Monthly Performance Measurement Report

August 3, 2022

Table of Contents

Summary

#	Indicator	Unit of Measure	Reporting Period	Proposed Target	Current Performance	Status
1	Caregiver distress among home care clients	%	Jun 2022	<= 56%	57.8	
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	Apr 2022	<= 20.40 monthly (61.20 quarterly) (244.80 annually)	21.1	
3	Total ALC (Acute and Non-Acute) Rate	%	Jun 2022	<=16.70%	17.2	
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Jun 2022	-	14.9	
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	--	

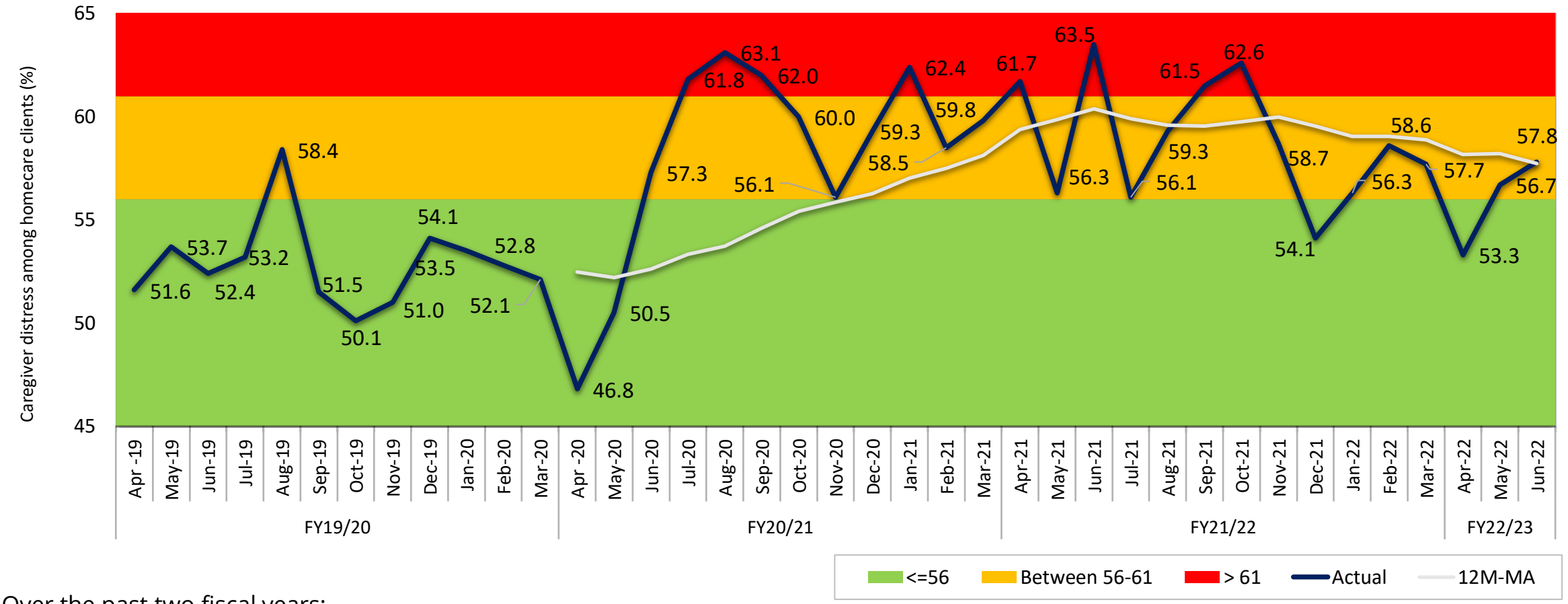
Performance Corridors: Greater than 10% of Target | Within 10% of Target | Meets Target

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 (%)	✓	✓	✓										
2. Ambulatory Care Sensitive Conditions Best Managed Elsewhere (Rate)	✓	✗	✗										Some hospital data is currently only available in IDS until April, 2022
3. Total ALC (Acute and Non-Acute) Rate (%)	✓	✓	✓										
4. Frequent ED Visits for Help with Mental Health and Addiction (%)	✓	✓	✓										
5. Total Expense/HPG Population for Palliative and Dementia (M $)	FY2019/20												
	FY2019/20												

