Monthly Performance Measurement Report

November 28, 2022

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1. Summary – snap shot of current performance and current data availability
2. Performance details for each measure
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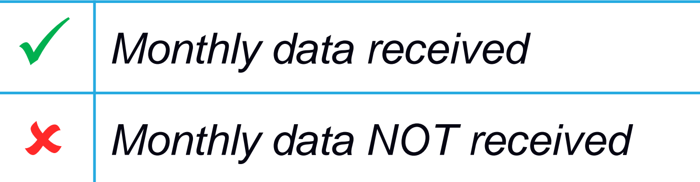
Summary : Latest Month Report

#	Indicator	Unit of Measure	Reporting Period	Proposed Target	Current Performance	Status
1	Caregiver distress among home care clients (%)	%	Sep 2022	<= 56%	57.6%	
2	Hospitalization rate for conditions that can be managed outside hospital (asthma, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, angina and epilepsy)	Rate per 100,000 population	Aug 2022	<= 20.4 monthly (61.2 quarterly) (244.8 annually)	15.4	
3	Total ALC (Acute and Non-Acute) (%)	%	Sep 2022	<=16.7%	20.1%	
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions (%)	%	Aug 2022	-	15.8%	
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 (YTD) 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 (please refer to accompanying Briefing Note)
4. Frequent ED Visits for Help with Mental Health and Addiction (%)	✓	✓	✓	✓	✓	✗							Data Source: NACRS
5. Total Expense/HPG Population for Palliative and Dementia ($M)	FY2019/20												Data is updated annually by MOH. OH will be releasing cost of care on it's dashboard by EO March 2023. As a result details related to this measure are not included in this report
	FY2019/20												



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

Caregiver Distress Among Homecare Clients

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

Caregiver distress among homecare clients (%)

65
60
55
50
45

63.5 63.1 62.6 62.4 62.0 61.8 61.7 61.5 60.0 59.8 59.3 59.3 58.7 58.6 58.5 58.4 57.8 57.8 57.7 57.6 57.3 57.2 56.7 56.3 56.3 56.1 56.1 54.1 54.1 53.7 53.5 53.3 53.2 52.8 52.4 52.1 51.6 51.5 51.0 50.5 50.1 46.8

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20
FY19/20

Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21
FY20/21

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22
FY21/22

Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
FY22/23

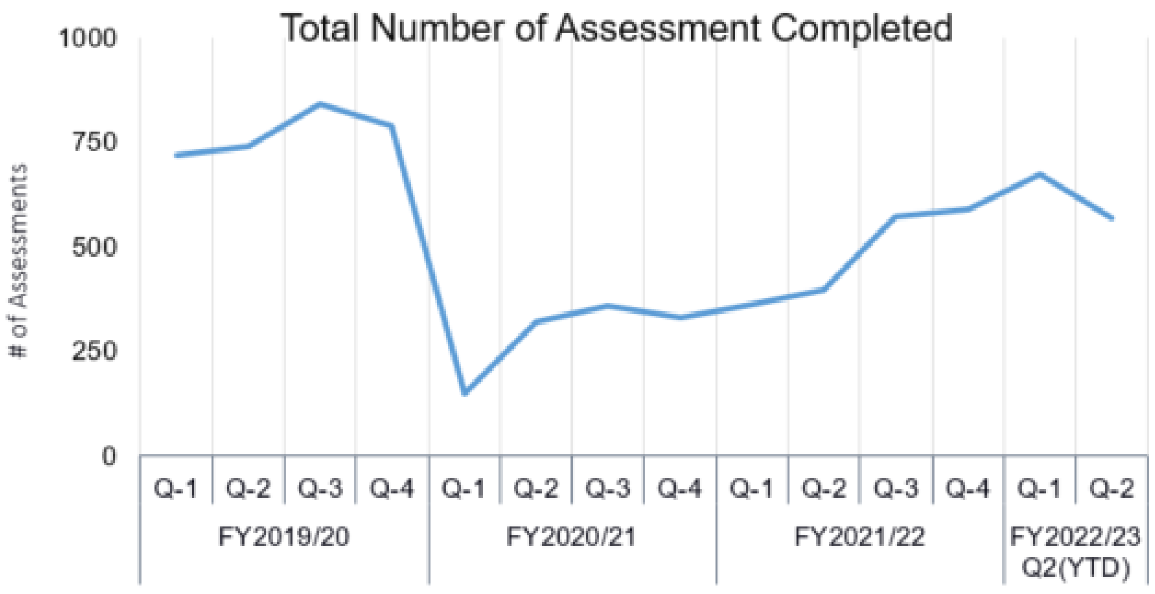
<=56 | Between 56-61 | > 61 | Actual | 12M-MA

Source: Inter-RAI
12M-MA : 12 months moving average

- Caregiver distress among homecare clients increased significantly during the pandemic and continued relatively high until October 2021
- The downward trend began during the recovery period, however to date, remains higher than the set target

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

FY/Qtr	FY2019/20	FY2020/21	FY2021/22	FY2022/23 Q2(YTD)
Q-1	720	151	361	673
Q-2	740	322	397	570
Q-3	841	359	572	
Q-4	787	331	588	
Total	**3,088**	**1,163**	**1,918**	**1,243**



- 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 we are on track to increase again, if completion rates remain consistent throughout the rest of this year (1,243 interRAI HC assessments were completed in the first half of the year).

Caregiver Distress Among Homecare Clients - Commentary

Contributing Factors:

- The pandemic **limited face-to-face visits** and the ability to complete interRAI Homecare Assessments (which our data is based on). It is important to note that other non face to face assessments of complex patients occurred during the timeframe which did not use the interRAI HC as the assessment tool. The interRAI HCA it's not a tool that is validated using a virtual platform,
- **Staffing shortages, long wait time for LTC , and limited access to day programs or respite care** are some of the contributing factors to increased caregiver distress.

