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
Number of individuals for whom the emergency department was the first point of contact for mental health and addictions care per 100 population aged 0 to 105 years with an incident MHA-related ED visit.	P	% / People	See Tech Specs / Oct 2021– Sept 2022	23.60	22.60	• KW4 OHT's performance for the period Oct 2021 – Sept 2022 was 23.6%. • Ontario's performance for the period Oct 2021 – Sept 2022 was 22.9 • 2021/22 performance in priority neighbourhoods (N2G, N2H, N2M, N2C) was 28.8% • Some of the approved quality initiatives will be specifically related to our priority neighbourhoods while others will be broader in reach (i.e., KW4 or Regional) • Our aim is to reach 10% of our priority neighbourhoods and 2% of the other neighbourhoods in 2023/24 to ensure the ED is not their first point of contact for MH&A related care. • It is important to note that this indicator only considers if the patient had a MH&A related visits with a psychiatrist, primary care provider or pediatrician and excludes community visits with other health providers. • Based on this our overall improvement target for KW4 OHT is 22.6%	Traverse Independence, ACCKWA, Carizon, Centre for Family Medicine FHT, CMHA WW, Community Care Concepts, Community Support Connections, eHealth Centre of Excellence, Grand River Hospital, Hospice Waterloo Region, Independent Living Waterloo Region, KDCHC/Sanctuary, KW Habilitation, Lisaard & Innisfree Hospice, Parkwood Mennonite Home, Ray of Hope, St. Mary's General Hospital, The Working Centre, Thresholds, Waterloo Region Nurse Practitioner Led Clinic, Woolwich CHC, University of Waterloo, House of Friendship, New Vision Family Health Team, Home and Community Care Support Services Waterloo Wellington, Alzheimer Society WW, SHORE Centre, Lutherwood, Sanguen Health Centre

Change Ideas

Change Idea #1	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.

Methods	Process measures	Target for process measure	Comments

KW4 OHT has partnered with Optimus SBR to support the first portion of this change initiative including the development of patient personas, journey maps and integrated care pathways. A phased approach will be utilized and consists of the following 5 steps: Step 1 – Project Launch and Discovery Step 2 – Persona and Journey Map Development Step 3 – Future State: Integrated Care Pathways Step 4 – Future State Final Report Recommendations and Next Steps Step 5 – Project Closeout and Knowledge Transfer. A project plan for this portion of the work which is expected to be completed in Q1 2023/24 will be developed, and weekly status reporting will occur to highlight project activities and review progress on deliverables. Following this, KW4 OHT will develop and implement Neighbourhood Integrated Care Teams for the 3 remaining quarters. A Leadership Action Committee will oversee the progress on this work and provide strategic oversight. Project updates will also be shared with all KW4 OHT Members as well as the community through our monthly Executive Director Report.

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.

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

Change Idea #2	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.

Methods	Process measures	Target for process measure	Comments

KW4 OHT has partnered with the University of Waterloo and other stakeholders on this initiative. Capability Sensitive Design methodologies will be used to gather information to inform the design of a web-based health and social service navigation system for newcomers. This will involve a participatory design approach to understand newcomers and service provider organizations through individual and group-based interviews, co-design and prototype evaluation sessions. The project will be completed in 2 phases: (Phase 1) Requirements gathering and prototype development, and (Phase 2) App build. A Leadership Action Committee will oversee the progress on this work and provide strategic oversight. Project updates will also be shared with all KW4 OHT Members as well as the community through our monthly Executive Director Report.

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.

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

Change Idea #3	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.

Methods	Process measures	Target for process measure	Comments
A Leadership Action Committee will oversee the progress on this work and provide strategic oversight. Project updates will also be shared with all KW4 OHT Members as well as the community through our monthly Executive Director Report.	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.	Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.	

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

Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.	P	% / People	See Tech Specs / Oct 2021–Sept 2022	22.80	21.60	• For the period Oct 2021 – Sept 2022: o KW4 OHT's performance was 22.8% which falls in the 75th percentile. o Ontario's performance was 21.6% o KW4 OHT's attributed population accumulated 32,550 ALC Days, of which 67.3% of those days where at GRH (which includes ALC transitional care beds) and 19.5% were at SMGH. The remaining 13.2% were scattered across 91 other hospitals in the province. • We are aiming for a reduction in 2,400 ALC days which equates to an overall improvement target for KW4 OHT of 21.6% which is in alignment with Ontario's average performance.	Traverse Independence, ACCKWA, Carizon, Centre for Family Medicine FHT, CMHA WW, Community Care Concepts, Community Support Connections, eHealth Centre of Excellence, Grand River Hospital Corporation, Hospice Waterloo Region, Independent Living Waterloo Region, KDCHC/Sanctuary, KW Habilitation, Lisaard & Innisfree Hospice, Parkwood Mennonite Home, Ray of Hope, St. Mary's General Hospital, The Working Centre, Thresholds, Waterloo Region Nurse Practitioner Led Clinic, Woolwich CHC, University of Waterloo, House of Friendship, New Vision Family Health Team, Home and Community Care Support Services Waterloo Wellington, Alzheimer Society WW, SHORE Centre, Lutherwood, Sanguen Health Centre

Change Ideas

Change Idea #1	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.

