EXECUTIVE DIRECTOR

DECEMBER 2023

Ashnoor Rahim
Executive
Director

GENERAL UPDATES

OUR KW4 OHT TEAM

Team Update

Join us in welcoming KW4 OHT's newest team member, Shaz Rahaman, who will be our Communications Coordinator for the next year, while Nichola Harrilall is on maternity leave. In this role, she will be supporting KW4 OHT with tasks such as communication strategy implementation, social media campaigns, newsletters, and supporting the projects and initiatives from a communications perspective.

We are happy to have Shaz as part of our team and know we will benefit from her knowledge and expertise in marketing and communications.

GOVERNANCE

<u>Strategic Planning</u>

On December 7, 2023, the KW4 OHT held a Strategic Planning event at RIM Park in Waterloo. Over 70 people attended the event including Leaders and Board Representatives from Member organizations, Partner organizations, Ontario Health, and community members.

Cathy Harrington and Ron Gagnon, the co-chair of the KW4 OHT Steering Committee, discussed the evolution of Ontario Health and Ontario Health Teams, the priorities OHTs will be required to deliver on over the next several years as part of their transfer payment agreements, work we have already started in this regard, and the importance of working together to enhance patient experience, improve population health, enhance provider experience, improve value, and advance health equity in our community.

Participants ranked mandated Ontario Health priorities and discussed their alignment with local needs and their organizational priorities.

Following the event, the Strategic Planning Working Group began engaging in smaller group discussions to allow for additional feedback. These sessions will continue until mid-January. The information gathered from these sessions will help inform our second planning session at the end of January. In March, the penultimate strategic plan will be shared for feedback and in April we will seek approval of the final plan.

GOVERNANCE

Strategic Planning

COMMUNICATION HIGHLIGHTS

Know Your Care Options

The Waterloo and Wellington region hospitals, in partnership with the Ontario Health Teams - KW4, Cambridge North Dumfries, and Guelph Wellington - partnered to create a Know Your Care Options website and guide to help our communities know where to go to get the right care at the right time. The KW4 OHT was proud to be a partner in supporting this website go-live and campaign that was released in early December.

Please visit the knowyourcareoptions.ca to learn more and the local Student Health and Walk-In Clinic contact information can be found here on the KW4 OHT website (under the Resources tab).

If you have any questions or would like more information, please contact: Kara Weiler (she/her), Integrated Communications Director, Grand River Hospital & Foundation at 226.751.6508

COMMUNITIES AND STAKEHOLDERS WORK

Clinician Summit

The Clinician Summit held at the end of November encouraged discussions and idea generation for consideration in our region. Building on this input we have connected with our OHT members to provide them with feedback, themes, and potential solutions. Discussions have begun with Grand River Hospital, SCOPE, and the Mental Health and Addictions Advisory Group to determine opportunities to implement the feedback received.

Some of the key themes that arose from these discussions include:

- Pursuing regional approaches to common challenges – e.g. regional-wide locum and shared on call schedule
- Centralized referral for mental health/increasing provider awareness
- Virtual care options for mental health care (i.e. psychiatry)
- Sharing existing resources and access to team-based care
- Patient choice/preference and patient education
- Wrap around supports embedded into care plans for patients who have experienced or received life altering diagnoses (e.g. cancer, post-cardiac arrest)

A full report of the event will be circulated shortly.

COMMUNITIES AND STAKEHOLDERS WORK

Clinician Summit

PERFORMANCE

Primary Care Attachment

Ontario's acting Auditor General report which was released on December 6, 2023, indicates that patients who do not require emergency care, but lack timely access to primary care, contribute to long wait times. The report also noted that one in five emergency visits involved patients who went to emergency for non-urgent issues because they did not have access to a family doctor or other services.

A report by the Ontario College of Family Physicians last month indicated that last year, 2.3 million Ontarians didn't have a family doctor, which will increase to 4.4 million by 2026.

As of December 4, 2023, 6,217 patients in KW4 have registered for the Health Care Connect Program in search of a primary care provider, slightly higher than last quarter (6,025 on September 5, 2023) and significantly greater than a year ago (4,907 on December 1, 2022).

1,870 of the registered unattached patients are from our 4 priority neighbourhoods. These neighbourhoods represent 18% of KW4's population but 30% of patients registered with Health Care Connect. This percentage has remained unchanged since the last quarter.

PERFORMANCE

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 three of our performance measures (caregiver distress among home care clients, hospitalization for ambulatory care sensitive conditions and alternate level of care (ALC) days.

