KW4 Ontario Health Team

Quarterly Performance Measurement Report

May 2023

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Summary : Latest Month Report

#	Indicator	Unit of Measure	Reporting Period	Proposed Target	Current Performance	Status	Change since last report
1	Caregiver distress among home care clients	%	Mar 2023	<= 56%	52.3%		 Slight slippage from 52.2%
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	Feb 2023	<= 20.4 monthly (61.2 quarterly) (244.8 annually)	21.0		 Improvement from 22.7
3	Total ALC (Acute and Non-Acute)	%	Mar 2023	<=16.7%	20.4%		 Slippage from 18.0%
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Mar 2023	<=10.0%	12.8%		 Improvement from 16.9%

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

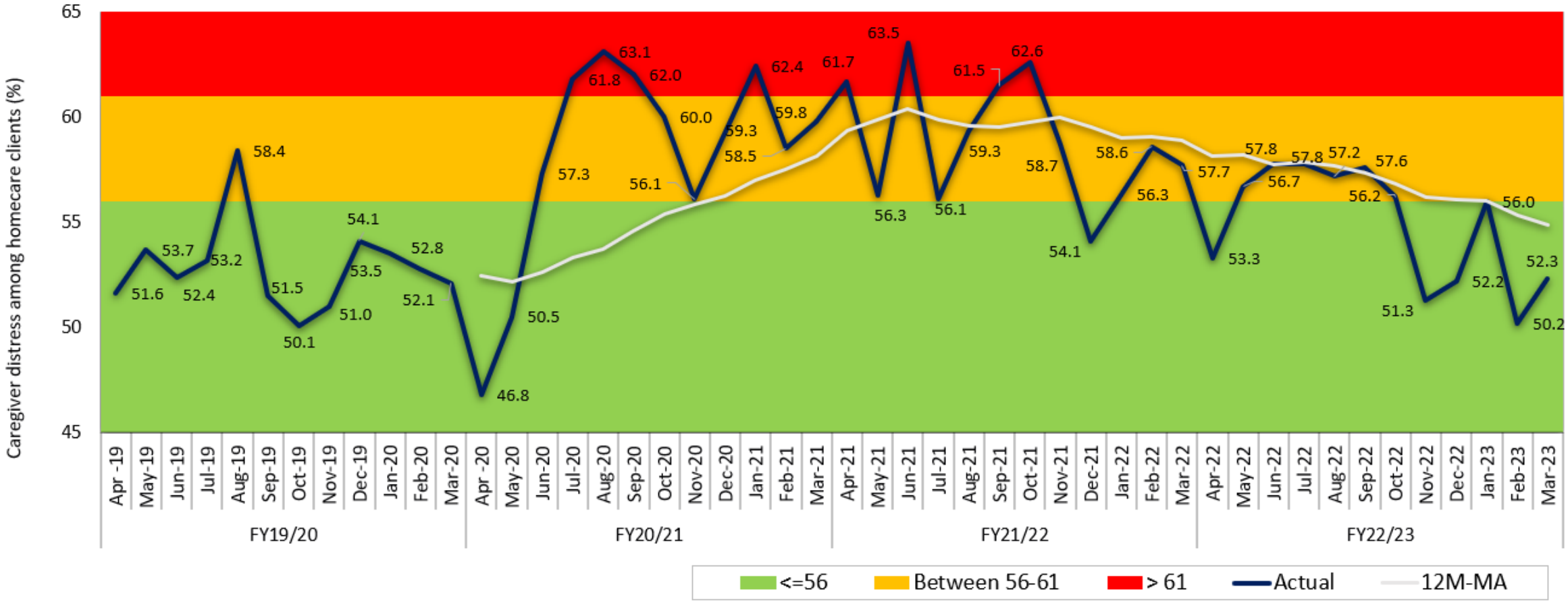
Data Availability

Indicator	Status - FY2022/23 data												Comments
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
1. Caregiver Distress Among Homecare Clients(%)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Date Source – Inter-RAI
2. Ambulatory Care Sensitive Conditions Best Managed Elsewhere (Rate)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✘	Data Source: IDS
3. Total ALC (Acute and Non-Acute) Rate (%)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Data Source: Change from DAD to CCO-WTIS
4. Frequent ED Visits for Help with Mental Health and Addiction (%)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Data Source: NACRS

✓	*Monthly data received*
✘	*Monthly data NOT received*

Caregiver Distress Among Homecare Clients

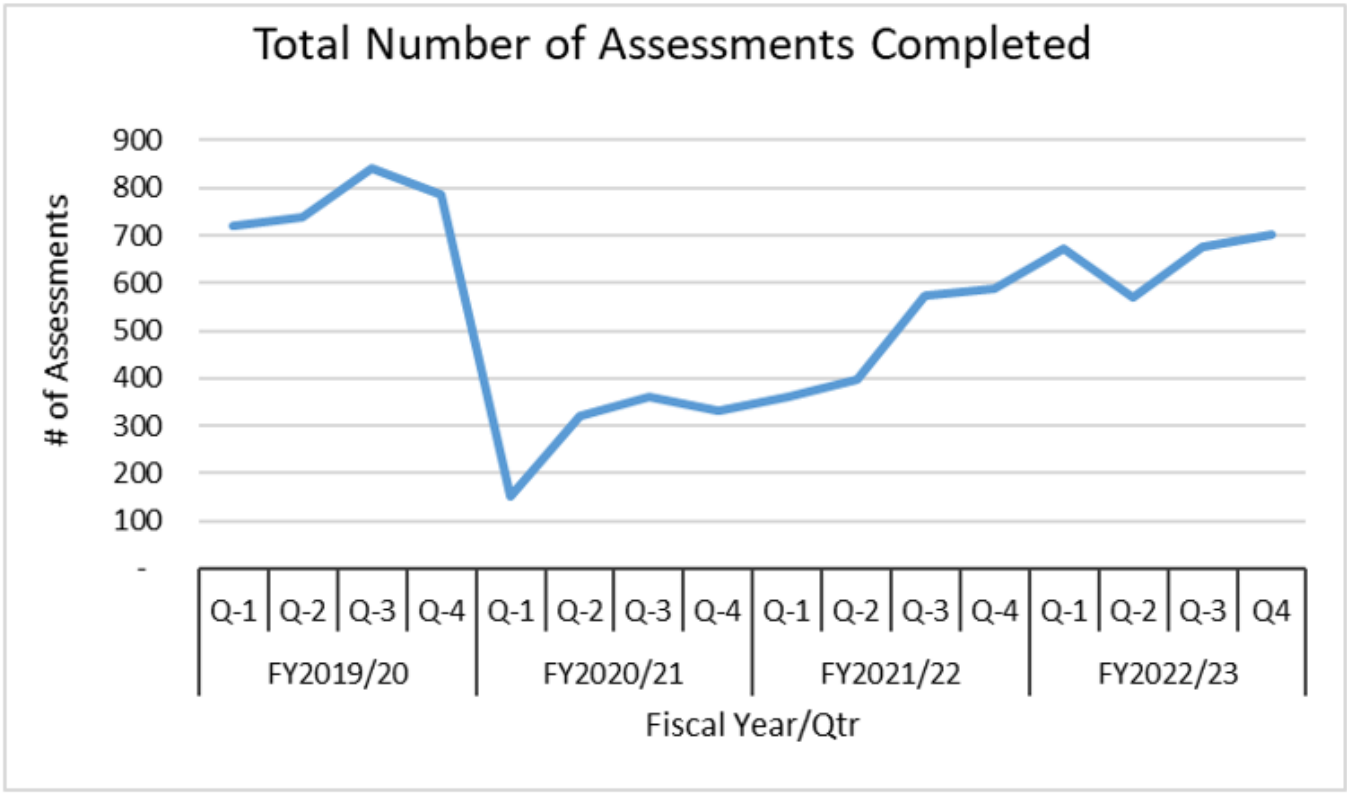
Caregiver Distress Among Homecare Clients (%): April 2019 to March 2023



- Caregiver distress among homecare clients increased significantly during the pandemic and continued relatively high until October 2021
- A downward trend then began, and since November 2022 we have been at or below the target we have set.

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

FY/Qtr	FY2019/20	FY2020/21	FY2021/22	FY2022/23
Q-1	720	151	361	673
Q-2	740	322	397	570
Q-3	841	359	572	677
Q-4	787	331	588	703
Total	**3,088**	**1,163**	**1,918**	**2,623**



- 3,088 interRAI HC assessments were completed in FY2019/20.
- This decreased significantly in FY2020/21 to 1,163 interRAI HC assessments.
- In FY2021/22 the number of assessments completed rose to 1,918, which is still below pre-pandemic levels but a jump from 20/21.
- In FY2022/23 the number of assessments completed rose to 2,623, which is a significant jump from 21/22 but still below the pre-pandemic level.

