EXECUTIVE DIRECTOR

NOVEMBER 2023

Ashnoor Rahim
Executive
Director

GENERAL UPDATES

GOVERNANCE

Strategic Planning

This month, the KW4 OHT Strategic Planning Working group continued preparing for the upcoming Members planning session on December 7th. A pre-read package has been circulated to participants to help them prepare for the session.

Following this upcoming Member planning session, smaller group engagements will occur to allow time for more feedback in advance of a subsequent Members planning session in the new year. In March the penultimate strategic plan will be shared for feedback and in April we will seek approval of the final plan.

We have also continued with our engagement work and have collected input from an additional 77 community members and 15 primary care providers and specialists.

GENERAL UPDATES

COMMUNICATIONS HIGHLIGHTS

Waterloo Seniors Fair

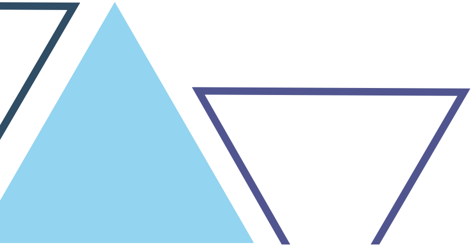
On November 16, 2023, the City of Waterloo and KW4 OHT provided seniors and caregivers with the opportunity to learn more about community programs and services that can help older adults remain healthy, active and connected in the community. The Seniors Fair included presentations, 38 information/vendor booths, and free hearing tests, blood pressure checks, and mobility assessments.

There was overwhelming interest and excitement with participation far exceeding expectations. Feedback from the 265 participants has been very positive. We look forward to collaborating on future events where we can continue to educate and support our community.

COMMUNICATIONS HIGHLIGHTS

Wilmot Seniors Fair

On November 23, 2023, KW4 OHT attended the Aging Well in Wilmot, A Seniors Information and Active Living Fair, organized by Community Care Concepts. We had the opportunity to connect with the community through our information booth. The event was a great success with 150 participants attending. This event offered opportunities for the community to obtain valuable information from the guest speakers, panel discussions, and 30 organization/vendor information booths. Participants shared positive feedback regarding the event. We look forward to attending the Woolwich Fair in February and the Wellesley Fair in March.



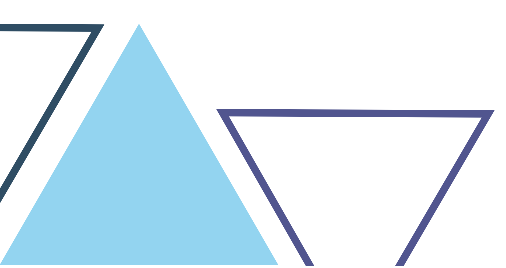
COMMUNICATIONS HIGHLIGHTS

Region of Waterloo Public Health Webinars on Respiratory Preparedness

This month, in partnership with the Region of Waterloo Public Health, we held two l webinars focused on Respiratory Preparedness for the 2023/2024 season. The first session focused on supporting Primary Care providers and the second was dedicated to engaging with community providers. Both the events, hosted by Region of Waterloo Public Health, addressed the challenges posed by overlapping peaks of COVID-19, Respiratory Syncytial Virus (RSV), and Influenza. The Region of Waterloo public health team emphasized the critical role of vaccines in preventing the surge in health system pressures. The presentations included updates about latest tools, such as the Ontario Respiratory Virus Tool, and local data on COVID-19 and Influenza. The collaborative efforts of the KW4 OHT and Public Health demonstrated a commitment to community health and preparedness in the face of evolving respiratory threats.

The Clinician Summit

58 clinicians from across the region, representatives from Ontario Health, and leaders in our community participated in our very successful 3rd Clinician Summit at RIM Park on November 29th. After networking over dinner, information was shared regarding creating a secure messaging solution for primary care and specialist providers, current and future physician recruitments efforts in our area, as well as an update from Camino Wellbeing + Mental Health. Two breakout discussions occurred, one focused on primary care and mental health and the other on primary care and the emergency department. Discussions focused on addressing shared challenges and improving connections. These discussions are always a highlight of the event, and we are excited to apply these ideas to future initiatives. We are grateful for the ongoing leadership and commitment from our clinician leaders as they shape this keystone event.

