Area of Focus - Increase Overall Access to Community Mental Health and Addiction (MHA) Services | Timely | Priority Indicator

Indicator #2

Number of individuals for whom the emergency department was the first point of contact for mental health and addictions care per 100 population aged 0 to 105 years with an incident MHA-related ED visit. (KW4OHT)

OHT Population: Newcomers and 4 neighbourhoods with high levels of material deprivation and highest concertation of newcomers.

Last Year		This Year	
35.32	**35.31**	**23.60**	**22.60**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Examine baseline population health data at a segmented level to better understand the MH&A needs of the KW4 population. Continue to understand the patient/client experience, build on a previously completed gap analysis, and analyze data to help inform system planning. What: Understand the profile of individuals, residing in the 4 priority neighbourhoods, presenting to the ED for MH&A as well as patients who are currently waiting for community-based care (i.e. individuals at risk for future presentation at the ED) Work with GRH and SMGH Emergency Departments to flag patients residing in our 4 priority neighbourhoods, who accessed the ER as a first point of contact for MH&A, to better understand the population, their health and social needs, and the reason for accessing the ER. Explore opportunities to better understand the patient/client experience (i.e. through patient journey mapping, surveys, focus groups, etc.) Refresh a previously completed gap analysis Work with OHT members to leverage existing community data to help inform the future direction of work for this indicator and subsequent projects. Scope out the change initiatives we wish to undertake. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Collect information on patient experience • Gather and analyze data • Identify barriers • Develop care pathways Q4 2022/23 • Identify 1-2 change strategies for 2023-2024 2023/24 • Pilot, evaluate, refine • Identify the opportunity to scale and spread to other populations and to other neighbourhoods Where: 4 FSAs (N2G, N2H, N2M and N2C) Why: Appropriately and effectively addressing the MHA needs of the KW4 community will require a measured, and evidence-based approach. Additional qualitative and quantitative analysis will provide a foundation on which we will build change concepts. Understanding the barriers encountered when accessing community MHA care and involving patient, family, and caregiver advisors in co-designing solutions will allow us to identify which improvement opportunities we should focus on. When access to timely community-based mental health assessment and treatment is insufficient, individuals who require services may use the emergency department (ED) as their first point of contact. How much: The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census. Based on HSPN/IC/ES analysis the 2020/21 rate of ED as first point of contact for MH&A related care by BC Matrix Segment: • 3,046 individuals in KW4 had a MH&A related ED visits • 35% of those individuals (1,072) had no previous MH&A related care • 47% (507) were from the Healthy (low user) segment • 19% (205) were from the Low Chronic Conditions segment • 14% (152) were from the Non-User segment.

Target for process measure

- To be confirmed next year

Lessons Learned

KW4 OHT continued to dive into this measure to help inform where we wanted to focus improvement initiatives. We found that our four priority neighbourhoods account for only 19% of the population in KW4 but 26% of ED visits as first point of contact for MH&A care.
We also determined that 32% of males who visit the ED for MH&A care have not received care in the community as compared to only 25.2% of females.
We also found that ED as first point of contact rates are the highest at each end of the age spectrum. 37% of children aged 0-9 years and 38 – 46% of adults aged 70+ have not received care in the community prior to coming to the ER. This is compared to 26% for 30–40-year-olds.
As we continue to focus on mental health and addiction in 2023/24, we have several new initiatives either underway or planned for 2023/24 that we are hoping will positively impact this measure including:
- As of April 1, 2023, Carizon, KW Counselling Services and Monica Place will become one organization with the hope of increasing capacity to serve more effectively and become more sustainable, while strengthening and expanding programs and services.
- As part of the Neighbourhood Integrated Care Team (NICT) Project KW4 OHT will develop a patient persona and journey map for a client seeking care for MH&A, identifying opportunities for improved integrated care and transition between providers, through integrated care pathways.

Area of Focus - Increase Overall Access to Community Mental Health and Addiction (MHA) Services | Timely | Custom Indicator

Indicator #1

Four or more ED visits in the last 12 months for mental health or addiction (KW4OHT)

OHT Population: Newcomers and 4 neighbourhoods with high levels of material deprivation and highest concertation of newcomers

Last Year		This Year	
16.38	**14.04**	**16.90**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Continue to build on the root cause analysis and solution ideation sessions held in the Fall of 2021 with a narrower focus on Newcomers and the 4 priority neighbourhoods. What: In the Fall of 2020 we held 2 large engagement sessions. Attendance has been phenomenal and included a wide array of stakeholders including Member organizations, Primary Care, and patients, families and community representatives. The first session had 54 participants with 47 representing 21 organizations and 7 patient, family, caregiver, community representatives and the second session had 44 participants with 39 representing 17 organizations and 5 patient, family, caregiver, community representatives To help inform our previous engagement session, we analyzed national, provincial and local data. This included looking at who frequently visited the ED for help with mental health and addictions, how often they came, why they were coming, where they were coming from, when they came, and what we know about them. This analysis provided key insights so we have decided to re-run the analysis with a narrower focus – focusing on those in priority neighbourhoods. We will augment this data with the patient/client experience (i.e. through patient journey mapping, surveys, focus groups, etc.) Based on this additional information we will scope out the change initiatives we collectively wish to undertake. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Collect information on patient experience • Gather and analyze data • Solution ideation Q4 2022/23 • Identify 1-2 change strategies for 2023-2024 2023/24 • Pilot, evaluate, refine • Identify the opportunity to scale and spread to other populations and to other neighbourhoods Where: 4 FSAs (N2G, N2H, N2M and N2C) Why: Between April 2021 and June 2021, 349 individuals comprised the high user group (4+ ER visits in the last 12 months). These individuals represented under 10% of all individuals coming to the ER for help with mental health and/or addictions in KW4, but accounted for over 30% of the visits. On average, they each had 6.6 visits but this ranged from 4-49 visits. How much: The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census.