Methods	Process measures	Target for process measure	Comments
KW4 OHT has partnered with Optimus SBR to support this change initiative including the development of patient personas, journey maps and integrated care pathways. A phased approach will be utilized and consists of the following 5 steps: Step 1 – Project Launch and Discovery Step 2 – Persona and Journey Map Development Step 3 – Future State: Integrated Care Pathways Step 4 – Future State Final Report Recommendations and Next Steps Step 5 – Project Closeout and Knowledge Transfer. A project plan for this portion of the work which is expected to be completed in Q1 2023/24 will be developed, and weekly status reporting will occur to highlight project activities and review progress on deliverables.	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.	Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.	

Change Idea #2	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.

Methods	Process measures	Target for process measure	Comments
KW4 OHT will develop and implement Neighbourhood Integrated Care Teams (NICT) Between Q2-Q4, 2023/24. This will involve developing a common vision of a NICT across different organizations and sectors, co-developing a model of care in partnership with neighbourhood residents and primary care, building on the great work of support networks and facilities that already exist in the neighbourhoods, and using a population health management approach implement upstream initiatives to reduce ALC rates focused on Self-Directed Individuals (low-risk), and Supported Individuals (moderate-risk), as well as optimize hospital capacity and patient flow by applying best practices in admission avoidance for those presenting in the ED by diverting patients back to home with the appropriate support(s) in place. A Leadership Action Committee will oversee the progress on this work and provide strategic oversight. Project updates will also be shared with all KW4 OHT Members as well as the community through our monthly Executive Director Report.	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.	Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.	

Change Idea #3	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.

Methods	Process measures	Target for process measure	Comments
A KW4 ICT/CCP Implementation Working Group has been formed and will continue to meet every two weeks until project closure at the end of 2023/24. A project plan is being developed and progress towards this plan will be reported on at each meeting.	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.	Once process measures have been finalized, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.	

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

The percentage of screen-eligible people aged 21 to 69 years who had a cytology (Pap) test within the previous 3 years.	P	% / Population	See Tech Specs / 2nd Quarter - up to Sept 2022	55.10	56.50	• Current average in priority neighbourhoods (N2G, N2H, N2M, N2C) is 51.63% • Current average in KW4 OHT is 55.10% • Ontario Health (OH) target is 60.0% • Some of the approved quality initiatives will be specifically related to our priority neighbourhoods while others will be broader in reach (i.e., KW4 or Regional) • Our aim is to increase screening rates in our priority neighbourhoods to OH's target of by 8.37% (to 60.0%) which equates to an additional 828 residents who would otherwise not have been screened. • Our aim is to also increase screening rates in our other neighbourhoods by 0.5% (to 55.6%) which equates to an additional 205 residents who would otherwise not have been screened. • Based on these two aims our overall improvement target for KW4 OHT is 56.5%	Traverse Independence, ACCKWA, Carizon, Centre for Family Medicine FHT, CMHA WW, Community Care Concepts, Community Support Connections, eHealth Centre of Excellence, Grand River Hospital Corporation, Hospice Waterloo Region, Independent Living Waterloo Region, KDCHC/Sanctuary, KW Habilitation, Lisaard & Innisfree Hospice, Parkwood Mennonite Home, Ray of Hope, St. Mary's General Hospital, The Working Centre, Thresholds, Waterloo Region Nurse Practitioner Led Clinic, Woolwich CHC, University of Waterloo, House of Friendship, New Vision Family Health Team, Home and Community Care Support Services Waterloo Wellington, Alzheimer Society WW, SHORE Centre, Lutherwood, Sanguen Health Centre

Change Ideas

Change Idea #1	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.

Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation Team has been formed and is meeting bi-weekly to move this work forward. A Leadership Action Committee will oversee the progress on this work and provide strategic oversight. Project updates will also be shared with all KW4 OHT Members as well as the community through our monthly Executive Director Report.	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.	Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.	

Change Idea #2	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.		
Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation Team has been formed and is meeting bi-weekly to move this work forward. A Leadership Action Committee will oversee the progress on this work and provide strategic oversight. Project updates will also be shared with all KW4 OHT Members as well as the community through our monthly Executive Director Report.	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.	Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.	

