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

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency department visit as first point of contact for mental health and addictions–related care	P	% / People Marginalized populations in KW4	See Tech Specs / October 2022 to September 2023	28.40	26.30	50th percentile of Ontario Values	Camino Mental Health + Wellbeing, Counselling Collaborative Waterloo Region, Centre for Family Medicine FHT, Chaplain Family YMCA, Lutherwood, Woolwich CHC, Langs, Somali Canadian Association of Waterloo Region, Sanguen Health, Region of Waterloo, Thresholds Homes and Supports, Canadian Mental Health Association Waterloo Wellington, Waterloo Region Police Services, Region of Waterloo Paramedic Services, Traverse Independence, House of Friendship, Homewood Health, Maplehurst Correctional, Vanier Correctional, Native Inmate Liaison Officer, Interfaith Counselling Centre, Porchlight Counselling and Addictions Services, Woolwich Counselling Centre, Shalom Counselling Services

Change Ideas

Change Idea #1 Continued roll-out of Ontario Structured Psychotherapy (OSP) to adults with depression and anxiety-related concerns. OSP services are based on cognitive-behavioural therapy approaches which teaches people how to change their patterns of behaviour and thinking.

Methods	Process measures	Target for process measure	Comments
The KW4 OHT Mental Health and Addictions Working Group will oversee and monitor progress on this initiative during their meetings which occur four times per year.	- # of presentations to social service/health agencies - # of referrals - # of views of OSP referral page on partner agency websites - patient experience - % satisfied with the OPS program - Patient outcomes - pre and post measures (Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder Questionnaire (GAD-7))	- Provide referral presentations/resources to 15 Waterloo-based social service/health agencies by March 31, 2025 - Increase the number of Waterloo Region residents referred to OSP to 150% of the caseload for two FTE's by March 31, 2025 - Increase views of OSP referral page by 100% from 40 views per month to 80 views per month by May 1, 2024 - 80% of patients indicated they were very satisfied or satisfied with their experience with the OPS program - 70% of patients enrolled in the OSP program reported lower PHQ-9/GAD-7 scores after completing the program	

Change Idea #2 Continue to explore the establishment of Youth Wellness Hubs that provide high-quality integrated youth services to support the well-being of young people aged 12 to 25, including mental health and substance use supports, primary health care, community and social supports, and more. The aim of this Community Collaborative is to offer a model that combines recreation, school support, mental health services, and connection, all designed with input from youth and led by the community.

Methods	Process measures	Target for process measure	Comments
A consultant is being procured to support this work and will report progress to a Steering Committee.	- EOI for consultant issued and consultant hired - Approach to the wellness hubs initiative determined - Framework that meets the needs of Waterloo Region established - Proposal developed and submitted to the Ministry of Health - # and range of diverse group of agencies represented and participating in the planning, potential partnerships, etc.	- Consultant in place by April 15, 2024 - Approach and framework determined by September 30, 2024 - Proposal developed and submitted by March 31, 2025 - 150 people and 30 organizations/agencies engaged in process.	Additional collaborators will be identified as the approach, framework and partnerships are determined.

Change Idea #3 Improve care for individuals experiencing a mental health crisis through the opening of an integrated crisis centre and strengthen pathways from the centre to community resources to support ED diversion.

Methods	Process measures	Target for process measure	Comments
Working Group has been established to oversee this project. The KW4 OHT Mental Health and Addictions Working Group will oversee and monitor progress on this initiative during their meetings which occur four times per year.	- # of patients diverted from the ED - # of walk-in clients - # of police drop-offs - # of ambulance drop offs - # of referrals - # of clients discharged from care	- Targets still to be established.	Targeted opening of phase 1 (use of existing resources) is the summer of 2024, pending due diligence. Phase 2 will require the development of a funding proposal for an expanded model of care.

Change Idea #4 Launch on-site programming at Supportive Housing locations across the Region of Waterloo through the Supportive Housing Health Initiative (SHHI) Program. This team will include Nurse Practitioners, Peer Support Workers, and Addictions Counsellors who provide Primary Care and addictions care.