Target for process measure

- To be confirmed next year

Lessons Learned

KW4 OHT continued to build on the previous data analysis and engagement work. We took a deeper dive into this measure to help inform areas of focus for improvement initiatives. What we found was that our four priority neighbourhoods (N2C, N2G, N2H, N2M) account for only 18% of KW4's population but 34% of the visits and 31% of the individuals.

We also looked at the top diagnosis for those patients who had frequent ED visits for help with MH&A. The top diagnoses which accounted for almost 13% of individuals and almost 12% of visits over the last three fiscal years was 'anxiety disorder, unspecified'. We also found that 'acute stress reaction' had the largest percentage increase in visits since last fiscal year.

Next, we looked at the breakdown of visits by age. Almost 31% of Frequent ED visits for help with MH&A are from the age group 21–30-year-olds and on average they come to the ED between 7 and 9 times per year. All of this information provided KW4 OHT with some additional direction on where we want to focus our improvement initiatives.

Overall, there has been a downward trend in frequent ER visits for help with mental health & addictions since April 2020, with a slight uptick this current fiscal year. Several potential contributing factors have been identified including:

- Mental Health is the 'next wave' of the COVID pandemic. Social isolation, physical distancing, fear, pandemic related stressors like caring for at-risk children or parents, job loss, supporting children with virtual learning, uncertainty, etc. can all lead to a range of mental health disorders like anxiety, depression and also trigger heavier consumption of alcohol and drugs and even post-traumatic stress disorder.
- The supply of opioid drugs on the street has become more toxic and extremely dangerous leading to drug poisonings, overdoses, drug-induced psychosis and death.
- Primary care providers are seeing an increase in the complexity and acuity of patients coming through their doors and this is also being seen in shelters and encampments.
- Those seeking a primary care provider in KW4 continues to increase. As of February 2023, 5,438 people have registered with Health Care Connect Program in search of a provider. This is up from 4,907 on December 1, 2022.
- Waitlist for mental health services continuing to grow. Referrals are also increasing with the most significant increase being for crisis services. While people wait for these services, the ED is sometimes the only place people feel they can go for help.
- The retention and recruitment of health care professionals over the last year has been challenging. This impacts organizations' ability to maximize the number of clients they can see, and the continuity of service clients receive. A change in a caseworker for a client may require time to build that trusting relationship – one where they are comfortable sharing their challenges.

As we continue to focus on mental health and addiction in 2023/24, we will consider how best to address these contributing factors. We have several new initiatives either underway or planned for 2023/24 that we are hoping will positively impact this measure including:

- As of April 1, 2023, Carizon, KW Counselling Services and Monica Place will become one organization with the hope of increasing capacity to serve more effectively and become more sustainable, while strengthening and expanding programs and services.
- As part of the Neighbourhood Integrated Care Team (NICT) Project KW4 OHT will develop a patient persona and journey map for a client seeking care for MH&A, identifying opportunities for improved integrated care and transition between provides, through integrated care pathways.
- As we develop these integrated care pathways, we will consider the great work that is happening with Ontario Structured Psychotherapy (OSP), Alternative Destination for Paramedics Services and Acquired Brain Injury in the Streets.

Area of Focus- Improving Overall Access to Care in the Most Appropriate Setting | Efficient | Priority Indicator

Indicator #4

Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.
(KW4OHT)

OHT Population: Frail/complex, Dementia, Newcomers and 4 neighbourhoods disproportionately impacted by ALC

Last Year		This Year	
19.17	**19.60**	**22.80**	**21.60**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Using a population health management approach we will look at upstream initiative to reduce ALC rates. What: Select an evidence based tool(s) that predicts risk of being admitted to hospital, becoming a long-stay patient/ALC to help create consistent pathways and resources based on individual needs. Llow-moderate risk clients connected to programs to keep them healthy in the community. High risk of ALC proactively manage integrated care to prevent hospitalization/ALC. At each stage of care, the Senior Friendly System Complexity Tool will assist with guiding upstream opportunities ensuring the team inclusive of patient/family understand potential solutions. Through education and connections in the community we will support independence to safely and successfully manage care at home for as long as possible. Use the opportunity to identify individuals waiting in the community for crisis to LTC who need more frequent re-assessment and engagement to prevent the need to seek support via ED. Palliative approaches of care inclusive of goals of care planning and advance care planning will be supported including Hospice Waterloo to provide education sessions for patients/families and community partners. Community Support Services including WW Alzheimer's Society to enhance care models to include therapeutic/social activation as well as staff with expert knowledge in Dementia Care. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Finalize risk assessment tool to be used, identify change management strategy, identify pilot area, develop and roll-out training and communication. • Develop care pathways Q4 2022/23 • Pilot, evaluate, refine 2023/24 • Identify the opportunity to scale and spread this model to other neighbourhoods Where: Four FSAs (N2G,N2H,N2M, N2C) Why: Our high priority neighbourhoods account for only 19% of the population in KW4 but 32% of ALC cases and 30% of the ALC Days. These neighbourhoods which appear to be disproportionately impacted are also the same neighbourhoods with the highest proportion of recent immigrants, which is a priority population for us in 2022/23. By focusing on upstream initiatives and addressing the social determinants of health for frail older adults we will enable them to live at home safely, for longer. Lack of access to these supports often leads to an increase in frailty, and an increasing risk of ED use and hospitalization. How much: The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census. In FY 2021/22, patients who resided in these neighbourhoods accounted for 543 ALC cases and 8,824 ALC days. From April 2020 to October 2021, the top reasons for patient admissions (prior to being designated as ALC) that had the highest number of associated ALC Days in KW4 was Dementia, totaling 4,785 ALC Days over 42 patients.

