KW4
ONTARIO HEALTH TEAM

EXECUTIVE DIRECTOR

OCTOBER 2023

Ashnoor Rahim
Executive
Director

GENERAL UPDATES

GOVERNANCE

Strategic Planning

The KW4 OHT Strategic Planning Working group has been busy this month preparing for the upcoming Members planning session in November. This includes developing some foundational documents to inform our plan including:

- A Political, Economic, Social, Technological, Environmental, and Legal (PESTEL) analysis
- A Strengths, Weakness, Opportunities, Threats (SWOT) analysis
- An early community engagement survey to learn what they think about KW4 OHT's current vision, mission and values, as well as their current experience with health and social services in KW4, and finally what they think we should be focusing on in the future

The Working Group has also developed an early draft of strategic priorities to consider using a Convergence Framework where various priority inputs were considered based on our landscape including:

- KW4 OHT's mandate in order to become a fully mature and designated OHT
- Strategic priorities of our Members
- Feedback from community members regarding potential KW4 OHT priorities
- Ministry and Ontario Health priorities

We are looking forward to our upcoming session as Member engagement and active participation in this process is crucial. After this session the Working Group will be conducting smaller group discussions to allow time for more reflection before finalizing the vision, missions and values, and strategic priorities. The Strategic Plan Working Group Terms of Reference can be found here: https://www.kw4oht.com/strategic-plan

GENERAL UPDATES

GOVERNANCE

KW4 OHT Steering Committee Strategic Advisors

The OHT Steering Committee has asked Dr. Neil Naik, KW4 OHT Primary Care Lead and Karyn Lumsden, VP Home, and Community Care Support Services to join the SC as strategic advisors to our current SC. Given that our primary care clinicians have agreed to develop a Clinician Network, and the projected anticipated changes to homecare services, we are excited to have Neil and Karyn join the SC and provide advice on how best to successfully navigate through these initiatives.

KW4 OHT Primary Care Network

The Primary Care Network Development Committee met for the first time on October 30th. This diverse group of 9 primary care providers bring a wealth of experience and expertise. They will create the foundations for a unified primary care voice in a Primary Care Network (PCN). Building on the work completed during the Spring of 2023, this Committee will lead the incorporation process for a new not-for-profit entity, define the mission, vision, and values for this entity, and facilitate the election of the inaugural Board of Directors. The KW4 OHT is excited to support the creation of a PC network in our region and will continue to work closely with the working group to support their success. The Committee's membership can be seen here: https://www.kw4oht.com/primary-care-integration-and-governance

GENERAL UPDATES

COMMUNICATIONS HIGHLIGHTS

Alzheimer Society Event

On October 19, the KW4 OHT organized a remarkable virtual community engagement event in collaboration with the Waterloo Wellington Alzheimer's Society. During this informative session, dedicated members from the Alzheimer's Society presented an insightful discussion on the various types of Alzheimer's disease and dementia, shedding light on their distinct characteristics and implications. They also provided valuable information about the resources and support available for individuals and families affected by these conditions. This event served as a significant step in raising awareness, offering support, and fostering a stronger sense of community within the KW4 region. The session was recorded and will be available on the OHT's website.

COMMUNITIES AND STAKEHOLDERS WORK

Integrated Care Pathways (ICPs)

The Integrated care pathways were co-designed over four in-person workshops with approximately 60 participants including a mix of community members and those with lived experiences as well as representatives from 30 organizations ranging from hospitals, community organizations, and grassroots organizations. The pathways aligned with Ontario Health direction and were also refined and targeted based on the population and community's needs. The 3 integrated care pathways include:

- Senior with heart failure pathway
- Youth transitioning to adult mental health services pathway
- Diabetes pathway

The pathways were developed considering five stages of the patient journey including intake, triage, assessment, care planning, and care delivery. These pathways include the integration of community support to ensure holistic care for the patient/client.

The pathways embody an ideal future state of patient care for these disease states. The finalized pathways were presented to the Leadership Action Committee of the project and approved. The committee engaged in various conversations with stakeholders to determine how best to implement these pathways in the priority neighborhoods focusing on the immediate needs and barriers to holistic care. The finalized ICPs report can be viewed here https://www.kw4oht.com/nict

For seniors with heart failure, the project's leadership approved the opportunity to support Seniors in the Heart Function Clinic at St. Mary's General Hospital (SMGH) with transitions into the community and navigation to community support and resources.