Methods	Process measures	Target for process measure	Comments
The KW4 OHT Mental Health and Addictions Working Group will oversee and monitor progress on this initiative during their meetings which occur four times per year.	- MOU finalized - Staff recruited - Program launched	- MOU finalized by April 1, 2024 - Staff recruited by June 30, 2024 - Program launched and being successfully being delivered by December 31, 2024	

Change Idea #5 Provide long-term housing alongside dedicated holistic direct support for individuals navigating a concurrent disorder and at risk of homelessness upon exiting incarceration through the Region of Waterloo and Justice Mental Health Project.

Methods	Process measures	Target for process measure	Comments
The KW4 OHT Mental Health and Addictions Working Group will oversee and monitor progress on this initiative during their meetings which occur four times per year.	- # of supportive housing units provided through the program	- 6 dedicated subsidized apartment units secured and occupied by March 31, 2025	

Change Idea #6 Expanded Walk-in services at Counselling Collaborative of Waterloo Region.

Methods	Process measures	Target for process measure	Comments
The KW4 OHT Mental Health and Addictions Working Group will oversee and monitor progress on this initiative during their meetings which occur four times per year.	- # of days walk-in available - waitlist times - utilization of service - # of individuals attending workshops while on waitlist	- Walk-in services expanded to 5 days per week - Waitlists for ongoing counselling reduced by an average of 10-days from 40 days to 30 days by March 31, 2025 - Walk-in utilization increased by an average of 20 individuals per week from 30 individuals per week to 50 individuals per week - 40 individuals attend a newly developed workshop deigned for those on the waitlist for counselling	

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

Measure - Dimension: Efficient

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care days expressed as a percentage of all inpatient days in the same period	P	% / People Marginalized populations in KW4	See Tech Specs / October 2022 to September 2023	19.30	17.40	Targeting a 10% improvement 50th percentile of Ontario Values is 19.2, the 25th percentile is 15.8.	St. Mary's General Hospital, St. Joseph's Home Care, Home and Community Care Support Services WW, Bayshore Healthcare, Community Healthcaring KW, Grand River Hospital Corporation, University of Waterloo, Bloom Care Solutions, Community Care Connections, New Vision FHT, Alzheimer Society Waterloo Wellington, Behavioural Supports Ontario, Canadian Mental Health Association (CMHA) Waterloo Wellington, Community Paramedicine, Community Ward, GeriMedRisk, Hospice Waterloo Region, Intensive Geriatric Service Worker Program, Region of Waterloo Paramedic Services, Lisaard and Innisfree Hospice, Cambridge Memorial Hospital, Cambridge North Dumfries OHT, Waterloo Wellington Older

							Adult Strategy, K-W Seniors Day Program, Parkwood Mennonite Home, Provincial Geriatrics Leadership Ontario (PGLO), Guelph Wellington Paramedic Services, St. Joseph's Health Centre Guelph, Regional Geriatric Program Toronto, Regional Geriatric Program Central, Canadian Coalition for Seniors Mental Health (CCSMH), North Simcoe Muskoka Specialized Geriatric Services, Guelph Wellington OHT, Community Care Concepts, eHealth Centre of Excellence, Centre for Family Medicine FHT, City of Waterloo, Immigration Partnership of Waterloo Region, Kitchener-Waterloo Multicultural Centre, Guelph General Hospital

Change Ideas

Change Idea #1 Launch the St. Joseph's Home Care Hospital to Home Program to help adults who no longer require hospital care to continue their recovery, healing, and rehabilitation at home, while other longer-term community-based services are arranged.

Methods	Process measures	Target for process measure	Comments
Bi-weekly update meetings with OHT, CSS and Hospitals to review impact and opportunities for feedback on process, outcomes and ongoing process measures.	- # of patients participating in program - # of patients enrolled PRIOR to ALC designation - % of patients who indicated they were very satisfied or satisfied with their experience - # of ED visits with patients enrolled in program - # of readmissions	-20 patients per month enrolled starting April 2024 -By March 31, 20025 we will have seen a 10% decrease in ALC LOS for patients in the categories of Home with CCAC and Retirement Home with Supports	

Change Idea #2 Continue to provide access to primary care services for unattached patients who reside in the four priority neighbourhoods (N2H, N2M, N2G, N2C) through the Rapid Access to Primary Care (RAP) Clinic while reducing the use of the emergency room department for non-emergency conditions.

