Quarterly Performance Measurement Report

November 2023

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Summary : Latest Month Report

#	Indicator	Unit of Measure	Reporting Period	Proposed Target	Current Performance (lower is better)	Status	Change since last report
1	Caregiver distress among home care clients	%	Sep 2023	<= 56%	53.3%		Slippage from 50.9%
2	Hospitalization rate for conditions that can be managed outside hospital (asthma, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, angina and epilepsy)	Rate per 100,000 population	Aug 2023	<= 20.4 monthly (61.2 quarterly) (244.8 annually)	16.1		Significant Improvement from 20.8
3	Total ALC (Acute and Non-Acute)	%	Sep 2023	<=16.7%	15.7%		Slippage from 13.7%
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Sep 2023	<=10.0%	15.3%		Slight Improvement from 15.5%

Performance Corridors: Greater than 10% of Target | Within 10% of Target | Meets Target

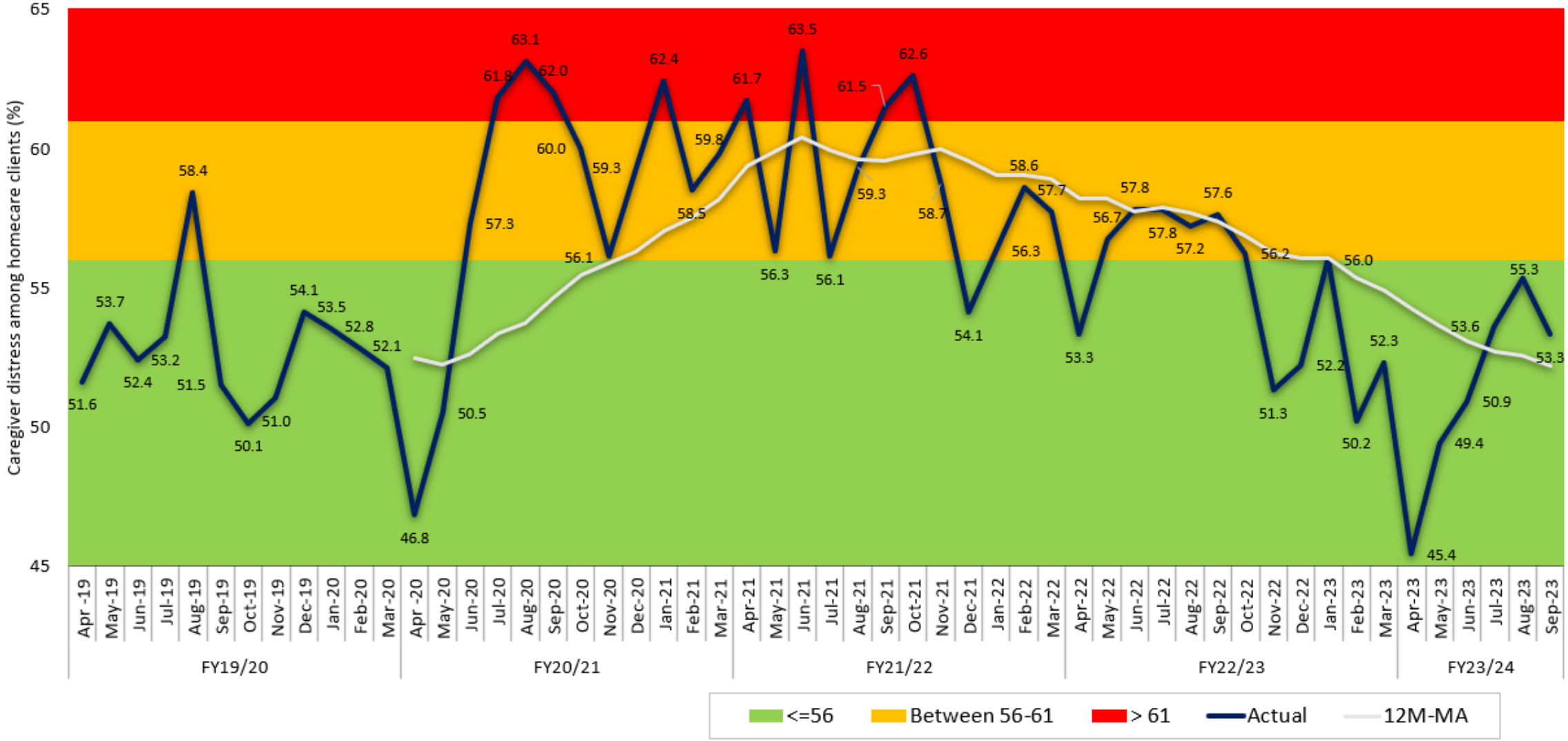
Data Availability

Indicator	Status - FY2023/24 data												Comments
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
1. Caregiver Distress Among Homecare Clients(%)	✓	✓	✓	✓	✓	✓							Date Source – Inter-RAI
2. Ambulatory Care Sensitive Conditions Best Managed Elsewhere (Rate)	✓	✓	✓	✓	✓	✗							Data Source: IDS
3. Total ALC (Acute and Non-Acute) Rate (%)	✓	✓	✓	✓	✓	✓							Data Source: Change from DAD to CCO-WTIS
4. Frequent ED Visits for Help with Mental Health and Addiction (%)	✓	✓	✓	✓	✓	✓							Data Source: NACRS

✓	*Monthly data received*
✗	*Monthly data NOT received*

Caregiver Distress Among Homecare Clients

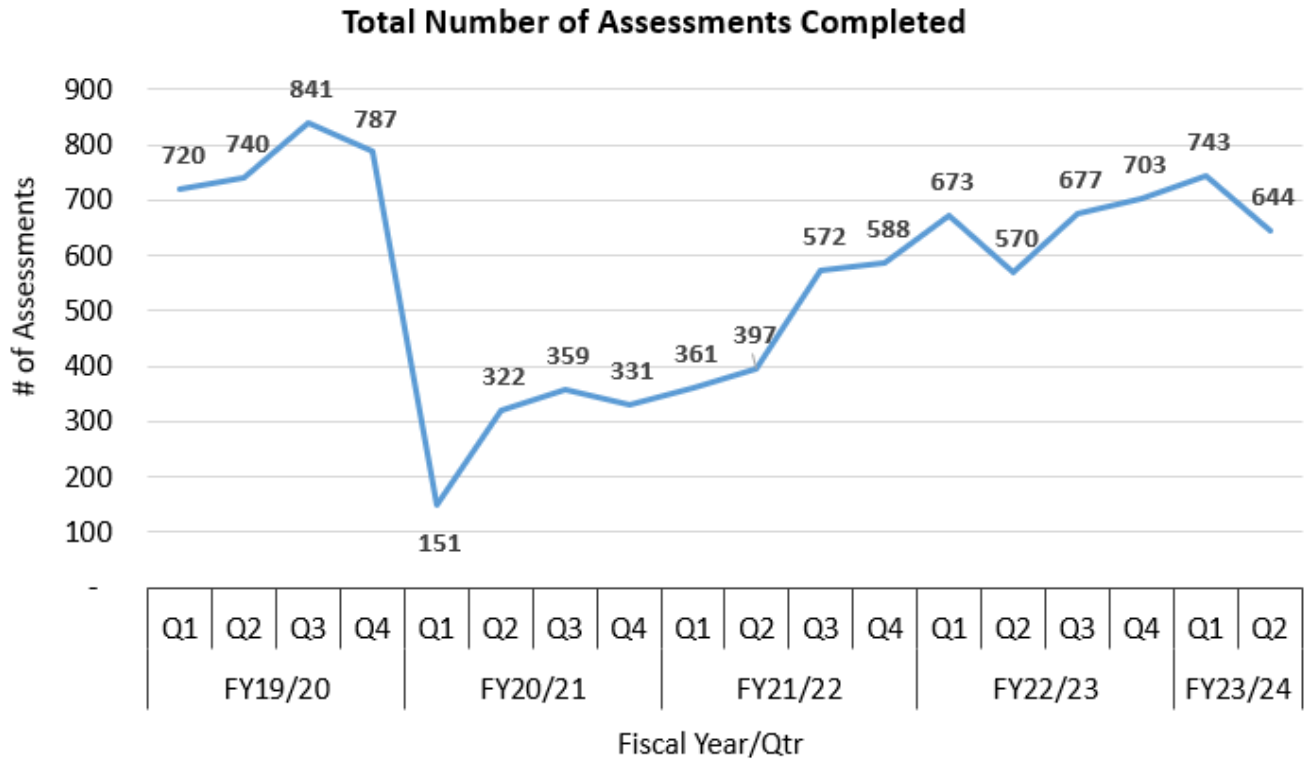
Caregiver Distress Among Homecare Clients (%): April 2019 to September 2023



- Caregiver distress among homecare clients increased significantly during the pandemic and continued relatively high until October 2021
- A downward trend then began, and since November 2022 we have been at or below the target, we have set.

Number of Completed Homecare Assessments by Fiscal Quarter, and Fiscal Year

FY/Qtr	FY19/20	FY20/21	FY21/22	FY22/23	FY23/24
Q1	720	151	361	673	743
Q2	740	322	397	570	644
Q3	841	359	572	677	
Q4	787	331	588	703	
Total	**3,088**	**1,163**	**1,918**	**2,623**	**1,387**



- 3,088 interRAI HC assessments were completed in FY2019/20.
- This decreased significantly in FY2020/21 to 1,163 interRAI HC assessments.
- In FY2021/22 the number of assessments completed rose to 1,918, which is still below pre-pandemic levels but a jump from 20/21.
- In FY2022/23 the number of assessments completed rose to 2,623, which is a significant jump from 21/22 but still below the pre-pandemic level.
- In FY2023/24-Q2 the number of assessments rose to 644, which is a significant jump from FY22/23-Q2.

Contributing Factors

Factors contributing to our current performance results:

- The pandemic **limited face-to-face visits** and the ability to complete interRAI Homecare Assessments (which our data is based on). It is important to note that other non face to face assessments of complex patients occurred during the timeframe which did not use the interRAI HCA as the assessment tool. The interRAI HCA is not a tool that is validated using a virtual platform. As the pandemic restrictions wane, the overall number of in-home assessments being completed are increasing and caregiver distress continues to improve for KW4.
- Home and Community Care Support Services (HCCSS) has found stabilization within their Health Human Resources.
- As the pandemic continued, **more day program and respite care spots opened,** which may have contributed to the reduction in caregiver stress. There is an ongoing opening of community respite programs. Of note, HCCSS is seeing a noticeable increase in service provider capacity. Additionally, **the short stay respite and convalescent care programs in long term care remain paused in WW**, provincially other short stay respite and convalescent care has restarted.
- The number of **face-to-face vs virtual visits has also increased** (including home visits) for primary care and the Alzheimer's society which also may have contributed to a decrease in caregiver stress.
- The **Let's go Home program (LEGHO)** was introduced in November 2022 as well as the **knowledge exchange on social prescribing** which may also have contributed to a decrease in caregiver stress.
- The support of **the community paramedic program** may also have reduced caregiver stress.
- Development of a **delirium collaborative** that will include education for caregivers on how to recognize signs of delirium earlier on which may contribute to decreasing caregiver distress. Education is targeted to occur in March 2024 to align with other world delirium awareness day initiatives.
- The **ICT/CCP model** of care, which provides support for patients and families may result in decreasing caregiver distress
- Role of function of **intensive geriatric service worker (IGSW)** continues to support families and caregivers

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Models of Care Innovation Fund EOI</u>
  - As part of Ontario's plan to enable forward-looking, collaborative, and responsive solutions to the healthcare needs of every Ontarian, Ontario Health launched an expressions of interest for their **Models of Care Innovation Fund**. This fund will assist organizations in implementing innovative ways of maximizing the skills and expertise of their current health care workers. As with previous expressions of interests, **partners from across the KW4 OHT collaborated to create proposals**. These submissions align with our focus and commitment to our priority populations and Ontario Health's equity priorities. The suggested initiatives offer partnership-driven, sustainable approaches to address healthcare challenges in our community. The Centre for Family Medicine along with partners from across the KW4 region submitted a proposal to **expand the MINT Memory Clinic model** that includes cross-sectoral partnerships with local or regional specialists to **reduce wait times and travel for patients and their caregivers**. If this proposal is selected by Ontario Health, it will expand the model to reach 300 primary care providers and 50 multi-disciplinary primary care teams across Ontario. These providers will be fully-trained, mentored and operational to assess and **address the needs of patients with dementia and frailty and their caregivers**.

