Quarterly Performance Measurement Report

February 2024

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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	%	Dec 2023	<= 56%	53.3%		No change from 53.3%
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	Nov 2023	<= 20.4 monthly (61.2 quarterly) (244.8 annually)	18.3		Slippage from 16.1
3	Total ALC (Acute and Non-Acute)	%	Dec 2023	<=16.7%	17.7%		Slippage from 15.7%
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Dec 2023	<=10.0%	13.3%		Improvement from 15.3%

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

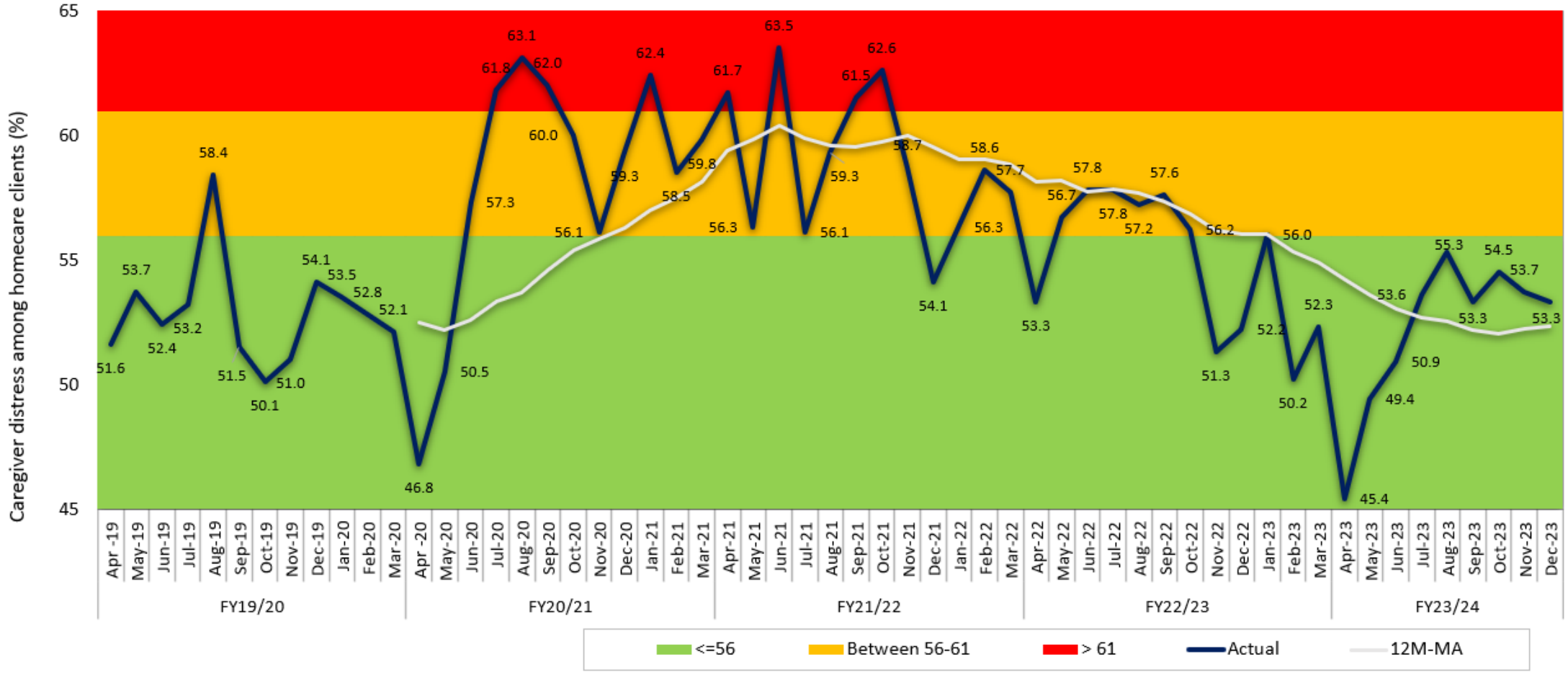
Data Availability

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

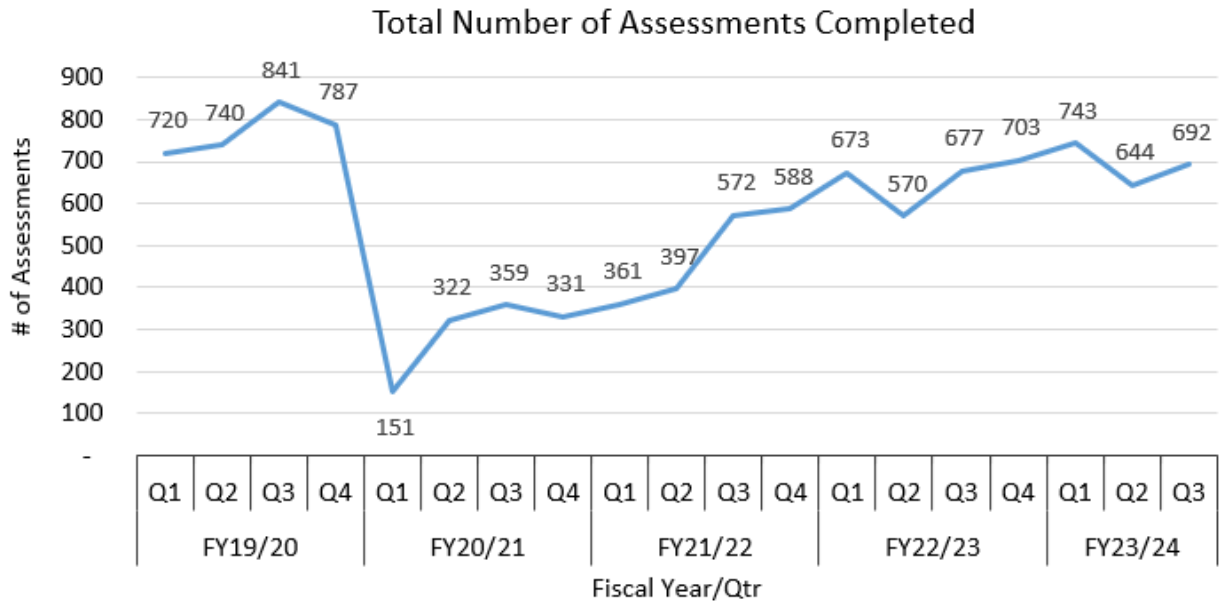
Caregiver Distress Among Homecare Clients (%): April 2019 to December 2023



- 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	692
Q4	787	331	588	703	
Total	**3,088**	**1,163**	**1,918**	**2,623**	**2,079**



- 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-Q3 the number of assessments rose to 692, which is a slight increase from FY22/23-Q3.

