Chronic Disease Prevention and Management | Timely | Priority Indicator

Indicator #2

Emergency department visit as first point of contact for mental health and addictions–related care (Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT)

OHT Population: Marginalized populations in KW4

Last Year		This Year		
28.40	**26.30**	**27.90**	**1.76%**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continued roll-out of Ontario Structured Psychotherapy (OSP) to adults with depression and anxiety-related concerns. OSP services are based on cognitive-behavioural therapy approaches which teaches people how to change their patterns of behaviour and thinking.

Process measure

- - # of presentations to social service/health agencies - # of referrals - # of views of OSP referral page on partner agency websites - patient experience - % satisfied with the OPS program - Patient outcomes - pre and post measures (Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder Questionnaire (GAD-7))

Target for process measure

- - Provide referral presentations/resources to 15 Waterloo-based social service/health agencies by March 31, 2025 - Increase the number of Waterloo Region residents referred to OSP to 150% of the caseload for two FTE's by March 31, 2025 - Increase views of OSP referral page by 100% from 40 views per month to 80 views per month by May 1, 2024 - 80% of patients indicated they were very satisfied or satisfied with their experience with the OPS program - 70% of patients enrolled in the OSP program reported lower PHQ-9/GAD-7 scores after completing the program

Lessons Learned

Successes:
The OSP program continues to operate with great success in Waterloo Region. 685 WR residents received services through OSP with 280 (41%) receiving "high intensity" counselling services. This is over the period from October 2022 to September 2024. Wait time from initial referral to first appointment is approximately 7 weeks. Our two OSP therapists are both fully trained and maintain an expected caseload of 25 sessions per week. A fulsome clinical outcome report is not yet available from OSP West although preliminary data indicate outcomes consistent with industry standards. Traffic to the webpage has increased substantially with 85 views recorded during the past month. An important step forward during this reporting period is that we now have an OSP therapist located in each of our partner agencies, for at least one day per week. This meets our goal of providing this service across locations in Waterloo Region.
Challenges:
Our greatest challenge right now is that only 30% of Waterloo Region referrals are seen by one of our therapist. This is a challenge that is faced by all regions across Ontario as clients who are willing to receive virtual appointments are connected with the first available therapist. We have been working with OSP Administration to increase the proportion of local clients seen by our local therapists.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continue to explore the establishment of Youth Wellness Hubs that provide high-quality integrated youth services to support the well-being of young people aged 12 to 25, including mental health and substance use supports, primary health care, community and social supports, and more. The aim of this Community Collaborative is to offer a model that combines recreation, school support, mental health services, and connection, all designed with input from youth and led by the community.

Process measure

- - EOI for consultant issued and consultant hired - Approach to the wellness hubs initiative determined - Framework that meets the needs of Waterloo Region established - Proposal developed and submitted to the Ministry of Health - # and range of diverse group of agencies represented and participating in the planning, potential partnerships, etc.

Target for process measure

- - Consultant in place by April 15, 2024 - Approach and framework determined by September 30, 2024 - Proposal developed and submitted by March 31, 2025 - 150 people and 30 organizations/agencies engaged in process.

Lessons Learned

Successes:
The Student's Commission of Canada (SCC) successfully led the consultancy for this initiative between spring and fall 2024. Through their efforts, extensive community consultations were conducted, engaging youth, organizational leaders, and other community care-holders. While the timing of consultations did pose some obstacles in capturing a fully representative range of voices, the decision to proceed allowed us to maintain momentum and advance the work. SCC utilized a combination of events, one-on-one conversations, and feedback opportunities to gather valuable insights on setting principles and identifying community priorities. The consultations highlighted three priority focus areas:

- Access to opportunities
- Meaningful opportunities for youth to contribute
- Safer spaces where youth feel welcome

At the onset of SCC's engagement in Waterloo Region, it was determined that focusing on a single youth wellness model (e.g., YWHO, Planet Youth) would not serve the community's long-term needs. Instead, SCC adopted a holistic approach, developing a resilient framework that could adapt to and support any wellness model the community chooses to pursue. This flexible approach positions the community for sustained success in applying the framework across various initiatives.
The core of this work involved 19 organizations representing diverse focus areas, with broad engagement from over 30 organizations throughout the process. To ensure intergenerational representation and meaningful youth involvement, youth research assistants were hired to contribute directly to the process.
The outcomes of this initiative are significant. As a result of the consultations, three community applications were submitted to the National Youth Mental Health Fund, supported by a strong, adaptable framework that will guide future applications and initiatives.
Challenges:
Recognizing the importance of timely action, consultations were launched during the summer months despite potential challenges with participation due to seasonal availability.
Despite diverse engagement, there was limited representation from Indigenous organizations, which remains an area for future focus.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Improve care for individuals experiencing a mental health crisis through the opening of an integrated crisis centre and strengthen pathways from the centre to community resources to support ED diversion.

