KW4 Ontario Health Team

Monthly Performance Measurement Report

March 09, 2022

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Summary

#	Indicator	Unit of Measure	Reporting Period	Proposed Target	Current Performance	Status
1	Caregiver distress among home care clients	%	Jan 2022	<= 56%	56.3	
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	Dec 2021	<= 20.40 monthly (61.20 quarterly) (244.80 annually)	20.1	
3	Alternate Level of Care (ALC) rate	%	Jan 2022	<=16.70%	27.0	
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Dec 2021	<=7.40%	14.0	
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	--	

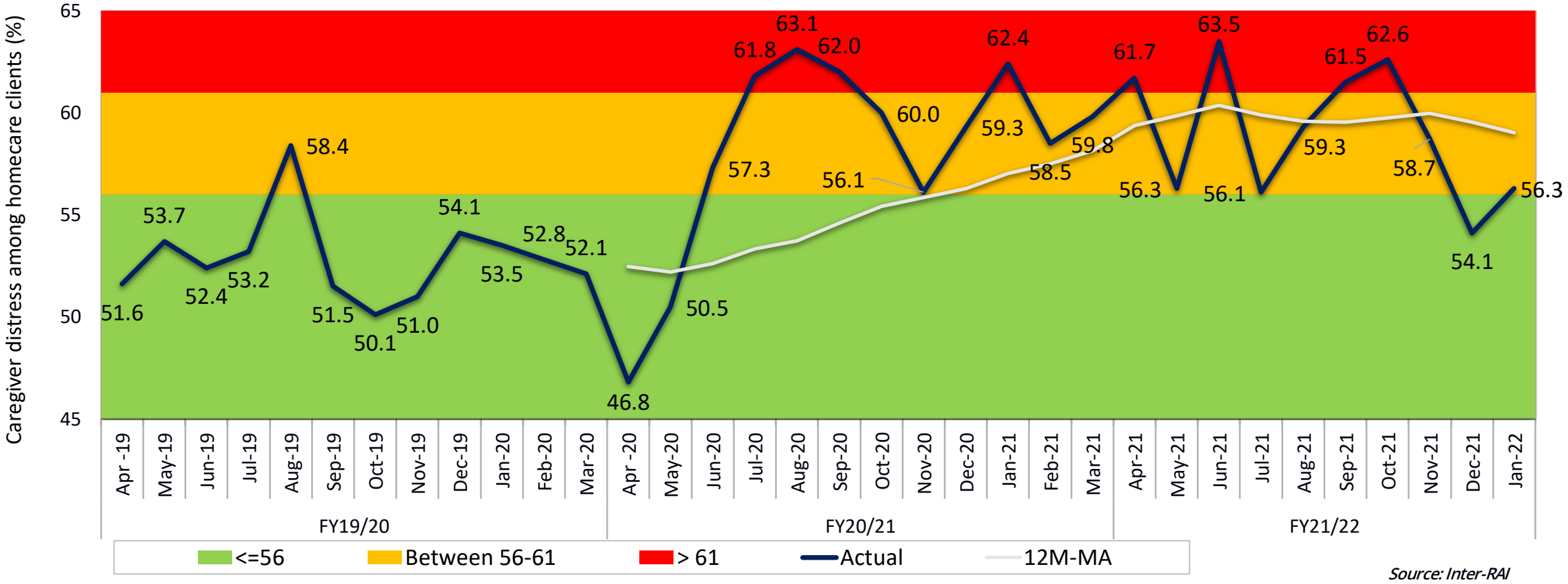
Performance Corridors: Greater than 10% of Target | Within 10% of Target | Meets Target

Data Availability

Indicator	Status - FY2021/22 data										Comments
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Caregiver Distress Among Homecare Clients (%)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Ambulatory Care Sensitive Conditions Best Managed Elsewhere (Rate)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	Jan 2022 data will be available by mid April 2022
ALC Rate (%)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Frequent ED Visits for Help with Mental Health and Addiction (%)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	SMGH: January 2022 data is not received yet
Total Expense/HPG Population for Palliative and Dementia (M $)	FY2017/18, FY2019/20										
	FY2020/21, FY2021/22										

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

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



Source: Inter-RAI

Over the past 2 FY's:

- This trend shows the pandemic-related level shift of increased caregiver distress after the first 3 months of the pandemic.
- The caregiver distress among home care clients is significantly increased since 2020 until October 2021 with some declines in November 2020, May 2021, July 2021, and December 2021.
- Tight admission criteria for LTC/ client or family choice not to enter LTC
- Staffing difficulties in home care
- Decreased access to other supports such as day programs and respite care

