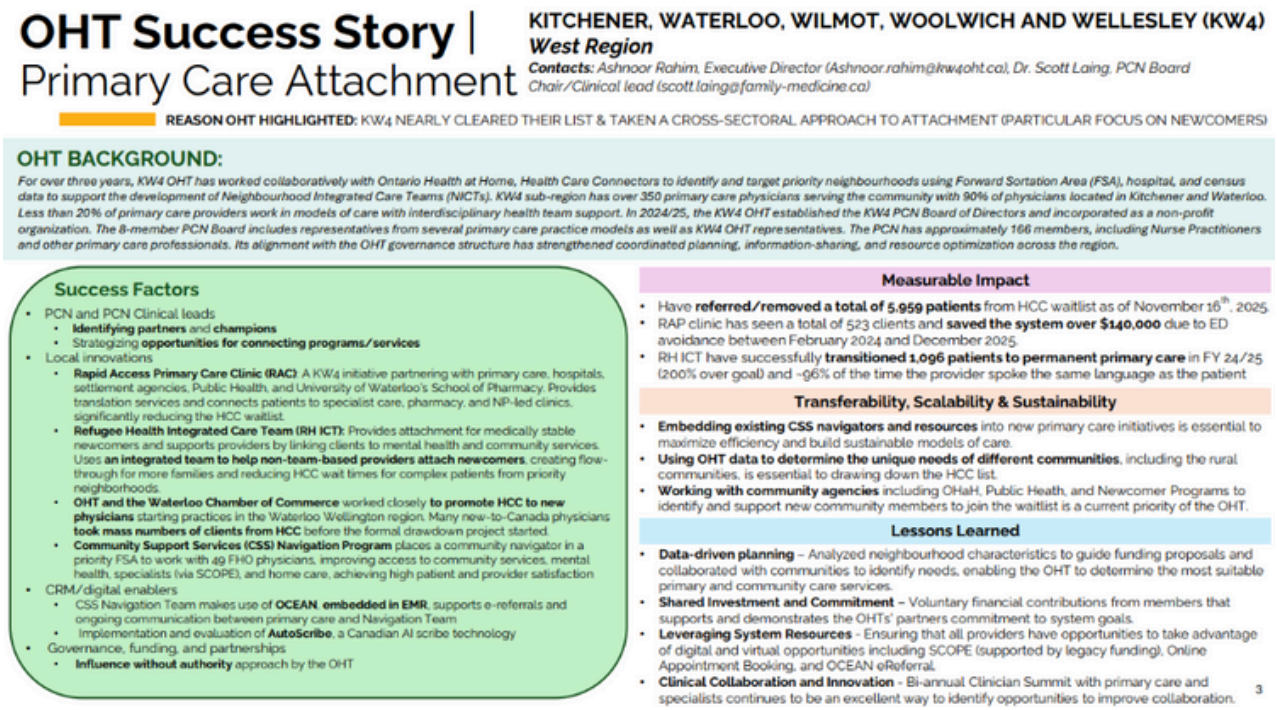
- The Woolwich Community Health Centre (WCHC0 was pleased to provide Nicole Robinson with a tour of the St. Jacob's location, and to speak to the unique client base they serve.

- The Waterloo Region Nurse Practitioner Led Clinic hosted Matt Anderson and Nicole Robinson at their Pioneer Park site. The history of the NPLC, stories of their growth over the past few years, their successful proposals, their specialty services and their impact on the broader health system through partnership were all shared.

COMMUNICATIONS & ENGAGEMENT

HEALTH CARE CONNECT OUTREACH UPDATE

Ontario Health West has recently launched a series of success stories to showcase successful initiatives from OHTs and Primary Care Networks that have contributed to reducing the Health Care Connect (HCC) waitlist. KW4 OHT is proud to share that our ongoing commitment and success was featured in OH West's first series. In KW4, 98% of patients on the HCC list since January 1, 2025, have now been referred or removed.