- <u>Delirium Collaborative</u>
  - The KW4 OHT Frail Elderly Collaborative in partnership with the Waterloo Wellington Older Adult Strategy is developing educational materials for patients, families, and clinical teams to assist with **recognizing early signs of delirium** to initiate interventions and supports sooner.

- <u>Wellness Calendars</u>
  - In collaboration with partners, the KW4 OHT 2024 **wellness calendar** for older adults in the KW4 Region has been completed and distributed to stakeholders.

- <u>SCOPE (Seamless Care Optimizing Patient Experience)</u>
  - SCOPE is a joint SMGH-GRH program to **support KW4 primary care providers with clinical consultation for complex and urgent patients, including** helping with more efficient and seamless access to services that could decrease caregiver distress.

- <u>Complex Care Program (CCP), Integrated Care Team (ICT) Expansion Project</u>
  - In December 2022, the ministry provided 16 months of funding for a KW4 OHT Integrated Care Team (ICT) Complex Care program (CCP) expansion.

- <u>YourCare+</u>
  - YourCare+ provides tools to use in the home, send to a family member or friend, or share with health care professionals.
  - The **tool allows caregivers to explore information, tips, and resources to help them feel confident and stronger in their caregiver role** and provides advice about ways to protect their own health and avoid stress and burnout while caring for others.
  - This tool has been implemented in KW4 in collaboration with Dr Andrew Costa and team.

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Moving Forward

Initiatives currently underway, or planned for the near future, that will impact our performance on a go-forward basis:

- Building HCCSS WW Capacity
  - HCCSS WW continues to build capacity in home care and address health human resources shortages. HCSS continues to maximize/expand community clinics locally and across the province. **Optimization of rapid response nurses and direct care therapy to support patients waiting for service has demonstrated effectiveness in supporting patients** requiring health care teaching, wound care, teaching of injections, home safety to enhance patient safety at home.

- Retirement Homes
  - The HCCSS's campaign to **increase the number of Retirement Homes providing all-in care** (i.e., PSW) has begun implementation in Wellington. Expansion to KW is currently in the planning phases. This care is funded by HCCSS WW but provided by the Retirement Home workforce. Expansion is being targeted for later this fiscal year.

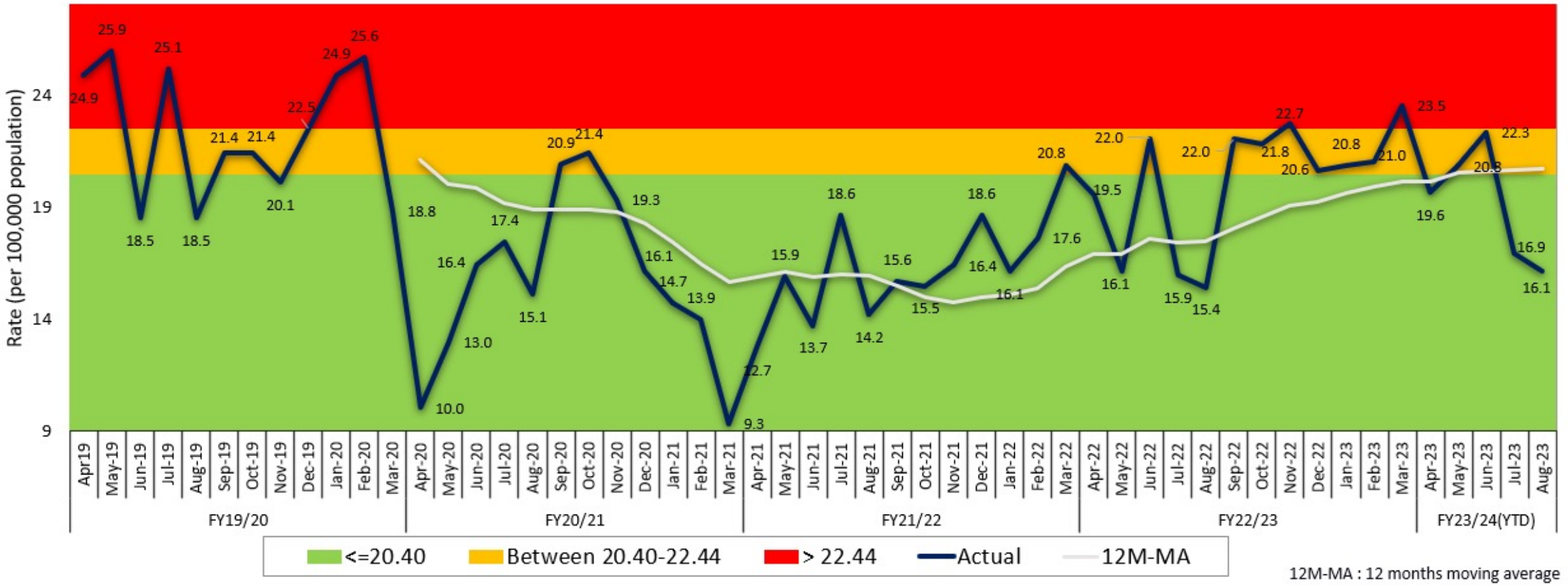
- Principles of sfCare across sectors:
  - Hospital partners have promoted the exchange of knowledge related to principles of senior friendly care (sfCare) across sectors. Leading practices in Community Based Early Identification, Assessment & Transition: Preventing Alternate Level of Care supports facilitating proactive identification and promoting practices in care and self-management that prevent, slow or reverse declines in the physical and mental capacities of older adults, care plan development and ongoing re-assessment, delivery of interventions and sfCare, and proactive transitions.

- Ministry of Health: A Plan for Connected and Convenient Care:
  - Care for seniors and those needing long-term care (LTC) continues to be a priority for the Ministry and OH so it will be important that KW4 continues to advocate for improvements for our community.
  - In the Plan for Connected and Convenient Care, released February 2, 2023, current and future provincial investments were highlighted:
    - **expanding access to home care services and recruiting and training more home care workers**.
    - Working with Ontario Health Teams and home and community care providers to **establish new home and community care programs**.
    - **Expanding the Community Paramedicine program** to help people with seniors live independently at home, where they want to be, by providing home visits for a range of services, including increasing assessments and referrals to local community services, such as home care.
    - **Expanding palliative care services** in local communities and adding new hospice beds.

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Ambulatory Care Sensitive Conditions Best Managed Elsewhere

Ambulatory Care Sensitive Conditions Best Managed Elsewhere (ACSC) (%): Apr 2019 to Aug 2023

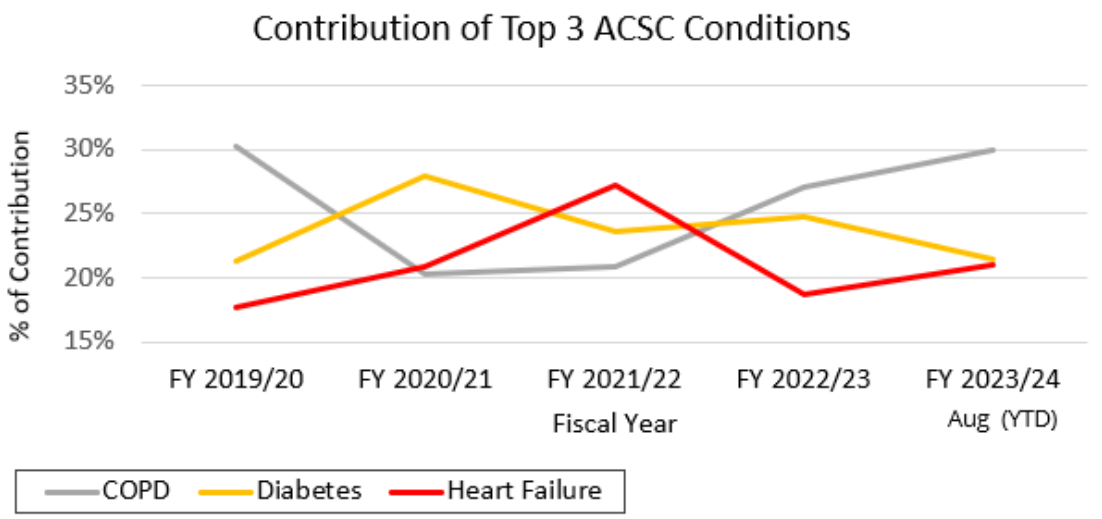


- Rate of ACSC best managed elsewhere decreased during the pandemic.
- This could potentially be an artificial decrease based on patients deferring to seek face-to-face care or having the option of virtual care.
- FY2022/23, we can see an increase in the rates with its last two quarters being above our target.
- FY2023/24, a downward shift was noticed in the rates since the beginning of this fiscal year.

Note: The ACSC BME calculation has been updated, beginning in Apr 2021, to reflect 2021 Census Data

Contribution of Ambulatory Care Sensitive Conditions (in %) by Fiscal Year: FY2019/20 to FY2023/24 Aug(YTD)

Contributing Condition	FY 2019/20	FY 2020/21	FY 2021/22	FY 2022/23	FY 2023/24 Aug(YTD)
COPD	30.2%	20.3%	20.8%	27.0%	29.9%
Diabetes	21.3%	27.9%	23.7%	24.7%	21.5%
Heart Failure	17.7%	20.9%	27.2%	18.7%	21.0%
Angina	2.5%	3.0%	1.9%	1.8%	2.0%
Asthma	11.8%	5.2%	9.7%	13.3%	7.7%
Epilepsy	12.5%	16.8%	12.4%	11.1%	12.0%
Hypertension	4.0%	5.9%	4.3%	3.3%	5.9%



The top 3 ACSC Conditions (Chronic Obstructive Pulmonary Disease **(**COPD), Diabetes, Heart Failure) accounted for

- 69.2% in FY2019/20, with the most prevalent being 'COPD' at 30.2%
- 69.1% in FY2020/21, with the most prevalent being 'Diabetes' at 27.9%
- 71.7% in FY2021/22, with the most prevalent being 'Heart Failure' at 27.2%
- 70.4% in FY2022/23, with the most prevalent being 'COPD' at 27.0%, followed closely by Diabetes at 24.7%
- 72.4% in FY2023/24 Aug(YTD), with the most prevalent being 'COPD' at 29.9%, followed by Diabetes at 21.5%

- **COPD** had a significant decrease of 9.9% points in FY2020/21, a slight increase of 0.5% points in FY2021/22, a significant increase of 6.2% points in FY2022/23, and **an increase of 2.9% points in FY2023/24 Aug(YTD).**

- **Diabetes** had a significant increase of 6.6% points in FY2020/21, a decrease of 4.2% points in FY2021/22, a slight increase of 1.0% points in FY2022/23, and **a decrease of 3.2% points in FY2023/24 Aug(YTD)**

- **Heart Failure** had an increase of 3.2% points in FY2020/21, 6.3% points in FY2021/22, a significant decrease of 8.5% points in FY2022/23, **and an increase of 2.3% points in FY2023/24 Aug(YTD)**

Contributing Factors

Factors contributing to our current performance results:

COPD:

- Many COPD exacerbations that require hospitalization at SMGH are related to infections and newly diagnosed patients. **The increase in rates for 2022 and 2023 reflects the removal of public PPE measures and expanded social circles, etc. which increased the transmission rates for respiratory infections and COPD exacerbations.**
- We are seeing a return to our normal number of referrals for diagnostic testing and asthma education appointments at the hospital. **The total number of 2023 visits YTD have surpassed 2022 volumes by 42% and are approaching pre- pandemic levels**.
    - Increased volume from primary care as they return to normal practices
    - Increased referrals from local specialists
    - Stable referrals from the emergency department
- Referrals at SMGH's community airway clinics operating in the regions CHCs (Woolwich, Kitchener, Guelph, Langs/Cambridge) remain strong with increased volumes at some sites with Covid barriers improving.
- In October 2023, SMGH restarted contracted RRT services with University of Waterloo. They have resumed sending a respiratory educator to UW for asthma education/self management appointments to reduce student impact on regional acute healthcare resources as many of this group do not have local primary care options.