12M-MA : 12 months moving average

Caregiver Distress Among Homecare Clients Additional Commentary

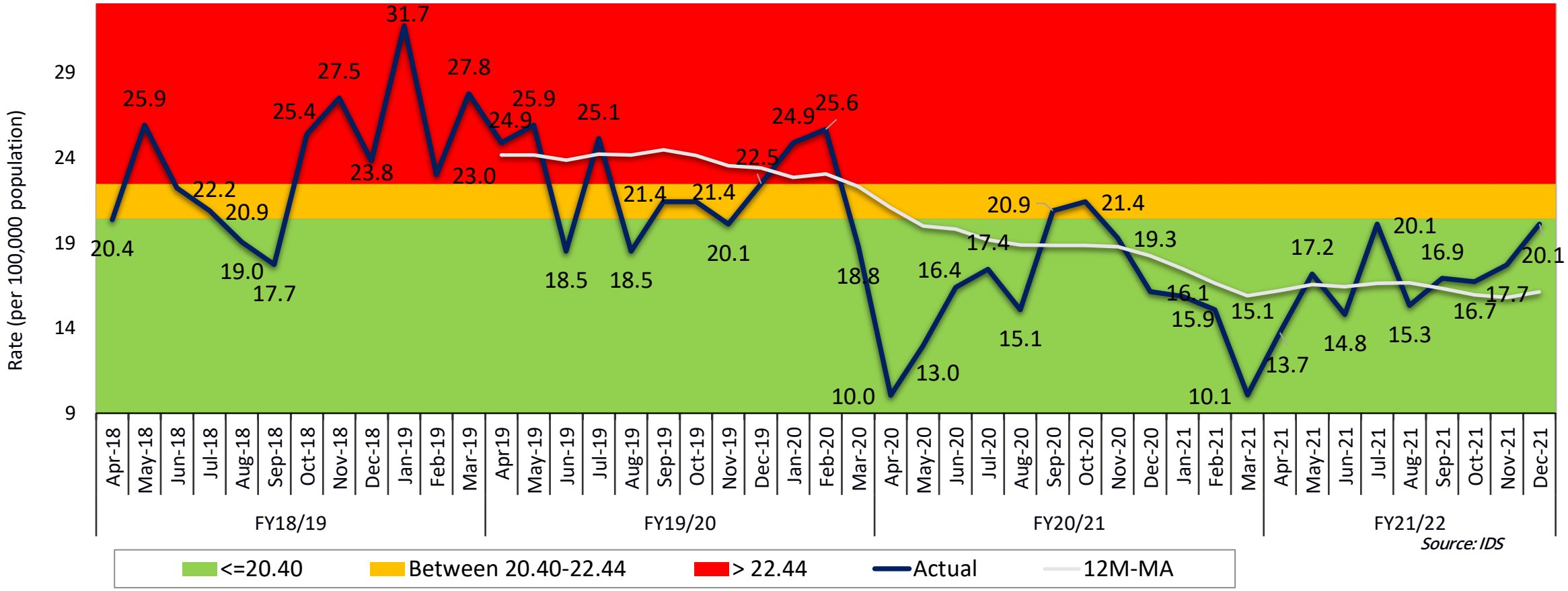
- **The calculation for this indicator is:**
  - **Numerator divided by the denominator times 100**
  - **Numerator - Total number of home care clients who, at the time of their most recent assessment in the given year, have an unpaid caregiver who is experiencing distress.**
  - **Denominator - Total number of long-stay home care clients with a caregiver at the time of their most recent assessment in the given year**

- **As of June 2021, the number of assessments completed during the pandemic had decreased - 11,000 prior to the pandemic and 4,800 during the pandemic (thereby decreasing the denominator). HCCSS added the interRAI Check-UP Self report tool as a telephone virtual option when a video virtual interRAI HC was not possible. Caregiver distress captured in other assessment modes (i.e. telephone/ virtual visits and self-assessment check-in tools) are not captured in this measure.**

- **As the various waves of the pandemic ebbed and flowed so to did HCCSS's ability to conduct in-persons visits.** At certain 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. It stands to reason that caregiver distress will increase the more urgent and complex a patients needs become and therefore as we limited visits to this population the number of caregivers experiencing distress would increase (**increase in the numerator).**

- As with all health care providers HCCSS during the first wave HCCSS invested heavily in virtual care and the change management necessary to support adoption. As HCCSS 'lived with' COVID, they have steadily increased their face to face visits including for completion of interRAI HC assessments whenever possible while also leveraging virtual assessments when necessary including as by patient choice.