Caregiver Distress Among Homecare Clients - Contributing Factors

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 HCA as the assessment tool. The interRAI HCA is not a tool that is validated using a virtual platform. As the pandemic restrictions wane, the overall number of in-home assessments being completed are increasing and caregiver distress continues to improve for KW4.
- **Staffing shortages, long wait time for LTC , and limited access to day programs or respite care** were some of the contributing factors to increased caregiver distress during the beginning of the pandemic.
- As the pandemic continued, **more day program and respite care spots opened,** which may have contributed to the reduction in caregiver stress. There is an ongoing opening of community respite programs. Of note, short stay respite and convalescent care programs in long term care hasn't yet returned to KW4.
- The number of **face-to-face vs virtual visits has also increased** (including home visits) for primary care and the Alzheimer's society which also may have contributed to a decrease in caregiver stress.
- The **Let's go Home program (LEGHO)** was introduced in November 2022 as well as the **knowledge exchange on social prescribing** which may also have contributed to a decrease in caregiver stress.
- The support of **the community paramedic program** may also have reduced caregiver stress.
- Development of a **delirium collaborative** that will include education for caregivers on how to recognize signs of delirium earlier on which may contribute to decreasing caregiver distress.
- The **ICT/CCP model** of care, which provides support and wrap around services for patients and families who may be waiting for a specialist, may result in decreasing caregiver distress

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Caregiver Distress Among Homecare Clients - Moving Forward

Moving Forward:

- Retirement Homes
  - The HCCSS's campaign to increase the number of Retirement Homes providing all-in care (i.e., PSW) has begun implementation in Wellington. Expansion to KW is currently in the planning phases. This care is funded by HCCSS WW but provided by the Retirement Home workforce. Expansion is being targeted for later this fiscal year.

- YourCare+
  - YourCare+ provides tools to use in the home, send to a family member or friend, or share with health care professionals.
  - The **tool allows caregivers to explore information, tips, and resources to help them feel confident and stronger in their caregiver role** and provides advice about ways to protect their own health and avoid stress and burnout while caring for others.
  - This tool has been implemented in KW4 in collaboration with Dr Andrew Costa and team.

- Wellness Calendars
  - In collaboration with partners, we are producing a 2024 **wellness calendar** for older adults in the KW4 Region.

- SCOPE (Seamless Care Optimizing Patient Experience)
  - SCOPE is a joint SMGH-GRH program to **support KW4 primary care providers with clinical consultation for complex and urgent patients, including** helping with more efficient and seamless access to services that could decrease caregiver distress.

- Complex Care Program (CCP), Integrated Care Team (ICT) Expansion Project
  - In December 2022, the ministry provided 16 months of funding for an Integrated Care Team (ICT) Complex Care program (CCP) expansion to provide **wrap around services while patients are waiting to see a geriatrician**.

- Building HCCSS WW Capacity
  - HCCSS WW aims to build capacity in home care and the broader health care system and address health human resources shortages. One of the initiatives is to maximize/expand community clinics. This improvement initiative will be a focus in Q2/3. Currently, approximately 35% of nursing patients receive care in clinics. Optimization of rapid response nurses and direct care therapy to support patients waiting for service has demonstrated effectiveness in supporting patients requiring health care teaching, wound care, teaching of injections, home safety to enhance patient safety at home.

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Caregiver Distress Among Homecare Clients – Moving Forward

Moving Forward:

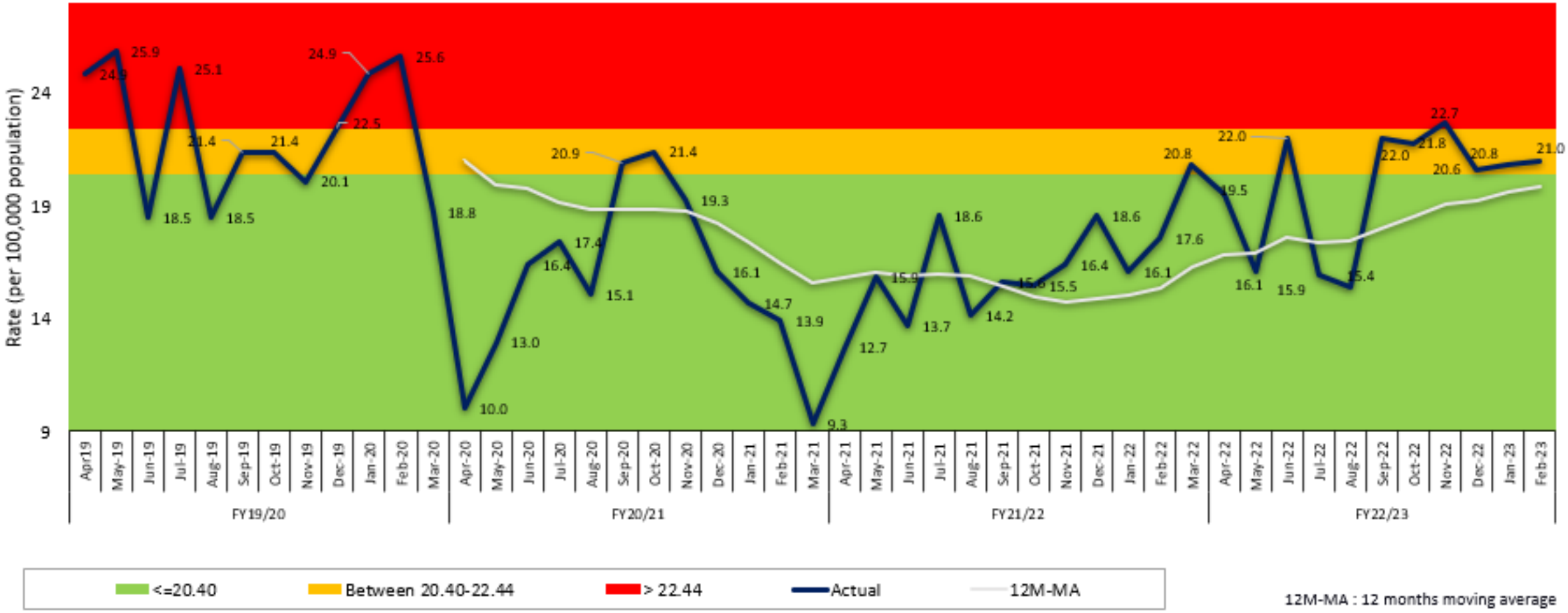
- Delirium Collaborative
  - The delirium collaborative is developing educational materials for patients, families, and clinical teams to assist with **recognizing early signs of delirium** in order to initiate interventions and supports sooner.

- Ministry of Health: A Plan for Connected and Convenient Care:
  - Care for seniors and those needing long-term care (LTC) continues to be a priority for the Ministry and OH
  - Some of these changes will happen immediately to address pressing issues, while others will be phased in over the months and years ahead
  - It will be important that KW4 continues to advocate for improvements for our community.
  - In their plan released February 2, 2023, progress to date and upcoming work related to seniors was shared including:
    - Over $1 billion is being invested over the next three years to assist families who rely on home care including **expanding access to home care services and recruiting and training more home care workers**.
    - Working with Ontario Health Teams and home and community care providers to **establish new home and community care programs**.
    - **Expanding the Community Paramedicine program** to help people with seniors live independently at home, where they want to be, by providing home visits for a range of services, including increasing assessments and referrals to local community services, such as home care.
    - **Expanding palliative care services** in local communities and adding new hospice beds.

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Ambulatory Care Sensitive Conditions Best Managed Elsewhere

Ambulatory Care Sensitive Conditions Best Managed Elsewhere (ACSC) (%): Apr 2019 to Feb 2023

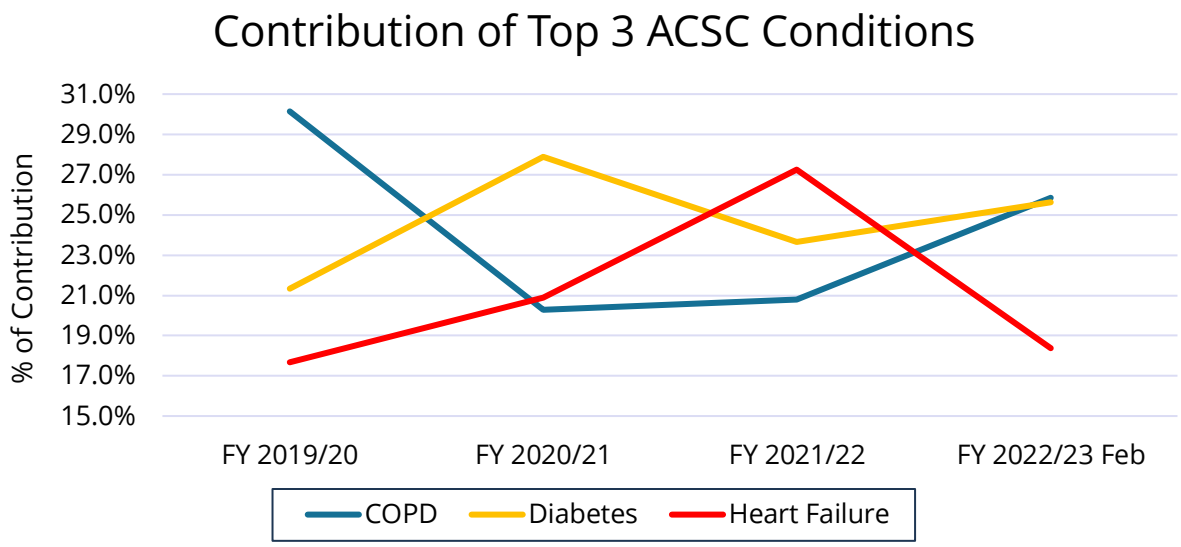


- Rate of ACSC best managed elsewhere decreased during the pandemic.
- This could potentially be an artificial decrease based on patient deferring to seek face-to-face care or having the option of virtual care.
- In 2022, we are now seeing an increase in the rates with the latest two quarters being above our target.