Target for process measure

- To be confirmed next year

Lessons Learned

KW4 OHT successfully piloted a Frail Elderly Integrated Care Team this year. This involved multiple partners of the KW4 OHT, including those involved in the care of people at risk of or living with frailty.

Partners agreed to focus on triaging and better characterizing concerns and needs of clients using the interRAI Check-up. The ICT team met weekly to review patient information and Check-Up outputs to develop care plans, including referrals to community services or urgent geriatrician assessment.

The results of this pilot were very positive from a client/patient perspective and a provider perspective and will be expanded upon in 2023/24.

KW4 OHT will continue to utilize a population health management approach and look at upstream initiative to reduce ALC rates in 2023/24.

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

Proactively identify admitted patients who may require behavioural supports to accommodate timely and successful discharge and engage in a collaborative, integrated and multisystem partner approach to reduce the amount of time these patients are awaiting discharge to the most appropriate destination. What: Enhance inpatient care planning and support seamless transitions for patients with high risk behaviours, through early identification (using a discharge planning risk assessment tool at the time of admission) and proactively partnering with the community (i.e. BSO) and Long-Term Care. Review the BSO Acute Care Collaborative's 'Behavioural Supports in Acute Care – Current Practices and Opportunities for Growth' report to understand current practices, gaps and opportunities for growth within acute care hospitals in supporting older adults living with, or at risk of, responsive behaviours/personal expressions associated with dementia, complex mental health, substance use and/or other neurological conditions. Explore opportunities to provide intense care-coordination by specially trained individuals who understand not only the system (i.e. key stakeholders, resources, and supports) as it relates to patients experiencing personal expressions, but also have a solid understanding of the barriers that these individuals and their families face both within the hospital and the community. Explore culturally safe approaches to working with patients and families in finding the appropriate destination. When: Q3 2022/23 • Finalize risk assessment tool to be used, identify change management strategy, develop and roll-out training and communication. • Identify system partners and community resources (i.e. BSO), build upon existing resources and initiatives, and encourage the development of synergies among existing and new partners to ensure access to a full range of integrated services and flexible supports based on need. • Develop care pathways Q4 2022/23 • Pilot, evaluate, refine Q1 2023/24 Identify the opportunity to scale and spread this model to other barriers to discharge (i.e. social supports – housing, financial) Where: Grand River Hospital and St. Mary's General Hospital. Why: Unnecessary extended stays in hospitals can have negative effects on: • patient outcomes (i.e. increased risk of hospital-acquired infections and functional decline while in hospital) • health care system efficiency (i.e. through high costs and decreased access to acute services for patients who truly require them) • patient and provider experience Greater awareness of potential barriers upon admission will allow for early mitigation and creative solutions for discharge planning. How much: From April 1 – October 31, 2021, KW4 OHT hospitals reported 16 ALC Cases totaling 4,030 ALC Days where behavioural supports was a barrier to discharge. In FY 2020/21 this accounted for 32 ALC cases totaling 2,807 days.

Target for process measure

- To be confirmed next year

Lessons Learned

KW4 OHT is beginning and will continue to implement concepts of the Acute Care BSO Collaborative – Behavioural Supports Capacity Building work to enhance how acute care teams engage with older adults' responsive behaviours.

This will involve proactively identifying admitted patients who may require behavioural supports to accommodate timely and successful discharge and engaging in a collaborative, integrated and multisystem partner approach to reduce the amount of time these patients are awaiting discharge to the most appropriate destination.

Geriatric Emergency Management (GEM) nurses who work in the ED continue to attend multidisciplinary team rounds on the inpatient units to help identify older adults at high risk for readmission. Upon discharge, the GEM nurse phones the patient or caregiver 24-48 hours after discharge to ensure the transition home went smoothly and connects them with resources in the community if the patient is experiencing challenges.

