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

	Last Year		This Year	
	23.60	**22.60**	**28.40**	**26.30**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

KW4 OHT will develop Mental Health and Addictions patient personas, journey maps and integrated care pathways as part of the Neighbourhood Integrated Care Team (NICT) project. During this work we will consider how regional initiatives such as Ontario Structured Psychotherapy (OSP), Alternative EMS Destination Model for MHA related concerns, Acquired Brain Injury in the Streets, etc. play a role in the pathway. The aim of the project is to identify opportunities for improved integrated care and strategies for implementation that will stem from the journey maps and suggestions for improved transitions based on the integrated care pathways, and to use these learnings to inform the development of new integrated funding models. The integrated care pathways will outline the most appropriate care based on available evidence and a consensus of best practice, with a focus on improving transitions across providers and sectors to create a seamless experience for clients and providers. This work will be co-designed in collaboration with members, providers, and patients/clients, families and caregivers. Building on the learnings from our past two successful ICT pilots, and the newly developed integrated care pathways, as noted above, KW4 OHT will develop a Neighbourhood Integrated Care Team Model in our four priority neighbourhoods to identify high-risk clients and support them in the community through an integrated model of care that includes primary and community care. Our goal is to prevent ED visits and hospitalizations by improving the health and wellness of residents living in the community through enhanced support. In the design of the NICT we will consider the various drivers of health and wellness by looking at the social determinants of health such as education, housing, food security, transportation, income, social relationships, etc. to successfully wrap quality care and services around clients and families. We will also research and develop a model for social prescribing.

Process measure

- Once phase one of this improvement initiative is complete, KW4 OHT will be better positioned to develop process measures. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Successes:

• Through 4 in-person co-design sessions a persona, journey maps and integrated care pathway from intake to care delivery were created for youth transitioning to adult mental health services. A MH&A Working Group has been created to identify opportunities to begin implementation of the pathway.

• Several organizations from KW4 OHT along with other partner organizations and community organizations held a Youth Wellness Community Conversation to discuss the creation of Youth Wellness Hubs in Waterloo Region. The first event was attended by almost 100 people, demonstrating a high level of interest in collaborating to improve youth wellness in KW4. Subsequently, 30 people volunteered to be actively involved in the planning to help move this ahead in our Region.

• A Transitional Age Youth Clinic was created for youth aged 17-22 to address the challenges of lack of access to, and follow-up with, ongoing psychiatric care as youth turn 18 and age out of existing clinics. The clinic commenced in August 2023 and seeks to bridge the gap between primary care and specialist care.

• An Alternate Destination Clinic for Mental Health and Addictions Community Steering Committee has been established which includes representatives from community members with lived experience, mental health organizations and paramedic services. This is a collaboration between KW4 OHT and CND OHT. The Clinic aims to embed health equity, community engagement, and social determinants of health into their ongoing work. The model would allow Paramedics Services to transfer eligible patients to a 24/7 Walk-In Crisis Centre instead of dropping them off at a hospital emergency department.

Challenges:

• Mental Health Services have historically been siloed so navigation across services is difficult.

Lessons Learned:

• Collaboration with community members and various health and social organizations is essential to achieving integration and access however it can affect the speed of implementation.

Change Idea #2 ☑ Implemented ☐ Not Implemented

KW4 OHT plans to augment existing Mental Health and Addiction navigation tools as part of the Newcomer App project. The aim of the Newcomer App is to provide Newcomers with a technology that empowers them 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. This improvement initiative builds on work conducted by KW4 OHT in 2022, which involved the journey mapping of the lived experience of newcomers related to their health and wellness within the first two years of their arrival in KW4. The key themes from this exercise included: - many are not connected to primary care services - most are trying to self-navigate the health system and often use the ED as a point of care because of limited options - all spoke about their mental health challenges and the stress of “not knowing” or “waiting” despite wanting to be proactive and move forward. KW4 OHT will be working closely with Newcomers to determine what is most important to them in the co-design of this app in order to empower Newcomers to better integrate into our community. KW4 OHT will also be working with our members, including organizations who provide health services as well as settlement agencies, along with our community at large to ensure that the services our community provides to Newcomers or the opportunities our community has for Newcomers are considered. This app will also help providers better understand the types of resources and services being searched for by newcomers and thereby provide valuable insight into the value of current programs/services and their possible evolution.

