KW4 Ontario Health Team

Quarterly Performance Measurement Report

February 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	%	Dec 2022	<= 56%	52.2%		Improvement from 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	Nov 2022	<= 20.4 monthly (61.2 quarterly) (244.8 annually)	22.7		Slippage from 15.4
3	Total ALC (Acute and Non-Acute)	%	Dec 2022	<=16.7%	18.0%		Improvement from 20.1%
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Oct 2022	-	16.9%		Slippage from 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

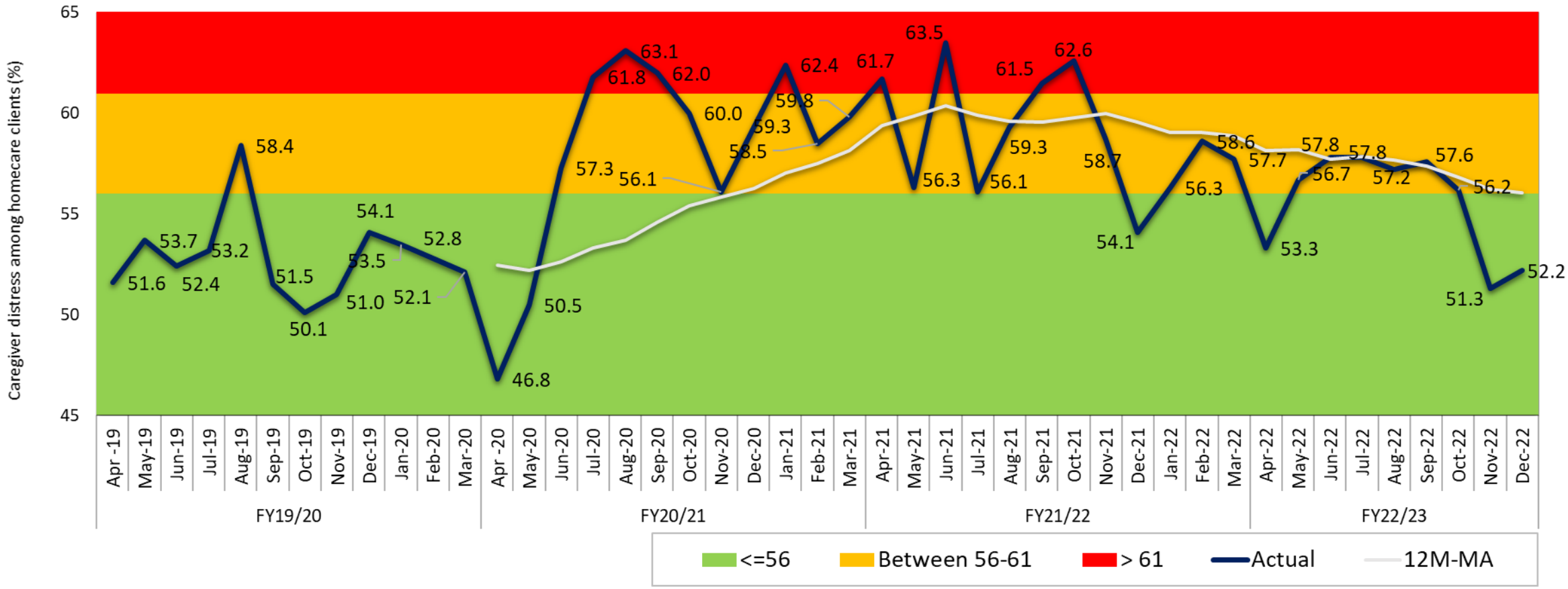
Data Availability

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
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 its dashboard early next fiscal year. 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

