# Workshop 16:

# Addressing Health Inequities in Action-Population Health Cervical Screening

**Presenters:**

| | | |
|---|---|---|
| • Kimberley Floyd | CEO | WellFort Community Health Services |
| • Charline Dominguez | | WellFort Community Health Services |
| • Flormalyn Suppiah<br>• Devi Raghunauth | | WellFort Community Health Services<br>Rexdale CHC |

**Description:**

Leaders within one OHT in Peel, these two CHC's demonstrated a robust collaborative Quality Improvement project focusing on cervical screening. With one of the lowest rates of cervical screening in the province and a highly diverse community with a lack of access to comprehensive primary care, these partners operated improvements focusing both on internal primary care improvements as well as a whole community population health model.

**Session objectives and learning outcomes:**

- Share successes and challenges of population health focus
- Review the importance of being data-driven organizations
- Review community-centric practices that support organizational and population health

## Full description:

**Challenge**:

With one of the lowest cervical screening rates in the province the population served by the Central West Ontario Health Team is culturally diverse with a high unattachment rate to comprehensive primary care. With a rate of 54.3% of eligible people being screened for cervical cancer in 2019, the rate of screening dropped to 46.7% during the pandemic. The barriers to screening were reviewed from several perspectives including research, analyzing population health data and community-based engagement activities by holding focus groups. The key barriers to screening were summarized as structural access, cultural, religious, & socioeconomic elements.

**Action**:

As two strong Community Health Centres in the OHT, WellFort CHS and Rexdale CHC partnered together while also initially including a local Family Health Team to commit to improving cervical screening rates within their practices and also a concentrated implementation of supporting population screening for eligible clients regardless of whether they were part of the CHC/FHT practice.

By first utilizing population health data the partners identified the most at-risk communities by postal code zoning. Then the partners committed to owning that postal code zone to improve the rate of cervical screening of eligible individuals in that geography. The quality aim statement was as follows: Increase cervical cancer screening rate by 8% of eligible clients living in FSA-L4T, L6T, & L6V, and M9V by March 2024.

Despite the complication of the different primary practices having different electronic medical record systems, the team focused on ensuring that all practices in the project defined and measured data consistently.

The benefits of the CHC action of the model of health and well being were uniquely demonstrated during this project with a focus on health equity, capturing and analyzing the social determinants of health, community engagement and standardizing care.

**Impact**:

At the time of submission, the team is in active gathering of summary data to see the impact on primary care cervical screening rates in each practice as well as the population health impact. As an early signal of success, however, the teams have noted meaningful population health impacts with one example of 80% of eligible individuals being screened at one site through mobile health outreach and within the targeted postal code neighbourhoods.

Learnings include both successes and opportunities that increase as the scale of population health systems of care are analyzed and leveraged in practice. Elements related to differing organizational commitments to health equity that are not universal in our current system were noted as some challenges that were experienced during this project. Leveraging the CHC's model of care and experience in this area was noted as a key strength in the population health approach.

Increased competency building for point-of-care staff in areas of quality improvement, system thinking, population health and collection and analysis of social determinants of health were a few key areas of success. The most profound element of success however was the client and community focus that allowed our model to challenge systemic barriers

impacting access to care and culturally appropriate care and drove the execution of our implementation of care.

**Trajectory**:

This project continues to garner attention from our OHT partners, Regional Cancer Centre and our inspiring journey is expected to take our roadmap of implementation and spread to other primary care practices within our community. Regardless of the primary care model, we expect that the elements of becoming data-driven, population-focused with a health equity lens are expected to spread and scale and be hardwired within our practices.