Methods	Process measures	Target for process measure	Comments
Data from the clinic will be collated and evaluated to measure the impact and outcome of the clinic. Progress report from the clinic will be shared on a quarterly basis with the Advisory Committee and the KW4 OHT Steering Committee. The process will also be reviewed on an ongoing basis to identify opportunities for improvement.	- # of clients served through the RAP clinic - % of unattached patient who report that ED would have been their first point of contact - Client satisfaction rates with model of care	This is a pilot initiative and we will use this period to collect baseline information for some of our indicators: - 40 clients served per month through the RAP Clinic. - 80% of patients report the ED would have been their first point of contact - 85% client satisfaction rates with model of care	RAP Clinic's continuation and expansion inclusive of targets is based on resource availability.

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

Methods	Process measures	Target for process measure	Comments
Data will be collected by Bloom Care Solutions as part of their standard processes at the referral stage. Bloom Care Solutions will analyze the data and present to the Integrated Transitional Care Team members and leadership at monthly reviews which will then be transitioned to quarterly reviews once program has been stabilized.	- # of participants referred to the program - # of participants accepted to the program - # of patients entering the program who were already designated ALC - # of days the patient is in the program - # of patient receiving PSS plus other home services - # of patients requiring ED visit while on program - # of patient requiring re-admission while on program - % patients who said they were satisfied or, very satisfied - Discharge destination from program	- 10-15 participants referred to the program per month - 5-10 participants accepted to the program per month - <50% of patients entering the program designated ALC - <3 months patient in the program - # of patient receiving PSS plus other home services (Baseline needed) - 0 patients requiring ED visit while on program - 0 patient requiring re-admission while on program - >85% of patients satisfied or, very satisfied - Discharge destination from program (Baseline needed)	Sustainable funding still to be determined.

Change Idea #4 Continue to expand the KW4 Integrated Care Team for older adults (ICT) to support older adults living with complex and chronic conditions through advanced care planning, system navigation, and complex case management.

Methods	Process measures	Target for process measure	Comments
a) Co-design an integrated care team (i.e. shared care model with care pathways) with interprofessional supports and specialist expertise in a primary care setting b) Use the interRAI Check Up tool to identify older adult patients and their self-reported health and social care needs c) Collect data on the patient population and their health and social care needs from interRAI Check Up outputs d) Provide comprehensive assessment and care planning for patients and their primary care provider in a shared care model with the interprofessional team; and e) Consider opportunities to spread this model to additional primary care practices that do not presently have access to an interprofessional team (i.e. FHO physicians). Data will be collected by New Vision FHT staff from: interRAI Check Up outputs; care plans from the FHT's EMR (i.e. PSS); and surveys of patients, care partners, primary care providers, and ICT members. Data will be analyzed by New Vision FHT and partner organizations. Data will be reviewed and shared by all partner organizations through the bi-monthly KW4 ICT Implementation Committee.	- # of patient appointments - % of patients followed up for ongoing care and case management - # of family health organizations and individual providers added to the initiative - % of patients/care partners who indicate the ICT made them more confident in managing their health - % of patients/care partners who indicate they were very satisfied or satisfied with their experience with the ICT - % of primary care providers who indicate they were very satisfied or satisfied with their experience with the ICT - % of ICT members who indicate they were very satisfied or satisfied with their experience as part of the ICT	Over the course of 2024/25: - 2,170 patient appointments (10% increase) - 75% of patients followed up for ongoing care and case management - 15 new FHO physician practices added - 80%+ of patients/care partners who indicate the ICT made them more confident in managing their health - 75%+ of patients/care partners who indicate they were very satisfied or satisfied with their experience with the ICT - 80%+ of primary care providers who indicate they were very satisfied or satisfied with their experience with the ICT - 80%+ of ICT members who indicate they were very satisfied or satisfied with their experience as part of the ICT	The KW4 ICT has been recognized with a provincial award at the Association of Family Health Teams of Ontario; presentations/posters at the 2024 Summit on Aging Care in Ontario, the Canadian Academy of Geriatric Psychiatry Annual Scientific Meeting, and the Canadian Geriatrics Society Annual Scientific Meeting; and briefings of OHTs, the Ontario Collaborative on Aging Well, Regional Geriatric Programs, and specialized geriatric service providers across the province.