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

Optimize hospital capacity and patient flow by applying best practices in admission avoidance for those presenting in the ED by diverting patients back to home with the appropriate support(s) in place. What: Using a risk assessment tool (i.e. AUA) we will identify patients in the ED who are deemed as high risk for hospital admission and who might otherwise become ALC. A 'Home First' philosophy and approach to care will be used. This will involve a streamlined process initiated by a GEM Nurse and/or HCCSS in the ED. Education and training opportunities will be provided for staff on ALC designation that includes: evaluating admission criteria (i.e., only being admitted for medical reasons, not social) We will utilize pre-established partnerships (i.e. Bloom) whereby dedicated, consistent teams provide staff who "wrap around" patient's/families presenting to ED with Caregiver burnout (recognizing caregivers of Persons with Dementia (PwD) are a priority population) for a defined period of time (i.e. 3 weeks). This will assist families and caregivers with feeling more confident in managing their care at home for as long as possible. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Finalize risk assessment tool to be used, identify change management strategy, develop and roll-out training and communication. • Identify the resources required to create a neighbourhood care team with wrap around health and social supports to mitigate future ED visits and hospital admissions, compare this to the existing services and resources currently available and identify any potential gaps. • Develop care pathways Q4 2022/23 • Work with partners to service fill gaps in the community • Implement and evaluate the change thru PDSA cycles. 2023/24 • Identify the opportunity to scale and spread this model to other neighbourhoods Where: Patients presenting in the ED who reside in the neighbourhoods in the N2H and N2C. Why: The caregiver distress value considers Activities of Daily Living (ADLH), Cognitive Performance Scale (CPS), and Medical Complexity/ Frailty (CHESS). The higher the scores of these covariates, the more likely a person is to have a distressed caregiver (i.e. the likelihood of caregivers to experience distress for a patient who scores a level 3 for their ADLs is 3.6 times higher than those who scored 0). The two highest areas of caregiver distress prevalence in KW4 are in the N2H and N2C FSAs. These are also the same neighbourhoods with the highest proportion of recent immigrants, which is a priority population for us in 2022/23. These two neighbourhoods account for only 8% of the population in KW4 but 15% of ALC cases and 15% of the ALC Days. By supporting both the patient and the caregivers of these patients we are more likely to avoid hospital admission. How much: The 2 FSAs (N2H and N2C) have a population of 40,211, according to the 2016 census. In FY 2021/22, patients who resided in these neighbourhoods accounted for 246 ALC cases and 4415 ALC days.

Target for process measure

- To be confirmed next year

Lessons Learned

In July 2022, Community Care Concepts was approved by OH West to be the CSS organization for the Cambridge North Dumfries and KW4 OHT. In collaboration with Waterloo Wellington hospitals, LEGHO has successfully been implemented. Through the LEGHO model, partners developed a LEGHO program leveraging existing services and providers (with the possibility to add capacity) within their OHT to support ED Diversion/Admission Avoidance and Hospital Discharge.

'Know Your Options' information was refreshed, updated and shared through hospital communications to support care in the most appropriate place.

Home and Community Care Support Services Waterloo Wellington expanded transitional care options for community and hospital patients. Through partnerships, innovative models were and continue to be considered for opportunities to open one or two transitional care beds on existing units rather than on an entirely new/separate unit. In Q4 2022/23, there was an expansion of transitional care beds in Highland Place to 33 beds including memory care beds.

Work on optimizing hospital capacity and patient flow by applying best practices in admission avoidance for those presenting in the ED by diverting patients back to home with the appropriate support(s) in place will continue in 2023/24.

Area of Focus- Increase Overall Access to Preventative Care | Effective | Priority Indicator

Indicator #3

percentage of female patients aged 23 to 69 years who had a Pap test within the previous three years. (KW4OHT)

OHT Population: Second lang, Newcomers and 4 neighbourhoods with high levels of material deprivation.

Last Year		This Year	
53.93	**60**	**55.10**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Explore the feasibility and interest in providing a collaborative pop-up Pap screening clinic put on by primary care providers in the community once per quarter. Collaborate and operate a cervical cancer screening clinic, once per quarter. Similar to the COVID-19 Community Vaccine Hub, our partners would provide staff resources to assist at a centralized location for planning and operating the clinic. With a focus on women's health, the clinic may also provide education on breast cancer screening for those overlapping populations eligible for both cervical and breast cancer screening. When planning events we will consider clinics that provide culturally appropriate care (i.e. events may include female providers/physicians who can provide Pap testing and/or speak common languages of the community, as language can be a barrier for screening. We would work closely with community members – volunteers, or "Community Ambassadors" to inform engagement strategies, raise awareness, reduce stigma and hesitancy. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Identify partners willing to participate in planning and running the clinics • Identify appropriate venues/ locations for a clinic • Plan all logistics • Co-design and roll-out an outreach and engagement strategy with patient, family, caregiver advisors and community leaders. Q4 2022/23 • Host first pop-up clinic, evaluate, refine Q1 2023/24 Identify opportunities for future clinics Where: The pop-up clinics would be held In one of our four priority FSAs (N2G, N2H, N2M, N2C). Why: This model proved successful with COVID-19 vaccines. We want to ensure we remove barriers and ensure equitable access for patients in priority neighbourhoods. How Much: Success of this initiative will be based on three measures: • percentage of primary care teams participating • the number of events held per year • the number of patients participating at each event

Target for process measure

- To be confirmed next year

Lessons Learned

KW4 OHT has formed a Cancer Screening Implementation Team. This group continues to evaluate the feasibility of a pop-up pap screening clinic and is actively reviewing the learnings from the neighborhood pop-up COVID, Cold and Flu Care Clinics, which have seen poor turnout for the targeted populations despite early assumptions of how to improve access. Before proceeding we will need to determine strategies to better target our priority neighbourhoods, which may include launching a marketing campaign first and utilizing metrics to iterate along the way.

The team continues to evaluate this change idea from a patient and provider perspective. Initial work has been done to identify partnerships, potential locations and the logistics required to host a clinic, if we do decide to move forward with this idea.

The Implementation Team has benefitted from a variety of perspectives including primary care, community providers, healthcare professionals, and community members.

We are also gathering local neighbourhood data to assess the scale of the intervention or solution required. We were able to use the 2021 Census Data to give us much needed information on our priority neighbourhoods.