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

Contribution of Ambulatory Care Sensitive Conditions (in %) by Fiscal Year: FY2019/20 to FY 2022/23 Feb(YTD)

Contributing Conditions	FY 2019/20	FY 2020/21	FY 2021/22	FY 2022/23 Feb(YTD)
COPD	30.2%	20.3%	20.8%	25.9%
Diabetes	21.3%	27.9%	23.7%	25.6%
Heart Failure	17.7%	20.9%	27.2%	18.4%
Epilepsy	12.5%	16.8%	12.4%	11.3%
Asthma	11.8%	5.2%	9.7%	13.7%
Angina	2.5%	3.0%	1.9%	1.9%
Hypertension	4.0%	5.9%	4.3%	3.2%



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%
- 69.9% in FY2022/23 Feb(YTD), with the most prevalent being 'COPD' at 25.9%, followed closely by Diabetes at 25.6%

- **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 5.1% points in FY2022/23 Feb (YTD)**
- **Diabetes** had an increase of 6.6% points in FY2020/21, a decrease of 4.2% points in FY2021/22, and **an increase of 1.9% points in FY2022/23 Feb (YTD)**
- **Heart Failure** had an increase of 3.2% points in FY2020/21, 6.3% points in FY2021/22, and **a significant decrease of 8.8% points in FY2022/23 Feb (YTD)**

Contributing Factors

Contributing Factors:

COPD:

- Many COPD exacerbations that require hospitalization that we are seeing at SMGH are related to infections and newly diagnosed patients. 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 and 2023 reflects the removal of public PPE measures and expanded social circles, etc. which increased the transmission rates for respiratory infections and COPD exacerbations.**
- We are seeing lower than normal number of referrals for diagnostic testing and asthma education appointments at the hospital. We do not have an official cause but expect it may be multifactorial
    - Less patients seeking care
    - Providers assuming, we still have testing limitations in place
    - ED visit patients cancelling as they are feeling better
    - More focused on managing their disease due to the pandemic risks

Heart Failure:

- **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
- 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 TelusPS Suite EMRs with versions for OSCAR and Accuro coming in 2023. This heart failure tool leverages the most up-to-date evidence and best practices, and embeds quality standards, to assist clinicians in appropriate diagnoses, investigations, treatment, and transitions in care across the continuum. This can assist clinicians with identifying, tracking and supporting at-risk patients as well as resources to support medication plan management. An accompanying educational resource from CEP will support clinicians to fill knowledge gaps, build confidence and support them in diagnosing and managing patients living with heart failure.
    - Hospital Information System enhancements that support existing workflow and improve quality of care. "The work we have done with the pilot has re-confirmed many of the clinical care standards we had in place as a regional cardiac centre. We enhanced the application of best practices, allowing any physician (not just cardiologists) with a patient in heart failure to use our heart failure orders and be guided through the best evidence-based care".
    - Standardized clinician-facing discharge summaries as well as patient-facing discharge summaries

Courtesy of:

- *Brandon Douglas, Director, Regional Cardiac Program and Critical Care Program, SMGH*
- *Sarah Farwell, Director Strategy, Innovation and Communications, SMGH*
- *Danny Veniott, Program Manager - Respiratory Therapy, Airway Clinics, SMGH*
- *Dr. Amelia Yip, Heart Functional Lead and Cardiologist, SMGH and the Evidence2Practice Ontario*

Moving Forward – Diabetes and COPD

Moving Forward – Diabetes:

- Neighbourhood Integrated Care Team (NICT) Project
- Optimus has partnered with KW4 OHT to design patient personas, journey maps and **integrated care pathways**. One of the pathways being developed is for Newcomers with diabetes. Three interactive workshops have been completed and were well attended by various stakeholders with planning for the fourth workshop on June 15th well underway. The goal of this pathway is to increase knowledge of resources and services available in the KW4 region, provide strong system navigation and culturally competent care, improve chronic disease management in the community, reduce duplication of efforts between providers and reduce barriers to accessing care.

Moving Forward - COPD:

- Reminder to all providers that:
  - **SMGH's Airway clinic has fully reopened** all in person diagnostic testing and education sessions.
  - **SMGH is fully operational at Community Healthcare Clinic hosted COPD and Asthma education/self management programs** operated through Woolwich, Lang's, Kitchener Downtown and Guelph CHC's and including some of their remote program sites
- **In-person COPD appointments continue to increase**. SMGH also continues to offer **telephone or virtual options** when required or requested
- The COPD program continue to be involved in the **joint GRH/SMGH WebEx virtual visit program** using the PHIPA compliant WebEx platform from within Cerner, their electronic health record vendor. Staff and Patients continues to find it more user friendly than OTN
- SMGH ran a **successful virtual COPD activation remote/virtual care project** with great patient outcomes despite low referral numbers. Many of the patients referred wanted to come onsite after so many years of reduced social gathering. Operating a program that offers both in-person care and virtual care provides the ability for patients to choose the care that meets their needs and allows for flexibility in the patient's journey. The program aligned with the KW4 OHT's philosophy of using digital health solutions as enablers of care, while understanding that digital first is not always the best approach for every patient as care teams must adapt to meet the patient where they are at. The patients enrolled in the virtual program were those who mainly could not come to an onsite exercise program due to physical, emotional, geographical, and socioeconomic reasons. In most cases, patients would have had a combination of two or more of these factors which would have made access to onsite care even more challenging. This program is a great partnership with the KW4 OHT, especially the digital support team and communications teams. **SMGH is assessing and most likely adding the virtual option on a case-by-case basis to their current COPD activation program** to help those with true or perceived barriers to an onsite program access care within our current operational budget
    - Referrals can be sent via Ocean at out site **St. Mary's General Hospital - Virtual COPD Activation Exercise Program**

Courtesy of:

- *Sarah Farwell, Director Strategy, Innovation and Communications, SMGH*
- *Danny Veniott, Program Manager - Respiratory Therapy, Airway Clinics, SMGH*

Heart Failure –Moving Forward

Moving Forward – Heart Failure:

- 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.
  - Work is underway to **improve access to BNP and NT-proBNP testing**, including standardization where possible as well as improving education.
  - **SMGH's Heart Failure RCM program submitted an EOI for 2023/24 Digital Funding** in May 2023 to expand their existing program. The focus this year will include:
    - leveraging existing relationships to expand the program (e.g., larger geographic reach), and beyond the walls of SMGH (i.e., enrollment through PCP office).
    - working with other programs to realize further efficiencies that impact the patient experience
    - ensuring the social determinants of health are being realized with the Institute for Healthcare Improvement (IHI) model of quality
    - obtaining and analyzing metrics further (such as patient experience, delivery clinical excellence)

- Neighbourhood Integrated Care Team (NICT) Project
  - Optimus has partnered with KW4 OHT to design **patient personas, journey maps and integrated care pathways**. One of the pathways being developed is for a senior with congestive heart failure transitioning from hospital care to home. Three interactive workshops have been completed and were well attended by various stakeholders with planning for the fourth workshop on June 15th well underway.

- Clinical Pathway Development and SCOPE
  - Local KW4 OHT partners have been working together since Summer 2022 to improve the **dyspnea pathway** in the Region **to specifically support improved heart failure diagnosis and management in the community**. The purpose of the pathway is to support Primary Care Practitioners in the referral process of appropriate patients with possible heart failure, ensuring patients receive the right care at the right time in the right place. If the patient does not meet the criteria for referral to the Heart Function Clinic, the SCOPE Nurse Navigator will assist to locate the appropriate services for continuity of care. The pathway went live in October 2022 with feedback being collected to inform future iteration. The CHF development team is expanding their membership to include more primary care physicians, NPs, and the KW4 OHT SCOPE Nurse Navigator.
  - **SCOPE** (Seamless Care Optimizing Patient Experience) is a joint SMGH-GRH program to **support KW4 primary care providers with clinical consultation for complex and urgent patients, including resource navigation for patients experiencing heart failure**. SCOPE is available through the Ocean eReferral platform.

