

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

Indicator #2	Last Year		This Year		
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)
Average number of patients per month with 4 or more ED visits for MH care in past 365 days (Cambridge North Dumfries OHT) OHT Population: Mental Health & Addictions	11.00	10	NA	--	NA

Change Idea #1 Implemented Not Implemented

We will relaunch our Community and Mental Health and Addictions Clinic (C-MAC) after our successful pilot of the clinic in 2023/2024.

Process measure

- 1.Number of unique clients seen 2.Number of client encounters 3.Percentage of clients unattached to primary care

Target for process measure

- 1.500 2.1000 3.75%

Lessons Learned

We were unable to re-launch our C-MAC due to funding challenges in 2024/2025.

Comment

We are unable to get current data on this indicator.

Chronic Disease Prevention and Management | Timely | Priority Indicator

	Last Year		This Year		
Indicator #3	25.10	20	26.40	-5.18%	20
Emergency department visit as first point of contact for mental health and addictions-related care (Cambridge North Dumfries OHT)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 Implemented Not Implemented

We will relaunch our Community and Mental Health and Addictions Clinic (C-MAC) after our successful pilot of the clinic in 2023/2024.

Process measure

- 1. Number of unique clients seen 2. Number of client encounters 3. Percentage of clients unattached to primary care

Target for process measure

- 1. 500 2. 1000 3. 75%

Lessons Learned

We were unable to re-launch our C-MAC due to funding challenges in 2024/2025.

Comment

We continue to try to find ways to address MHA issues in our community and are taking a joint regional approach.

Chronic Disease Prevention and Management | Effective | Priority Indicator

Indicator #6	Last Year		This Year		
	Percentage of screen-eligible people who are up to date with Pap tests (Cambridge North Dumfries OHT)	59.60 Performance (2024/25)	72 Target (2024/25)	60.30 Performance (2025/26)	1.17% Percentage Improvement (2025/26)

Change Idea #1 Implemented Not Implemented

We will establish a regional working group with local stakeholders (Waterloo Wellington Regional Cancer Program, KW4 OHT and GW OHT) to align our preventative care efforts and resources.

Process measure

- To be confirmed next fiscal year

Target for process measure

- To be confirmed next fiscal year

Lessons Learned

A regional working group was established to align our preventative care efforts and resources.

Change Idea #2 Implemented Not Implemented

We will conduct a needs assessment for preventative care screening in Cambridge and North Dumfries.

Process measure

- Results of the needs assessment will inform change ideas and process measures in 2025/2026.

Target for process measure

- Completion of a needs assessment by FY 2025/2026.

Lessons Learned

A needs assessment has been conducted and will be used to inform future outreach efforts.

Change Idea #3 **Implemented** **Not Implemented**

We will launch a public education campaign focusing on preventative cancer screening.

Process measure

- 1. Number of public education initiatives launched as part of campaign 2. Reach of public education initiatives (# of people)

Target for process measure

- 1. 2 public education initiatives in 2024/2025 2. 10,000 people

Lessons Learned

We continue to amplify preventative cancer screening on our social media channels.

Change Idea #4 **Implemented** **Not Implemented**

Increase access to pop-up pap clinics in Cambridge and North Dumfries to support unattached patients.

Process measure

- 1. Number of clients served 2. Number of clients served unattached to primary care 3. Satisfaction with clinical encounter

Target for process measure

- 1. 200 2. 150 3. 90%

Lessons Learned

While the CND OHT was not able to continue offering pop-up pap clinics, our member organization, the Waterloo Region Nurse Practitioner-Led Clinic was able to continue to offer quick access to preventative screening for unattached patients. This has been an important initiative to build capacity for preventative screening in our community.

Comment

We knew this year would be a challenging year with the discontinuation of preventative care bonuses and expected to see a decrease. We continue to work with primary care providers to understand how we as an OHT can continue to support preventative screening efforts. We look forward to launching bot technology in 2025/2026 to support primary care to identify patients due for cancer screening.

Indicator #5	Last Year		This Year		
	Percentage of screen-eligible people who are up to date with mammograms (Cambridge North Dumfries OHT)	61.20 Performance (2024/25)	68 Target (2024/25)	57.90 Performance (2025/26)	-5.39% Percentage Improvement (2025/26)

Change Idea #1 Implemented Not Implemented

We will establish a regional working group with local stakeholders (Waterloo Wellington Regional Cancer Program, KW4 OHT and GW OHT) to align our preventative care efforts and resources.

Process measure

- To be confirmed next fiscal year

Target for process measure

- To be confirmed next fiscal year

Lessons Learned

A regional working group was established to align our preventative care efforts and resources.

Change Idea #2 Implemented Not Implemented

We will conduct a needs assessment for preventative care screening in Cambridge and North Dumfries.

Process measure

- Results of the needs assessment will inform change ideas and process measures in 2025/2026.

Target for process measure

- Completion of a needs assessment by FY 2025/2026.

Lessons Learned

A needs assessment has been conducted and will be used to inform future outreach efforts.