Process measure

- KW4 OHT is continuing to finalize process measures. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information. Some preliminary measures we are considering include app download and retention rates, user and provider satisfaction surveys, up-time rates, etc.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Successes:
• KW4 OHT along with our partners are developing a Newcomer App to help Newcomers self-navigate to health and social services. This work has involved collaborating with the University of Waterloo to conduct interview sessions with Newcomers to identify needs and understand gaps in navigating services. A co-design session to create features that Newcomers will find useful in the App was also held. Prototype development and evaluation is ongoing.

Challenges:
• Finding translation services to allow Newcomers to access the information in the app in the language they prefer has been challenging. Work in this area is ongoing.
• Grant funding outside of the OHT is required to continue with this work.

Lessons Learned:
• Navigating ethical approvals can take longer than anticipated and therefore adequate time should be built into the timelines.
• Co-designing the solution with the intended end-user and collaboration between the OHT, an academic institution, settlement organizations, and mental health organizations is fundamental to the success of this work.
• Obtaining insights from industry leaders has been an asset.

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

KW4 OHT will support primary care providers' and MH&A specialists' engagement and participation in co-designing an integrated model as part of Primary Care Integration and Governance Project. These models will wrap services around the patient, improving the coordination of services, facilitating better collaboration among providers and providing better healthcare to the population. Primary Care Providers are an integral part of OHTs and their leadership in building inter-professional, integrated teams that share accountability for patients is key.

Process measure

- KW4 OHT is continuing to finalize process measures. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information. Some preliminary measures we are considering include number of primary care providers engaged in KW4 OHT work, provider experience surveys to evaluate cross-sectoral team collaboration, cooperation, and partnership, etc.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Successes:

• KW4 OHT has hosted 3 Clinician Summits which bring together primary care, specialist, and other healthcare professionals to discuss initiatives in the region and topics of common interest. At our last Summit in November 2023, we hosted 58 attendees including Mental Health and Addictions community providers to discuss connection points with primary care and specialists. The attendees learned about a central intake process from the Counselling Collaborative that streamlines mental health referrals to 5 community organizations.

• Community mental health and addictions service providers such as The Working Centre, Sanguen, and Reception House along with primary care providers and Community Healthcaring KW (a community health centre) developed a rapid access to primary care pilot clinic for unattached patients with frequent visits to emergency department for non-urgent care, including but not limited to mental health and addictions.

• A Community Support Service Navigation Team pilot was developed. The team is physically embedded in a space with a concentration of primary care providers who practice in a FHO model. The program has 4 clinician advisors who have been instrumental in its development. The program has been actively accepting referrals since December 2023 and 70-80% of referrals received involve mental health support.

Challenges:

• Given the number of mental health and addictions providers and services available, primary care providers and specialist providers are challenged with maintaining up to date information and awareness of all options available to their patients. This provides the opportunity to further the work of a central intake model.

Lessons Learned:

• It is beneficial to provide primary care providers with regular reminders of the mental health and addiction services available through multi-modes of communication such as digital and in-person.

• Access to community service navigation support is key for primary care providers. It can help facilitate the connection to the mental health and addictions community supports available.

• We have learned the importance of facilitating regular connection points to encourage ongoing co-design efforts. As a result, our Mental Health and Addictions working group has updated their Terms of Reference to include updating and connecting regularly with primary care leadership moving forward.