Process measure

- - # of patients diverted from the ED - # of walk-in clients - # of police drop-offs - # of ambulance drop offs - # of referrals - # of clients discharged from care

Target for process measure

- - Targets still to be established.

Lessons Learned

Successes:
Three months into its launch (July 30 – October 31, 2024), ICC has seen over 70 unique clients with varying mental health, substance use, and social determinants of health needs.
The ICC provides an open door, other than the Emergency Department, for extended-hour care for some of our most complex individuals in the Kitchener downtown area.
This program was launched with design help from our community partners, led by the Region of Waterloo, using existing CMHA WW staffing and the welcoming space provided in kind by Thresholds and then moving to downtown Kitchener—the existing site for Crisis, Peer Support, and Adult Intensive Services of CMHA WW. This consolidation of services allows the program to maintain operational hours for the ICC within a limited existing staffing complement.
In December 2024, ICC had the pleasure of hosting Minister Michael Tibollo, Ontario's Associate Minister of Mental Health and Addictions, for a tour. We were very proud of the front-line staff who showcased the facility and highlighted the program's value. Since that meeting, through Chair Karen Redmond's Office, we have sent in a refreshed copy of the full ICC proposal to include updated stats, and we are all working with Minister Tibollo's office to push for full funding for the ICC.
Hours of operation are Monday – Friday from 2:00 to 8:00p.m. We will continue to advance this model of care as we passionately believe providing this model to create an alternate option to the emergency department is needed in our community.
Challenges:
Along with many other health service providers, ICC is feeling the impact of chronic underfunding, increased costs, and growing complexity among clients. Unfortunately, no new funding has been received for this project to date. To realize this project as a full Alternate Destination Model, an unsolicited proposal for funding was submitted to the Ministry of Health.
ICC has also been working with the HART Hub partners to understand its relationship with the ICC model. It was communicated by Ontario Health that with the announcement of HART, no new funding pathways for an Alternate Destination Model would be available. Although we have worked out many ways for our community to have a "no wrong door" approach, the HART funding cannot be stretched to meet both the needs of the HART model and the ICC model—there simply is not enough funding to make this happen.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Launch on-site programming at Supportive Housing locations across the Region of Waterloo through the Supportive Housing Health Initiative (SHHI) Program. This team will include Nurse Practitioners, Peer Support Workers, and Addictions Counsellors who provide Primary Care and addictions care.

Process measure

- - MOU finalized - Staff recruited - Program launched

Target for process measure

- - MOU finalized by April 1, 2024 - Staff recruited by June 30, 2024 - Program launched and being successfully being delivered by December 31, 2024

Lessons Learned

Successes:
On site programming at YW Lincoln, YW Blockline, Charles St Village, Starling, OneRoof, SHOW & Bridges, building trust with participants, participants beginning to engage regularly

Challenges:
Each site has participants that attend who aren't actually struggling with health/mental health/addictions, instead want to talk/hangout (figuring out where to invest relationships, who needs service from SHHI, who would benefit to referral to other programs)

Change Idea #5 ☑ **Implemented** ☐ **Not Implemented**

Expanded Walk-in services at Counselling Collaborative of Waterloo Region.

Process measure

- - # of days walk-in available - waitlist times - utilization of service - # of individuals attending workshops while on waitlist

Target for process measure

- - Walk-in services expanded to 5 days per week - Waitlists for ongoing counselling reduced by an average of 10-days from 40 days to 30 days by March 31, 2025 - Walk-in utilization increased by an average of 20 individuals per week from 30 individuals per week to 50 individuals per week - 40 individuals attend a newly developed workshop deigned for those on the waitlist for counselling

Lessons Learned

Successes:
Adult Quick Response has been expanded to 5 days a week since June of 2024. As of January 2025, attendance at Adult Quick Response has increased from 30 individuals per week on average to 45 individuals per week on average, just short of the 50 individuals an overage per week target. Children and Youth Quick Response soft launched 5 days a week in November and full launch in January of 2025. Year end statistics will report on whether this increase has been effective with this population.
Between April 1, 2024 and January 2025, 1755 Adult Quick Response Sessions have occurred. This is a 50% increase over the prior fiscal year. Hope to achieve the goal of a 66% increase by March 31, 2025.