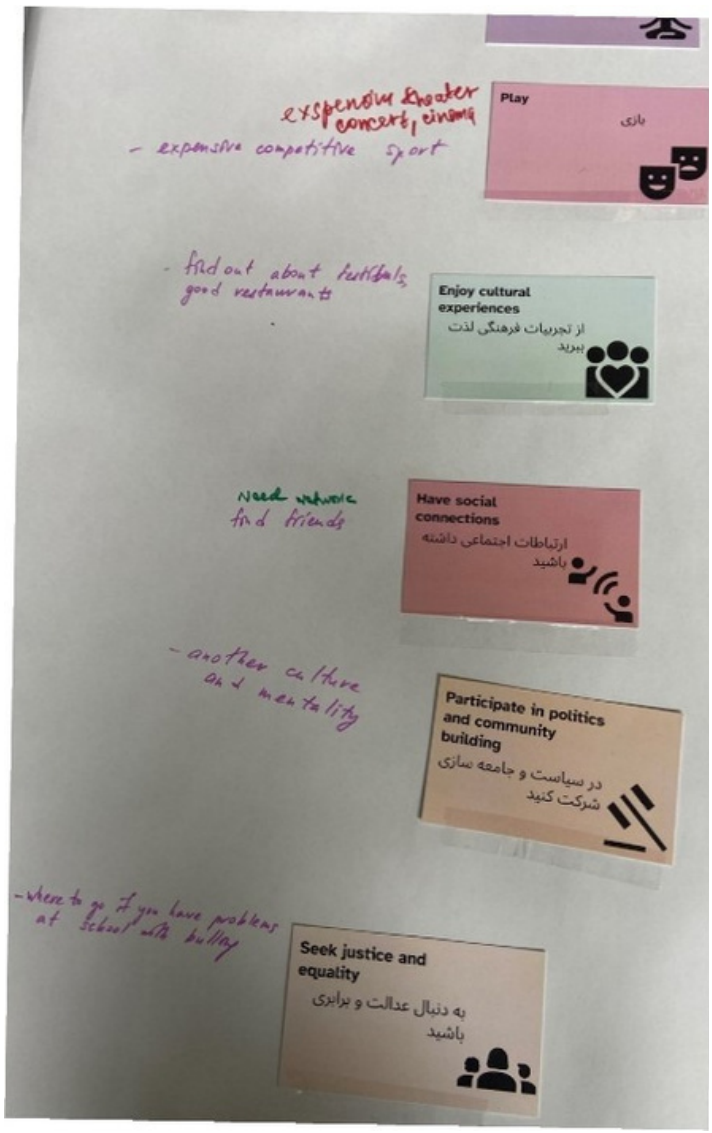
For the youths transitioning to adult mental health services, the next steps involve conducting exploratory research with youths through various youth programs run by different organizations to identify the needs and barriers around mental health support for youths. The project team will also be mapping community resources and mental health services available to youth and young adults in the priority neighborhoods, to have a better understanding of what supports exist, the current transition plans, and any gaps.

For the diabetes pathway, the Project Team will be working with the Regional Coordination Centre to create awareness regarding the Waterloo-Wellington Central Intake Program self-referral pathway to assist residents of KW4 with accessing resources and managing their health through diabetes education and self-management where possible.

COMMUNITIES AND STAKEHOLDERS WORK

Newcomer App Co-Design Session

The Co-design session for the Newcomer App was held on October 21st, 2023. The objective of this session was to bring together newcomers and organizations that provides services to newcomers in the same space to design potential features of the app based on their lived experience. The session was attended by 30 participants consisting of 23 newcomers and 7 organizations. The session was also facilitated in Spanish and Farsi.



COMMUNITIES AND STAKEHOLDERS WORK

Graham Seed Fund (GSF)

This year, the University of Waterloo is linking the GSF to the priorities of local hospitals and the KW4 OHT. The GSF is designed to broadly encourage innovative health-care solutions to challenges of today and tomorrow. The KW4 OHT was delighted to have the opportunity to participate in an information event this month and network with researchers to share a the KW4 OHT's priorities including:

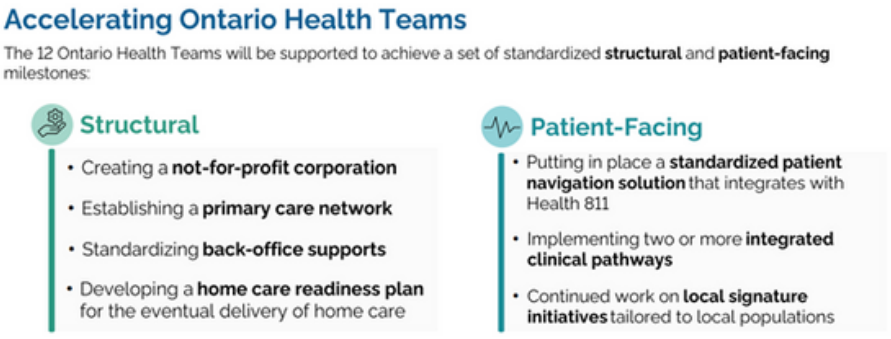
1. Building teams of support around Primary Care Providers and increasing their capacity to take on more patients
2. Finding innovative ways to improve access to services for marginalized populations in our priority neighborhood with a social determinants of health lens and considering social prescribing
3. Improving navigation services by working with hospitals to determine how to create secure messaging between hospitals and Primary Care Providers
4. Improving access to and coordination of mental health services.