Moving Forward:

- Neighbourhood Integrated Care Team (NICT) Project
  - KW4 OHT is developing a Neighbourhood Integrated Care Team Model (NICT) in our four priority neighbourhoods to **identify high-risk clients and support them and their caregivers in the community** through an integrated model of care that includes primary and community care.
  - As part of this initiative we will examine how we can utilize established partnerships (i.e. Bloom) or build new partnerships whereby dedicated, consistent **teams provide staff who "wrap around" patients/families presenting to ED with Caregiver burnout for a defined period of time** (i.e. 3 weeks). The aim is to **assist families and caregivers with feeling more confident in managing their care at home for as long as possible**.

- Home and Community Care Support Services (HCCSS)
  - HCCSS WW has **added a number of overflow agencies** to support access to care over the last quarter in order to maximize their capacity to support patients in the community. These contracts with overflow agencies (privately paid agencies) contain no volume guarantees and are used to augment service when partner agencies are unable to meet their market share volumes.
  - Not yet implemented, but currently underway, is HCCSS **campaign to increase the number of Retirement Homes providing all-in care** (i.e. PSW) in partnership with HCCSS WW. This care is funded by HCCSS but provided by Retirement Home workforce. Implementation is being targeted for this fiscal year.
  - HCCSS WW has initiated discussion with the **Community Ward in-home team**. Scope, feasibility, and potential evaluation metrics are being discussed to determine if this evolving partnership is a viable option.

- Ontario Bill 7
  - While the **Bill** is designed to free up hospital beds for patients requiring hospital care, it **may increase caregiver distress**.

Ambulatory Care Sensitive Conditions Best Managed Elsewhere

Ambulatory Care Sensitive Conditions Best Managed Elsewhere (ACSC) (%): Apr 2019 to Aug 2022

Rate (per 100,000 population)

24
19
14
9

24.9 25.9 18.5 25.1 18.5 21.4 21.4 20.1 22.5 24.9 25.6 18.8 10.0 13.0 16.4 17.4 15.1 20.9 21.4 19.3 16.1 14.7 13.9 9.3 12.7 15.9 13.7 18.6 14.2 15.6 15.5 16.4 18.6 16.1 17.6 20.8 19.5 16.1 22.0 15.9 15.4

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22

FY19/20 FY20/21 FY21/22 FY22/23

<=20.40 | Between 20.40-22.44 | > 22.44 | Actual | 12M-MA

Source: IDS

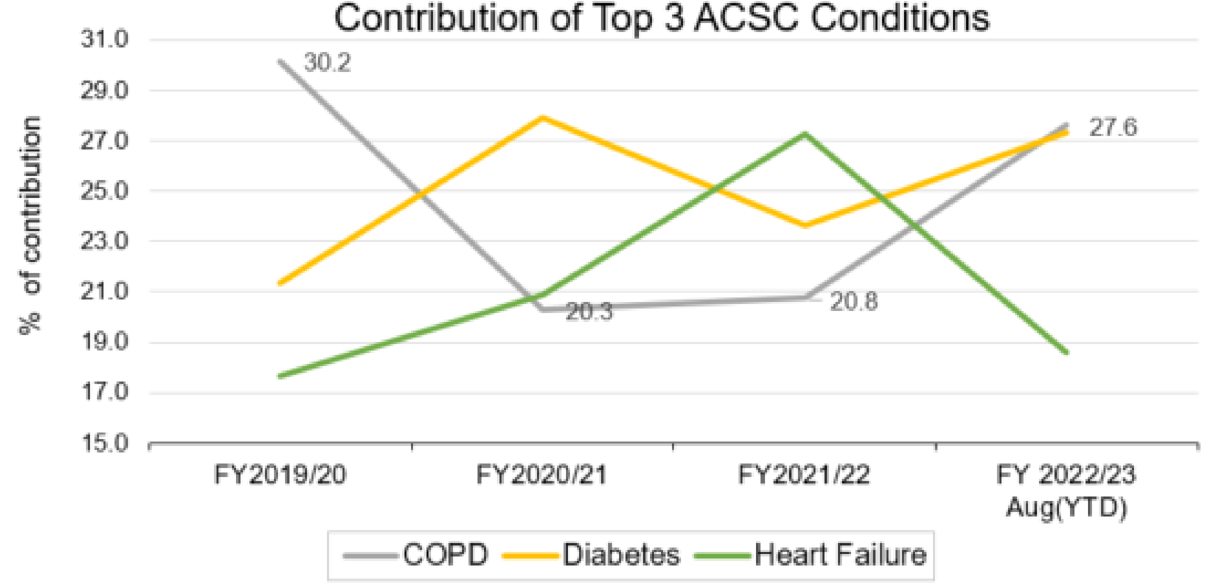
12M-MA : 12 months moving average

- Rate of ACSC best managed elsewhere decreased during the pandemic.
- This could potentially be an artificial decrease based on patient deferring to seek face-to-face care, or having the option of virtual care.
- In 2022, we are now seeing an increase in the rate however it is still below pre-pandemic levels.