Challenges:
Despite the availability of Adult Quick Response 5 days a week, our waitlist numbers continue to be lengthy. Adult Quick Response has provided a timely service to meet immediate needs for those on waitlists, but has not had the impact of reducing waitlists as anticipated. The CCWR was not able to secure any additional fundings to implement workshops to address waitlist demands across the Region, despite applying to numerous grants. This goal of implementing workshops has been differed to 2025/26 fiscal year.

Change Idea #6 ☑ **Implemented** ☐ **Not Implemented**

Provide long-term housing alongside dedicated holistic direct support for individuals navigating a concurrent disorder and at risk of homelessness upon exiting incarceration through the Region of Waterloo and Justice Mental Health Project.

Process measure

- - # of supportive housing units provided through the program

Target for process measure

- - 6 dedicated subsidized apartment units secured and occupied by March 31, 2025

Lessons Learned

Successes:
AC fully staffed, 3 units currently filled, successful relationships with participant's wrap around supports

Challenges:
4-6 weeks to fill unit (from call-out to move-in day); waits between unit call outs (waits for units to become available)

Comment

A cross-OHT (KW4 and CND OHTs) MHA System Transformation Team ("STT") table has recently been formed with the aim of developing common goals and workplans to improve the MHA system across the region. The focus will be on continuous quality improvement initiatives related to Frequent Emergency Department visits for MHA-related care. The STT is being co-chaired by three organizations with deep cross-sectional knowledge of the MHA system alongside a community representative with lived experience. Grassroots organizations have also been engaged with the process and have joined the STT. This work will continue into 2025/26.

Chronic Disease Prevention and Management | Effective | Priority Indicator

Indicator #5

Percentage of screen-eligible people who are up to date with Pap tests (Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT)

OHT Population: Marginalized populations in KW4

Last Year		This Year		
58.50	**59.60**	**59.00**	**0.85%**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to increase public outreach and education through various channels and in various languages.

Process measure

- - # of presentations - # of audience members for presentations - # of languages material translated to - Reach of ad campaign

Target for process measure

- - 10 presentations - 800 audience members - 15 languages - Reach of ad campaign - TBD

Lessons Learned

Successes:
We participated in several in person events and had great conversations with a wide group of people. We engaged more people through building partnerships with groups like the Mental Health Outreach group at GRH. This group now includes sharing preventative cancer screening information in their outreach and ensures high risk patients receive preventative screening. Other hospital-based groups are considering a similar approach.
Participation in sharing circles and a PowWow were also successful with building awareness for indigenous populations.

Challenges:
Staffing - In person presentations are impactful but they are also an investment of time that can be challenging.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Keep abreast of the change for cervical cancer screening switching from cytology screening to HPV screening (currently slated for some time in 2025) and identify future improvement initiatives.

Process measure

- - timeliness of information shared

Target for process measure

- - Information will be disseminated in various forms to the appropriate audience within 1-month of receiving with opportunities to provide input and feedback given.

Lessons Learned

Successes:
Accredited physicians leading information sessions has led to a huge amount of registrations for the presentations. Physicians want to learn from their peers.
By announcing the changes to HPV screening for cervical cancer screening to no more than 1 or 2 months in advance, we have avoided a drop in screening rates. If physicians hear of a change in testing, they will stop conducting the old test until the new test is live.

Challenges:
Delays in timelines with information from OH/CCO makes planning and timing key messages challenging.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Explore cross-regional opportunities to collaborate on all 3 indicators.

Process measure

- - # of cross-regional opportunities identified and initiated by March 31, 2025.

Target for process measure

- - 2 cross-regional opportunities identified and initiated by March 31, 2025

Lessons Learned

Successes:
By pursuing this exploration, the OHTs and the Waterloo Wellington Regional Cancer Program have developed a more thorough understanding our region. Building the partnership across three OHTs with the WWRCP was also valuable.
Patients span across OHTs/Regions and holding an event in one can often benefit those OHTs around it as well (dependent on geography).

Challenges:
Competing pressures and varying levels of commitment to indicators can cause challenges when it comes to cross-OHT collaboration with a regional entity. It is important to set clear expectations and obtain commitment to shared goals early.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Continue to explore ways to leverage digital tools to assist patients and providers with screening (i.e. online appointment booking (OAB), Poppy Bot.)