Area of Focus- Improving Overall Access to Care in the Most Appropriate Setting | 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)

Last Year		This Year	
22.80	**21.60**	**19.30**	**17.40**
Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

KW4 OHT will develop senior patient personas, journey maps and integrated care pathways as part of the Neighbourhood Integrated Care Team (NICT) project. During this work we will consider how regional initiatives such as Let's Go Home (LEGHO), etc. play a role in the pathway. We will also consider the recommendations that come from the review of regional palliative services in our community as well as the recommendations that come from the review of regional specialized geriatric services in order to maximize resources and improve overall care for the frail elderly. The aim of the project is to identify opportunities for improved integrated care and strategies for implementation that will stem from the journey maps and suggestions for improved transitions based on the integrated care pathways, and to use these learnings to inform the development of new integrated funding models. The integrated care pathways will outline the most appropriate care based on available evidence and a consensus of best practice, with a focus on improving transitions across providers and sectors to create a seamless experience for clients and providers. This work will be co-designed in collaboration with members, providers, and patients/clients, families and caregivers.

Process measure

- KW4 OHT is continuing to finalize process measures. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information. Some preliminary measures we are considering include the number of personas and journey maps developed, number of clients/patients, families and caregivers as well as providers engaged in this process, etc.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Successes:
• Through 4 in-person co-design sessions two personas, journey maps and integrated care pathway from intake to care delivery were created including one for seniors with heart failure and another for people with diabetes.

Lessons Learned:
• Collaboration with community members and various health and social organizations is essential to achieve integration and access however it can affect the speed of implementation.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Building on the learnings from our past two successful Integrated Care Team pilots, and the newly developed integrated care pathways, as noted above, KW4 OHT will develop a Neighbourhood Integrated Care Team Model in our four priority neighbourhoods to identify high-risk clients and support them in the community through an integrated model of care that includes primary and community care. Our goal is to prevent ED visits and hospitalizations by improving the health and wellness of residents living in the community through enhanced support. In the design of the NICT we will consider the various drivers of health and wellness by looking at the social determinants of health such as education, housing, food security, transportation, income, social relationships, etc. to successfully wrap quality care and services around clients and families. We will also research and develop a model for social prescribing.

Process measure

- Once the Integrated Care pathways have been developed (improvement initiative 1), KW4 OHT will be better positioned to develop process measures for this improvement initiative. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Successes:
• A couple initiatives have stemmed from the development of the diabetes integrated care pathway as noted above. First, a program was developed to increase awareness about the ability to self-refer to the diabetes education programs. This involved designing posters and translating them into the top ten languages in KW4 and circulating them through community programs and events. Collaboration with the Regional Coordination Centre who coordinates the diabetes education pathway and other community organizations was key in the success of this initiative. The second initiative stemming from the diabetes pathway included the roll-out of the Diabetes Fit Program in our priority neighborhoods in collaboration with the YMCA of Three Rivers. This program provides access to community supports (diet education, exercise, and transportation), and social connections for patients living with pre-diabetes and type 2 diabetes with the goal of improving quality of life through increased levels of physical activity and improved physical fitness. The first intake included 15 participants from our priority neighborhoods.
• KW4 OHT is currently exploring opportunities to collaborate with our regional cardiac centre to support seniors with heart failure as they transition into the community.
• KW4 OHT continued to build on the Remote Care Monitoring (RCM) and Surgical Transition Program. This program monitors heart failure patients from the heart failure clinic. On average, 80 patients are monitored per month for an average of 89 days. There has been a 96% patient satisfaction rating overall and 80% of patients had a decreased need to visit family doctor/nurse practitioner or walk-in clinic.
• KW4 OHT also continued to build on the Let's Go Home (LEGHO) program which supports ED Diversion/ Admission Avoidance and Hospital Discharge. LEGHO supports the discharge processes for vulnerable older adults and persons with disabilities by offering a customized comprehensive bundle of community support services and access to a continuum of health and social supports in the community, thereby supporting access and flow across the system and addressing barriers to discharge. The program has been well received by hospitals and has been of great benefit to patients.
• KW4 OHT also continues to build on the SCOPE (Seamless Care Optimizing the Patient Experience) program. This program promotes integrated and collaborative work between primary care, hospital services and community health partners to serve patients with complex needs. Through a single point of access, primary care providers are connected with a Nurse Navigator who assists with navigating the health care system, to ensure providers and patients are connected to the appropriate resources in the timeliest way possible. By connecting primary care providers to appropriate resources, unnecessary Emergency Department visits and hospital admissions are avoided, ultimately avoiding ALC.