Contributing Factors

Factors contributing to our current performance results:

- Home and Community Care Support Services (HCCSS) is seeing a noticeable increase in service provider capacity for personal support services. HCCSS WW has recently launched the provincial PSS framework.
- The short stay respite and convalescent care programs in long term care remain paused in Waterloo Wellington (WW), provincially other short stay respite and convalescent care has restarted.
- Face-to-face visits continue to be the standard based on clinical assessment supplemented by virtual visits as clinically appropriate.
- WW robustly utilizes the **Let's go Home program (LEGHO)** program to support patients being discharged from hospital to provide short term wrap around care.
- GRH in collaboration with the Alzheimer's Society WW launched the **DREAM program** in January 2024 which could have contributed to the decrease in caregiver distress.
- The support of the **community paramedic program** may also have reduced caregiver stress.
- A **delirium collaborative** has been developed and will provide education for caregivers on how to recognize signs of delirium earlier on, which may contribute to decreasing caregiver distress. Education is targeted to occur on March 13, 2024, to align with other world delirium awareness day initiatives.
- The **ICT model** of care, which provides support for patients and families may result in decreasing caregiver distress.
- The **Geriatric Medically Complex Clinic** (GMCC) has stabilized the health human resources in the clinic, reducing wait time to see a geriatrician which could have contributed to the reduction in 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

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

- Delirium Collaborative
  - 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.

- Wellness Calendars
  - In collaboration with partners, the KW4 OHT 2024 **wellness calendar** for older adults in the KW4 Region has been completed and distributed to stakeholders. Paramedics report this as a useful tool for patient care.

- SCOPE (Seamless Care Optimizing Patient Experience)
  - 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.

- Integrated Care Team (ICT) Expansion Project
  - We currently have a proposal in with the ministry for base funding for this program.

- Building HCCSS WW Capacity
  - 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.

- St Mary's Hospital to Home Program
  - St Mary's has recently received agency status and is launching a **transitional care hospital to home model program** to reduce ALC.

- Acquired Brain Injury (ABI) Caregiver Support Program
  - Traverse Independence in collaboration with Ontario Health West, Brain Injury Association Waterloo Wellington, St. Joseph's Health Centre Foundation Guelph, and Jett Psychological Services is offering a **free virtual support group for family members and caregivers of survivors of a brain injury**. These eight weekly meetings begin on March 24, 2024, and extend to May 14, 2024. Topics discussed will include self-care, changing family roles, managing stress and emotions, effective communication, and local ABI resources.

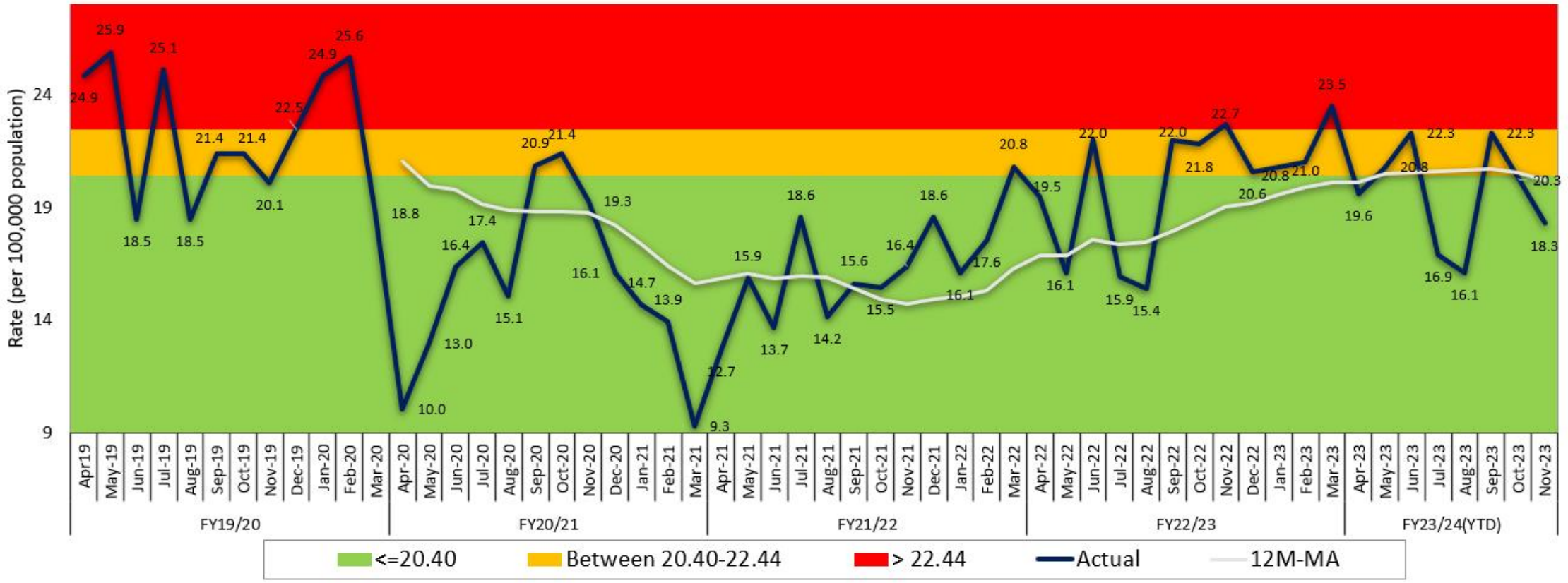
- Principles of sfCare across sectors:
  - Hospital partners have promoted the exchange of knowledge related to principles of senior friendly care (sfCare) across sectors. Leading practices in Community Based Early Identification, Assessment & Transition: Preventing Alternate Level of Care supports facilitating 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.