Process measure

- Poppy Bot - # of patients contacted by Forward Sortation Area (FSA) OAB - # of providers offering Online Appointment Booking (OAB) - % of patient's overall satisfaction with OAB - % of provider's overall satisfaction with OAB - # of patients with access to book appointment online

Target for process measure

- Poppy Bot: - Target will be set after pilot evaluation is complete. If there is funding: - We aim to increase the number of providers offering OAB, by 5%, from 119 to 125 providers by March 31, 2025. - We aim to increase the percent of patient’s overall satisfaction with OAB, by 3%, from 87% to 90% satisfaction by March 31, 2025. - We aim to increase the percent of providers overall satisfaction with OAB, by 6.6%, from 75% to 80% satisfaction by March 31, 2025. - We aim to increase the number of patients with access to book appointments online by 4%, from 138,500 to 144,500 patients by March 31, 2025.

Lessons Learned

Successes:
In the fourth year of OAB implementation in KW4 OHT, we had 5 net new organizations implement online appointment booking for the first time, expanding the potential access to preventative screening appointments for patients.
Challenges:
Some participating sites had greater fluctuations in provider availability thus active licenses for some of our returning (sustainment) sites was lower than targeted.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Increase opportunities for unattached individuals to receive cervical screening through the addition of extra screening appointments each week and/or through the planning and implementation of collaborative cervical cancer screening clinics in various locations around the region.

Process measure

- - # of pap test administered to unattached patients - % of abnormal results from pap tests for unattached patients resulting in follow-up with an NP. - patient satisfaction with the clinic care

Target for process measure

- Targets will be set in early 2024/25 for this initiative.

Lessons Learned

Successes:
WR NPLC provided barrier-free access to breast, colon, and cervical cancer screening across the region. Anyone in the community—whether they have a healthcare provider or not—can book online with an RPN at any of their three sites. This program will continue through 2025.

Comment

KW4 OHT has been performing better than the provincial average for pap test rates for the last four and a quarter fiscal years. Although this measure will not be included the KW4 OHT 2025/26 cQIP we will continue to work with the Regional Cancer Program to advance this work.

Indicator #4

Percentage of screen-eligible people who are up to date with mammograms (Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT)

OHT Population: Marginalized populations in KW4

Last Year		This Year		
58.20	**61**	**54.50**	**-6.36%**	**57.20**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to increase public outreach and education through various channels and in various languages.

Process measure

- - # of presentations - # of audience members for presentations - # of languages material translated to - Reach of ad campaign

Target for process measure

- - 10 presentations - 800 audience members - 15 languages - Reach of ad campaign - TBD

Lessons Learned

Successes:
We participated in several in person events and had great conversations with a wide group of people. We engaged more people through building partnerships with groups like the Mental Health Outreach group at GRH. This group now includes sharing preventative cancer screening information in their outreach and ensures high risk patients receive preventative screening. Other hospital-based groups are considering a similar approach.
Participation in sharing circles and a PowWow were also successful with building awareness for indigenous populations.

Challenges:
Staffing - In person presentations are impactful but they are also an investment of time that can be challenging.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Explore opportunities to increase capacity at existing OBSP sites our area to handle the increased volume/demand.

Process measure

- - # of consultations held to identify opportunities to increase throughput - % of OBSP sties involved in consultations

Target for process measure

- - Conduct 4 consultations by March 31, 2024 - Received feedback from 70% of OBSP sites on opportunities for improvement

Lessons Learned

Successes:
The WWRCP continues to engage with local OBSP site leads on a regular basis to build relationships.

Challenges:
Due to the expansion of ages eligible for the OBSP program, we pivoted from the original change initiative to supporting the Waterloo Wellington Regional Cancer Program (WWRCP) and their efforts to share information and awareness regarding the expansion with the public and with primary care providers.

We invited the Breast Imaging Clinical Lead to speak at the KW4 OHT's Clinician Summit event and hosted an information booth to support awareness of the updates to OBSP and the new wait times website. We also included this information in our primary care newsletter to contribute to increased awareness within primary care.

Comment

KW4 OHT fell below the provincial average for mammogram screening rates beginning in Q1 2023/24. This trend has continued into 2024/25 Q1. Performance is also below the target established in the 2024/25 cQIP. KW4 OHT will continue to focus on this indicator in the 2025/26 cQIP.

Indicator #3

Percentage of screen-eligible people who are up to date with colorectal tests (Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT)

OHT Population: Marginalized populations in KW4

Last Year		This Year		
64.70	**65.40**	**64.70**	**0.00%**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to increase public outreach and education through various channels and in various languages.

