KW4 ONTARIO HEALTH TEAM

Report to
Steering Committee

EXECUTIVE DIRECTOR

APRIL 2024

Ashnoor Rahim
Executive
Director

GENERAL UPDATES

GOVERNANCE

Strategic Planning

Work on the development and approval of KW4 OHTs inaugural strategic plan continued during the month of April.

The Strategic Plan has been built by our Members, key stakeholders and the communities we serve. The plan identifies how we will transform together over the next five years for everyone's benefit.

Please stay tuned for our official launch in May 2024!

KW4 ONTARIO HEALTH TEAM
KITCHENER | WATERLOO | WELLESLEY | WILMOT | WOOLWICH

TRANSFORMING TOGETHER
STRATEGIC PLAN 2024-2028

GENERAL UPDATES

COMMUNITIES AND STAKEHOLDER WORK

RAP Clinic Early Successes

The Rapid Access Primary Care Clinic (RAP), located at Community Healthcaring KW, provides a vital service for individuals without a primary care provider who frequently seek routine care at the Emergency Department for routine care.

This initiative, which is proudly sponsored by KW4 OHT, is in alignment with KW4 OHT's strategic priority of transforming our health and wellness system to ensure people can access the right care, at the right time, and in the right place. Partners include:

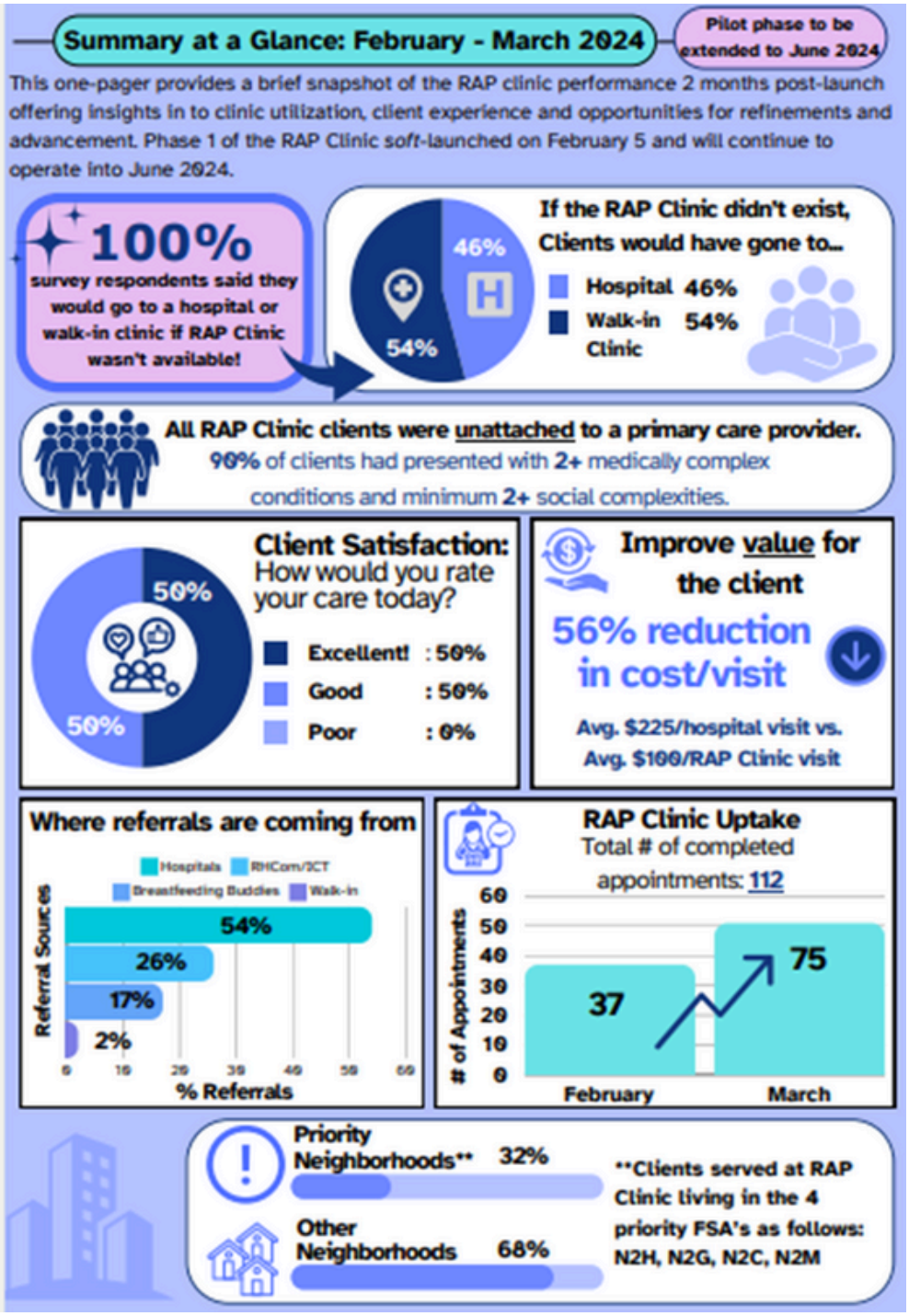
- Blue Heron Midwives
- Community HealthcaringKW
- Genesis Midwives
- Grand River Hospital
- KW Midwifery Associates
- St. Mary's General Hospital
- Reception House
- Regional EMS,
- Sanguen Outreach – Mobile Bus,
- The Neighborhood Nursing Team – Region of Waterloo Public Health
- The Working Centre Outreach,
- Traverse Independence - ABI on the Streets,