Ambulatory Care Sensitive Conditions Best Managed Elsewhere (%): April 2018 to December 2021



Over the past 2 FY's:

- **This trend shows the pandemic-related level shift of decreased rate since April 2020, and it may be due to increased virtual care visits for Ambulatory Care Sensitive Conditions patients.**
- **The Ambulatory care sensitive conditions best managed elsewhere is performing better since April 2020 and below** the target value (rate) of 20.4

12M-MA : 12 months moving average

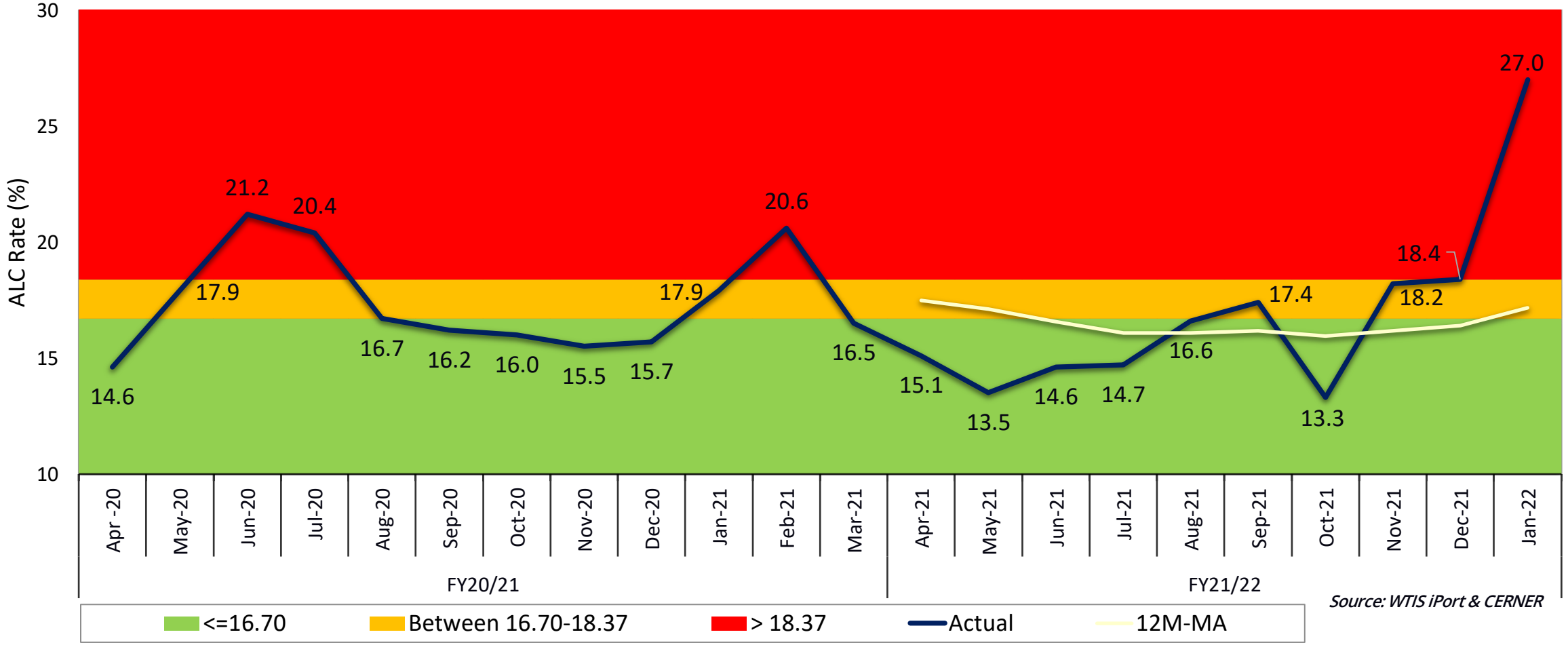
Ambulatory Care Sensitive Conditions Best Managed Elsewhere – Contributing Conditions