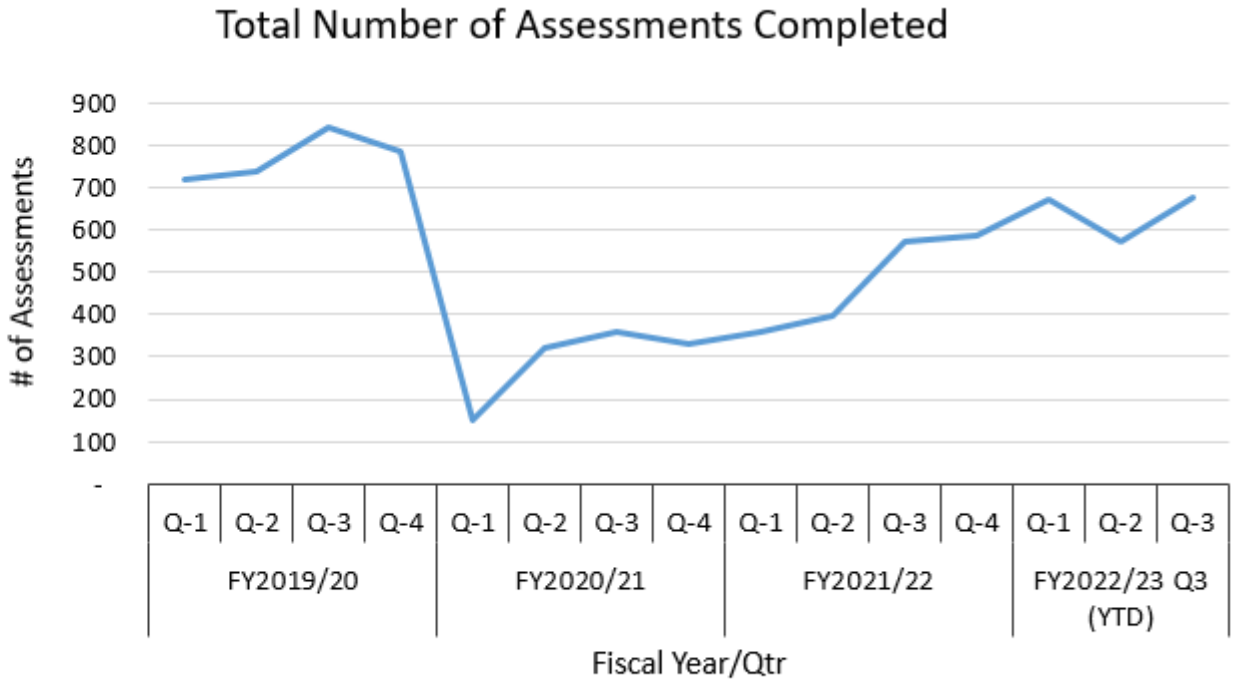
Caregiver Distress Among Homecare Clients (%): April 2019 to December 2022



- Caregiver distress among homecare clients increased significantly during the pandemic and continued relatively high until October 2021
- A downward trend then began, and in October and November 2022 we were 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 Q3(YTD)
Q-1	720	151	361	673
Q-2	740	322	397	570
Q-3	841	359	572	677
Q-4	787	331	588	
Total	**3,088**	**1,163**	**1,918**	**1,920**



- 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 the first three quarters of FY2022/23 we have already surpassed the total number of assessments completed last fiscal year and are nearing pre-pandemic completion rates.

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.
- **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** up which may have contributed to the reduction in care giver stress. Waterloo Wellington has also successfully enabled the utilization of Transitional Care Beds for respite stay. Short Stay Respite in Long Term Care in Waterloo Wellington has not yet opened.
- 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.

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

Caregiver Distress Among Homecare Clients - 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 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 continued to **add a number of overflow agencies** this quarter to support access to care 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 the Retirement Home workforce. Implementation is being targeted for this fiscal year.
  - HCCSS WW has initiated discussion with the **Community Ward in-home team**. The Community Ward team is a multi-disciplinary team providing in-home outreach services and primary care as an extension to support physicians with patients that are medically and/or socially complex. HCCSS WW has engaged with the KW4 Community Ward team to solidify meaningful metrics with the intention of ongoing collaboration with the team.
  - HCCSS WW supported the Region of Waterloo Community Paramedicine Program in launching the palliative care program to support access to care and symptom management by paramedics in the community to avoid ED transfers.

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

Caregiver Distress Among Homecare Clients – Moving Forward

Moving Forward:

- 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**.