Courtesy of:
- *Dr. Amelia Yip, Heart Functional Lead and Cardiologist, SMGH*
- *Brandon Douglas, Director, Regional Cardiac Program and Critical Care Program, SMGH and*
- *Sarah Farwell, Director, Strategy, Innovation and Communications, SMGH*

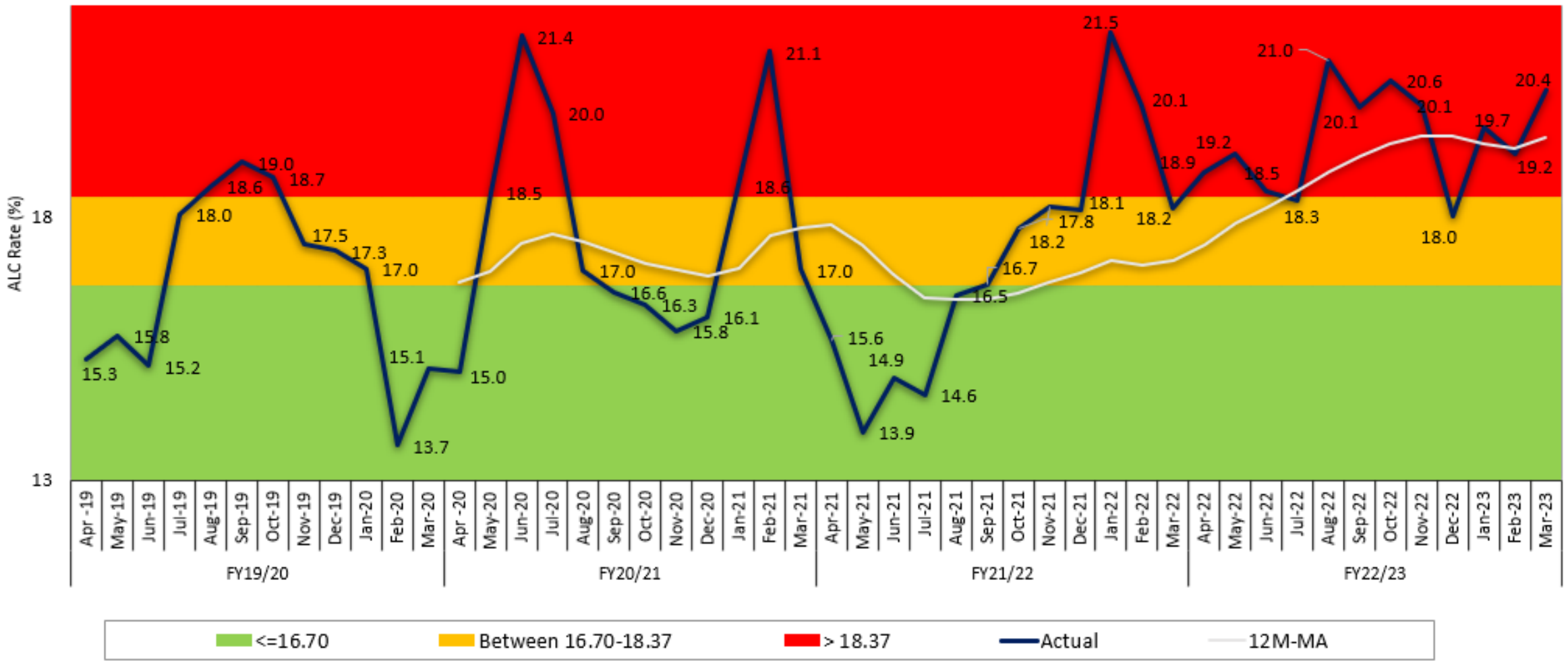
ACSC BME- Moving Forward

Moving Forward:

- Ministry of Health: A Plan for Connected and Convenient Care:
  - Care for those with chronic conditions continues to be a priority for the Ministry and OH.
  - When people have health care available in their communities, and in ways that are convenient for them, they are more likely to seek and receive the treatment they need when they need it and stay healthier.
  - Delivering convenient care to people in their communities will help keep them healthier by diagnosing illnesses earlier and starting treatment as soon as possible.
  - Some of these changes will happen immediately to address pressing issues, while other will be phased in over the months and years ahead
  - It will be important that KW4 continues to advocate for improvements for our community.
  - In their plan released February 2, 2023, progress to date and upcoming work related to caring for those with chronic conditions was shared including:
    - **Expanding the Community Paramedicine program to help people with chronic health conditions** live independently at home, where they want to be, by providing home visits to seniors for a range of services, including managing chronic conditions
    - **Developing stronger care pathways for people that suffer from chronic illnesses** like congestive heart failure, chronic obstructive pulmonary disease, stroke and diabetes to allow for greater care throughout the lifecycle of their treatment, from screening and prevention to community support and recovery at home.
    - More than 40 communities across the province have expanded successful 9-1-1 models of care that provide paramedics more flexibility to treat certain patients who call 911 at home or on-scene in the community rather than in emergency rooms, and Ontario is now working with key partners to **expand these models to different patient groups, such as people with diabetes and epilepsy, and implement a new treat-and-release model with recommendations to patients for appropriate follow-up care.**

Alternative Level of Care (ALC)

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



- Overall, the KW4 ALC rate has been fluctuating over the past 4 years, and the total ALC rate shows an increase year over year since the beginning of the pandemic.
- FY 2022/23, the ALC rate is 19.6% which is 1.8 percentage points higher than the overall average of 17.8%.

12M-MA : 12 months moving average

ALC Open Cases as of March 2023

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

	Open Cases				% of Cumulative ALC Days											
Facility	Volume (Mar 2023)	Volume (Mar 2022)	%Change (Mar 2023 vs. Mar 2022)	Cumulative ALC Days (Mar 2023)	Long Term Care	Rehab	Complex Continuing Care	Home with CCAC	Home with Comm. Services	Home without Support	Supervised or Assisted Living	Convalescent Care	Mental Health	Palliative Care	Unknown	TBD
St. Mary's	30	19	58%	1,757	1.0%	34.0%	0.0%	0.5%	0.0%	0.1%	27.0%	0.0%	0.0%	0.5%	36.0%	0.6%
Grand River	116	118	-2%	5,750	41.0%	5.0%	0.0%	0.1%	1.0%	0.0%	36.0%	9.0%	3.0%	0.1%	0.0%	4.0%
Total	146	137	6%	7,507	31.6%	11.8%	0.0%	0.2%	0.8%	0.0%	33.9%	6.9%	2.3%	0.2%	8.4%	3.2%

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

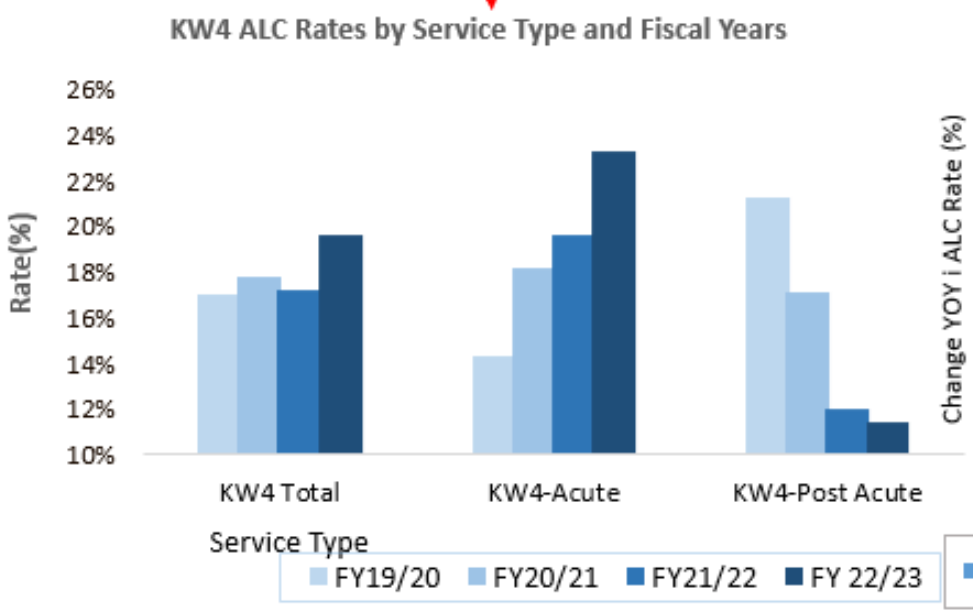
Source - Waterloo Wellington Sub-Region Monthly Alternate Level of Care Performance Summary - March 2023

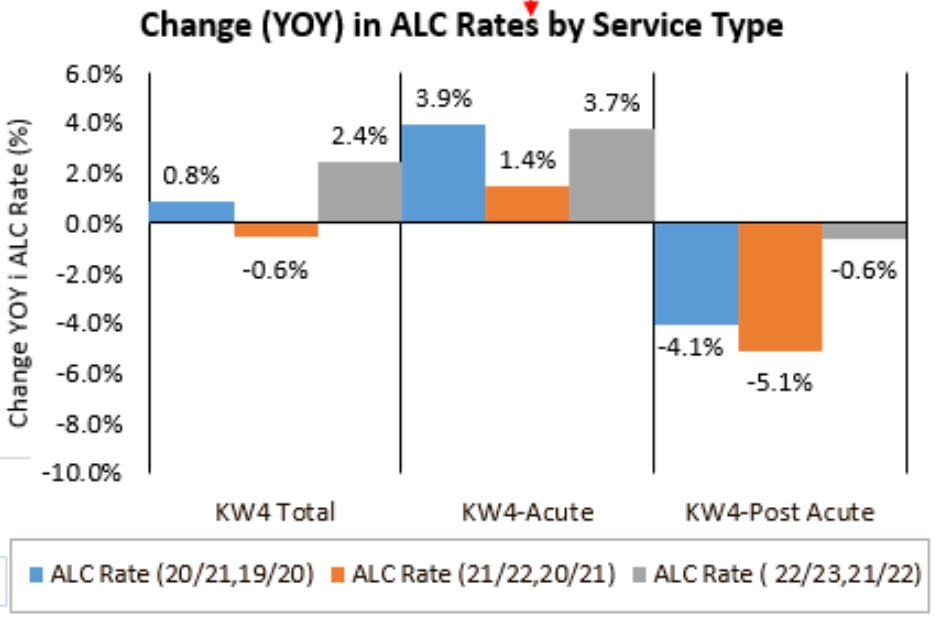
As of March 31, 2023:

- There were 146 patients designated ALC on the waitlist in the two KW4 OHT hospitals. This translates into 9 more cases compared to March 31, 2022
- These patients have accumulated 7,507 ALC days.
- Of the cumulative ALC Days 31.6% were attributed to patients waiting for Long Term Care, 33.9% waiting for Supervised or Assisted Living and 11.8% were waiting for Rehab

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

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





KW4 Total ALC Rate:

- increased 0.8% points between FY19/20 and 20/21
- decreased by 0.6% points between FY 20//21 and 21/22
- increased 2.4% points between FY21/22 and 22/23
- **had an increase of 2.6% points over the last 4 years**

KW4 Acute ALC Rate:

- increased 3.9% points in between FY19/20 and 20/21
- increased 1.4% points between FY 20//21 and 21/22
- increased 3.7% points between FY21/22 and 22/23
- **had an increase of 9.0% points over the last 4 years**

KW4 Post Acute ALC Rate:

- decreased 4.1% points between FY19/20 and 20/21
- decreased another 5.1% points between FY 20//21 and 21/22
- decreased 0.6% points between FY21/22 and 22/23
- **had a decrease of 9.8% points over the last 4 years**

Source: ALC Rate Quarterly Release CCO-WTIS

Alternate Level of Care (ALC) – Moving Forward

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 is being implemented 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 **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**. An evaluation working group has been formed to evaluate the project.
  - The expansion will 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 high-risk older adults living in retirement homes
    - Support of older adults waiting on the Specialized Geriatric Services (SGS) waitlist
    - Support and establishment of referral pathways for safe and timely discharge of identified appropriate hospitalized patients in lieu of ALC designation or after ALC designation
    - Additional support for identified Independent primary health care provider practices without an interprofessional team.
  - **Advanced care planning and community support services are considered part of the patients care plan**
  - **Education is being provided** to the ICT team through the Provincial Geriatrics Leadership Ontario (PGLO) orientation program and regional geriatric program central.
  - The first meeting of senior leaders on the OH West Steering Committee occurred on May 18th, to discuss **sustainability of funding, connections with system partners, and potential spread of the ICT model.**
  - Work began in May and will continue into June with OH West to onboard ICT to **Ocean eReferral** for primary care providers in our area to access. Team members are supporting VPN access so primary care can seamlessly refer their patients to the ICT at New Vision Family Health Team. The ICT team, supported by home and community care, will go live with **Hypercare for secure communication** once agreements are signed between all ICT partners and Hypercare.

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Alternate Level of Care (ALC) – Moving Forward

Moving Forward:

- Transitional Care Beds (TCU)
  - HCCSS continues to operate a 25 bed TCU that focuses on supporting ALC patients and patients in the community at risk of admission to hospital. The unit has 15 general unit beds, and 10 memory care beds. In Dec. 2022, 8 surge beds were opened for a 15-month period in partnership with OH to increase capacity for ALC reduction and hospital admission avoidance. This fiscal year will see an expansion of the programs geographic space to further support the Guelph Wellington area.

- Long Term Care
  - In collaboration with our LTC partners, HCCSS WW supported:
    - The closure of the waiting list of Pinehaven and the **transfer of LTC beds and residents from Pinehaven** to Winston Park. HCCSS WW also supported residents of Pinehaven who wanted to transfer to other LTCH's instead of The Village of Winston Park.
    - The **opening of 45 additional LTCH beds at The Village Winston Park. Additional LTC beds are expected to come online in the fall of 2023**
    - The **closure of Twin Oaks of Maryhill LTCH** which included the transfer of residents to long term care homes of their choice

- Emergency Department (ED) Diversion Program
  - In Q4 of 2022 ED Diversion was re-launched at all KW hospital sites (SMGH, GRH, with expansion to CMH). The re-launch included re-education of frontline staff, and engagement of key hospital stakeholders that can support early identification of patients that meet the eligibility for ED Diversion and could be supported with enhanced PSW services in the community to avoid an admission to the hospital.

- 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. In collaboration with WW hospitals, LEGHO has successfully been implemented. We will continue supporting quality improvement efforts learned through implementation during this quarter.
  - Through the LEGHO model, partners developed 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.

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Alternate Level of Care (ALC) – Moving Forward

Moving Forward:

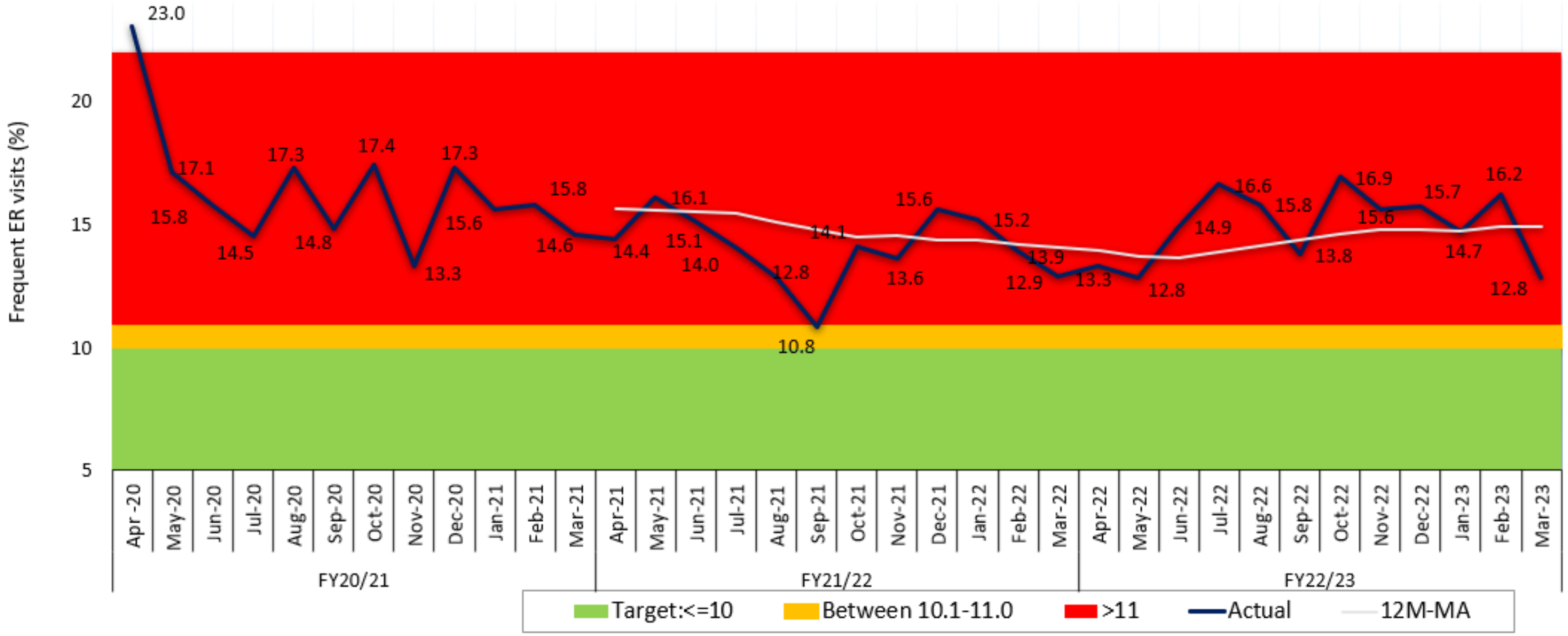
- SCOPE (Seamless Care Optimizing the Patient Experience)
  - SCOPE is a platform that promotes integrated and collaborative work between primary care, hospital services and community health partners to serve patients with complex needs. Through a single point of access, primary care providers are connected with a Nurse Navigator who assists with navigating the health care system, to ensure providers and patients are connected to the appropriate resources in the timeliest way possible. By connecting primary care providers to appropriate resources, unnecessary Emergency Department visits and hospital admissions can be avoided ultimately avoiding ALC. Several pathways have been developed (including some examples of Diagnostic imaging, and General Internal Medicine) to assist in seamless access for patients.

- Ministry of Health: A Plan for Connected and Convenient Care:
  - Care for seniors and those needing long-term care (LTC) continues to be a priority for the Ministry and OH
  - Some of these changes will happen immediately to address pressing issues, while other will be phased in over the months and years ahead
  - It will be important that KW4 continues to advocate for improvements for our community.
  - In their plan released February 2, 2023, progress to date and upcoming work related to seniors was shared including:
    - $6.4 billion is being invested to **build 30,000 new LTC beds** by 2028, and **upgrade 28,000 LTC beds** to modern design standards to help address wait lists for LTC and ensure seniors are being cared for in the right place, where they can connect to more supports, activities and social activities that may not be available if they are being cared for in a hospital while waiting to move into a LTC home.
    - $5 billion is being invested over four years to **hire more than 27,000 long-term care staff**, including nurses and personal support workers, to provide LTC home residents with an **average of four hours of hands-on care** by nurses and personal support workers each day by March 31, 2025.
    - Over $40 million is being invested this year to help LTC homes provide **specialized services and supports to residents with more complex needs** to help LTC residents get the care they need without having to go to emergency rooms or be admitted to hospitals. A portion of this expanded funding is also supporting the transfer of patients in hospitals who no longer require acute care to long-term care homes.
    - Enhancing **access to more diagnostic services** for LTC residents through partnerships with hospitals and community labs, to identify solutions to close service gaps, increase timeliness and convenience and improve overall experience.