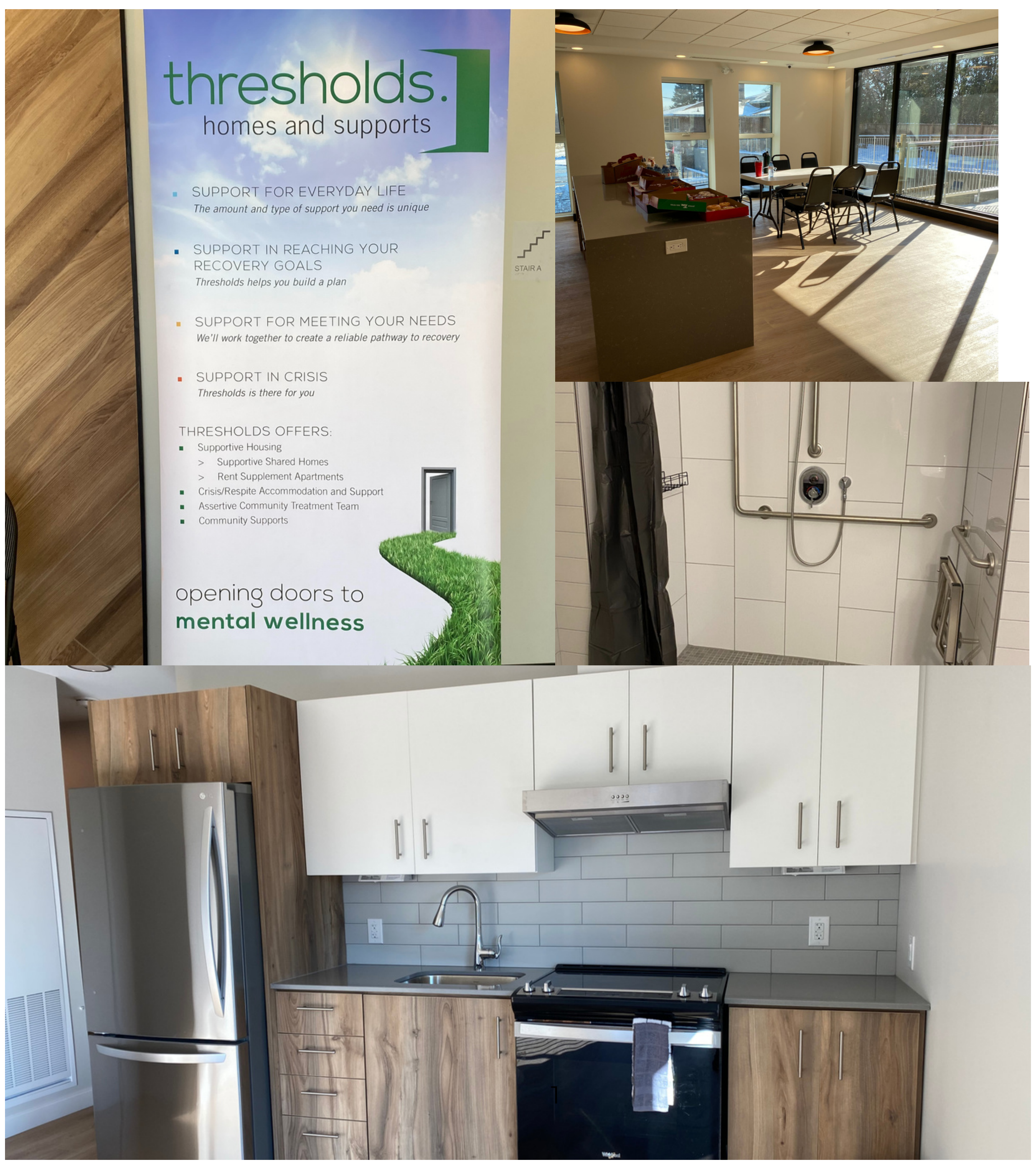


GENERAL UPDATES

COMMUNICATIONS HIGHLIGHTS

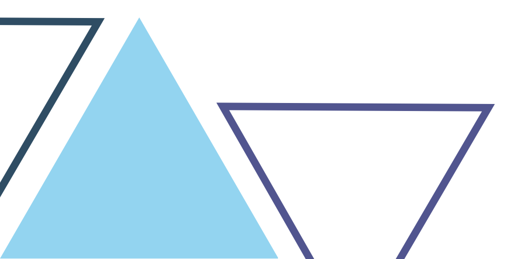
Threshold's New Supportive Housing Building

On November 30, 2023 we were thrilled to celebrate Threshold's new 25 unit supportive housing building on Sheldon Ave North in Kitchener. The site is reaching the final stages of construction and we were grateful to be able to tour the new space. We were impressed with the design, the abundance of natural lighting, and the accessible and barrier-free options, all of which will make this a welcoming space for their clients. The space is accepting of pets and has options for both single and double occupancy. Thresholds is hoping to begin moving clients into the space in December. The KW4 OHT would like to extend our congratulations on this incredible accomplishment.



Mental Health Breakfast

This month, through the generosity of tickets donated by Community Care Concepts Woolwich, Wellesley and Wilmot, KW4 OHT was able to attend a breakfast event in New Hamburg hosted by Interfaith Counselling Centre and Wilmot Family Resource Centre. This breakfast offered a great opportunity to network and engage in intentional conversations about mental health, relationships, human resiliency and the strength of community. Theatre of the Beat presented a short play reflecting lived experiences of intimate partner violence in youth relationships, with a focus on how to recognize the subtle early signs of abuse. Together participants worked to find solutions to address unsafe and unhealthy behaviours.