Process measure

- - # of presentations - # of audience members for presentations - # of languages material translated to - Reach of ad campaign

Target for process measure

- - 10 presentations - 800 audience members - 15 languages - Reach of ad campaign TBD

Lessons Learned

Successes:
We participated in several in person events and had great conversations with a wide group of people. We engaged more people through building partnerships with groups like the Mental Health Outreach group at GRH. This group now includes sharing preventative cancer screening information in their outreach and ensures high risk patients receive preventative screening. Other hospital-based groups are considering a similar approach.
Participation in sharing circles and a PowWow were also successful with building awareness for indigenous populations.
Challenges:
Staffing - In person presentations are impactful but they are also an investment of time that can be challenging.

Comment

KW4 OHT has been performing better than the provincial average for colorectal screening rates for the last four and a quarter fiscal years, however as of Q1 2024/25 we were slightly below our target established in our 2024/25 cQIP. Although this measure will not be included the KW4 OHT 2025/26 cQIP we will continue to work with the Regional Cancer Program to advance this work.

Integrated Care - Transitions in Care | Efficient | Priority Indicator

Indicator #1

Alternate level of care days expressed as a percentage of all inpatient days in the same period
(Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT)

OHT Population: Marginalized populations in KW4

Last Year		This Year		
19.30	**17.40**	**17.80**	**7.77%**	**17**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Launch the St. Joseph's Home Care Hospital to Home Program to help adults who no longer require hospital care to continue their recovery, healing, and rehabilitation at home, while other longer-term community-based services are arranged.

Process measure

- - # of patients participating in program - # of patients enrolled PRIOR to ALC designation - % of patients who indicated they were very satisfied or satisfied with their experience - # of ED visits with patients enrolled in program - # of readmissions

Target for process measure

- -20 patients per month enrolled starting April 2024 -By March 31, 20025 we will have seen a 10% decrease in ALC LOS for patients in the categories of Home with CCAC and Retirement Home with Supports

Lessons Learned

Successes:
-~175 patients enrolled as of Q3 24/25
-100% acceptance rate of referrals from our SPO with 0.8 days to service initiation
-2 streams have been implemented in this program: A 21 day bridging program, that allows for OH atHome to more fulsomely plan longer term care plans while patients wait at home and an up to 16 week Frail elderly stream that targets the frail seniors population, providing restorative services to help retore independence.
-More than 50% of patients in both program streams are discharged without ongoing services
-A re-admission/ED visit rate in this program of less than 10% has been noted, with the provincial benchmark being ~12%
-A notable reduction of ALC LOS for patient enrolled in this program has been seen, with almost a 50% reduction for those ALC patients going into H2H vs. all other medicine ALC patients
-Program has been now built into base budget for SMGH

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

Continue to provide access to primary care services for unattached patients who reside in the four priority neighbourhoods (N2H, N2M, N2G, N2C) through the Rapid Access to Primary Care (RAP) Clinic while reducing the use of the emergency room department for non-emergency conditions.

Process measure

- - # of clients served through the RAP clinic - % of unattached patient who report that ED would have been their first point of contact - Client satisfaction rates with model of care

Target for process measure

- This is a pilot initiative and we will use this period to collect baseline information for some of our indicators: - 40 clients served per month through the RAP Clinic. - 80% of patients report the ED would have been their first point of contact - 85% client satisfaction rates with model of care

Lessons Learned

Successes:
- Served over 400 unique patients with 55% indicating that they otherwise would have gone to the ED, and remainder, 45%, would have gone to walk in clinic.
- Average of 30 unique patients served per month /or 85 total visits per month through the RAP/PREVENT clinic program.
- 100% patient satisfaction rate with model
- Successfully connecting and attaching unattached patients to stable primary care.
- Support and enthusiasm from the Grand River Hospital and St. Mary's General Hospital Emergency Department teams.
- Successful partnerships with several partners across KW4 including St. Mary's General Hospital and the PREVENT Clinic.

Challenges:
- Maintaining consistent staffing due to uncertain funding. Due to funding, we have been able to provide short term contracts but this makes it challenging to maintain ongoing clinical and administrative staffing for continuity of care.
- Frequent staffing changes have contributed to challenges with training, knowledge loss, and accurate data collection.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Provide complex transitional care within a patient's home instead of an inpatient unit through the Integrated Transitional Care Team. This team is composed of a GRH Transistional Care Navigator (TCN), HCCSS Care Coordinators, and leads from both Bloom Care Solutions and Community Support Services (CSSs) will collaboratively design an Integrated Transitional Care Plan while the patient is in the inpatient setting. This care plan will be delivered to the patient from the comfort of their home and be composed of coordinated services from Bloom, and where required HCCSS, and CSS. The program can last for up to 3 months in duration and patients can be discharged to existing HCCSS and/or CSS or assisted living options. As the patient progresses and transition from the program is being planned the TCN and Bloom care supervisors will collaborate on a discharge plan from the program and receive support from the HCCSS community coordinators if required.