KW4 OHT is not meeting the target set for one of our performance measures although we have seen a slight improvement since last quarter (frequent emergency room visits for mental health and addictions).Almost 45% of the frequent ED visits for MH&A care from KW4 residents are from people who live in our priority neighbourhoods even though they make up less than 20% of our population.Conversely, approximately 55% of the visits are from people in the KW4 region who reside outside of our priority neighbourhoods even though they make up more than 80% of our population. This is a good example of why our priority neighbourhoods remain an important area of focus for our OHT.

Table 1 below provides a summary of this quarter's performance.

#	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	%	Sep 2023	<= 56%	53.3%	Green	Slippage from 50.9%
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	Aug 2023	<= 20.4 monthly (61.2 quarterly) (244.8 annually)	16.1	Green	Significant Improvement from 20.8
3	Total ALC (Acute and Non-Acute)	%	Sep 2023	<=16.7%	15.7%	Green	Slippage from 13.7%
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Sep 2023	<=10.0%	15.3%	Red	Slight Improvement from 15.5%

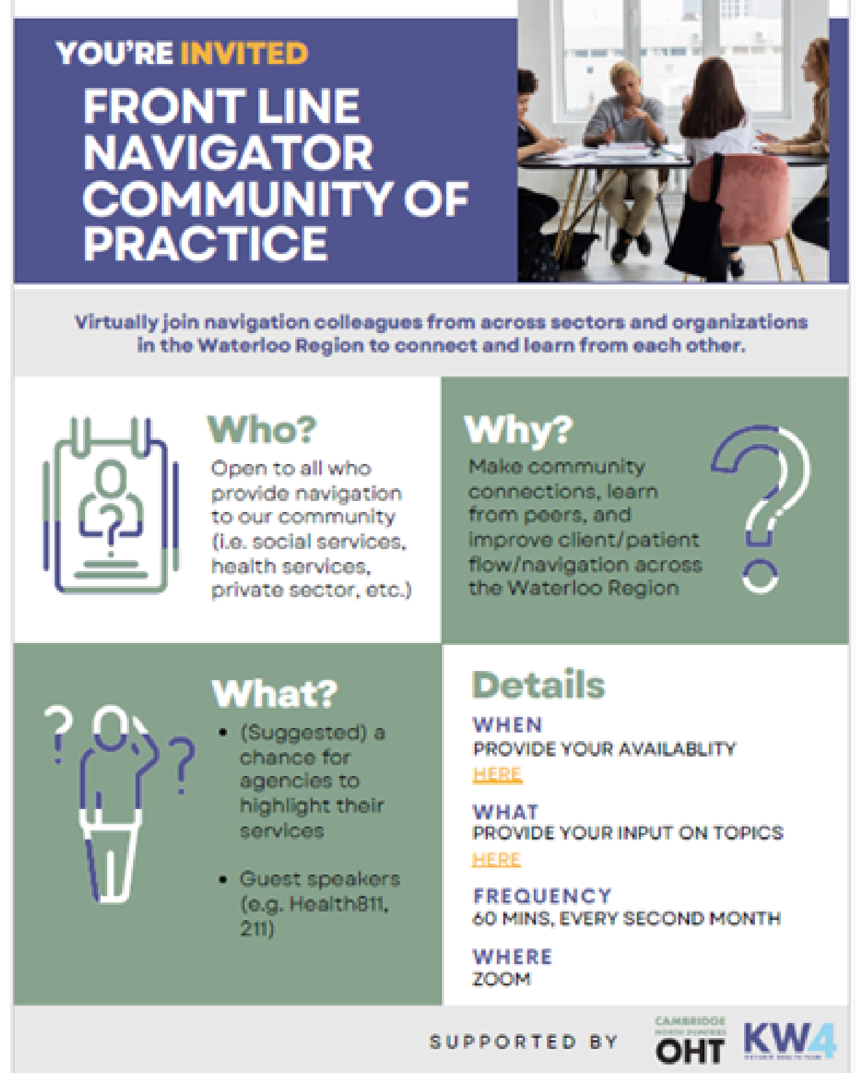
Performance Corridors: Red: Greater than 10% of Target; Yellow: Within 10% of Target; Green: Meets Target

The full report, including contributing factors and initiatives currently underway, or planned for the near future is available here.

DIGITAL HEALTH UPDATES

Front-Line Navigator Community of Practice (CoP

The flyer (below) and invite to participate in the in-development Front Line Navigator Community of Practice was circulated to members and sent to navigators across the KW4 OHT and CND OHT. Feedback on topics of interest have begun to be received which will help support the future agendas for this Community of Practice.