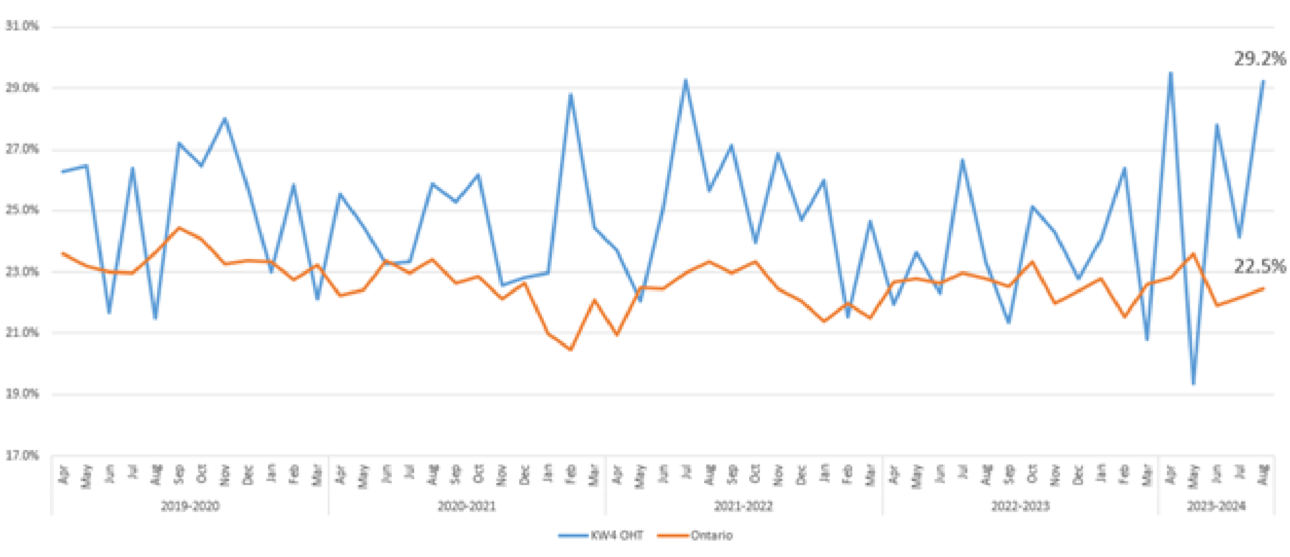
PERFORMANCE

Ontario Health, OHT Data Dashboard

Ontario Health's business intelligence tool, the OHT Data Dashboard, is available to all OHTs and their supporting partners through the eReports platform. To obtain access to the dashboard please email OHTanalytics@ontariohealth.ca.

Emergency Department (ED) First Contact for Mental Health and Addictions (MHA)
In last month's report we focused on three of our five Collaborative Quality Improvement indicators, all related to cancer screening. This month, we will examine our fourth indicator – ED First Contact for MHA. This indicator measures the number of individuals for whom the emergency department was the first point of contact for MHA care. This indicator is calculated as the number of individuals without an MHA-related service contact and more specifically those who did not have an MHA-related outpatient visit to a psychiatrist, primary care provider, or pediatrician, or an MHA-related ED visit or hospitalization in the two years preceding their ED visit. For this indicator a lower rate is better.

The graph below shows that KW4 OHT has been consistently underperforming in this area when compared to the province. In August of 2023, KW4 OHTs rate was 29.2% compared to the province at 22.5% and to our target of 23.6%.



PERFORMANCE

Prevention System Quality Index

Ontario Health has released a new report, Prevention System Quality Index (PSQI) 2023. The PSQI series monitors Ontario's progress on population-level policies and programs that can reduce the incidence of chronic disease. Topics include commercial tobacco, alcohol, healthy eating, physical activity, environmental and occupational exposures and infectious agents.

Despite being largely preventable, chronic diseases are the leading cause of death in Ontario. The following is an excerpt from the report:

The conditions under which people are born, grow, live, work and age directly shape their health and are known as the social determinants of health (SDOH). Extensive research has demonstrated a strong link between the SDOH and chronic diseases.