OHT Success Story | Primary Care Attachment

KITCHENER, WATERLOO, WILMOT, WOOLWICH AND WELLESLEY (KW4)
West Region
Contacts: *Ashnoor Rahim, Executive Director (Ashnoor.rahim@kw4oht.ca), Dr. Scott Laing, PCN Board Chair/Clinical lead (scott.laing@family-medicine.ca)*

REASON OHT HIGHLIGHTED: KW4 NEARLY CLEARED THEIR LIST & TAKEN A CROSS-SECTORAL APPROACH TO ATTACHMENT (PARTICULAR FOCUS ON NEWCOMERS)

OHT BACKGROUND:

For over three years, KW4 OHT has worked collaboratively with Ontario Health at Home, Health Care Connectors to identify and target priority neighbourhoods using Forward Sortation Area (FSA), hospital, and census data to support the development of Neighbourhood Integrated Care Teams (NICTs). KW4 sub-region has over 350 primary care physicians serving the community with 90% of physicians located in Kitchener and Waterloo. Less than 20% of primary care providers work in models of care with interdisciplinary health team support. In 2024/25, the KW4 OHT established the KW4 PCN Board of Directors and incorporated as a non-profit organization. The 8-member PCN Board includes representatives from several primary care practice models as well as KW4 OHT representatives. The PCN has approximately 166 members, including Nurse Practitioners and other primary care professionals. Its alignment with the OHT governance structure has strengthened coordinated planning, information-sharing, and resource optimization across the region.

Success Factors

- PCN and PCN Clinical leads
  - **Identifying partners** and **champions**
  - Strategizing **opportunities for connecting programs/services**
- Local innovations
  - **Rapid Access Primary Care Clinic (RAC)**: A KW4 initiative partnering with primary care, hospitals, settlement agencies, Public Health, and University of Waterloo's School of Pharmacy. Provides translation services and connects patients to specialist care, pharmacy, and NP-led clinics, significantly reducing the HCC waitlist.
  - **Refugee Health Integrated Care Team (RH ICT)**: Provides attachment for medically stable newcomers and supports providers by linking clients to mental health and community services. Uses **an integrated team to help non-team-based providers attach newcomers**, creating flow-through for more families and reducing HCC wait times for complex patients from priority neighborhoods.
  - **OHT and the Waterloo Chamber of Commerce** worked closely **to promote HCC to new physicians** starting practices in the Waterloo Wellington region. Many new-to-Canada physicians **took mass numbers of clients from HCC** before the formal drawdown project started.
  - **Community Support Services (CSS) Navigation Program** places a community navigator in a priority FSA to work with 49 FHO physicians, improving access to community services, mental health, specialists (via SCOPE), and home care, achieving high patient and provider satisfaction
- CRM/digital enablers
  - CSS Navigation Team makes use of **OCEAN**, **embedded in EMR**, supports e-referrals and ongoing communication between primary care and Navigation Team
  - Implementation and evaluation of **AutoScribe**, a Canadian AI scribe technology
- Governance, funding, and partnerships
  - **Influence without authority** approach by the OHT

Measurable Impact

- Have **referred/removed a total of 5,959 patients** from HCC waitlist as of November 16th, 2025.
- RAP clinic has seen a total of 523 clients and **saved the system over $140,000** due to ED avoidance between February 2024 and December 2025.
- RH ICT have successfully **transitioned 1,096 patients to permanent primary care** in FY 24/25 (200% over goal) and ~96% of the time the provider spoke the same language as the patient

Transferability, Scalability & Sustainability

- **Embedding existing CSS navigators and resources** into new primary care initiatives is essential to maximize efficiency and build sustainable models of care.
- **Using OHT data to determine the unique needs of different communities**, including the rural communities, is essential to drawing down the HCC list.
- **Working with community agencies** including OHaH, Public Heath, and Newcomer Programs to identify and support new community members to join the waitlist is a current priority of the OHT.

Lessons Learned

- **Data-driven planning** – Analyzed neighbourhood characteristics to guide funding proposals and collaborated with communities to identify needs, enabling the OHT to determine the most suitable primary and community care services.
- **Shared Investment and Commitment** – Voluntary financial contributions from members that supports and demonstrates the OHTs' partners commitment to system goals.
- **Leveraging System Resources** - Ensuring that all providers have opportunities to take advantage of digital and virtual opportunities including SCOPE (supported by legacy funding), Online Appointment Booking, and OCEAN eReferral.
- **Clinical Collaboration and Innovation** - Bi-annual Clinician Summit with primary care and specialists continues to be an excellent way to identify opportunities to improve collaboration.