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

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



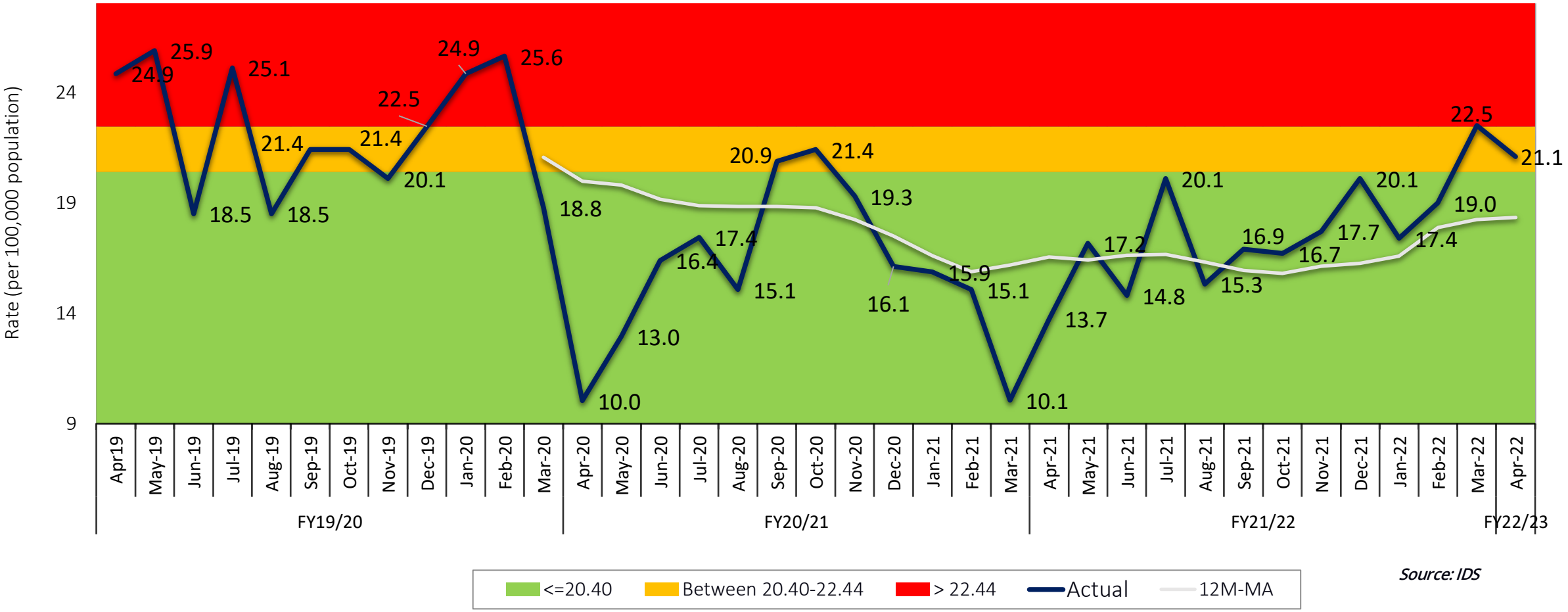
Over the past two fiscal years:

- 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 however we are recently beginning to see a slight downward trend.
- 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
- There was also decreased access to other supports such as day programs and respite care