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

Increase system capacity by training nursing staff to perform Pap tests. Who: What: Partner with the South West Regional Cancer Program who is offering an in-person Pap training education session with their regional Cervical Screening and Colposcopy Lead. Train nursing staff to perform Pap tests in primary care offices located in our priority neighbourhoods or in pop-up/mobile clinics. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Partner with training provider to understand training schedule and capacity for enrollment • Identify primary care providers supporting Newcomers or practicing in priority neighbourhoods with low screening rates. • Select a subset of providers to participate in a pilot • Recruit nursing staff to enroll in training Q4 2022/23 • Pilot, evaluate, refine Q1 2023/24 Identify the opportunity to scale and spread to other providers and to other neighbourhoods Where: In WW region, Pap tests are performed mainly in primary care provider offices. We will target primary care providers with practices in four FSAs (N2G,N2H,N2M,N2C) Why: The Ontario Cervical Screening Program (OCSP) is designed to reduce the risk of developing or dying from cervical cancer by inviting clients to have Papanicolaou (Pap) testing, advise on the next steps following a Pap test and reminds them to return to screening. Having additional staff performing Paps will help decrease backlogs accumulated over the past two years during the pandemic. How much: The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census. The number of nurses to be trained will be determined during project charter development

Target for process measure

- To be confirmed next year

Lessons Learned

KW4 OHT has identified potential Pap training programs in Southern Ontario (we were unable to secure a partnership with the South West Regional Cancer Program as originally planned). A budget has been allocated and we have begun our outreach to potential nursing staff candidates to gauge interest. The feedback from the nursing outreach efforts has been positive to date.

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

Enhance provider education and support with using existing reports/ electronic tools and encourage increased utilization and tracking of patients overdue for cancer screening by providers. What: Continue to encourage patient enrolment model (PEM) physicians to register with ONE ID®, so they can access the Screening Activity Report (SAR) available from Ontario Health – Cancer Care Ontario. Offer and deliver training to physicians and administrative staff, in collaboration with Ontario MD, on how to use their EMRs and reports to enhance tracking of patients/clients overdue for cancer screening. Continue to encourage PEM physicians to sign up for physician-linked correspondence, so that their patients receive invitation letters from Cancer Care Ontario that include their doctor's name. Continue to encourage physicians to register for My Practice Primary Care Reports in order to receive confidential reports about their practice and advice on quality improvement initiatives. Leverage online appointment booking (OAB) to provide additional convenience for patients to book screening appointments. Approximately 40 clinics are 'interested' in OAB for FY 22/23 between KW4 and CND OHT (collaborative approach). When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Develop an engagement and change management strategy • Identify PEM physicians supporting Newcomers or practicing in priority neighbourhoods who are not fully utilizing existing reports/tools • Select a subset of providers to participate in a pilot • Develop training and communication material Q4 2022/23 • Pilot, evaluate, refine Q1 2023/24 Identify the opportunity to scale and spread to other providers and to other neighbourhoods Where: Four FSAs (N2G,N2H,N2M,N2C) Why: Regular cancer screening is important from a prevention and treatment perspective because early detection and intervention can improve health outcomes. Due to the COVID-19 pandemic many people are delayed in getting their cancer screening tests. Primary care providers play a key role in the success of cancer screening programs. The SAR report provides screening data to help physicians improve their cancer screening rates and appropriate follow-up. Evidence shows a positive relationship between physician recommendation for screening and patient participation in screening. By enrolling in physician-linked correspondence with Ontario Health – Cancer Care Ontario, the letters generated by the cancer screening program inviting patients to participate in screening, will include the name of the patient's physician. How much: Adoption rate for SAR in WW as of June 30, 2021 • 37% physicians registered and viewed within last 6 months (169) • 28% registered but did not view within last 6 months (128) • 35% are not registered (160) Adoption rate for Physician-Linked Correspondence in WW as of June 30, 2021 • 47% PEM Physicians enrolled (217) • 53% (240) not enrolled The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census.

Target for process measure

- To be confirmed next year

Lessons Learned

Primary care education sessions continue to be offered and include the physician-linked correspondence and My Practice Primary Care Reports, ONE ID etc. KW4 OHT has partnered with the Waterloo Wellington Regional Cancer Program to promote this through multi-modal communication to drive adoption.

KW4 OHT is also working with the eHealth Centre of Excellence (eCE) to digitize patient engagement, requiring MDs to sign up for this.

As of September 30, 2022, 40% of PEMs had registered for ONE ID and viewed the SAR within the last 6 months. This is up from 37% since June of 2021.

As of September 2022, 45% had enrolled which is down from 47% in June of 2021.

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

Increased public outreach and engagement through various channels and in various languages for neighbourhoods with the highest proportion of newcomers. What: Continue to encourage primary care providers to utilize the cancer screening regional resource hub for communication material. Material is available in the most popular spoken languages in Ontario including Arabic, Punjabi, Hindi, Italian, Spanish, Chinese, Tamil, Tagalog and Urdu. Explore opportunities to increase the use of language interpretation services, where appropriate. Engage community leaders/ ambassadors and associations (i.e. Muslim Women's Association) to assist in increasing public awareness and in encouraging screening. Collaborate with the Grand River Hospital Foundation and Launch Waterloo (a company who inspires kids to explore science, technology, engineering, art and math) to communicate the importance of screening to students and their families at one of their upcoming quarterly events. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter • Complete the Refugee Health patient journey mapping exercise and identify opportunities for improved outreach and communication. Q3 2022/23 • Co-design an outreach and engagement strategy with patient, family, caregiver advisors and community leaders. • Develop evaluation metrics to measure the impact of the outreach/engagement • Develop materials to support this strategy, incorporating plain language and health literacy principles. • Roll-out outreach and engagement strategy Q4 2022/23 • Pilot, evaluate, refine Q1 2023/24 Identify the opportunity to scale and spread to other providers and to other neighbourhoods Where: Four FSAs (N2G,N2H,N2M,N2C) Why: According to the segmented data from HSPN, it will be important for KW4 to target cancer screening strategies to those with little to no contact with the health care system (as per the BC Metrix Segmentation). There are 160,000 residents of Waterloo Region and Guelph Wellington whose first language is not English or French and 12,000 people who cannot communicate in either official language. By providing communication material in various languages we can help to ensure equitable access. How much: The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census.