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HEALTH CARE CONNECT OUTREACH UPDATE CON'T

Outreach efforts for HCC continue to expand across the KW4 community and beyond, with measurable engagement across community partners and regional health system partners. To date, hundreds of posters have been distributed through the KW4 OHT Clinician Summit, Healthcaring KW, and seniors-focused events in Waterloo and Wilmot.

HCC outreach was also featured in the YMCA of Three Rivers Community Connections mailing, helping expand awareness among a diverse community audience. Electronic outreach included sharing promotional materials with approximately 100 recipients across KW4 OHT members, CAC members, and governance partners, with an additional 75+ targeted outreach emails sent to community centres, faith-based organizations, libraries, school boards/newcomer centres, pharmacies, and other local partners across the KW4 region.

In support of broader system collaboration, KW4 OHT shared multilingual and editable HCC promotional materials with Ontario Health West, coordinated by the Lead, Health Equity & System Transformation, who facilitated circulation across West Region Ontario Health Teams.

Through this outreach, HCC materials were shared with the following OHTs: Guelph Wellington OHT, Central North Durham OHT, Burlington OHT, Greater Hamilton Health Network, Brant Community Healthcare System OHT, North East Simcoe OHT, Sarnia Lambton OHT, West Erie OHT, Chatham-Kent OHT, Western OHT, Elgin OHT, Huron Perth & Area OHT, Oxford OHT, and Brightshores OHT.

In addition to these OHT partnerships, we shared HCC materials with Dr. Jane Philpott, former federal Minister of Health, and current leader of Ontario's Primary Care Action Team, a provincial initiative focused on connecting all Ontarians to primary care, to support alignment with broader primary care access goals.

COMMUNICATIONS & ENGAGEMENT

WILMOT SENIORS FAIR

On Wednesday, November 19, the KW4 Ontario Health Team (OHT) proudly participated in the Wilmot Seniors Information and Active Living Fair 2025, alongside 34 esteemed community partners, including:

- Community Care Concepts of Woolwich, Wellesley, and Wilmot
- Woolwich Community Health Centre
- Waterloo Regional Health Network (PREVENT Clinic and Cancer Screening)
- Alzheimer Society
- Hospice Waterloo Region
- Independent Living Waterloo Region

The event welcomed more than 100 attendees and offered seniors a valuable opportunity to explore local health and social supports available within Wilmot Township. Participants also enjoyed an engaging presentation on “Aging Healthy in Every Way” by Dr. Nicole Didyk, Geriatrician and Associate Professor at McMaster University.

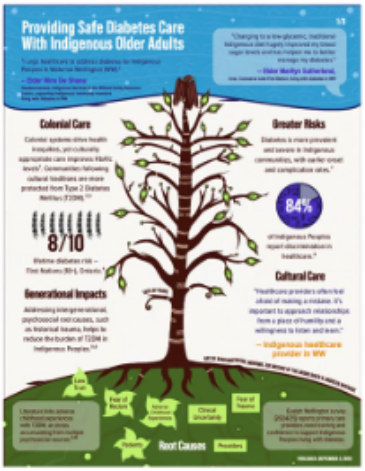
KW4 OHT presented information on Health Care Connect (HCC). HCC supports KW4 OHT’s goals and provincial priorities around primary care attachment and equity. Through the HCC program, people can register online or by phone.

We also provided information on chronic disease prevention and management including important information on prevention tips, common symptoms, risk factors, and relevant community resources to help support healthier living in our community.

We extend our sincere gratitude to our hosts, Community Care Concepts of Woolwich, Wellesley, and Wilmot, for making this event a success!

COMMUNICATIONS & ENGAGEMENT

LAUNCH OF INFOGRAPHIC: PROVIDING SAFE DIABETES CARE WITH INDIGENOUS OLDER ADULTS



On December 4, 2025, the Diabetes with Indigenous Older Adults working group hosted the official launch of the infographic Providing Safe Diabetes Care with Indigenous Older Adults. The session, titled “Integrating Indigenous Learnings into Clinical Practice,” aimed to highlight key messages and practical actions from the infographic, demonstrate the application of a Two-Eyed Seeing approach in clinical care, and emphasize humility, trust-building, and community engagement in working with Indigenous Peoples. It targeted specialists, primary care and diabetes providers, and other health professionals involved in diabetes care.

