KW4 Ontario Health Team

Monthly Performance Measurement Report

June 1, 2022

- You will find this report to be more robust than reports from previous months
- We will revert back to our traditional format next month
- We wanted to share some analysis we conducted to help inform the Operations Team and Priority Population Co-Lead Planning Retreat, as it relates to our current measures, since data will be a key enabler as we move towards a more of a population health management and equity approach
- By focusing on a smaller segment, we will be better able to allocate our finite resources and impact change in priority areas as we co-design, pilot, monitor, evaluate, refine and spread change.
- We will not be reviewing these slides in detail during the Members Meeting so I would encourage you to review the material in advance of the meeting and consider:
    1. What information was most impactful?
    2. Did the data change any preconceived notions you may have had?
- Please also feel free to reach out to me if you have specific questions about the data itself – brenda.vollmer@grhosp.on.ca

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2. Current data availability

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   - Caregiver Distress Amongst Home Care Clients
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Summary

#	Indicator	Unit of Measure	Reporting Period	Proposed Target	Current Performance	Status
1	Caregiver distress among home care clients	%	Apr 2022	<= 56%	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	Mar 2022	<= 20.40 monthly (61.20 quarterly) (244.80 annually)	22.5	
3	Total ALC (Acute and Non-Acute) Rate	%	Apr 2022	<=16.70%	21.6	
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Apr 2022	-	13.3	
5(a)	Total Expense / HPG Population for Palliative	$	FY 2019/20	<=$115.4M plus inflation	--	
5(b)	Total Expense / HPG Population for Dementia	$	FY 2019/20	<=$78.8M plus inflation	--	

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

Data Availability

Indicator	Status - FY2022/23 data												Comments
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
1. Caregiver Distress Among Homecare Clients (%)	✓												
2. Ambulatory Care Sensitive Conditions Best Managed Elsewhere (Rate)	✗												April data will be available the 3rd week of June 2022
3. Total ALC (Acute and Non-Acute) Rate (%)	✓												
4. Frequent ED Visits for Help with Mental Health and Addiction (%)	✓												New methodology for calculation is being used.
5. Total Expense/HPG Population for Palliative and Dementia (M $)	FY2019/20												
	FY2019/20												

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

Caregiver Distress Amongst Homecare Clients

Key Takeaway from the Data

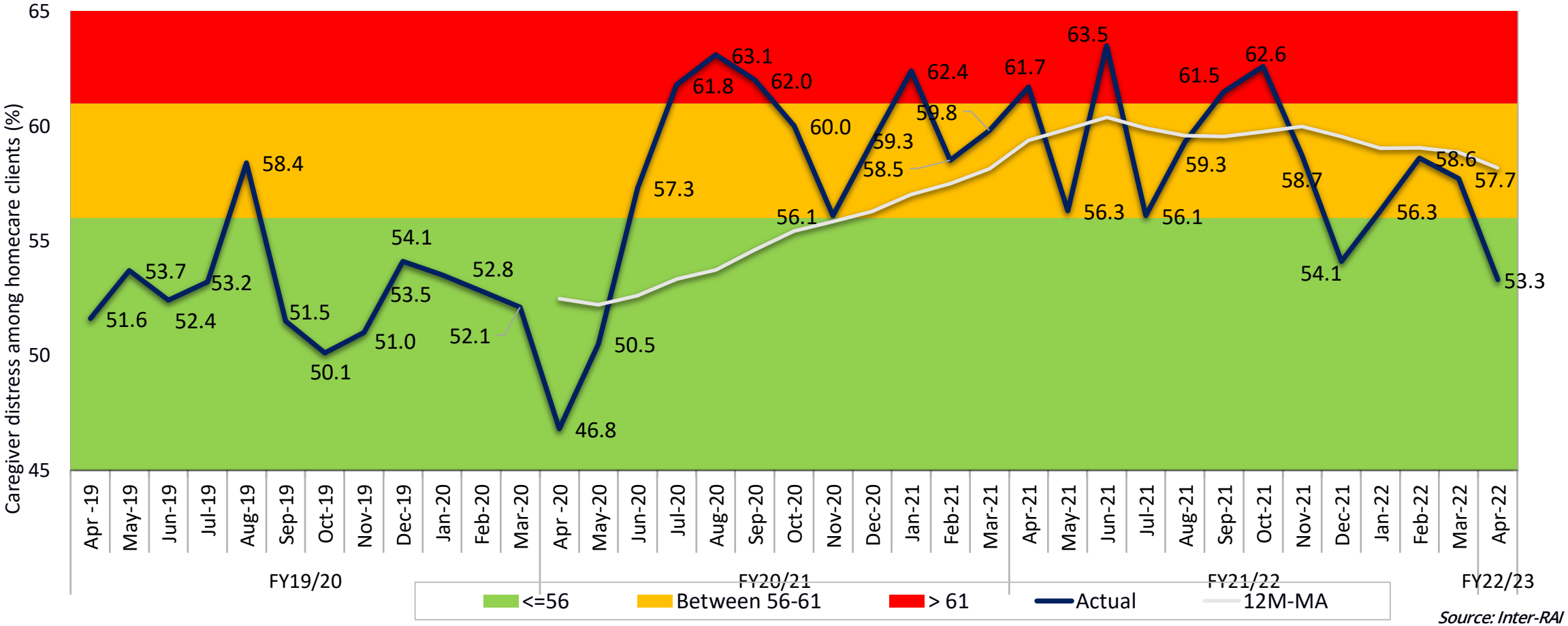
- Average caregiver distress has increased during the pandemic.

- Spouses and partners have higher levels of caregiver distress than other who provide care (i.e. children, parents, siblings, other relatives, or neighbours).

- 5 Forward Sortation Areas (FSA's) have higher prevalence of caregiver distress
  - N2B – Kitchener Northeast
  - N2C – Kitchener South Central
  - N2H – Kitchener North Central
  - N2T – Waterloo Southwest
  - N2V – Waterloo Northwest

- The higher the scores on Activities of Daily Living, Cognitive Performance, and Medical Complexity/Frailty scales, the more likely a person is to have a distressed caregiver

Caregiver Distress Among Homecare Clients (%): April 2019 to April 2022



Source: Inter-RAI

Over the past two fiscal years:

- This trend shows the pandemic-related level shift of increased caregiver distress.
- The caregiver distress among home care clients is significantly increased since April 2020.
- As the various waves of the pandemic ebbed and flowed so too did HCCSS's ability to conduct in-persons visits. At times face to face assessments visits were limited to essential visits and complex patients waiting for LTC admission only. At other times routine face to face visits occurred.
- During this same time there was also tight admission criteria for LTC and some clients or families chose not to enter LTC
- There was also staffing difficulties in home care and decreased access to other supports such as day programs and respite care

12M-MA : 12 months moving average

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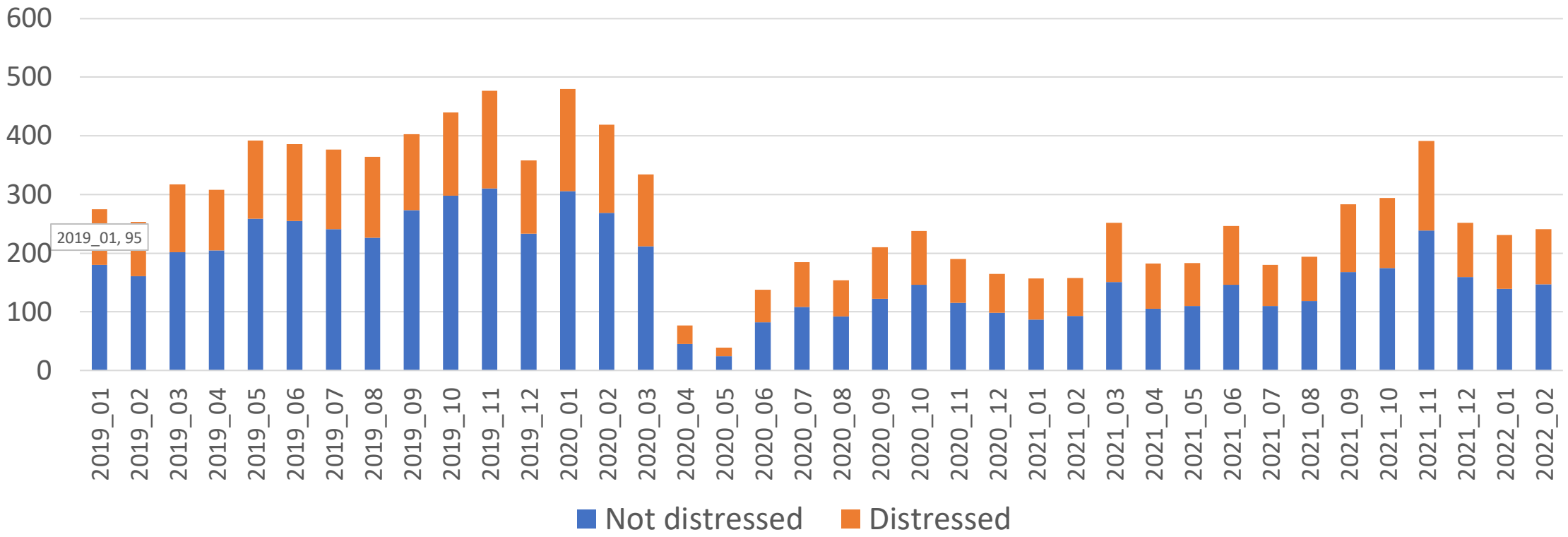
Caregiver Distress – Deeper Dive

interRAI™

Raw Number of Assessments in KW4 over time



- Pre-pandemic, the average number of assessments completed was 242/month. This dropped significantly at the start of the pandemic and has not yet returned to pre-pandemic levels with the average dropping in half to 121/month.
- The average distress between January 2019 and March 2020 (pre-pandemic) was 54%. The average distress during the pandemic (April 2020 to February 2022) was 67%.

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Caregiver Distress – Deeper Dive

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% With distress by person who is the primary caregiver

Primary Caregiver Category	% of Distress
Child or child in law	44.3
Spouse or partner	62.3
Parent	53.5
Sibling/relative/friend/neighbour	32.6

Spouses and partners have higher levels of caregiver distress than children, parents, siblings, other relatives, or neighbours.