Heart Failure:

- **Remote Care Monitoring** initiatives that have been put in place since March 2022 at SMGH for Congestive Heart Failure has had a significant positive impact (i.e., decrease in heart failure hospitalizations)
- **Access to primary care and specialists has also increased** this year compared to the past two fiscal years thereby diverting hospital visits/admissions
- SMGH in collaboration with Evidence2Practice Ontario, Centre for Effective Practice, eHealth Centre of Excellence and North York General participated in a use case to **seamlessly integrate Heart Failure quality standards to support clinicians with easy-to-use tools and supports at the point of care across primary care and acute care**. This project began in April 2022 with the identification of areas of improvement, and review of existing literature/best evidence and quality standards. Next was the scoping and development of digital interventions culminating in a go-live in mid-October 2022. Highlights from this project include:
    - Integrated Heart Failure Toolbar is now available in Primary Care Telus PS Suite, Oscar PRO and Accuro QHR EMRs. This heart failure tool leverages the most up-to-date evidence and best practices, and embeds quality standards, to assist clinicians in appropriate diagnoses, investigations, treatment, and transitions in care across the continuum. This can assist clinicians with identifying, tracking and supporting at-risk patients as well as resources to support medication plan management. An accompanying educational resource from CEP will support clinicians to fill knowledge gaps, build confidence and support them in diagnosing and managing patients living with heart failure.
    - Hospital Information System enhancements that support existing workflow and improve quality of care. "The work we have done with the pilot has re-confirmed many of the clinical care standards we had in place as a regional cardiac centre. We enhanced the application of best practices, allowing any physician (not just cardiologists) with a patient in heart failure to use our heart failure orders and be guided through the best evidence-based care".
    - Standardized clinician-facing discharge summaries as well as patient-facing discharge summaries

Courtesy of:

- *Brandon Douglas, Vice President – Clinical Services , SMGH, Sarah Farwell, Chief, Strategy and Governance, SMGH, Danny Veniott, Program Manager - Respiratory Therapy, Airway Clinics, SMGH, Dr. Amelia Yip, Heart Functional Lead and Cardiologist, SMGH and the Evidence2Practice Ontario, Angie Fraser, Program Manager, Inpatient Cardiac Surgery, SMGH, Ala Qahwash, Director of Cardiac Care and Critical Care, SMGH, Dr. Heather Warren, Vice President, Medical Programs & Quality, SMGH*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Models of Care Innovation Fund EOI</u>
- As part of Ontario's plan to enable forward-looking, collaborative, and responsive solutions to the healthcare needs of every Ontarian, Ontario Health launched an expressions of interest for their **Models of Care Innovation Fund**. This fund will assist organizations in implementing innovative ways of maximizing the skills and expertise of their current health care workers. As with previous expressions of interests, **partners from across the KW4 OHT collaborated to create proposals**. These submissions align with our focus and commitment to our priority populations and Ontario Health's equity priorities. The suggested initiatives offer partnership-driven, sustainable approaches to address healthcare challenges in our community. SMGH in partnership with various members submitted a proposal for the creation of an innovative **community-based primary care rapid access clinic** for unattached, medically complex patients who are at risk of hospital admission, and/or are post-discharge and at risk of readmission. If the proposal is selected by Ontario Health, this clinic will expand access to team-based care, connected to local specialist groups for rapid assessment, diagnosis, care and consult. This proposal also includes the development of a local eConsult pathway between the KW4 primary care sector, **starting with 3 specialty groups including SMGH cardiology, SMGH respirology and GRH/SMGH General Internal Medicine**.

COPD:

- Reminder to all providers that:
  - **SMGH's Airway clinic has fully reopened** all in person diagnostic testing and education sessions.
  - **SMGH is fully operational at Community Healthcare Clinic hosted COPD and Asthma education/self management programs** operated through Woolwich, Lang's, Community Healthcaring KW, and Guelph CHC's and including some of their remote program sites
  - **SMGH has restarted its asthma education self management program at UWaterloo**
- **In-person COPD appointments continue to increase**. SMGH also continues to offer **telephone or virtual options** when required or requested
- The COPD program continues to be involved in the **joint GRH/SMGH WebEx virtual visit program** using the PHIPA compliant WebEx platform from within Cerner, their electronic health record vendor. Staff and Patients continue to find it more user friendly than OTN
- SMGH ran a **successful virtual COPD activation remote/virtual care project** with great patient outcomes despite low referral numbers. The data showed our outcomes were **at least as good as SMGH's in-person program** and did not put the patient at any increased risk. In fact, the number of **patients who required escalation of care were lower than SMGH's standard program**, mainly because the monitoring team was alerted and could intervene prior to escalation to primary, urgent or emergent care. **This program is now available ongoing as part of SMGH's base program** for patients who have barriers to in person participation. The program aligned with the KW4 OHT's philosophy of using digital health solutions as enablers of care, while understanding that digital first is not always the best approach for every patient as care teams must adapt to meet the patient where they are at. The patients enrolled in the virtual program were those who mainly could not come to an onsite exercise program due to physical, emotional, geographical, and socioeconomic reasons. In most cases, patients would have had a combination of two or more of these factors which would have made access to onsite care even more challenging. This program is a great partnership with the KW4 OHT, especially the digital support team and communications teams.
- St Mary's issued an RFP and has signed a multiyear contract with CloudDx to continue the COPD and heart failure virtual/remote care projects. The same vendor has been used for the last 2 years of the COPD program and last year's heart function RCM project. The contract has options to expand services and add new programs over time.

Courtesy of:

- *Sarah Farwell, Chief, Strategy and Governance, SMGH*
- *Danny Veniott, Program Manager - Respiratory Therapy, Airway Clinics, SMGH*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

Heart Failure:

- <u>Remote Care Monitoring (RCM) and Surgical Transition Program:</u>
  - KW4 OHT, in collaboration with SMGH and Primary Care developed and submitted a proposal for **Heart Function Clinic Virtual sustainment and expansion**
    - The program kicked off in November 2022 with an enrollment target of 200 patients by March 31, 2024.
    - The current program monitors heart failure patients from the heart failure clinic. This funded proposal will help expand the program to include patient's post cardiovascular surgery with complication of heart failure post procedure.
  - Work is underway to **improve access to BNP and NT-proBNP testing**, including standardization where possible as well as improving education.
  - **SMGH's Heart Failure RCM program submitted an EOI for 2023/24 Digital Funding** in May 2023 to expand their existing program. The focus this year will include:
    - leveraging existing relationships to expand the program (e.g., larger geographic reach), and beyond the walls of SMGH (i.e., enrollment through PCP office).
    - working with other programs to realize further efficiencies that impact the patient experience
    - ensuring the social determinants of health are being realized with the Institute for Healthcare Improvement (IHI) model of quality
    - obtaining and analyzing metrics further (such as patient experience, delivery clinical excellence)

- <u>Neighbourhood Integrated Care Team (NICT) Project</u>
  - KW4 OHT in collaboration with member organizations and the community have designed a patient persona, journey map and **integrated care pathway for senior with congestive heart failure.** The goal of this pathway is to provide a clear community-based care pathway that adopts a chronic disease management approach, improves communication, increases access to information, offers more comprehensive and holistic care, improves the patient's quality of life, engages patients and care partners as members of the care team, better integrates services across sectors, creates a community support around the patients, and integrates palliative care earlier in the patient's care journey. Currently we are exploring new opportunities to support seniors with heart failure in the heart function clinic through community resources. This will include identifying ways to enhance access to community-based services, such as transportation, home care, and social support, to help seniors manage their health more effectively.
  - The CSS navigator pilot project has also been established, which is focused on connecting patients to the community resources they need to achieve holistic care based on a referral from their primary care clinician. Patients with heart failure form a part of the population served through the CSS navigator.

- <u>Clinical Pathway Development and SCOPE</u>
  - Local KW4 OHT partners have been working together since Summer 2022 to improve the **dyspnea pathway** in the Region **to specifically support improved heart failure diagnosis and management in the community**. The purpose of the pathway is to support Primary Care Practitioners in the referral process of appropriate patients with possible heart failure, ensuring patients receive the right care at the right time in the right place. If the patient does not meet the criteria for referral to the Heart Function Clinic, the SCOPE Nurse Navigator will assist to locate the appropriate services for continuity of care. The pathway went live in October 2022 with feedback being collected to inform future iteration. The CHF development team is expanding their membership to include more primary care physicians, NPs, and the KW4 OHT SCOPE Nurse Navigator.
  - **SCOPE** (Seamless Care Optimizing Patient Experience) is a joint SMGH-GRH program to **support KW4 primary care providers with clinical consultation for complex and urgent patients, including resource navigation for patients experiencing heart failure**. SCOPE is available through the Ocean eReferral platform.

Courtesy of:

- *Dr. Amelia Yip, Heart Functional Lead and Cardiologist, SMGH, Brandon Douglas, Vice President – Clinical Services , SMGH, Sarah Farwell, Chief, Strategy and Governance, SMGH, Ala Qahwash, Director of Cardiac Care and Critical Care, SMGH, and Dr. Heather Warren, Vice President, Medical Programs & Quality, SMGH*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

Prevention:

- St Mary's General Hospital is aiming to **launch a new program in April of 2024 called the PREvent Clinic**, for patients with increased cardiovascular risk identified by the Emergency Department, Urgent Care Clinic, or Primary Care Provider. Through a 16-week program, the clinic would focus on medical optimization of risk factors including hypertension, dyslipidemia, to a lesser extent diabetes, and smoking cessation as well as supporting education, dietary counseling and exercise prescriptions. This clinic has been made possible through an expanded partnership between SMGH and Manulife allowing more proactive illness prevention in the community as well as avoidance of hospital admission.

Unattached Patients:

- The Rapid Access Primary Care Clinic (RAP-Clinic) is a cross-organization effort being led by Community Healthcaring KW. This pilot clinic will focus on providing access to episodic primary care for unattached patients who frequently use the ED as their first point of access. The pilot is currently scheduled to begin in early 2024 with plans to create and test a proof of concept that could extend beyond March 2024. This pilot builds on a proposal created for the Expanding Team Based Care Expression of Interest. The sectors involved include KW4 OHT primary care, hospitals, community service providers.