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

Contribution of ACSC Conditions (in %) by Fiscal Year: FY2019/20 to FY 2022/23Aug(YTD)

Contributing Condition(%)	FY2019/20	FY2020/21	FY2021/22	FY 2022/23 Aug(YTD)
COPD	30.2	20.3	20.8	27.6
Diabetes	21.3	27.9	23.7	27.3
Heart Failure	17.7	20.9	27.2	18.6
Epilepsy	12.5	16.8	12.4	12.6
Asthma	11.8	5.2	9.7	7.7
Angina	2.5	3.0	1.9	1.9
Hypertension	4.0	5.9	4.3	4.4
Total	100.0	100.0	100.0	100.0



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%
- 73.5% in FY2022/23 Aug(YTD), with the most prevalent being 'COPD' at 27.6%

- **COPD** had a decrease of 9.9% points in FY2020/21, a slight increase of 0.5% points in FY2021/22, and **an increase of 6.8% points in FY2022/23(YTD)**

- **Diabetes** had an increase of 6.6% points in FY2020/21, a decrease of 4.2% points in FY2021/22, and a slight increase of 3.6% points in FY2022/23(YTD)

- **Heart Failure** had an increase of 3.2% points in FY2020/21, 6.3% points in FY2021/22, and **a decrease of 8.6% points in FY2022/23(YTD)**

COPD Commentary – Contributing Factors

Contributing Factors:

- In the beginning of the pandemic, SMGH's outpatient COPD program remained open for education and self-management advise
- Diagnostics testing continued, with a prioritization of confirming diagnosis vs follow-ups
- With the increasing hospitalization numbers, patients started self-canceling in-person appointments. When faced with an 80% no show/cancellation rate, the clinic closed to in-person appointments for diagnostic testing and RRT staff were re-assigned the to help the ICU burden
- **COPD appointments moved to virtual only. A third of the team were reassigned to inpatient demands**
- After the surge of wave 1 these **COPD programs re-opened as an in-person/virtual split model** trying to see new referrals in person and follow-up appointments virtually. COPD appointments restarted at the CHC sites at the same time SMGH re-opened their onsite clinic
- Diagnostic testing re-opened at a reduced capacity to allow for infection control requirements (80-85% capacity) with a focus on seeing new referrals first. There was a significant reduction in referrals received during this period so SMGH was able to quickly work away at cancelled and delayed testing. The reduced referrals may have been in part due to reduced primary care access or providers assuming SMGH was still closed to testing
- The **COPD activation program**, a 4-week in-person exercise program designed to help reduce ED visits and hospital re-admissions was **shut down** due to infection control guidelines. **In the late summer/fall of 2020 it re-opened virtually**. In Jan-March 2022 SMGH developed and launched a more elaborate version using a OH remote care monitoring grant.
- Many COPD exacerbations that require hospitalization are related to infections. The isolation and personal protective equipment requirements that were in place for Covid also protected patients with respiratory disease. **The increase in rates for 2022 reflects the removal of public PPE measures and expanded social circles, etc. which increased the transmission rates for respiratory infections and COPD exacerbations** much like we are seeing in the pediatric population since schools reopened.
- Also suspect there is some element of delayed diagnosis and or treatment over the last 2+ years but we are unable to quantify it.

Courtesy of Danny Veniott, Program Manager - Respiratory Therapy, Airway Clinics and Innovation Lead - Department of Strategy, Innovation and Communications, SMGH

COPD Commentary – Moving Forward

Moving Forward:

- Diagnostic testing has reopened to 99% of pre-covid services
- In-person COPD appointments continue to increase. SMGH also continues to offer telephone or virtual options
- SMGH started offering airway clinic referrals at SMGH via the Ocean e-referral platform for primary care instead of the previous FAX-only based model. This has been well used by primary care but not so much with the specialist groups
- The COPD program is involved in the joint GRH/SMGH Webex virtual visit pilot program using the PHIPA compliant Webex platform from within Cerner, their electronic health record vendor. So far staff and patients are finding it easier to use than OTN which will result in better ongoing use of the technology
- SMGH received special funding to operate a home-based Virtual COPD Activation program for those patients who cannot come to the onsite location for various geographical, socioeconomic, transportation or other barriers. This funded program will allow enrollment of patients in the program between November 2022 and April 2023. The enrollment target is 50 patients by March 31, 2023. SMGH is collecting data to make the business case for a permanent program so that the service is not lost after the OH funding ends

Courtesy of Danny Veniott, Program Manager - Respiratory Therapy, Airway Clinics and Innovation Lead - Department of Strategy, Innovation and Communications, SMGH

Heart Failure – Commentary – Contributing Factors

Contributing Factors:

- **Remote Care Monitoring** initiatives that have been put in place since March 2022 at SMGH for Congestive Heart Failure has had a significant positive impact (i.e. decrease in heart failure hospitalizations)
- **Access to primary care and specialists has also increased** this year compared to the past two fiscal years thereby diverting hospital visits/admissions

Courtesy of Brandon Douglas, Director, Regional Cardiac Program and Critical Care Program, SMGH

- SMGH in collaboration with Evidence2Practice Ontario, Centre for Effective Practice, eHealth Centre of Excellence and North York General participated in a use care 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 EMRs with versions for OSCAR and Accuro coming in 2023. This can assist clinicians with identifying, tracking and supporting at-risk patients as well as resources to support medication plan management.
    - Hospital Information System enhancements that support existing workflow and improve quality of care. "The work we have done with the pilot has re-confirmed many of the clinical care standards we had in place as a regional cardiac centre. We enhanced the application of best practices, allowing any physician (not just cardiologists) with a patient in heart failure to use our heart failure orders and be guided through the best evidence-based care".
    - Standardized clinician-facing discharge summaries as well as patient-facing discharge summaries

Courtesy of Dr. Amelia Yip, Heart Functional Lead and Cardiologist, SMGH and the Evidence2Practice Ontario November 19th webinar

Heart Failure – Commentary – Moving Forward

Moving Forward:

- Remote Care Monitoring (RCM) and Surgical Transition Program:
    - 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 100 patients by March 31, 2023.
    - 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.

- Neighbourhood Integrated Care Team (NICT) Project
    - KW4 OHT is developing a Neighbourhood Integrated Care Team Model (NICT) in our four priority neighbourhoods to **identify high-risk clients and support them in the community** through an integrated model of care that includes primary and community care.
    - Our goal is to prevent ER visits and prevent hospitalizations by improving the health and wellness of residents living in the community through enhanced support.
    - As part of the NICT project we aim to address **upstream initiatives** including ambulatory care sensitive conditions that could be best managed in the community.
    - Through education and connections to care in the community we hope to **support patient independence** to safely and successfully manage their care at home for as long as possible.