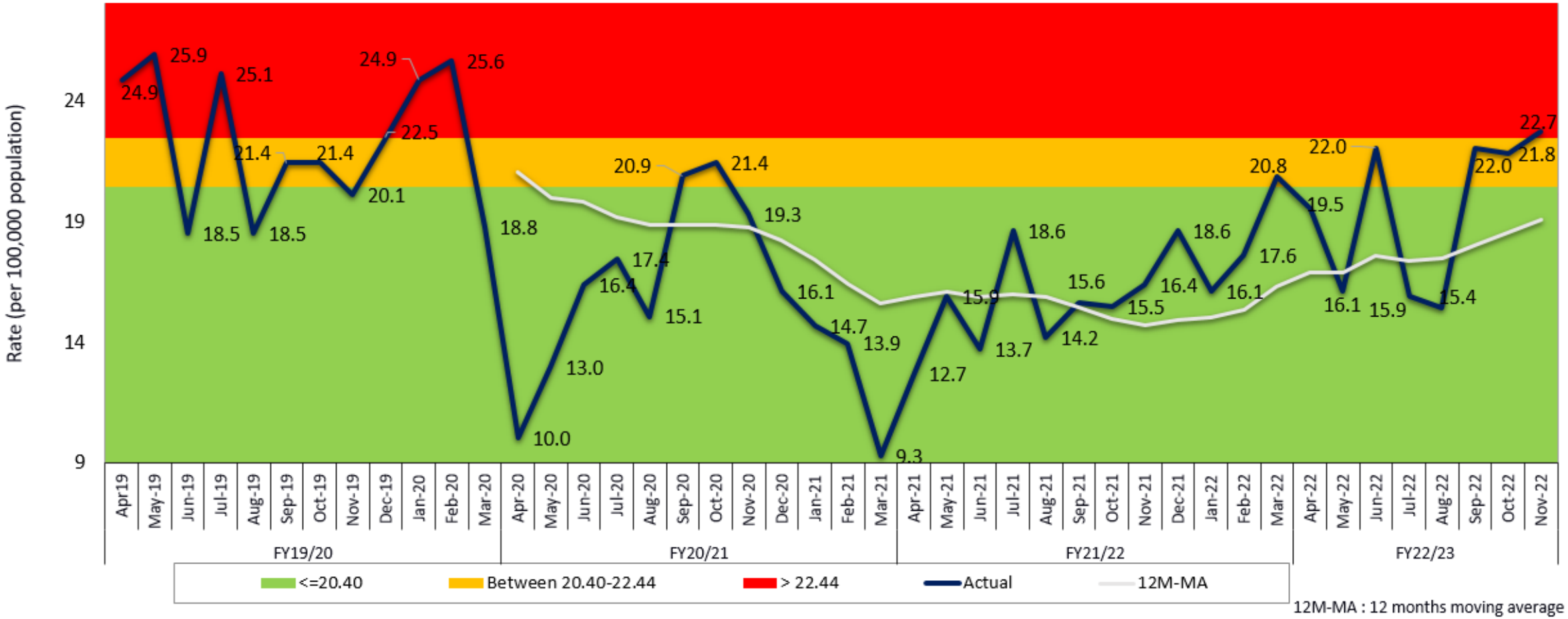
- Delirium Working Group
  - The delirium working group is developing educational materials for patients, families, and clinical teams to assist with **recognizing early signs of delirium** in order to initiate interventions and supports sooner.