Challenges:
• KW4 OHT was unable to implement the full extent of these pathways in this fiscal year due to time constraints.

Lessons Learned:
• Collaboration between organizations is essential.

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

KW4 OHT will support the expansion of the Complex Care Program (CCP), Integrated Care Team (ICT) for Older Adults, and GeriMedRisk project for upstream prevention of older adults living with complex and chronic conditions who are rostered with primary care provider practices without an inter-professional team, high-risk older adults living in retirement homes, and older adults waiting on the Specialized Geriatric Services (SGS) waitlist, as well as supporting the safe and timely discharge of hospitalized patients in lieu of ALC designation or after ALC designation. An interdisciplinary team of clinicians and administrators will support older adults living with complex and chronic conditions while they wait to see a geriatrician and/or geriatric psychiatrist. This integrated care team will provide service referral and delivery in concert with a geriatrician/geriatric psychiatrist's assessment, building a comprehensive care plan of health and social care supports that reflect multiple service providers in the region working seamlessly as one team. This project builds on 'Integrated Care System for Frail Elderly with Complex Needs,' a model of care created based on feedback from the KW4 OHT Frail Elderly Working Group. The KW4 Integrated Care Team for Older Adults (ICT) was piloted in Winter 2022 and lessons learned from that pilot will be used to build a sustainable model with efficient pathways to support integrated care for patients across the KW4 OHT catchment area. The ICT is the first step in creating new care pathways and will serve as a quality improvement project with PDSA cycles. The creation of new care pathways will be accomplished through the use of digital tools for case finding and navigation.

Process measure

- As this initiative is supported by Ontario Health, as part of the government's ALC Strategy, bi-weekly progress reporting to OH West is required. This includes reporting on how many patients/clients has the initiative served, how many patients/clients were diverted from the emergency department and/or a hospital admission, how many beds were opened, and net new full-time equivalent staffing and service delivery volumes associated with funding. The group is considering a dashboard with indicators in addition to the volume indicators OH West is looking for. Some of the measures we are considering include patient and care partner satisfaction, number of patients served, number of referrals made, number of patients scheduled for follow-up vs. returned to primary care, and provider satisfaction.

Target for process measure

- Once process measures have been finalized, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Successes:
• The CCP ICT project received funding from OH West under the Government ALC strategy. This initiative supports seniors living with complex and chronic conditions who are rostered with primary care providers practicing without an inter-professional team. Utilization of Hypercare across clinicians and providers for secure communication. This project saw:
o The addition of family health organizations, inclusive of 7 individual providers to the project.
o 231 patients assessed in 6 months (while building the team)
o 9.8 new patients per week
o 62% of patients followed for ongoing care and case management
o 82% of patients indicating they are more confident in managing their health.
o 100% of ICT members and primary care providers were satisfied with their experience with 100% response rate n=30.

Challenges:
• Securing sustainable funding to continue to expand this initiative.

Lessons Learned:
• Collaboration between different providers was pivotal in the success of this project.

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

Pilot an initiative for people living with dementia to prevent hospital readmission.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Progress/Successes:
• KW4 OHT is piloting the DREAM (Dementia, Resource, Education, Advocacy, Mentorship) initiative for people living with dementia to prevent hospital admissions. The potential benefits of this pilot include increased ER capacity, connection to community resources, admission diversion, reduced alternate level of care, reduced return visits to ER due to caregiver burnout and substantial savings to the healthcare system. A resource (RPN/social worker trained in behaviour prevention) is embedded in the Emergency Department of Grand River Hospital to help identify community resources, help with access, and support transition from hospital to home through the Alzheimer's Society respite program which offers support through a third party – Home Instead – who provides activation/therapeutic support (not personal care) for up to 12 hours per week or 40 hours per month to relieve caregiver burden. Since the onset of the initiative, there have been 39 clients who received system navigation and referral support and 14 diverted safely home with respite and other supports initiated.