Process measure

- - # of participants referred to the program - # of participants accepted to the program - # of patients entering the program who were already designated ALC - # of days the patient is in the program - # of patient receiving PSS plus other home services - # of patients requiring ED visit while on program - # of patient requiring re-admission while on program - % patients who said they were satisfied or, very satisfied - Discharge destination from program

Target for process measure

- - 10-15 participants referred to the program per month - 5-10 participants accepted to the program per month - <50% of patients entering the program designated ALC - <3 months patient in the program - # of patient receiving PSS plus other home services (Baseline needed) - 0 patients requiring ED visit while on program - 0 patient requiring re-admission while on program - >85% of patients satisfied or, very satisfied - Discharge destination from program (Baseline needed)

Lessons Learned

Successes:
- 67 patients enrolled as of Q3 2024/2025
- # of referrals not tracked at this time
- 3 patients designated ALC at time of enrollment, 64 patients enrolled preventing ALC designation as of end of Q3
- target LOS is up to 12 weeks in the program, average LOS is 52.2 days as of Q3
- 17 patients receiving PSS plus other home services as of end of Q3
- 20 patients required at least 1 ED visit as of Q3
- 9 patients required re-admission while in program as of Q3
- no standardized tool developed, all patients enrolled have reported very satisfied with program as of end of Q3
- Discharge destinations included:
  - 22 to OH AtHome
  - 1 to LTC
  - 3 to Hospice
  - 1 relocated out of Province
  - 1 self-care/independence

-The program has now been built into base budget moving forward.

Challenges:
-Patient criteria evolving
-Significantly high re-admission rate and return to ED rate (~50%) due to the complexity of patient served and unavailability of 24/7 access line from the SPO
-A full program review is underway to evaluate year 1 outcomes to determine future program development

Change Idea #4 ☑ **Implemented** ☐ **Not Implemented**

Continue to expand the KW4 Integrated Care Team for older adults (ICT) to support older adults living with complex and chronic conditions through advanced care planning, system navigation, and complex case management.

Process measure

- - # of patient appointments - % of patients followed up for ongoing care and case management - # of family health organizations and individual providers added to the initiative - % of patients/care partners who indicate the ICT made them more confident in managing their health - % of patients/care partners who indicate they were very satisfied or satisfied with their experience with the ICT - % of primary care providers who indicate they were very satisfied or satisfied with their experience with the ICT - % of ICT members who indicate they were very satisfied or satisfied with their experience as part of the ICT

Target for process measure

- Over the course of 2024/25: - 2,170 patient appointments (10% increase) - 75% of patients followed up for ongoing care and case management - 15 new FHO physician practices added - 80%+ of patients/care partners who indicate the ICT made them more confident in managing their health - 75%+ of patients/care partners who indicate they were very satisfied or satisfied with their experience with the ICT - 80%+ of primary care providers who indicate they were very satisfied or satisfied with their experience with the ICT - 80%+ of ICT members who indicate they were very satisfied or satisfied with their experience as part of the ICT

Lessons Learned

Successes:
- Onboarded 25 family physicians to date for their older adult patients to receive service.
- Continuing to receive referrals from 10+ other local and regional providers/programs (hospital, community, Score, IMACT, Geriatricians).
- Active collaboration and communication with community partners through continuous round-table updates with team, external agencies and specialists.
- ICT/CCP team is serving around 200 unique patients per quarter. Each quarter, the team has an average of 500 follow-ups either in office, via telephone or home visits.
- Initiated secure appointment reminder emails to promote appointment attendance.
- Hired a Team Administrator to oversee the program flow of appointments and patient screeners.
- InterRAI Check-up Assessment tool is used prior to each initial appointment. This tool is either completed over the phone with the Team Administrator or via secure messaging.
- To reduce care partner burnout, the team implemented use of SCaN (Self-Reported Care Needs) screening tool to identify risk factors and recognize specific care partner needs. This tool is sent ahead of appointments through secure messaging.
- Recently added a Clinical Pharmacist to team.
- Updated and revised many documentation processes to improve data output quality.
- Initiated satisfaction surveys for patients/care partners:
    - o 96% very satisfied/satisfied with their overall experience in the program
    - o 92% agreed they feel more confident in managing their (loved one's) care
    - o 45% agreed they would have gone to the Emergency Department without the support of the team
- Initiated satisfaction surveys for primary care providers:
    - o 78% agree that having access to our program has relieved hospital burden by preventing/decreasing the amount of ED visits/hospitalizations for their patient.
    - o 89% agree that the involvement of this program has helped improve access to care for their patient without requiring direct support from them, relieving burden off them as primary care providers.
- Recent publication by the Canadian College of Health Leaders in the Healthcare Management Forum. Article: The Integrated Care Team: A primary care-based approach to support older adults with complex health needs.