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Caregiver Distress – Deeper Dive

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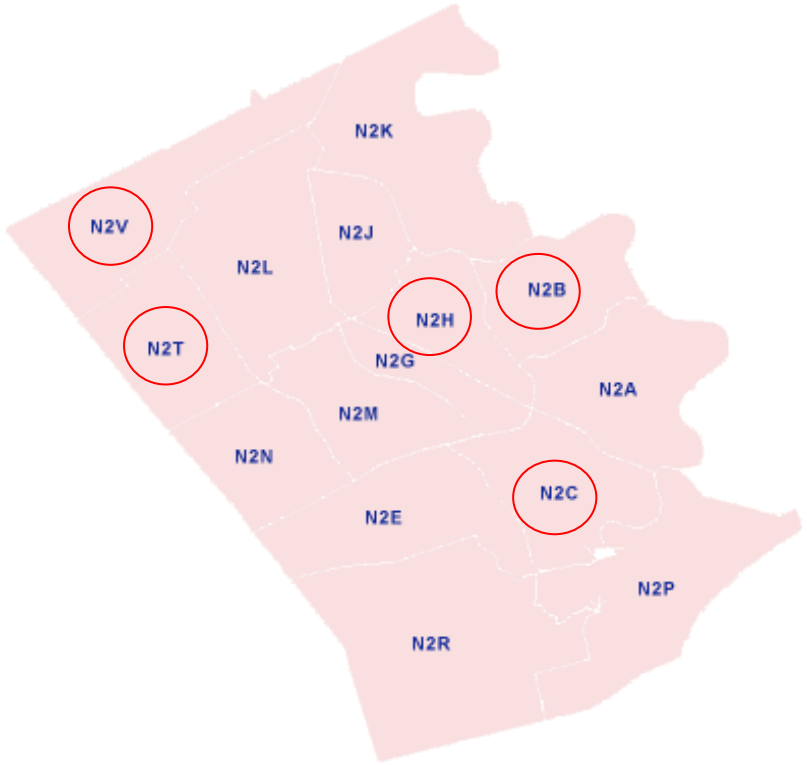
Adjusted Caregiver distress prevalence by KW4 FSA (2019_01 to 2022_02)



FSA	Material Deprivation	Significant	Rate (CI)	Adjusted
N0B*	Q2		NS	58.2 (55.2-61.0)
N2A	Q2		NS	62.6 (58.7-66.5)
N2B	Q4		HT	67.6 (61.8-73.3)
N2C	Q2		HT	69.7 (64.7-74.9)
N2E	Q1		LT	52.5 (48.6-56.5)
N2G	Q3		NS	55.1 (49.9-60.1)
N2H	Q3		HT	71.2 (65.5-76.8)
N2J	Q4		NS	63.7 (59.3-68.1)
N2K	Q1		NS	63.0 (58.3-67.7)
N2L	Q3		NS	59.4 (56.0-62.9)
N2M	Q2		LT	48.8 (45.1-52.5)
N2N	Q2		LT	50.8 (46.8-54.9)
N2P	Q1		NS	59.6 (54.5-64.6)
N2R	Q1		NS	50.5 (35.0-66.1)
N2T	Q1		HT	65.7 (60.7-70.9)
N2V	Q1		HT	68.8 (61.3-76.3)
N3A*	Q3		NS	61.9 (55.6-68.2)
N3B*	Q3		NS	63.9 (58.0-70.0)

* Rural area

- 5 FSA's (shown in red) have higher prevalence of caregiver distress
- Only 158 individuals with 'homeless' living status in the whole Ontario dataset.
- Data is not collected by Immigration/Refugee.

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Caregiver Distress – Deeper Dive

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Logistic regression, showing effect of covariates on caregiver distress

- The caregiver distress value takes 3 covariates into account
  - Activities of Daily Living (ADLH) – i.e. dressing, eating, attending to hygiene, toileting, walking
  - Cognitive Performance Scale (CPS) – i.e. decision making, understanding, short-term memory
  - Medical Complexity/Frailty (CHESS) – i.e. changes in health, end-stage disease

- The higher the scores of these covariates, the more likely a person is to have a distressed caregiver (correlation). For example, the likelihood of caregivers to experience distress for a patient who scores a level 3 for their Activities of Daily Living (ADLs) is 3.6 times higher than those who scored 0.

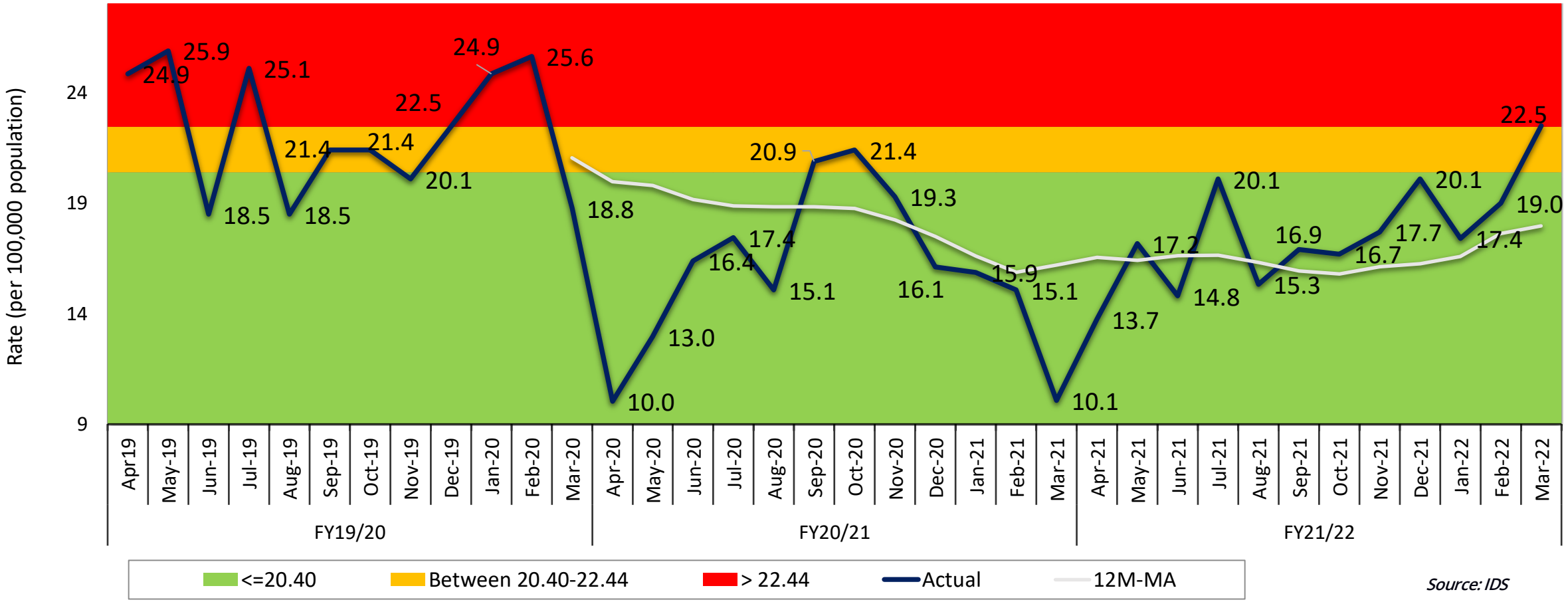
Effect	Point Estimate	95% Wald Confidence Limits	
ADL_hier_L 1 vs 0	2.047	1.817	2.307
ADL_hier_L 2 vs 0	2.898	2.560	3.280
ADL_hier_L 3 vs 0	3.603	3.044	4.264
cps_L 1 vs 0	1.859	1.587	2.177
cps_L 2 vs 0	4.364	3.678	5.177
cps_L 3 vs 0	4.248	3.048	5.921
chess_L 1 vs 0	1.349	1.183	1.538
chess_L 2 vs 0	2.180	1.936	2.455
chess_L 3 vs 0	3.369	2.822	4.021

Ambulatory Care Sensitive Conditions (ACSC)
Best Managed Elsewhere (BME)

Key Takeaway from the Data

- There are 7 conditions that are considered in the ACSC BME measure including asthma, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, angina and epilepsy.
- Of the 7 conditions, heart failure, diabetes, and COPD are the top three contributing factors.
- Almost 70% of patients admitted for an ACSC provided the name of the primary care provider upon registration.
- There is a higher per capita concentration of ACSC hospitalizations amongst residence living in Kitchener and more specifically in three FSAs (first three digits of postal code):
  - N2M - Kitchener Northwest
  - N2H - Kitchener Northcentral
  - N2G - Kitchener Central
- Although 20% of KW4 OHT's population resides in a neighborhood in the 3rd quintile when it comes to material deprivation, they account for 31% of the top three ACSC

Ambulatory Care Sensitive Conditions Best Managed Elsewhere (%): April 2019 to March 2022



Source: IDS

Over the past two fiscal years:

- This trend shows the pandemic-related level shift of decreased rate since April 2020. This may be due to increased virtual care visits for Ambulatory Care Sensitive Conditions patients or patients choosing to defer seeking care.
- The Ambulatory care sensitive conditions best managed elsewhere have been performing better since April 2020 and below the target value of 20.4; however, the rate has been increasing since April 2021 and above the target value in March 2022.
- The top three conditions included Heart Failure, COPD and Diabetes.

12M-MA : 12 months moving average

KW4 ACSC best managed elsewhere – contributing conditions

FY/Condition	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Percentage
FY 2019/20	**81**	**87**	**64**	**82**	**57**	**65**	**71**	**66**	**80**	**76**	**82**	**61**	**872**	
Angina	1	2	1		1	3	5	1	1	4	1	2	22	2.5%
Asthma	13	12	6	6	3	15	11	7	7	9	7	7	103	11.8%
COPD	24	27	24	21	16	12	22	23	22	23	31	18	263	**30.2%**
Diabetes	18	19	11	17	12	13	14	14	15	17	20	16	186	**21.3%**
Epilepsy	9	3	8	12	14	11	7	7	12	11	8	7	109	12.5%
Heart Failure	12	21	14	19	8	6	10	11	21	12	11	9	154	**17.7%**
Hypertension	4	3		7	3	5	2	3	2		4	2	35	4.0%
FY 2020/21	**37**	**47**	**53**	**56**	**54**	**65**	**70**	**60**	**56**	**52**	**50**	**56**	**656**	
Angina	1	2	2		3		5	4			2	1	20	3.0%
Asthma	1		4	1		3	4	9	4	2	4	2	34	5.2%
COPD	11	12	11	13	13	15	17	8	9	7	8	9	133	**20.3%**
Diabetes	13	14	15	19	10	17	18	10	22	18	14	13	183	**27.9%**
Epilepsy	4	10	11	5	12	16	9	15	5	7	7	9	110	16.8%
Heart Failure	6	9	7	13	10	12	13	10	12	14	13	18	137	**20.9%**
Hypertension	1		3	5	6	2	4	4	4	4	2	4	39	5.9%
FY 2021/22	**74**	**65**	**56**	**77**	**58**	**64**	**67**	**67**	**76**				**604**	
Angina			1	4		1	3		2				11	1.8%
Asthma	7	2	3	5	1	11	5	9	8				51	8.4%
COPD	8	13	10	23	14	10	15	12	18				123	**20.4%**
Diabetes	25	17	11	16	16	14	12	14	18				143	**23.7%**
Epilepsy	5	6	12	9	13	10	9	10	7				81	13.4%
Heart Failure	25	22	17	15	10	17	19	19	21				165	**27.3%**
Hypertension	4	5	2	5	4	1	4	3	2				30	5.0%
Total	**192**	**199**	**173**	**215**	**169**	**194**	**208**	**193**	**212**	**128**	**132**	**117**	**2132**	

Top three contributing conditions by Fiscal Year:

FY 2019/20

- COPD (30.2%)
- Diabetes (21.3%)
- Heart Failures (17.7%)

FY 2020/21

- Diabetes (27.9%)
- Heart Failure (20.9%)
- COPD (20.3%)

FY 2021/22 (YTD Dec)

- Heart Failure (27.3%)
- Diabetes (23.7%)
- COPD (20.4%)

Access to primary care for ACSC Patients - FY 2019/20 to FY2021/22 (YTD Dec)

FY/Conditions	FY 2019/20	FY 2020/21	FY 2021/22	Total	Description
Blank	70	43	78	191	Patient chooses not to disclose physician information
Family Physician	622(71.3%)	403(61.4%)	422(69.8%)	1447(67.9%)	Patient has Family Physician Name
None	134(15.4%)	185(28.2%)	100(16.6%)	419(19.7%)	Patient has no PCP/Patient has not interviewable/Patient unsure of PCP name
Other	6	1		7	Family Health Team, Walk-in Clinic, etc.
Unknown/ Unavailable	40	24	4	68	Patient is unconscious or deceased on arrival
Total	**872**	**656**	**604**	**2,132.0**	

- **Of patients admitted for an ACSC in FY 21/22 (YTD Dec)**
  - **69.8% provided the name of the primary care provider upon registration.**
  - **16.6% indicated that they did not have a primary care provider.**

ACSC cases by condition and access to primary care – FY21/22 (YTD Dec)