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

	Last Year		This Year	
Indicator #5 Percentage of screen-eligible people who are up to date with Pap tests (Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT)	**55.10** Performance (2023/24)	**56.50** Target (2023/24)	**58.50** Performance (2024/25)	**59.60** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

KW4 OHT will increase public outreach and education through various channels and in various languages for all three screening areas of focus. The focus of this work will be on developing and engaging in equity-driven and culturally appropriate community outreach. This will involve providing primary care with cancer screening resource in various languages. This will also involve engaging community leaders/ambassadors and associations (i.e., Muslim Women's Association) to assist in increasing public awareness and in encouraging screening.

Process measure

- KW4 OHT is continuing to finalize process measures. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Successes:
• In partnership with the Waterloo Wellington Regional Cancer Centre (WWRCP), webpages focused on preventative screening have been enhanced to include Google Translate. This allows patients to access information in the language of their choice. We have also included more clarity for unattached patients who wish to find preventative screening.
• We have hosted 5 booths at local events to share information and materials from the WWRCP, encouraging patient awareness. We have spoken with approximately 700 individuals. The materials were shared in a variety of languages.
• The WWRCP celebrated their 20th anniversary with a series of events focused on encouraging preventative screening, including the popular Mobile Mole Bus.
• We created, designed, and are running an advertising campaign to promote preventative screening. Ads are strategically located in our priority neighbourhoods and include QR codes to direct individuals to the updated WWRCP webpages. The campaign aims to encourage patient knowledge and awareness of their options regardless if they have a primary care provider or not and is scheduled to run from the end of January until April 2024.
• In collaboration with the YWCA and Community Healthcaring KW, we held a preventative screening information session for the Investing in Women's Futures program. The program participants are newcomers who identify as female.

Challenges:
• Many organizations are focused on this work but are siloed or pursuing these common goals separately. Organizational alignment directed from a local level but also a provincial level will assist in creating more alignment.

Lessons Learned:
• Patients need to be engaged on their terms.
• As evaluation of initiatives is conducted, being able to pivot based on the results is an important part of any PDSA cycle.
• We explored the option of the Regional Primary Care Lead signing off for unattached patient results. While it is technically possible, the solution would be unsustainable. We have therefore pivoted our efforts to direct unattached patients to contact 811.
• We need to continue to advocate for system changes that are geared to patients without a primary care provider (i.e. there are limitations regarding unattached patients being able to access FIT kits at community locations such as pharmacies, shelters, libraries).

Change Idea #2 ☑ Implemented ☐ Not Implemented

KW4 OHT will work with our partners to offer additional cervical screening opportunities in our priority neighbourhoods. This will begin with a survey to help identify the barriers primary care practitioners and other key stakeholders face in providing cancer screening. In parallel to this, we will identify barriers from a patient perspective. Information collected will be used to inform the creation or augmentation of screening services including encouraging/enabling primary care to screen their eligible patients and other strategies for unattached patients.

Process measure

- KW4 OHT is continuing to finalize process measures. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Success:
• We explored the feasibility of providing a collaborative pop-up pap clinic.
• We connected with several other OHTs who had pursued similar solutions to understand their experience and the outcomes of their clinics.
• We surveyed primary care providers to understand their ability, incentives, and barriers to participate in a pop-up clinic.
• Two local organizations pursued pop-up pap clinic days. Collectively they administered over 75 pap tests.
• KW4 OHT worked with the Centre for Family Medicine FHT Mobility clinic to improve equity and access to screening. The clinic, which provides accessible space and necessary equipment during screening, and any required follow-up, provides cervical and breast cancer screening for persons with physical disabilities. The clinic worked with KW4 OHT to develop and distribute posters to promote this service with primary care providers.

