Chronic Disease Prevention and Management

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with mammograms	O	% / Population All KW4 OHT screen-eligible people aged 50 to 74 with a special focus on 6 neighbourhoods (N2C, N2E, N2G, N2H, N2M, N2R) - those with below average screening rates.	See Tech Specs / Q2 (covering 2 yrs of participation up to Sept 2024)	54.50	57.20	KW4 OHT is targeting an approximate 5% overall performance improvement. KW4 OHT's screening rates fell below the provincial average beginning in Q1 2023/24. This trend has continued into 2024/25 Q2. Screening rates varied significantly by neighbourhood with a high of 65.0% (N3A) to a low of 47.4% (N2C), a difference of 17.6%.	City of Kitchener, City of Waterloo, Community Care Concepts WW, Community Healthcaring Kitchener-Waterloo, Grand River Hospital Corporation, House of Friendship, Immigration Partnership, Independent Living WR, KW Habilitation, New Vision FHT, St. Mary's General Hospital, Waterloo Region NPLC, Waterloo Wellington Regional Cancer Program

Change Ideas

Change Idea #1	In collaboration with Waterloo Wellington Regional Cancer Program and Primary Care, continue to increase public outreach and education regarding breast cancer screening through various channels and in various languages with a focus on our priority neighbourhoods.		
Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- # of local partners who shared public outreach material - # of in person and virtual events held in KW4 - # of attendees at outreach events in KW4	- 8 partners - 10 events with >50% in priority neighbourhoods - 600 attendees	

Change Idea #2	In collaboration with the Waterloo Wellington Regional Cancer Program and other partners, provide Primary Care Provider education regarding updated best practice for accessing mammograms in order to increase screening rates of their patients.		
Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- # of provider education events held educating providers on best practice for mammogram access - % of low screening providers who attended educational sessions - % of providers with KW Habilitation Aging in Place model trained in best practices for mammogram access.	- 4 educational events - 75% of low screening providers attend - 100% of providers involved with KW Habilitation Aging in Place trained.	

Measure - Dimension: Efficient

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Admissions per 100 heart failure patients	P	Rate per 100 / Patients All KW4 OHT residents deemed at high or at increased risk of developing cardiovascular disease.	See Tech Specs / Oct 2023 to Sept 2024	56.30	53.50	KW4 OHT is targeting an approximate 5% overall performance improvement. KW4 OHT has been performing better than Ontario and OH West Region for this measure for the last 5 fiscal years.	Bloom Care Solutions, Centre for Family Medicine FHT, City of Kitchener, City of Waterloo, Community Care Concepts WW, Community Healthcaring KW, eHealth Center of Excellence, Grand River Hospital Corporation, Immigration Partnership, Independent Living Waterloo Region, KW Habilitation, KW Seniors Day Program, New Vision FHT, Ontario Health at Home, Region of Waterloo Paramedic Services, Region of Waterloo Public Health, St. Mary's General Hospital, Waterloo Region NPLC, Woolwich CHC

Change Ideas

Change Idea #1 Connect more patients deemed high or at increased risk of developing cardiovascular disease with a multidisciplinary team for education on lifestyle interventions to reduce cardiovascular risk.

Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting	- # of referrals to the SMGH PREVENT Clinic - % of patients who feel that the PREVENT program has helped them lead healthier lives (using the quality-of-life QOL measure) - % of patients in the PREVENT program who feel empowered to make good decisions around their health, exercise routines or nutrition options - # of referrals to the SMGH Integrated Comprehensive Care (ICC) program - group convened to conduct a review of current wellness and chronic disease self-management offerings, and to explore opportunities to more effectively and efficiently use our collective resources to expand our reach - # of local community organizations Public Health provides healthy lifestyle education and referral information to for distribution to diverse communities through peer health workers - SCOPE pathway developed for existing CHF services - # of primary care providers benefitting from the free eHealthCe change management support for the implementation of the EMR-integrated heart failure management tool - # of partners who distribute and post educational information - OH atHome will continue to support connecting at risk patients through the standard use of the interRAI suite of tools	- 10% increase - > 90% of patients - > 90% of patients - 10% increase - group convened, review conducted - 14 organizations - SCOPE pathway developed - 5% of primary care providers (pending refresh happening provincially and dependent on funding) - > 10 partners - ongoing use of interRAI tools	

Change Idea #2 Collaborate with partners to ensure patients hospitalized or treated in the emergency department for heart failure receive a follow-up appointment with a health care provider within 7 days of leaving the hospital.

Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- OH atHome will continue to collaborate with GRH/SMGH to support coordinating appointments prior to discharge with multidisciplinary team. - % of appointments coordinated prior to hospital discharge - # of referrals for unattached patients to the RAP Clinic - # of referrals to the KW4 OHT Older Adult Integrated Care Team (ICT) from ER and community - # of providers offering online appointment booking (OAB) - submit Primary Care Action Plan proposals to expand access to team-based primary care in KW4 - 7-day follow-ups after being discharged home following an ED visit 7-day follow-ups after being discharged home following an inpatient hospital stay - # of referral to the Community Paramedicine program for medically complex clients with CHF in community. - # of clients with CHF receiving Community Paramedicine program support - # of clients with CHF supported with remote patient monitoring.	- support for coordinating appointments - > 50% - 10% increase, pending funding - 10% increase, pending funding - 5% increase (dependent on funding) - at least 1 proposal submitted - 5% improvement - 5% improvement - Community Paramedicine targets to be determined	

Measure - Dimension: Efficient

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Admissions per 100 COPD patients	P	Rate per 100 / Patients All KW4 OHT residents aged 35 and older who were diagnosed with COPD with a special focus on six neighbourhoods (N2A, N2G, N2H, N2M, N2N and N2J) - those performing worse than the provincial average.	See Tech Specs / Oct 2023 to Sept 2024	25.10	23.90	KW4 OHT is targeting an approximate 5% overall performance improvement. KW4 has been performing better than the province on this measure for the last five fiscal years however this varies by neighbourhood with six neighbourhoods being above the provincial average in 2023/24.	Bloom Care Solutions, Centre for Family Medicine FHT, City of Kitchener, City of Waterloo, Community Care Concepts WW, Community Healthcaring KW, eHealth Center of Excellence, Grand River Hospital Corporation, Immigration Partnership, Independent Living Waterloo Region, KW Habilitation, KW Seniors Day Program, New Vision FHT, Ontario Health at Home, ProResp, Region of Waterloo Paramedic Services, Region of Waterloo Public Health, St. Mary's General Hospital, Waterloo Region NPLC, Woolwich CHC

Change Ideas

Change Idea #1 Connect more patients with a confirmed diagnosis of COPD to a multidisciplinary team to help patients self-manage their disease.

Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- # of referrals to the SMGH Community Airways Clinic for Asthma and COPD - # of referrals to the CHC Rapid Respirology Clinic - # of asthma education/self-management appointments through SMGH contracted RRT services with University of Waterloo - # of referrals to the SMGH Integrated Comprehensive Care (ICC) program - group convened to conduct a review of current wellness and chronic disease self-management offerings, and to explore opportunities to more effectively and efficiently use our collective resources to expand our reach - # of local community organizations Public Health provides COPD referral information to for distribution to diverse communities through peer health workers - SCOPE pathway developed for existing COPD services - # of primary care providers benefitting from the free eHealthCe change management support for the implementation of the EMR-integrated COPD management tool - # of partners who distribute and post educational information - OH atHome will continue to support connecting at risk patients through the standard use of the interRAI suite of tools	- 10% increase - 10% increase - 10% increase - 10% increase - group convened, review conducted - 14 organizations - SCOPE pathway developed - 5% of primary care providers (pending refresh happening provincially and dependent on funding) - > 10 partners - ongoing use of interRAI tools	