Condition	Blank		Family Physician		None		Other		Unknown/ Unavailable		Total
	# of patients	% of patients	# of patients	% of patients	# of patients	% of patients	# of patients	% of patients	# of patients	% of patients	# of patients
Angina	3	27%	8	73%		0%		0%		0%	11
Asthma	4	8%	34	67%	13	25%		0%		0%	51
COPD	7	6%	95	77%	20	16%		0%	1	1%	123
Diabetes	24	17%	91	64%	28	20%		0%		0%	143
Epilepsy	7	9%	54	67%	18	22%		0%	2	2%	81
Heart Failure	28	17%	117	70%	19	11%	1	1%	1	1%	166
Hypertension	5	17%	23	77%	2	7%		0%		0%	30
Total	78	13%	422	70%	100	17%	1	0%	4	1%	605

- In 21/22 (YTD Dec) the number of patients admitted for the top three ACSC who provided the name of the primary care provider upon registration ranged from 64%-77% as follows:
  - COPD(77%)
  - Heart Failure(70%)
  - Diabetes(64%)

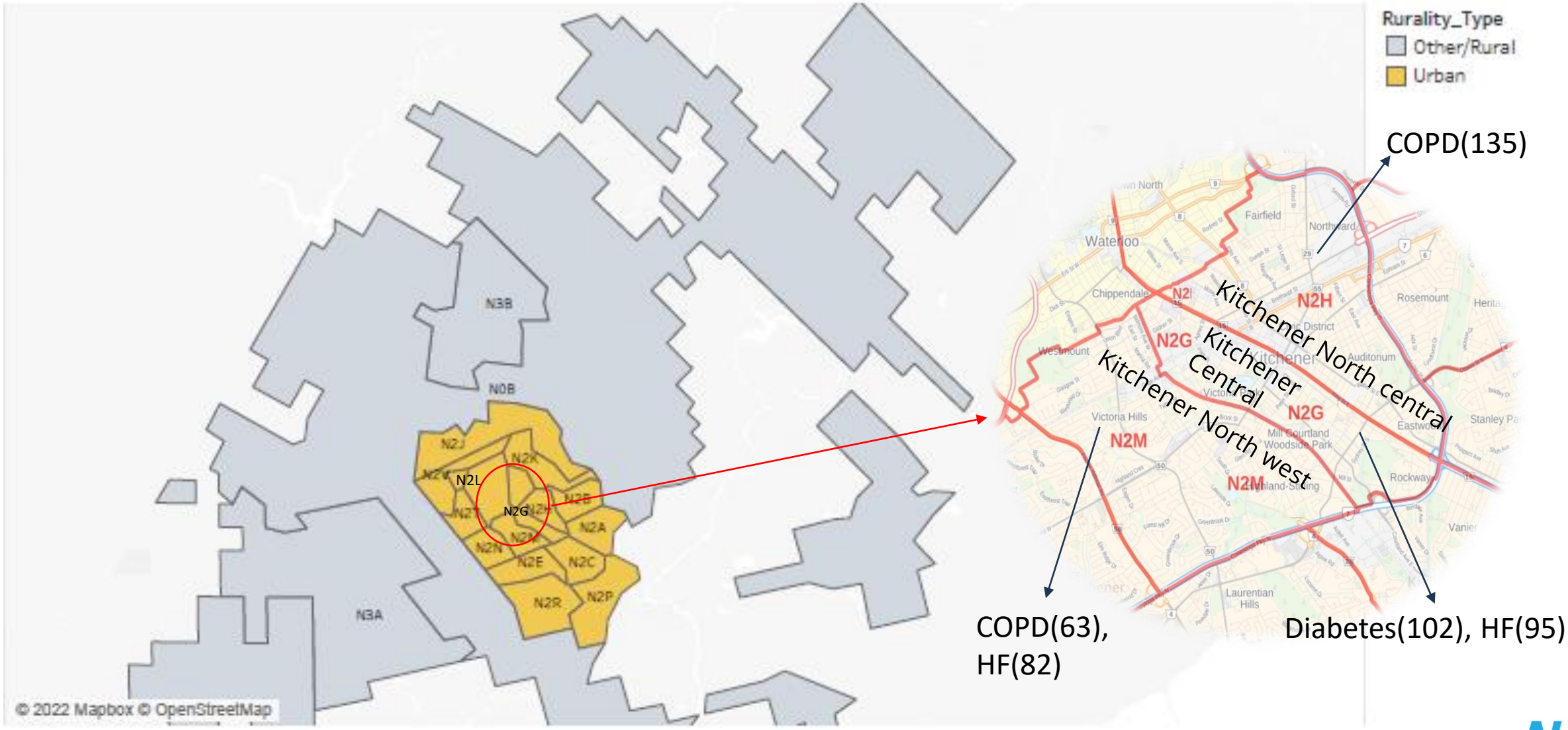
ACSC rate (per 100,000 population) by condition and FSA (sorted by FSA)

Urban\ Rural	Forward Sortation Area	Population (2016 Census)	FY2021/22 Dec(YTD) # of cases							FY2021/22 Dec(YTD) Rate (per 100000 population)							
			Angina	Asthma	COPD	Diabetes	Epilepsy	Heart Failure	Hypertension	Angina	Asthma	COPD	Diabetes	Epilepsy	Heart Failure	Hypertension	FY 2021/22 Total
Kitchener	**Kitchener (Central) - N2G**	15,756			8	16	6	15	3	0	0	51	102	38	95	19	305
	Kitchener (East) - N2A	32,495	2	1	11	11	12	15	1	6	3	34	34	37	46	3	163
	Kitchener (North Central) - N2H	22,267		5	30	10	3	7		0	22	135	45	13	31	0	247
	Kitchener (Northeast) - N2B	17,413	2	1	2	7	6	9	1	11	6	11	40	34	52	6	161
	Kitchener (Northwest) - N2M	36,560		7	23	10	8	30	3	0	19	63	27	22	82	8	222
	Kitchener (South Central) - N2C	17,944		5	6	11	7	5	4	0	28	33	61	39	28	22	212
	Kitchener (South West) - N2E	42,027		7	10	14	7	10	2	0	17	24	33	17	24	5	119
	Kitchener (South) - N2R	16,559	1	4	1		2	3		6	24	6	0	12	18	0	66
	Kitchener (Southeast) - N2P	22,889			3	2	1	7		0	0	13	9	4	31	0	57
	Kitchener (West) - N2N	28,077	1	1	3	3	5	9	5	4	4	11	11	18	32	18	96
Waterloo	Waterloo (East) - N2K	29,869		4	2	8		7	2	0	13	7	27	0	23	7	77
	Waterloo (Northwest) - N2V	19,420	1	1		5	1	9		5	5	0	26	5	46	0	88
	Waterloo (South) - N2L	29,181	1	4	9	17	3	10	4	3	14	31	58	10	34	14	164
	Waterloo (Southeast) - N2J	18,469		3	3	4	3	7	1	0	16	16	22	16	38	5	114
	Waterloo (Southwest) - N2T	22,161	1	2	2	6	5	3	1	5	9	9	27	23	14	5	90
Other/ Rural	Elmira - N3B	12,462		2	4		4			0	16	32	0	32	0	0	80
	New Hamburg (Baden) - N3A	17,344			1	5	2	2	2	0	0	6	29	12	12	12	69
	Wellington County & Rural Waterloo Region - N0B	84,875	2	2		9	3	10	1	2	2	0	11	4	12	1	32
NA		-		2	5	5	3	7									
Grand Total		**485,768**	**11**	**51**	**123**	**143**	**81**	**165**	**30**								

There is a higher per capita concentration of ACSC hospitalizations amongst residence living in Kitchener and more specifically in three FSAs (first three digits of postal code). These FSAs only represent 30% (74,583) of the population of Kitchener (251,987) but account for over 45% of ACSC cases.

- COPD – Kitchener North Central - N2H
- Diabetes – Kitchener Central - N2G
- Heart Failure – Kitchener Central - N2G and Kitchener Northwest - N2M

The rate (per 100000 population)of top three ACSC conditions in KW4 Sub-region by top three Forward sortation areas

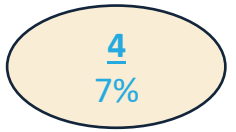


ACSC patients rate (per 100,000 population) by condition and FSA (sorted by material deprivation)

Forward Sortation Area	ON-MARG Material Deprivation	FY2021/22 Dec(YTD) # of cases			Rate (per 100000 population)		
		COPD	Diabetes	Heart Failure	COPD	Diabetes	Heart Failure
Waterloo (Southeast) - N2J	4	3	4	7	16	22	38
Kitchener (Northeast) - N2B	4	2	7	9	11	40	52
Waterloo (South) - N2L	3	9	17	10	31	58	34
Kitchener (Central) - N2G	3	8	16	15	51	102	95
Kitchener (North Central) - N2H	3	30	10	7	135	45	31
New Hamburg (Baden) - N3A	3	1	5	2	6	29	12
Elmira - N3B	3	4			32	0	0
Kitchener (Northwest) - N2M	2	23	10	30	63	27	82
Kitchener (South Central) - N2C	2	6	11	5	33	61	28
Kitchener (East) - N2A	2	11	11	15	34	34	46
Kitchener (West) - N2N	2	3	3	9	11	11	32
Wellington County & Rural Waterloo Region - N0B	2		9	10	0	11	12
Kitchener (South West) - N2E	1	10	14	10	24	33	24
Kitchener (Southeast) - N2P	1	3	2	7	13	9	31
Waterloo (Southwest) - N2T	1	2	6	3	9	27	14
Waterloo (Northwest) - N2V	1		5	9	0	26	46
Kitchener (South) - N2R	1	1		3	6	0	18
Waterloo (East) - N2K	1	2	8	7	7	27	23
N/A		5	5	7			
Grand Total		**123**	**143**	**165**			

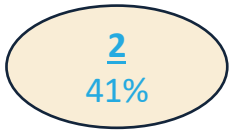
Total population by quintile

Material deprivation

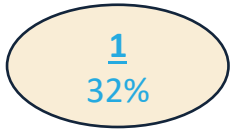


7% of KW4 OHT's population resides in neighborhoods in the 4th quintile & account for 7% (32/431) of the top three ACSC

20% of KW4 OHT's population resides in neighborhoods in the 3rd quintile & account for 31% (134/431) of the top three ACSC



41% of KW4 OHT's population resides in neighbourhoods in the 2nd quintile & account for 36% (156/431) of the top three ACSC