Source: Inter-RAI

12M-MA : 12 months moving average

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



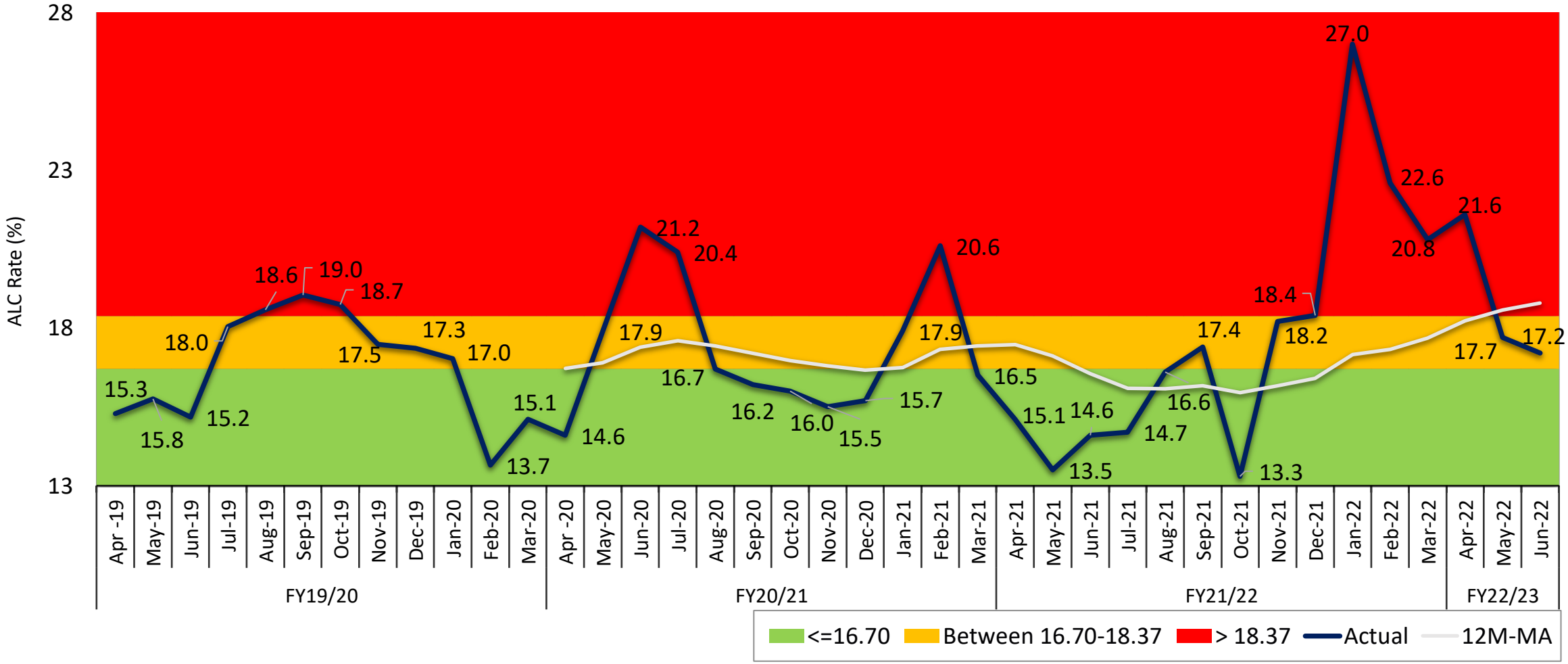
Source: IDS

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 (rate) of 20.4; however, the rate has been increasing since April 2021 and above the target value in March and April 2022.
- The top three conditions included Heart Failure, COPD and Diabetes.

12M-MA : 12 months moving average

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



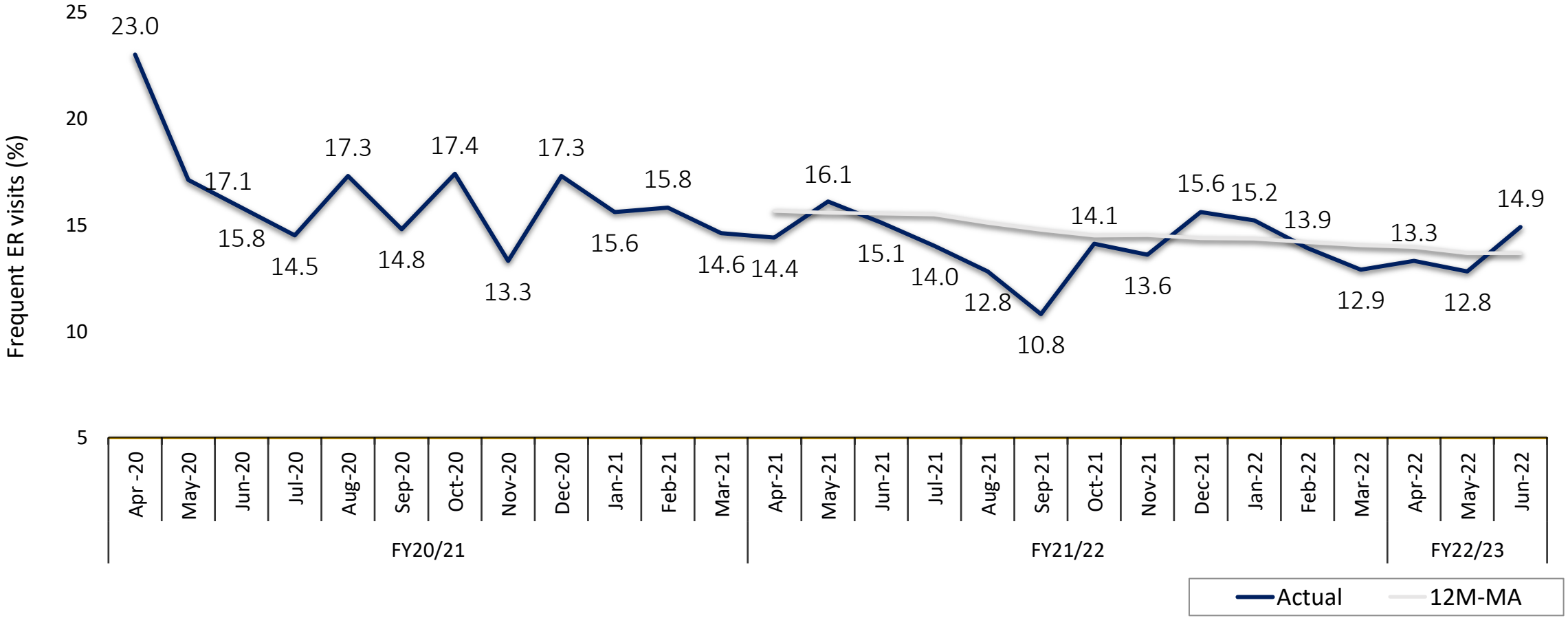
Since April 2019, KW4 ALC rate:

- Has been at an overall average of 17.4%
- 53.8% of the time above the target of 16.70%
- As the various waves of the pandemic ebbed and flowed so too did ALC

Source: WTIS iPort & CERNER

12M-MA : 12 months moving average

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



Over the past two fiscal years:

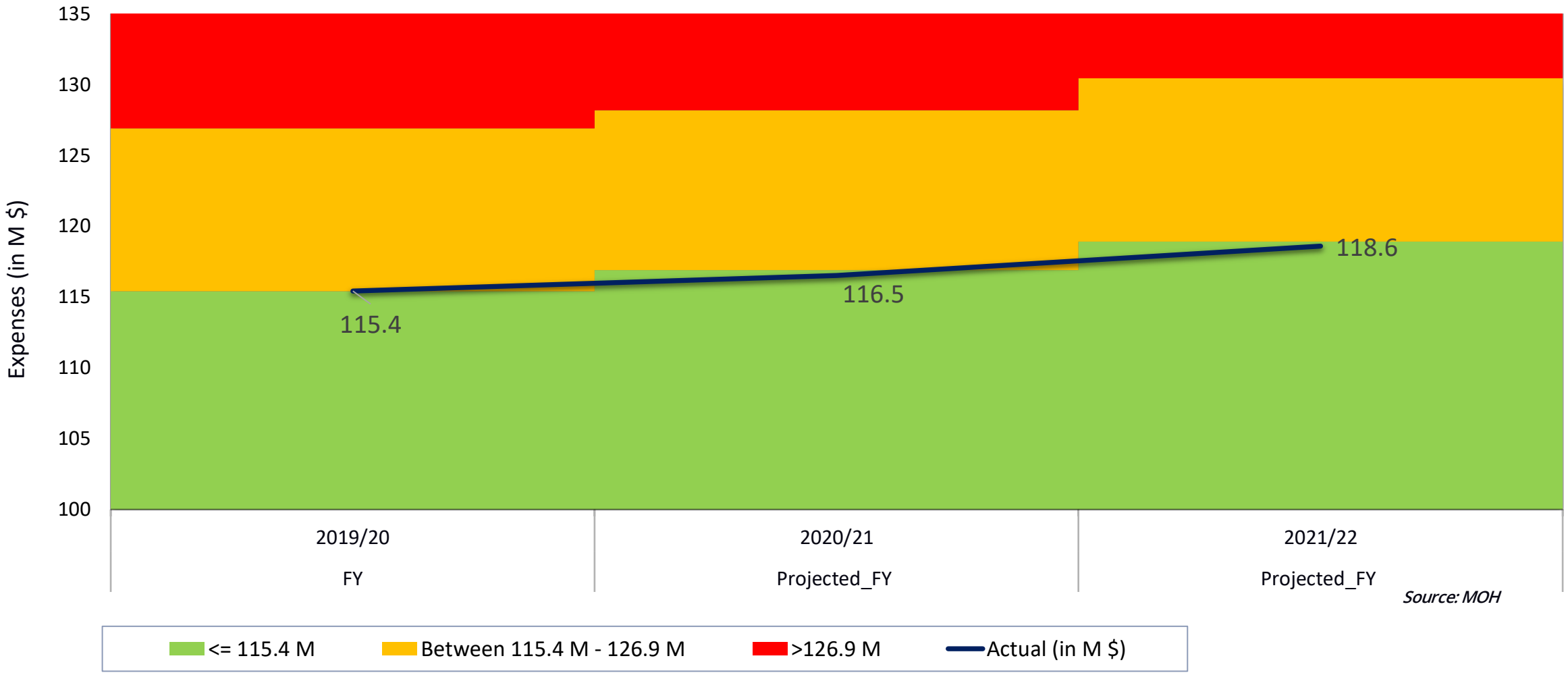
- There has been a downward trend in frequent ER visits for help with mental health & addictions.