COMMUNICATIONS & ENGAGEMENT

LAUNCH OF INFOGRAPHIC: PROVIDING SAFE DIABETES CARE WITH INDIGENOUS OLDER ADULTS CON'T

The session highlighted practical ways to apply the infographic in clinical practice, including:

Centering Indigenous voices by actively listening to patients and involving them in their own care decisions.

Avoiding generalizations, recognizing the diversity among Indigenous Peoples, and tailoring care to each individual's experiences and priorities.

Supporting, not directing, cultural identity, acknowledging that it is not the role of health care providers to advise Indigenous patients on reclaiming cultural identity, but rather to offer resources and create a safe, supportive space if they choose to explore it.

Acknowledging power imbalances by using one's professional voice to create space for patients to be heard, respected, and treated with dignity, rather than to instruct or impose solutions. Allowing Indigenous clients to identify what matters most to them.

Providing non-blaming care, recognizing systemic and historical factors that impact health rather than placing responsibility solely on the individual.

The infographic is positioned as a practical tool to support action on the Truth and Reconciliation Commission (TRC) Calls to Action, emphasizing the responsibility of health systems and providers to foster culturally safe care environments.

View and Download Infographic Here

COMMUNICATIONS & ENGAGEMENT

KW4 OHT CLINICIAN SUMMIT - CONNECTED CARE: BRIDGING PRIMARY AND SPECIALTY HEALTH

On December 11, 2025, KW4 OHT was pleased to host over 50 healthcare leaders and clinicians who came together to strengthen collaboration between primary care providers, specialists, and hospital leadership.

The attendees learned about many exciting developments across our region including the launch of the new KW4 Prenatal Clinic, Health Care Connect, and the impacts of their feedback on the development of the Waterloo Region Health Network Strategic Plan. Participants also contributed to brainstorming the essential features and requirements for the future of integrated health care in KW4.

A big thank you to all participants and partners for their commitment to building a more connected and patient-centered healthcare system.

COMMUNICATIONS & ENGAGEMENT

LAUNCH OF THE KW4 PRENATAL CLINIC

The KW4 OHT is excited to share that the new KW4 Prenatal Clinic launched in October 2025. The KW4 Prenatal Clinic provides early prenatal care for patients who do not currently have a primary care provider. Care is provided by a multidisciplinary team including family physicians, nurse practitioner, midwives, and medical residents, offering coordinated, patient-centered care for those who are unattached to a primary care provider.

This collaborative initiative between the Waterloo Regional Health Network (WRHN), Centre for Family Medicine Family Health Team (CFFM), and KW4 Ontario Health Team ensures that every pregnant patient in our region can access timely, high-quality prenatal care from their first trimester until transfer to an obstetrician for third-trimester care.

This innovative model was developed to address the growing number of unattached patients and to help manage capacity challenges across primary and obstetric care. This is a great example of various sectors working together to improve care in KW4. Sparked by a conversation at the June 2025 Clinician Summit, pathways were developed and further refined during a PCN Clinical Facilitation event in September, culminating in the launch of the clinic in October.

Ontario Health has recognized the KW4 Prenatal Clinic as a “one-of-a-kind” solution to improving access to early antenatal care in our community.

Learn more here: Prenatal and Pregnancy Support | KW4 Prenatal Clinic

PMO/PROJECT UPDATES

PALLIATIVE MODELS OF CARE

OBJECTIVE:

The Palliative Model of Care for Communities (Adult) Initiative supports a Clinical Coach to work with the Ontario Health Regional Implementation Team to implement the Adult Community Model of Care. This initiative also includes the provision of palliative care education to primary care providers from community organizations participating in the implementation of the Adult Community Model of Care.

The Health Services Delivery Framework serves as a guide for transformational change to improve palliative care in Ontario. The Model of Care approach rethinks the organization, integration, and delivery of health services for a patient population as they progress along a care pathway.

This Palliative Model of Care initiative focuses on community settings and applies to individuals in their usual place of residence, including Adults living in the community, Residents of long-term care homes (LTCHs), and Indigenous communities.