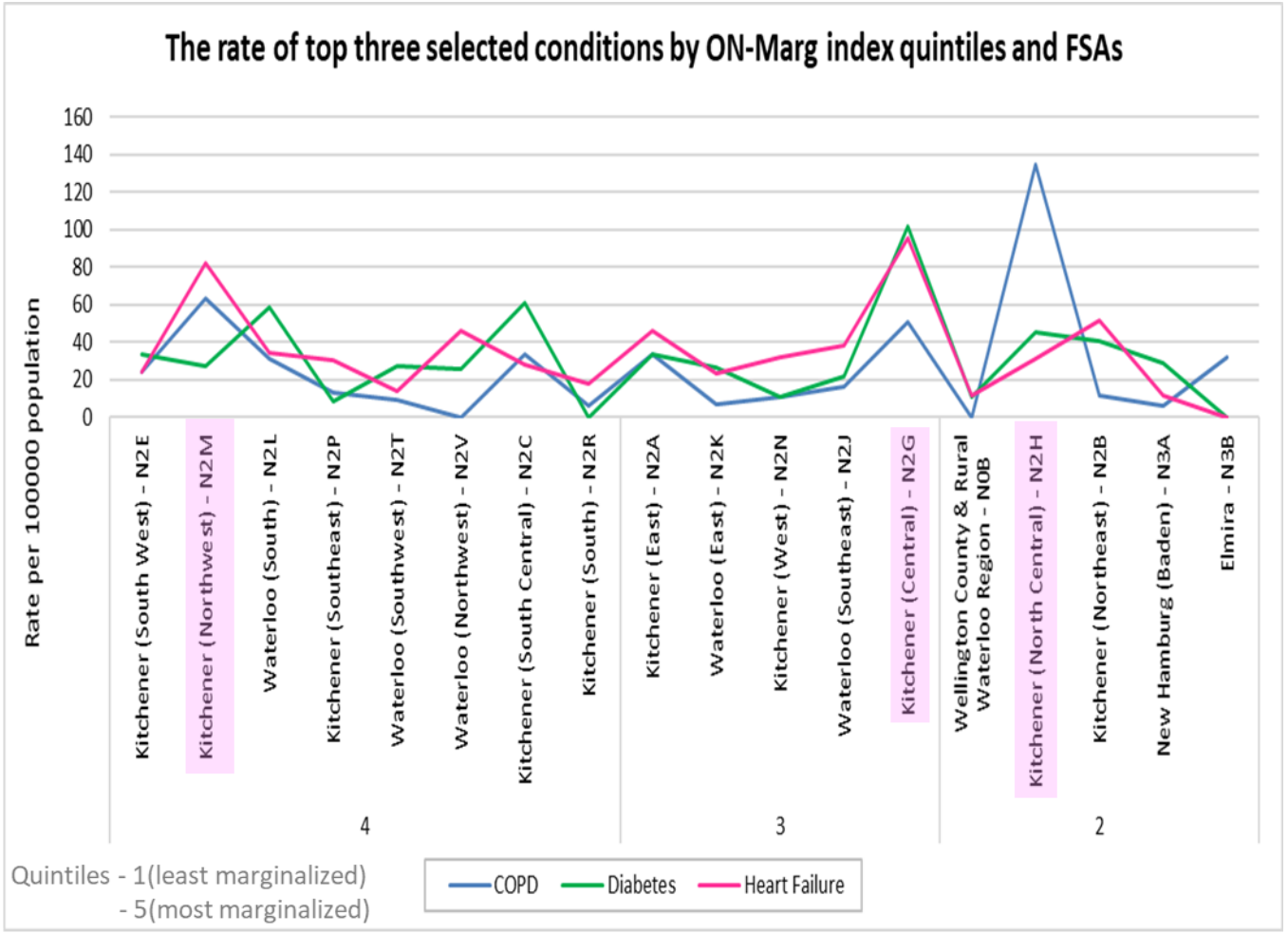
32% of KW4 OHT's population resides in neighbourhoods in the 1st quintile & account for 21% (92/431) of the top three ACSC

Quintiles - 1(least marginalized)
- 5(most marginalized)

- Material deprivation is closely connected to poverty, and it refers to inability for individuals and communities to access and attain basic material needs.
- Although 20% of KW4 OHT's population resides in a neighborhood in the 3rd quintile, they account for 31% of the top three ACSC

ACSC rate (per 100,000 population) by condition and FSA (sorted by ethnic concentration)

ON-MARG Ethnic Concentration	Forward Sortation Area	Percentage of population	COPD	Diabetes	Heart Failure
4	Kitchener (South West) - N2E	8.7%	24	33	24
	Kitchener (Northwest) - N2M	7.5%	63	27	82
	Waterloo (South) - N2L	6.0%	31	58	34
	Kitchener (Southeast) - N2P	4.7%	13	9	31
	Waterloo (Southwest) - N2T	4.6%	9	27	14
	Waterloo (Northwest) - N2V	4.0%	0	26	46
	Kitchener (South Central) - N2C	3.7%	33	61	28
	Kitchener (South) - N2R	3.4%	6	0	18
3	Kitchener (East) - N2A	6.7%	34	34	46
	Waterloo (East) - N2K	6.1%	7	27	23
	Kitchener (West) - N2N	5.8%	11	11	32
	Waterloo (Southeast) - N2J	3.8%	16	22	38
	Kitchener (Central) - N2G	3.2%	51	102	95
2	Wellington County & Rural Waterloo Region - N0B	17.5%	0	11	12
	Kitchener (North Central) - N2H	4.6%	135	45	31
	Kitchener (Northeast) - N2B	3.6%	11	40	52
	New Hamburg (Baden) - N3A	3.6%	6	29	12
	Elmira - N3B	2.6%	32	0	0



Ethnic Concentration refers to high area-level concentrations of people who are recent immigrants and/or people belonging to a 'visible minority' group (defined by Statistics Canada as "persons, other than aboriginal peoples, who are non-Caucasian in race or non-white in colour")

- Kitchener Northwest-N2M who are in quintile 4 are mostly impacted by the Heart Failure and then followed by COPD conditions.
- Kitchener Central-N2G who are in quintile 3 are mostly impacted by the Diabetes and then followed by Heart Failure conditions.
- Kitchener Northcentral-N2H who are in quintile 2 are mostly impacted by the COPD condition.

Top three FSAs with highest prevalence of selected ACS conditions by age-group

Forward Sortation Area	COPD (# of cases)						Diabetes (# of cases)								Heart Failure (# of cases)						Grand Total
	00-10	21-30	41-50	51-60	61-74	Total	00-10	11-20	21-30	31-40	41-50	51-60	61-74	Total	21-30	31-40	41-50	51-60	61-74	Total	
Kitchener (Central)-N2G		1		15	28	44	2	2	6	12	9	8	4	43	3	1	3	6	24	37	124
Kitchener (North Central)-N2H			3	14	62	79	2	3	4	14	15	4	4	46		1	2	4	16	23	148
Kitchener (Northwest)-N2M	1			20	70	91	4	5	3	15	6	18	9	60	1	4	2	12	50	69	220
Grand Total	**1**	**1**	**3**	**49**	**160**	**214**	**8**	**10**	**13**	**41**	**30**	**30**	**17**	**149**	**4**	**6**	**7**	**22**	**90**	**129**	**492**
Percetnage	0.5%	0.5%	1.4%	**22.9%**	**74.8%**	100%	5.4%	6.7%	8.7%	**27.5%**	20.1%	20.1%	11.4%	100%	3.1%	4.7%	5.4%	17.1%	**69.8%**	100%	

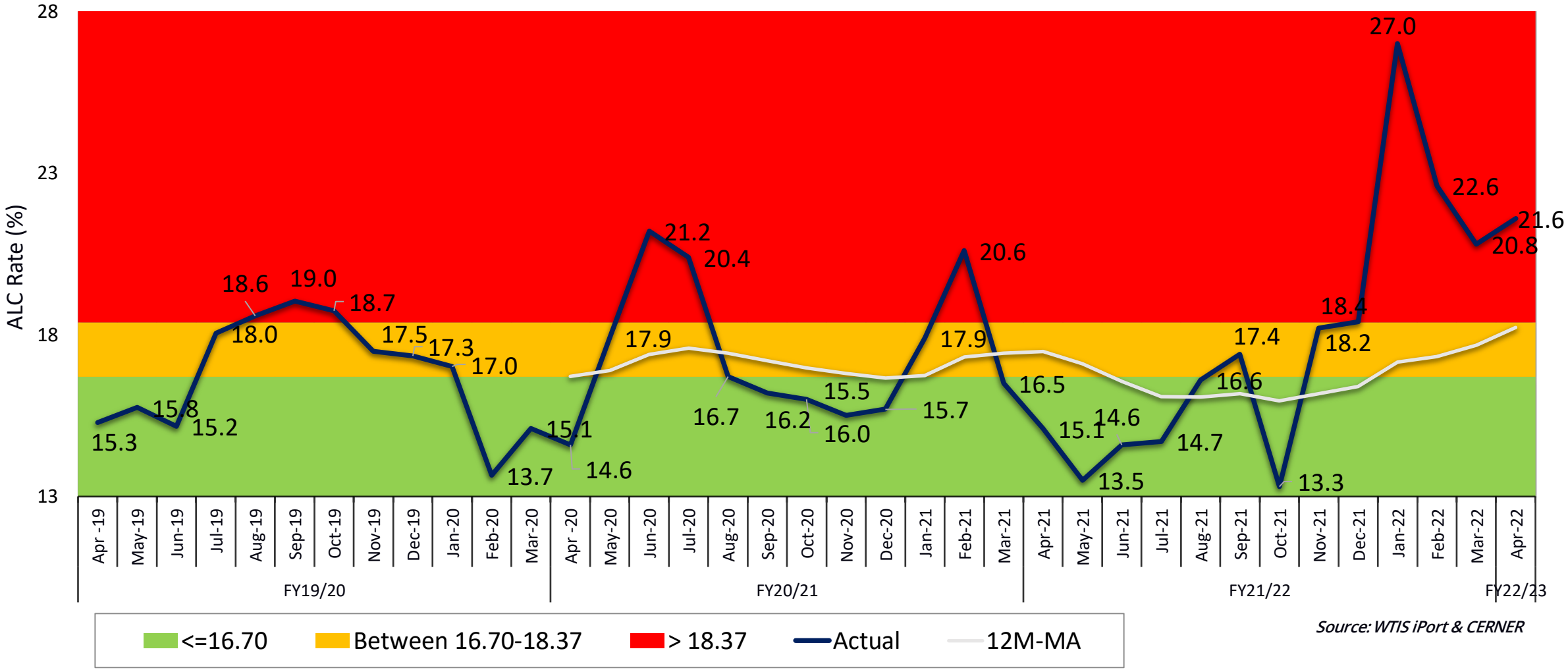
- COPD – 97.7% of cases where in the 51-74 years age groups with 74.8% between 61-74 years age group.
- Diabetes – prevalence is equally observed amongst all age groups, with highest (27.5%) being in 31-40 years age group
- Heart Failure – 69.8% of cases where in the 61-74 years age group.

Alternate Level of Care (ALC)

Key Takeaway from the Data

- ALC has been a long-standing issue in KW4 and across the province.
- Since April 2019, on average, 17.4% of inpatient bed days in KW4 were occupied by patients designated as ALC.
- There is variability month over month with peaks coinciding with the various waves of the pandemic.
- Both Acute and Post-acute (CCC, Rehab, Mental Health) beds are occupied by patients designated as ALC.
- The top 2 reasons for patient admissions (prior to being designated as ALC) that had the highest number of associated ALC Days are Dementia and General Weakness
- The High Chronic with Frailty population segment accounted for the largest proportion of ALC Days in 2020/21 followed by the High Chronic Conditions population segment.
- 4 FSAs (N2G,N2H,N2M, N2C) account for only 19% of the population in KW4 but 32% of ALC cases
- There are several discharge and transfer destinations for patients designated as ALC. As of January 31, 2022:
  - KW4 had 177 patients designated ALC on the waitlist. These patients have accumulated 9,750 ALC days.
  - By facility, GRH had the highest number of patients designated ALC on the waitlist.
  - GRH had 148 patients designated ALC on the waitlist. These patients have accumulated 9,156 ALC days.
    - 74% are waiting for LTC
  - SMGH had 29 patients designated ALC on the waitlist. These patients have accumulated 594 ALC days.
    - 35% are waiting for Home with Community Services
- The top three barriers which prevent, or delay discharge of patients designated as ALC in KW4 and which accounted for over 6,600 ALC days as of 2021/22 (Oct YTD) are housing/homelessness, financial constraints, aggressive behaviours
- The median wait time for ALC has been declining since September 2020.
- As of January 31, 2022, the vast majority (85%) or 150 patients designated as ALC were age 65+.
- ALC discharges typically occur during weekdays, with declining discharges on Saturdays and minimal discharges occurring on Sundays