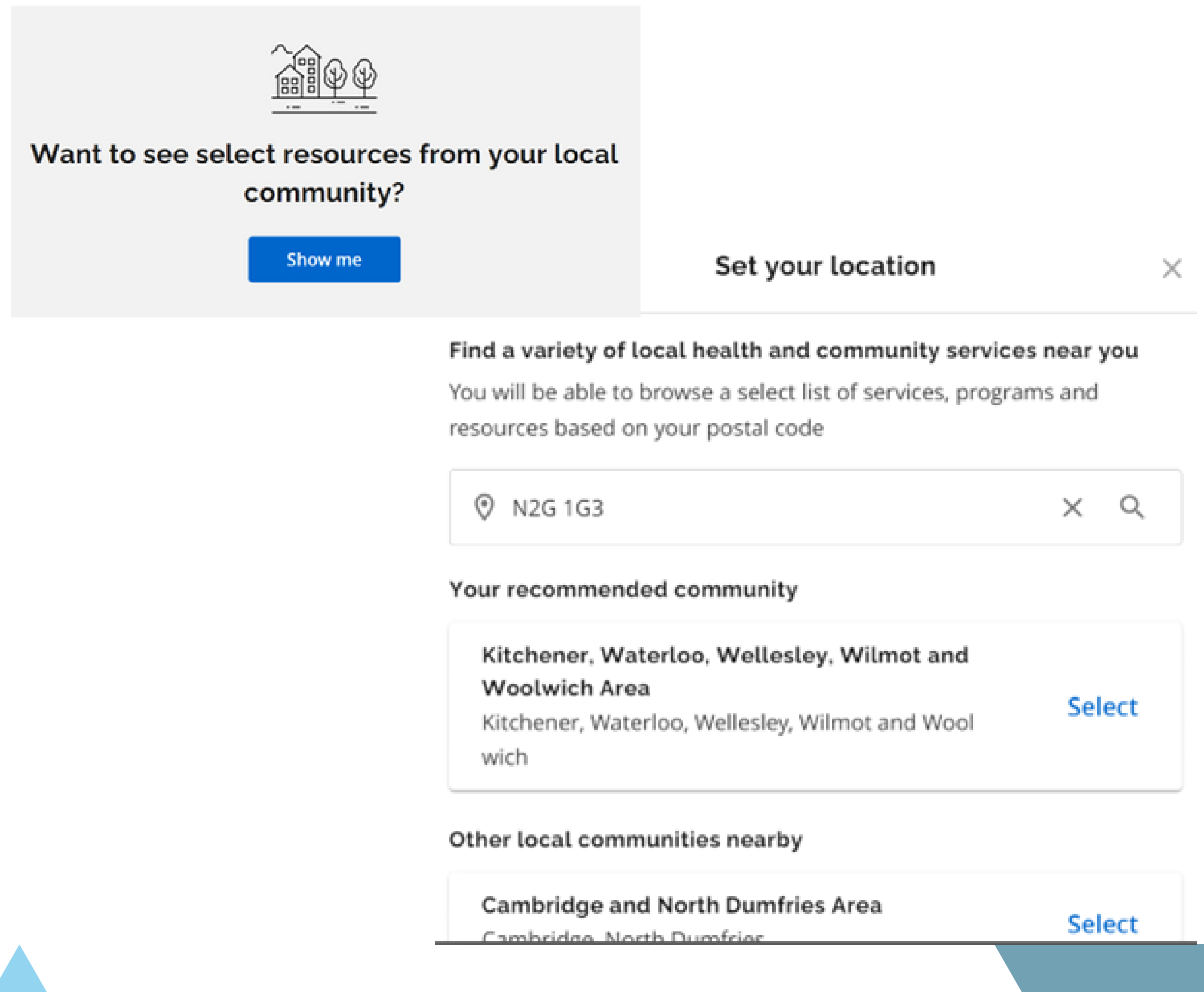
DIGITAL HEALTH UPDATES

System Navigation

Health811

As you may recall during the summer of 2023, the KW4 OHT sought feedback from members regarding the local content that would be made available on the provincial Health811 website. Over the fall months, the provincial Health811 team added all the Ontario Health Teams content to the provincial website. As of December 1st, the KW4 OHT local content is now live for patients and the community to access.

To review this information, please visit Health811 and scroll to the middle of the webpage, select 'show me' and enter your postal code. A list of local communities will populate as seen below, as well as other communities nearby, such as our neighbours in CND OHT. Once the community is selected, the local content 'tiles' will appear on screen for you to access and select local information and services.



DIGITAL HEALTH UPDATES

System Navigation

Health811, cont'd

The KW4 OHT joined OHT's from across the province in a lunch and learn on December 13th hosted by the province Health811 team to see a live demo of the OHT content, review current product issues that are being addressed, understand how the content will be managed by Ontario Health now, and by the OHT's in the future, and future content related roadmap updates regarding Health811. The Health811 team has indicated that they will be moving forward with implementing a content management system (CMS) for the next round of updates (will not be in place until Q2/Q3 of next fiscal year). This will allow OHTs to have more direct control over their content in the future.