OHT Acceleration

On September 27th, the Ministry of Health announced the next steps to accelerate Ontario Health Team progress and impact. This includes:

- Providing each OHT up to $2.2 million over three years ($750K per year) starting April 2024. This will provide stable funding for OHTs to continue their work in the communities they serve.
- Supporting twelve Cohort 1 OHTs to advance rapidly towards maturity and be considered for designation under the Connecting Care Act, 2019. These teams will lead the way for other OHTs during future phases of acceleration
- Releasing guidance, resources, and supports for OHTs, beginning in November 2023, on key elements of The Path Forward, including primary care networks and governance (OHT not-for-profit incorporation and back-office support through operational support providers)
- Developing an 'OHT Maturity Framework' to guide OHTs in their journey from the current state to a mature state.

The Minister acknowledged that there are a lot of high performing OHTs and that all OHTs have had success in advancing the OHT model. The KW4 OHT is keen leverage the learning from our 12 OHT partners and accelerate our own priorities and maturity.



PERFORMANCE

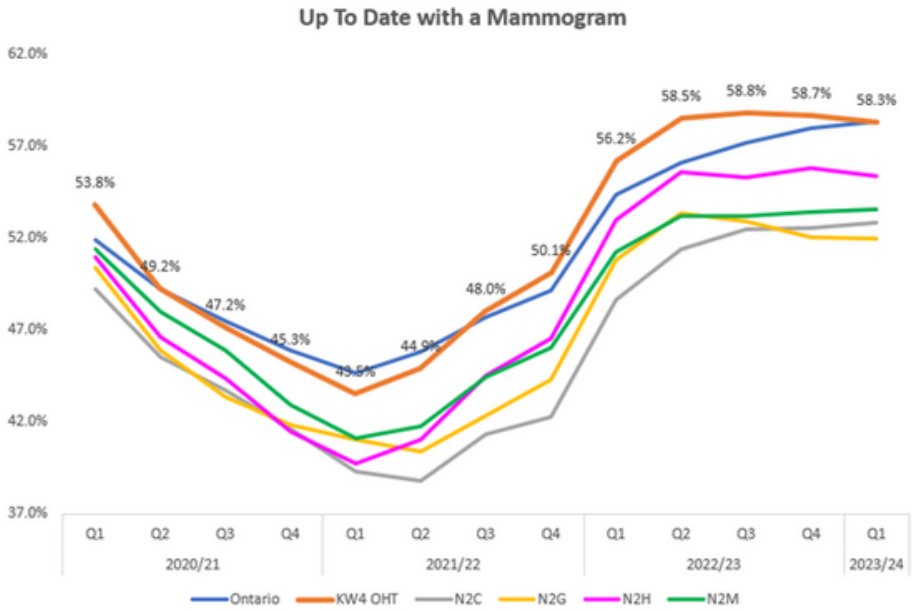
Ontario Health, OHT Data Dashboard

In September 2022, Ontario Health launched a new business intelligence tool, the OHT Data Dashboard. The 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.
In this month's report, we will focus on three of our five Collaborative Quality Improvement indicators. These three indicators are related to cancer screening.