Change Idea #2	Collaborate with partners to ensure more patients hospitalized or treated in the emergency department for COPD receive a follow-up appointment with a healthcare provider within 7 days of leaving the hospital.		
Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- OH atHome will continue to collaborate with GRH/SMGH to support coordinating appointments prior to discharge with multidisciplinary team. - % of appointments coordinated prior to hospital discharge - # of referrals for unattached patients to the RAP Clinic - # of referrals to the KW4 OHT Older Adult Integrated Care Team (ICT) from ER and community - # of providers offering online appointment booking (OAB) - submit Primary Care Action Plan proposals to expand access to team-based primary care in KW4 - 7-day follow-ups after being discharged home following an ED visit 7-day follow-ups after being discharged home following an inpatient hospital stay - # of referral to the Community Paramedicine program for medically complex clients with COPD in community. - # of clients with COPD receiving Community Paramedicine program support - # of clients with COPD supported with remote patient monitoring.	support for coordinating appointments - > 50% - 10% increase, pending funding - 10% increase, pending funding - 5% increase (dependent on funding) - at least 1 proposal submitted - 5% improvement - 5% improvement - Community Paramedicine targets to be determined	

Measure - Dimension: Efficient

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hospitalizations for ambulatory care sensitive conditions.	P	Rate per 10,000 / Patients All KW4 OHT residents with one of the seven chronic conditions with a special focus on those with diabetes living in seven neighbourhoods (N2B, N2C, N2G, N2H, N2M, N2J and N3B) - those performing worse than the provincial average.	See Tech Specs / Oct 2023 to Sept 2024	26.20	24.90	KW4 OHT is targeting an approximate 5% overall performance improvement. KW4 has been performing better than the province on this measure for the last five fiscal years however this varies by neighbourhood with six neighbourhoods being above the provincial average in 2023/24.	Bloom Care Solutions, Centre for Family Medicine FHT, City of Kitchener, City of Waterloo, Community Care Concepts WW, Community Healthcaring KW, eHealth Center of Excellence, Grand River Hospital Corporation, Immigration Partnership, Independent Living Waterloo Region, KW Habilitation, KW Seniors Day Program, New Vision FHT, Ontario Health at Home, Region of Waterloo Paramedic Services, Region of Waterloo Public Health, Regional Coordination Centre, St. Mary's General Hospital, Waterloo Region NPLC, Woolwich CHC

Change Ideas

Change Idea #1 Collaborate with Primary Care and Community partners to connect more patients diagnosed with prediabetes or type 2 diabetes with education and coaching on healthy behaviour changes, with a focus on priority neighborhoods.

Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- # of self-referrals to the Regional Coordination Centre diabetes education program - group convened to conduct a review of current wellness and chronic disease self-management offerings, and to explore opportunities to more effectively and efficiently use our collective resources to expand our reach - # of local community organizations Public Health provides prediabetes/type 2 diabetes education and referral information to for distribution to diverse communities through peer health workers - SCOPE pathway developed for existing diabetes services - # of primary care providers benefitting from the free eHealthCe change management support for the implementation of the EMR-integrated diabetes management tool - OH atHome will continue to support connecting at risk patients through the standard use of the interRAI suite of tools	- 10% increase - group convened, review conducted - 14 organizations - SCOPE pathway developed - 5% of primary care providers (pending refresh happening provincially and dependent on funding) - ongoing use of interRAI tools	

Change Idea #2	Collaborate with partners to ensure more patients hospitalized or treated in the emergency department for diabetes are connected with a health care provider.

Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- OH atHome will continue to collaborate with GRH/SMGH to support coordinating appointments prior to discharge with multidisciplinary team. - % of appointments coordinated prior to hospital discharge - # of referrals for unattached patients to the RAP Clinic - # of referrals to the KW4 OHT Older Adult Integrated Care Team (ICT) from ER and community - # of providers offering online appointment booking (OAB) - submit Primary Care Action Plan proposals to expand access to team-based primary care in KW4 - 7-day follow-ups after being discharged home following an ED visit 7-day follow-ups after being discharged home following an inpatient hospital stay - # of referral to the Community Paramedicine program for medically complex clients with Diabetes in community. - # of clients with Diabetes receiving Community Paramedicine program support - # of clients with Diabetes supported with remote patient monitoring.	- support for coordinating appointments - > 50% - 10% increase, pending funding - 10% increase, pending funding - 5% increase (dependent on funding) - at least 1 proposal submitted - 5% improvement - 5% improvement - Community Paramedicine targets to be determined	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Frequent (4+) emergency department visits for help with	C	% / Mental health	CIHI NACRS / October 2023	13.80	13.14	KW4 OHT is targeting an approximate 5% overall	Cambridge Memorial Hospital, Camino Wellbeing + Mental