We are thrilled to share some early successes being realized by the pilot program.

GENERAL UPDATES

COMMUNITIES AND STAKEHOLDER WORK

RAP Clinic Early Successes



GENERAL UPDATES

COMMUNITIES AND STAKEHOLDER WORK

New Hospital to Home Programs

Grand River Hospital and St. Mary's General Hospital have both launched new and innovative hospital to home programs. This work is in direct alignment with two of KW4 OHT's new strategic priorities:

- Integrate services across health and social partners to serve the needs of our community
- Transform our health and wellness system to ensure people can access the right care, at the time, and in the right place

These programs allow patients to transition safely and receive care in their homes, freeing up hospital beds while helping patients to continue to heal and recover more quickly, while other longer-term community-based services are arranged. This model also reduces the risks of functional decline, delirium, pressure injuries, and hospital associated infections that can be associated with prolonged hospital stays.

These initiatives are funded by Ontario Health and include partnerships with Bayshore Integrate Care Solutions, Bloom Care Solutions, Community Care Concepts, Home and Community Care Support Services, KW4 OHT, St. Joseph's Health System, and St. Joseph's Home Care.

You can read additional information on these two programs at SMGH program, GRH program.

GENERAL UPDATES

COMMUNITIES AND STAKEHOLDER WORK

Innovative Healthcare Solutions in Partnership with the University of Waterloo

KW4 OHT is grateful to partner with the University of Waterloo, regional hospitals and health care partners on innovative solutions to pressing challenges.

This is consistent with KW4 OHT's values of Partnerships, Adaptability and Accountability, and the strategic goal to spearhead the development of new and innovative approaches to care delivery, using a system thinking approach and leveraging local partnerships.

Made possible by the J.W. Graham Trust Endowment Fund, interdisciplinary teams will work on the following eight proposals:

- Good data housekeeping: Building data strategies to make Canadian hospitals AI-ready
- Newcomer app for health and social service navigation: A field study
- Improving door-to-needle time in acute stroke at Grand River Hospital
- Optimal operating room scheduling at the Cambridge Memorial Hospital
- Multisensory perception and control for robotic biohazardous material handling
- Pre-surgical appointment scheduling
- Enhancing senior care with social robots: A remote health monitoring initiative
- Quantifying skin thickness across populations to improve delineation of the skin during radiation treatment planning of breast and head & neck cancers

Additional information can be found at the following link.

GENERAL UPDATES

COMMUNITIES AND STAKEHOLDER WORK

The Newcomer App at the World Summit AI Americas 2024

The Newcomer App team participated in the World Summit AI Americas conference held in Montreal on the 24th and 25th of April 2024. The World AI Summit brought together a diverse group of global AI leaders from various fields.