Total ALC (Acute and Non-Acute) Rate (%) - April 2019 to April 2022



Source: WTIS iPort & CERNER

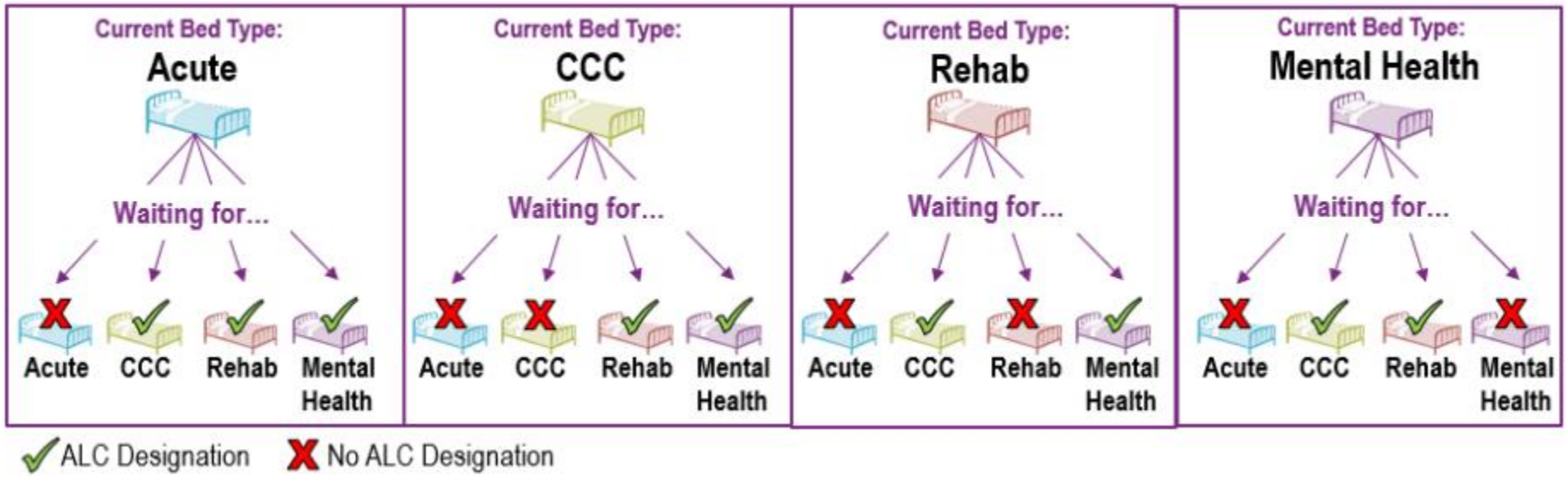
Since April 2019, KW4 ALC rate:

- On average 17.4% of inpatient bed days were occupied by patients designated as ALC.
- 51.4% of the time we were above the KW4 OHT target of 16.70%
- As the various waves of the pandemic ebbed and flowed so too did ALC

12M-MA : 12 months moving average

Alternate Level of Care (ALC) Designation

- Alternate level of care (ALC) is used to identify patients who are admitted to a hospital but no longer require the level of care provided at that facility.
- When a patient is occupying a bed in a hospital and does not require the intensity of resources/ services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient is designated ALC at that time by the physician or delegate in collaboration with members of that patient's inter-professional team.
- The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies)
- ALC does not apply to patients who are moving from one bed to another within the same level of care (e.g., Acute to Acute, CCC to CCC) or to a higher level of care (e.g., Rehab to Acute)



Source: CCO/Access To Care ALC Reference Manual - https://ext.cancercare.on.ca/ext/databook/db2122/documents/Appendix/ALC_Reference_Manual_v2.pdf

ALC Rate (%) by Inpatient Service - January 2022

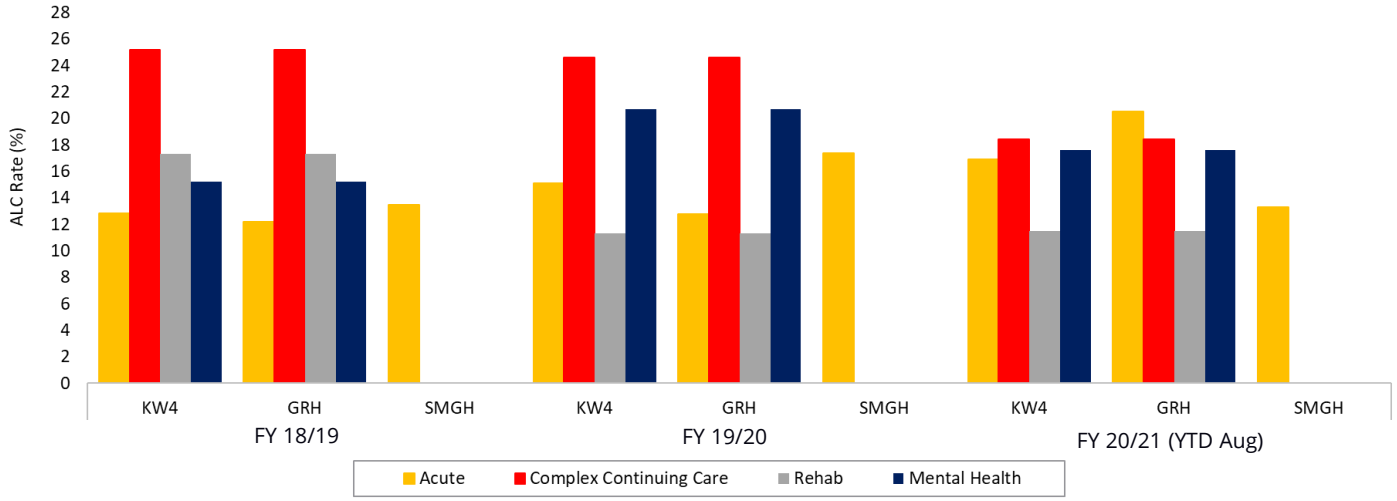
LHIN/Facility	All	Acute	Post-Acute			
			All Post-Acute	Complex Continuing Care	Mental Health	Rehab
Waterloo Wellington	**19.5%**	**22.3%**	**14.7%**	**27.8%**	**4.9%**	**29.9%**
Homewood Health	1.7%	NV	1.7%	NV	1.7%	NV
Groves Memorial	18.9%	18.9%	NV	NV	NV	NV
Cambridge Memorial	22.1%	24.2%	13.4%	NV	0.0%	55.9%
Guelph General	21.6%	21.6%	NV	NV	NV	NV
St Joseph's Health	27.8%	NV	27.8%	29.1%	NV	25.0%
St Mary's General	19.6%	19.6%	NV	NV	NV	NV
Grand River	22.0%	23.0%	20.4%	26.8%	12.0%	28.7%
North Wellington	34.7%	34.7%	NV	NV	NV	NV

Source: Ontario Health – Access to Care, WW LIN Monthly ALC Performance Summary – January 2022

As of January 31, 2022:

- SMGH – had an overall ALC rate of 19.6% with all the patients occupying acute care beds.
- GRH - had an overall ALC rate of 22.0% with patients in both acute and post-acute beds. The ALC rate by inpatient service was:
  - Acute – 23%
  - Complex Continuing Care – 26.8%
  - Mental Health - 12.0%
  - Rehab – 28.7%.

Annual ALC Rate(%) by Inpatient Services - FY2018/19 to FY20/21 (YTD Aug)



Over the past 3 Fiscal Years:

- Patients designated ALC occupied beds most often in the following services:
  - KW4 – Complex Continuing Care for all 3 years
  - GRH – Complex Continuing Care for in FY 18/19 and 19/20 and then shifted to Acute in FY 20/21 YTD
  - SMGH – Acute for all 3 years

KW4 - Top 10 Reasons for Patient Admissions (prior to becoming ALC Patients) FY2020/21 to FY2021/22 (YTD Oct)

Reason	Total ALC Days	# of patients
General Weakness	2945	200
Emergency Medical Service	1682	118
Shortness of Breath	955	107
Fall	1250	100
Confusion	1556	71
Dementia	4785	42
Mental Health & Addiction	1047	24
Covid+ From LTC	1046	17
Schizophrenia	1873	10
Schizoaffective Disorder	1218	1

Source: Ontario Health – WTIS (iPort Access)
Cerner

From April 2020 to October 2021 in KW4 OHT:

- The top 2 reasons for patient admissions (prior to being designated as ALC) that had the highest number of associated ALC Days are Dementia and General Weakness, totaling 7,730 ALC Days over 242 patients.

Methodology : To Care ALC Reference Manual - https://ext.cancercare.on.ca/ext/databook/db2122/documents/Appendix/ALC_Reference_Manual_v2.pdf

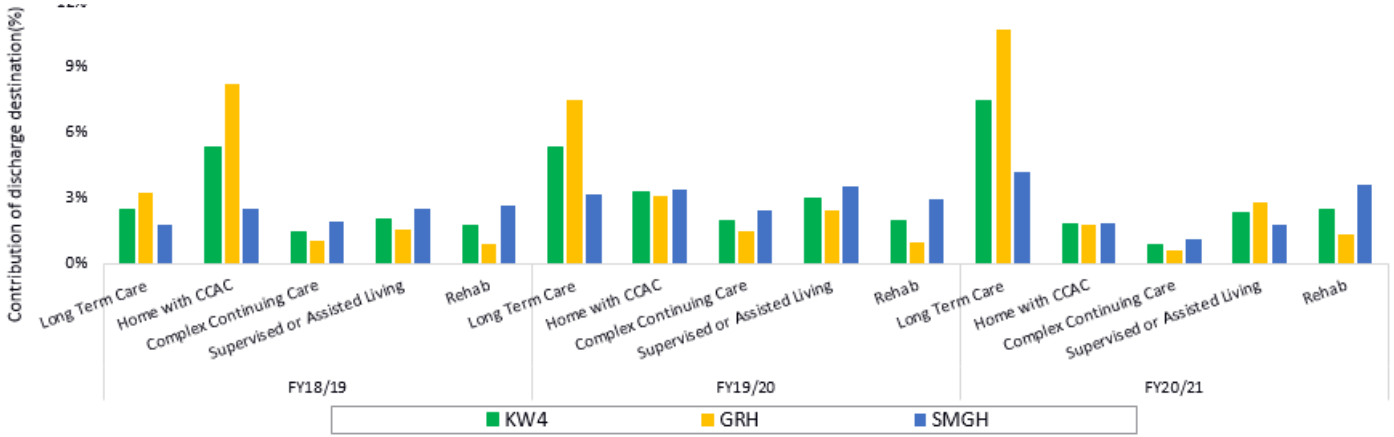
% Cumulative ALC Days of Open Patients Designated ALC by Discharge Destination- January 2022

LHIN/Facility	Open Cases				% of LHIN/Facility Cumulative ALC Days											
	Volume (Jan 2022)	%Change (Jan 2022 vs. Jan 2021)	Cumulative ALC Days (Jan 2022)	%of LHIN Cumulative ALC Days	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
Waterloo Wellington	**293**	**14%**	**13,697**		**61%**	**11%**	**2%**	**6%**	**2%**	**0.2%**	**11%**	**3%**	**0.7%**	**0.5%**	**0%**	**2%**
Homewood Health	4	-20%	162	1%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Groves Memorial	9	-18%	174	1%	45%	0.6%	0%	55%	0%	0%	0%	0%	0%	0%	0%	0%
Cambridge Memorial	30	0%	1,704	12%	3%	80%	0.1%	11%	0%	0%	2%	4%	0%	0.2%	0%	0%
Guelph General	35	40%	593	4%	37%	0.5%	8%	46%	0%	6%	1%	0.7%	2%	0%	0%	0%
St Joseph's Health	27	-13%	1,148	8%	80%	0%	0%	10%	0%	0%	10%	0%	0%	0%	0%	0%
St Mary's General	29	61%	594	4%	15%	17%	8%	8%	35%	0%	13%	0%	0%	4%	0%	0%
Grand River	148	11%	9,156	67%	74%	0.5%	2%	2%	1%	0%	14%	4%	0.9%	0%	0%	2%
North Wellington	11	267%	166	1%	38%	13%	0%	5%	0%	0%	16%	0%	0.6%	27%	0%	0%