Change Idea #5 Continue implementation of the Palliative Alternate Destination Program for palliative care patients (approved August 2023), including: - treat and refer - patient are treated by paramedics on scene for symptom management including for pain or dyspnea, hallucinations or agitation, terminal congested breathing, and nausea or vomiting, and then receive follow up care from their palliative care team or be referred to an appropriate care provider for follow-up care (if the patient does not have one). - alternate destination - Eligible palliative care patients calling 9-1-1 will have the option to be treated by paramedics on-scene as needed. In appropriate situations, individuals with a complete pre-registration may be transported by paramedics directly to a local hospice for wrap-around care.

Methods	Process measures	Target for process measure	Comments
Data will be managed by the Region (Public Health and Paramedic Services) and the area hospices. We will work with the hospices to review QA/QI pieces.	- # of patients diverted from the ED - # of times pain and symptom management provided in the home - patient and family experience - provider experience - # of patients transported directly to hospice	We will use 2024/25 to establish utilization baseline data and therefore have not set performance targets. Our aim for this year will be improved care experience for patient and providers during the end-of-life trajectory.	

Change Idea #6 Rollout of delirium resource toolkit for caregivers, clients and patients in various settings (i.e., Emergency Department) to assist with recognizing the early signs of delirium so that interventions and supports can be initiated sooner.

Methods	Process measures	Target for process measure	Comments
A Delirium Collaborative has been formed and meets monthly.	- # of hospitals Delirium resources distributed to - # of Delirium Education sessions delivered - # of attendees at World Delirium Day webinar	- Kits distributed to 7 hospitals - One Delirium education session to be held on World Delirium Day in March 2025. - Increase registration for the 2025 World Delirium Day webinar by 10% from 245 to 270 people by March 31, 2025.	

Change Idea #7 Continue with the LEGHO program, leveraging existing services and providers within our OHT to support ED Diversion, Admission Avoidance, and Hospital Discharge

Methods	Process measures	Target for process measure	Comments
Community Care Concepts will track performance and share it with the KW4 OHT Frail Elderly Working Group.	- # of patients referred - # of patients supported - # of patients diverted safely back to the community - # of rides provided - # of meals provided - # of care hours provided - # of ED visits while on LEGHO - # of hospital admission while on LEGHO - patient experience	Targets will be set in early 2024/25 for this initiative.	

Change Idea #8 Continue to expand the reach of the SCOPE (Seamless Care Optimizing the Patient Experience) program, connecting primary care providers with a nurse navigator to connect patients to appropriate community resources in a timely way.

Methods	Process measures	Target for process measure	Comments
- Pathways developed will be shared and reviewed by the SCOPE steering committee - Progress will be reviewed at bi-weekly SCOPE operations meetings.	- # of calls/month - # of new pathways/services added - # of marketing/engagement opportunities - # to PCPs utilizing service - PCP satisfaction - % of ED visits diverted	- Increase the number of calls per month to 60 by March 31, 2025 - Develop 6 new pathways or services by March 31, 2025 - Conduct 2-4 in-person visits or lunch and learns per month to increase awareness and utilization of the SCOPE program - Increase the number of PCPs utilizing services to 200 by March 31, 2025 -Increase primary care provider's reported satisfaction with the SCOPE program. - Maintain percentage of ED visits diverted to 100%	

Change Idea #9 Implement Year 2 of the 'Improving Access to Home Support Services in Waterloo' initiative to increase the ability of low income, newcomer, or otherwise vulnerable seniors to age in place. This is a three-year initiative, focusing on service expansion with transportation, snow clearing, yard maintenance, and volunteer liaison/service navigation.