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 Nov 2023



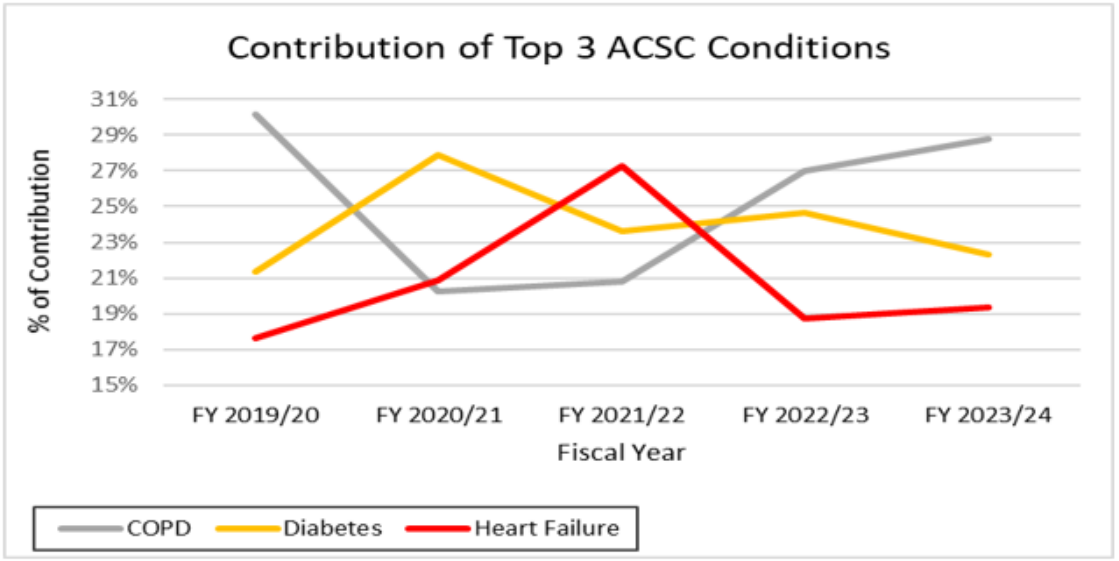
12M-MA : 12 months moving average

- 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.
- Since Q3 FY2022/23, we can see an upward trend in the rates.

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 Nov(YTD)

Diagnosis	FY 2019/20	FY 2020/21	FY 2021/22	FY 2022/23	FY 2023/24 Nov(YTD)
COPD	30.2%	20.3%	20.8%	27.0%	28.8%
Diabetes	21.3%	27.9%	23.7%	24.7%	22.3%
Heart Failure	17.7%	20.9%	27.2%	18.7%	19.4%
Angina	2.5%	3.0%	1.9%	1.8%	1.9%
Asthma	11.8%	5.2%	9.7%	13.3%	10.5%
Epilepsy	12.5%	16.8%	12.4%	11.1%	12.2%
Hypertension	4.0%	5.9%	4.3%	3.3%	5.0%



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%
- 70.5% in FY2023/24 Nov(YTD), with the most prevalent being 'COPD' at 28.8%, followed by Diabetes at 22.3%

- **COPD** had a 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 1.8% points in FY2023/24 Nov(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 2.4% points in FY2023/24 Nov(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 0.7% points in FY2023/24 Nov(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 SMGH airway clinic continues to see strong referrals following ED and hospitalizations for newly diagnosed patients to help establish community treatment options to reduce re-occurrences.
- Fall and Winter 23/24 so far show a return to seasonal trends for COPD exacerbations due to circulating upper respiratory viruses
- We are seeing a return to our normal number of referrals for diagnostic testing and asthma/COPD education appointments at the airway clinic **The total number of 2023/24 visits YTD have surpassed 2022 volumes and are approaching pre- pandemic levels**. For the 10 months of 23/24 we are already 12% ahead of all of 22/23.
    - 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 the relocation of the Wellesley site of WCHC, we will be able to see 25-33% more patients per day at the Wellesley site community Respiratory Clinic days due to better ventilation and space options
- 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.
- In 23/24 we shifted our smoking cessation classes to a more group-based counselling model with some options for individuals if required. This was due to a increase in referrals from primary care and the regional cancer center. The adaptation has been positive and also allowed us to work cooperatively with the cardiac rehab program to increase access to these services for the cardiac population and maintain very short or no waitlists for the service.

Heart Failure:

- **Remote Care Monitoring** initiatives, in place at SMGH since March 2022, 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

Diabetes:

- The Regional Coordination Centre has seen a steady increase in the volume of self-referral data in KW4. This could be due to the self-referral to diabetes education program (DEP) awareness campaign that is ongoing through the Neighborhood Integrated Care Team Project.

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:

COPD:

- The **Relocation of the Airway Clinic** to the Boardwalk has been a very positive experience for patients and staff. On Dec 22 SMGH said farewell to the 1st floor location at the hospital and reopened Dec 27th at the Boardwalk site seeing their first patients. The new location has 2 additional exam/treatment rooms to allow for current and future growth, larger more accessible rooms, free parking, on the Ira Needles GRT transit corridor and is on the same floor as our cardiac rehab program and the private offices of many of our respirologists. This allows for improved consultation and service alignment
- 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 it 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. 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.