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

Source: Ontario Health – Access to Care, WW LIN Monthly ALC Performance Summary – January 2022

- There are a number of discharge and transfer destinations for ALC patients. The location is determined by the physician or delegate, in collaboration with an inter-professional team, as to where a patient should be discharged or transferred based on the care needs of the patient. This decision is irrespective of whether or not the discharge destination is available, accessible and/or exists within the community.
- As of January 31, 2022:
  - KW4 - there were 177 patients designated ALC on the waitlist. These patients have accumulated 9,750 ALC days.
  - SMGH – there were 29 patients designated ALC on the waitlist. These patients have accumulated 594 ALC days.
    - The top 3 discharge destinations are Home with Community Services (35%, 208 ALC Days), Rehab (17%, 101 ALC Days) and LTC (15%, 89 ALC Days).
  - GRH - there were 148 patients designated ALC on the waitlist. These patients have accumulated 9,156 ALC days.
    - The top 3 discharge destinations are LTC (74%, 6,775 ALC Days), Supervised or Assisted Living (14%, 1,282 ALC Days), and Convalescent Care (4%, 366 ALC Days)



Source: Ontario Health – ALC MADD Report

- The top Discharge Destinations has shifted from FY18/19 to FY20/21 (YTD Aug)
  - KW4 – Home with CCAC in 18/19 to LTC in FY 19/20 and 20/21 (YTD Aug)
  - GRH – Home with CCAC in 18/19 to LTC in FY 19/20 and 20/21 (YTD Aug)
  - SMGH - Rehab in FY 18/19 to LTC, Home with CCAC, Supervised or Assisted Living and Rehab in FY19/20 to LTC and Rehab in FY 20/21

KW4 Ontario Health Team

Top 10 Barriers to Discharge for ALC Patients in GRH,SMGH and KW4 OHT - FY2020/21 to FY2021/22(YTD Oct)

Specialized Needs and Supports (Barrier cases only)	GRH				SMGH				KW4			
	FY2020/21		FY2021/22 (YTD OCT)		FY2020/21		FY2021/22 (YTD OCT)		FY2020/21		FY2021/22 (YTD OCT)	
	Days	Cases	Days	Cases	Days	Cases	Days	Cases	Days	Cases	Days	Cases
Social Requirements - Housing/Homelessness	2,481	16	2,419	15	21	5	23	4	2,502	21	2,442	19
Social Requirements - Financial Constraints	2,719	18	2,076	5	988	27	95	11	3,707	45	2,171	16
Behavioural Requirements - Aggressive Behaviours	305	5	1,993	7	169	7	8	2	474	12	2,001	9
Behavioural Requirements - Unspecified	1,036	7	1,071	3	521	9	53	3	1,557	16	1,124	6
Mental Health Requirements - Unspecified	1,845	5	1,058	2	129	4	0	0	1,974	9	1,058	2
Social Requirements - Lack of Social Support	1,748	15	923	2	508	25	44	6	2,256	40	967	8
Behavioural Requirements - 1:1 Support	717	3	905	1	59	1	0	0	776	4	905	1
Medications/Labs/Therapy Requirements		5	61	4	946	71	406	27	946	76	467	31
Mental Health Requirements - Concurrent Disorders	33	4	191	5	329	1	30	2	362	5	221	7
Equipment/Structural Requirements (excludes bariatrics)	264	4	116	8	325	12	48	3	589	16	164	11
Total	**11,148**	**82**	**10,813**	**52**	**3,995**	**162**	**707**	**58**	**15,143**	**244**	**11,520**	**110**

- Barriers to discharged are defined as the specialized care needs/supports of the patient required at their ALC Discharge Destination that are preventing or delaying discharge.
- The top three barriers which prevent or delay discharge of ALC patients in KW4 and which accounted for over 6,600 ALC days as of 2021/22 (Oct YTD) are:
  - Housing/homelessness
    - Services designed for patients who experience housing limitations or have homelessness issues. This may include but is not limited to patients who are; inadequately or insecurely housed, utilizing shelter services or subsidized housing, or have no fixed address, etc.
  - Financial constraints
    - Services designed to support patients who experience financial constraints including but not limited to; unemployment, job insecurity, fixed incomes, or who are receiving social assistance, etc.
  - Aggressive behaviours
    - Services designed to provide care for patients who exhibit aggressive behaviours including but not limited to; pushing, spitting, hitting, property destruction, etc.

Methodology : To Care ALC Reference Manual - https://ext.cancercare.on.ca/ext/databook/db2122/documents/Appendix/ALC_Reference_Manual_v2.pdf

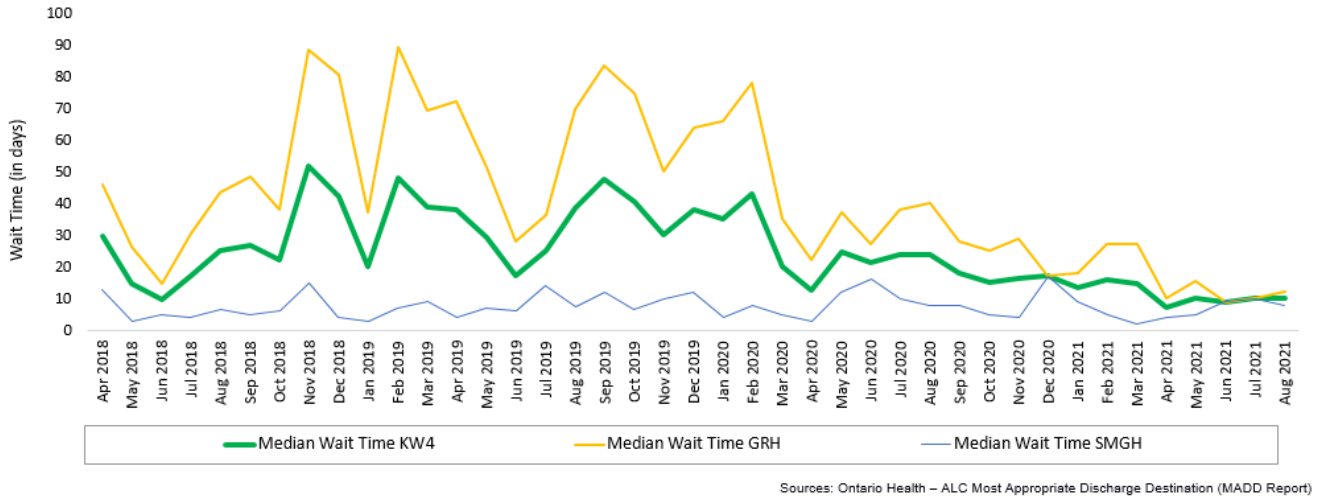
Volume and 90th Percentile Wait Time for Open Patients Designated ALC 65+ years old

LHIN/Facility	January 31, 2021			January 31, 2022			Jan 2022 vs. Jan 2021		
	Open Cases	% of LHIN Open Cases	90th Pctl	Open Cases	% of LHIN Open Cases	90th Pctl	Open Cases	% of LHIN Open Cases	90th Pctl
Waterloo Wellington	**228**		**103**	**255**		**73**	**11.8%**		**-29.1%**
Grand River	114	50.0%	114	127	49.8%	102	11.4%	-0.2%	-10.5%
Guelph General	22	9.6%	25	32	12.5%	51	45.5%	2.9%	104.0%
Cambridge Memorial	28	12.3%	45	29	11.4%	55	3.6%	-0.9%	22.2%
St Joseph's Health	29	12.7%	135	23	9.0%	61	-20.7%	-3.7%	-54.8%
St Mary's General	16	7.0%	19	23	9.0%	31	43.8%	2.0%	63.2%
North Wellington	3	1.3%	LV	10	3.9%	40	233.3%	2.6%	NV
Groves Memorial	11	4.8%	103	9	3.5%	58	-18.2%	-1.3%	-43.7%
Homewood Health	5	2.2%	LV	2	0.8%	LV	-60.0%	-1.4%	NV

Source: Ontario Health – Access to Care, WW LIN Monthly ALC Performance Summary – January 2022

As of January 31, 2022:
- KW4 – had 150 patients designated ALC 65+
- GRH – had 127 patients designated ALC 65+, and 90% of the senior population waited 102 or less days
- SMGH – had 23 patients designated ALC 65+ and 90% of the senior population waited 31 or less days

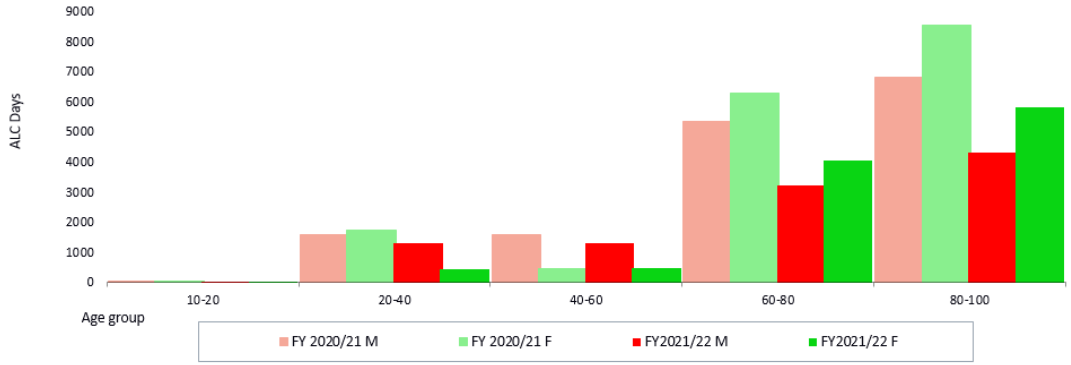
ALC Patient Median Wait Time (in days) - FY2018/19 to FY2020/21 (YTD Aug)



Sources: Ontario Health – ALC Most Appropriate Discharge Destination (MADD Report)

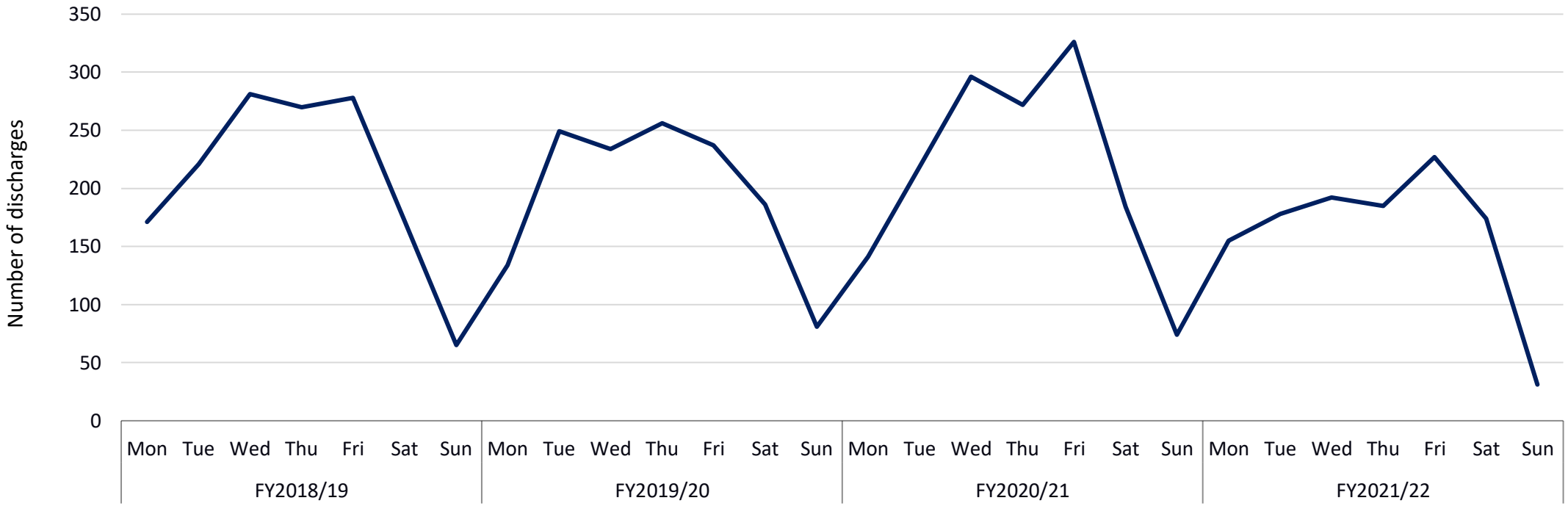
Over the past 4 Fiscal Years:
- Median Wait Time has been variable across Facilities
- Since Sep 2020, Wait Times started to see a decline