OHT MEMBERS INVOLVED:

Centre for Family Medicine Family Health Team, Community Healthcaring Kitchener-Waterloo, Hospice Waterloo Region, KW Habilitation, Region of Waterloo Paramedic Services, Waterloo Region Health Network, Woolwich Community Health Centre

PMO/PROJECT UPDATES

PALLIATIVE MODELS OF CARE

2025-26 UPDATES:

- Since the start of this fiscal year, our Clinical Coach has onboarded eight organizations and completed eight Community Organization Assessment Tools (COATs). These assessments help identify competency gaps, determine education needs, and support practice change through coaching, mentorship, and quality improvement approaches. The goal is to strengthen local teams and transform the delivery of palliative care in the community.

- Additionally, seven organizations have completed their second follow-up COAT since the beginning of the fiscal year.

- The Palliative Care Toolbar, an Electronic Medical Record tool designed to assist clinicians and local palliative care outreach teams, has recently been revised and is now available for use. Amplify Care has engaged interested organizations to understand how the tool fits into their existing workflows. Learn more about the Palliative Care EMR tool for TELUS PS Suite

PMO/PROJECT UPDATES

SEAMLESS CARE OPTIMIZING PATIENT EXPERIENCE (SCOPE)

OBJECTIVE:

The aim of the SCOPE program is to support primary care providers to navigate the health system through a single centralized and standardized point of access (both community and hospital resource navigation). The SCOPE program provides real-time consultation and support for complex and urgent patients.

The SCOPE program works in tandem with the SCOPE Black Health Initiative (SCOPE BHI) which aims to improve access to care for Black communities. SCOPE BHI focuses on equipping primary care providers and specialists with streamlined navigation to local health and social resources, while prioritizing the co-design of culturally responsive care pathways. These pathways are grounded in community-identified needs, lived experience, and identified service gaps, supporting more equitable and culturally save care delivery.

OHT MEMBERS INVOLVED:

Waterloo Regional Health Network (WRHN), Primary Care Clinical Advisors

UPDATES:

In July 2025, SCOPE BHI successfully launched a Mental Health Pathway for Black Youth.

- This pathway connects youth to regional mental health supports, including Kind Minds Family Wellness (KMFW), Inner Compass Well-being, and Camino Wellbeing + Mental Health, strengthening coordinated access to care across the region.
- Primary care providers and patients are supported by a dedicated interdisciplinary team, including Nurse Navigators and a Social Worker, who provide real-time guidance, care coordination and system navigation.
- This team helps create a safe, caring, and culturally responsive environment, while supporting timely access to appropriate services.

PMO/PROJECT UPDATES

SEAMLESS CARE OPTIMIZING PATIENT EXPERIENCE (SCOPE) CON'T

UPDATES:

In July 2025, SCOPE BHI successfully launched a Mental Health Pathway for Black Youth.

- Early engagement with providers indicates improved clarity around referral pathways, increased confidence in navigation of mental health supports, and enhanced continuity of care for youth and families.

- Planning and development of the Cardiac/Heart Failure Pathway under the broader SCOPE Program began in late August and is currently ongoing, with a targeted launch by end of fiscal year.

- The Cardiac-SCOPE Pathway core objectives include:
  - Improving congestive heart failure (CHF) management by bridging gaps between primary care and specialty services
  - Optimizing the use of existing resources, like Nurse Practitioners (NPs), and established clinical infrastructure
  - Enhancing proactive management and follow up for patients with CHF
  - Reducing avoidable emergency department (ED) visits and hospitalizations through early intervention, coordinated care, and improved access to clinical expertise

Overall, the SCOPE program continues to advance integrated, equity-focused system navigation, supporting both providers and patients while contributing to improved care coordination, patient experience, and health system sustainability.

PMO/PROJECT UPDATES

BREAST CANCER SCREENING

OBJECTIVE:

The Breast Cancer Screening Quality Improvement Plan initiative seeks to increase mammography rates in KW4 with a focus on our priority neighbourhoods through public outreach and provider education.

OHT MEMBERS INVOLVED:

Community Care Concepts, Community Healthcaring KW, City of Waterloo, KW Habilitation, Independent Living WR, Immigration Partnership, New Vision Family Health Team, Waterloo Wellington Regional Cancer Program, Waterloo Regional Health Network (WRHN), Woolwich Community Health Centre.

UPDATES:

The Public Outreach team collaborated with the Chronic Disease Public Outreach team to engage with more than 15 local organizations, fostering meaningful connections and sharing valuable resources. These conversations provided important insights into community needs, and plans are underway for several in-person sessions scheduled for early 2026. This team has also attended several events around the region, spoken with almost 400 people, and has connected individuals to supports, enabling access to mammograms.

