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

Indicator #1

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. (Cambridge North Dumfries)

OHT Population: Youth, Pop in crisis, schizophrenia, Depression, Anxiety, WO OHIP, Substance, Eating disoders

Last Year		This Year	
32.74	**30**	**24.80**	**20**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Understand who is presenting to the ED for mental health and addictions-related care. We will analyze the data provided to the CND OHT and work with OHT members to understand the demographics of the population going to the emergency department for first point of care. We will work with OHT members to leverage existing community data sets to help inform the future direction of work for this indicator and subsequent projects.

Target for process measure

- To be confirmed next year

Lessons Learned

We worked with Cambridge Memorial Hospital to understand the data available locally for mental health and addictions-related care. Through the data, we were able to identify who was accessing the ED (by sex and age), the CTAS level and their primary presenting concerns. We will continue to work with our hospital partners to better understand attachment to primary care and other metrics related to social determinants of health.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Understand why people present to the ED for mental health and addictions-related care and not elsewhere. We will examine current gaps in service, and barriers to access this care in the community through work of the Mental Health and Addictions Work Stream.

Target for process measure

- To be confirmed next year

Lessons Learned

Through the work of our CND OHT Mental Health and Addictions Work Stream, members were able to identify current gaps in service and barriers to access in the community. Through this identification exercise, we have been able to identify four (4) different change ideas to improve care and access for mental health and addictions related issues in Cambridge and North Dumfries.

Area of Focus- Improving Overall Access to Care in the Most Appropriate Setting | Efficient | Priority Indicator

Indicator #3

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.
(Cambridge North Dumfries)

OHT Population: Frail/complex

Last Year		This Year	
18.40	**17**	**24.20**	**17**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

We will implement frailty screening to support upstream intervention and optimize patient experience. Through the work of our Medical Complexity and Older Adult Work Stream, we have developed a screening tool to identify frailty. We intend to pilot this in primary care settings within CND OHT over the next year to support identification and proactive intervention to prevent hospitalizations.

Target for process measure

- To be confirmed next year

Lessons Learned

We are continuing to work on this change idea and hope to launch our frailty screening in 2023.

Change Idea #2 ☑ Implemented ☐ Not Implemented

We will work to understand roles and responsibilities related to ALC across the system. We will conduct an environmental scan of the healthcare system to understand ALC in CND OHT. We will work with our OHT member to look at local performance and how this data is being captured locally. In partnership with Cambridge Memorial Hospital, we will undertake a project to review discharge destinations and the coding of ALC.

Target for process measure

- To be confirmed next year

Lessons Learned

Through the work of our CND OHT Medical Complexity and Older Adult Work Stream, we have conducted an environmental scan of our local healthcare system to understand the challenges and complexities of ALC.

Area of Focus- Increase Overall Access to Preventative Care | Effective | Priority Indicator

Indicator #2

percentage of female patients aged 23 to 69 years who had a Pap test within the previous three years. (Cambridge North Dumfries)

OHT Population: Resistant to screen

Last Year		This Year	
56.32	**61**	**55.60**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase awareness of primary care providers' performance on these indicators. We will engage with all primary care providers across CND OHT on quality improvement coaching, education on reports available to providers (such as MyPractice), and awareness of EMR tools.

Target for process measure

- To be confirmed next year

Lessons Learned

The ongoing COVID-19 pandemic has impacted efforts to address primary care preventative care screening and has delayed our work to increase awareness of providers' performance on these indicators. The CND OHT plans to address this in 2023/2024 through targeted primary care engagement.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Use a health equity lens to understand who is not up-to-date with preventative care screening and better understand barriers within our local healthcare system with our 5 CND OHT member primary care practices. We will use data available from ICES to understand barriers based on health system segmentation and attachment to primary care. This will help us to work with OHT members to understand performance and ways to capture this information locally.

Target for process measure

- To be confirmed next year

Lessons Learned

We have begun to look at our local data to understand who is not up-to-date with preventative care screening through the Ontario Health dashboard for OHTs. This work is ongoing and will continue in 2023/2024.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Work with primary care providers to assist with identification and screening for high-risk patients with our 5 CND OHT member primary care practices. There has been an emphasis on focusing on catch-up efforts for high-risk patients to prevent severe outcomes. We can accomplish this through quality improvement coaching and awareness of EMR tools.