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and*
- *KW4 OHT Frail Elderly Reference Group co-Leads - Caitlin Agla, Chantelle Archer, Jane McKinnon-Wilson, Krysta Simpson*

Frequent Emergency Department Visits for Help with Mental Health and Addictions

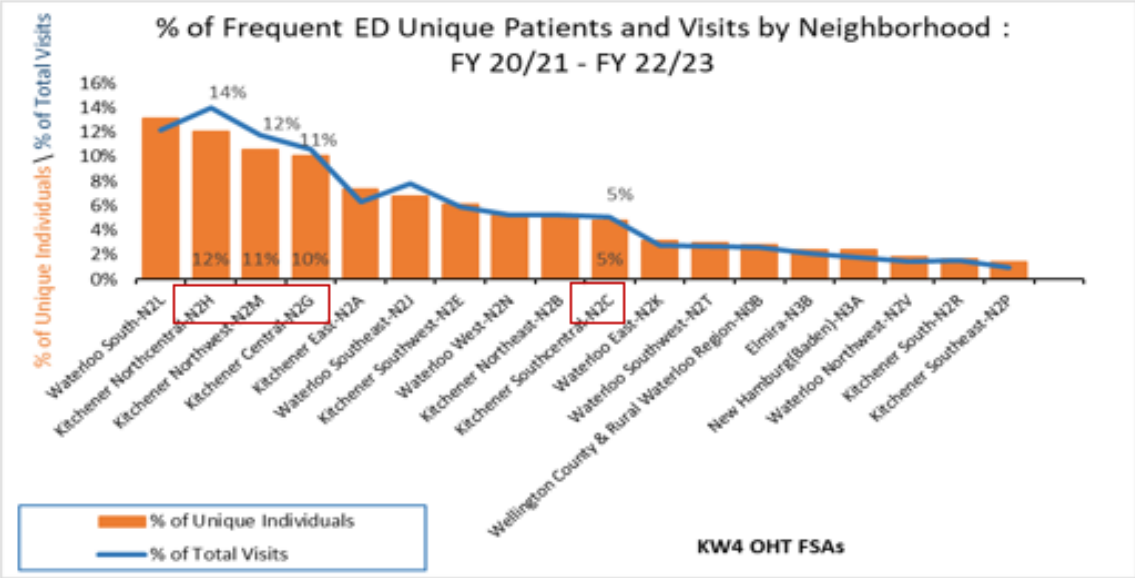
Frequent ER Visits For Help with Mental Health & Addictions (%) - April 2020 to March 2023



- 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.

KW4 OHT: Unique # of Patients and ED Visits by Neighbourhood : FY 20/21 to 22/23

>=4 Visits												
FSA	Population (2021 Census)	% of Population	Unique# of Individuals			# of Visits			3 Fiscal Years			
			FY2020/21	FY2021/22	FY2022/23	FY2020/21	FY2021/22	FY2022/23	Total: Unique# of Individuals	Total # of Visits	% of Unique Individuals	% of Total Visits
KW4 Priority Neighbourhoods	**91,210**	**18%**	**88**	**82**	**95**	**708**	**622**	**668**	**265**	**1,998**	**37.5%**	**41.4%**
Kitchener Northcentral-N2H	22,455	5%	27	28	30	252	216	206	**85**	**674**	**12.0%**	**14.0%**
Kitchener Northwest-N2M	36,495	7%	27	18	30	206	147	214	**75**	**567**	**10.6%**	**11.7%**
Kitchener Central-N2G	14,580	3%	22	25	24	180	179	153	**71**	**512**	**10.0%**	**10.6%**
Kitchener Southcentral-N2C	17,680	4%	12	11	11	70	80	95	**34**	**245**	**4.8%**	**5.1%**
Other KW4 Neighbourhoods	**405,360**	**82%**	**146**	**156**	**140**	**928**	**1,037**	**865**	**442**	**2,830**	**62.5%**	**58.6%**
KW4 OHT FSAs Total	**496,570**	**100%**	**234**	**238**	**235**	**1,636**	**1,659**	**1,533**	**707**	**4,828**	84%	83%
Other FSAs/Non-KW4 OHT FSAs									134	1,017	16%	17%

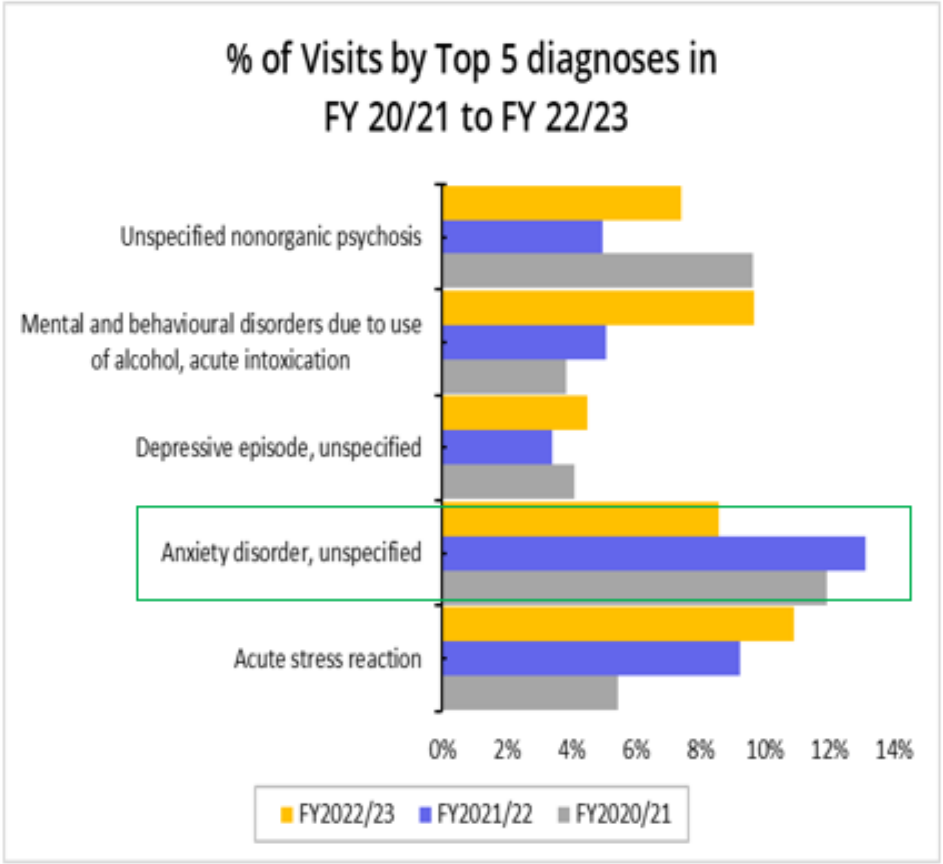


Between FY20/21 and 22/23, 707 unique individuals residing in KW4 had four or more ED visits for help with MH&A, totaling 4,828 visits.

- Our four priority neighbourhoods (N2C, N2G, N2H, N2M) account for only 18% of KW4's population but 41.4% of the visits and 37.5% of the individuals from KW4
- The other fourteen KW4 neighbourhoods account for 82% of KW4's population but 58.6% of the visits and 62.5% of unique individuals
- Although the Waterloo South neighborhood (N2L) appears to have a high percentage of visits (13%) and individuals (12%) this is in line with the % of the people who reside there (8%) of KW4's population and therefore this neighbourhood does not appear to be disproportionately represented.
- 17% of the visits to a hospital located within KW4 and 16% of the individuals reside outside of KW4 OHT neighbourhoods.

