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

Measure - Dimension: Timely

Indicator #9	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	CB	CB		Espanola General Hospital, Maamwesying North Shore Community Health Services, Health Sciences North, North Shore Health Network, St. Joseph's General Hospital

Change Ideas

Change Idea #1 Ensure mental health and addiction statistics are received from partner hospitals

Methods	Process measures	Target for process measure	Comments
Collaborate with partner hospitals who have implemented the self-identification question upon presentation to the Emergency Department	Receive standardized reports quarterly for mental health and addictions emergency visits	Establish standardized reports from 100% of partnering hospitals that have implemented self-identification by September 2024	Reports will be consistent with reports provided by Espanola Regional Hospital

Change Idea #2 Receive timely notification from partnering hospitals to improve continuity of care for clients.

Methods	Process measures	Target for process measure	Comments
Improve access to mental health and addictions services prior to the need for hospitalization	Decrease in the amount of ED visits as first point of contact for mental health and addictions	Establish notification from 100% of partnering hospital sites by September 2024	

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	CB	CB	Reduce ALC days	Espanola General Hospital, Maamwesying North Shore Community Health Services, Health Sciences North, North Shore Health Network, St. Josephs General Hospital

Change Ideas

Change Idea #1 Ensure inpatient notifications are received from partner hospitals

Methods	Process measures	Target for process measure	Comments
Collaborate with partner hospitals who have implemented the self-identification question upon admission	Receive standardized reports for admissions	Establish standardized notification from 100% of partnering hospitals upon admission by September 2024	

Change Idea #2 Establish workflow for Indigenous System Navigator (ISN)

Methods	Process measures	Target for process measure	Comments
Establish consistent workflow for clients admitted to hospital who are connected with the ISN	Number of admitted clients for which notification was received by the ISN from hospital partners.	Workflow to be implemented by August 2024	The Transitions in Care Implementation Working Group will be focused on establishing a consistent workflow for the ISN's.

Measure - Dimension: Efficient

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of persons who had a transition plan developed prior to a transition in care	C	% / Population Clients at risk of delayed transitions in care	EMR/Chart Review / 2024-25	CB	CB	Reduce the risk of readmission	Maamwesying North Shore Community Health Services

Change Ideas

Change Idea #1 Develop transition plan template for consistent data entry

Methods	Process measures	Target for process measure	Comments
Develop and implement transition plan template into EMR	Number of transition plans completed for admitted clients	Transition plan template implemented by August 2024	

Change Idea #2 Establish workflow for Indigenous System Navigator (ISN)

Methods	Process measures	Target for process measure	Comments
Establish consistent workflow for clients admitted to hospital who are connected with the ISN.	Number of admitted clients for which notification was received by the ISN from hospital partners	60% of admitted clients will have documentation of a transition plan by September 2024 and 70% by March 31, 2025	The Transitions in Care Implementation Working Group will be focused on improving the process for continuity of care

Measure - Dimension: Efficient

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of persons who had the best possible medication history completed at all transition points	C	% / Patients Clients at risk of delayed transitions in care	EMR/Chart Review / 2024-25	CB	CB	Ensure medication safety	Maamwesying North Shore Community Health Services

Change Ideas

Change Idea #1 Develop transition plan template for consistent data entry

Methods	Process measures	Target for process measure	Comments
Develop and implement transition plan template into EMR	Number of medication reconciliations documented in a transition plan completed for admitted clients	Transition plan template implemented by August 2024	

Change Idea #2 Establish workflow for Indigenous System Navigator (ISN)

Methods	Process measures	Target for process measure	Comments
Establish consistent workflow for clients admitted to hospital who are connected with the ISN.	Number of admitted clients for which notification was received by the ISN from hospital partners.	60% of admitted clients will have medication reconciliation documented in a transition plan by September 2024 and 70% by March 2025	The Transitions in Care Implementation Working Group will be focused on improving the process for continuity of care.

