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
Emergency department visit as first point of contact for mental health and addictions–related care	P	% / People	See Tech Specs / October 2022 to September 2023	25.10	20.00	This target has been set in alignment with Cambridge Memorial Hospital's Quality Scorecard.	Cambridge Memorial Hospital, Langs, Two Rivers FHT, Grandview FHT

Change Ideas

Change Idea #1 We will relaunch our Community and Mental Health and Addictions Clinic (C-MAC) after our successful pilot of the clinic in 2023/2024.

Methods	Process measures	Target for process measure	Comments
Staffed by an interdisciplinary team and led by primary care, this clinic will see patients on a walk in basis to address low acuity mental health and addictions concerns. This is a low barrier clinic and is open to anybody, regardless if they have a primary care clinician or a health card.	1. Number of unique clients seen 2. Number of client encounters 3. Percentage of clients unattached to primary care	1. 500 2. 1000 3. 75%	In addition to our hospital and primary care partners, we have also included many key community stakeholders in this work, including Porchlight Counselling Services, House of Friendship and Canadian Mental Health Association Waterloo Wellington.

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average number of patients per month with 4 or more ED visits for MH care in past 365 days	C	Months / ED patients Mental Health & Addictions	Hospital collected data / 2023/2024	11.00	10.00	This target has been set in alignment with Cambridge Memorial Hospital's Quality Scorecard.	Cambridge Memorial Hospital, Langs, Two Rivers FHT, Grandview FHT

Change Ideas

Change Idea #1 We will relaunch our Community and Mental Health and Addictions Clinic (C-MAC) after our successful pilot of the clinic in 2023/2024.

Methods	Process measures	Target for process measure	Comments
Staffed by an interdisciplinary team and led by primary care, this clinic will see patients on a walk in basis to address low acuity mental health and addictions concerns. This is a low barrier clinic and is open to anybody, regardless if they have a primary care clinician or a health card.	1.Number of unique clients seen 2.Number of client encounters 3.Percentage of clients unattached to primary care	1.500 2.1000 3.75%	In addition to our hospital and primary care partners, we have also included many key community stakeholders in this work, including Porchlight Counselling Services, House of Friendship and Canadian Mental Health Association Waterloo Wellington.

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
Alternate level of care days expressed as a percentage of all inpatient days in the same period	P	% / People	See Tech Specs / October 2022 to September 2023	23.30	20.00	This target has been set in alignment with Cambridge Memorial Hospital's Quality Scorecard.	Cambridge Memorial Hospital, Grand River Hospital Corporation, St. Mary's General Hospital, Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT

Change Ideas

Change Idea #1 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.

Methods	Process measures	Target for process measure	Comments
We will proactively screen patients who meet program criteria and assess for frailty. Those at the highest risk will be referred to appropriate clinical pathways.	1. Number of patients that complete screening program 2. Percentage of patients screened that are identified as frail	1. 300 patients that have completed screening program 2. 10% of patients screened are identified as frail	In addition to our hospital and primary care partners, we have also included many key community stakeholders in this work, including Delta FHO, Geriatric Services Clinical Intake Service for Waterloo Wellington, and Home and Community Care Support Services Waterloo Wellington.

Change Idea #2	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.

Methods	Process measures	Target for process measure	Comments
Data will be managed by the Region (Public Health and Paramedic Services) and the area hospices. We will work with the hospices to review QA/QI pieces.	- # 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	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.	

Change Idea #3	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.

Methods	Process measures	Target for process measure	Comments
This group has been recently re-convened and is working with partners to prevent avoidable hospitalizations and support our local LTC and retirement homes.	1. Number of cases reviewed at collaborative 2. Number of hospitalizations prevented	Since this group has recently re-convened, we are collecting baseline data in 2024/2025.	

Change Idea #4	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.

Methods	Process measures	Target for process measure	Comments
We are using research and best practice guidelines to identify areas for improvement in transitions in care and services.	This work is in progress and process measures are still being determined.	To be confirmed next fiscal year.	This work is being led by the CND OHT, with Cambridge Memorial Hospital and Langs CHC as signatory organizations.

Change Idea #5	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.		
Methods	Process measures	Target for process measure	Comments
This alignment table will continue to look at ALC challenges and work collaboratively to identify opportunities to support this work.	Number of collaborative projects identified	To be confirmed next fiscal year.	

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
Percentage of screen-eligible people who are up to date with Pap tests	P	% / Population	See Tech Specs / Q2 (covering 3 years of participation up to September 2023)	59.60	72.00	We believe that we can significantly increase our performance for paps by continuing our community outreach efforts and partnership with primary care.	Langs, Two Rivers FHT, Grandview FHT, Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT, Waterloo Region NPLC

Change Ideas

Change Idea #1 Increase access to pop-up pap clinics in Cambridge and North Dumfries to support unattached patients.