The conference provided an opportunity to showcase the tremendous work that has been done in exploring and understanding newcomer needs through a co-design model and the use of the Capability Sensitive Design which led to the development of a prototype for the Newcomer App. The demos of the prototype were demonstrated at the team's booth at the conference and the team provided information about the Newcomer App to those that visited the booth.

KEY AND EMERGING ISSUES

HEALTH SYSTEM UPDATES

Ontario Health's Social Determinants of Health (SDoH) Framework

This month, Ontario Health released the SDoH framework. This framework was developed through extensive research and consultations and includes eight key evidence-based principles.

The framework is intended to shift the focus from managing illness to creating wellness and to deal with the underlying health inequities and root causes that hold illness in place.

The aim of the framework is to support a paradigm shift where social needs are incorporated into care planning, at both the individual and population level. Accompanying resource guides for each of the eight principles, that will provide tangible examples and resources to action each one, will be shared once finalized.

In line with KW4 OHTs strategic goal of collaborating with community organizations to address local social determinants of health challenges, this year KW4 OHT will review the framework and accompanying resource guides and identify opportunities with Members where we can apply this framework in our population health framework.

Ontario Health's Social Determinants of Health Framework... A Paradigm Shift

Ontario Health

KEY AND EMERGING ISSUES

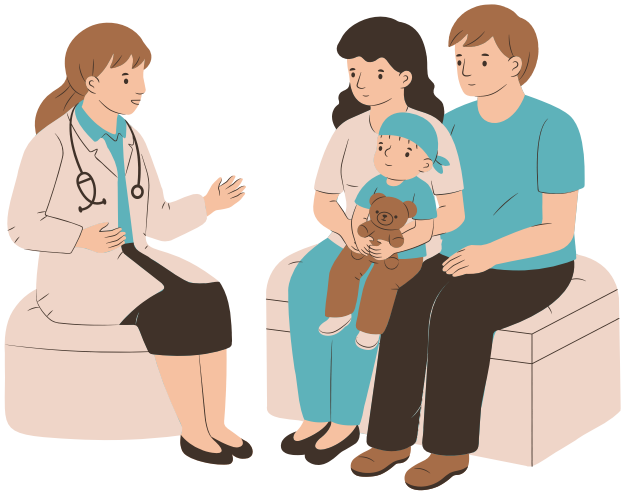
PROGRESS AND RESULTS

Primary Care Attachment

As of April 5, 2024, 6,736 patients in KW4 have registered for the HealthCare Connect Program in search of a primary care provider. This is 8.4% higher than last quarter (6,217 on December 4, 2023) and 35.0% higher than almost a year ago (4,990 on June 1, 2023).

2,084 (previously 1,870) of the registered unattached patients are from our 4 priority neighbourhoods. These neighbourhoods represent 18% of KW4's population but 31% of patients registered with Health Care Connect. This percentage is slightly above the last quarter (30%).

This year, Members of the KW4 OHT will continue to look for opportunities to provide services to unattached patients as per the KW4 OHT's strategic goal of improving access to primary care and team-based models of care.