Mental Health and Addiction		patients All KW4 OHT residents who had at least four emergency department visits for mental health and/or addiction in a 365-day period.	- September 2024			performance improvement. Overall, in KW4 there has been a downward trend for this measure in FY 20/21 and 21/22. This was followed by an upward trend in FY 22/23. In 2023/24 we saw a downward trend which is continuing into 2024/25, however performance is still well above our target.	Health, Centre for Family Medicine FHT, City of Waterloo, CMHA Waterloo Wellington, Cambridge North Dumfries OHT, Coalition of Muslim Women of KW, Community Healthcaring KW, Community Care Concepts WW, Crow Shield Lodge, Engage Rural, Family and Children Services of Waterloo Region, Grand River Hospital Corporation, House of Friendship, Independent Living WR, Kinbridge, KW Habilitation, Langs, Muslim Social Services, Muslim Women of Cambridge, New Vision FHT, Ontario Health at Home, Porchlight Counselling and Addiction Services, ProResp, Ray of Hope, Region of Waterloo Paramedic Services, Region of Waterloo Public Health, Rhythm and Blues Cambridge, Sanguen, Somali Canadian Association of Waterloo Region,

							St. Mary's General Hospital, Starling Community Services, Sunbeam, The Working Centre, Thresholds Homes and Supports, Traverse Independence, Two Rivers FHT, University of Waterloo, Waterloo Region District School Board, Waterloo Region Integrated Drug Strategy, Waterloo Region NPLC, Waterloo Regional Police Service, Woolwich CHC, YMCA of Three Rivers

Change Ideas

Change Idea #1	In collaboration with the Waterloo Region MHA System Transformation Team and Primary Care consider the circumstances of individuals who are frequently visiting the ED for MHA, including a deeper dive in neighbourhoods that are disproportionally impacted, and implement strategies to address these gaps.		
Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- deep dive to consider the circumstances of individuals who are frequently visiting the ED for MHA conducted by FSA - % of chart reviews for patients with 10 or greater ED visits for MHA in a year - % of patients with greater than 10 visits who are asked to participate in longitudinal (cross sector) data sharing - % of patients that access ED via 911 response due to being unattached or lack of viable alternate care pathways	- deep dive complete - 80% of charts reviewed - 80% of patients asked - Baseline to be collected through Paramedic Services data	

Change Idea #2	In collaboration with the Waterloo Region MHA System Transformation Team 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.		
Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- governance structure established including a Strategy and Accountability Table, an Implementation Table, a Living and Lived Experience Table, and a Community Advisory Table - positions to support the HART Hub's initial launch identified - Scaled start-up initiated - # of partners providing service - # of referral pathways developed - # of clients served in 2025/26 - Submit proposal to become an approved Alternate Destination Clinic (ADC) for Paramedic Services 911 patients and include Paramedic Treat and Refer to system partners as part of the work.	- Tables/Committee established by Spring 2025 - all positions filled - Initial start-up on April 1, 2025 - > 12 partners providing service - core pathway developed by April 1, 2025 - target for # of clients served still be finalized - Review and analyze 911 patients that could be considered for ADC or Paramedic Treat and Refer and submit proposal	