Up To Date with Mammogram

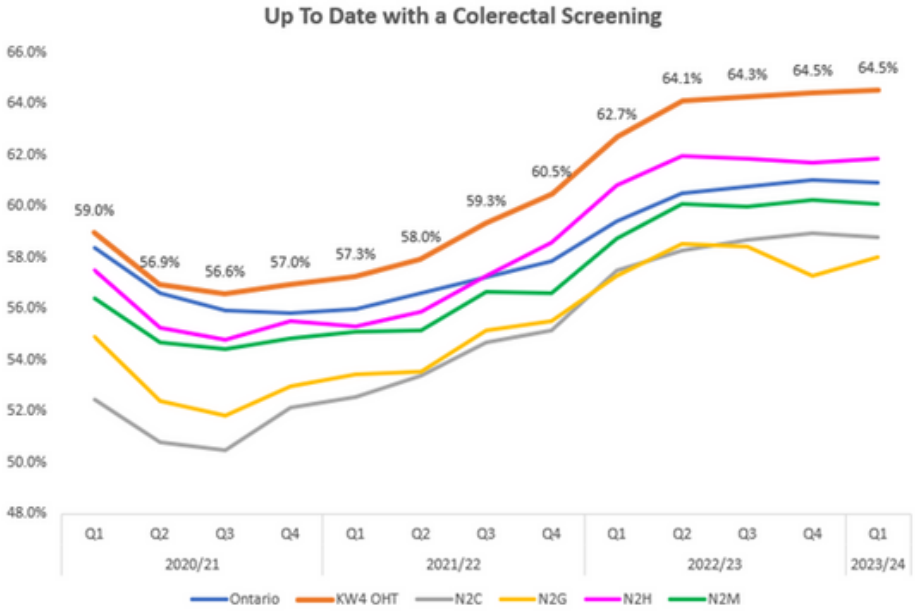
This indicator is calculated as the rate of screen-eligible people aged 50 to 74 who completed at least one screening mammogram within the past 2 years. The graph below demonstrates how screening rates decreased during the beginning of the COVID-19 pandemic but have since rebounded and now exceed pre-pandemic levels.On average the KW4 OHT screening rates were above the provincial average in 2022/23 with both rates now being equal at 58.3% for the first quarter of 2023/24. We can also see that screening rates in the KW4 OHT's four priority neighbourhoods for this same quarter are between 2.9% and 6.3% below both the provincial and local averages.

PERFORMANCE



Up To Date with Colorectal Screening

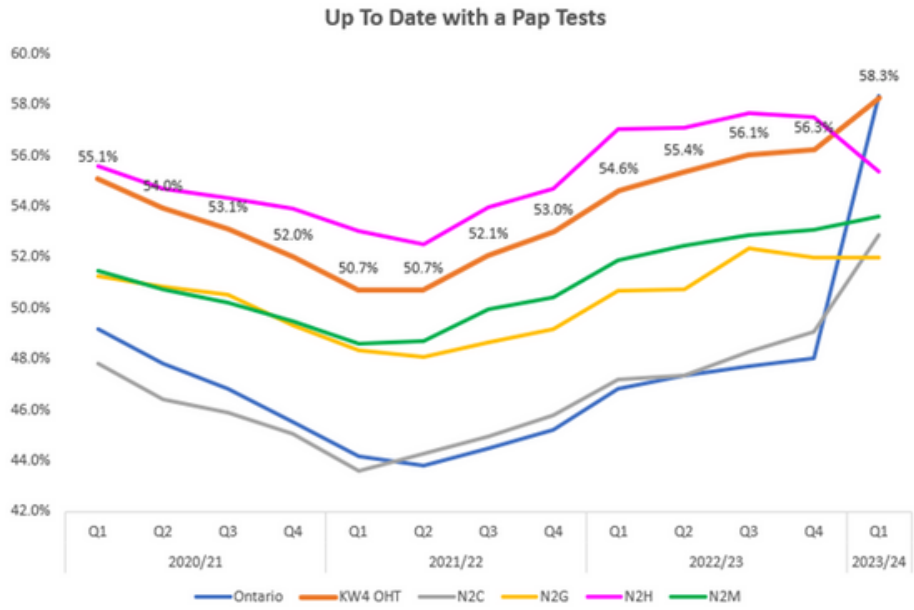
This indicator is calculated as the rate of screen-eligible people aged 50 to 74 who had a FIT within the past two years, or colonoscopy or flexible sigmoidoscopy within the past 10 years. On average the KW4 OHT screening rates have been above the provincial average and was at 64.5% for the first quarter of 2023/24. However, the screening rates in the KW4 OHT's four priority neighbourhoods during this same quarter are between 2.7% and 6.5% below the KW4 OHT average.



PERFORMANCE

Up To Date with Pap Tests

This indicator is calculated as the rate of screen-eligible people aged 21 to 69 who have completed at least one cytology (pap) test within the past 3 years. We can once again see the impact of screening during the pandemic where there was a drop in rates, however as of Q1 2023/24 rates now exceed pre-pandemic levels. Historically, the KW4 OHT screening rates have been above the provincial average with both rates now being equal at 58.3% for the first quarter of 2023/24. Screenings rates in this same quarter for the KW4 OHT's four priority neighbourhoods range between 2.9% and 6.3% below both the provincial and local averages.