- Data from 2005 to 2012 show a greater prevalence of multimorbidity (including cancers, COPD, diabetes and heart disease) in the lowest income quintile compared to the highest income quintile in Ontario.
- Adults in Ontario who lived in households experiencing food insecurity had more than twice the risk of developing type 2 diabetes compared to food secure households.
- Poor-quality housing affects chronic disease risk through exposure to respiratory toxins due to cold and damp conditions, overcrowding and a reduced sense of wellbeing.
- Race-based data collected from June 2020 to April 2021 found that racialized populations had up to 7 times higher rates of COVID-19 infection than White Ontarians.

Prevention System Quality Index, cont'd

Collectively, First Nation, Inuit, Métis and urban Indigenous peoples experience a greater impact on health and well-being from chronic diseases than all other populations living in Canada. This impact is a result of intergenerational trauma from colonialism and violent assimilation efforts including residential schools and Indian hospitals, combined with ongoing inequities in the SDOH.

First Nations people in Ontario:
- The prevalence of type 2 diabetes is 3 to 5 times higher amongst First Nations people compared to non-First Nations in Ontario.
- First Nations people have a 2.5 times higher prevalence of cardiovascular disease (CVD) than non-First Nations people. CVD mortality is also disproportionately higher among First Nations people.
- In Ontario, the incidence of some common cancers, including lung, colorectal, kidney, cervical, and liver cancers, is higher amongst First Nations than other populations. First Nations women had higher incidence of all cancers combined than non-First Nations women.
- Inuit people in Ontario
- Incidence rates for lung cancer in Inuit men and women living in the Canadian Arctic are the highest in the world.
- ·One study of cancer in the population living in Inuit Nunangat showed that Inuit are more likely to be diagnosed with lung and colorectal cancer than other Canadians, and less likely to be diagnosed with breast and prostate cancer.