Target for process measure

- To be confirmed next year

Lessons Learned

KW4 OHT has formed a Cancer Screening Implementation Team. This group has begun the evaluation process. Aspects being evaluated include patient perspectives, provider perspectives, and potential partnerships.

The group has gathered local neighbourhood data to assess the scale of the intervention or solution required and determined the priority neighbourhoods. This work will inform our next steps and help us determine channels and languages best suited to our target populations.

We are also exploring what other regions have done in this regard so that we can build on their successes and benefit from their learnings.

Indicator #5

Percentage of screen eligible female patients aged 52 to 69 years who had a mammogram within the past two years. (KW4OHT)

OHT Population: Second lang, Newcomers and 4 neighbourhoods with high levels of material deprivation.

Last Year		This Year	
46.16	**60**	**58.50**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Explore the feasibility and develop a business case (if warranted) for a comprehensive mobile screening bus. What: Partner with Thunder Bay Regional Health Sciences Centre to better understand their business model for their Screen For Life Coach (a mobile cancer screening service, offering breast, cervical and colon cancer screening in one convenient location). The bus offers digital mammography and is affiliated with the Ontario Breast Screening Program (OBSP). It also offers cervical cancer screening and provides patients with take-home colon cancer screening kits When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 – Q4 2022/23 • Reach out to areas who are currently operating a comprehensive mobile screening bus to understand their business model and any lessons learned. • Develop a business case Where: Waterloo Wellington (WW) region currently has 13 Ontario Breast Screening Program (OBSP) sites at 4 hospitals (Cambridge Memorial, Grand River, Groves Memorial and Guelph General); and 9 independent health facilities. Why: The OBSP is an organized screening program designed to encourage eligible people to get screened for breast cancer. Current capacity is not sufficient to catch-up on the backlog caused by the pandemic while also keeping up with new demand. Bringing services closer to home may increase participation rates. How much: As of September 2021 the overdue screening versus pre-pandemic level capacity was: • GRH – 4,617 overdue, monthly volume 840. • The Boardwalk DI – 1,377 overdue, monthly volume 129 • Victoria-Kitchener –overdue 2,764, monthly volume 377 • Waterloo Nuclear and Radiology – overdue 0, monthly volume 15 • Waterloo X-ray and Ultrasound – overdue 449, monthly volume 136 • Total – 9,207 overdue, pre-pandemic monthly volume 1,497

Target for process measure

- To be confirmed next year

Lessons Learned

Screen For Life Coach was a project initiated and funded by OH-CCO several years ago. A few regions in Ontario were selected and provided with a Coach to operate in their region (notably regions with larger geography and their population spread wide). Waterloo-Wellington applied at the time but was not selected.

KW4 OHT revisited this option again but determined that without a sponsor and funding that a favourable business case was not feasible. This change idea has subsequently been removed.

Engagement with partner organizations in other regions with a mobile mammography bus to determine costs, skills, and human resources associated with this change idea was helpful in KW4 OHT coming to this conclusion. Starting with an exploratory analysis of what is available, has allowed KW4 OHT to pivot and now focus on other priorities.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increased public outreach and engagement through various channels and in various languages for neighbourhoods with the highest proportion of newcomers. What: Continue to encourage primary care providers to utilize the cancer screening regional resource hub for communication material. Material is available in the most popular spoken languages in Ontario including Arabic, Punjabi, Hindi, Italian, Spanish, Chinese, Tamil, Tagalog and Urdu. Explore opportunities to increase the use of language interpretation services, where appropriate. Engage community leaders/ ambassadors and associations (i.e. Muslim Women's Association) to assist in increasing public awareness and in encouraging screening. Collaborate with the Grand River Hospital Foundation and Launch Waterloo (a company who inspires kids to explore science, technology, engineering, art and math) to communicate the importance of screening to students and their families at one of their upcoming quarterly events. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter • Complete the Refugee Health patient journey mapping exercise and identify opportunities for improved outreach and communication. Q3 2022/23 • Co-design an outreach and engagement strategy with patient, family, caregiver advisors and community leaders. • Develop evaluation metrics to measure the impact of the outreach/engagement • Develop materials to support this strategy, incorporating plain language and health literacy principles. • Roll-out outreach and engagement strategy Q4 2022/23 • Pilot, evaluate, refine Q1 2023/24 Identify the opportunity to scale and spread to other providers and to other neighbourhoods Where: Four FSAs (N2G,N2H,N2M,N2C) Why: According to the segmented data from HSPN, it will be important for KW4 to target cancer screening strategies to those with little to no contact with the health care system (as per the BC Metrix Segmentation). There are 160,000 residents of Waterloo Region and Guelph Wellington whose first language is not English or French and 12,000 people who cannot communicate in either official language. By providing communication material in various languages we can help to ensure equitable access. How much: The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census.