- Clinical Pathway Development
    - Initial results from the work culminating in the go-live in mid-October, show promising developments - e-Consult in particular.
    - The pathway is undergoing several tests and results will be used to inform the next iteration.
    - The CHF development team is expanding their membership to include more primary care physicians, NPs, and the KW4 OHT SCOPE Nurse Navigator. They will be meeting on December 12th, 2022 to review the test results and plan next steps.

Alternative Level of Care (ALC)

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

<=16.70 | Between 16.70-18.37 | > 18.37 | Actual | 12M-MA

Source: CCO-ALC Rates Report

- Overall, KW4 ALC rate have been fluctuating over the past 3.5 years, and total ALC rate shows an increase year over year since the beginning of the pandemic
- YTD Sep 2022, ALC rate is 19.1% which is 1.6 percentage points higher than the overall average of 17.5% during the pandemic

Note: This indicator has been updated as per the new methodology.

12M-MA : 12 months moving average

	Open Cases				% of Cumulative ALC Days											
Facility	Volume (Sep 2022)	Volume (Sep 2021)	%Change (Sep 2022 vs. Sep 2021)	Cumulative ALC Days (Sep 2022)	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	44	15	300%	815	7%	23%	8%	2%	0%	0%	25%	0.1%	2%	0.2%	32%	0.7%
Grand River	116	104	12%	5002	50%	2%	6%	0%	0.8%	0%	27%	11%	3%	0.2%	0%	0.7%
Total	160	118	35%	5817	44%	5%	6%	0.3%	0.7%	0%	27%	9%	3%	0.2%	4%	0.7%

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

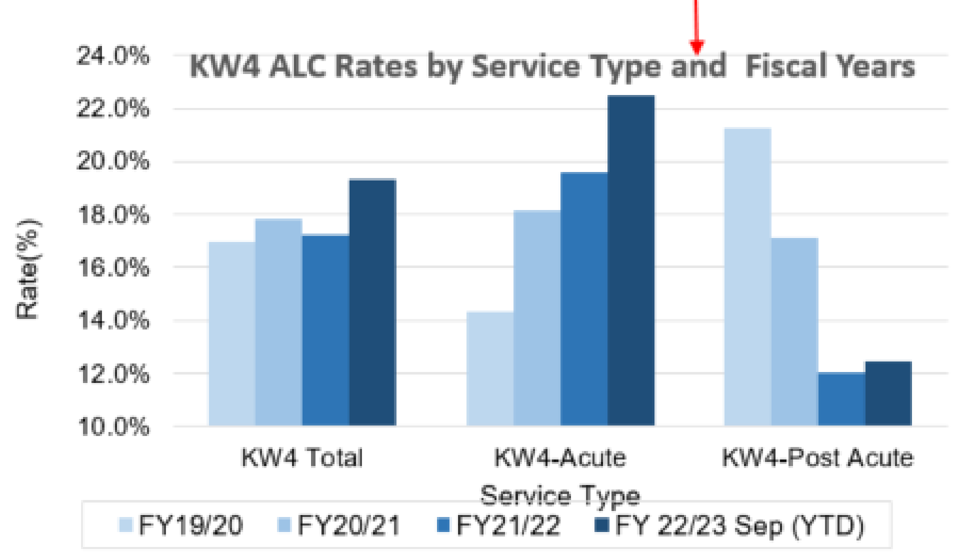
Source - Waterloo Wellington Sub-Region Monthly Alternate Level of Care Performance Summary – Sep 2022

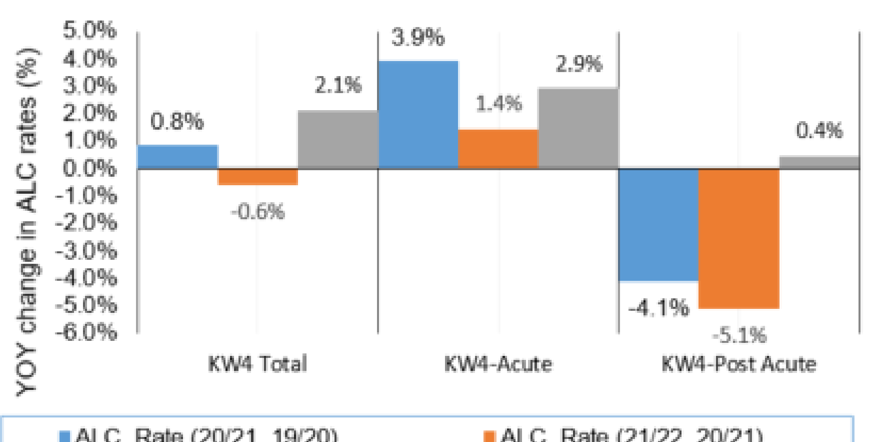
As of Sep 30, 2022:

- There were 160 patients designated ALC on the waitlist in the two KW4 OHT hospitals. This translates into 42 more cases compared to Sep 30, 2021
- These patients have accumulated 5,817 ALC days.
- Of the cumulative ALC Days 44% were attributed to patients waiting for Long Term Care, 27% waiting for Supervised or Assisted Living and 9% were waiting for Convalescent Care

ALC Rate by Facility, Service Type, and Fiscal Year FY19/20 to FY22/23 Sep (YTD)