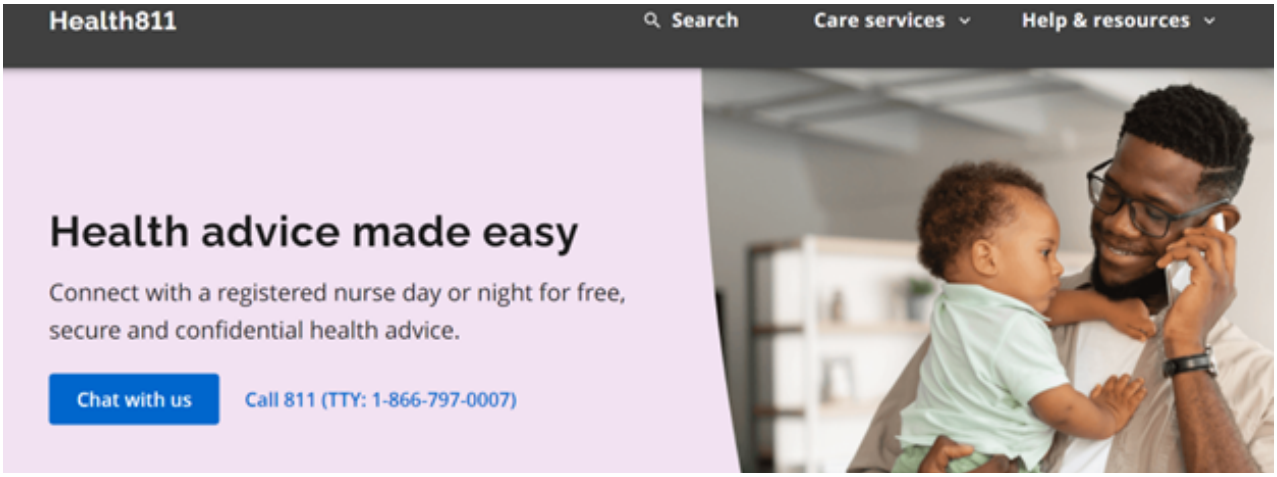
DIGITAL HEALTH UPDATES

SYSTEM NAVIGATION

Health811 Roadmap Ideation Sessions and Upcoming Enhancements

In April, KW4 OHT attended the Health811 2025-2026 Ideation session which helps Health811 outline future product features and functionality for how the service will evolve. Partners from across the province and different sectors, including patients, were brought together to provide feedback about Health811 and have discussions about gaps in the health care system.

If you have any questions or additional feedback about Health811, please contact health811program@ontariohealth.ca



DIGITAL HEALTH UPDATES

SYSTEM NAVIGATION

For this current fiscal year, the release plans for Health811 include the following features and enhancements.

Feature	Description
Gender Question Enhancement	We will update the dropdown menu/options for gender-related questions across the Health811 service.
Online appointment Booking	We will integrate an online appointment booking platform that allows Health811 advisors to book appointments for patients at virtual urgent care clinics across Ontario.
Provincial Health Services Directory Integration	We will integrate the provincial health services directory, a consolidated feed of all health services available across the province, into Health811 so users of Health811 can more easily find services in their community.
Knowledge Hub Structural Program Enhancement	We will refresh Health811's "Knowledge Hub" to improve how users navigation information about the Health811 service.
Ontario Breast Screening Program Enhancement	We will add the Ontario Breast Screening Program to Health811. Additionally, staff will receive additional training to be able to discuss the harms and benefits of breast screening with people age 40 to 49.
Secure Patient Access	We will provide a secure method for patients to authorize their identity to enable access to different features of Health811 and other provincial tools, such as the Provincial Patient Viewer.
Provincial Patient Portal Integration	We will create a main access point for the provincial patient viewer so people in Ontario can see common and unified data related to their drugs and lab results.
Interaction Records Sent to Primary Care Providers	We will securely transfer notes from Health811 to primary care providers following the Health811 interaction.

SYSTEM NAVIGATION

eReferral

In April, the St.Mary's Cardiodiagnostic Services went live on eReferral. This department provides comprehensive cardiac testing and imaging including; echocardiography (e.g. transthoracic echodardiogram), electrocardigrpah (e.g. holter monitoring), and cardiac stress testing (E.g. treadmill stress test), working in conjunction with the Arrhythmia, Device and Heart Function Clinics.

Moving these referrals from paper to electronic will positively impact the region as referrals can be sent from both primary care and specialists and help increase referral volumes.
To find out more about the clinic, including who can be referred, please visit the St.Mary's Website.

The objective of the Newcomer App project is to develop an app to improve Newcomer's ability to self-navigate local health and social services with accurate, up to date information. Our goal is to empower Newcomers to better participate in their own health and wellness journey and help guide them to the most appropriate care and support for their given circumstance, 24 hours a day, 7 days a week, in the language of their choice.