FY/Condition	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Trend
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	
Asthma	13	12	6	6	3	15	11	7	7	9	7	7	103	
COPD	24	27	24	21	16	12	22	23	22	23	31	18	263	
Diabetes	18	19	11	17	12	13	14	14	15	17	20	16	186	
Epilepsy	9	3	8	12	14	11	7	7	12	11	8	7	109	
Heart Failure	12	21	14	19	8	6	10	11	21	12	11	9	154	
Hypertension	4	3		7	3	5	2	3	2		4	2	35	
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	
Asthma	1		4	1		3	4	9	4	2	4	2	34	
COPD	11	12	11	13	13	15	17	8	9	7	8	9	133	
Diabetes	13	14	15	19	10	17	18	10	22	18	14	13	183	
Epilepsy	4	10	11	5	12	16	9	15	5	7	7	9	110	
Heart Failure	6	9	7	13	10	12	13	10	12	14	13	18	137	
Hypertension	1		3	5	6	2	4	4	4	4	2	4	39	
FY 2021/22	**74**	**65**	**56**	**77**	**58**	**64**	**67**	**67**	**76**				**604**	
Angina			1	4		1	3		2				11	
Asthma	7	2	3	5	1	11	5	9	8				51	
COPD	8	13	10	23	14	10	15	12	18				123	
Diabetes	25	17	11	16	16	14	12	14	18				143	
Epilepsy	5	6	12	9	13	10	9	10	7				81	
Heart Failure	25	22	17	15	10	17	19	19	21				165	
Hypertension	4	5	2	5	4	1	4	3	2				30	

Top contributing conditions per fiscal year:

- FY 2019/20 – COPD (30.2%), Diabetes (21.3%), Heart Failures (17.7%), Epilepsy (12.5%) and Asthma (11.8%)
- FY 2020/21 – Diabetes (27.9%), Heart Failure (20.9%), COPD (20.3%) and Epilepsy (16.8%)
- FY 2021/22 (Apr-Dec) - Heart Failure (26.5%), Diabetes (24.1%), COPD (20.2%), and Epilepsy (13.9%)