DIGITAL HEALTH UPDATES

Secure Messaging

A small clinical advisory group consisting of primary care and hospital representatives, along with the KW4 OHT back-office staff, met on October 6th, 2023, to discuss secure provider to provider messaging in the KW4 OHT. The goal of the secure messaging initiative is to move forward with implementing secure clinical messaging across the region with the use of a single platform. The group reviewed draft use cases to identify potential priority areas to focus on across the region. This includes use cases within the hospital, between acute and community sectors, and within primary care and community care. We discussed key clinical requirements based on the experience and expertise of the clinical advisors. Next steps include further engagement with primary care and community care, identifying mechanisms to support funding, and finally, selecting a platform/vendor.

Online Appointment Booking

In October, participating online appointment booking (OAB) primary care sites submitted Quarter 1 and Quarter 2 activity reports, a key deliverable for the Ontario Health funding. Below is a snapshot of the activity from the first half of the fiscal year:
-67 physicians using OAB*
-16 nurse practitioners using OAB*
-11 allied health providers using OAB*
-5 net new licences launched the first week of October
-10 net new licenses implementation in progress
-103,349 patients with access to OAB*
*Numbers reflect sites that submitted Q1 and Q2 data, and were active with OAB at the time of the reporting

- OH-West Digital Health Advisory Council (DHAC)
- System Navigation
- OH-West Patient Navigation and Digital Access Community of Practice
- CSS Navigation in Primary Care – eReferral and Caredove

eServices Update

St. Mary's General Hospital and St. Joseph's Health Care London will be co-leading the second phase of the West Region Cataract Central Waitlist Management project in 2023-24. The objectives are to:

- Optimize the Waterloo Wellington hub (based out of the Regional Coordination Centre) so that intelligent routing of referrals can be built in
- Build a Cataract Central Intake (CI) hub in London to serve the Erie St. Claire and Southwest regions
- Work with referrers (optometrists) to integrate their EMRs with Ocean eReferral

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: October 25, 2023

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

Milestones — Legend: On Track | At Risk | Overdue | 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		2023/12/30	NA	50%	Feedback survey and materials for the co-design session have been developed and translated to Spanish and Farsi for the session. Co-design session held on the 21st Oct,2023 and it was attended by 30 participants consisting of 23 newcomers and 7 organizations. NSERC Alliance application for grant funding was submitted on the 23rd Oct,2023.
7	Initial Prototype design		2024/01/31	NA	10%	The initial prototype concept was shared with the Leadership Action Committee for feedback. The prototype will continue to be refined based on the co-design session and field testing.
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: October 25, 2023

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

Milestones	**Legend**	On Track	At Risk	Overdue	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	NA	55%	Pending finalization of budget and benefits measures.	
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	60%	The Leadership Action Committee meeting held on the 28th Sep, 2023. The next steps and decisions were made on the initiatives to be supported through the Integrated Care Pathways.	
6	Develop Social Prescribing model for the project.		2023/12/31	NA	50%	Social Prescribing model to be incorporated into the 3 Integrated Care Pathways developed.	
7	Deployment of digital enablers for use by 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 implement team(s).		2023/06/23	NA	0%	Dependent on completion of ICPs	
9	Complete detailed implementation plan		2023/07/07	NA	10%	Dependent on completion of ICPs.	
10	Complete project logic framework including indicator matrix and performance measures.		2023/07/07	NA	90%	Final draft developed. Awaiting validation and approval.	
11	Develop a communication strategy for the project.		2023/08/28	NA	10%		
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: October 25, 2023

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

Legend On Track | At Risk | Serious Concerns

Milestones **Legend** **On Track** | **At Risk** | **Overdue** | **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		2024/01/31	NA	60%	Public outreach opportunities pursued and partnerships with local organizations continue to be fostered. Initial potential sites for Poppy Bot pilot assessed. Financial context updated and in discussion.
7	Clinician Engagement initiatives implemented		2024/01/31	NA	60%	Clinician Summit planning continued. Agenda set. Facilitators and speakers are being recruited. Primary care newsletter curated and published. Specialist Council convened.
8	Primary Care Network developed		2024/03/31	NA	20%	PCN Development Committee recruited. The first meeting was held. Deliverables reviewed and Committee Co-Chairs elected.
9	Care pathways initiatives implemented		2024/01/31	NA	35%	Ongoing support for active Care and Clinical Pathways.
10	Interim Evaluation Report complete		2024/02/29	NA	0%	
11	Sustainability Plan developed		2024/02/29	NA	0%	

Primary Care Integration and Governance Project Status Report

12	Identify opportunities to scale and spread to other providers and to other neighbourhoods		2024/02/29	NA	0%	
13	Project Closure/Lessons Learned		2024/03/31	NA	0%	
14	Final Evaluation Report complete		2024/04/30	NA	0%	