Diabetes:

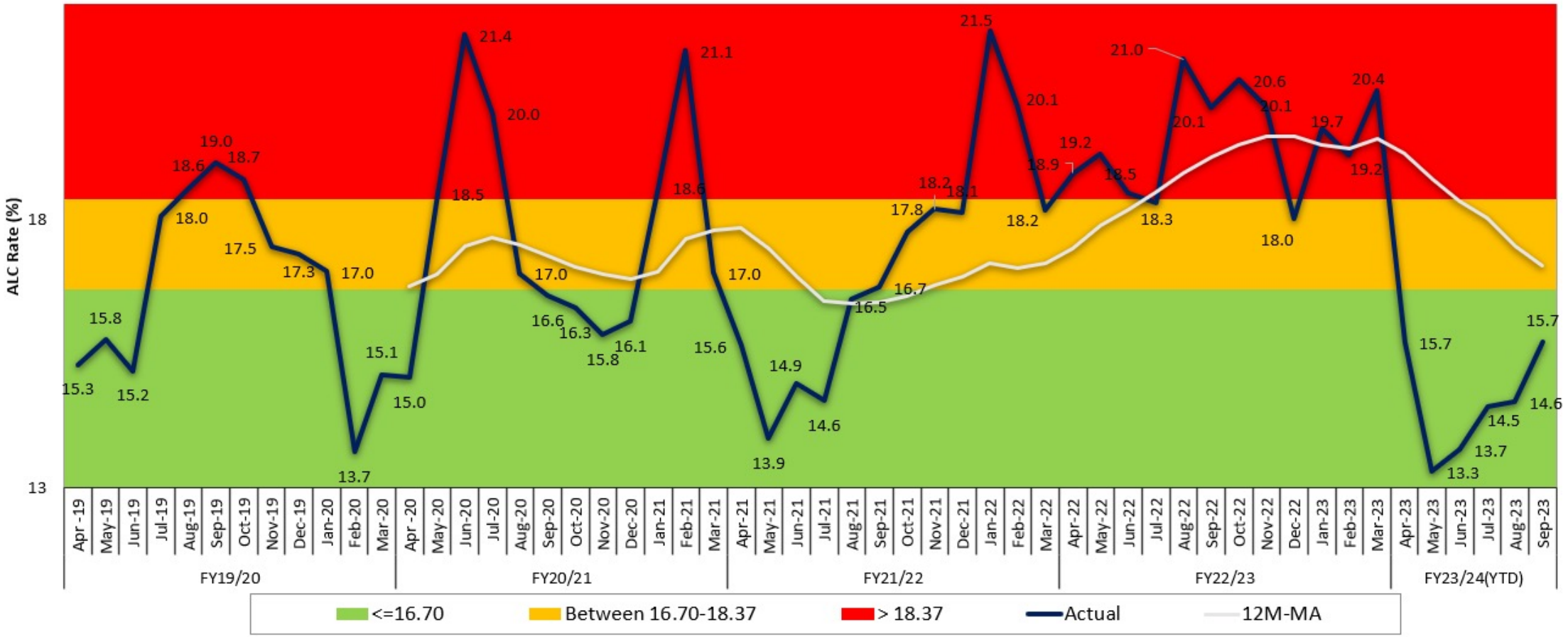
- <u>Neighbourhood Integrated Care Team (NICT) Project</u>
- KW4 OHT in collaboration with member organizations and the community have designed a patient persona, journey map and **integrated care pathway for Diabetes.** The goal of this pathway is to increase knowledge of resources and services available in the KW4 region, provide strong system navigation and culturally competent care, improve chronic disease management in the community, reduce duplication of efforts between providers and reduce barriers to accessing care.
- The OHT is working with the Regional Coordination Centre to create awareness about **Self-referral to Diabetes Education Programs** with a focus on the priority neighborhoods. These programs equip patients with the proper education, tools and support in managing Diabetes.
- The OHT is also collaborating with the YMCA of Three Rivers to roll out two sessions of **Diabetes Fit Program**, a health management program that is focused on leveraging lifestyle modifications to diet and exercise as a way to improve the overall quality of life in patients with Pre-diabetes and Type 2 Diabetes.

<u>Ministry of Health: A Plan for Connected and Convenient Care:</u>

- Care for those with chronic conditions continues to be a priority for the Ministry and OH, so it will be important that KW4 continues to advocate for improvements for our community.
- In the Plan for Connected and Convenient Care, released February 2, 2023, current and future provincial investments were highlighted:
  - **Expanding the Community Paramedicine program to help people with chronic health conditions** live independently at home, where they want to be, by providing home visits to seniors for a range of services, including managing chronic conditions
  - **Developing stronger care pathways for people that suffer from chronic illnesses** like congestive heart failure, chronic obstructive pulmonary disease, stroke and diabetes to allow for greater care throughout the lifecycle of their treatment, from screening and prevention to community support and recovery at home.
  - Expanding 9-1-1 models of care that provide paramedics more flexibility to treat certain patients who call 911 at home or on-scene in the community rather than in emergency rooms, **to different patient groups, such as people with diabetes and epilepsy, and implement a new treat-and-release model with recommendations to patients for appropriate follow-up care.**

Alternative Level of Care (ALC)

Total ALC (Acute and Non-Acute) Rate (%) - April 2019 to September 2023



12M-MA : 12 months moving average

- Overall, the KW4 ALC rate has been fluctuating over the past 4 ½ years, and the total ALC rate shows an increase year over year since the beginning of the pandemic until the end of FY2022/23. However, there is a sudden downward shift since the beginning of FY2023/24.
- FY 2023/24 Sep(YTD), the average ALC rate is 14.6% which is 2.9 percentage points lower than the overall average of 17.5%.

ALC Open Cases as of September 2023

Cumulative ALC Days of Open Patients Designated ALC by Discharge Destination - September 2023

	Open Cases				% of Cumulative ALC Days											
Facility	Volume (Sept 2023)	Volume (Sep 2022)	%Change (June 2023 vs. June 2022)	Cumulative ALC Days (Sept 2023)	Long Term Care	Rehab	Complex Continuing Care	Home with CCAC	Home with Comm. Services	Home without Support	Supervised or Assisted Living	Convalescent Care	Mental Health	Palliative Care	Unknown	TBD
St. Mary's	27	44	-29%	226	39.0%	44.0%	0.0%	15.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	1.0%
Grand River	109	116	-10%	4,723	60.0%	3.0%	0.5%	0.3%	2.0%	0.0%	19.0%	7.0%	5.0%	1.0%	0.0%	2.0%
Total	136	160	-15%	4,949	59.0%	4.9%	0.5%	1.0%	1.9%	0.0%	18.1%	6.7%	4.8%	1.0%	0.0%	2.0%

Cumulative ALC Days Contributor - Top 3 Discharge Destination (excl. TBD) 1st 2nd 3rd

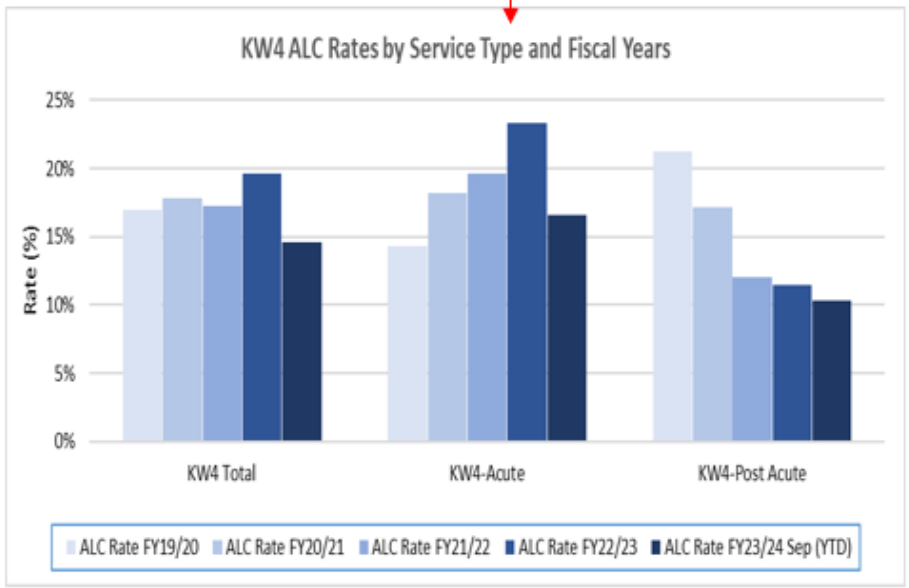
Source - Waterloo Wellington Sub-Region Monthly Alternate Level of Care Performance Summary - September 2023

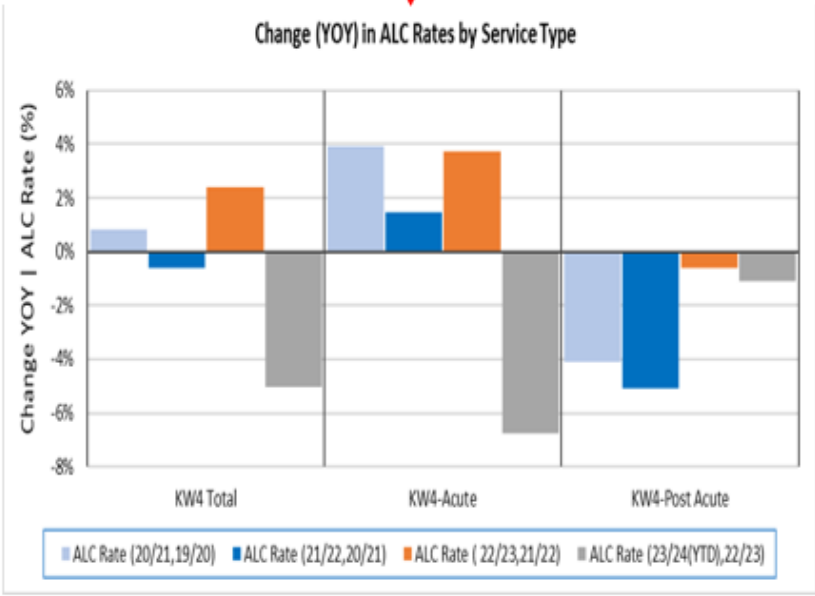
As of June 30, 2023:

- There were 136 patients designated ALC on the waitlist in the two KW4 OHT hospitals. This translates into 24 fewer cases compared to September 30, 2022
- These patients have accumulated 4,949 ALC days
- Of the cumulative ALC Days 59.0% were attributed to patients waiting for Long Term Care, 18.1% waiting for Supervised or Assisted Living and 6.7% were waiting for Convalescent Care

ALC Rate by Facility, Service Type, and Fiscal Year FY19/20 to FY23/24 Sep(YTD)

Facility	ALC Rate					Year Over Year (YOY) Change in ALC Days			
	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24 Sep (YTD)	Between FY 19/20 and 20/21	Between FY 20/21 and 21/22	Between FY 21/22 and 22/23	Between 22/23 and 23/24 (YTD)
GRH	16.9%	19.1%	18.3%	20.4%	15.7%	2.2%	-0.8%	2.1%	-4.6%
Acute	12.8%	20.5%	22.5%	26.4%	19.5%	7.7%	2.0%	3.9%	-6.9%
Post Acute	21.2%	17.1%	12.0%	11.4%	10.3%	-4.1%	-5.1%	-0.6%	-1.1%
CCC	24.6%	18.4%	14.2%	12.7%	10.2%	-6.2%	-4.2%	-1.5%	-2.5%
MH	20.7%	17.6%	10.6%	10.9%	11.0%	-3.1%	-7.1%	0.4%	0.1%
Rehab	11.3%	11.5%	10.0%	9.9%	8.8%	0.2%	-1.5%	-0.1%	-1.1%
SMGH-Acute	17.4%	13.3%	13.7%	17.1%	10.8%	-4.1%	0.4%	3.4%	-6.2%
KW4 Total	17.0%	17.8%	17.2%	19.6%	14.6%	0.8%	-0.6%	2.4%	-5.0%
KW4-Acute	14.3%	18.2%	19.6%	23.3%	16.6%	3.9%	1.4%	3.7%	-6.8%
KW4-Post Acute	21.2%	17.1%	12.0%	11.4%	10.3%	-4.1%	-5.1%	-0.6%	-1.1%