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 **launching 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:

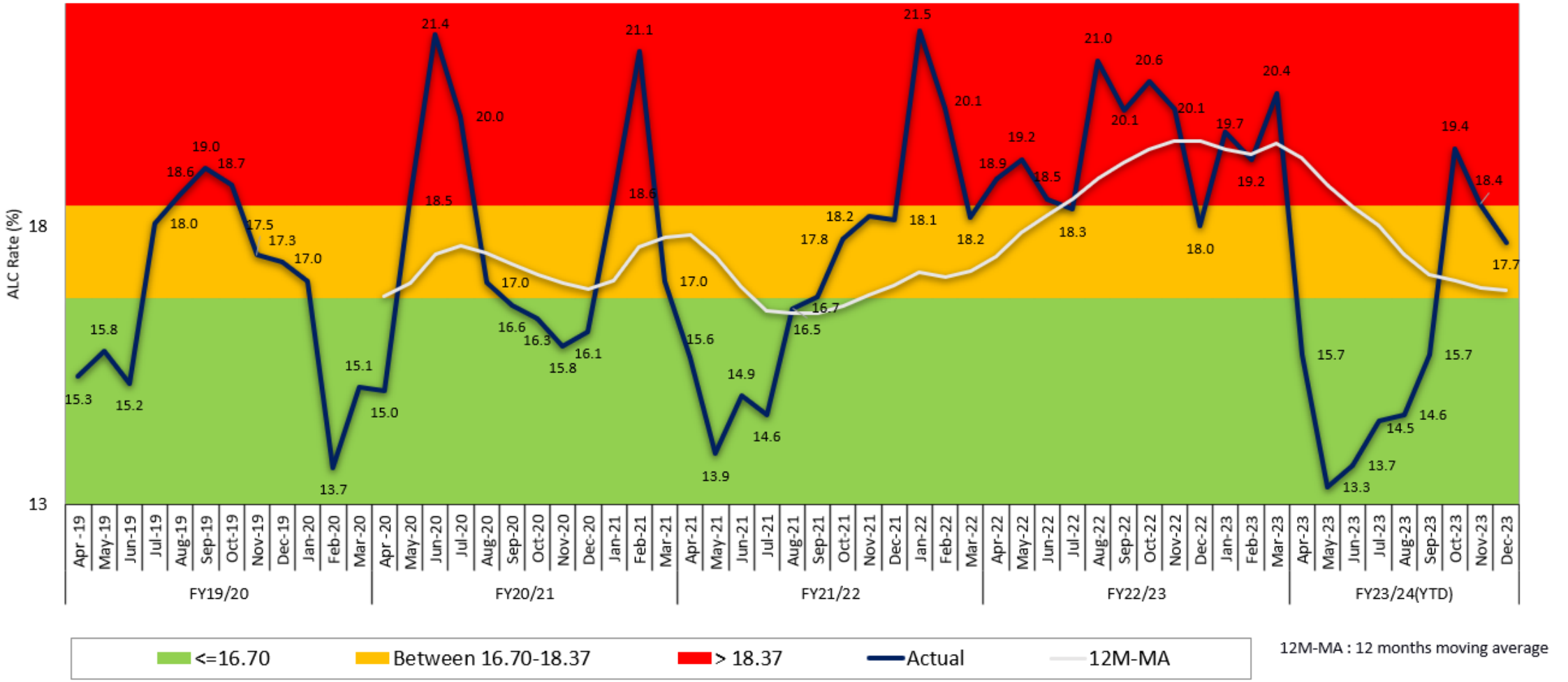
- The Rapid Access Primary Care Clinic (RAP-Clinic) is a cross-organization effort being led by Community Healthcaring KW. This pilot clinic is focusing on providing access to episodic primary care for unattached patients who frequently use the ED as their first point of access. The pilot plans to create and test a proof of concept. 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 Regional Coordination Centre is also working towards providing self-referral forms in top languages spoken by newcomers to the region and will continue to report on volumes of self-referral data.
- 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.

Alternative Level of Care (ALC)

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



12M-MA : 12 months moving average

- Overall, the KW4 ALC rate has been fluctuating over the past 4¾ years.
- There was an upward trend since the beginning of the pandemic and then a downward trend beginning in the third quarter of FY2022/23.
- FY 2023/24 Dec (YTD), the average ALC rate is 15.9% which is below our target, however the last quarter averaged 18.5% which exceeds our target of 16.7%.

ALC Open Cases as of December 2023

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

	Open Cases				% of Cumulative ALC Days											
Facility	Volume (Dec 2023)	Volume (Dec 2022)	%Change (Dec2023 vs. Dec 2022)	Cumulative ALC Days (Dec 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	21	29	-28%	345	53.0%	7.0%	19.0%	5.0%	0.0%	0.0%	0.0%	6.0%	0.0%	8.0%	1.0%	0.3%
Grand River	115	124	-7%	5,428	76.0%	2.0%	2.0%	0.0%	3.0%	0.3%	11.0%	3.0%	0.5%	0.5%	0.0%	2.0%
Total	136	153	-11%	5,773	74.6%	2.3%	3.0%	0.3%	2.8%	0.3%	10.3%	3.2%	0.5%	0.9%	0.1%	1.9%

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

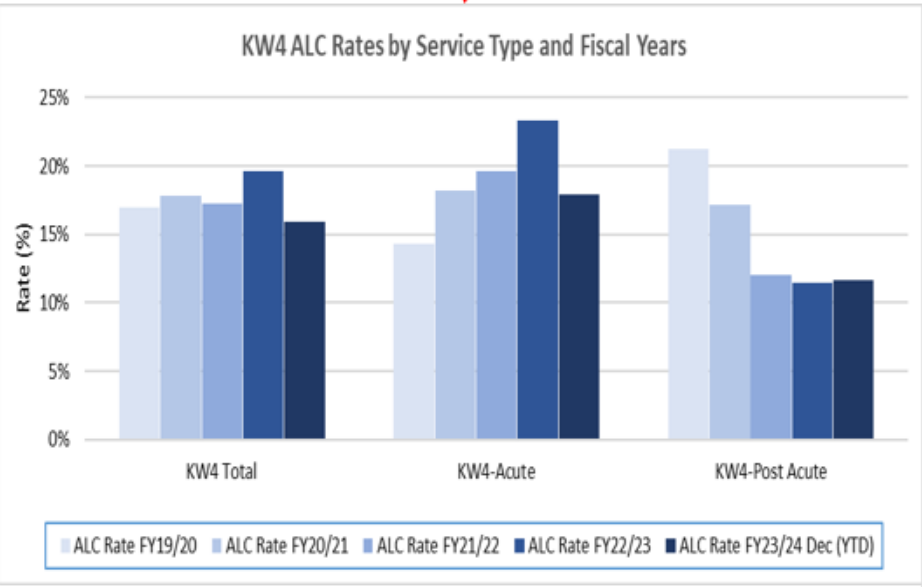
Source - Waterloo Wellington Sub-Region Monthly Alternate Level of Care Performance Summary - December 2023