KW4 ALC Days by age group and gender - FY20/21(Oct) to FY21/22 (Oct)



Over the past 2 Fiscal Years in KW4 OHT:
- ALC days of Male is lower than Female for the age groups 60-80 and 80-100
- 35% of ALC days are attributed to those between the age of 60-80 and 48% to those over the age of 80

KW4 - Number of ALC discharges by day of the week: FY2018/19 – FY21/22 (YTD Oct)

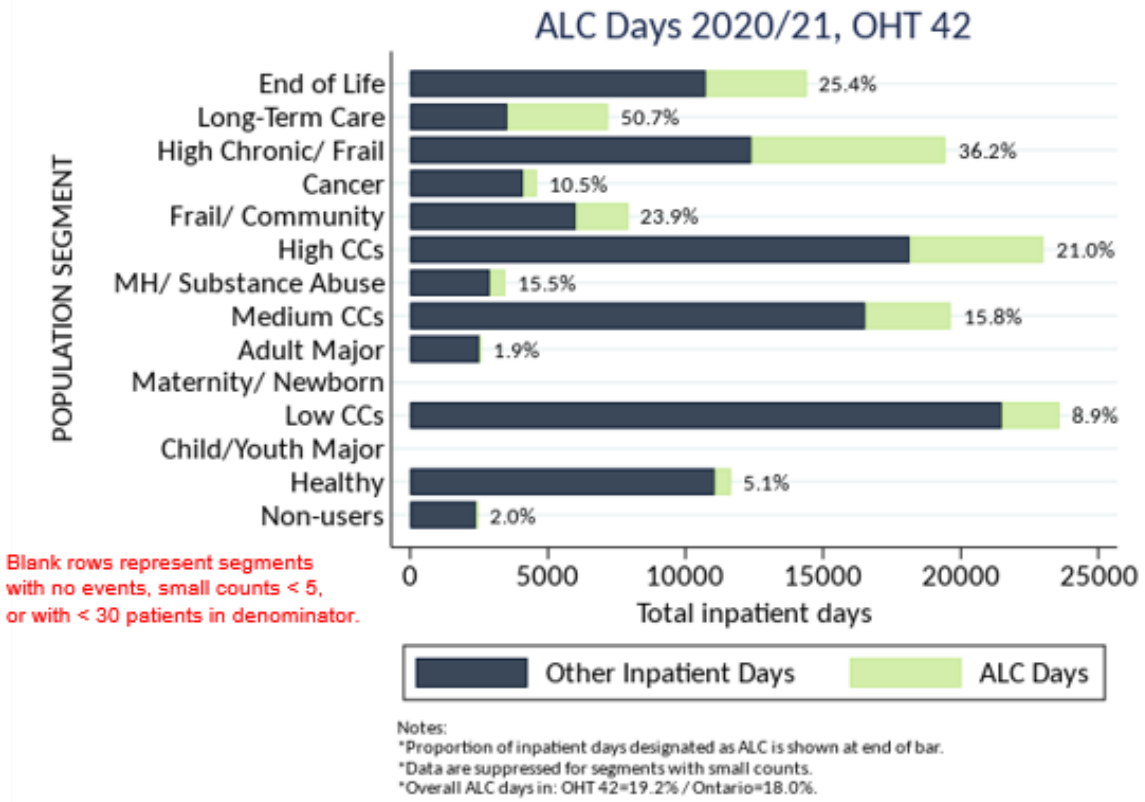


Source: Ontario Health – WTIS (iPort Access)

- ALC discharges typically occur during weekdays, with declining discharges on Saturdays and minimal discharges occurring on Sundays.
- This may be attributed to a lower availability of allied health and discharge coordinator resources on weekends at the sending facility as well as a lower availability of resources at the receiving destination.

Methodology : CCO/Access To Care ALC Reference Manual - https://ext.cancercare.on.ca/ext/databook/db2122/documents/Appendix/ALC_Reference_Manual_v2.pdf

HSPN-IC/ES Report – 2020/21 ALC Days (percent of acute days) in acute hospital by BC Matrix Segment



2020/21			
Segment Label	**ALC days**	**Inpatient days**	**ALC days (%)**
Total for KW4 Attributed Population	**27,947**	**145,840**	**19.16**
End of Life	3,656	14,405	25.38
Long-Term Care	3,640	7,178	50.71
High Chronic with Frailty	7,034	19,435	36.19
Cancer	483	4,595	10.51
Frail in Community (Home Care)	1,896	7,925	23.92
High Chronic Conditions	4,833	22,991	21.02
Mental Health & Substance Abuse	534	3,442	15.51
Medium Chronic Conditions	3,093	19,628	15.76
Adult Major Age 18+ yrs	49	2,577	1.9
Maternity & Healthy Newborn	.	.	.
Low Chronic Conditions	2,090	23,587	8.86
Child and Youth Major <18 yrs	.	.	.
Healthy (low user)	589	11,659	5.05
Non-user	50	2,462	2.03

- In KW4, multiple population segments contribute to total ALC days in 2020/21.
- The High Chronic with Frailty population segment accounted for the largest proportion of ALC Days in 2020/21 (7,034 days – 25%) followed by the High Chronic Conditions population segment (4,833 days – 17%).
  - High Chronic with Frailty - residents who do receive selected support services for activities of daily living and who have one or more high chronic conditions (Alzheimer's, dementia, cystic fibrosis, heart failure, or organ transplant), had stroke or are on dialysis, or have a specific combination of chronic conditions (AMI & pre-dialysis chronic kidney disease, angina & COPD, diabetes & hypertension & osteoarthritis), as defined by the Chronic Disease Registries.
  - High Chronic Conditions - residents who do not receive support services for activities of daily living and who have one or more high chronic conditions.

Alternate Level of Care (ALC) by Forward Sortation Area (FSA)

Urban/ Rural	FSA Description	Population 2016 Census	% of population	FY 2021/22 ALC Cases	ALC Cases per 100,000 population	ALC Days	ALC Days per 100,000 population	Inpatient Days	Inpatient Days per 100,000 population	ALC Rate (%)
Kitchener	Kitchener(Southwest)-N2E	42,027	8.7%	116	276	2,164	5,149	4,061	9,663	53.3%
	Kitchener(Northwest)-N2M	36,560	7.5%	164	449	2,345	6,414	4,848	13,260	48.4%
	Kitchener(East)-N2A	32,495	6.7%	170	523	4,468	13,750	8,658	26,644	51.6%
	Kitchener(West)-N2N	28,077	5.8%	107	381	1,498	5,335	3,058	10,891	49.0%
	Kitchener(Southeast)-N2P	22,889	4.7%	36	157	636	2,779	1,218	5,321	52.2%
	Kitchener(NorthCentral)-N2H	22,267	4.6%	149	669	2,874	12,907	5,744	25,796	50.0%
	Kitchener(Southcentral)-N2C	17,944	3.7%	97	541	1,541	8,588	2,866	15,972	53.8%
	Kitchener Northeast-N2B	17,413	3.6%	89	511	1,476	8,476	3,027	17,384	48.8%
	Kitchener(South)-N2R	16,559	3.4%	14	85	211	1,274	411	2,482	51.3%
	Kitchener(Central)-N2G	15,756	3.2%	133	844	2,064	13,100	4,703	29,849	43.9%
Waterloo	Waterloo(East)-N2K	29,869	6.1%	64	214	918	3,073	2,263	7,576	40.6%
	Waterloo(South)-N2L	29,181	6.0%	155	531	2,206	7,560	4,309	14,766	51.2%
	Waterloo(Southwest)-N2T	22,161	4.6%	72	325	953	4,300	1,903	8,587	50.1%
	Waterloo(Northwest)-N2V	19,420	4.0%	56	288	1,126	5,798	1,912	9,846	58.9%
	Waterloo(Southeast)-N2J	18,469	3.8%	107	579	2,063	11,170	3,799	20,570	54.3%
Other / Rural	Wellington County&Rural Waterloo Region-N0B	84,875	17.5%	82	97	1,351	1,592	2,602	3,066	51.9%
	New Hamburg(Baden)-N3A	17,344	3.6%	51	294	1,060	6,112	1,955	11,272	54.2%
	Elmira-N3B	12,462	2.6%	36	289	662	5,312	1,150	9,228	57.6%
Selected FSAs (N2G, N2H, N2M, N2C)		92,527		543	587	8,824	9,537	18,161	19,628	48.6%
KW4 OHT Total		485,768		1,698	350	29,616	6,097	58,487	12,040	50.6%
Selected FSAs as a percentage of KW4 OHT			19.0%	32.0%		29.8%		31.1%		

- 4 FSAs (N2G,N2H,N2M, N2C) with the highest proportion of recent immigrants account for only 19% of the population in KW4 but 32% of ALC cases
- The highest per capita concentration of ALC cases occurs amongst residence living in:
  - **N2G** (part of Victoria Hills/Cherry Hill/KW Hospital and Vanier/Rockway)
  - **N2H** (part of Victoria Hills/Cherry Hill/KW Hospital)