Executive Sponsor: Dr. Charmaine Dean, University of Waterloo
Project Lead: Dr. Catherine Burns, University of Waterloo
Project Manager: Aderonke Saba
Report Due Date: April 26, 2024

Overall Status		
	Status	**Comments (Comments required for a Yellow or Red Status)**
Scope		
Schedule		
Budget		
Quality		
Legend	On Track	At Risk	Serious Concerns

Milestones	**Legend**	**On Track**	**At Risk**	**Overdue**	**Complete** ✓

#	Project Milestone	Status	Target Due Date (yyyy/mm/dd)	Revised Date (yyyy/mm/dd)	% Complete	Comment
1	Approval of Project Charter	✓	2023/05/18	2023/06/30	100%	Completed.
2	Project Kickoff	✓	2023/01/23	NA	100%	Completed.
3	Project Agreement/ signed MOU by KW4 OHT and University of Waterloo	✓	2023/03/01	NA	100%	Completed.
4	Ethics Approval	✓	2023/05/03	NA	100%	Completed.
5	Interview data findings/ outcomes	✓	2023/10/31	NA	100%	Completed.
6	Co-design findings/ Design document	✓	2023/12/30	NA	100%	Completed.
7	Initial Prototype design	✓	2024/01/31	NA	100%	Completed.
8	Prototype Evaluation report	✓	2024/04/30	NA	100%	Completed. The prototype evaluation was conducted with 10 newcomers and 10 organizations.
9	Revised Prototype design	✓	2024/05/31	NA	100%	Completed.
10	Hire Software development company/Programmer	✓	2024/01/01	NA	100%	Completed.
11	App Development	✓	2024/04/30	NA	100%	Completed. The App prototype has been developed.
12	Quality Assurance and Testing		2024/05/31	NA	70%	The prototype is being optimized to improve efficiency once deployed.
13	Deployment and Support		2024/12/30	NA	0%	
14	Field Evaluation of App		2024/12/30	NA	20%	Ethics extension was received for the project however ethics amendment to include the field study is under development.
15	Phase 1 and 2 Project Closeout	✓	2024/04/21	NA	100%	Transition plan to Phase 3 (field evaluation) completed.

The Neighborhood Integrated Care Team (NICT) project seeks to develop and implement a NICT model to improve access to health services and proactively support community members thereby preventing unnecessary emergency department visits and potential hospitalizations. The main objectives of the project are:

- Determine use of resources in the communities we serve to improve health outcomes
- Develop and implement NICT model to improve access to health services and support high-risk seniors and adults
- Improve overall access to community Mental Health & Addiction services

Executive Sponsor: John Neufeld, House of Friendship
Project Lead: Dauda Raji, House of Friendship
Project Manager: Aderonke Saba
Report Due Date: April 26, 2024

Overall Status		
	Status	**Comments (Comments required for a Yellow or Red Status)**
Scope		
Schedule		
Budget		
Quality		
Legend	On Track	At Risk / Serious Concerns

Milestones — **Legend**: On Track | At Risk | Overdue | Complete ✓

#	Project Milestone	Status	Target Due Date (yyyy/mm/dd)	Revised Date (yyyy/mm/dd)	% Complete	Comment
1	Approval of Project Charter.	✓	2023/05/31	2023/11/30	100%	Completed.
2	Formalize memorandum of Agreement between KW4 and project sponsor, House of Friendship.	✓	2023/02/01	NA	100%	Completed.
3	Establish project Leadership Advisory Committee (LAC)	✓	2022/12/01	NA	100%	Completed.
4	Develop Patient Personas, Journey Maps, and Integrated Care Pathways (ICPs).	✓	2023/06/20	2023/07/14	100%	Completed.
5	Develop a Neighborhood Integrated Care Team Model for Newcomers and Residents in priority neighborhoods		2023/12/31	2024/04/30	80%	The second session of the Diabetes Fit Program is in progress.
6	Develop Social Prescribing model for the project.	✓	2023/12/31	2024/04/30	100%	Completed. Diabetes Pathway- Incorporation of diet education and exercise for clients with Pre-diabetes and Type 2 diabetes.
7	Deployment of digital enablers for service providers to efficiently and effectively coordinate patient care on the project.	✓	2023/12/31	NA	100%	Completed.
8	Establish project implementation team(s).	✓	2023/06/23	2023/12/31	100%	Completed.
9	Complete detailed implementation plan	✓	2023/07/07	2024/02/31	100%	Completed.
10	Complete project logic framework including indicator matrix and performance measures.	✓	2023/07/07	NA	100%	Completed.
11	Develop a communication strategy for the project.	✓	2023/08/28	2023/12/31	100%	Completed.
12	Conclude evaluation of effectiveness and efficiency of the NICT model.	✓	2024/04/30	NA	100%	Completed. Key Performance Indicators were measured and tracked through the detailed project status report.