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We will launch a public education campaign focusing on preventative cancer screening.

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- 1. Number of public education initiatives launched as part of campaign 2. Reach of public education initiatives (# of people)

Target for process measure

- 1. 2 public education initiatives in 2024/2025 2. 10,000 people

Lessons Learned

We continue to amplify preventative cancer screening on our social media channels.

Comment

We knew this year would be a challenging year with the discontinuation of preventative care bonuses and expected to see a decrease. We continue to work with primary care providers to understand how we as an OHT can continue to support preventative screening efforts. We look forward to launching bot technology in 2025/2026 to support primary care to identify patients due for cancer screening.

Indicator #4	Last Year		This Year		
	Percentage of screen-eligible people who are up to date with colorectal tests (Cambridge North Dumfries OHT)	63.60 Performance (2024/25)	70 Target (2024/25)	63.10 Performance (2025/26)	-0.79% Percentage Improvement (2025/26)

Change Idea #1 Implemented Not Implemented

We will establish a regional working group with local stakeholders (Waterloo Wellington Regional Cancer Program, KW4 OHT and GW OHT) to align our preventative care efforts and resources.

Process measure

- To be confirmed next fiscal year

Target for process measure

- To be confirmed next fiscal year

Lessons Learned

A regional working group was established to align our preventative care efforts and resources.

Change Idea #2 Implemented Not Implemented

We will conduct a needs assessment for preventative care screening in Cambridge and North Dumfries.

Process measure

- Results of the needs assessment will inform change ideas and process measures in 2025/2026.

Target for process measure

- Completion of a needs assessment by FY 2025/2026.

Lessons Learned

A needs assessment has been conducted and will be used to inform future outreach efforts.

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We will launch a public education campaign focusing on preventative cancer screening.

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- 1. Number of public education initiatives launched as part of campaign 2. Reach of public education initiatives (# of people)

Target for process measure

- 1. 2 public education initiatives in 2024/2025 2. 10,000 people

Lessons Learned

We continue to amplify preventative cancer screening on our social media channels.

Comment

We knew this year would be a challenging year with the discontinuation of preventative care bonuses and expected to see a decrease. We continue to work with primary care providers to understand how we as an OHT can continue to support preventative screening efforts. We look forward to launching bot technology in 2025/2026 to support primary care to identify patients due for cancer screening.

Integrated Care - Transitions in Care | Efficient | Priority Indicator

	Last Year		This Year		
Indicator #1	23.30	20	22.00	5.58%	20
Alternate level of care days expressed as a percentage of all inpatient days in the same period (Cambridge North Dumfries OHT)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 Implemented Not Implemented

We will launch our primary care frailty screening program at a local FHO in spring 2024. We hope to proactively identify health care issues related to frailty in an effort to prevent unexpected hospitalizations.

Process measure

- 1. Number of patients that complete screening program 2. Percentage of patients screened that are identified as frail

Target for process measure

- 1. 300 patients that have completed screening program 2. 10% of patients screened are identified as frail

Lessons Learned

We continue to roll out our frailty screening program and look for ways to support primary care in this initiative.

Change Idea #2 Implemented Not Implemented

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.

Process measure

- - # 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

Target for process measure

- 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.

Lessons Learned

This work is delayed and was not implemented in 2024/2025.

Change Idea #3 Implemented Not Implemented

We will continue to review ALC best practices at the Cambridge Collaborative to support collective problem solving among hospital, LTC and retirement homes in our community.

Process measure

- 1. Number of cases reviewed at collaborative 2. Number of hospitalizations prevented

Target for process measure

- Since this group has recently re-convened, we are collecting baseline data in 2024/2025.

Lessons Learned

The Cambridge Collaborative continues to operate and support problem solving among hospital, LTC and retirement homes in our community.

Change Idea #4 Implemented Not Implemented

We are working with the Registered Nurses Association of Ontario (RNAO) as a Best Practice Spotlight Organization (BPSO) on the Transitions in Care and Services guidelines.

Process measure

- This work is in progress and process measures are still being determined.

Target for process measure

- To be confirmed next fiscal year.

Lessons Learned

This work is underway. Indicators for this work include:

1. Assessment Prior to Transition in Care (transition_pro01_2024): Percentage of persons who received an assessment to determine care needs and readiness for the transition prior to the transition in care.
2. Experience with Transition in Care (transition_out06_2024): Percentage of persons who had a positive experience with their transition in care.

Change Idea #5 Implemented Not Implemented

The CND OHT Ontario Health West System Alignment Table, formerly our COVID-19/Surge Response, continues to meet to meet to address health system issues in our OHT.

Process measure

- Number of collaborative projects identified

Target for process measure

- To be confirmed next fiscal year.

Lessons Learned

This table was discontinued in 2024/2025. We continue to look for ways to work together across the system to address health system issues in our OHT.

Comment

We continue to experience significant challenges with ALC in our community. The CND OHT, along with other community partners continue to work with Ontario Health to address this.