Source: ALC Rate Quarterly Release CCO-WTIS

KW4 Total ALC Rate:

- increased 0.8% points between FY19/20 and 20/21
- decreased by 0.6% points between FY 20//21 and 21/22
- increased 2.4% points between FY21/22 and 22/23
- decreased 5.0% points between FY22/23 and 23/24 Sep(YTD)
- **decreased 2.4% points over the last 4 ½ years.**

KW4 Acute ALC Rate:

- increased 3.9% points in between FY19/20 and 20/21
- increased 1.4% points between FY 20//21 and 21/22
- increased 3.7% points between FY21/22 and 22/23
- decreased 6.8% points between FY22/23 and 23/24 Sep(YTD)
- **increased 2.3% points over the last 4 ½ years.**

KW4 Post Acute ALC Rate:

- decreased 4.1% points between FY19/20 and 20/21
- decreased another 5.1% points between FY 20//21 and 21/22
- decreased 0.6% points between FY21/22 and 22/23
- decreased 1.1% points between FY22/23 and 23/24 Sep(YTD)
- **decreased 10.9% points over the last 4 ½ years**

KW4 Ontario Health Team

Contributing Factors

Factors contributing to our current performance results:

- Long Term Care (LTC)
  - In collaboration with our LTC partners, HCCSS WW supported:
    - The closure of the waiting list of Pinehaven and the transfer of LTC beds and residents from Pinehaven to Winston Park. HCCSS WW also supported residents of Pinehaven who wanted to transfer to other LTCH's instead of The Village of Winston Park.
    - The **opening of 45 additional LTCH beds at The Village Winston Park** have supported a reduction in ALC to LTC. The closure of Twin Oaks of Maryhill LTCH which included the transfer of residents to long term care homes of their choice.
    - **Better access to service providers through home and community support services** may have also resulted in a decreased ALC rate within hospitals
    - **Integrated discharged planning team members have fully implemented the Bill 7 legislation to support movement to** LTC, which may have supported a reduction in ALC.

- Hospice
  - **Additional beds were added to Hospice Waterloo Region**. This increase to 11 beds allows for the provision of additional palliative care for those at end of life and support for their families.

- Emergency Department (ED) Diversion Program
  - In Q4 of 2022 **ED Diversion was re-launched** at all KW hospital sites (SMGH, GRH, with expansion to CMH). The re-launch included re-education of frontline staff, and engagement of key hospital stakeholders that can support early identification of patients that meet the eligibility for ED Diversion and could be supported with enhanced PSW services in the community to avoid an admission to the hospital.

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Neighbourhood Integrated Care Team (NICT) Project</u>
  - KW4 OHT is developing a Neighbourhood Integrated Care Team Model (NICT) in our four priority neighbourhoods to **identify high-risk clients and support them in the community** through an integrated model of care that includes primary and community care.
  - Using a population health management approach, we will look at **upstream initiatives** to reduce ALC rates focused on Self-Directed Individuals (low-risk), and Supported Individuals (moderate-risk)
  - We will also aim to optimize hospital capacity and patient flow by applying best practices in **admission avoidance** for those presenting in the ED by **diverting patients back to home with the appropriate support(s) in place**.
  - We will also focus on **timely discharge of patients designated ALC** through intensive care coordination and partnering with Behavioural Supports Ontario (BSO).

- <u>Alternate Destination – Hospice</u>
  - On August 31, 2023, Region of Waterloo Paramedic Services received approval from the Ministry of Health, for the **Alternation Destination (Hospice) project** under the ministry's Patient Care Model initiative for eligible 9-1-1 palliative care and end of life patients. KW4 OHT was a proponent for this model and offered a letter of support earlier this year. Under this model, palliative care patients calling 9-1-1 will have the option to be treated on-scene for pain and symptom management, including pain or dyspnea, hallucinations or agitation, terminal congested breathing, and nausea or vomiting. Following treatment on-scene, patients have the option for paramedics to coordinate the patient's follow-up care directly with the patient's primary palliative care provider or with a local hospice for further treatment and wrap-around care, including direct admission to hospice. This **ensures that paramedics have more options to provide safe and appropriate treatment for patients while helping to protect hospital capacity**. Meetings to move this initiative forward have been scheduled.

- <u>Emergency Department (ED) Diversion Program</u>
  - The KW4 OHT Frail Elderly Collaborative in partnership with the Waterloo Wellington Older Adult Strategy is **developing education tools** built on the RGP Toronto materials **to assist with education and knowledge transfer in assessing and recognizing delirium early in the Emergency Department** with treatment and care options. **Education tools to be launched in March 2024**

- <u>Let's Go Home (LEGHO)</u>
  - In July 2022, Community Care Concepts was approved by OH West to be the CSS organization for the Cambridge North Dumfries (CND) and KW4 OHT. In collaboration with WW hospitals, LEGHO has successfully been implemented. We will continue supporting quality improvement efforts learned through implementation during this quarter.
  - Through the LEGHO model, partners developed a LEGHO program leveraging existing services and providers (with the possibility to add capacity) within their OHT to support ED Diversion/Admission Avoidance and Hospital Discharge.
  - This program offers up to 6 weeks of Community Support Services, customized to the unique needs of vulnerable patients, and at no cost to the patient, supporting their stabilization in the community post discharge.
  - System Navigation links patients to ongoing Community Support Services as needed.
  - The program has been well received by hospitals and has been of great benefit to patients with 152 patients supported in Q1. At the end of Q1, our LEGHO program is at 43.4% of our overall annual capacity.

Courtesy of:

- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Complex Care Program (CCP), Integrated Care Team (ICT) Expansion Project</u>
  - As part of Ontario's Plan to Stay Open, a proposal is being implemented to **expand the existing CPP/ICT for Older Adults, and GeriMedRisk for upstream prevention of ALC designation** within the KW4 Ontario Health Team catchment area.
  - The proposal **aims to create a sustainable pathway for older adults living with frailty to avoid hospital visits and decrease the active number of alternate level of care designations**.
  - The expansion will allow for:
    - Support of 60-80+ older adults living with complex and chronic conditions who are rostered with primary care provider practices without an inter-professional team
    - Assessment and case management for high-risk older adults living in retirement homes
    - Support of older adults waiting on the Specialized Geriatric Services (SGS) waitlist
    - Support and establishment of referral pathways for safe and timely discharge of identified appropriate hospitalized patients in lieu of ALC designation or after ALC designation
    - Additional support for identified Independent primary health care provider practices without an interprofessional team.
  - An evaluation working group has been formed to evaluate the project and will be pulling data for the fall.
    - A couple of additional family health organizations, inclusive of 7 individual providers, have been added to the project
    - 82% of patients said the program made them more confident in managing their health
    - 100% of ICT members and primary care providers were satisfied with their experience with 100% response rate n=30
  - **Advanced care planning and community support services are considered part of the patients care plan**
  - **Education is being provided** to the ICT team through the Provincial Geriatrics Leadership Ontario (PGLO) orientation program and regional geriatric program central.
  - OH West Steering Committee continues to discuss **sustainability of funding, connections with system partners, and potential spread of the ICT model.**
  - OH West has now completed the onboarding of ICT to **Ocean eReferral** for primary care providers in our area to access. VPN access continues between primary care and New Vision as a form of seamlessly referring their patients. The ICT team, supported by home and community care, will go live with **Hypercare for secure communication** once agreements are signed between all ICT partners and Hypercare.
  - The team was at full compliment for this quarter for this project which enabled them to support timely discharges from hospital
  - The team's work continues to be recognized nationally and they have presented at the Association of Family Health Teams of Ontario (AFTHO) and Canadian Academy of Geriatric Psychiatry Conference (CAGP) in Newfoundland with positive feedback.

- <u>Community Navigation Team</u>
  - The Community Navigation pilot initiative, being led by Community Care Concepts, supports primary care providers in connecting patients with community social services. This program builds off learnings from LEGHO, SCOPE, and the CCP ICT and will connect in with these initiatives as appropriate. The Navigation Team is leveraging the Ocean eReferral platform to provide team-based resources to clinicians in Family Health Organizations (FHOs). The Navigation Team will connect patients with community-based supports for upstream preventative care. The team has created a soft launch trial with a few primary care clinicians with plans to expand within The Boardwalk in early 2024.

Courtesy of:
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Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>SCOPE (Seamless Care Optimizing the Patient Experience)</u>
  - SCOPE is a platform that promotes integrated and collaborative work between primary care, hospital services and community health partners to serve patients with complex needs. Through a single point of access, primary care providers are connected with a Nurse Navigator who assists with navigating the health care system, to ensure providers and patients are connected to the appropriate resources in the timeliest way possible. By connecting primary care providers to appropriate resources, unnecessary Emergency Department visits and hospital admissions can be avoided ultimately avoiding ALC. Several pathways have been developed (including some examples of Diagnostic imaging, and General Internal Medicine) to assist in seamless access for patients.

- <u>ALC Leading Practices</u>
  - **Self assessments have been completed by hospitals and community organizations** for ALC leading best practices and in collaboration with OH West **will develop plans for implementation** by individual organizations.
  - The second step is review and use of the self-assessment results:
    - Ontario Health West will complete thematic analysis of all self-assessments and share the analysis with Sub-Region Access and Flow Tables.
    - Sub-Region Access and Flow Tables will build workplans to address/improve transitions across sectors with a focus on reducing health inequities, transition points of early identification, ED diversion, hospital admission avoidance, barriers to hospital discharge, etc.

- <u>Transitional Care Beds (TCU)</u>
  - HCCSS continues to operate a 25 bed TCU that focuses on supporting ALC patients and patients in the community at risk of admission to hospital. The unit has 15 general unit beds, and 10 memory care beds. TCU operates 5 beds in Guelph Wellington area at Stone Lodge Retirement Residence.