Facility	ALC Rate				Year Over Year(YOY) Change in ALC Rates		
	FY19/20	FY20/21	FY21/22	FY 22/23 Sep (YTD)	Between FY 19/20 and 20/21	Between FY 20/21 and 21/22	Between FY 21/22 and 22/23 YTD
GRH	16.9%	19.1%	18.3%	20.4%	2.2%	-0.8%	2.1%
Acute	12.8%	20.5%	22.5%	25.7%	7.7%	2.0%	3.2%
Post Acute	21.2%	17.1%	12.0%	12.5%	-4.1%	-5.1%	0.4%
CCC	24.6%	18.4%	14.2%	12.9%	-6.2%	-4.2%	-1.3%
MH	20.7%	17.6%	10.6%	12.6%	-3.1%	-7.1%	2.0%
Rehab	11.3%	11.5%	10.0%	11.3%	0.2%	-1.5%	1.3%
SMGH-Acute	17.4%	13.3%	13.7%	15.6%	-4.1%	0.4%	1.9%
KW4 Total	17.0%	17.8%	17.2%	19.3%	0.8%	-0.6%	2.1%
KW4-Acute	14.3%	18.2%	19.6%	22.5%	3.9%	1.4%	2.9%
KW4-Post Acute	21.2%	17.1%	12.0%	12.5%	-4.1%	-5.1%	0.4%





Source: CCO-ALC Rate Report – Sep 2022

KW4 Total ALC Rate:

- increased 0.8% points between FY19/20 and 20/21
- decreased 0.6% points between FY 20//21 and 21/22
- increased 2.1% points between FY21/22 and 22/23 (YTD)
- **had an increase of 2.3% points over the last 3.5 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 2.9% points between FY21/22 and 22/23 (YTD)
- **had an increase of 8.2% points over the last 3.5 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
- increased 0.4% points between FY21/22 and 22/23 (YTD)
- **had a decrease of 8.7% points over the last 3.5 years**

Alternate Level of Care (ALC) - Commentary

Moving Forward:

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

- Complex Care Program (CCP), Integrated Care Team (ICT) Expansion Project
  - As part of Ontario's Plan to Stay Open, a proposal was submitted to **expand the existing CPP/ICT for Older Adults, and GeriMedRisk for upstream prevention of ALC designation** within the KW4 Ontario Health Team catchment area.
  - The proposal received OH West endorsement on October 21, 2022 and is currently awaiting Ministry of Health approval.
  - If approved, this proposal **aims to create a sustainable pathway for older adults living with frailty to avoid hospital visits and decrease the active number of alternate level of care designations**.
  - The expansion would allow for:
    - Support of 60-80+ older adults living with complex and chronic conditions who are rostered with primary care provider practices without an inter-professional team
    - Assessment and case management for 100+ high-risk older adults living in retirement homes
    - Support of 12-15 older adults waiting on the Specialized Geriatric Services (SGS) waitlist per week
    - Support for safe and timely discharge of up to 7 hospitalized patients in lieu of ALC designation or after ALC designation per week

- More Beds, Better Care Act
  - **Ontario Bill 7** was announced earlier in the fall and went into effect across Ontario's hospitals on Sunday, November 20. While the bill is designed to free up hospital beds for patients requiring hospital care, understandably it is causing concern for patients and their family members who fear their loved ones will be transferred to long term care facilities that are far from home. KW4 OHT hospitals along with HCCSS WW will ensure patients and their families will be treated with dignity and respect should they need to discharge them to more appropriate settings to ensure they receive the right care in the right place.

Alternate Level of Care (ALC) – Commentary Continued

Moving Forward:

- Transitional Care Beds
  - HCCSS WW is **expanding transitional care options** for community and hospital patients. Through partnerships with Highland Place and other Retirement Homes, innovative models are being considered for opportunities to open one or two transitional care beds on existing units rather than on an entirely new/separate unit.

- Repatriation Guidelines
  - **West Region Repatriation Guidelines** have now been implemented to support care closer to home. We previously had local guidelines and – now we have regional guidelines.

- Let's Go Home (LEGHO)
  - In July 2022, Community Care Concepts was approved by OH West to be the CSS organization for the Cambridge North Dumfries (CND) and KW4 OHT.
  - Through the **LEGHO** model, partners will develop a LEGHO program leveraging existing services and providers (with the possibility to add capacity) within their OHT to **support ED Diversion/Admission Avoidance and Hospital Discharge**.

- Coordinated Bed Access
  - HCCSS has restarted and are continuously improving **coordinated bed access to post acute sites through a HCCSS central waitlist.**

- Know Your Options
  - **'Know Your Options' information** has been refreshed, updated and shared through hospital communications to support care in the most appropriate place

Courtesy of Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington

Frequent Emergency Department Visits

for Help with Mental Health and Addictions

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

Frequent ER visits (%)

25
20
15
10
5

23.0 17.1 15.8 14.5 17.3 14.8 17.4 13.3 17.3 15.6 14.6 15.8 14.4 16.1 14.0 15.1 12.8 10.8 14.1 13.6 15.6 15.2 13.9 12.9 13.3 12.8 14.9 16.6 15.8