ALC Rate (%) - April 2020 to January 2022



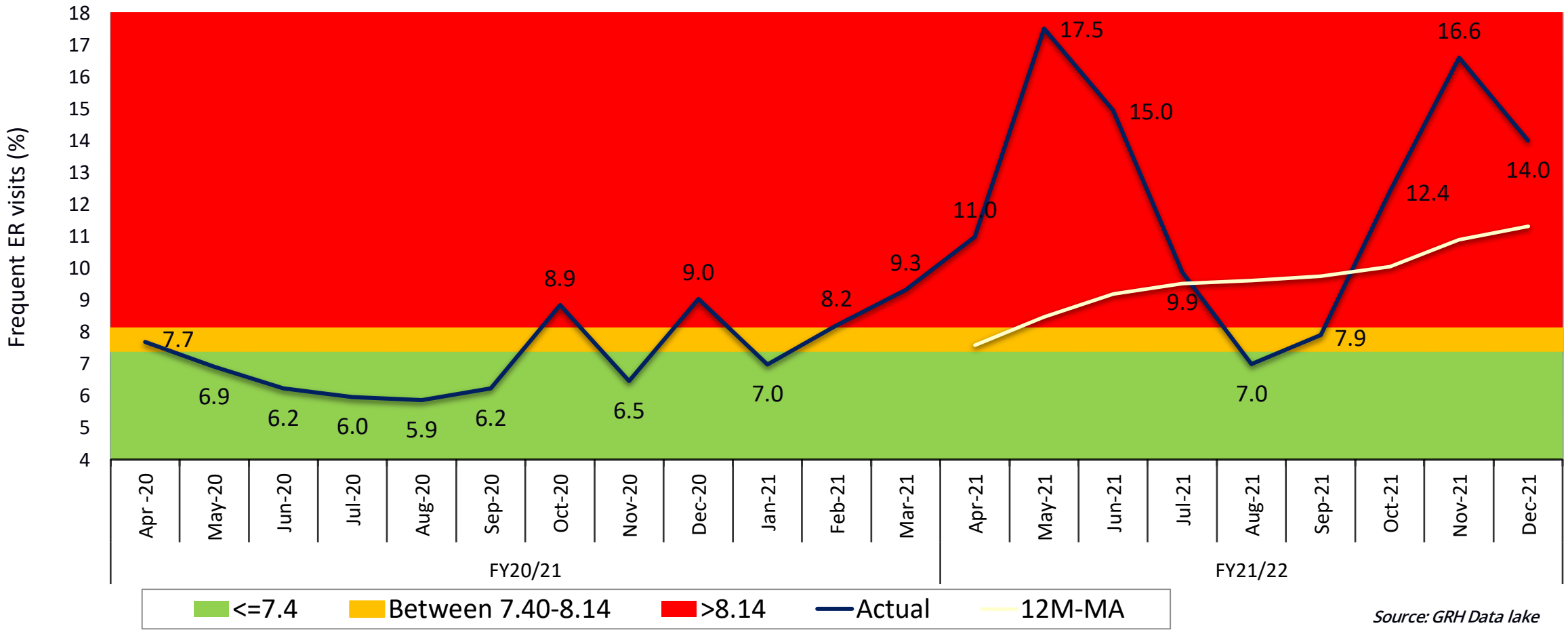
Source: WTIS iPort & CERNER

Since April 2020, KW4 ALC rate:

- **Has been at an overall average of 17.2%**
- **41.0% of the time above the target of 16.70%.**
- **Peak in Jun2020-Jul 2020 happened because GRH accepted patients from LTC homes that had outbreak**
- **Peak in Jan 2021-Feb 2021 happened because GRH accepted regional ALC patients from SMGH, CMH, etc.**
- There is a high peak in January 2022. GRH opened 48 additional ALC beds in January 2022 in response to Omicron.

12M-MA : 12 months moving average

Frequent ER Visits For Help with Mental Health & Addictions (%) - April 2020 to December 2021



Source: GRH Data lake

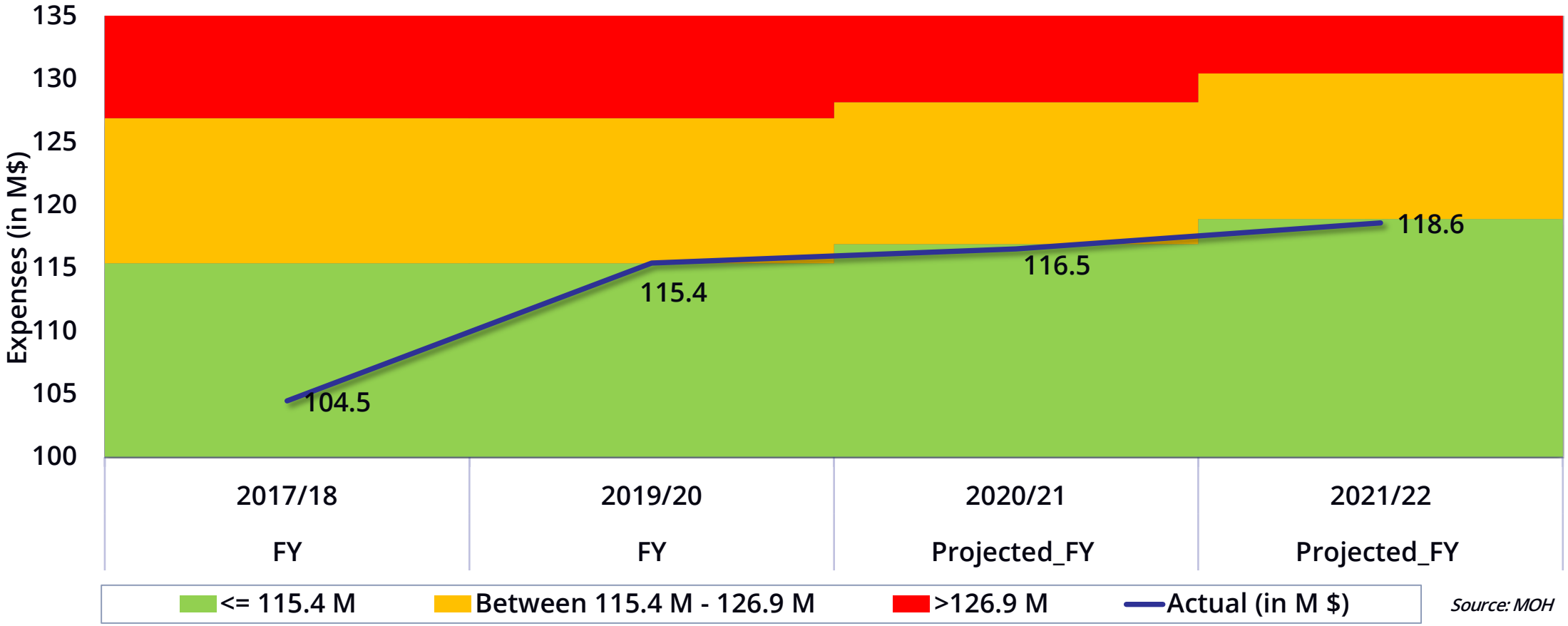
Over the past 2 FY's:

- **The frequent ER visits for help with mental health & addictions is significantly increased between February 2021 and June 2021 and there is an increase between October 2021 and December 2021 .**
- **Since FY2021/22, KW4 frequent ER visits for help with MH & A : 88.9% of the time above the target value of 7.4%**

Note: Some data issues encountered soon after the three fiscal years data is update in December,2021. The team is looking into the issue and the programming.