Online Appointment Booking

At the end of November, KW4 OHT participated in the Ontario Health West Online Appointment Booking Community of Practice hosted by Ontario Health. The Ontario Health provincial team, along with OHT representatives from across OH-West reviewed pain points and opportunities related to the reporting deliverables of this fiscal year's OAB funding. The group disused lessons learned, and members were able to leverage tips/tricks to share with the OAB participating sites.

Newcomer App Project Status Report

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: December 18, 2023

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	90%	Leadership Action Committee meeting held on December 5th, 2023. Information about prototype features for the app was shared. The next few weeks will be focused on streamlining and collaborating with organizations to determine content for the app. Conversation is still ongoing about the translation piece of the app. The design document for the prototype is also in its final stages.
7	Initial Prototype design		2024/01/31	NA	40%	The Prototype demo (wireframe) is being refined based on the features shared at the LAC meeting.
8	Prototype Evaluation report		2024/04/30	NA	10%	Posters for the recruitment of participants to the prototype evaluation phase were translated and printed. Recruitment for this phase is ongoing.
9	Revised Prototype design		2024/05/31	NA	0%	
10	Hire Software development company/Programmer		TBD	NA	0%	
11	App Development		TBD	NA	0%	
12	Quality Assurance and Testing		TBD	NA	0%	
13	Deployment and Support		TBD	NA	0%	
14	Field Evaluation of App		TBD	NA	0%	
15	Project Closeout		TBD	NA	0%	

Neighborhood Integrated Care Team Project Status Report

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: December 18, 2023

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

Milestones — Legend: On Track (Green) · At Risk (Yellow) · Overdue (Red) · 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%	Project Charter was approved at the Leadership Action Committee meeting that held on November 30. 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	Green	2023/12/31	NA	70%	The top languages in KW4 were identified and Voyce was used in the translation of the Diabetes self-referral poster to the languages. Had a meeting with YMCA of Three Rivers to determine the strategy and roll-out of the Diabetes Fit program in the priority neighborhoods.
6	Develop Social Prescribing model for the project.	Green	2023/12/31	2024/03/31	60%	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.	Green	2023/12/31	NA	50%	Progress with this milestone dependent on formation of project implementation teams.
8	Establish project implementation team(s).	Green	2023/06/23	2023/12/31	50%	Collaborating with Regional Coordination Centre and House of Friendship to implement the creation of awareness to the Diabetes Central Intake Program. A MH&A Working Group has been developed to identify and lead implementation of pilot initiatives for the Youth transitions to Adult Mental health Services Pathway.

9	Complete detailed implementation plan		2023/07/07	2023/01/31	30%	A work plan for the initiatives piloted through the Diabetes Pathway has been developed.
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%	The communication strategy/plan document has been developed. Completed.
12	Conclude evaluation of effectiveness and efficiency of the NICT model.		2024/03/31	NA	20%	Key Performance Indicators are being measured and tracked through the detailed project status report.
13	Initiate formal closeout processes.		2024/02/05	NA	0%	

Primary Care Integration and Governance Project Status Report

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: December 18, 2023

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

Legend: On Track (Green) | At Risk (Yellow) | Serious Concerns (Red)

Milestones

Legend: **On Track** (Green) | **At Risk** (Yellow) | **Overdue** (Red) | **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	Green	2024/01/31	2024/03/15	67%	Information session with Investing in Women's Futures program in partnership with YWCA and Community Healthcaring KW planned for Dec 19. Implementation Team working with Pattison Outdoor advertising on GRT ads. Poppy Bot pilot confirmed one clinic participation and another pending.
7	Clinician Engagement initiatives implemented	Green	2024/01/31	2024/03/15	67%	Follow up from Clinician Summit and resulting actions in progress. Next phase of newsletters in early planning stage.
8	Primary Care Network developed	Green	2024/03/31	NA	30%	Connected with East Toronto Health Partners to discuss their experience. Terms of Reference approved. Early discussions on Board composition, structure, and memberships composition initiated.
9	Care pathways initiatives implemented	Green	2024/01/31	2024/03/15	45%	

Primary Care Integration and Governance Project Status Report

10	Community Support Service Navigation		2024/03/31	NA	30%	eReferral pathway complete on Ocean. Soft launch began with three FHO primary care providers for early testing and debugging.
11	Interim Evaluation Report complete		2024/02/29	NA	25%	
12	Sustainability Plan developed		2024/02/29	NA	2%	Briefing Note to support LAC discussion in progress.
13	Identify opportunities to scale and spread to other providers and to other neighbourhoods		2024/02/29	NA	0%	
14	Project Closure/Lessons Learned		2024/03/31	NA	0%	
15	Final Evaluation Report complete		2024/04/30	NA	0%	