Apr -20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22

FY20/21 FY21/22 FY22/23

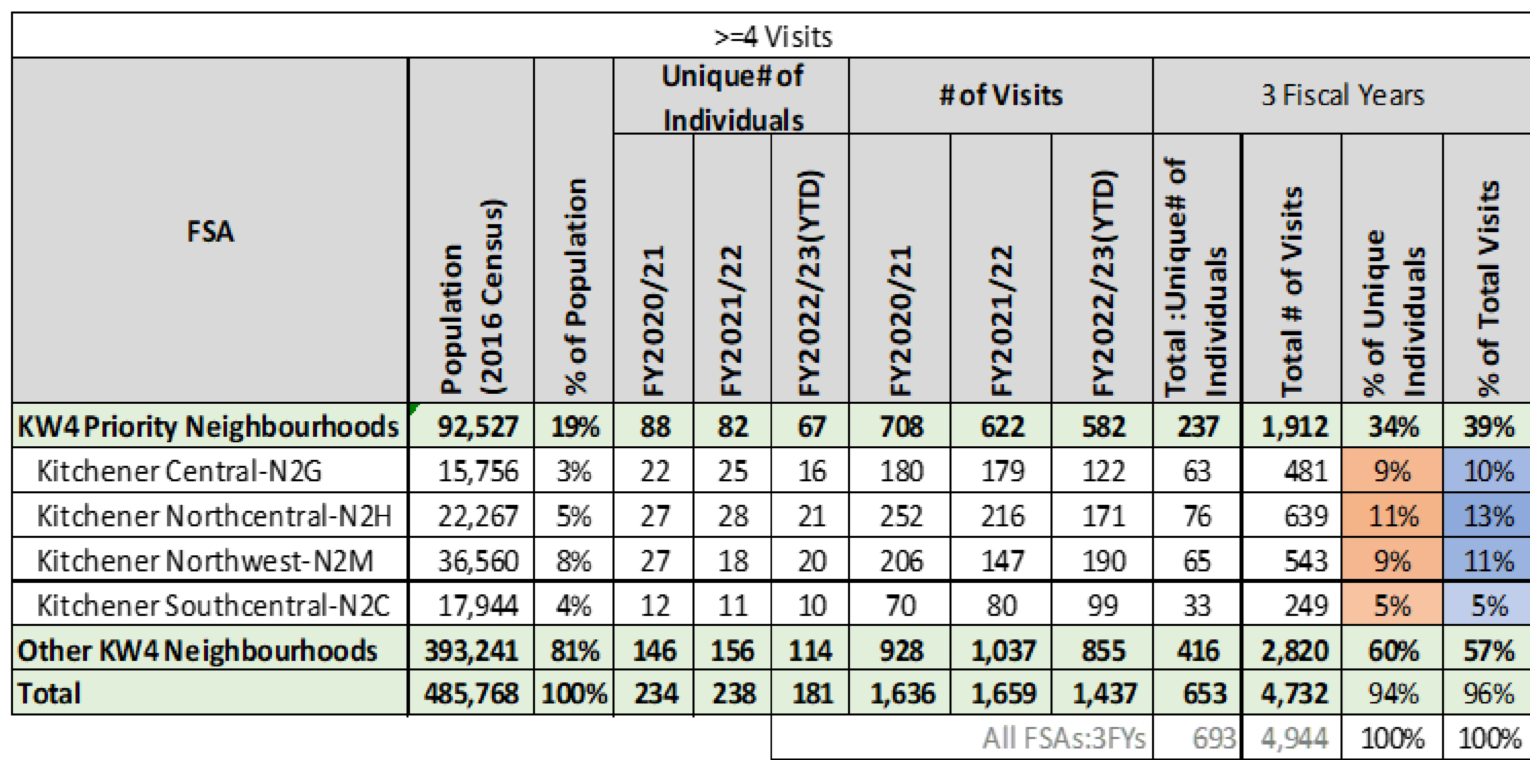
Actual 12M-MA

Source: GRH Data lake

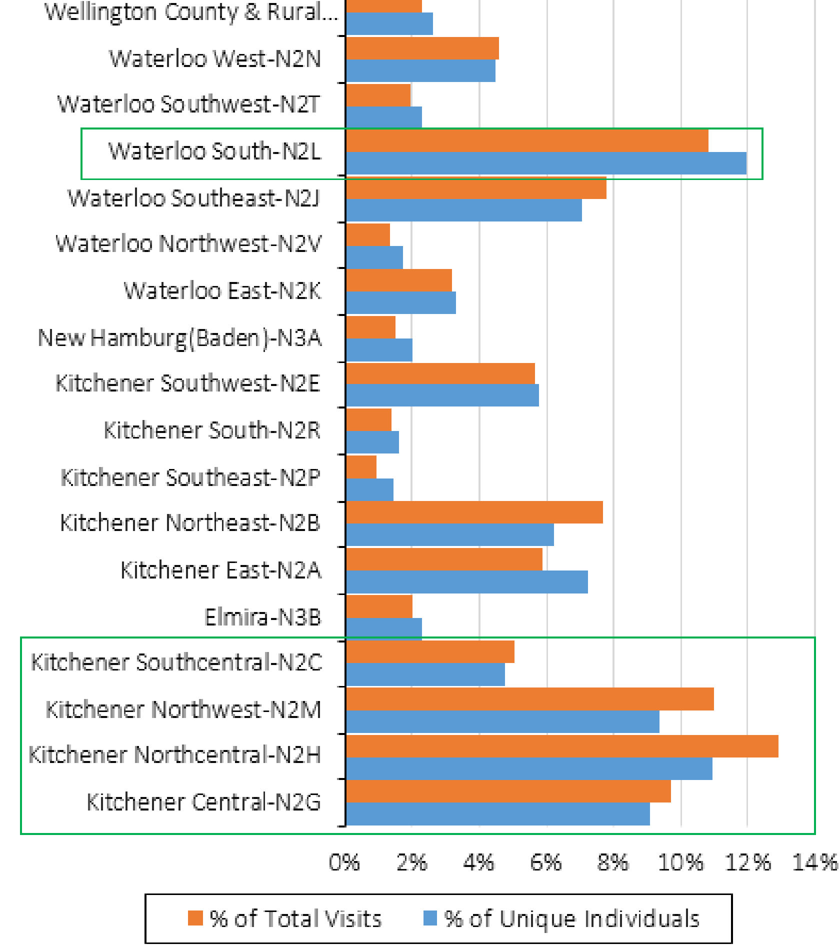
12M-MA : 12 months moving average

- Overall, there has been a downward trend in frequent ER visits for help with mental health & addictions with a slight uptick this current fiscal year.