Métis people in Ontario
- Compared to the general Ontario population, Métis people have a 1.6 times higher prevalence of chronic obstructive pulmonary disease.
- Métis people who had diagnosed congestive heart failure had more frequent hospitalizations and emergency department visits than non-Métis people in Ontario.

Urban Indigenous people in Ontario
- Healthcare services offered in urban areas are not consistently appropriate for First Nations, Inuit, Métis peoples, and studies have found that urban Indigenous populations have reservations about accessing healthcare services because of the risk of stigmatization and discrimination.

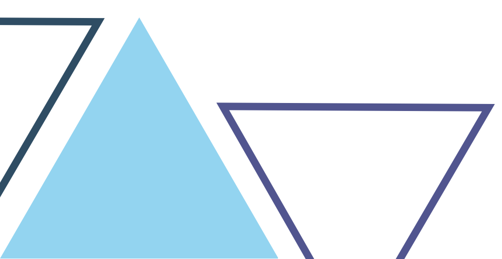
The full 104-page report can be found here.

System Navigation

KW4 and CND OHTs continued to work with the System Navigation working group to plan the implementation of the Front-Line Navigator Community of Practice (CoP). An overview of this CoP is found below:

- Purpose: better support connections, learnings, and improve system design
- Membership: Voluntary and open to all who provide navigation to our community (i.e., social services, health services, private sector, etc.)
- Suggested Content: In each meeting 2-3 agencies present highlights of their services
- Some meetings to include guest speakers (e.g., Health811)
- Include options for co-design within OHTs and community projects
- Frequency and location: Every second month, 60-90 minutes virtually via Zoom (hosted by CND OHT's Zoom)

In November, the OHT's sought feedback and input from the System Navigation working group members on the communications materials to promote the CoP and gather contacts to connect with the navigators. Next steps include finalizing the Front-Line Navigator Community of Practice flyer (meeting flyer) which includes a survey link to better understand the topics that navigators would like to discuss. These materials are anticipated to be circulated in December across both OHT's via email and social media to invite navigators across the region to join this new group to bridge connections. We anticipate the first CoP will be held early in Q4, this will depend on the response and availability of navigators.



KW4 OHT Digital Health Reference Group

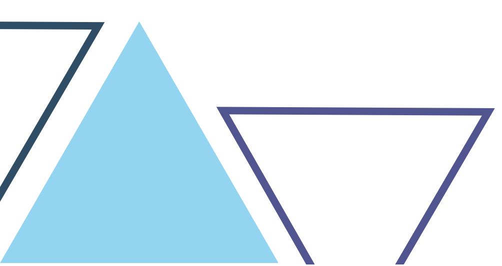
The KW4 OHT Digital Health Reference Group members met in November to discuss patient portals, secure provider messaging, and system navigation. A key highlight of the meeting was the presentation and demo of the My Connected Care patient portal, provided by Grand River Hospital's Chief Practice Information Officer, Tammy Wehrle. My Connected Care is a free patient portal where patients can:

- View parts of their health record: Labs, radiology reports, pathology, some clinical notes
- View upcoming appointments
- View problem list, procedure list, allergies, vital signs
- Patient information available for both KW4 hospitals from one account
- Community wide launch was July 10, 2023

The reference group members gained a better understanding of the functionalities of the portal, patient usage and feedback, and future items on the hospital's portal roadmap. The KW4 OHT along with the support of the Digital Health Reference Group looks forward to spreading more awareness about the portal across the region to aid in patient registration and ongoing usage of the portal.

For more information about the My Connected Care portal, along with how to register for an account, please visit
My Connected Care: SMGH or
My Connected Care: GHH

(information is the same for both hospital websites).