Frequent ED Visits for Help with Mental Health and Addictions

Change in Calculation Methodology

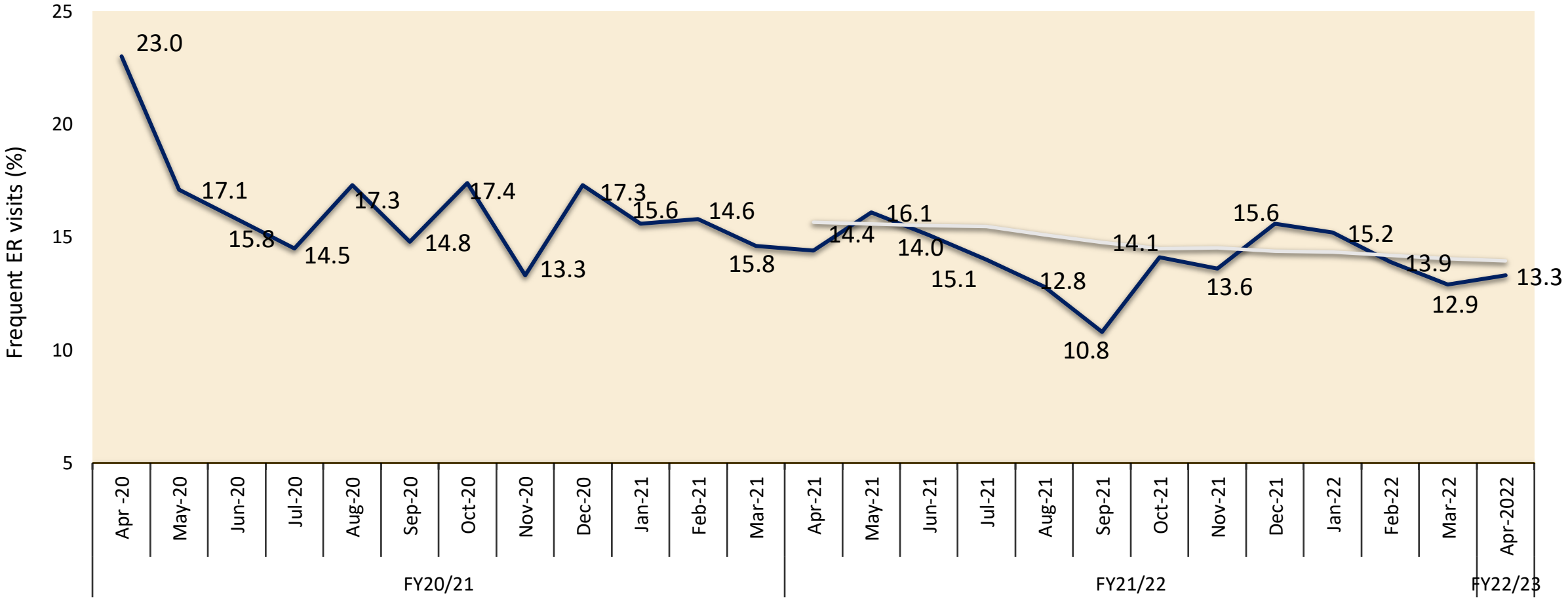
- As indicated in the last couple of reports, reporting on this measure was temporarily paused as we investigated a concern with the methodology being used to calculate this indicator.

- Previous Methodology:
  - calculated based on a Year-To-Date (YTD) rolling value per month
  - impacts the previous month's results every time new monthly data is added

- New Methodology:
  - after internal and external stakeholders consultation, we have moved to a monthly snapshot methodology
  - this is based on the annual CIHI methodology but applied to each month independently (takes each patient visit in the reporting month as an index visit and counts back the number for each patient within the last 365 days)
  - ensures the index case of the month before is not inadvertently impacted

- Next Steps:
  - determine revised target
  - inform OH/MOH of the change in methodology and in our performance during our next quarterly report submission

Frequent ER Visits For Help with Mental Health & Addictions (%) - April 2020 to April 2022



Over the past two fiscal years:

- There has been a downward trend in frequent ER visits for help with mental health & addictions.

Source: GRH Data lake

Note: This indicator has been updated as per the new methodology. The target still needs to be determined.

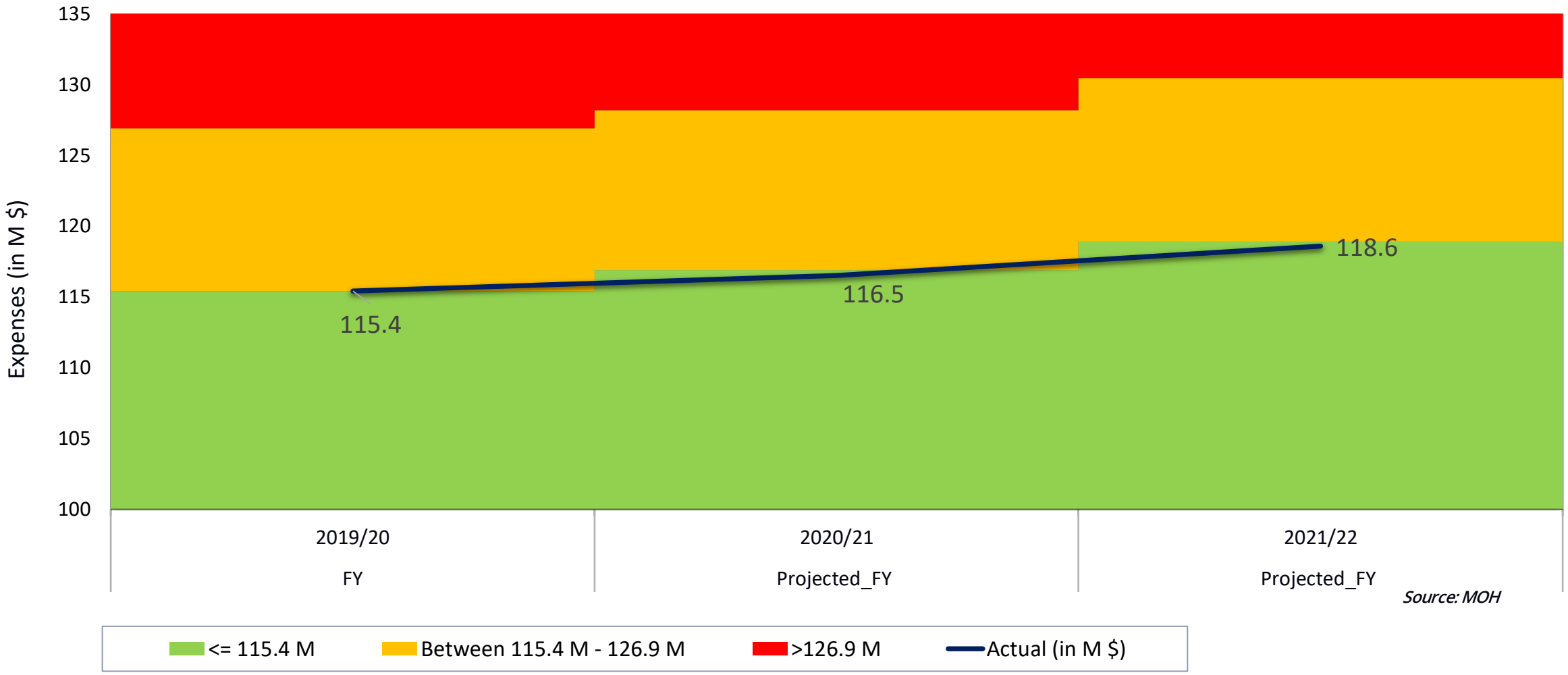
12M-MA : 12 months moving average

Total Expense / Health Profile Group Population

Change in Calculation Methodology

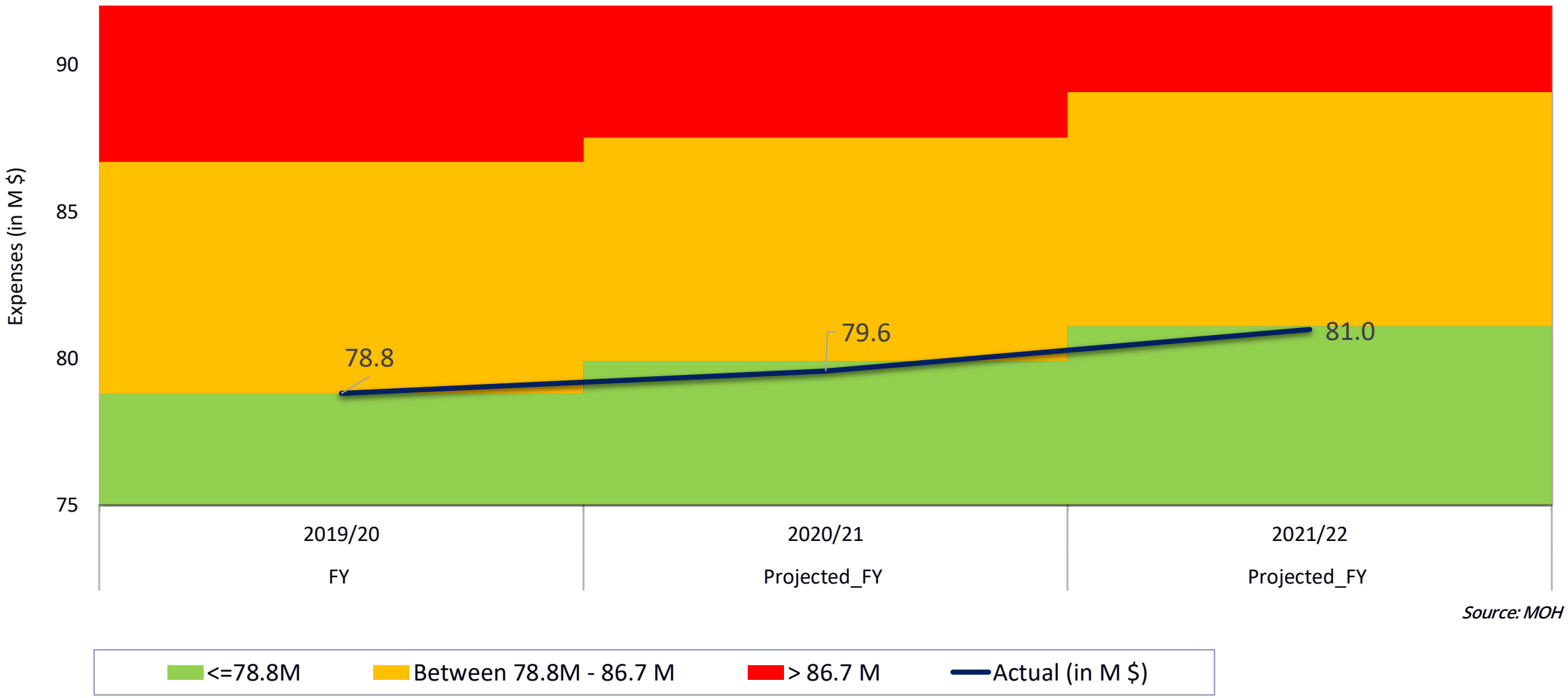
- As indicated in previous reports, KW4 OHT is unable to calculate this KPI and therefore relies on the ministry for their annual updates.
- The last update we received was July 2021 which depicted fiscal year 2019 health care spending.

Total Expense / Health Profile Group Population for Palliative Care in Millions($)



Source: MOH

Total Expense / Health Profile Group Population for Dementia ($M)



Source: MOH

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.	• 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
			GRH and SMGH Cerner Patient Days Report
			
			Wait Time Information System (WTIS)
				<=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.	• 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 – 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	To be determined	

Indicator Definitions

Indicator Name	Indicator Description	Calculation Method	Data Source	Target	Performance Corridor
Total Expense / HPG Population for Palliative and Dementia	• CIHI has identified 239 Health Profile Groups (HPGs) that summarize an individual's clinical profile down to the most complex and clinically relevant health condition (i.e., each Ontario resident has been assigned to only one HPG). • This indicator calculates all publicly funded health care spending including hospital, home and community care, long term care, physician services and drugs expenses per Health Profile Group.	• Calculated by dividing total health care expenditures for each HPC / HPG by the OHT population assigned to each HPC or HPG. • Health Profile Category (HPC) – CIHI has identified 16 HPCs that summarize condition by type and severity. • Health Profile Group (HPG) - CIHI has identified 239 HPGs that summarize an individual's clinical profile down to the most complex and clinically relevant health condition (i.e., each Ontario resident has been assigned to only one HPG). • S001 – Palliative state (Acute) • Q007 – Dementia (including Alzheimer's) with significant comorbidities.	Ministry of Health provides this data to OHT on a periodic basis (currently annually).	Palliative - <=$115.4M plus inflation Dementia - <=$78.8M plus inflation	<u>Palliative:</u> • Green – Less than or equal to $115.4M plus inflation • Yellow – Between $115.4M – $126.9M plus inflation • Red – Greater than $126.9M plus inflation <u>Dementia:</u> • Green – Less than or equal to $78.8M plus inflation • Yellow – Between $78.8M – $86.7M plus inflation • Red – Greater than $86.7M plus inflation