Change Idea #3	KW4 OHT will work toward increasing system capacity by training nursing staff to perform pap tests.		
Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation Team has been formed and is meeting bi-weekly to move this work forward. A Leadership Action Committee will oversee the progress on this work and provide strategic oversight. Project updates will also be shared with all KW4 OHT Members as well as the community through our monthly Executive Director Report.	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.	Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.	

Measure **Dimension:** Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators

The percentage of screen-eligible people aged 50 to 74 years who had completed at least one screening mammogram within the past 2 years.	P	% / Population	See Tech Specs / 2nd Quarter - up to Sept 2022	58.50	58.70	• Current average in priority neighbourhoods (N2G, N2H, N2M, N2C) is 50.87% • Current average in KW4 OHT is 58.50% • Ontario Health (OH) target is 60.0% • Currently there is a high backlog for Mammograms. • Increased emphasis in this area would not necessarily increase screening rates but rather increase wait times. • Our recommendation is that we do some promotion/improvement in this area but concentrate the majority of our efforts on cervical and colorectal screening efforts. • Our aim is to increase screening rates in our priority neighbourhoods to 53.15% which equates to an additional 108 residents who would otherwise not have been screened. • Based on this our overall improvement target for KW4 OHT is 58.70%	Traverse Independence, ACCKWA, Carizon, Centre for Family Medicine FHT, CMHA WW, Community Care Concepts, Community Support Connections, eHealth Centre of Excellence, Grand River Hospital Corporation, Hospice Waterloo Region, Independent Living Waterloo Region, KDCHC/Sanctuary, KW Habilitation, Lisaard & Innisfree Hospice, Parkwood Mennonite Home, Ray of Hope, St. Mary's General Hospital, The Working Centre, Thresholds, Waterloo Region Nurse Practitioner Led Clinic, Woolwich CHC, University of Waterloo, House of Friendship, New Vision Family Health Team, Home and Community Care Support Services Waterloo Wellington, Alzheimer Society WW, SHORE Centre, Lutherwood, Sanguen Health Centre

Change Ideas

Change Idea #1	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.

Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation Team has been formed and is meeting bi-weekly to move this work forward. A Leadership Action Committee will oversee the progress on this work and provide strategic oversight. Project updates will also be shared with all KW4 OHT Members as well as the community through our monthly Executive Director Report.	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.	Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.	

Measure

Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators

The percentage of screen-eligible people aged 50 to 74 years who had a fecal immunochemical test (FIT) within the past 2 years, a colonoscopy within the past 10 years, or a flexible sigmoidoscopy within the past 10 years.	P	% / Population	See Tech Specs / 2nd Quarter - up to Sept 2022	64.20	64.50	• Current average in priority neighbourhoods (N2G, N2H, N2M, N2C) is 58.74% • Current average in KW4 OHT is 64.20% • Ontario Health (OH) target is 60.0% • Some of the approved quality initiatives will be specifically related to our priority neighbourhoods while others will be broader in reach (i.e., KW4 or Regional) • Our aim is to increase screening rates in our priority neighbourhoods by 1.26% (to 60.0%) which equates to an additional 141 residents who would otherwise not have been screened. • Our aim is to also increase screening rates in our other neighbourhoods by 0.5% (to 64.7%) which equates to an additional 258 residents who would otherwise not have been screened. • Based on these two aims our recommended overall improvement target for KW4 OHT is 64.5%	Traverse Independence, ACCKWA, Carizon, Centre for Family Medicine FHT, CMHA WW, Community Care Concepts, Community Support Connections, eHealth Centre of Excellence, Grand River Hospital Corporation, Hospice Waterloo Region, Independent Living Waterloo Region, KDCHC/Sanctuary, KW Habilitation, Lisaard & Innisfree Hospice, Parkwood Mennonite Home, Ray of Hope, St. Mary's General Hospital, The Working Centre, Thresholds, Waterloo Region Nurse Practitioner Led Clinic, Woolwich CHC, University of Waterloo, House of Friendship, New Vision Family Health Team, Home and Community Care Support Services Waterloo Wellington, Alzheimer Society WW, SHORE Centre, Lutherwood, Sanguen Health Centre

Change Ideas

Change Idea #1	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.

Methods	Process measures	Target for process measure	Comments
A Cancer Screening Implementation Team has been formed and is meeting bi-weekly to move this work forward. A Leadership Action Committee will oversee the progress on this work and provide strategic oversight. Project updates will also be shared with all KW4 OHT Members as well as the community through our monthly Executive Director Report.	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.	Once process measures have been identified, KW4 OHT will develop SMART – specific, measurable, achievable, realistic, and time sensitive targets.	