Methods	Process measures	Target for process measure	Comments
Working with partners at the Waterloo Region Nurse Practitioner-Led Clinic (WRNPLC), Kinbridge Community Association, Langs Community Health Centre (Langs CHC) and Region of Waterloo Public Health, we will continue to offer pop-up pap clinics at accessible locations in Cambridge and North Dumfries.	1. Number of clients served 2. Number of clients served unattached to primary care 3. Satisfaction with clinical encounter	1. 200 2. 150 3. 90%	

Change Idea #2 We will conduct a needs assessment for preventative care screening in Cambridge and North Dumfries.			
Methods	Process measures	Target for process measure	Comments
Given the changing landscape of preventative care screening in Ontario, we aim to conduct a needs assessment to understand the following: 1. The knowledge gaps for both providers and patients 2. We will assess access gaps for patients (ie. what are the pathways for unattached patients) 3. What are the specific preventative care needs for Cambridge and North Dumfries (ie. populations that need a specific approach, a population that consistently experiences barriers)	Results of the needs assessment will inform change ideas and process measures in 2025/2026.	Completion of a needs assessment by FY 2025/2026.	

Change Idea #3 We will launch a public education campaign focusing on preventative cancer screening.			
Methods	Process measures	Target for process measure	Comments
We will utilize the results of a needs assessment to support a public education campaign, ensuring that we are reaching patients in Cambridge and North Dumfries.	1.Number of public education initiatives launched as part of campaign 2. Reach of public education initiatives (# of people)	1. 2 public education initiatives in 2024/2025 2. 10,000 people	

Change Idea #4 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.			
Methods	Process measures	Target for process measure	Comments
A working group will be established that brings together primary care providers, representatives from our regional cancer program and project managers from local OHTs. Members will work towards increasing cancer screening rates locally and improving knowledge dissemination.	To be confirmed next fiscal year	To be confirmed next fiscal year	

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with mammograms	P	% / Population	See Tech Specs / Q2 (covering 2 years of participation up to September 2023)	61.20	68.00	Mammogram testing relies on other partners in our healthcare system. We set a target of 10% increase to reflect the role that primary care has in educating patients about the importance of this test.	Langs, Two Rivers FHT, Grandview FHT, Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT, Waterloo Region NPLC

Change Ideas

Change Idea #1	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.		
Methods	Process measures	Target for process measure	Comments
A working group will be established that brings together primary care providers, representatives from our regional cancer program and project managers from local OHTs. Members will work towards increasing cancer screening rates locally and improving knowledge dissemination.	To be confirmed next fiscal year	To be confirmed next fiscal year	

Change Idea #2 We will conduct a needs assessment for preventative care screening in Cambridge and North Dumfries.

Methods	Process measures	Target for process measure	Comments
Given the changing landscape of preventative care screening in Ontario, we aim to conduct a needs assessment to understand the following: 1. The knowledge gaps for both providers and patients 2. We will assess access gaps for patients (ie. what are the pathways for unattached patients) 3. What are the specific preventative care needs for Cambridge and North Dumfries (ie. populations that need a specific approach, a population that consistently experiences barriers)	Results of the needs assessment will inform change ideas and process measures in 2025/2026.	Completion of a needs assessment by FY 2025/2026.	

Change Idea #3 We will launch a public education campaign focusing on preventative cancer screening.

Methods	Process measures	Target for process measure	Comments
We will utilize the results of a needs assessment to support a public education campaign, ensuring that we are reaching patients in Cambridge and North Dumfries.	1. Number of public education initiatives launched as part of campaign 2. Reach of public education initiatives (# of people)	1. 2 public education initiatives in 2024/2025 2. 10,000 people	

Measure - Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with colorectal tests	P	% / Population	See Tech Specs / Q2 (covering 2 years of participation for FIT and 10 years of participation for flexible sigmoidoscopy or colonoscopy up to September 2023)	63.60	70.00	FIT testing relies on other partners in our healthcare system. We set a target of 10% increase to reflect the role that primary care has in educating patients about the importance of this test.	Two Rivers FHT, Grandview FHT, Langs, Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT, Waterloo Region NPLC

Change Ideas

Change Idea #1 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.

Methods	Process measures	Target for process measure	Comments
A working group will be established that brings together primary care providers, representatives from our regional cancer program and project managers from local OHTs. Members will work towards increasing cancer screening rates locally and improving knowledge dissemination.	To be confirmed next fiscal year	To be confirmed next fiscal year	

Change Idea #2 We will conduct a needs assessment for preventative care screening in Cambridge and North Dumfries.

Methods	Process measures	Target for process measure	Comments
Given the changing landscape of preventative care screening in Ontario, we aim to conduct a needs assessment to understand the following: 1. The knowledge gaps for both providers and patients 2. We will assess access gaps for patients (ie. what are the pathways for unattached patients) 3. What are the specific preventative care needs for Cambridge and North Dumfries (ie. populations that need a specific approach, a population that consistently experiences barriers)	Results of the needs assessment will inform change ideas and process measures in 2025/2026.	Completion of a needs assessment by FY 2025/2026.	

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Methods	Process measures	Target for process measure	Comments
We will utilize the results of a needs assessment to support a public education campaign, ensuring that we are reaching patients in Cambridge and North Dumfries.	1. Number of public education initiatives launched as part of campaign 2. Reach of public education initiatives (# of people)	1. 2 public education initiatives in 2024/2025 2. 10,000 people	