Challenges:
- Funding confirmation for 2024/25 received at end of October 2024. This has resulted in staffing gaps and operating below capacity, though the team and partners have diligently filled gaps where possible.

Change Idea #5 ☑ **Implemented** ☐ **Not Implemented**

Continue implementation of the Palliative Alternate Destination Program for palliative care patients (approved August 2023), including: - treat and refer - patient are treated by paramedics on scene for symptom management including for pain or dyspnea, hallucinations or agitation, terminal congested breathing, and nausea or vomiting, and then receive follow up care from their palliative care team or be referred to an appropriate care provider for follow-up care (if the patient does not have one). - alternate destination - Eligible palliative care patients calling 9-1-1 will have the option to be treated by paramedics on-scene as needed. In appropriate situations, individuals with a complete pre-registration may be transported by paramedics directly to a local hospice for wrap-around care.

Process measure

- - # of patients diverted from the ED - # of times pain and symptom management provided in the home - patient and family experience - provider experience - # of patients transported directly to hospice

Target for process measure

- We will use 2024/25 to establish utilization baseline data and therefore have not set performance targets. Our aim for this year will be improved care experience for patient and providers during the end-of-life trajectory.

Lessons Learned

Successes:
Implementation was later than anticipated however this allowed for productive conversations and learnings between Paramedic Services and our local hospice sites/palliative providers. Our Regional Field Office, Dispatch (Central Ambulance Communications Centre CACC), and CPER are supportive of this initiative. Over the coming months, the access pathway will be monitored, and Paramedic Services will work with hospice sites to improve processes and identify areas for improvement.

Change Idea #6 ☑ **Implemented** ☐ **Not Implemented**

Rollout of delirium resource toolkit for caregivers, clients and patients in various settings (i.e., Emergency Department) to assist with recognizing the early signs of delirium so that interventions and supports can be initiated sooner.

Process measure

- - # of hospitals Delirium resources distributed to - # of Delirium Education sessions delivered - # of attendees at World Delirium Day webinar

Target for process measure

- - Kits distributed to 7 hospitals - One Delirium education session to be held on World Delirium Day in March 2025. - Increase registration for the 2025 World Delirium Day webinar by 10% from 245 to 270 people by March 31, 2025.

Lessons Learned

Successes:
Webinar was held on World Delirium Day – March 12, 2025, and was attended by over 110 people.
Continue meeting monthly to support Delirium Awareness initiatives

Challenges:
As the Collaborative has no funding, it is difficult to provide updated tool kits to hospitals and community partners, we will distribute electronically
Difficult finding representation from LTC

Change Idea #7 ☑ Implemented ☐ Not Implemented

Continue with the LEGHO program, leveraging existing services and providers within our OHT to support ED Diversion, Admission Avoidance, and Hospital Discharge

Process measure

- - # of patients referred - # of patients supported - # of patients diverted safely back to the community - # of rides provided - # of meals provided - # of care hours provided - # of ED visits while on LEGHO - # of hospital admission while on LEGHO - patient experience

Target for process measure

- Targets will be set in early 2024/25 for this initiative.

Lessons Learned

Successes:
This program continues to offers up to 6 weeks of Community Support Services, customized to the unique needs of vulnerable patients, and at no cost to the patient, supporting their stabilization in the community post discharge.
The program has been well received by hospitals and has been of great benefit to patients.

Change Idea #8 ☑ Implemented ☐ Not Implemented

Continue to expand the reach of the SCOPE (Seamless Care Optimizing the Patient Experience) program, connecting primary care providers with a nurse navigator to connect patients to appropriate community resources in a timely way.

Process measure

- - # of calls/month - # of new pathways/services added - # of marketing/engagement opportunities - # to PCPs utilizing service - PCP satisfaction - % of ED visits diverted

Target for process measure

- - Increase the number of calls per month to 60 by March 31, 2025 - Develop 6 new pathways or services by March 31, 2025 - Conduct 2-4 in-person visits or lunch and learns per month to increase awareness and utilization of the SCOPE program - Increase the number of PCPs utilizing services to 200 by March 31, 2025 -Increase primary care provider's reported satisfaction with the SCOPE program. - Maintain percentage of ED visits diverted to 100%