Methods	Process measures	Target for process measure	Comments
Data Sources: - Recorded participant registration and attendance numbers - Direct participant responses through surveys, questionnaires, one-on-one interviews - Both quantitative and qualitative techniques will be used to analyze the data that will be collected. Quantitative techniques such as comparison of result rates, cross tabulations and frequency counts will be used. Qualitative techniques such as content analysis, thematic analysis, and narrative analysis will be used to analyze responses from one-on-one participant interviews for reoccurring themes and patterns. - The data gathered from the evaluation will be measured against the pre-determined program benchmarks. Who: - AWAH Project Team, City of Waterloo Dissemination: - Evaluation findings will be disseminated through various mediums and to various audiences including reports, briefing note and presentations	- # of seniors identified as low-income, newcomer and otherwise vulnerable registered in AWAH programs/services - % of seniors identified as low-income, newcomer and otherwise vulnerable who report enhanced social inclusion such as a sense of belonging, connection, and inclusion in their communities - # of new services developed and implemented	- Expand delivery of eligible volunteer-based services to seniors identified as low-income, newcomer and otherwise vulnerable by 30 individual seniors by March 31 2025 to help them age at home. - 80% of individual seniors served, identified as low-income, newcomer and otherwise vulnerable, report enhanced feelings of social inclusion such as a sense of belonging, connection, and inclusion in their community following their participation in the program. - Development and implementation of 3 new services for eligible seniors identified as low-income, newcomer and otherwise vulnerable by September 2025.	This initiative has been made possible by Employment and Social Development Canada (ESDC), through the Age Well at Home (AWAH) federal funding initiative.

Change Idea #10	Pending funding approval, continue with the DREAM (Dementia, Resource, Education, Advocacy, Mentorship) initiative at GRH for people living with dementia to prevent hospital admissions and look to expand to SMGH.		
Methods	Process measures	Target for process measure	Comments
Quarterly statistical report provided by ASWW to key hospital partners, includes # of interventions and # of patients diverted safely home. - Once the Program moves to the hospital EMR, we will be able to track readmittances – goal Summer 2024	- # of clients who received system navigation and referral support - # of clients diverted safely home with respite and other supports initiated - % of repeat visits to ER due to caregiver burnout	- We will use 2024/25 to establish baseline data. Our aim per Hospital is: - 250 interventions - 100 Diversions - % of repeat visits to the ER – goal of less than 25%	DREAM is a temporary pilot funded until March 31, 2024. The expansion, as outlined in this initiative, is dependent on securing sustainable funding.

Area of Focus- Increase Overall Access to Preventative Care

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with Pap tests	P	% / Population Marginalized populations in KW4	See Tech Specs / Q2 (covering 3 years of participation up to September 2023)	58.50	59.60	25th percentile of Ontario Values (we have already exceeded the 50th percentile which is 57.0) Risk - We are not sure what the impact of removing the preventative care bonus for physicians as of April 1, 2024, will have on our target and will be monitoring this throughout the year.	Waterloo Wellington Regional Cancer Program, YMCA Three Rivers, Cambridge North Dumfries OHT, Guelph Wellington OHT, Primary Care Providers in KW4 OHT, Waterloo Region NPLC, Woolwich CHC, Community Healthcaring KW

Change Ideas

Change Idea #1 Continue to increase public outreach and education through various channels and in various languages.

Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation has already been established and will continue to meet to review progress on this initiative.	- # of presentations - # of audience members for presentations - # of languages material translated to - Reach of ad campaign	- 10 presentations - 800 audience members - 15 languages - Reach of ad campaign - TBD	

Change Idea #2 Keep abreast of the change for cervical cancer screening switching from cytology screening to HPV screening (currently slated for some time in 2025) and identify future improvement initiatives.

Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation has already been established and will continue to meet to review progress on this initiative.	- timeliness of information shared	- Information will be disseminated in various forms to the appropriate audience within 1-month of receiving with opportunities to provide input and feedback given.	