Secure Provider to Provider Messaging

Since our last update, a secure provider to provider (P2P) messaging survey was distributed to primary care providers in KW4 to gain their feedback and insight on the priorities and needs of a P2P messaging solution in our OHT. Accompanying this survey was a presentation and discussion by Dr. Mohamed Alarakhia about P2P messaging at the KW4xClinican Summit held on November 29th. A survey will also be shared in December with Community Support Services providers to understand their perspective and needs. The surveys will remain open for several weeks to provide an opportunity for the KW4 OHT to gather more feedback from providers and care teams across the region. The Summit feedback and the survey results will be synthesized in the new year to help inform the collective next steps of this initiative. This includes meeting with a variety of P2P solution vendors to better understand their product and services and how these may enable the KW4 region's integrated care priorities. Many thanks to the clinical advisors in primary care and the hospital leadership for supporting to move this work forward.

Newcomer App Project Status Report

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

Executive Sponsor: Dr. Charmaine Dean, University of Waterloo
Project Lead: Dr. Catherine Burns, University of Waterloo
Project Manager: Aderonke Saba
Report Due Date: November 27, 2023

Overall Status

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

Legend	On Track	(green)	At Risk	(yellow)	Serious Concerns	(red)

Milestones

Legend	On Track	(green)	At Risk	(yellow)	Overdue	(red)	Complete	✓

#	Project Milestone	Status	Target Due Date (yyyy/mm/dd)	Revised Date (yyyy/mm/dd)	% Complete	Comment
1	Approval of Project Charter	✓	2023/05/18	2023/06/30	100%	Completed.
2	Project Kickoff	✓	2023/01/23	NA	100%	Completed.
3	Project Agreement/ signed MOU by KW4 OHT and University of Waterloo	✓	2023/03/01	NA	100%	Completed.
4	Ethics Approval	✓	2023/05/03	NA	100%	Completed.
5	Interview data findings/ outcomes	✓	2023/10/31	NA	100%	Completed.
6	Co-design findings/ Design document	(green)	2023/12/30	NA	80%	Feedback survey from the co-design session has been analyzed. There was a 96.6% satisfaction rating by participants at the session. The research team held a couple of brainstorming sessions to identify and streamline features that will be beneficial to newcomers based on the top values identified at the co-design session.
7	Initial Prototype design	(green)	2024/01/31	NA	20%	Wireframe sketches were developed in line with identified features for the App.
8	Prototype Evaluation report		2024/04/30	NA	0%	
9	Revised Prototype design		2024/05/31	NA	0%	
10	Hire Software development company/Programmer		TBD	NA	0%	
11	App Development		TBD	NA	0%	
12	Quality Assurance and Testing		TBD	NA	0%	
13	Deployment and Support		TBD	NA	0%	
14	Field Evaluation of App		TBD	NA	0%	
15	Project Closeout		TBD	NA	0%	

Neighborhood Integrated Care Team Project Status Report

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

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

Executive Sponsor: John Neufeld, House of Friendship
Project Lead: Dauda Raji, House of Friendship
Project Manager: Aderonke Saba
Report Due Date: November 27, 2023

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

Legend: On Track (green) | At Risk (yellow) | Serious Concerns (red)

Milestones — Legend: On Track (green) | At Risk (yellow) | Overdue (red) | Complete ✓

#	Project Milestone	Status	Target Due Date (yyyy/mm/dd)	Revised Date (yyyy/mm/dd)	% Complete	Comment
1	Approval of Project Charter.		2023/05/31	2023/11/30	80%	The Project Charter has been reviewed based on the next steps approved by the Leadership Action Committee. The updated charter will be presented for approval at the next LAC meeting on Nov 30.
2	Formalize memorandum of Agreement between KW4 and project sponsor, House of Friendship.	✓	2023/02/01	NA	100%	Completed.
3	Establish project Leadership Advisory Committee (LAC)	✓	2022/12/01	NA	100%	Completed.
4	Develop Patient Personas, Journey Maps, and Integrated Care Pathways (ICPs).	✓	2023/06/20	2023/07/14	100%	Completed.
5	Develop a Neighborhood Integrated Care Team Model for Newcomers and Residents in priority neighborhoods		2023/12/31	NA	70%	Posters to promote self-referral to Diabetes Education Programs have been developed and printed. Attended the Waterloo and Wilmot Seniors Fair, created awareness and circulated posters to participants at the event.
6	Develop Social Prescribing model for the project.		2023/12/31	NA	50%	Social Prescribing to be incorporated into the 3 Integrated Care Pathways developed.
7	Deployment of digital enablers for service providers to efficiently and effectively coordinate patient care on the project.		2023/12/31	NA	50%	Progress with this milestone dependent on formation of project implementation teams.
8	Establish project implementation team(s).		2023/06/23	2023/12/31	20%	Collaborating with Regional Coordination Centre and House of Friendship to implement the creation of awareness to the Diabetes Central Intake Program.
9	Complete detailed implementation plan		2023/07/07	2023/12/31	20%	A work plan for the initiatives piloted through the Diabetes Pathway has been developed.
10	Complete project logic framework including indicator matrix and performance measures.		2023/07/07	NA	100%	Completed.