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

Diagnosis	Unique # of Individuals(%)			% of Visits			Total Unique # of Individuals	Total # of Visits
	FY2020/21	FY2021/22	FY2022/23	FY2020/21	FY2021/22	FY2022/23		
Acute stress reaction	6.5%	9.4%	11.2%	5.5%	9.2%	10.9%	9.0%	8.6%
Anxiety disorder, unspecified	12.9%	14.4%	9.4%	11.9%	13.1%	8.6%	12.2%	11.2%
Depressive episode, unspecified	5.4%	3.6%	4.5%	4.1%	3.4%	4.5%	4.5%	4.0%
Mental and behavioural disorders due to use of alcohol, acute intoxication	4.3%	5.4%	6.3%	3.9%	5.1%	9.7%	5.4%	6.2%
Unspecified nonorganic psychosis	11.5%	6.1%	7.3%	9.6%	5.0%	7.4%	8.3%	7.3%
Total	40.6%	39.0%	38.8%	35.0%	35.9%	41.1%	39.5%	37.3%

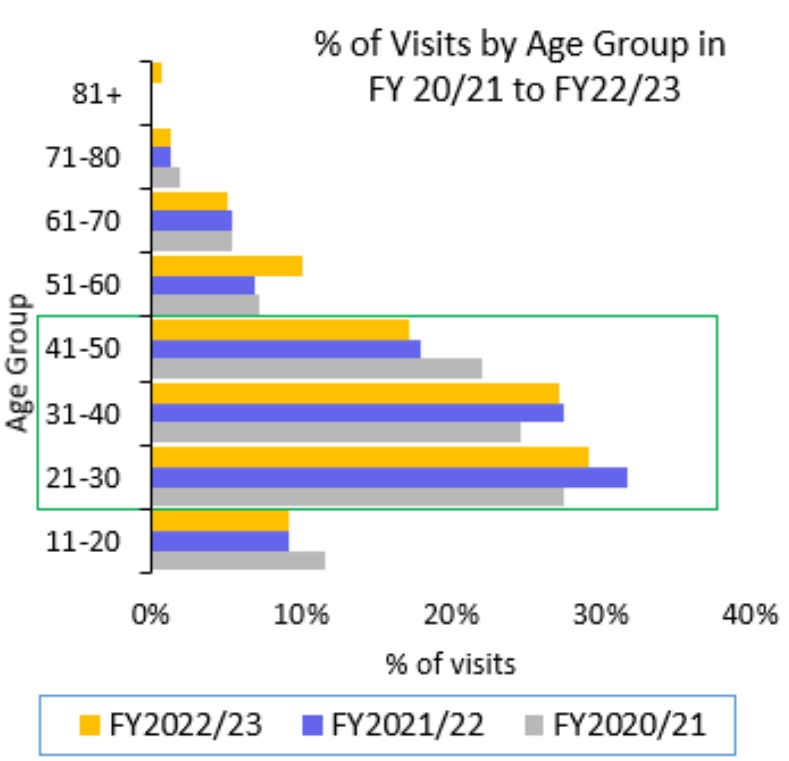


Diagnoses:

- The top 5 diagnoses codes accounted for 37.3% of visits for 39.5% of the individuals, with the most prevalent being 'Anxiety Disorder, unspecified' at 11.2% for the last 3 fiscal years however this diagnosis also saw the largest percentage decrease in visits since last fiscal year.
- Mental and behavioural disorders due to use of alcohol, acute intoxication had the largest percentage increase in visits since last fiscal year

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

									Average Visits per Person		
	FY2020/21	FY2021/22	FY2022/23	FY2020/21	FY2021/22	FY2022/23	Total % of Individuals	Total % of Visits	FY2020/21	FY2021/22	FY2022/23
0-10											
11-20	14.4%	11.2%	11.5%	11.6%	9.1%	9.2%	12.4%	9.9%	5.6	5.8	5.4
21-30	27.7%	32.5%	25.9%	27.6%	31.7%	29.3%	28.7%	29.5%	6.9	7.0	7.7
31-40	24.5%	25.6%	24.1%	24.6%	27.6%	27.2%	24.7%	26.5%	6.9	7.7	7.7
41-50	18.7%	15.2%	17.8%	22.0%	18.0%	17.2%	17.2%	19.0%	8.1	8.5	6.5
51-60	7.2%	7.6%	11.9%	7.1%	6.9%	10.1%	8.9%	8.0%	6.9	6.5	5.8
61-70	5.4%	6.1%	5.9%	5.3%	5.4%	5.1%	5.8%	5.3%	6.8	6.3	5.9
71-80	2.2%	1.8%	1.7%	1.8%	1.3%	1.2%	1.9%	1.4%	5.8	5.0	4.8
81+	0.0%	0.0%	1.0%	0.0%	0.0%	0.7%	0.4%	0.2%			4.7
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	6.7	6.7	6.1



Age Groups

- The top three age groups listed below accounted for 75.0% of the visits and 70.6% of the individuals from April 2020 to March 2023:
  - 21-30 at 29.5% visits and 28.7%
  - 31-40 at 26.5% visits and 24.7%
  - 41-50 at 19.0% visits and 17.2%

Frequent ER Visits For Help with Mental Health & Addictions – Contributing Factors

Contributing Factors:

- **Mental Health is the 'next wave' of the COVID pandemic.** Social isolation, physical distancing, fear, pandemic related stressors like caring for at-risk children or parents, job loss, supporting children with virtual learning, uncertainty, etc. can all lead to a range of mental health disorders like anxiety, depression and trigger heavier consumption of alcohol and drugs and even post-traumatic stress disorder.
- The supply of **opioid drugs on the street** has become more toxic and extremely dangerous leading to drug poisonings, overdoses, drug-induced psychosis and death. Between February 11 and 14, 2023 there we three suspected drug poisoning-related deaths in Waterloo Region.
- Primary care providers are seeing an **increase in the complexity and acuity of patients** coming through their doors and this is also being seen in shelters and encampments.
- The list of **people seeking a primary care provider** in KW4 continues to increase. As of February 17, 2023, 5,438 people are on the Health Care Connect Program waiting for connection to a provider. This is up from 4,907 on December 1, 2022.
- **Waitlist for mental health services** are continuing to grow with minimal investment in the last 10-years. The **volume of referrals** is also increasing with the most significant increase being for crisis services. While people wait for these services, the ED is sometimes the only place people feel they can go for help.
- The **retention and recruitment of health care professionals** over the last year has been challenging. This not only impacts organizations' ability to maximize the number of clients they can see but also impacts the **continuity of service clients receive**. A change in a case workers for a client may require time to build that trusting relationship – one where they are comfortable sharing their challenges.

Courtesy of:
- *KW4 OHT Mental Health and Addictions Reference Group and*
- *GRH Mental Health Families for Awareness, Change and Education (FACE) Committee*

Frequent ER Visits For Help with Mental Health & Addictions – Moving Forward

Moving Forward:

- Unification of Carizon, KW Counselling Services and Monica Place
  - In December of 2022 the three Boards of Directors from Carizon, KW Counselling, and Monica Place came together and agreed to formally become one agency, Camino. This was effective on April 1, 2023.
  - There were many compelling reasons for this potential unification. Together, they will create a system that brings greater impact to the growing mental health and wellbeing needs of individuals, families, and communities in Waterloo Region. They hope to increase capacity to **serve more effectively and become more sustainable, while strengthening and expanding programs and services**.

- Neighbourhood Integrated Care Team (NICT) Project
  - Optimus has partnered with KW4 OHT to design **patient personas, journey maps and integrated care pathways**. One of the pathways being developed is for a mental health and addictions pathway for Individual with depression and/or anxiety transitioning from youth to adult services. Three interactive workshops have been completed and were well attended by various stakeholders with planning for the fourth workshop on June 15th well underway.

- Youth Wellness Hubs
  - Several organizations from KW4 OHT (i.e., Camino, Lutherwood, Woolwich Community Health Centre) along with other partner organizations (i.e., Langs, YMCA, Counselling Collaborative Agencies, etc.) and community organizations (i.e., Somali Canadian Association of WR, Muslim Women of Cambridge, etc.) are jointly planning a Youth Wellness Community Conversation on June 13th to **discuss the creation of Youth Wellness Hubs in Waterloo Region**.
  - Youth Wellness Hubs Ontario offers a model that combines recreation, school support, mental health services, and connection, all designed with input from youth and led by the community.

- 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 and went live in December 2022.
  - In Waterloo Region, OSP is provided in partnership with the members of the Counselling Collaborative of Waterloo Region and the Centre for Family Medicine, by 2 full time therapists, with clients being able to be seen at the location of their choice.
  - The OSP program provides access to publicly funded, evidence-based, short-term (8-12 weeks), **cognitive behavioural therapy (CBT) and related approaches to clients with depression, anxiety, and anxiety-related conditions**.
  - Anxiety disorder and depressive episodes 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.
  - Priority populations include people without access to healthcare benefits, those living on a low income, people who are Indigenous, Black and other people of colour, Francophone, those who identify as 2SLGBTQ+, people living with disabilities and people living in remote areas.
  - Wait times for initial contact for an intake assessment is 4 to 8 weeks during which time walk-in counselling is available at Camino.

Courtesy of:

- *KW4 OHT Mental Health and Addictions Reference Group*
- *GRH Mental Health Families for Awareness, Change and Education (FACE) Committee*

KW4 Ontario Health Team

Frequent ER Visits For Help with Mental Health & Addictions – Moving Forward

Moving Forward:

- Alternate Destination Model for Paramedic Services
  - Paramedic Services in Waterloo Region is hoping to adopt an **Alternative Destination Model for MHA related concerns**, a model successfully adopted by London-Middlesex.
  - The model would allow Paramedics Services to **transfer eligible patients to a 24/7 Walk-In Crisis Centre instead of dropping them off at a hospital emergency department**.
  - Paramedics would provide an on-scene assessment and if the patient consents, is cooperative and non-combative, paramedics can call ahead and transfer/offload the patient at the Crisis Centre.
  - As a key partner in the region, KW4 OHT along with some of our members have been asked to collaborate on the design, development and implementation, pending provincial approval.
  - 30% of MH&A ED cases that arrived by ambulance between FY20/21 and 22/23 Sept (YTD) were for patients who resided in our 4 priority neighbourhoods yet these neighbourhoods only account for 18% of KW4's population indicating that these neighbourhoods are disproportionately impacted.