Measure - Dimension: Efficient

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of clients with diabetes who have received a foot exam using the Inlow's 60 second diabetic foot screen tool	C	% / patients with diabetes, aged 18 or older Clients at risk of lower limb amputation	EMR/Chart Review / 2024-25	51.00	80.00	Reduce the risk of lower limb amputation	Maamwesying North Shore Community Health Services

Change Ideas

Change Idea #1 Promote consistency of diabetic, peripheral vascular disease and wound assessment

Methods	Process measures	Target for process measure	Comments
Integrate digital assessment tool (Inlow's 60 second foot screening tool) into PSS/EMR	% of clients who have had an Inlow 60 second foot screen in the last 3 months	50% of clients diagnosed with Diabetes will have the Inlow 60 second foot screen completed in the last 3 months by September 2024 and 80% by February 2025	

Measure - Dimension: Efficient

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of lower limb assessment completed using the Lower Limb Assessment Tool on clients with diabetes and peripheral vascular disease (PVD)	C	Number / patients with diabetes, aged 18 or older Clients at risk of lower limb amputation	EMR/Chart Review / 2024-25	CB	CB	To promote consistency of diabetic, PVD and wound assessment	

Change Ideas

Change Idea #1 Promote consistency of diabetic, Peripheral Vascular Disease (PVD) and wound assessment

Methods	Process measures	Target for process measure	Comments
Integrate digital Lower Limb Preservation assessment tool (Lower Limb Assessment Tool) into EMR	# of lower limb assessments completed on clients with Diabetes and PVD in the last 3 months	% of clients who have had an Inlow 60 second foot screen that required a lower limb assessment	

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)	50.00	54.00	To align with the provincial average of 54% and NE 53.4%	Maamwesying North Shore Community Health Services, North East Regional Cancer Program

Change Ideas

Change Idea #1 Improve access to preventative care with mobile coach screening available in community.

Methods	Process measures	Target for process measure	Comments
Continued collaboration with the North East Cancer Program to launch mobile cancer screening.	Decrease the number of eligible clients overdue for cervical screening.	To achieve the provincial target of 54% by March 2025.	

Change Idea #2 Improve screening rates for clients who have refused cervical screening.

Methods	Process measures	Target for process measure	Comments
Analyze response data captured in EMR e.g. refused, advised, scheduled to increase preventative care screening.	Decrease the amount of clients due for cervical screening.	To achieve the provincial target of 54% by March 2025.	

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)	44.20	57.00	To align with the provincial average of 57.7% and the NE 58%	Maamwesying North Shore Community Health Services, North East Regional Cancer Program

Change Ideas

Change Idea #1 Improve access to preventative care with mobile coach screening available in community.

Methods	Process measures	Target for process measure	Comments
Continued collaboration with the North East Cancer Program to launch mobile cancer screening.	Decrease the number of eligible clients overdue for mammogram.	To be within 5% of the provincial target by March 2025.	

Change Idea #2 Improve screening rates for clients who have refused breast cancer screening.

Methods	Process measures	Target for process measure	Comments
Analyze response data captured in EMR e.g. refused, advised, scheduled to increase preventative care compliance.	Decrease the amount of clients due for breast cancer screening.	To be within 5% of the provincial target by March 2025.	

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)	35.30	43.00	To align with the provincial average of 43.7% and NE 40.2%	Maamwesying North Shore Community Health Services, North East Regional Cancer Program

Change Ideas

Change Idea #1 Improve access to preventative care with mobile coach screening available in community

Methods	Process measures	Target for process measure	Comments
Continued collaboration with the North East Cancer Program to launch mobile cancer screening	Decrease the number of eligible clients overdue for colorectal screening	To be within 5% of the provincial target by March 2025	

Change Idea #2 Improve screening rates for clients who have refused colorectal screening

Methods	Process measures	Target for process measure	Comments
Analyze response data captured in EMR e.g. refused, advised, scheduled to increase preventative care compliance	Decrease the amount of eligible clients due for colorectal screening	To be within 5% of the provincial target by March 2025	