Collaborative quality improvement plan (cQIP)

Narrative for Ontario Health Teams

March 31, 2023

PROVIDE AN OVERVIEW OF YOUR OHT AND PATIENT POPULATION

In 2019, Ontario Health Teams otherwise known as OHTs were introduced as a way of better connecting a fragmented system in their local communities. There are currently 54 OHTs across the province, with another 4 being considered.

In October 2020, KW4 OHT officially became an OHT. KW4 is the acronym we use to describe our OHT's geographic area with the 'K' representing the City of Kitchener, and the 4Ws representing the City of Waterloo, and the 3 Townships of Wellesley, Wilmot and Woolwich.

The KW4 Ontario Health Team is a collective of 40 member organizations from primary care, home care, hospitals, community agencies, long-term care, mental health and addictions, municipalities and post-secondary education. Together with patients and families, the KW4 OHT is working towards co-designing a health and wellness system for all 400,000 residents. This system will offer seamless, interconnected care and continuity across providers.

Recognizing the importance of focusing our improvement initiatives in order to effectively allocate our finite resources, and generate an impactful, measurable change before scaling and spreading across our community, KW4 OHT began to engage our members and our community to determine the area of greatest need. We also looked at our data from a health equity perspective as health equity is central to the work of the KW4 OHT. KW4 OHT adopted Wellbeing Waterloo Region's community aspiration of "A community where everyone thrives, and no one is left behind" as our vision.

Based on this, KW4 OHT Members approved that Newcomers and the four neighbourhoods where the highest proportion of recent immigrants reside will be our area of focus for this 2023/24 fiscal year.

The rationale behind selecting this population is multifold. Canada, under its latest Immigration Levels Plan, is looking to welcome over 460,000 new immigrants each year, which is the highest levels in its history. Our Region is identified as a designated resettlement area for Government Assisted Refugees (GARs) and other newcomers so we know our local numbers will also continue to grow. In fact, the number of new permanent residents settling in the Waterloo-Wellington region almost tripled between 2020 and 2021.

Research on the physical health of immigrants in Canada demonstrates that immigrants tend to be healthier than non-immigrants upon arrival in Canada. However, across every immigration category the longer immigrants live in the country the more their health declines. The experience of arriving with a health advantage and losing it over time is called the 'healthy immigrant effect". A number of factors contribute to declining health outcomes among immigrants, such as income levels, official language proficiency, circumstances of arrival, original location, unfair treatment or discrimination, health literacy and ability to integrate.

Based on the 2021 Statistics Canada Census Data we also know that Immigrants accounted for just over a quarter of the population in KW4 in 2021, with newcomers, which is defined as those arriving in the last 5 years, accounting for just over 5% of the population.

From a growth perspective, we also know that recent immigrants made up a large proportion of the KW4's population growth. The total population of KW4 grew by just over 43,000 in the last 5 years and recent immigrants made up more than half of that growth.

We also know that relocating to KW4 can come with challenges. Recent immigrants are twice as likely to be living in unaffordable housing, six times more likely to be living in unsuitable housing, twice as likely to be unemployed and three times more likely to be living in poverty.

When we look at our health data, neighbourhoods where the highest proportion of recent immigrants reside are among the same neighbourhoods that are disproportionately impacted. These neighbourhoods account for only 19% of the population in KW4 but:

- 36% of hospitalization for conditions best managed elsewhere, including angina, asthma, COPD, diabetes, epilepsy, heart failure and hypertension.
- 32% of Alternate Level of Care (ALC) cases. A patient is designated as ALC when they no longer require hospital care and are awaiting discharge to an alternate location.
- 32% of Frequent Emergency Department (ED) visits for Help with MH&A
- 26% of ED visits as the First Point of Contact for MH&A care

These neighbourhoods also have the lowest cancer screening rates in KW4 OHT and are 13-17% below the screening rates of the best performing neighbourhoods in KW4.

As we consider the initiatives which we wished to include in our

2023/24 cQIP, we knew that many regional initiatives and the work of the KW4 OHT's three priority projects are already focused on improving overall access to care in the most appropriate setting, increasing access to community mental health and addictions services, as well as increasing overall access to preventative screening. In this year's cQIP, we will therefore show alignment of these provincial areas of focus with the work we are already doing, as we see the cQIP as being part of our work rather than something separate.

Through the creation of neighbourhood integrated care teams, KW4 OHT aims to address disparities that limit access to health and wellness services for residents in our four priority neighbourhoods. This work builds on the Refugee Health and Specialized Geriatric Services Integrated Care Team pilots, as well as the Newcomer Journey Map exercise completed last year. These initiatives led to improvement in care for the populations we serve that are more commonly affected by social determinants.

DESCRIBE YOUR OHT'S GREATEST QUALITY IMPROVEMENT (QI) ACHIEVEMENT FROM THE PAST YEAR

KW4 OHT has three quality initiatives from last year which we would like to highlight as they have shaped our areas of focus and strategic initiatives for 2023/24.