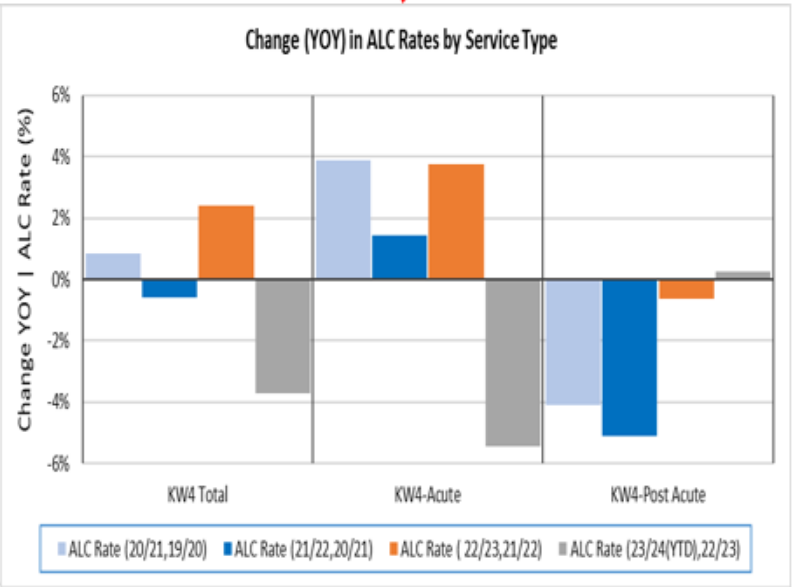
As of Dec. 31, 2023:

- There were 136 patients designated ALC on the waitlist in the two KW4 OHT hospitals. This translates into 20 fewer cases compared to December 31, 2022
- These patients have accumulated 5,773 ALC days
- Of the cumulative ALC Days 74.6% were attributed to patients waiting for Long Term Care, 10.3% waiting for Supervised or Assisted Living and 3.2% were waiting for Convalescent Care

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

Facility	ALC Rate					Year Over Year (YOY) Change in ALC Days			
	FY19/20	FY20/21	FY21/22	FY22/23	FY23/24 Dec (YTD)	Between FY 19/20 and 20/21	Between FY 20/21 and 21/22	Between FY 21/22 and 22/23	Between FY 22/23 and 23/24 (YTD)
GRH	16.9%	19.1%	18.3%	20.4%	16.9%	2.2%	-0.8%	2.1%	-3.4%
Acute	12.8%	20.5%	22.5%	26.4%	20.6%	7.7%	2.0%	3.9%	-5.8%
Post Acute	21.2%	17.1%	12.0%	11.4%	11.6%	-4.1%	-5.1%	-0.6%	0.2%
CCC	24.6%	18.4%	14.2%	12.7%	11.6%	-6.2%	-4.2%	-1.5%	-1.1%
MH	20.7%	17.6%	10.6%	10.9%	12.4%	-3.1%	-7.1%	0.4%	1.5%
Rehab	11.3%	11.5%	10.0%	9.9%	9.8%	0.2%	-1.5%	-0.1%	-0.1%
SMGH-Acute	17.4%	13.3%	13.7%	17.1%	12.6%	-4.1%	0.4%	3.4%	-4.5%
KW4 Total	17.0%	17.8%	17.2%	19.6%	15.9%	0.8%	-0.6%	2.4%	-3.7%
KW4-Acute	14.3%	18.2%	19.6%	23.3%	17.9%	3.9%	1.4%	3.7%	-5.4%
KW4-Post Acute	21.2%	17.1%	12.0%	11.4%	11.6%	-4.1%	-5.1%	-0.6%	0.2%





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 3.7% points between FY22/23 and 23/24 Dec(YTD)
- **Decreased 1.1% points over the last 4¾ 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 5.4% points between FY22/23 and 23/24 Dec(YTD)
- **increased 3.6% points over the last 4¾ 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
- increased 0.2% points between FY22/23 and 23/24 Dec(YTD)
- **decreased 9.6% points over the last 4¾ years**

Contributing Factors

Factors contributing to our current performance results:

- Home with HCCSS Services
  - Provincial commitment to provide education on ALC designation. Weekly oversight and escalation of ALC to home with HCCSS in collaboration with the hospital partners.
  - **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.

- ALC Rounds
  - St Mary's General Hospital in collaboration with HCCSS has implemented including our community partner CSS in our ALC rounds to provide support to patients and families and problem solve through discharge barriers and try to prevent ALC designations.

- 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
  - ED diversion remains a focus of hospitals to 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>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 if treatment on-scene is not managing the symptoms and the patient is registered in the Alternate Destination Hospice project, the patient can be moved directly to Hospice for end-of-life care. 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>
  - This program continues to 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.
  - The program has been well received by hospitals and has been of great benefit to patients.

- <u>Integrated Care Team (ICT) Expansion Project</u>
  - A proposal has been put forth to the ministry for base funding for this project.

- <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 dinicians with plans to expand within The Boardwalk in early 2024.

- <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.**

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>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.