Target for process measure

- To be confirmed next year

Lessons Learned

The ongoing COVID-19 pandemic has impacted efforts to address primary care preventative care screening and has delayed our work to increase awareness of providers' performance on these indicators. The CND OHT plans to address this in 2023/2024 through targeted primary care engagement.

Indicator #4

Percentage of screen eligible female patients aged 52 to 69 years who had a mammogram within the past two years. (Cambridge North Dumfries)

OHT Population: Resistant to screen

Last Year		This Year	
48.82	**54**	**59.20**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase awareness of primary care providers' performance on these indicators. We will engage with all primary care providers across CND OHT on quality improvement coaching, education on reports available to providers (such as MyPractice), and awareness of EMR tools.

Target for process measure

- To be confirmed next year

Lessons Learned

The ongoing COVID-19 pandemic has impacted efforts to address primary care preventative care screening and has delayed our work to increase awareness of providers' performance on these indicators. The CND OHT plans to address this in 2023/2024 through targeted primary care engagement.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Work with primary care providers to assist with identification and screening for high-risk patients with our 5 CND OHT member primary care practices. There has been an emphasis on focusing on catch-up efforts for high-risk patients to prevent severe outcomes. We can accomplish this through quality improvement coaching and awareness of EMR tools.

Target for process measure

- To be confirmed next year.

Lessons Learned

We have begun to look at our local data to understand who is not up-to-date with preventative care screening through the Ontario Health dashboard for OHTs. This work is ongoing and will continue in 2023/2024.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Use a health equity lens to understand who is not up-to-date with preventative care screening and better understand barriers within our local healthcare system with our 5 CND OHT member primary care practices. We will use data available from ICES to understand barriers based on health system segmentation and attachment to primary care. This will help us to work with OHT members to understand performance and ways to capture this information locally.

Target for process measure

- To be confirmed next year

Lessons Learned

The ongoing COVID-19 pandemic has impacted efforts to address primary care preventative care screening and has delayed our work to increase awareness of providers' performance on these indicators. The CND OHT plans to address this in 2023/2024 through targeted primary care engagement.

Indicator #5

Percentage of screen eligible patients aged 52 to 74 years who had a FOBT/FIT within the past two years, other investigations (i.e., flexible sigmoidoscopy) or colonoscopy within the past 10 years. (Cambridge North Dumfries)

OHT Population: Resistant to screen

Last Year		This Year	
60.10	**65**	**62.20**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Work with primary care providers to assist with identification and screening for high-risk patients with our 5 CND OHT member primary care practices. There has been an emphasis on focusing on catch-up efforts for high-risk patients to prevent severe outcomes. We can accomplish this through quality improvement coaching and awareness of EMR tools.

Target for process measure

- To be confirmed next year

Lessons Learned

The ongoing COVID-19 pandemic has impacted efforts to address primary care preventative care screening and has delayed our work to increase awareness of providers' performance on these indicators. The CND OHT plans to address this in 2023/2024 through targeted primary care engagement.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Use a health equity lens to understand who is not up-to-date with preventative care screening and better understand barriers within our local healthcare system with our 5 CND OHT member primary care practices. We will use data available from ICES to understand barriers based on health system segmentation and attachment to primary care. This will help us to work with OHT members to understand performance and ways to capture this information locally.

Target for process measure

- To be confirmed next year

Lessons Learned

We have begun to look at our local data to understand who is not up-to-date with preventative care screening through the Ontario Health dashboard for OHTs. This work is ongoing and will continue in 2023/2024.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Increase awareness of primary care providers' performance on these indicators. We will engage with all primary care providers across CND OHT on quality improvement coaching, education on reports available to providers (such as MyPractice), and awareness of EMR tools.

Target for process measure

- To be confirmed next year

Lessons Learned

The ongoing COVID-19 pandemic has impacted efforts to address primary care preventative care screening and has delayed our work to increase awareness of providers' performance on these indicators. The CND OHT plans to address this in 2023/2024 through targeted primary care engagement.