Source: GRH Data lake

12M-MA : 12 months moving average

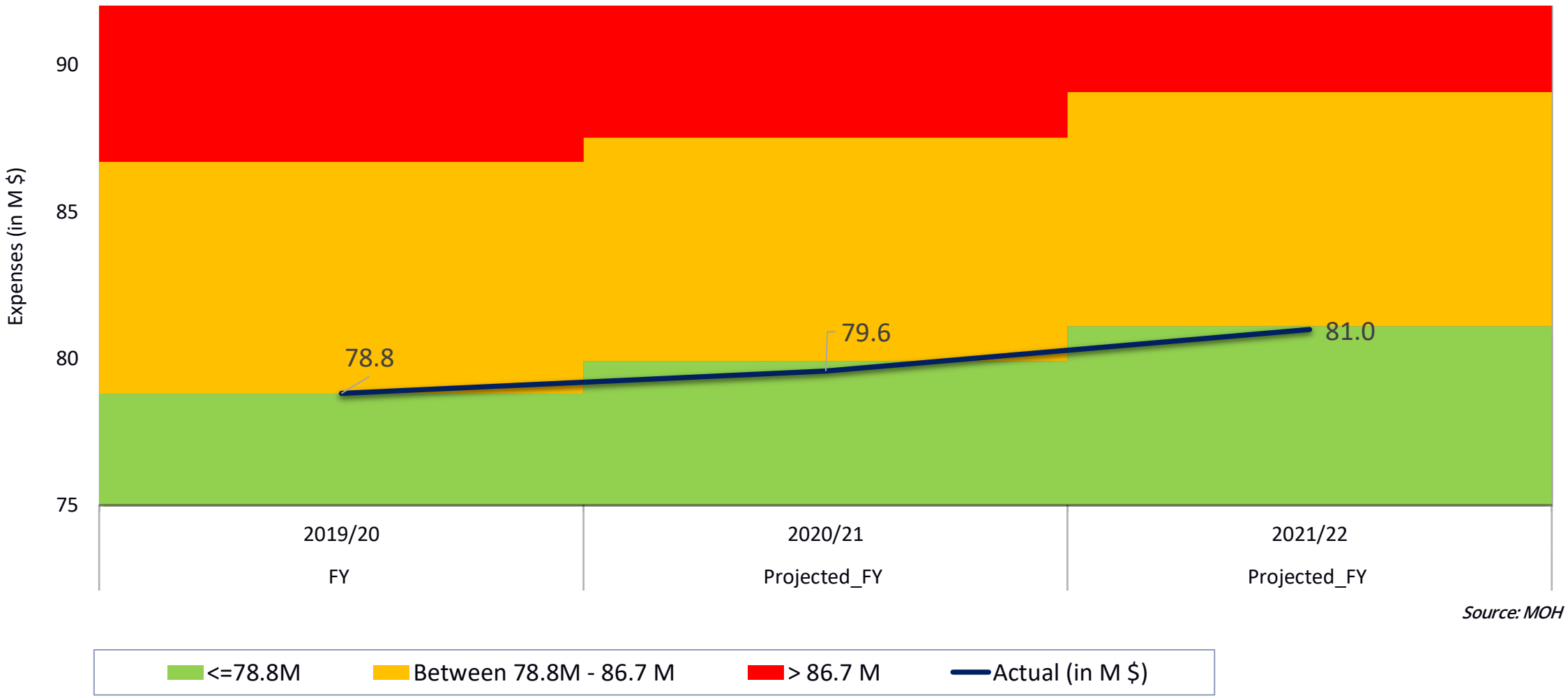
Note: This indicator has been updated as per the new methodology. The target still needs to be determined.

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



- 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 Dementia ($M)



Source: MOH

- 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.

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 – 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