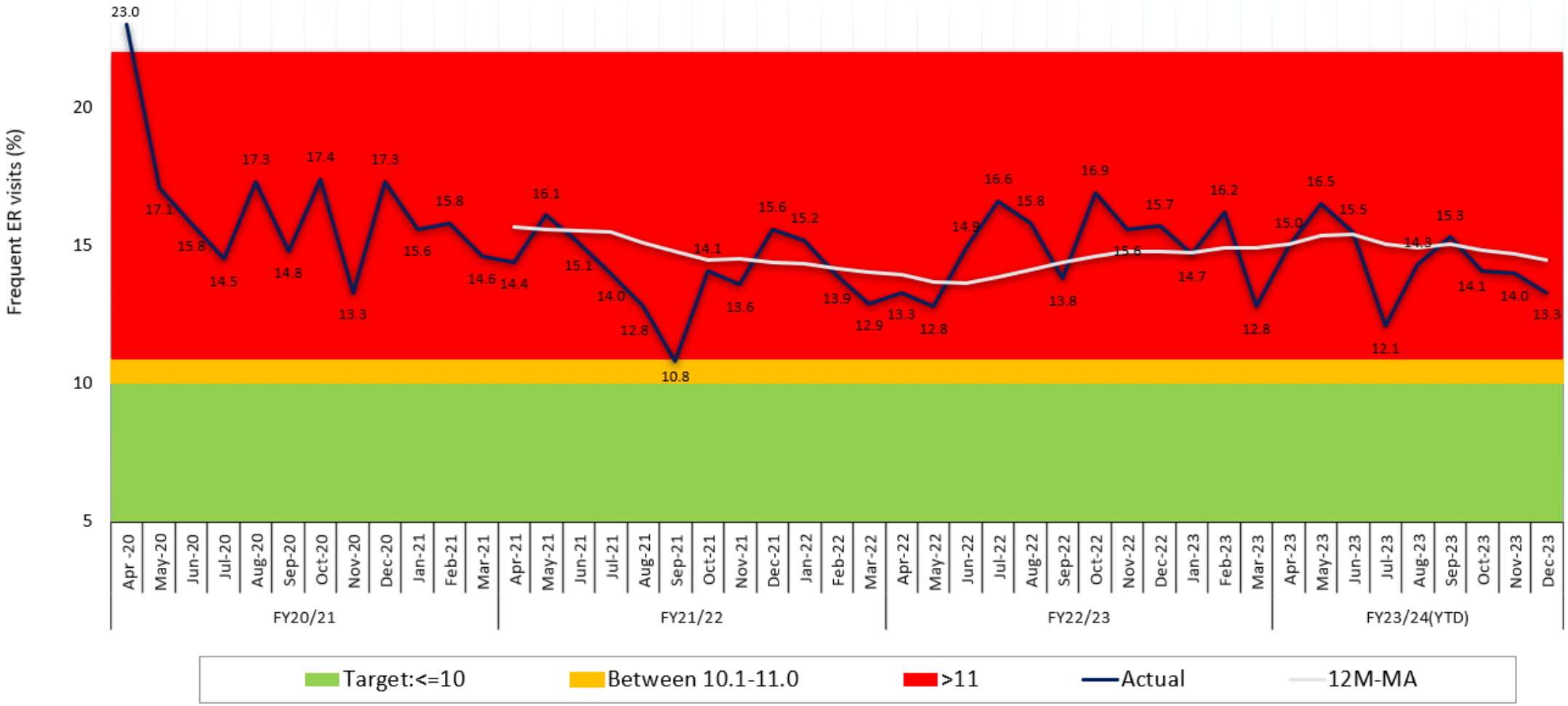
- <u>Integrated Dementia Resource Team</u>
  - The Waterloo-Wellington **DREAM (Dementia, Resource, Education, Advocacy, Mentorship) initiative** is an extension of a pilot project operated in Brantford Brant Norfolk OHT for people living with dementia to prevent hospital admissions. These previous pilots 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:

- *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

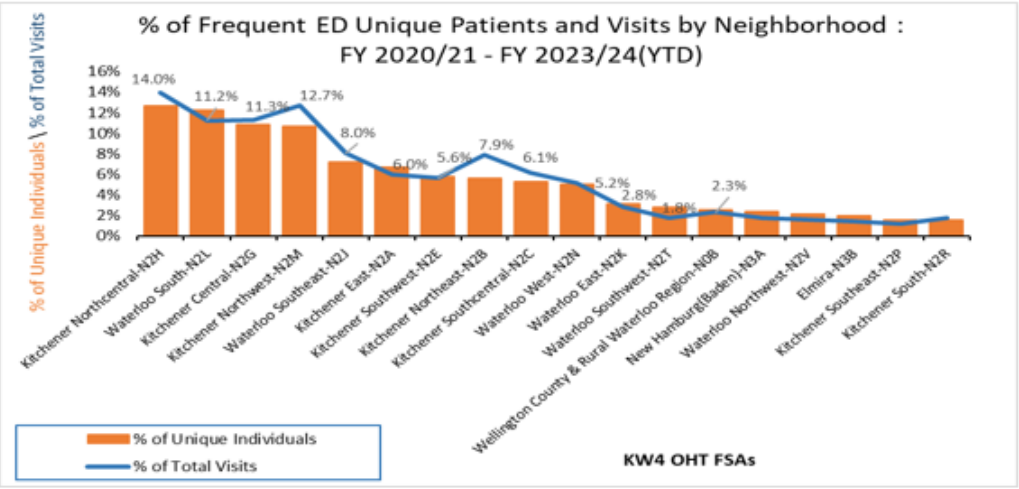
Frequent ER Visits For Help with Mental Health & Addictions (%) - April 2020 to Dec 2023



- Overall, there was been a downward trend in frequent ER visits for help with mental health and addictions in FY 20/21 and 21/22.
- This was followed by an upward trend in FY 22/23.
- In Q2 and Q3 of FY 2023/24 we are once again seeing a downward trend, however performance is still well above our target.