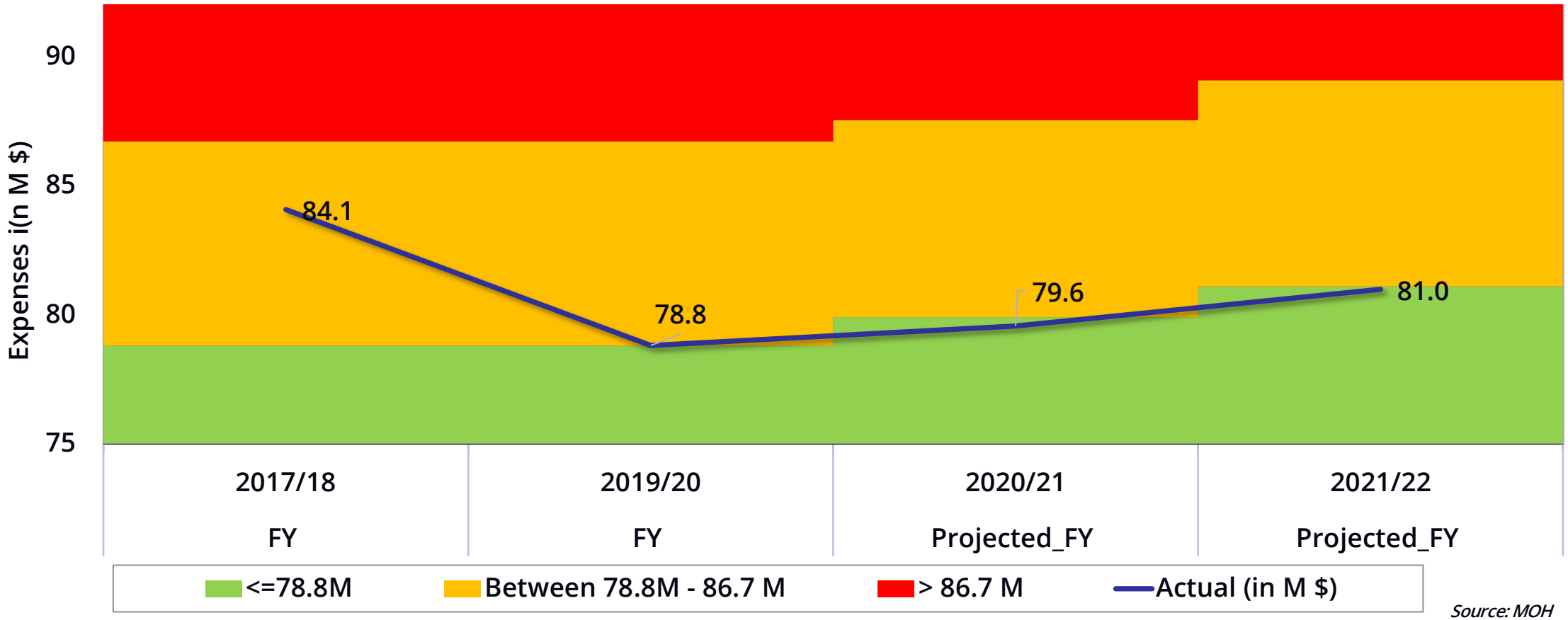
12M-MA : 12 months moving average

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 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

Alternate Level of Care (ALC) 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 • Numerator - Total number of individuals who had at least one emergency visit for mental health and/or addictions (MHA) in a fiscal year. The most recent visit in a fiscal year is the index visit. • Denominator - Total number of individuals in the denominator who had at least four emergency department visits for mental health and/or addiction in a 365-day period. Each individual has a 12-month look-back period prior to his or her most recent visit in a given year. Therefore, data for two fiscal years is necessary to obtain the data for the numerator. • 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)	<=7.40%	• Green – Less than or equal to 7.40% • Yellow – Between 7.40 – 8.14% • Red – Greater than 8.14%

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