Target for process measure

- To be confirmed next year

Lessons Learned

KKW4 OHT has formed a Cancer Screening Implementation Team. This group has begun the evaluation process. Aspects being evaluated include patient perspectives, provider perspectives, and potential partnerships.

The group has gathered local neighbourhood data to assess the scale of the intervention or solution required and determined the priority neighbourhoods. This work will inform our next steps and help us determine channels and languages best suited to our target populations.

We are also exploring what other regions have done in this regard so that we can build on their successes and benefit from their learnings.

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

Enhance provider education and support with using existing reports/ electronic tools and encourage increased utilization and tracking of patients overdue for cancer screening by providers. What: Continue to encourage patient enrolment model (PEM) physicians to register with ONE ID®, so they can access the Screening Activity Report (SAR) available from Ontario Health – Cancer Care Ontario. Offer and deliver training to physicians and administrative staff, in collaboration with Ontario MD, on how to use their EMRs and reports to enhance tracking of patients/clients overdue for cancer screening. Continue to encourage PEM physicians to sign up for physician-linked correspondence, so that their patients receive invitation letters from Cancer Care Ontario that include their doctor's name. Continue to encourage physicians to register for My Practice Primary Care Reports in order to receive confidential reports about their practice and advice on quality improvement initiatives. Leverage online appointment booking (OAB) to provide additional convenience for patients to book screening appointments. Approximately 40 clinics are 'interested' in OAB for FY 22/23 between KW4 and CND OHT (collaborative approach). When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Develop an engagement and change management strategy • Identify PEM physicians supporting Newcomers or practicing in priority neighbourhoods who are not fully utilizing existing reports/tools • Select a subset of providers to participate in a pilot • Develop training and communication material Q4 2022/23 • Pilot, evaluate, refine Q1 2023/24 Identify the opportunity to scale and spread to other providers and to other neighbourhoods Where: Four FSAs (N2G,N2H,N2M,N2C) Why: Regular cancer screening is important from a prevention and treatment perspective because early detection and intervention can improve health outcomes. Due to the COVID-19 pandemic many people are delayed in getting their cancer screening tests. Primary care providers play a key role in the success of cancer screening programs. The SAR report provides screening data to help physicians improve their cancer screening rates and appropriate follow-up. Evidence shows a positive relationship between physician recommendation for screening and patient participation in screening. By enrolling in physician-linked correspondence with Ontario Health – Cancer Care Ontario, the letters generated by the cancer screening program inviting patients to participate in screening, will include the name of the patient's physician. How much: Adoption rate for SAR in WW as of June 30, 2021 • 37% physicians registered and viewed within last 6 months (169) • 28% registered but did not view within last 6 months (128) • 35% are not registered (160) Adoption rate for Physician-Linked Correspondence in WW as of June 30, 2021 • 47% PEM Physicians enrolled (217) • 53% (240) not enrolled The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census.

Target for process measure

- To be confirmed next year

Lessons Learned

Primary care education sessions continue to be offered and include the physician-linked correspondence and My Practice Primary Care Reports, ONE ID etc. KW4 OHT has partnered with the Waterloo Wellington Regional Cancer Program to promote this through multi-modal communication to drive adoption.

KW4 OHT is also working with the eHealth Centre of Excellence (eCE) to digitize patient engagement, requiring MDs to sign up for this.

As of September 30, 2022, 40% of PEMs had registered for ONE ID and viewed the SAR within the last 6 months. This is up from 37% since June of 2021.

As of September 2022, 45% had enrolled which is down from 47% in June of 2021.

Indicator #6

Percentage of screen eligible patients aged 52 to 74 years who had a FOBT/FIT within the past two years, other investigations (i.e., flexible sigmoidoscopy) or colonoscopy within the past 10 years. (KW4OHT)

OHT Population: Second lang, Newcomers and 4 neighbourhoods with high levels of material deprivation.

Last Year		This Year	
60.68	**60.70**	**64.20**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Enhance provider education and support with using existing reports/ electronic tools and encourage increased utilization and tracking of patients overdue for cancer screening by providers. What: Continue to encourage patient enrolment model (PEM) physicians to register with ONE ID®, so they can access the Screening Activity Report (SAR) available from Ontario Health – Cancer Care Ontario. Offer and deliver training to physicians and administrative staff, in collaboration with Ontario MD, on how to use their EMRs and reports to enhance tracking of patients/clients overdue for cancer screening. Continue to encourage PEM physicians to sign up for physician-linked correspondence, so that their patients receive invitation letters from Cancer Care Ontario that include their doctor's name. Continue to encourage physicians to register for My Practice Primary Care Reports in order to receive confidential reports about their practice and advice on quality improvement initiatives. Leverage online appointment booking (OAB) to provide additional convenience for patients to book screening appointments. Approximately 40 clinics are 'interested' in OAB for FY 22/23 between KW4 and CND OHT (collaborative approach). When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Develop an engagement and change management strategy • Identify PEM physicians supporting Newcomers or practicing in priority neighbourhoods who are not fully utilizing existing reports/tools • Select a subset of providers to participate in a pilot • Develop training and communication material Q4 2022/23 • Pilot, evaluate, refine Q1 2023/24 Identify the opportunity to scale and spread to other providers and to other neighbourhoods Where: Four FSAs (N2G,N2H,N2M,N2C) Why: Regular cancer screening is important from a prevention and treatment perspective because early detection and intervention can improve health outcomes. Due to the COVID-19 pandemic many people are delayed in getting their cancer screening tests. Primary care providers play a key role in the success of cancer screening programs. The SAR report provides screening data to help physicians improve their cancer screening rates and appropriate follow-up. Evidence shows a positive relationship between physician recommendation for screening and patient participation in screening. By enrolling in physician-linked correspondence with Ontario Health – Cancer Care Ontario, the letters generated by the cancer screening program inviting patients to participate in screening, will include the name of the patient's physician. How much: Adoption rate for SAR in WW as of June 30, 2021 • 37% physicians registered and viewed within last 6 months (169) • 28% registered but did not view within last 6 months (128) • 35% are not registered (160) Adoption rate for Physician-Linked Correspondence in WW as of June 30, 2021 • 47% PEM Physicians enrolled (217) • 53% (240) not enrolled The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census.