13	Initiate formal closeout processes.	✓	2024/04/30	NA	100%	Completed. The NICT Project Leadership Action Committee held its lessons learned and closeout meeting on March 28, 2024. Some of the achievements during the project include; • Creation of patient personas with a focus on our priority population and area of greatest need in KW4. • Creation of journey maps for the patient personas highlighting their needs, touchpoints, challenges, emotions, and possible solutions to the gaps within the first 2 years. • Development of 3 Integrated Care Pathways through co-design with community members and representatives from various health and social organizations. • Awareness creation about Self-referral to Diabetes Education Programs in KW4 • Roll-out of 2 sessions of Diabetes FIT program in collaboration with the YMCA of Three Rivers. • Conducted exploratory research with youths through various youth programs run by different organizations to identify the needs and barriers around mental health support for youths. • Service mapping of the community resources and mental health services available to youth and young adults in the priority neighborhoods.

The Primary Care Integration and Governance Project aims to support primary care providers to better lead, participate and co-design health system integration activities with a patient-first focus. This project also aims to increase overall access to preventative care with a focus on reducing inequities for individuals in our priority populations.

Executive Sponsor: Dr. Sarah Gimbel, New Vision Family Health Team
Project Lead: Dr. Neil Naik, Regional Primary Care Lead
Project Manager: Rebecca Petricevic
Report Due Date: April 26, 2024

Overall Status	
Status	**Comments (Comments required for a Yellow or Red Status)**
Scope	
Schedule	
Budget	
Quality	

Legend On Track | At Risk | Serious Concerns

Milestones **Legend** **On Track** | **At Risk** | **Overdue** | **Complete** ✓

#	Project Milestone	Status	Target Due Date (yyyy/mm/dd)	Revised Date (yyyy/mm/dd)	% Complete	Comment
1	Approval of Project Charter	✓	2023/04/30	2023/09/19	100%	
2	Project Agreement/MOU signed by KW4 OHT and New Vision FHT.	✓	2023/01/10	NA	100%	
3	Project Planning and Project Kick-off	✓	2023/04/30	NA	100%	
4	Environmental Scan Complete	✓	2023/04/30	NA	100%	
5	Primary Care Network Development/ Governance Consulting report complete	✓	2023/04/30	2023/07/30	100%	
6	Preventative Cancer Screening initiatives implemented	✓	2024/03/29	2024/04/19	100%	The GRT ad campaign completed. The estimated non-unique reach was 7.5 million impressions. The Poppy Bot pilot implementation continues and will be led by the eHealth Centre for Excellence. New initiatives focusing on increasing access to preventative screening have been identified as part of the OHT's commitment to the 2024/25 cQIP.
7	Clinician Engagement initiatives implemented	✓	2024/01/31	2024/03/29	100%	
8	Primary Care Network developed		2024/03/31	2024/06/14	65%	Bylaws have been revised and sent back to legal counsel for review. Board recruitment strategy and member recruitment strategy are in development.
9	Care pathways initiatives implemented	✓	2024/01/31	NA	100%	
10	Community Support Service Navigation		2024/03/31	2024/08/31	65%	All primary care providers in Medical Building 1 of the Boardwalk will be onboarded by the end of April. Medical

						Building 2 will be next. Discussions regarding how to improve the connection with Home and Community Care and reduce primary care provider burden continue.
11	Interim Evaluation Report complete	✓	2024/02/29	NA	100%	
12	Sustainability Plan developed	✓	2024/03/29	NA	100%	
13	Identify opportunities to scale and spread to other providers and to other neighbourhoods	✓	2024/02/29	NA	100%	
14	Project Closure/Lessons Learned		2024/03/31	2024/04/30	50%	