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

>=4 Visits														
FSA	Population(2021 Census)	% of Population	Unique# of				# 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**	**102**	**708**	**622**	**668**	**1043**	**367**	**3,041**	**39.5%**	**44.0%**
Kitchener Central-N2G	14,580	3%	22	25	24	30	180	179	153	266	**101**	**778**	**10.9%**	**11.3%**
Kitchener Northcentral-N2H	22,455	5%	27	28	30	33	252	216	206	290	**118**	**964**	**12.7%**	**14.0%**
Kitchener Northwest-N2M	36,495	7%	27	18	30	24	206	147	214	309	**99**	**876**	**10.6%**	**12.7%**
Kitchener Southcentral-N2C	17,680	4%	12	11	11	15	70	80	95	178	**49**	**423**	**5.3%**	**6.1%**
Other KW4 Neighbourhoods	**405,360**	**82%**	**146**	**156**	**140**	**121**	**928**	**1,037**	**865**	**1035**	**563**	**3,865**	**60.5%**	**56.0%**
KW4 OHT FSAs Total	**496,570**	**100%**	**234**	**238**	**235**	**223**	**1,636**	**1,659**	**1,533**	**2078**	**930**	**6,906**	84%	86%
Other FSAs/Non-KW4 OHT FSAs											172	1,132	16%	14%

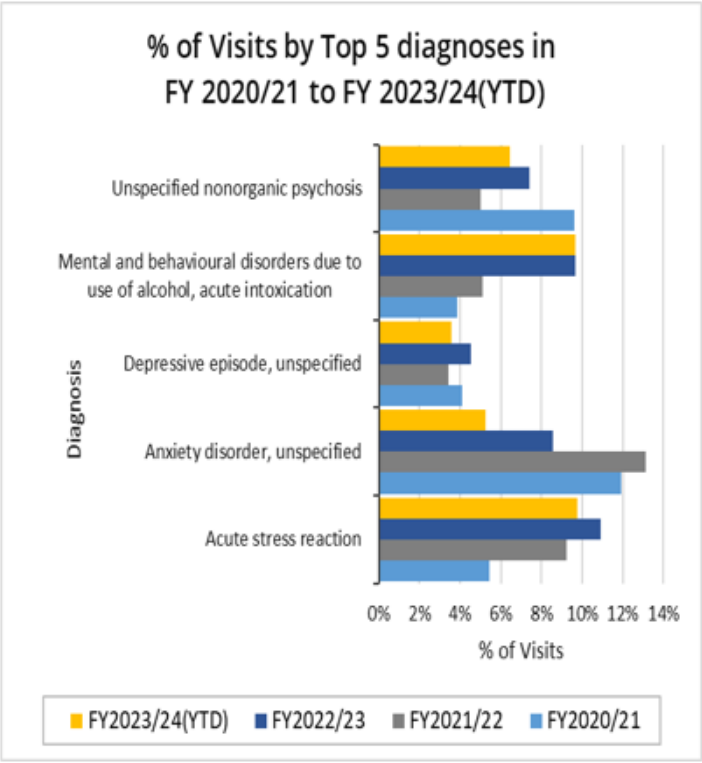


Between FY20/21 and 23/24 Dec(YTD), 930 unique individuals residing in KW4 had four or more ED visits for help with MH&A, totaling 6,906 visits.

- Our four priority neighbourhoods (**N2C, N2G, N2H, N2M**) account for only 18% of KW4's population but 44.0% of the visits and 39.5% of the individuals from KW4
- The other fourteen KW4 neighbourhoods account for 82% of KW4's population but 56.0% of the visits and 60.5% of unique individuals
- Although the Waterloo South neighbourhood (N2L) appears to have a high percentage of visits (11.2%) and individuals (12.3%) 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.
- 14% of the visits to a hospital located within KW4 and 16% 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 Dec(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%	9.9%	5.5%	9.2%	10.9%	9.8%	9.3%	9.0%
Anxiety disorder, unspecified	12.9%	14.4%	9.4%	5.7%	11.9%	13.1%	8.6%	5.2%	10.2%	9.1%
Depressive episode, unspecified	5.4%	3.6%	4.5%	3.7%	4.1%	3.4%	4.5%	3.6%	4.2%	3.9%
Mental and behavioural disorders due to use of alcohol, acute intoxication	4.3%	5.4%	6.3%	9.4%	3.9%	5.1%	9.7%	9.7%	6.6%	7.4%
Unspecified nonorganic psychosis	11.5%	6.1%	7.3%	8.6%	9.6%	5.0%	7.4%	6.4%	8.4%	7.0%
Total	40.6%	39.0%	38.8%	37.3%	35.0%	35.9%	41.1%	34.7%	38.8%	36.4%

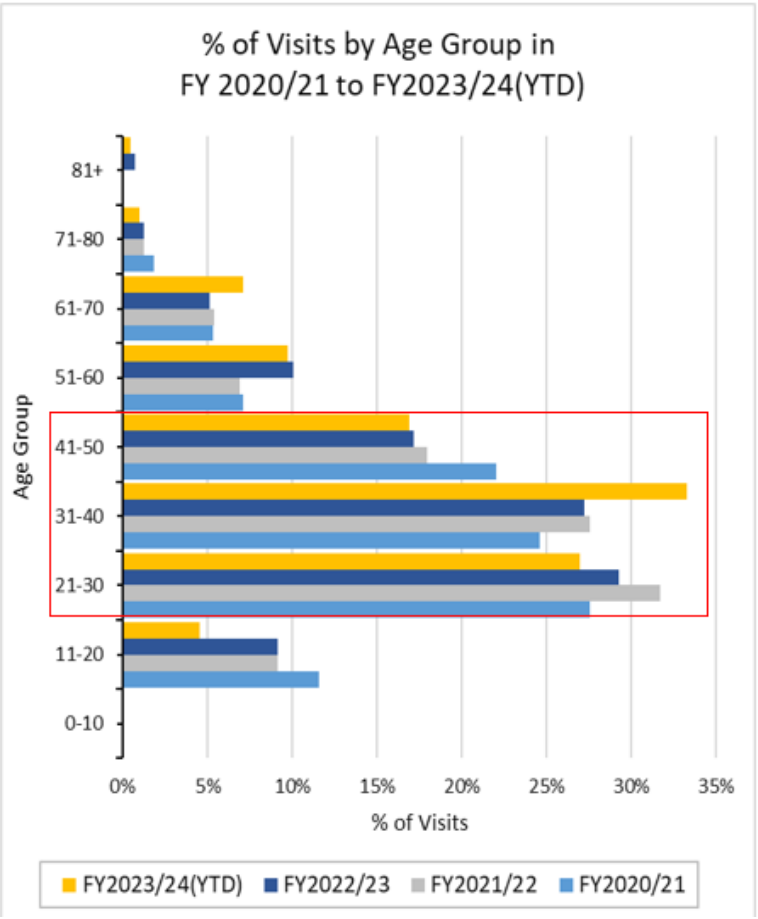


Diagnoses:

- The top 5 diagnoses codes accounted for 36.4% of visits for 38.8% of the individuals, with the most prevalent being 'Anxiety Disorder, unspecified' at 10.2% for the last 3¾ fiscal years, however, this diagnosis also saw the largest percentage decrease in visits since last fiscal year.