- <u>Integrated Dementia Resource Team</u>
  - The Waterloo-Wellington DREAM (Dementia, Resource, Education, Advocacy, Mentorship) initiative is an extension of a pilot project operated in Brantford Brant Norfolk OHT for people living with dementia to prevent hospital admissions. These previous pilots have shown an increase # of ED visits for dementia but a decrease in admissions, decreased caregiver burden, reduction in repeat visits, and decreased ALC.
  - A soft Launch will begin in November and extend to March 31, 2024.
  - Guelph and GRH are included in the pilot, and we would look to scale to all 7 hospitals in WW if the pilot is successful.
  - As part of this initiative, the Alzheimer's Society would embed a resource (RPN/social worker trained in behaviour prevention) in the Emergency Department Monday to Friday, 8:00-4:00. This resource will help to identify community resource, help with access, and support transition from hospital to home through the Alzheimer's Society respite program. Activation/therapeutic support (not personal care) would be provided for up to 12 hours per week or 40 hours per month to relieve caregiver burden.
  - This Team will also support the individual with dementia in the emergency department and support capacity building with staff within the emergency department

Courtesy of:
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Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

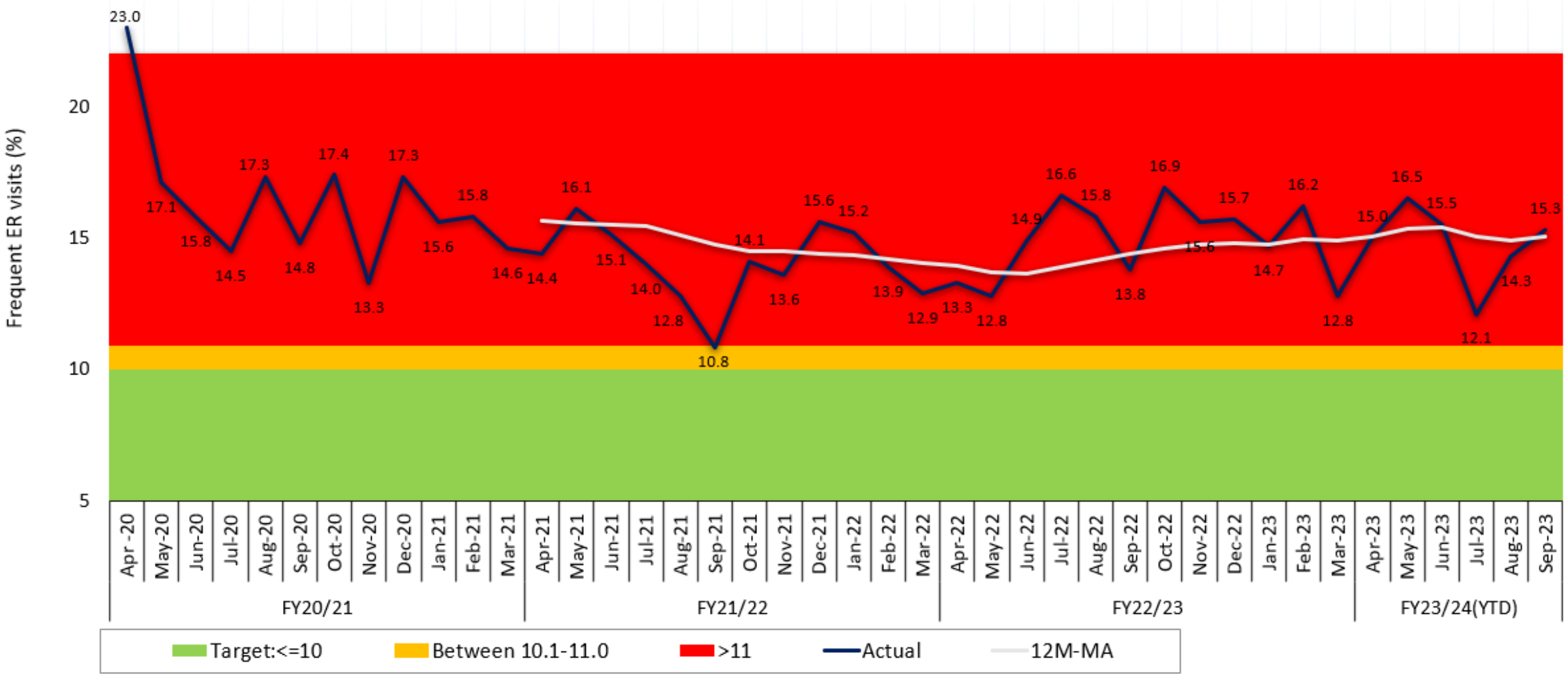
- <u>Long Term Care (LTC)</u>
  - In collaboration with LTC partners, HCCSS WW is supporting the opening of **additional LTC beds which are expected to come online in the spring of 2024.**

- <u>Ministry of Health: A Plan for Connected and Convenient Care:</u>
  - Care for seniors and those needing long-term care (LTC) continues to be a priority for the Ministry and OH, so it will be important that KW4 continues to advocate for improvements for our community.
  - In the Plan for Connected and Convenient Care, released February 2, 2023, current and future provincial investments were highlighted:
    - **building 30,000 new LTC beds** by 2028 and **upgrading 28,000 LTC beds** to modern design standards
    - **hiring more than 27,000 long-term care staff**, including nurses and personal support workers, to provide LTC home residents with an **average of four hours of hands-on care** by nurses and personal support workers each day
    - providing **specialized services and supports to residents with more complex needs** to help LTC residents get the care they need without having to go to emergency rooms or be admitted to hospitals.
    - Enhancing **access to more diagnostic services** for LTC residents through partnerships with hospitals and community labs, to identify solutions to close service gaps, increase timeliness and convenience and improve overall experience.

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Frequent Emergency Department Visits for Help with Mental Health and Addictions

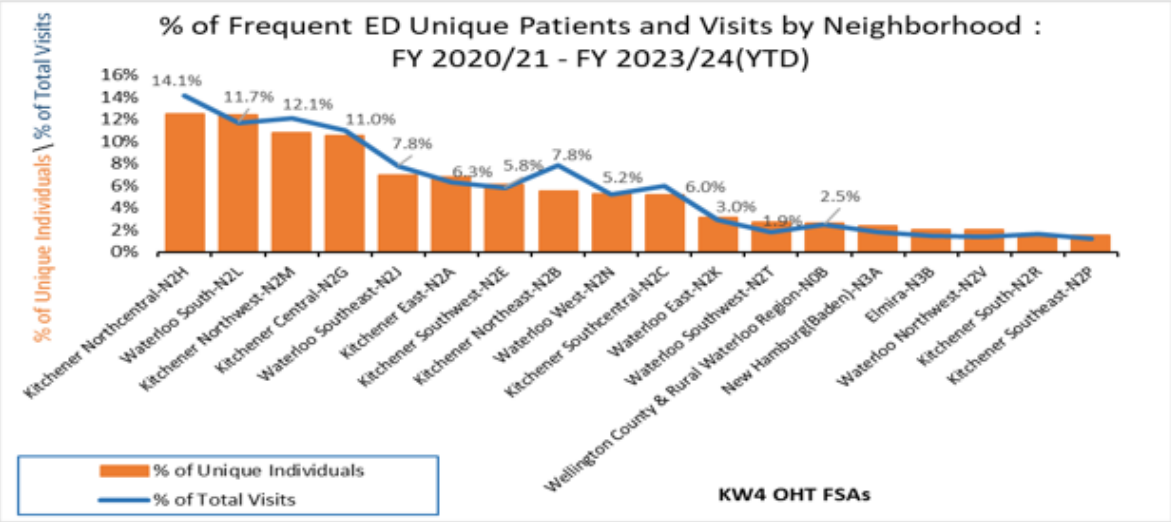
Frequent ER Visits For Help with Mental Health & Addictions (%) - April 2020 to Sep 2023



- Overall, there has been a downward trend in frequent ER visits for help with mental health and addictions in FY 20/21 and 21/22 with an uptick in 22/23.

KW4 OHT: Unique # of Patients and ED Visits by Neighbourhood : FY 20/21 to 23/24 Sep(YTD)

>=4 Visits														
FSA	Population(2021 Census)	% of Population	Unique# of Individuals				# of Visits				4 Fiscal Years			
			FY2020/21	FY2021/22	FY2022/23	FY2023/24(YTD)	FY2020/21	FY2021/22	FY2022/23	FY2023/24(YTD)	Total :Unique# of individuals	Total # of Visits	% of Unique Individuals	% of Total Visits
KW4 Priority Neighbourhoods	**91,210**	**18%**	**88**	**82**	**95**	**75**	**708**	**622**	**668**	**664**	**340**	**2,662**	**38.9%**	**43.2%**
Kitchener Central-N2G	14,580	3%	22	25	24	21	180	179	153	168	**92**	**680**	**10.5%**	**11.0%**
Kitchener Northcentral-N2H	22,455	5%	27	28	30	24	252	216	206	197	**109**	**871**	**12.5%**	**14.1%**
Kitchener Northwest-N2M	36,495	7%	27	18	30	19	206	147	214	177	**94**	**744**	**10.8%**	**12.1%**
Kitchener Southcentral-N2C	17,680	4%	12	11	11	11	70	80	95	122	**45**	**367**	**5.2%**	**6.0%**
Other KW4 Neighbourhoods	**405,360**	**82%**	**146**	**156**	**140**	**91**	**928**	**1,037**	**865**	**668**	**533**	**3,498**	**61.1%**	**56.8%**
KW4 OHT FSAs Total	**496,570**	**100%**	**234**	**238**	**235**	**166**	**1,636**	**1,659**	**1,533**	**1332**	**873**	**6,160**	79%	77%
Other FSAs/Non-KW4 OHT FSAs											229	1,878	21%	23%

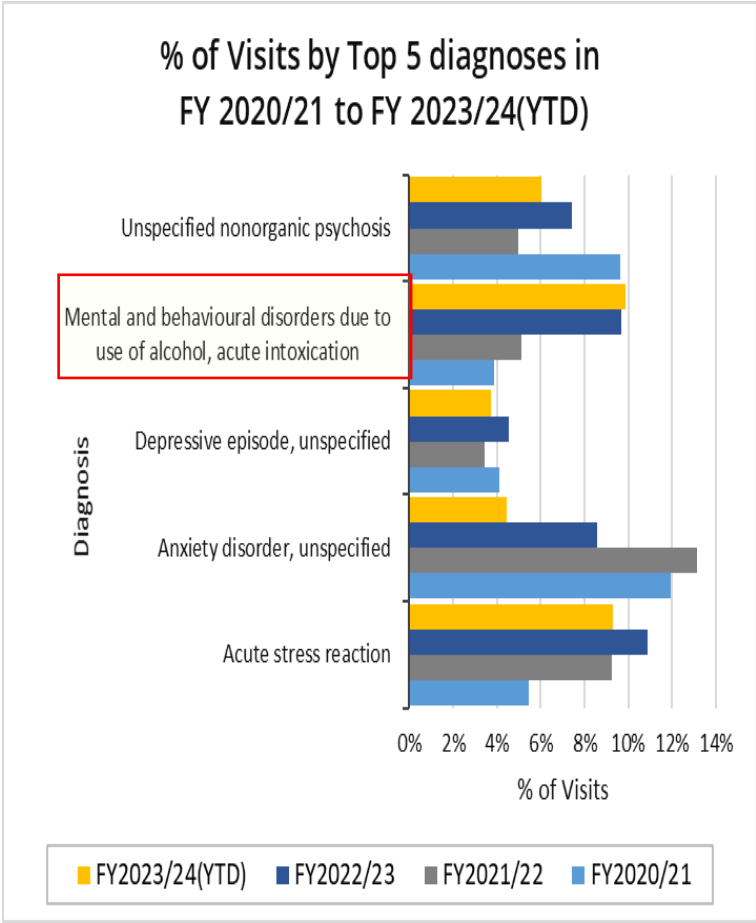


Between FY20/21 and 23/24 Sep(YTD), 873 unique individuals residing in KW4 had four or more ED visits for help with MH&A, totaling 6,160 visits.

- Our four priority neighbourhoods (**N2C, N2G, N2H, N2M**) account for only 18% of KW4's population but 43.2% of the visits and 38.9% of the individuals from KW4
- The other fourteen KW4 neighbourhoods account for 82% of KW4's population but 56.8% of the visits and 61.1% of unique individuals
- Although the Waterloo South neighbourhood (N2L) appears to have a high percentage of visits (11.7%) and individuals (12.4%) this is in line with the % of the people who reside there (8%) of KW4's population and therefore this neighbourhood does not appear to be disproportionately represented.
- 23% of the visits to a hospital located within KW4 and 21% of the individuals reside outside of KW4 OHT neighbourhoods.