Unique # of Patients and ED Visits by KW4 Forward Sortation Areas in FY 2020/21 to FY2022/23 Aug(YTD)



>=4 Visits												
FSA	Population (2016 Census)	% of Population	Unique# of Individuals			# of Visits			3 Fiscal Years			
			FY2020/21	FY2021/22	FY2022/23(YTD)	FY2020/21	FY2021/22	FY2022/23(YTD)	Total :Unique# of Individuals	Total # of Visits	% of Unique Individuals	% of Total Visits
KW4 Priority Neighbourhoods	**92,527**	**19%**	**88**	**82**	**67**	**708**	**622**	**582**	**237**	**1,912**	**34%**	**39%**
Kitchener Central-N2G	15,756	3%	22	25	16	180	179	122	63	481	9%	10%
Kitchener Northcentral-N2H	22,267	5%	27	28	21	252	216	171	76	639	11%	13%
Kitchener Northwest-N2M	36,560	8%	27	18	20	206	147	190	65	543	9%	11%
Kitchener Southcentral-N2C	17,944	4%	12	11	10	70	80	99	33	249	5%	5%
Other KW4 Neighbourhoods	**393,241**	**81%**	**146**	**156**	**114**	**928**	**1,037**	**855**	**416**	**2,820**	**60%**	**57%**
Total	**485,768**	**100%**	**234**	**238**	**181**	**1,636**	**1,659**	**1,437**	**653**	**4,732**	94%	96%
					All FSAs:3FYs				693	4,944	100%	100%



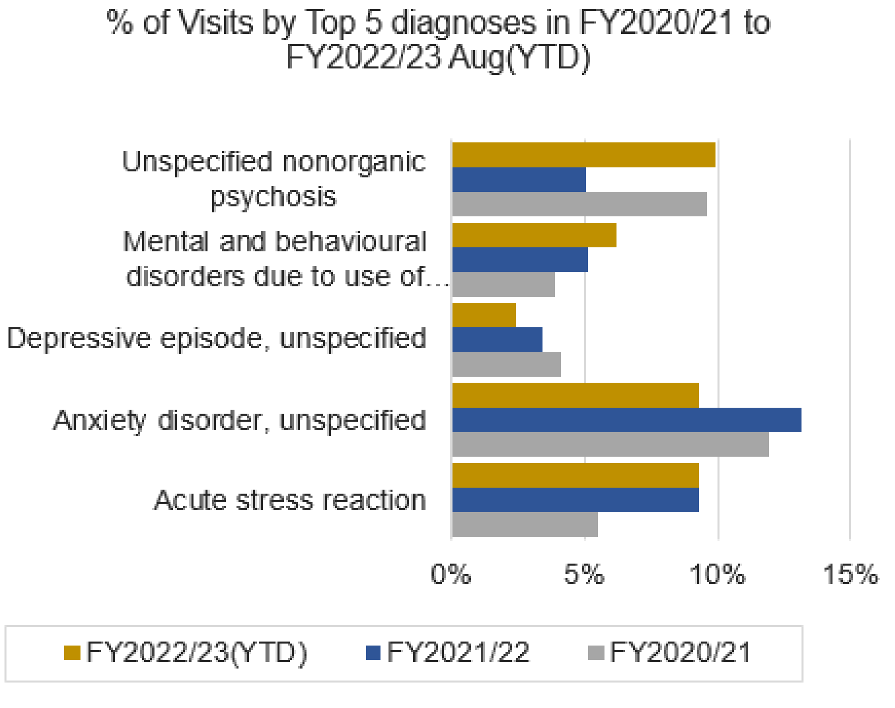
Between FY20/21 to 22/23 Aug YTD, 693 unique individuals had four or more ED visits for help with MH&A, totaling 4,944 visits in KW4 Region.

As per the 2016 census:

- our four priority neighborhoods (**N2C, N2G, N2H, N2M**) account for only 19% of KW4's population but 39% of the visits and 34% of the individuals
- the other fourteen KW4 neighborhoods account for 81% of KW4's population but 57% of the visits and 60% of the individuals
- one of these fourteen other KW4 neighborhoods which appear to be disproportionately represented was the Waterloo South neighborhood (N2L) which accounts for 6% of KW4's population but 11% of the visits and 12% of the individuals

Unique # of Patients and # of ED Visits by Top 5 Diagnoses in FY2020/21 to FY2022/23 Aug(YTD)

Diagnosis	Unique # of Individuals			# of Visits			Total Unique # of Individuals	Total # of Visits
	FY2020/21	FY2021/22	FY2022/23(YTD)	FY2020/21	FY2021/22	FY2022/23(YTD)		
Acute stress reaction	6.5%	9.4%	10.1%	5.5%	9.3%	9.3%	8.4%	7.8%
Anxiety disorder, unspecified	12.9%	14.5%	10.8%	11.9%	13.2%	9.3%	13.1%	11.9%
Depressive episode, unspecified	5.4%	3.6%	2.9%	4.1%	3.4%	2.4%	4.2%	3.5%
Mental and behavioural disorders due to use of alcohol, acute intoxication	4.3%	5.4%	5.0%	3.9%	5.1%	6.2%	4.9%	4.9%
Unspecified nonorganic psychosis	11.5%	6.2%	10.8%	9.6%	5.0%	9.9%	9.2%	7.8%
Total	40.6%	39.1%	39.6%	35.0%	36.0%	37.0%	39.8%	35.8%

