

# EXECUTIVE DIRECTOR

MARCH 2025

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COMMUNITIES AND STAKEHOLDERS WORK

# WATERLOO WELLINGTON WORLD DELIRIUM DAY

On March 12, 2025, KW4 OHT had the privilege of participating in the Waterloo Wellington World Delirium Day event. With over 110 attendees, the event provided valuable insights into best practices and practical strategies for preventing, recognizing, and managing delirium.

A special thank you to the Waterloo Wellington Delirium Collaborative for hosting this important event, as well as to our KW4 OHT members—including the Alzheimer Society WW, Canadian Mental Health Association WW, Community Care Concepts, Grand River Hospital, and K-W Seniors Day Program—along with other partner organizations for their role in organizing the session.

A recording of the event is available at: [webinar presentation](#)

## World Delirium Awareness Day

*Clear Minds: Raising Delirium Awareness  
Together We Will Make a Difference*

**Date:** Wednesday March 12, 2025 - 12:00 p.m. – 1:15 p.m.

**Location:** Virtual Webinar – ZOOM platform



## COMMUNITIES AND STAKEHOLDERS WORK

# INTERNATIONAL WOMEN'S DAY EVENT

On March 8, the Congress of Black Women – Waterloo Region Chapter hosted a vibrant event celebrating Black women in our community, and KW4 OHT was honored to participate. The event fostered meaningful connections through informal networking, followed by a sharing circle where attendees reflected on female role models and discussed coping strategies, exchanging valuable insights.

During the gathering, we had the opportunity to introduce KW4 OHT's Black Health Initiatives, emphasizing our commitment to improving access to culturally responsive healthcare and addressing health disparities within the Black community. We look forward to continuing our collaboration to shape and strengthen this initiative together.



## COMMUNITIES AND STAKEHOLDERS WORK

# SPRING PALLIATIVE EDUCATION EVENING

On March 25, 2025, the Spring Palliative Education Evening brought together healthcare professionals for an evening of learning, collaboration, and knowledge-sharing. KW4 OHT was honored to attend this impactful event, which featured a keynote presentation by Ellen Cronin-Irwin, RN, BScN, MEd, KW4 OHT's Palliative Care Clinical Coach. Ellen's presentation, *Improving Palliative Care: The Implementation of the Model of Care for Adults in the Community*, highlighted the ongoing efforts to enhance palliative care delivery through the Palliative Model of Care Implementation project. As a clinical coach, Ellen provides healthcare providers with essential resources, tools, and training while fostering community connections and raising awareness of the importance of palliative care.



The event also featured engaging breakout sessions on key palliative care topics:

- **Dr. Deborah Robinson** led a discussion on Palliative Sedation Therapy (PST) and Medical Assistance in Dying (MAiD).
- **Charles Skeete** presented on Resilient Presence in Caregiving.
- **Dr. Dave Lysecki** explored The Role of Pediatric Hospice Facilities in Regional Pediatric Palliative Care.

This educational evening reinforced the value of collaboration in advancing palliative care and ensuring that patients and families receive compassionate, high-quality support.

## COMMUNITIES AND STAKEHOLDERS WORK

# STARLING COMMUNITY SERVICES VISIT

On Wednesday, March 26th, the KW4 OHT Operations Team had the privilege of visiting Starling Community Services at their Benjamin Road location in Kitchener. This visit provided valuable insights into the essential programs and services they offer to our community. It was also an opportunity to tour their facilities and engage with their senior leadership team.

Starling Community Services delivers preventative and supportive children's mental health services across various settings. In addition, they provide employment services, youth justice programs, and housing support, playing a critical role in our region.



We extend our gratitude to the Starling team for their warm welcome and for their leadership in fostering a healthier and more supportive community.

COMMUNITIES AND STAKEHOLDERS WORK

# COMMUNITY ADVISORY COMMITTEE RECRUITMENT UPDATE

Recruitment for the Community Advisory Committee (CAC) is underway to enhance community engagement and co-design initiatives that address local health system needs.

The CAC, composed of dedicated volunteers from Kitchener, Waterloo, Wellesley, Wilmot, and Woolwich, plays a key role in identifying service gaps and improving access to care. Members meet monthly to collaborate on meaningful projects that directly impact community health and well-being.

Outreach efforts include digital promotion and community-based engagement, with hard copies of the application available upon request.

Interested individuals can contact [info@kw4oht.com](mailto:info@kw4oht.com) for more details. This initiative reflects our commitment to inclusive, community-driven health planning, and we will provide updates on recruitment progress in the coming months.



# KW4 OHT 2025/26 COLLABORATIVE QUALITY IMPROVEMENT PLAN (CQIP)

OHTs are required to submit a cQIP to Ontario Health at the beginning of each fiscal year. A cQIP is a formal commitment to quality that an OHT makes to their community. It aligns both provincial and local health system priorities with the quintuple aim of reducing costs, improving population health, improving patient experience, improving provider experience, and improving health equity through the consideration of populations most at risk. The cQIP program is designed to coordinate quality improvement efforts among our partners, by identifying and bridging gaps in care using quality improvement, population health, and change management principles, with an emphasis on improving care for those most affected by the social determinants of health to reduce health disparities.

There are **4 areas of focus**, and **6 indicators** associated with the KW4 OHT 2025-26 cQIP including:

1

Improving early detection, intervention and outcomes for people with chronic diseases and the three indicators we will be monitoring are admissions of patients with heart failure, admission of patients with COPD, and hospitalizations for ambulatory care sensitive conditions like diabetes.

2

Improving transitions in care and the associated indicator is Alternative Level of Care or ALC Days.

3

Increasing overall access to community mental health and addictions services and the indicator is Frequent ED visits for mental health and addictions related care.