Neighborhood Integrated Care Team Project Status Report

11	Develop a communication strategy for the project.		2023/08/28	2023/12/31	90%	Communication strategy document in final stages of development.
12	Conclude evaluation of effectiveness and efficiency of the NICT model.		2024/03/08	NA	0%	
13	Initiate formal closeout processes.		2024/02/05	NA	0%	

Primary Care Integration and Governance Project Status Report

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

Executive Sponsor: Dr. Sarah Gimbel, New Vision Family Health Team
Project Lead: Dr. Neil Naik, Regional Primary Care Lead
Project Manager: Rebecca Petricevic
Report Due Date: November 29, 2023

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

Milestones	**Legend**	**On Track**	Green	**At Risk**	Yellow	**Overdue**	Red	**Complete**	✓

#	Project Milestone	Status	Target Due Date (yyyy/mm/dd)	Revised Date (yyyy/mm/dd)	% Complete	Comment
1	Approval of Project Charter	✓	2023/04/30	2023/09/19	100%	
2	Project Agreement/MOU signed by KW4 OHT and New Vision FHT.	✓	2023/01/10	NA	100%	
3	Project Planning and Project Kick-off	✓	2023/04/30	NA	100%	
4	Environmental Scan Complete	✓	2023/04/30	NA	100%	
5	Primary Care Network Development/ Governance Consulting report complete	✓	2023/04/30	2023/07/30	100%	
6	Preventative Cancer Screening initiatives implemented	Green	2024/01/31	NA	65%	Information session held and pilot clinics and clinicians identified. The business case to determine long term sustainability of the pilot is in development. Preventative screening information disseminated through meaningful discussion with over 300 people at the Waterloo and Wilmot seniors' fairs and the Regional Cancer Centre's 20th Anniversary weekend event. Additional information sessions are in the planning stages.
7	Clinician Engagement initiatives implemented	Green	2024/01/31	NA	65%	The third bi-annual Clinician Summit was held with over 100 registered to attend. Webinar on RSV, COVID, and Flu held in partnership with the Region of Waterloo Public Health.
8	Primary Care Network developed	Green	2024/03/31	NA	25%	PCN Development Committee convened. Co-Chairs elected. Deliverables agreed upon and subcommittees formed.

Primary Care Integration and Governance Project Status Report

9	Care pathways initiatives implemented		2024/01/31	NA	45%	Waterloo Wellington High Grade Colposcopy Central Intake launched.
10	Community Support Service Navigation		2024/03/31	NA	25%	Navigator and Project Lead hired in September. Draft referral pathway complete. Program in the process of set up on OCEAN eReferral and CareDove. Soft launch planned for December and initial clinician advisors engaged.
11	Interim Evaluation Report complete		2024/02/29	NA	25%	Performance measure tracking started.
12	Sustainability Plan developed		2024/02/29	NA	0%	
13	Identify opportunities to scale and spread to other providers and to other neighbourhoods		2024/02/29	NA	0%	
14	Project Closure/Lessons Learned		2024/03/31	NA	0%	
15	Final Evaluation Report complete		2024/04/30	NA	0%	