Challenges:
• While there was some interest in creating a pop-up clinic, the cost efficiency and cost-benefit analysis identified challenges with scaling this initiative.
• Target neighbourhoods include some non-OHIP patients however they will not show up on provincial tracking mechanisms.

Lessons Learned:
• A review of the success and challenges of the pop-up clinic is required to determine opportunities for improvement.
• Additional insight into how best to target the intended populations and designing effective marketing strategies is required.

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

KW4 OHT will work toward increasing system capacity by training nursing staff to perform pap tests.

Process measure

- KW4 OHT is continuing to finalize process measures. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Success:
• We connected with several nurses and determined that there is interest in expanding their scope of practice and in pursuing this training.

Challenges:
• We reached out to several organizations and found there were low levels of interest to host additional nursing staff
• There did not appear to be additional, regular clinic space for the trained nurses to conduct the screening.

Lessons Learned:
• We need to look at non-HR resources for space and launching this program.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Implement new referral program for patients with a high-grade pap test to see a Colposcopist.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Progress/Success:
• KW4 OHT and our partners at eHealth Centre of Excellence, Waterloo Wellington Cancer Program, Grand River Hospital, St. Mary's General Hospital, and the SCOPE Program were excited to be featured in an article highlighting the new pilot program for cervical cancer patients - https://kitchener.citynews.ca/2024/01/25/new-referral-program-means-faster-treatment-for-cervical-cancer-patients-in-the-region/
• We are proud to be leading the way by being the first multi-site central intake pilot. The centralized referral program will make transferring patient's information between primary care providers and specialists easier, while also decreasing wait times.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Leverage digital tools to assist patients and providers with screening.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Progress/Success:
• Many of the clinicians in KW4 use digital tools to support their work.
• KW4 OHT is leveraging online appointment booking (OAB) to provide additional convenience for patients to book screening appointments. As of December 2023, 116 licenses (physician, nurse practitioner, and allied health providers) in KW4 are reported to be using OAB under the Ontario Health funding. 18 of these OAB licenses are net new for FY 23/24.
• KW4 OHT launched a pilot initiative with a FHO physician to implement an automated bot called Poppy Bot with the eHealth Centre for Excellence. This bot offers an automated solution or virtual assistant that identifies patients overdue for cancer screening through advanced algorithms, stratifies identified patients into priority groups and automatically initiates patient follow-up such as the completion of FIT requisitions and direct patient communication through existing secure messaging channels. The aim of this initiative is to reduce administrative burden. This first pilot clinic began in early 2024 with evaluation beginning in March 2024.

Challenges:
• The screening incentive being rescinded has negatively impacted one of the motivating factors for primary care providers to engage in and pursue solutions in this area.

	Last Year		This Year	
Indicator #4 Percentage of screen-eligible people who are up to date with mammograms (Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT)	**58.50** **Performance (2023/24)**	**58.70** **Target (2023/24)**	**58.20** **Performance (2024/25)**	**61** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

KW4 OHT will increase public outreach and education through various channels and in various languages for all three screening areas of focus. The focus of this work will be on developing and engaging in equity-driven and culturally appropriate community outreach. This will involve providing primary care with cancer screening resource in various languages. This will also involve engaging community leaders/ambassadors and associations (i.e., Muslim Women's Association) to assist in increasing public awareness and in encouraging screening.