Unique # of Patients and ED Visits by Age Group in FY2020/21 to FY2023/24 Dec(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%	6.8%	11.6%	9.1%	9.2%	4.6%	10.6%	8.0%	5.6	5.8	5.39	5.4
21-30	27.7%	32.5%	25.9%	25.0%	27.6%	31.7%	29.3%	26.9%	27.5%	28.6%	6.9	7.0	7.7	8.7
31-40	24.5%	25.6%	24.1%	30.1%	24.6%	27.6%	27.2%	33.3%	26.4%	28.9%	6.9	7.7	7.7	8.9
41-50	18.7%	15.2%	17.8%	17.2%	22.0%	18.0%	17.2%	16.9%	17.2%	18.3%	8.1	8.5	6.5	8.0
51-60	7.2%	7.6%	11.9%	12.6%	7.1%	6.9%	10.1%	9.7%	10.1%	8.6%	6.9	6.5	5.8	6.2
61-70	5.4%	6.1%	5.9%	6.1%	5.3%	5.4%	5.1%	7.1%	5.9%	5.9%	6.8	6.3	5.9	9.5
71-80	2.2%	1.8%	1.7%	1.5%	1.8%	1.3%	1.2%	1.0%	1.8%	1.3%	5.8	5.0	4.8	5.3
81+	0.0%	0.0%	1.0%	0.8%	0.0%	0.0%	0.7%	0.5%	0.5%	0.3%			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	7.4



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 December 2023:
  - 21-30 at 28.6% visits and 27.5% of unique individuals
  - 31-40 at 28.9% visits and 26.4% of unique individuals
  - 41-50 at 18.3% visits and 17.2% 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:
- *KW4 OHT Mental Health and Addictions Advisory Group*

Moving Forward

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

- Neighbourhood Integrated Care Team (NICT) Project
  - 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 goals 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.

- Transitional Age Youth Clinic
  - In September 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.

- Tirage Tools
  - The KW4 Mental Health and Addictions Advisory group has **developed two triage tools for physicians**: one for referring adults and refugees and one for referring children and youth. These tools aim to assist physicians in referring patients to the most appropriate community mental health support based on their presenting mental health, addiction, and brain injury needs. The adult and refugee tool can be found here. The children and youth tool can be found here.

- Youth Wellness Hubs
  - Members of the KW4 OHT continue to explore the establishment of **Youth Wellness Hubs** that provide high-quality integrated youth services to support the well-being of young people aged 12 to 25, including mental health and substance use supports, primary health care, community and social supports, and more. The aim of this Community Collaborative is to offer a model that combines recreation, school support, mental health services, and connection, all designed with input from youth and led by the community. In 2024/25, with the assistance of a consultant, the goal is to determine the approach to the wellness hub and establish a framework that meets the needs of Waterloo Region.

- Expanded Walk-in Counselling Services
  - Members of the KW4 OHT are working to **expand Walk-in services at Counselling Collaborative of Waterloo Region**. In 2024/25 they aim to:
    - Expand walk-in services to 5 days per week
    - Reduce waitlists for ongoing counselling by an average of 10-days from 40 days to 30 days
    - Increase utilization of walk-in services by an average of 20 individuals per week from 30 individuals per week to 50 individuals per week
    - Develop a newly developed workshop deigned for those on the waitlist for counselling

Courtesy of:
- *KW4 OHT Mental Health and Addictions Advisory Group*

Moving Forward

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

- <u>Ontario Structured Psychotherapy (OSP) Program</u>:
  - Members of the KW4 OHT will continue the roll-out of **Ontario Structured Psychotherapy** (OSP), 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.
  - The goal in 2024/25 is to:
    - Provide referral presentations/resources to 15 Waterloo-based social service/health agencies
    - Increase the number of Waterloo Region residents referred to OSP to 150% of the caseload for two FTE's
    - Increase views of OSP referral page by 100% from 40 views per month to 80 views per month
    - Enable a positive experience with 80% of patients indicated they were very satisfied or satisfied with their experience with the OPS program
    - Improve patient outcomes with 70% of patients enrolled in the OSP program reporting lower PHQ-9/GAD-7 scores after completing the program

- <u>Integrated Crisis Centre</u>
  - Members of the KW4 OHT are looking to improve care for individuals experiencing a mental health crisis through the opening of an **integrated crisis centre** along with strengthening pathways from the centre to community resources to support ED diversion.
  - Opening of phase 1 (use of existing resources) is targeted for the summer of 2024, pending due diligence. Phase 2 will require the development of a funding proposal for an expanded model of care.

- <u>Region of Waterloo and Justice Mental Health Project</u>
  - Members of the KW4 OHT are working to provide long-term housing alongside dedicated holistic direct support for individuals navigating a concurrent disorder and at risk of homelessness upon exiting incarceration through the Region of Waterloo and Justice Mental Health Project. This project aims to have **6 dedicated subsidized apartment units** secured and occupied in 2024/25.

- <u>Supportive Housing Health Initiative</u>
  - Members of the KW4 OHT are planning to launch on-site programming at Supportive Housing locations across the Region of Waterloo through the **Supportive Housing Health Initiative (SHHI) Program**. This team will include Nurse Practitioners, Peer Support Workers, and Addictions Counsellors who provide Primary Care and addictions care.

- <u>Supportive Transitional Indigenous Housing</u>
  - Member of the KW4 OHT are planning to construct **new supportive housing for indigenous/non-indigenous individuals** in need of mental health support. The project aims to be constructed by December 2025.

Courtesy of:
- *KW4 OHT Mental Health and Addictions Advisory Group*

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>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.

Courtesy of:
- *KW4 OHT Mental Health and Addictions Advisory Group*

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%