- Acquired Brain Injury in the Streets
  - This is a **low barrier, relationship-based program that provides support, advise, and education to clients and other workers on brain injury** and targets clients who are homeless or living rough with an acquired brain injury
  - Specialized brain injury workers screen for brain injury using a low barrier HELPS Brain Injury Screening Tool.

- Ontario Health Teams – The Path Forward
  - The Ministry of Health is setting new direction for OHTs to support their progress towards maturity as they work to connect care and improve patient experience in their local communities.
  - During a November 30, 2022, webinar hosted by the Ministry of Health and Ontario Health, entitled "Accelerating Ontario Health Team Impact and Next Steps for OHTs", five main topics were discussed, one of which was the creation of clinical pathways to improve patient care.
  - A phased introduction of integrated clinical pathways will occur for people living with four chronic conditions including congestive heart failure, diabetes with a focus on avoiding amputation, chronic obstructive pulmonary disease (COPD) and stroke.
  - After these initial four pathways are successfully implemented additional integrated **clinical pathways will be developed in the areas of mental health and addiction** and palliative and end-of-life care.

Courtesy of:
- *KW4 OHT Mental Health and Addictions Reference Group*
- *GRH Mental Health Families for Awareness, Change and Education (FACE) Committee*

Frequent ER Visits For Help with Mental Health & Addictions – Moving Forward

Moving Forward:

- Ministry of Health: A Plan for Connected and Convenient Care
  - Mental Health and Addictions (MHA) continues to be a priority for the Ministry and OH as shown throughout the plan.
  - Some of these changes will happen immediately to address pressing issues, while other will be phased in over the months and years ahead.
  - It will be important that KW4 continues to advocate for improvements for our community.
  - In the Plan released February 2, 2023, progress to date and upcoming work related to caring for those with MHA conditions was shared including:
    - Investing $3.8 billion over 10 years to **develop and implement a comprehensive and connected MHA system** for Ontarians
    - One-time investment of $90 million over three years through the **Addictions Recovery Fund** to meet the anticipated surge in demand for substance use services (announced February 2022). This funding will open **150 new addictions beds and other substance use services** across the province.
    - Investing $10.5 million to address gaps in care and improve access while decreasing existing wait lists and extensive wait times, including **expanding the child and youth mental health Secure Treatment Program** and **adding up to 24 new beds to serve vulnerable children and youth** experiencing acute and complex mental health challenges that may put them at risk of self-harm or harm to others.
    - Investing $3.5 million for **two new step-up, step-down live-in treatment programs** to connect more youth to care in communities in western and northern regions of the province including **adding up to 16 new beds** to meet the needs of youth who don't require the highly intensive care provided at a hospital or secure treatment setting but need more support than a community-based live-in treatment program is designed to offer.
    - **Opening eight new Youth Wellness Hubs** (to the existing 14 that are already operational) to make it faster and easier for children and youth aged 12-25 to connect to MHA support, primary care, social services, and other services, such as vocational support, education services, housing and recreation and wellness.
    - Launching the **Ontario Structured Psychotherapy Program** to provide more Ontarians support for anxiety and depression with Cognitive Behaviour Therapy
    - **Launching new eating disorders prevention and early intervention programming**
    - Investing $4.75 million to support a **new virtual walk-in counselling service (One Stop Talk)** for children, youth, and families, providing access to mental health care with a clinician by phone, video, text or chat.
    - The **new Health811** (formerly known as Health Connect Ontario), allows users to chat online or call 811 to talk to a registered nurse day or night for free in multiple languages as well as obtain assistance in finding mental health supports
    - **New service models and strategies to divert patients from emergency departments** when safe to do so, and to reduce patient offload times at hospitals.

Courtesy of:
- *KW4 OHT Mental Health and Addictions Reference Group*
- *GRH Mental Health Families for Awareness, Change and Education (FACE) Committee*

Indicator Definitions

Indicator Definitions

Indicator Name	Indicator Description	Calculation Method	Data Source	Target	Performance Corridor
Caregiver distress among home care clients	• This outcome indicators measures the percentage of long-stay home care clients whose unpaid caregivers experience distress in a 1-year period (a risk-adjusted percentage). • A caregiver is defined as a person who takes on an unpaid caring role for someone who needs help because of a physical or cognitive condition, an injury or a chronic life-limiting illness. • This caregiver can be a spouse, child/child-in-law, other relative or friend, or neighbour who lives or does not live with the client. • Caregivers who are distressed are defined as primary caregivers who express feelings of distress, anger or depression and/or any caregiver who is unable to continue in their caring activities. • This indicator defines long-stay clients as those who have already been receiving home care for at least 60 days. • When a client has more than one home care assessment within a given year, the most recent assessment will be included in the analysis. • A lower rate is better.	• Numerator divided by the denominator times 100 • Numerator - Total number of home care clients who, at the time of their most recent assessment in the given year, have an unpaid caregiver who is experiencing distress. • Denominator - Total number of long-stay home care clients with a caregiver at the time of their most recent assessment in the given year • HQO Indicator Library for this measure • Reported value is adjusted for cognitive impairment, Activities of daily living impairment, medical complexity. • The current performance data is for the WWLHIN. In future reports we hope to be able to report this at the KW4 OHT level.	interRAI Home Care © assessments, data supplied by Ontario Health Shared Services	<=56.0%	• Green – Less than or equal to 56.0% • Yellow – Between 56..0% - 61.0% • Red – Greater than 61.0%
Hospitalization rate for conditions that can be managed outside hospital Rate of hospitalization for Ambulatory Care Sensitive Conditions (ACSCs)	• This outcome indicator measures the rate of hospitalization, per 100,000 people aged 0 to 74 years, for one of the following conditions that, if effectively managed or treated earlier, may not have resulted in admission to hospital: asthma, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, angina and epilepsy. • A lower rate is better. • 2021 Census data has been used since January 2021 for ACSC BME KPI calculations.	• This indicator is calculated as the numerator divided by the denominator per 100,000 population • Numerator - The number of inpatient records from acute care hospitals during each fiscal year with any ambulatory care sensitive condition (ACSC) as the most responsible diagnosis. • Denominator - The number of people in Ontario aged 0 to 74 years. • HQO Indicator Library for this measure	Discharge Abstract Database (DAD) Registered Persons Database (RPDB)	<=20.40 monthly (244.80 annually)	• Green – Less than or equal to 20.40 monthly (244.80 annually) • Yellow – Between 20.40 – 22.44 • Red – Greater than 22.44

Indicator Definitions

Indicator Name	Indicator Description	Calculation Method	Data Source	Target	Performance Corridor

Total ALC (Acute and Non-Acute) Rate	• This process indicator measures the total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data.
	• Alternate level of care (ALC) refers to those cases where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of their treatment.
	• A lower rate is better.
		• This indicator is calculated as the numerator divided by the denominator times 100.
		• Numerator - The total number of inpatient days designated as alternate level of care (ALC) in a given time period (i.e., monthly, quarterly, yearly). Inpatient service type is identified in the Wait Time Information System (WTIS).
		  • Calculation:- Acute ALC days equals the total number of ALC days contributed by ALC patients waiting in non-surgical, surgical and intensive/critical care beds. Post-acute ALC days equals ALC days for Inpatient Services in complex continuing care, rehabilitation and mental health beds.
		• Denominator - The total number of inpatient days in a given time period (i.e., monthly, quarterly, yearly).
		  • Calculation: Acute Patient days = the total number of patient days occupying Acute with Mental Health Children/Adolescent (AT) beds. Post-Acute Patient days = the total number of patient days occupying Complex Continuing Care (CR) + General Rehabilitation (GR) + Special Rehabilitation (SR) + Mental Health - Adult (MH) Beds. CCC Patient days = the total number of patient days occupying Complex Continuing Care (CR) Beds. Rehab Patient days = the total number of patient days occupying in General Rehabilitation (GR) + Special Rehabilitation (SR) Beds. Mental Health Patient days = the total number of patient days occupying Mental Health - Adult (MH) Beds
		• HQO Indicator Library for this measure
			Wait Time Information System (WTIS)
			
			WTIS ALC Rates Report - Quarterly Release
				<=16.70%	• Green – Less than or equal to 16.70%
					• Yellow – Between 16.70 – 18.37%
					• Red – Greater than 18.37%

Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	• This outcome indicator measures the percentage of people with four or more visits over the previous 12 months, among people who visited the emergency department for a mental illness or addiction. • A lower rate is better. • Monthly snapshot reporting	• Numerator divided by the denominator times 100 • Frequent ED Visitor for MH&A (Numerator) - The total number of patients with 4 or more ER visits within a year (past 365 days) for mental health and addictions. The 365 day lookback is based on the most recent visit date (Triage Date) for that month. If a patient had 3 visits in April 2022, it would lookback 365 days from the most recent April 2022 visit. • Total Visits for MH&A (Denominator) - The total number of patients with at least 1 or more ER visits within time period for mental health and addictions. • HQO Indicator Library for this measure • One difference – We include patients with invalid health card numbers (e.g. HCN=1 or 0). They are linked using Cerner Person ID as this is shared between GRH and SMGH.	National Ambulatory Care Reporting System (NACRS), CERNER	<=10%	• Green – Less than or equal to 10.0% • Yellow – Between 10.1% – 11.0% • Red – Greater than 11.0%