Lessons Learned

Successes:
Supported several very complex referrals and were able to successfully obtain resources to assist patients. For example,
• Patient needed support to get to LHSC for Cancer treatment. SCOPE worked with LHSC program and patient to assist in arranging transportation and accommodations multiple times over the course of months to allow patient to attend doctors appointments, chemo and radiation therapies.
• Assisted PCP to obtain urgent imaging, GIM consult and appointment, connected with LDAP and Oncology clinics to organize and clarify patient appointments within 1-2 weeks over the holidays for patient to obtain diagnosis and start treatment for cancer.
• As of Dec 31, 2024:
- 61 calls per month (average
- 1 pathway developed, 3 in development
- 2 in-person activities completed, 4 marketing activities completed
- 206 PCPs utilizing SCOPE
- 97% ED diversion

Challenges:
Expansion of High Grade Colposcopy program to Guelph and Cambridge
•"soft launch"did not have sufficient communication with OB/Gyn offices so challenging uptake for booking referrals (currently working to remedy, much improvement over last few months)
• Cambridge had staffing challenges due to medical leaves of specialists so unable to accept referrals thus Cambridge patients had to be redirected to KW and Guelph
• "inappropriate" referrals to program, i.e. "lost to follow up" patients for Colposcopists that had gone off, challenging to try to accommodate

Change Idea #9 ☑ **Implemented** ☐ **Not Implemented**

Implement Year 2 of the 'Improving Access to Home Support Services in Waterloo' initiative to increase the ability of low income, newcomer, or otherwise vulnerable seniors to age in place. This is a three-year initiative, focusing on service expansion with transportation, snow clearing, yard maintenance, and volunteer liaison/service navigation.

Process measure

• - # of seniors identified as low-income, newcomer and otherwise vulnerable registered in AWAH programs/services - % of seniors identified as low-income, newcomer and otherwise vulnerable who report enhanced social inclusion such as a sense of belonging, connection, and inclusion in their communities - # of new services developed and implemented

Target for process measure

- - Expand delivery of eligible volunteer-based services to seniors identified as low-income, newcomer and otherwise vulnerable by 30 individual seniors by March 31 2025 to help them age at home. - 80% of individual seniors served, identified as low-income, newcomer and otherwise vulnerable, report enhanced feelings of social inclusion such as a sense of belonging, connection, and inclusion in their community following their participation in the program. - Development and implementation of 3 new services for eligible seniors identified as low-income, newcomer and otherwise vulnerable by September 2025.

Lessons Learned

Successes:
The "Improving Access to Home Support Services in Waterloo" Project successfully expanded delivery of both Yard Maintenance and Snow Removal Services with 29 additional clients added to service and an additional 284 units of service provided ending Dec 31, 2024.
A satisfaction survey was undertaken and 100% of Yard Maintenance clients surveyed strongly agreed that the program increased their ability to age in place. In addition, 70% strongly agree and the remaining 30% somewhat agree that the services help them feel socially connected and engaged; satisfaction surveys will continue into 2025-26.
Leveraging connections with University Health Network Naturally Occurring Retirement Communities (NORC) innovation centre to build local capacity around NORC support service programs with work continuing in 2025-26.

Challenges:
Additional time required to develop relationships with settlement services to enhance newcomer transportation, on track for expansion in 2025-26

Change Idea #10 ☑ Implemented ☐ Not Implemented

Pending funding approval, continue with the DREAM (Dementia, Resource, Education, Advocacy, Mentorship) initiative at GRH for people living with dementia to prevent hospital admissions and look to expand to SMGH.

Process measure

- - # of clients who received system navigation and referral support - # of clients diverted safely home with respite and other supports initiated - % of repeat visits to ER due to caregiver burnout

Target for process measure

- - We will use 2024/25 to establish baseline data. Our aim per Hospital is: - 250 interventions - 100 Diversions - % of repeat visits to the ER – goal of less than 25%

Lessons Learned

Successes:
Hospital staff and GEM nurse collaboration has been excellent and we are demonstrating great results.
Full capacity is anticipated by Spring of 2025.

Challenges:
HRR challenges have been significant as this role has a unique skillset working with the Hospital and CSS sector.
We have one employee on an extended sick leave but recruitment plans are in place and coverage is being provided at all three hospital (CMH, GRH, St. Mary's).
Collaboration with Ontario at Home, hospital, and community staff has been challenging. We are currently working with management to try and streamline the process.

Comment

KW4 OHT's ALC rate has most recently has been better than the provincial average for most of 2024/25, however despite an overall improvement of almost 8%, we remain the target established in our 2024/25 cQIP. ALC will continue to be an area of focus for KW4 OHT next year.