4

Increasing overall access to preventative care and more specifically in the areas of mammograms.

# CONT'D

## 2025/26 cQIP Workplan

### Chronic Disease Prevention and Management

- Connect patients with **COPD, cardiovascular disease, or diabetes** to a multidisciplinary team.
- Ensure more patients hospitalized or treated in the emergency department for COPD, heart failure or diabetes receive a timely **follow-up appointment with a healthcare provider.**

### Integrated Care Delivery

- Identify **older adults with complexity** that require coordinated care planning and community support management.
- Support the **transition from hospital to home** to improve patient flow and to help adults who no longer require hospital care to continue their recovery, healing, and rehabilitation at home.

### Mental Health

- Consider the circumstances of **individuals who frequently visit the ED for MHA and** implement strategies to address these gaps.
- Support the creation of Hart Hub model, ensuring services connect into the broader system of services while also exploring different access points for the most vulnerable in our community

### Prevention Care

- Increase public outreach and education regarding **breast cancer screening** through various channels and in various languages.
- Provide Primary Care Provider education regarding updated **best practice for accessing mammograms** to increase screening rates of their patients.

We were thrilled that this year we have **50 collaborators of which 31 of them are our members.**

The following is a summary of 2025/26 cQIP workplan – the full submission can be found at – <https://www.kw4oht.com/reports>

## HEALTH SYSTEM UPDATES

# KW4 OHT 2025/26 ANNUAL BUSINESS PLAN (ABP)

Annually, KW4 OHT develops a business plan, aligned to our strategic plan, to articulate in more detail the planned work that will be undertaken in collaboration with our partners in that specific year.

Delivering on the Annual Business Plan will require the collaborative effort of every Member as we incrementally work towards achieving our goals, so it was important that the Members were actively engaged in its development.

The 2025/26 ABP, which was approved by members on March 19, 2025, includes 37 initiatives. The ABP includes applicable carry-forward initiatives from the 2024/25 annual business plan, and new initiatives aligned with the strategic plan and the refreshed Collaborative Quality Improvement Plan (cQIP).

The following is a summary of 2025/26 ABP – the full Annual Business Plan can be found at – <https://www.kw4oht.com/reports>



## 2025-26 Annual Business Plan



Keep people well by implementing strategies that focus on wellness, prevention and early interventions

- Breast Cancer Screening – public outreach, education, screening for unattached patients
- Engaging Community – collaborate with CAC and grassroots organizations
- Mental Health – identify and address gaps for patients frequently seeking care in ED
- Black Health – improves health equity for children and youth MH&A, SCOPE care pathways
- Chronic Disease – education and coaching on healthy lifestyle interventions for HF, COPD, diabetes
- Early Intervention and Community Support Management – identify older adults with complexity
- HART Hub – creation of a HART Hum model



Transform our health and wellness system to ensure people can access the right care, at the right time, and in the right place

- Primary Care – EOLs to increase attachment and access to team-based care, Refugee Health Integrated Care Team, Rapid Access Primary care clinic (RAP),
- Chronic Disease – timely follow-up after hospitalization for HF, COPD, diabetes
- System navigation – LEGHO, SCOPE
- OBGYN Central Intake – develop business case
- Online appointment booking (OAB), Patients Before Paperwork (PB4P)



Integrate services across health and social partners to serve the needs of our community

- Community Support Service Navigation Team
- Social robot prototype to support health and wellbeing of older adults in LTC
- Hospital to home transition programs
- Palliative Models of Care

# CONT'D



## 2025-26 Annual Business Plan



### Governance

- CDMA Review, and Governance Policies
- Primary Care Network Board
- Operational Support Provider
- Advocacy
- Primary Care Engagement



### Tools

- Patient access to medical record - My Connected Care
- OHT Performance Framework



### Talented People

- Reduce admin burden - AI Scribe, PCN peer-led education series
- Health human resource analysis



### Co-design person-centered models of care

- CAC - Creating Engagement Capable Environments Framework
- DEIA courses as the first step in strengthening community engagement



### Integrate equity-driven approaches

- Refresh demographic and health outcome data by neighbourhood
- Participate in a hospital-led initiative to standardize the collection of standard socio-demographic data to inform care and service delivery through data analysis.

## PROGRESS AND REPORTS

# QUARTERLY PERFORMANCE REPORT

As part of KW4's September 2020 application to become an OHT, we were required to describe how our team will measure and monitor our success. Members endorsed the measures shown in the snapshot of our performance below, which we now report on quarterly.

KW4 OHT is performing at or better than the targets we have set for caregiver distress among home care clients. KW4 OHT is not meeting the target set for three of our performance measures including hospitalization for ambulatory care sensitive conditions, alternate level of care (ALC) days, and frequent emergency room visits for mental health and addictions.

#	Indicator	Unit of Measure	Reporting Period	Proposed Target	Current Performance (lower is better)	Status	Change since last report
1	Caregiver distress among home care clients	%	Dec 2024	<= 56%	55.8%	●	☹️ Slippage from 54.9%
2	Hospitalization rate for conditions that can be managed outside hospital (asthma, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, angina and epilepsy)	Rate per 100,000 population	Dec 2024	<= 20.4 monthly (61.2 quarterly) (244.8 annually)	23.8	●	😊 Improvement from 27.9
3	Total ALC (Acute and Non-Acute)	%	Dec 2024	<=16.7%	16.9%	●	☹️ Slight slippage from 15.8%
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Dec 2024	<=10.0%	15.7%	●	☹️ Slippage from 13.4%

**Performance Corridors:** ● Greater than 10% of Target ● Within 10% of Target ● Meets Target

The full report is available [here](#).