Unique # of Patients and # of ED Visits by Top 5 Diagnoses in FY2020/21 to FY2023/24 Sep(YTD)

Diagnosis	% of Unique Individuals				% of Visits				Total % of Unique Individuals	Total % of Visits
	FY2020/21	FY2021/22	FY2022/23	FY2023/24(YTD)	FY2020/21	FY2021/22	FY2022/23	FY2023/24(YTD)		
Acute stress reaction	6.5%	9.4%	11.2%	8.8%	5.5%	9.2%	10.9%	9.3%	9.0%	8.8%
Anxiety disorder, unspecified	12.9%	14.4%	9.4%	5.7%	11.9%	13.1%	8.6%	4.5%	10.7%	9.4%
Depressive episode, unspecified	5.4%	3.6%	4.5%	3.4%	4.1%	3.4%	4.5%	3.7%	4.3%	3.9%
Mental and behavioural disorders due to use of alcohol, acute intoxication	4.3%	5.4%	6.3%	8.8%	3.9%	5.1%	9.7%	9.8%	6.2%	7.2%
Unspecified nonorganic psychosis	11.5%	6.1%	7.3%	8.4%	9.6%	5.0%	7.4%	6.0%	8.3%	7.0%
Total	40.6%	39.0%	38.8%	35.2%	35.0%	35.9%	41.1%	33.4%	38.5%	36.3%

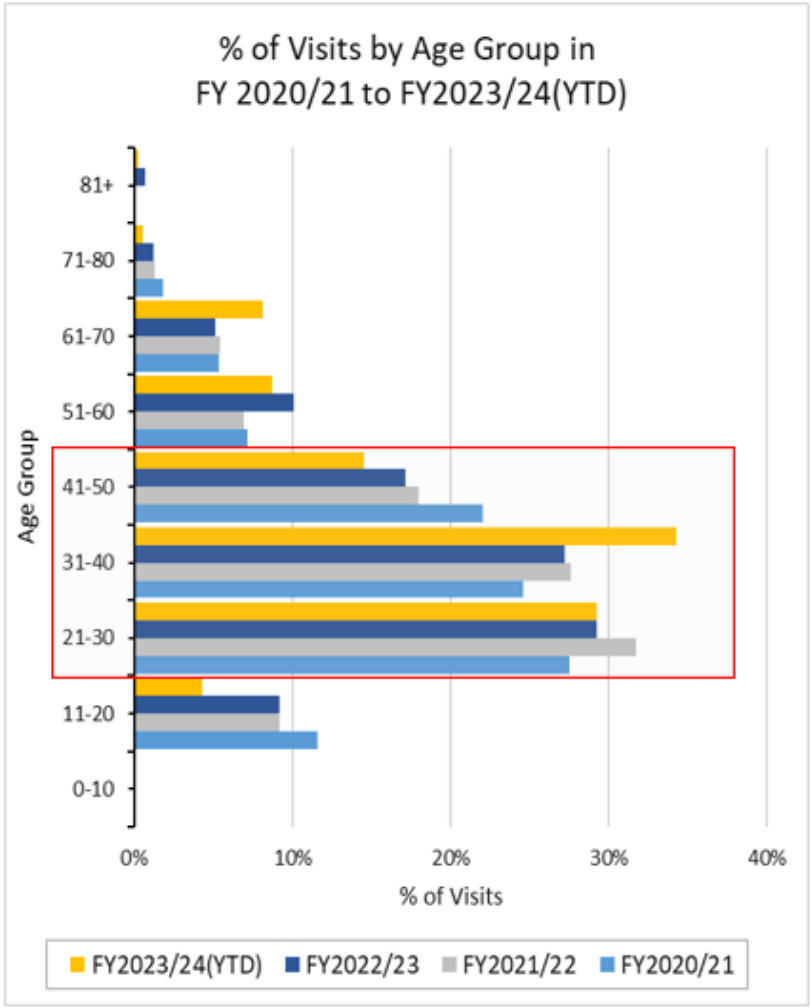


Diagnoses:

- The top 5 diagnoses codes accounted for 36.3% of visits for 38.5% of the individuals, with the most prevalent being 'Anxiety Disorder, unspecified' at 10.7% for the last 3 ½ fiscal years, however, this diagnosis also saw the largest percentage decrease in visits since last fiscal year.
- Mental and behavioral disorders due to the use of alcohol, and acute intoxication had a moderate percentage increase in visits since the last fiscal year

Unique # of Patients and ED Visits by Age Group in FY2020/21 to FY2023/24 Sep(YTD)

Age Group	% of Unique Patients				% of Visits				Total % of Individuals	Total % of Visits	Average Visits per Person			
	FY2020/21	FY2021/22	FY2022/23	FY2023/24(YTD)	FY2020/21	FY2021/22	FY2022/23	FY2023/24(YTD)			FY2020/21	FY2021/22	FY2022/23	FY2023/24(YTD)
0-10														
11-20	14.4%	11.2%	11.5%	6.9%	11.6%	9.1%	9.2%	4.3%	11.1%	8.4%	5.6	5.8	5.39	5.2
21-30	27.7%	32.5%	25.9%	26.8%	27.6%	31.7%	29.3%	29.2%	28.2%	29.4%	6.9	7.0	7.7	9.2
31-40	24.5%	25.6%	24.1%	30.3%	24.6%	27.6%	27.2%	34.3%	26.0%	28.6%	6.9	7.7	7.7	9.5
41-50	18.7%	15.2%	17.8%	15.7%	22.0%	18.0%	17.2%	14.5%	16.9%	17.8%	8.1	8.5	6.5	7.8
51-60	7.2%	7.6%	11.9%	11.5%	7.1%	6.9%	10.1%	8.8%	9.5%	8.2%	6.9	6.5	5.8	6.4
61-70	5.4%	6.1%	5.9%	6.9%	5.3%	5.4%	5.1%	8.1%	6.1%	6.1%	6.8	6.3	5.9	9.9
71-80	2.2%	1.8%	1.7%	1.5%	1.8%	1.3%	1.2%	0.5%	1.8%	1.2%	5.8	5.0	4.8	3.0
81+	0.0%	0.0%	1.0%	0.4%	0.0%	0.0%	0.7%	0.2%	0.4%	0.2%			4.7	
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	6.7	6.7	6.1	7.3



Age Groups

- The top three age groups listed below accounted for 75.8% of the visits and 71.1% of the individuals from April 2020 to September 2023:
  - 21-30 at 29.4% visits and 28.2% of unique individuals
  - 31-40 at 28.6% visits and 26.0% of unique individuals
  - 41-50 at 17.8% visits and 16.9% of unique individuals

Contributing Factors

Factors contributing to our current performance results:

- **Mental Health is the 'next wave' of the COVID pandemic.** Social isolation, physical distancing, fear, pandemic related stressors like caring for at-risk children or parents, job loss, supporting children with virtual learning, uncertainty, etc. can all lead to a range of mental health disorders like anxiety, depression and trigger heavier consumption of alcohol and drugs and even post-traumatic stress disorder.
- The supply of **opioid drugs on the street** has become more toxic and extremely dangerous leading to drug poisonings, overdoses, drug-induced psychosis and death. As of August 13, 2023, Waterloo Region Paramedics received just under 600 suspected opioid overdose/drug poisoning related calls in KW4 this calendar year and there have been 40 suspected opioid-related deaths.
- Primary care providers are seeing an **increase in the complexity and acuity of patients** coming through their doors and this is also being seen in shelters and encampments.
- The list of **people seeking a primary care provider** in KW4 continues to increase. As of December 4, 2023, 6,217 KW4 residents are registered with the Health Care Connect Program waiting for connection to a provider.
- **Waitlist for mental health services** are continuing to grow with minimal investment in the last 10-years. Investments in clinical services have not kept pace with the rapid growth of people to our region , many of whom have arrived with considerable adversities in their past , and complex health and mental health care needs. In many areas (i.e., community psychiatry), our region has been historically under resourced.
- The **volume of referrals** is also increasing with the most significant increase being for crisis services. While people wait for these services, the ED is sometimes the only place people feel they can go for help.
- There is an ongoing **lack of intensive team-based outpatient treatment resources** - most patients who present frequently to the ED have multiple and complex medical, mental health, addictions, and social needs that are not well addressed with either acute inpatient or office-based outpatient services.
- **Resources for individuals with borderline personality are limited**. They constitute a significant percentage of individuals visiting the emergency department. Expanded services and resources to connect individuals with treatment are needed to meet the current demand. CMHA, who is funded to deliver a DBT program, which is the gold standard of treatment for people with BPD, have a waiting list of 2 years or more.
- The **retention and recruitment of health care professionals** over the last couple of years has been challenging. This not only impacts organizations' ability to maximize the number of clients they can see but also impacts the **continuity of service clients receive**. A change in a case workers for a client may require time to build that trusting relationship – one where they are comfortable sharing their challenges.

Courtesy of:

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Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Neighbourhood Integrated Care Team (NICT) Project</u>
  - KW4 OHT in collaboration with member organizations and the community have designed a patient personas, journey maps and **integrated care pathway** for youths transitioning to adult mental health services. The goal of this pathway are to proactively anticipate and readily provide services and supports that will be needed, reduce stigma and create supportive care environments, reduce barriers to accessing care, ensure that the individual has an ongoing connection to the care team, create a community of support around the individual, reduce any potential trauma or anxiety related to service transitions, ensure a smooth transition from youth to adult services, increase awareness of care services available in the region and ensure connection to appropriate social supports **A small group is now building on this work and are developing a plan to implement. This group has been tasked with identifying potential pilot initiatives related to youth transitioning to adult mental health services (i.e., creating a more seamless intake process, standardizing assessments, training, recruitment strategies, etc.) that could be implemented this fiscal year. The KW4 OHT Mental Health and Addictions Advisory Group will be reviewing, prioritizing, and identifying MH&A organizations to lead, direct and move this work forward in our priority neighbourhoods in December 2023.**

- <u>Models of Care Innovation Fund EOI</u>
  - As part of Ontario's plan to enable forward-looking, collaborative, and responsive solutions to the healthcare needs of every Ontarian, Ontario Health launched an expressions of interest for their **Models of Care Innovation Fund**. This fund will assist organizations in implementing innovative ways of maximizing the skills and expertise of their current health care workers. As with previous expressions of interests, **partners from across the KW4 OHT collaborated to create proposals**. These submissions align with our focus and commitment to our priority populations and Ontario Health's equity priorities. The suggested initiatives offer partnership-driven, sustainable approaches to address healthcare challenges in our community. Camino Wellbeing + Mental Health along with partners across the region submitted a proposal to **create clearer, more accessible pathways into community mental health services and provide seamless, "warm transfer" connections with other community services.** If this proposal is selected by Ontario Health, it will **expand mental health triage and service navigation as well as access to community-based mental health services**.

- <u>Youth Wellness Hubs</u>
  - Several organizations from KW4 OHT (i.e., Camino, Lutherwood, Woolwich Community Health Centre) along with other partner organizations (i.e., Langs, YMCA, Counselling Collaborative Agencies, etc.) and community organizations (i.e., Somali Canadian Association of WR, Muslim Women of Cambridge, etc.) held a Youth Wellness Community Conversation on June 13th to **discuss the creation of Youth Wellness Hubs in Waterloo Region**. Over 100 people RSVP that they were interested and 96 people attended the conversation. Coming out of that discussion we heard that it is important to ensure equity is at the forefront of the development of this model in Waterloo Region. 30 people volunteered to be actively involved in the planning to help move this ahead in our Region.
  - Youth Wellness Hubs Ontario offers a model that combines recreation, school support, mental health services, and connection, all designed with input from youth and led by the community.

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Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Transitional Age Youth Clinic</u>
  - In August 2023, Grand River Hospital started a **Transitional Age Youth Clinic for youth aged 17-22** to address the challenges of lack of access to, and follow-up with, ongoing psychiatric care as the youth turn 18 and age out of our clinic.
  - The goal is to have young adult patients, their parents, GRH's clinical team and their primary care physician working together to manage the mental health issues.
  - Access to this clinic will initially be for patients who have already established care with a GRH child/adolescent psychiatrist, attend appointments regularly, and are interested in continuing psychiatric care. Newly referred youth or youth with urgent issues will continue to be seen via usual mechanisms. In the future GRH hopes to be able to extend this to referrals from GRH's adult inpatient or outpatient services, or possibly directly from the primary care physician.