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

Methods	Process measures	Target for process measure	Comments
A collaborative working group is being formed and will meet to determine opportunities.	- # of cross-regional opportunities identified and initiated by March 31, 2025.	- 2 cross-regional opportunities identified and initiated by March 31, 2025	

Change Idea #4 Continue to explore ways to leverage digital tools to assist patients and providers with screening (i.e. online appointment booking (OAB), Poppy Bot.)

Methods	Process measures	Target for process measure	Comments
Continue to use Poppy Bot pending success of pilot. If there is OAB funding: Collected by Digital Health lead and analyzed by Digital Health Lead and OH. Shared by Digital Health lead and OH. If there is no OAB funding: Collected, analyzed, reviewed, and shared by Digital Health lead.	Poppy Bot - # of patients contacted by Forward Sortation Area (FSA) OAB - # of providers offering Online Appointment Booking (OAB) - % of patient's overall satisfaction with OAB - % of provider's overall satisfaction with OAB - # of patients with access to book appointment online	Poppy Bot: - Target will be set after pilot evaluation is complete. If there is funding: - We aim to increase the number of providers offering OAB, by 5%, from 119 to 125 providers by March 31, 2025. - We aim to increase the percent of patient's overall satisfaction with OAB, by 3%, from 87% to 90% satisfaction by March 31, 2025. - We aim to increase the percent of providers overall satisfaction with OAB, by 6.6%, from 75% to 80% satisfaction by March 31, 2025. - We aim to increase the number of patients with access to book appointments online by 4%, from 138,500 to 144,500 patients by March 31, 2025.	

Change Idea #5 Increase opportunities for unattached individuals to receive cervical screening through the addition of extra screening appointments each week and/or through the planning and implementation of collaborative cervical cancer screening clinics in various locations around the region.

Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation has already been established and will review progress on this initiative.	- # of pap test administered to unattached patients - % of abnormal results from pap tests for unattached patients resulting in follow-up with an NP. - patient satisfaction with the clinic care	Targets will be set in early 2024/25 for this initiative.	

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with mammograms	P	% / Population Marginalized populations in KW4	See Tech Specs / Q2 (covering 2 years of participation up to September 2023)	58.20	61.00	50th percentile of Ontario Values. Risk - We are not sure what the impact of removing the preventative care bonus for physicians as of April 1, 2024, will have on our target and will be monitoring this throughout the year.	Waterloo Wellington Regional Cancer Program, YMCA Three Rivers

Change Ideas

Change Idea #1 Continue to increase public outreach and education through various channels and in various languages.

Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation has already been established and will continue to meet to review progress on this initiative.	- # of presentations - # of audience members for presentations - # of languages material translated to - Reach of ad campaign	- 10 presentations - 800 audience members - 15 languages - Reach of ad campaign - TBD	

Change Idea #2 Explore opportunities to increase capacity at existing OBSP sites our area to handle the increased volume/demand.

Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation has already been established and will continue to meet to review progress on this initiative.	- # of consultations held to identify opportunities to increase throughput - % of OBSP sties involved in consultations	- Conduct 4 consultations by March 31, 2024 - Received feedback from 70% of OBSP sites on opportunities for improvement	

Measure - Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with colorectal tests	P	% / Population Marginalized populations in KW4	See Tech Specs / Q2 (covering 2 years of participation for FIT and 10 years of participation for flexible sigmoidoscopy or colonoscopy up to September 2023)	64.70	65.40	50th percentile of Ontario Values. Risk - We are not sure what the impact of removing the preventative care bonus for physicians as of April 1, 2024, will have on our target and will be monitoring this throughout the year.	Waterloo Wellington Regional Cancer Program, YMCA Three Rivers

Change Ideas

Change Idea #1 Continue to increase public outreach and education through various channels and in various languages.

Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation has already been established and will continue to meet to review progress on this initiative.	- # of presentations - # of audience members for presentations - # of languages material translated to - Reach of ad campaign	- 10 presentations - 800 audience members - 15 languages - Reach of ad campaign TBD	