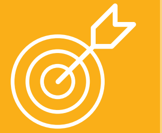
Eastern York Region North Durham
EYRND ONTARIO HEALTH TEAM

# OHT OVERARCHING STRATEGIC PLAN

## QUADRUPLE AIM



Improved Patient Experience
Improved Patient Outcomes
Lower Cost of Care
Improved Provider Experience

## MINISTRY OF HEALTH CQIP INDICATORS

Improving overall access to care in the most appropriate setting

**1. INDICATOR.** Alternate Level of Care Days

Increasing overall access to community mental health and addictions (MHA) services

**2. INDICATOR.** Rate of Emergency Department visits as first point of contact for MHA-related car

Increasing overall access to preventative care

**3. INDICATOR.** Percentage of screening eligible patients up-to-date with Papanicolaou (Pap) tests

**4. INDICATOR.** Percentage of screen-eligible patients up-to-date with mammogram

**5. INDICATOR.** Percentage of screen-eligible patients up-to-date with colorectal screening

## STRATEGIC GOALS

**GOAL 1.** Revolutionize 24/7 access and system navigation experience

**GOAL 2.** Increase access to mental health and addictions resources and community supports

**GOAL 3.** Strengthen the role of primary care providers

**GOAL 4.** Deliver client centered integrated care within an appropriate setting

## ENABLERS

Collaborations
Communications
Digital Tools
Health System Users
Privacy (Data Sharing Agreement)
Equity and Inclusivity

Eastern York Region North Durham
EYRND ONTARIO HEALTH TEAM

# 2021-2022 APPROVED INITIATIVES AND ALIGNMENT WITH OHT VISION

## GOAL 1

### Revolutionize 24/7 access and system navigation experience

#### Access and Navigation

Creating a repository of services and streamlining navigation supports to enable easier navigation of community services and resources by both residents and providers of EYRND OHT.

## GOAL 2

### Increase access to mental health and addictions supports

#### Adult day Program

Enhanced Adult Day Service for persons living with dementia at the various stages of the disease trajectory. Alternative/hybrid programming that includes virtual, recorded/email, on site and in home options. In-home 1:1 services with activity kits and tablets with data to access virtual programming.

#### First Link

Increasing awareness of First Link program, navigation services for people with dementia, amongst primary care providers and their patients.

#### Inner-City Hub

Creating an integrated mental health and addictions hub for marginalized populations in the community.

#### Under One Roof

Bringing primary care, acute care, health care service providers and social service providers under "one roof" (physically and/or virtually) to enable individuals who live and/or work in the "L3S" FSA the ability to access services in a more culturally relevant, user friendly and accessible manner.

#### Regional Youth Transition Program

Formalizing a partnership between child and youth mental health and addictions organizations and York Support Services Network with the goal of improving navigation and transition experience as individuals are aging out of child/adolescent services and moving into adult services.

## GOAL 3

### Engage primary care

#### SCOPE

Improving equitable and timely access to hospital specialists and team-based care for primary care providers and their patients through one-number to call.

#### Primary Care Physician Website

A robust engagement strategy including face-to-face meeting, Primary Care Physician Website, Townhalls and education webinars to build new relationship and /or strengthen existing relationship with community primary care providers and hospital.

#### Social Media

Leveraging social media (Instagram, Facebook, Twitter), to increase physician and resident awareness of mental health and addictions issues and available community resources.

## GOAL 4

### Deliver client centered integrated care within an appropriate setting

#### MSH Care@Home

A 16 week program that supports transitioning patients with multiple care needs from Oak Valley Health back into the community through offering wrap-around services.

#### Sunrise Short Stay Support Program

A program designed to help prepare patients who do not require intensive hospital care smoothly transition to the next appropriate destination.

#### Care@Home+

A novel program focusing on identifying at risk clients in the community and providing an intense level of home and community care supports with the goal of caring for individuals in the community and avoid hospitalization.