Target for process measure

- To be confirmed next year

Lessons Learned

Primary care education sessions continue to be offered and include the physician-linked correspondence and My Practice Primary Care Reports, ONE ID etc. KW4 OHT has partnered with the Waterloo Wellington Regional Cancer Program to promote this through multi-modal communication to drive adoption.

KW4 OHT is also working with the eHealth Centre of Excellence (eCE) to digitize patient engagement, requiring MDs to sign up for this.

As of September 30, 2022, 40% of PEMs had registered for ONE ID and viewed the SAR within the last 6 months. This is up from 37% since June of 2021.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase accessibility to FIT tests for unattached patients. Work with OH-CCO, WW PHU and Health Care Connect - to ensure accessibility of FIT kits at community locations (i.e. pharmacies, shelters, libraries) for unattached patients or at the very least connecting them to our walk-in clinics to access them. Explore whether the RPCL can sign off on unattached patient results, in order to increase screening. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter Q3 2022/23 • Partner with agencies and the community to identify appropriate locations for FIT kit distribution. • Co-design and roll-out an outreach and engagement strategy with patient, family, caregiver advisors and community leaders. Q4 2022/23 • pilot, evaluate, refine Q1 2023/24 Identify opportunities to spread to other neighbourhoods. Where: Four FSAs (N2G,N2H,N2M,N2C) Why: ColonCancerCheck (CCC) is the organized screening program designed to reduce the risk of developing or dying from colorectal cancer by inviting average-risk clients to complete the Fecal Immunochemical stool Test (FIT) every 2 years and a follow up colonoscopy for positive FIT. For attached patients, at-home fecal testing (Fecal Immunochemical Test or FIT) kits are requisitioned by primary care providers to Life Labs for their patients; Life Labs mails the kit to program participant. For unattached patients tests can be obtained by calling Telehealth Ontario at 1-866-828-9213. How much: The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census. Success of this initiative will be based on how many kits are accessed from community locations by unattached patients residing in the priority 4 FSAs.

Target for process measure

- To be confirmed next year

Lessons Learned

KW4 OHT has formed a Cancer Screening Implementation Team. This group has begun the evaluation process. Aspects being evaluated include patient perspectives, provider perspectives, potential partnerships, and existing community resources that unattached patients could access.

KW4 OHT has confirmed that the Regional Primary Care Lead can sign off on unattached patient results, however we were informed by the OH-CCO that distribution of FIT kits via community locations is currently not permitted. We are limited in what we can do by provincial rules pending the pilot project in NW RCP. KW4 OHT will continue to advocate for change in this area.

In a recent memo from Ontario Health, it was noted that Ontarians can also call Health811 to receive a free FIT for colorectal cancer screening.

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

Increased public outreach and engagement through various channels and in various languages for neighbourhoods with the highest proportion of newcomers. What: Continue to encourage primary care providers to utilize the cancer screening regional resource hub for communication material. Material is available in the most popular spoken languages in Ontario including Arabic, Punjabi, Hindi, Italian, Spanish, Chinese, Tamil, Tagalog and Urdu. Explore opportunities to increase the use of language interpretation services, where appropriate. Engage community leaders/ ambassadors and associations (i.e. Muslim Women's Association) to assist in increasing public awareness and in encouraging screening. Collaborate with the Grand River Hospital Foundation and Launch Waterloo (a company who inspires kids to explore science, technology, engineering, art and math) to communicate the importance of screening to students and their families at one of their upcoming quarterly events. When: Q2 2022/23 • Recruitment of a Project Manager and the creation of the project team. • Approval of Project Charter • Complete the Refugee Health patient journey mapping exercise and identify opportunities for improved outreach and communication. Q3 2022/23 • Co-design an outreach and engagement strategy with patient, family, caregiver advisors and community leaders. • Develop evaluation metrics to measure the impact of the outreach/engagement • Develop materials to support this strategy, incorporating plain language and health literacy principles. • Roll-out outreach and engagement strategy Q4 2022/23 • Pilot, evaluate, refine Q1 2023/24 Identify the opportunity to scale and spread to other providers and to other neighbourhoods Where: Four FSAs (N2G,N2H,N2M,N2C) Why: According to the segmented data from HSPN, it will be important for KW4 to target cancer screening strategies to those with little to no contact with the health care system (as per the BC Metrix Segmentation). There are 160,000 residents of Waterloo Region and Guelph Wellington whose first language is not English or French and 12,000 people who cannot communicate in either official language. By providing communication material in various languages we can help to ensure equitable access. How much: The 4 FSAs (N2G, N2H, N2M and N2C) have a population of 92,527, according to the 2016 census.

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