- <u>Ontario Structured Psychotherapy (OSP) Program:</u>
  - On April 21, 2022, Ontario Health officially announced that our region's **Ontario Structured Psychotherapy** (OSP) application submitted jointly by members of the Counselling Collaborative and the Centre for Family Medicine was approved.
  - We are excited that Waterloo Region is in the first wave of the broader rollout of this important program and went live in December 2022.
  - In Waterloo Region, OSP is provided in partnership with the members of the Counselling Collaborative of Waterloo Region and the Centre for Family Medicine, by 2 full time therapists, with clients being able to be seen at the location of their choice.
  - The OSP program provides access to publicly funded, evidence-based, short-term (8-12 weeks), **cognitive behavioural therapy (CBT) and related approaches to clients with depression, anxiety, and anxiety-related conditions**.
  - Anxiety disorder and depressive episodes were among the top 5 diagnosis for those frequenting the Emergency Room and we are hopeful this program will have a positive impact in this area.
  - Priority populations include people without access to healthcare benefits, those living on a low income, people who are Indigenous, Black and other people of colour, Francophone, those who identify as 2SLGBTQ+, people living with disabilities and people living in remote areas.
  - Wait times for initial contact for an intake assessment is 4 to 8 weeks during which time walk-in counselling is available at Camino.

- <u>Alternate Destination Model for Paramedic Services</u>
  - Paramedic Services in Waterloo Region is hoping to adopt an **Alternative Destination Model for MHA related concerns**, a model successfully adopted by London-Middlesex.
  - The model would allow Paramedics Services to **transfer eligible patients to a 24/7 Walk-In Crisis Centre instead of dropping them off at a hospital emergency department**.
  - Paramedics would provide an on-scene assessment and if the patient consents, is cooperative and non-combative, paramedics can call ahead and transfer/offload the patient at the Crisis Centre.
  - As a key partner in the region, KW4 OHT along with some of our members have been asked to collaborate on the design, development and implementation, pending provincial approval.
  - 30% of MH&A ED cases that arrived by ambulance between FY20/21 and 22/23 Sept (YTD) were for patients who resided in our 4 priority neighbourhoods yet these neighbourhoods only account for 18% of KW4's population indicating that these neighbourhoods are disproportionately impacted.

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Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Acquired Brain Injury in the Streets</u>
  - This is a **low barrier, relationship-based program that provides support, advise, and education to clients and other workers on brain injury** and targets clients who are homeless or living rough with an acquired brain injury. The team includes ABI specialists in psychiatry, occupational therapy, behaviour therapy and social work.
  - Specialized brain injury workers screen for brain injury using a low barrier HELPS Brain Injury Screening Tool.
  - During a screening blitz in 2022, Traverse Independence confirmed that a very high percentage of homeless and precariously housed people (73.1 per cent, or 68 of the 93 screened) have suffered from an ABI and would benefit enormously from this service.

- <u>Unification of Carizon, KW Counselling Services and Monica Place</u>
  - In December of 2022 the three Boards of Directors from Carizon, KW Counselling, and Monica Place came together and agreed to formally become one agency, Camino. This was effective on April 1, 2023.
  - There were many compelling reasons for this potential unification. Together, they will create a system that brings greater impact to the growing mental health and wellbeing needs of individuals, families, and communities in Waterloo Region. They hope to increase capacity to **serve more effectively and become more sustainable, while strengthening and expanding programs and services**.

- <u>9-8-8 Suicide Crisis Helpline Launch</u>
  - On November 30, 2023, a **new Canada-wide three-digit helpline that will provide urgent, mental health support in real-time was launched**. Accessible by text and phone, 9-8-8 will provide quick access to bilingual support from trained responders who can properly assess individuals in need of crisis support and direct them to resources and services across the community. The Centre for Addition and Mental Health (CAMH) is partnering with the Canadian Mental Health Association Waterloo Wellington and Compass Community Services, who have been selected as partners to support the new 988 mental health crisis helpline. Existing distress and crisis lines Here 24/7: 1-844-437-3247 and the Compass Community Services Distress Line: 1-888-821-7760 will also continue to ensure "that every door is the right door" to receiving quality mental health and addictions crisis services.

- <u>Ontario Health Teams – The Path Forward</u>
  - The Ministry of Health is setting new direction for OHTs to support their progress towards maturity.
  - During a November 30, 2022, webinar hosted by the Ministry of Health and Ontario Health, entitled "Accelerating Ontario Health Team Impact and Next Steps for OHTs", five main topics were discussed, one of which was the creation of clinical pathways to improve patient care.
  - A phased introduction of integrated clinical pathways will occur for people living with four chronic conditions to start. After these initial four pathways are successfully implemented additional integrated **clinical pathways will be developed in the areas of mental health and addiction** and palliative and end-of-life care.

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KW4 Ontario Health Team

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Ministry of Health: A Plan for Connected and Convenient Care</u>
  - MH&A continues to be a priority for the Ministry and OH, so it is important that KW4 continues to advocate for improvements for our community.
  - In the Plan for Connected and Convenient Care, released February 2, 2023, current and future provincial investments were highlighted:
    - **new addictions beds and other substance use services** to meet the anticipated surge in demand
    - **adding up to 24 new beds to serve vulnerable children and youth** experiencing acute and complex mental health challenges
    - **adding up to 16 new beds** to meet the needs of youth who don't require the highly intensive care provided at a hospital or secure treatment setting but need more support than a community-based live-in treatment program is designed to offer
    - **opening eight new Youth Wellness Hubs** to make it faster and easier for children and youth aged 12-25 to connect to MHA support, primary care, social services, and other services, such as vocational support, education services, housing and recreation and wellness.
    - launching the **Ontario Structured Psychotherapy Program** to provide more Ontarians support for anxiety and depression with Cognitive Behaviour Therapy
    - **launching new eating disorders prevention and early intervention programming**
    - supporting a **new virtual walk-in counselling service (One Stop Talk)** for children, youth, and families, providing access to mental health care with a clinician by phone, video, text or chat.
    - introducing the **new Health811** (formerly known as Health Connect Ontario)
    - **New service models and strategies to divert patients from emergency departments** when safe to do so, and to reduce patient offload times at hospitals.

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Indicator Definitions

Indicator Definitions

Indicator Name	Indicator Description	Calculation Method	Data Source	Target	Performance Corridor
Caregiver distress among home care clients	• This outcome indicators measures the percentage of long-stay home care clients whose unpaid caregivers experience distress in a 1-year period (a risk-adjusted percentage). • A caregiver is defined as a person who takes on an unpaid caring role for someone who needs help because of a physical or cognitive condition, an injury or a chronic life-limiting illness. • This caregiver can be a spouse, child/child-in-law, other relative or friend, or neighbour who lives or does not live with the client. • Caregivers who are distressed are defined as primary caregivers who express feelings of distress, anger or depression and/or any caregiver who is unable to continue in their caring activities. • This indicator defines long-stay clients as those who have already been receiving home care for at least 60 days. • When a client has more than one home care assessment within a given year, the most recent assessment will be included in the analysis. • A lower rate is better.	• Numerator divided by the denominator times 100 • Numerator - Total number of home care clients who, at the time of their most recent assessment in the given year, have an unpaid caregiver who is experiencing distress. • Denominator - Total number of long-stay home care clients with a caregiver at the time of their most recent assessment in the given year • HQO Indicator Library for this measure • Reported value is adjusted for cognitive impairment, Activities of daily living impairment, medical complexity. • The current performance data is for the WWLHIN. In future reports we hope to be able to report this at the KW4 OHT level.	interRAI Home Care © assessments, data supplied by Ontario Health Shared Services	<=56.0%	• Green – Less than or equal to 56.0% • Yellow – Between 56..0% - 61.0% • Red – Greater than 61.0%
Hospitalization rate for conditions that can be managed outside hospital Rate of hospitalization for Ambulatory Care Sensitive Conditions (ACSCs)	• This outcome indicator measures the rate of hospitalization, per 100,000 people aged 0 to 74 years, for one of the following conditions that, if effectively managed or treated earlier, may not have resulted in admission to hospital: asthma, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, angina and epilepsy. • A lower rate is better. • 2021 Census data has been used since January 2021 for ACSC BME KPI calculations.	• This indicator is calculated as the numerator divided by the denominator per 100,000 population • Numerator - The number of inpatient records from acute care hospitals during each fiscal year with any ambulatory care sensitive condition (ACSC) as the most responsible diagnosis. • Denominator - The number of people in Ontario aged 0 to 74 years. • HQO Indicator Library for this measure	Discharge Abstract Database (DAD) Registered Persons Database (RPDB)	<=20.40 monthly (244.80 annually)	• Green – Less than or equal to 20.40 monthly (244.80 annually) • Yellow – Between 20.40 – 22.44 • Red – Greater than 22.44

Indicator Definitions

Indicator Name	Indicator Description	Calculation Method	Data Source	Target	Performance Corridor

Total ALC (Acute and Non-Acute) Rate	• This process indicator measures the total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data.
	• Alternate level of care (ALC) refers to those cases where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of their treatment.
	• A lower rate is better.
		• This indicator is calculated as the numerator divided by the denominator times 100.
		• Numerator - The total number of inpatient days designated as alternate level of care (ALC) in a given time period (i.e., monthly, quarterly, yearly). Inpatient service type is identified in the Wait Time Information System (WTIS).
		  • Calculation:- Acute ALC days equals the total number of ALC days contributed by ALC patients waiting in non-surgical, surgical and intensive/critical care beds. Post-acute ALC days equals ALC days for Inpatient Services in complex continuing care, rehabilitation and mental health beds.
		• Denominator - The total number of inpatient days in a given time period (i.e., monthly, quarterly, yearly).
		  • Calculation: Acute Patient days = the total number of patient days occupying Acute with Mental Health Children/Adolescent (AT) beds. Post-Acute Patient days = the total number of patient days occupying Complex Continuing Care (CR) + General Rehabilitation (GR) + Special Rehabilitation (SR) + Mental Health - Adult (MH) Beds. CCC Patient days = the total number of patient days occupying Complex Continuing Care (CR) Beds. Rehab Patient days = the total number of patient days occupying in General Rehabilitation (GR) + Special Rehabilitation (SR) Beds. Mental Health Patient days = the total number of patient days occupying Mental Health - Adult (MH) Beds
		• HQO Indicator Library for this measure
			Wait Time Information System (WTIS)
			
			WTIS ALC Rates Report - Quarterly Release
				<=16.70%	• Green – Less than or equal to 16.70%
					• Yellow – Between 16.70 – 18.37%
					• Red – Greater than 18.37%

Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	• This outcome indicator measures the percentage of people with four or more visits over the previous 12 months, among people who visited the emergency department for a mental illness or addiction. • A lower rate is better. • Monthly snapshot reporting	• Numerator divided by the denominator times 100 • Frequent ED Visitor for MH&A (Numerator) - The total number of patients with 4 or more ER visits within a year (past 365 days) for mental health and addictions. The 365 day lookback is based on the most recent visit date (Triage Date) for that month. If a patient had 3 visits in April 2022, it would lookback 365 days from the most recent April 2022 visit. • Total Visits for MH&A (Denominator) - The total number of patients with at least 1 or more ER visits within time period for mental health and addictions. • HQO Indicator Library for this measure • One difference – We include patients with invalid health card numbers (e.g. HCN=1 or 0). They are linked using Cerner Person ID as this is shared between GRH and SMGH.	National Ambulatory Care Reporting System (NACRS), CERNER	<=10%	• Green – Less than or equal to 10.0% • Yellow – Between 10.1% – 11.0% • Red – Greater than 11.0%