The first initiative is related to the KW4 OHT Frail Elderly Integrated Care Team (ICT) pilot. This involved multiple partners of the KW4 OHT, including those involved in the care of persons at risk of, or living with, frailty. The Geriatric Medicine Complex Care Clinic (GMCC) serves older adults living with complex and chronic conditions. At the time of the pilot, the GMCC had a lengthy waitlist of approximately 445 patients, with an average wait time of approximately 175 days. The partners agreed to focus on re-triaging and better characterizing concerns and needs using the interRAI Check-up and offering support to those patients waiting to see a geriatrician at GMCC. 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. This approach favoured person-centered support of patients with complex health needs, including identifying personal goals, managing symptoms, and advanced care planning. During the six-week pilot, the ICT contacted 138 older adults on the GMCC waiting list, exceeding the original goal of 100. To capture the experiences of those involved with the ICT pilot, surveys were sent to patients and care partners, referring primary care providers, and ICT members. From a patient and care partner perspective, 84% rated their overall experience with the ICT as satisfied or very satisfied, and 77% agreed or somewhat agreed that the ICT would be helpful to access in the future if it were available. From a primary care provider perspective, 82% of respondents agreed or somewhat agreed that the ICT was helpful in the overall management of their patients and 94% agreed or somewhat agreed that they would find it helpful to access a team of resources like the ICT for complex geriatric patients in the future if it were available.

The second initiative is related to the KW4 OHT Refugee Health Integrated Care Team (ICT) pilot. The ICT is an interdisciplinary team from several partner organizations. The goal of the ICT is to provide support to Primary Care Providers (PCPs) participating in this program by directly delivering or linking refugee clients to, additional care and services, including mental health and

community-based services. This pilot successfully transitioned almost 500 medically stable patients, exceeding the goal of 300. Just over 90% of patients were provided with assistance in booking their first intake appointment and transitioning to their new clinic, 8% received more intensive support and referral to additional team members. Learning from this pilot will help inform the Neighbourhood Integrated Care Teams that KW4 OHT is creating. The in-development final evaluation report will include patient and provider data.

The third initiative is related to the KW4 OHT Newcomer Journey mapping exercise. With this initiative, KW4 OHT sought to better understand and improve the lived experiences of newcomers within the first two years of their arrival in KW4 with regard to their health and wellness. The KW4 OHT co-designed this project with the Refugee Health Working Group and recruited participants using various techniques and culturally and linguistically appropriate information resources. We translated the information poster into five languages and shared it with various local health and community care centers across the region. We conducted 20 qualitative individual interviews. Co-interpretation of research findings with people who had lived experience of newcomers' health allowed us to ensure the relevance, robustness and potential impact of the project outcomes for newcomers. The outcomes of this project helped inform a people-centered integrated health system approach to service redesign and the opportunity for a technological solution to improve newcomers' ability to self-navigate local health and social services toward more equitable population health outcomes.

DESCRIBE PATIENT/CLIENT/RESIDENT/PROVIDER ENGAGEMENT AND PARTNERING

Patient/clients/residents, families and caregivers are involved in all aspects of our KW4 OHT work. We have a Steering Committee consisting of 5 community leaders and 5 service provider leaders. Two of the five community members are experienced members of local and provincial Patient and Family Advisory Committees (PFAC) organizations.

We also have a Community Council Design Committee (CCDC) - embedded in our CDMA as our vision for an evolved PFAC. The continuously evolving group collectively brings the intersectionality of lived experiences evident across our community. There is agreement to leave open chairs at the table as the group continues with their work.

In September of 2021, KW4 OHT approved a Community Engagement Strategy. Our goals for Community Engagement include:
- Be guided by and honour the lived experiences and diverse ways of knowing and being of patients and recipients of care.
- Think and act in new ways to achieve equitable access to a safe, inclusive, and representative health and wellness care system.
- Focus intentionally on the historically excluded and our target populations.

In September of 2022, the CCDC approved the guiding principles as shown in the table below.

The involvement of patients, families and caregivers in the co-design of our cQIP has helped to ensure a patient centered approach, which will positively influence the patient/caregiver

experience. Multi-disciplinary implementation teams have been, and will continue to be, established for each of our cQIP initiatives. These implementation teams will include stakeholders from the KW4 OHT member organizations as well as patient, family, caregiver advisors.

For example, as part of our Neighbourhood Integrated Care Team (NICT) Project we will develop patient personas and journey maps to outline the path newcomers and residents in priority neighbourhoods follow when accessing care. One of the personas/journey maps will be related to seniors and how to improve overall access to care in the most appropriate setting and another will be related to mental health and addictions and improving overall access to community services. As part of this exercise, we will identify opportunities for improved integrated care and strategies for implementation. We will also create integrated care pathways. Patient/clients/residents, families and caregivers as well as providers, will be instrumental in informing this work.

PRINCIPLES	HOW	EXAMPLES
PARTNERSHIP	We will forge authentic and mutually beneficial relationships to build trust	Working with members in the most suitable capacity with their experience
EMPOWERMENT	We will empower community members and partners to openly express themselves	Sharing relevant resources and tools Supporting members into leadership roles and beyond
TRANSPARENCY	We will be open, honest, and inclusive at all times	Sharing scope of influence upfront Being open about constraints, etc.
RESPONSIVENESS	We value input and will incorporate it in programs, policies, etc.	Multiple channels of feedback available Regular project updates to members
RESPECT	We respect the lived experience of our members in our engagement with them	Use culturally appropriate language to address members across different identities
EQUITY	We will employ an equity-informed lens throughout our engagement cycle	Incorporate diversity and inclusion best practices in member recruitment

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on

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cQIP lead

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Other leadership as appropriate

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Other leadership as appropriate

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