The Provider Education team conducted a comprehensive survey that highlighted key perspectives and needs among primary care providers in supporting their patients. Building on these findings, the team is curating existing digital tools and exploring the most effective ways to make these resources easily accessible to providers.

EQUITY & SYSTEM INTEGRATION

ST. MARY'S FOOT CARE CLINIC

The newly opened St. Mary's Foot Care Clinic provides access to free foot care for everyone (even those without a health card). The clinic supports anyone in the community of Kitchener Waterloo and provides a range of services delivered by certified nurses.

Clinic Details

Location:
St. Joseph Church,
148 Madison Ave. S, Kitchener

Hours:
Tuesdays and Thursdays,
10 a.m. – 4 p.m.

Dates:
December 16, 2025 – March 31, 2026

To make an appointment, call 1-877-611-0669, drop-ins are also welcome.

Please help us spread the word and ensure our community has access to essential foot care.

If you have any questions about this program, please contact **Michelle Zivanovich at mzivanov@stjhc.ca**

EQUITY & SYSTEM INTEGRATION

VIRTUAL URGENT CARE | OUTREACH

Virtual Urgent Care is a service that gives children and youth (and families) timely access to urgent medical care and advice for non-life-threatening health concerns through secure online visits using a smartphone, tablet, or computer.

In response to this request to promote Virtual Urgent Care for children and youth, we shared this program through our Community Newsletter and across key social media platforms, including Instagram, X, and LinkedIn.

To further support system alignment and informed decision-making, the information was also shared broadly with KW4 OHT member organizations, and the Community Advisory Committee (CAC), reaching over 100 system leaders, partners, and community representatives.

EQUITY & SYSTEM INTEGRATION

ONTARIO HEALTH AT HOME – FALL/WINTER 2025 VACCINATION SERVICE | OUTREACH

KW4 OHT supported the promotion of the Ontario Health at Home Vaccination Service for Fall/Winter 2025, which provides in-home vaccination for individuals who are unable to attend community clinics due to medical, functional, or mobility-related reasons. The service helps ensure access to publicly funded seasonal vaccines during the fall and winter months.

Ontario Health atHome

Vaccination Service for Fall/Winter 2025

Information for Health System Partners

From October 2025 to March 2026, Ontario Health atHome will support homebound patients under our care to receive immunization against three respiratory diseases - influenza, COVID-19 and RSV. We will also contact patients under our care who meet the RSV eligibility criteria.

Ontario Health atHome care coordinators will help patients (or their substitute decision makers or caregivers) explore all available options to receive the vaccines. Options may include:

- Public health, primary care, family health teams, community health centres, pharmacy
- Community paramedicine, retirement homes, others offering in-home vaccination
- Ontario Health atHome contracted nursing service providers through in-home visits or local community nursing clinics. Service will depend on vaccine serum and nursing provider availability in each eligible patient's vicinity.

Health System Partners

If you have patients who are currently receiving Ontario Health atHome services and may benefit from vaccine counselling or service, please refer the patient to our team, per your regular process.

If you have any questions, please call **310-2222** (area code not required)

Eligibility Criteria for Influenza, COVID-19, RSV Vaccine Service

Must be an active patient with Ontario Health atHome who:

- Has valid Ontario health card
- Is currently receiving at least one service from Ontario Health atHome – e.g., care coordination, nursing, therapy, personal support services
- Is clinically homebound, **OR** mobile and able to attend a nursing clinic for RSV vaccination
- Meets NACI, Public Health or Ministry of Health eligibility guidelines for Influenza, COVID-19 or RSV
- Has provided consent for vaccination
- Is without known contraindications to receive a vaccine
- Is able to access emergency service in the event of emergency, if needed
- Nurse will administer one, two or all three vaccines, per patient's wishes
- Additionally, a caregiver who resides with a clinically homebound patient may be eligible to receive vaccine service during the same appointment as the clinically homebound patient

October 2025 **Ontario Health atHome** | 310-2222 | ontariohealthathome.ca

Information about this service was shared through the Community Newsletter and on social media platforms, including Instagram, X, and LinkedIn. It was also distributed to KW4 OHT member organizations, and the Community Advisory Committee (CAC) to support consistent awareness across the health system and community partners.