Process measure

- KW4 OHT is continuing to finalize process measures. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Successes:
• In partnership with the Waterloo Wellington Regional Cancer Centre (WWRCP), webpages focused on preventative screening have been enhanced to include Google Translate. This allows patients to access information in the language of their choice. We have also included more clarity for unattached patients who wish to find preventative screening.
• We have hosted 5 booths at local events to share information and materials from the WWRCP, encouraging patient awareness. We have spoken with approximately 700 individuals. The materials were shared in a variety of languages.
• The WWRCP celebrated their 20th anniversary with a series of events focused on encouraging preventative screening, including the popular Mobile Mole Bus.
• We created, designed, and are running an advertising campaign to promote preventative screening. Ads are strategically located in our priority neighbourhoods and include QR codes to direct individuals to the updated WWRCP webpages. The campaign aims to encourage patient knowledge and awareness of their options regardless if they have a primary care provider or not and is scheduled to run from the end of January until April 2024.
• In collaboration with the YWCA and Community Healthcaring KW, we held a preventative screening information session for the Investing in Women's Futures program. The program participants are newcomers who identify as female.

Challenges:
• Many organizations are focused on this work but are siloed or pursuing these common goals separately. Organizational alignment directed from a local level but also a provincial level will assist in creating more alignment.

Lessons Learned:
• Patients need to be engaged on their terms.
• As evaluation of initiatives is conducted, being able to pivot based on the results is an important part of any PDSA cycle.
• We explored the option of the Regional Primary Care Lead signing off for unattached patient results. While it is technically possible, the solution would be unsustainable. We have therefore pivoted our efforts to direct unattached patients to contact 811.
• We need to continue to advocate for system changes that are geared to patients without a primary care provider (i.e. there are limitations regarding unattached patients being able to access FIT kits at community locations such as pharmacies, shelters, libraries).

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

Leverage digital tools to assist patients and providers with screening.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Progress/Success:
• Many of the clinicians in KW4 use digital tools to support their work.
• KW4 OHT is leveraging online appointment booking (OAB) to provide additional convenience for patients to book screening appointments. As of December 2023, 116 licenses (physician, nurse practitioner, and allied health providers) in KW4 are reported to be using OAB under the Ontario Health funding. 18 of these OAB licenses are net new for FY 23/24.
• KW4 OHT launched a pilot initiative with a FHO physician to implement an automated bot called Poppy Bot with the eHealth Centre for Excellence. This bot offers an automated solution or virtual assistant that identifies patients overdue for cancer screening through advanced algorithms, stratifies identified patients into priority groups and automatically initiates patient follow-up such as the completion of FIT requisitions and direct patient communication through existing secure messaging channels. The aim of this initiative is to reduce administrative burden. This first pilot clinic began in early 2024 with evaluation beginning in March 2024.

Challenges:
• The screening incentive being rescinded has negatively impacted one of the motivating factors for primary care providers to engage in and pursue solutions in this area.

Indicator #3

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

Last Year		This Year	
64.20	**64.50**	**64.70**	**65.40**
Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

KW4 OHT will increase public outreach and education through various channels and in various languages for all three screening areas of focus. The focus of this work will be on developing and engaging in equity-driven and culturally appropriate community outreach. This will involve providing primary care with cancer screening resource in various languages. This will also involve engaging community leaders/ambassadors and associations (i.e., Muslim Women's Association) to assist in increasing public awareness and in encouraging screening.

Process measure

- KW4 OHT is continuing to finalize process measures. As these are developed, we will ensure alignment with the Quintuple Aim of improved Patient and Caregiver Experiences, Patient and Population Health Outcomes, Provider Experiences, Value and Efficiency, and Health Equity. As part of this process, we will also identify how the related data will be captured, when and how frequently data collection will occur and who is responsible for collecting and disseminating the information.

Target for process measure

- Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.

Lessons Learned

Progress/Successes:
• In partnership with the Waterloo Wellington Regional Cancer Centre (WWRCP), webpages focused on preventative screening have been enhanced to include Google Translate. This allows patients to access information in the language of their choice. We have also included more clarity for unattached patients who wish to find preventative screening.
• We have hosted 5 booths at local events to share information and materials from the WWRCP, encouraging patient awareness. We have spoken with approximately 700 individuals. The materials were shared in a variety of languages.
• The WWRCP celebrated their 20th anniversary with a series of events focused on encouraging preventative screening, including the popular Mobile Mole Bus.
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Lessons Learned

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