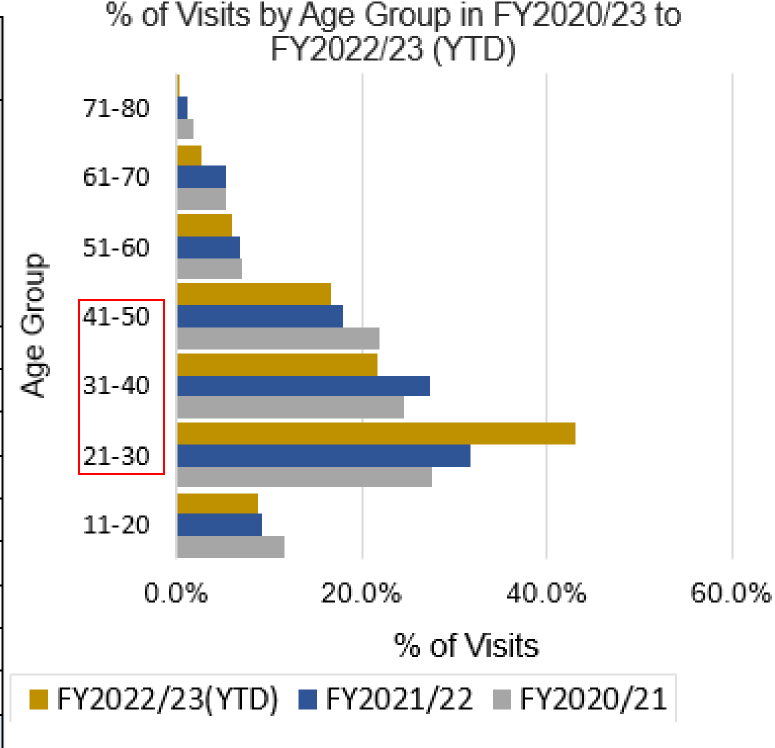


Diagnoses:

- The top 5 diagnoses codes accounted for 35.8% of visits for 39.8% of the individuals, with the most prevalent being 'Anxiety Disorder, unspecified' at 11.9% for the last 2.5 fiscal years.
- Anxiety Disorder had a decrease of 3.9% points, Depressive episodes by 1% points, and unspecified nonorganic psychosis increased by 4.9% points in the FY2022/23 (YTD).
- These diagnoses had an increased contribution with 1% in FY2021/22 and 1% in FY2022/23(YTD).

Unique # of Patients and ED Visits by Age Group in FY2020/21 to FY2022/23 (YTD)

Age Group	Unique # of Individuals(%)			% of Visits			Total % of Individuals	Total % of Visits	Average Visits per Person		
	FY2020/21	FY2021/22	FY2022/23(YTD)	FY2020/21	FY2021/22	FY2022/23(YTD)			FY2020/21	FY2021/22	FY2022/23(YTD)
0-10	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
11-20	14.4%	11.2%	9.4%	11.6%	9.2%	8.9%	12.1%	10.0%	5.6	5.8	7.2
21-30	27.7%	32.6%	37.4%	27.6%	31.8%	43.2%	31.6%	32.6%	6.9	7.0	8.7
31-40	24.5%	25.4%	23.7%	24.6%	27.4%	21.7%	24.7%	25.1%	6.9	7.7	6.9
41-50	18.7%	15.2%	18.0%	22.0%	18.0%	16.8%	17.2%	19.3%	8.1	8.5	7.0
51-60	7.2%	7.6%	7.2%	7.1%	6.9%	6.0%	7.4%	6.8%	6.9	6.5	6.3
61-70	5.4%	6.2%	2.9%	5.3%	5.4%	2.7%	5.2%	4.8%	6.8	6.3	7.0
71-80	2.2%	1.8%	0.7%	1.8%	1.3%	0.4%	1.7%	1.3%	5.8	5.0	4.0
81+	0.0%	0.0%	0.7%	0.0%	0.0%	0.4%	0.1%	0.1%			4.0
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	6.9	7.2	7.5



Age Groups

- The top three age groups listed below accounted for 77% of the visits and 73.5% of the individuals in the last 3 fiscal years:
  - 21-30 at 32.6% visits and 31.6%
  - 31-40 at 25.1% visits and 24.7%
  - 41-50 at 19.3% visits and 17.2%
- The age group '21-30' continued to increase since FY2021/22 with 4.8% points, and 11.4% and represented the largest increase in FY2022/23(YTD), 2.5 times higher than '41-50' and 2 times higher than the '31-40' age groups.
- The age group '21-30' had, on average, between 7 to 9 visits per person in the past three fiscal years.

Frequent ER Visits For Help with Mental Health & Addictions - Commentary

Moving Forward:

- Ontario Structured Psychotherapy (OSP) Program:
  - On April 21, 2022, Ontario Health officially announced that our region's **Ontario Structured Psychotherapy** (OSP) application submitted jointly by members of the Counselling Collaborative and the Centre for Family Medicine was approved.
  - We are excited that Waterloo Region is in the first wave of the broader rollout of this important program with a launch date of December 12, 2022.
  - The OSP program provides access to publicly funded, evidence-based, short-term, **cognitive behavioural therapy (CBT) and related approaches to clients with depression, anxiety, and anxiety-related conditions**.
  - Anxiety disorder and depressive episodes where 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.

- Neighbourhood Integrated Care Team (NICT) Project
  - KW4 OHT recognizes that this is a complex issue that requires system-wide partnership, planning and action.
  - As part of the NICT project we aim to understand the barriers encountered when accessing community MH&A care and involve patient, family and caregiver advisors and our Members in identifying opportunities and co-designing solutions.
  - To inform our work we will focus on better understanding the profile of those individuals, residing in our 4 priority neighbourhoods (N2G, N2H, N2M, and N2C), who present to the ER for MH&A as well as patients who are currently waiting for community-based care (i.e. individuals at risk for future presentation at the ER)

- Alternate Destination Model for Paramedic Services
  - The Region of Waterloo Public Health and Emergency Services (ROWPHE) and other Regional departments have been involved in the exploration of alternative mental health and additions (MHA) crisis response programming in the region.
  - Potential adoption of an Alternative Destination Model, a model adopted by London-Middlesex, was considered for Waterloo Region during recent brainstorming sessions with Paramedic Services and Waterloo Regional Police Services. A project team has been formed. As a key partner in the region, KW4 OHT has been asked to collaborate on the design, development and implementation. Initial meetings have been set for January 2023.

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	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	Palliative: • 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 Dementia: • 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