Integrated Care - Transitions in Care

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care days expressed as a percentage of all inpatient days in the same period	P	% / People All KW4 OHT older adults with complexity that require coordinated care planning and all KW4 OHT patients designated ALC.	See Tech Specs / Oct 2023 to Sept 2024	17.80	17.00	KW4 OHT is targeting an approximate 5% overall performance improvement. KW4 has been performing better than the province on this measure from April 2023 to September 2024 with the exception of two months.	Alzheimer Society, Bayshore HealthCare, Bloom Care Solutions, City of Waterloo, Community Care Concepts WW, Grand River Hospital Corporation, House of Friendship, KW Habilitation, KW Seniors Day Program, Ontario Health at Home, ProResp, Region of Waterloo Paramedic Services, St. Mary's General Hospital, Sunbeam, New Vision FHT, Waterloo Region NPLC, Woolwich CHC

Change Ideas

Change Idea #1 Collaborate with Primary Care and Community partners to identify older adults with complexity that require coordinated care planning to prevent hospitalization and reduce ALC risk through early intervention and community support management.

Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual	Hospital - % of older adults, 70+ visiting the ED with a completed AUA screening -	Hospital - targets to be finalized ICT for Older Adults - >85% LEGHO - 350	

Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	% of high-risk older adults referred to GEM nurse/team - % of patients linked to appropriate community resources ICT for Older Adults - % of patients/care partners who indicate the ICT made them more confident in managing their health LEGHO - # of patients diverted safely back to the community with support initiated. DREAM - # of clients diverted safely home with respite and other supports initiated CHC - # of times social prescribing used to reduce isolation Naturally Occurring Retirement Communities (NORC) in Waterloo - # of time education is provided - # of NORC ambassadors in place - # of times service navigation is provided - increase in one's perceived ability to age at home - increased sense of belonging and connection to the community KW Seniors Day Program - regular sharing of capacity planning data to Ontario Health atHome to ensure day program spaces are allocated effectively and efficiently. Alzheimer's Society - % of times timely access to counselling, system navigation and other support provided in relation to DREAM and ALC. Ontario Health atHome - Ongoing use of the ED and admission avoidance protocol developed by OH atHome to support discharge from the ED and ED avoidance. KW Habilitation - Ongoing use of the NTG-Early Detection Screen for Dementia (NTG-EDSD) tool for the early detection screening of adults with an intellectual disability who are suspected of or may be showing early signs of mild cognitive impairment or dementia.	patients (based on base funding) DREAM - 100 clients per hospital/per year will be diverted safely home CHC -collecting baseline Naturally Occurring Retirement Communities (NORC) in Waterloo - 5-7 times - 3 ambassadors - 45 times - 80% agree or strongly agree - 80% agree or strongly agree KW Seniors Day Program - capacity planning on bi-weekly basis. Alzheimer's Society - 250 older adults per hospital/per year. Ontario Health atHome - Ongoing use of the ED and admission avoidance protocol. KW Habilitation - Annual screening of anyone over the age of 40.

Change Idea #2	Continue with programs that 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.		
Methods	Process measures	Target for process measure	Comments
This change concept has been included in the KW4 OHT 2025/26 Annual Business Plan. Progress towards the plan is monitored on a regular basis by the KW4 OHT Operations Committee and semi-annual progress reporting is provided to the KW4 OHT Steering Committee and KW4 OHT Members. In addition, this indicator will be added to the KW4 OHT Balanced Scorecard with quarterly reporting.	- # of patients participating in the Hospital to Home program - time to SPO service initiation for the H2H program - re-admission/ED visit rate for those in the H2H program - % of ALC leading practices implemented by hospitals - expansion of Hospital to Home program to include Mental Health - Aging in Place program established at KW Habilitation - OH atHome Care Coordination will continue to be part of the multi-disciplinary team who develops care plans for discharge home and will continue to collaborate on determining the most appropriate programs that will support safe discharge. - Paramedic Services / Community Paramedicine support for discharge planning / ER Rounds, home visits and remote patient monitoring to keep patients safely at home post discharge - # of patients diverted back to the community through the Home At Last program - # of patients supported through Home At Last service coordination	- 20 patients/ month - same day - less then 12% - TBD - program expanded to include MH - Aging in Place program established - Development of care plans - support from Paramedic Services - 220 patients diverted back to the community through the Home At Last program - 220 patients supported through Home At Last service coordination	