- 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

Ambulatory Care Sensitive Conditions Best Managed Elsewhere

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



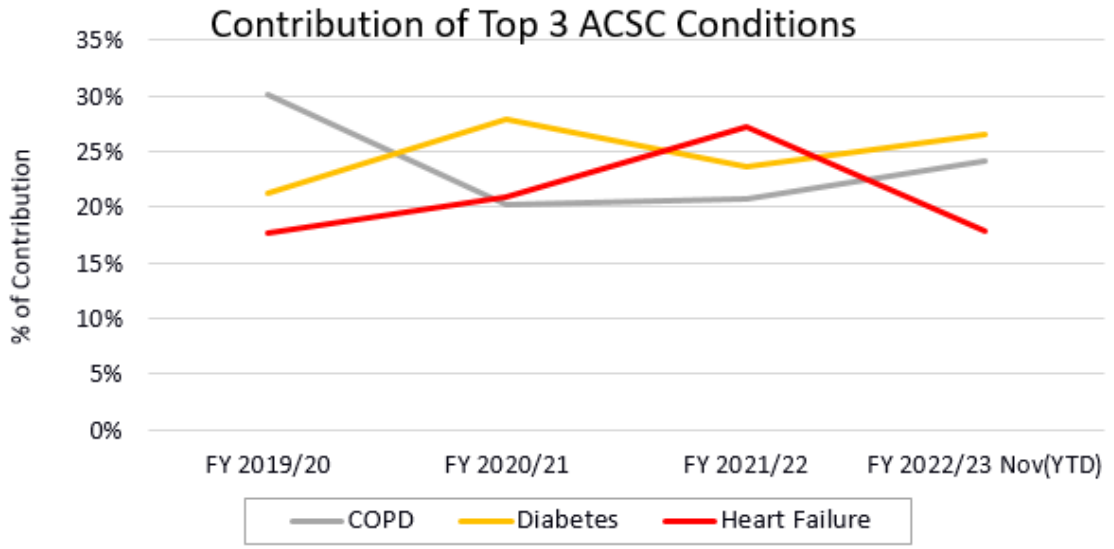
12M-MA : 12 months moving average

- 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 rates with the latest quarter 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 Nov(YTD)

Contributing Condition	FY 2019/20	FY 2020/21	FY 2021/22	FY 2022/23 Nov (YTD)
COPD	30.2%	20.3%	20.8%	24.1%
Diabetes	21.3%	27.9%	23.7%	26.5%
Heart Failure	17.7%	20.9%	27.2%	17.9%
Epilepsy	12.5%	16.8%	12.4%	12.1%
Asthma	11.8%	5.2%	9.7%	14.3%
Angina	2.5%	3.0%	1.9%	1.7%
Hypertension	4.0%	5.9%	4.3%	3.4%



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%
- 68.5% in FY2022/23 Nov(YTD), with the most prevalent being 'Diabetes' at 26.5%

- **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 3.3% points in FY2022/23 Nov (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 2.8% points in FY2022/23 Nov (YTD)**

- **Heart Failure** had an increase of 3.2% points in FY2020/21, 6.3% points in FY2021/22, and **a significant decrease of 9.3% points in FY2022/23 Nov (YTD)**

COPD – Contributing Factors

Contributing Factors:

- In the beginning of the pandemic, SMGH's outpatient COPD program remained open for education and self-management advice
- 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 Registered Respirology Therapist (RRT) staff were re-assigned to help the ICU burden
- **COPD appointments moved to virtual only. A third of the team were reassigned to inpatient demands**
- After the COVID 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 funding 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 and
Sarah Farwell, Director, Strategy, Innovation and Communications, SMGH

COPD – 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 eReferral 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 facing barriers to access their Onsite Program due to geographical, socioeconomic, transportation or other circumstances. There is additional support for those who do not have access to their own mobile device or internet. The program consists of a four-week education plan with knowledge-based modules and exercise videos. There is a quit smoking education and support program for those who currently smoke. The program also includes an online meeting with Activation program Nurse Practitioner and/or Respirologist. 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 and
Sarah Farwell, Director, Strategy, Innovation and Communications, SMGH

Heart Failure – 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
- 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 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 Dr. Amelia Yip, Heart Functional Lead and Cardiologist, SMGH and the Evidence2Practice Ontario
Brandon Douglas, Director, Regional Cardiac Program and Critical Care Program, SMGH and
Sarah Farwell, Director, Strategy, Innovation and Communications, SMGH

Heart Failure – 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.
  - Work is underway to improve access to BNP and NT-proBNP testing, including standardization where possible as well as improving education.

- 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 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

KW4 Ontario Health Team

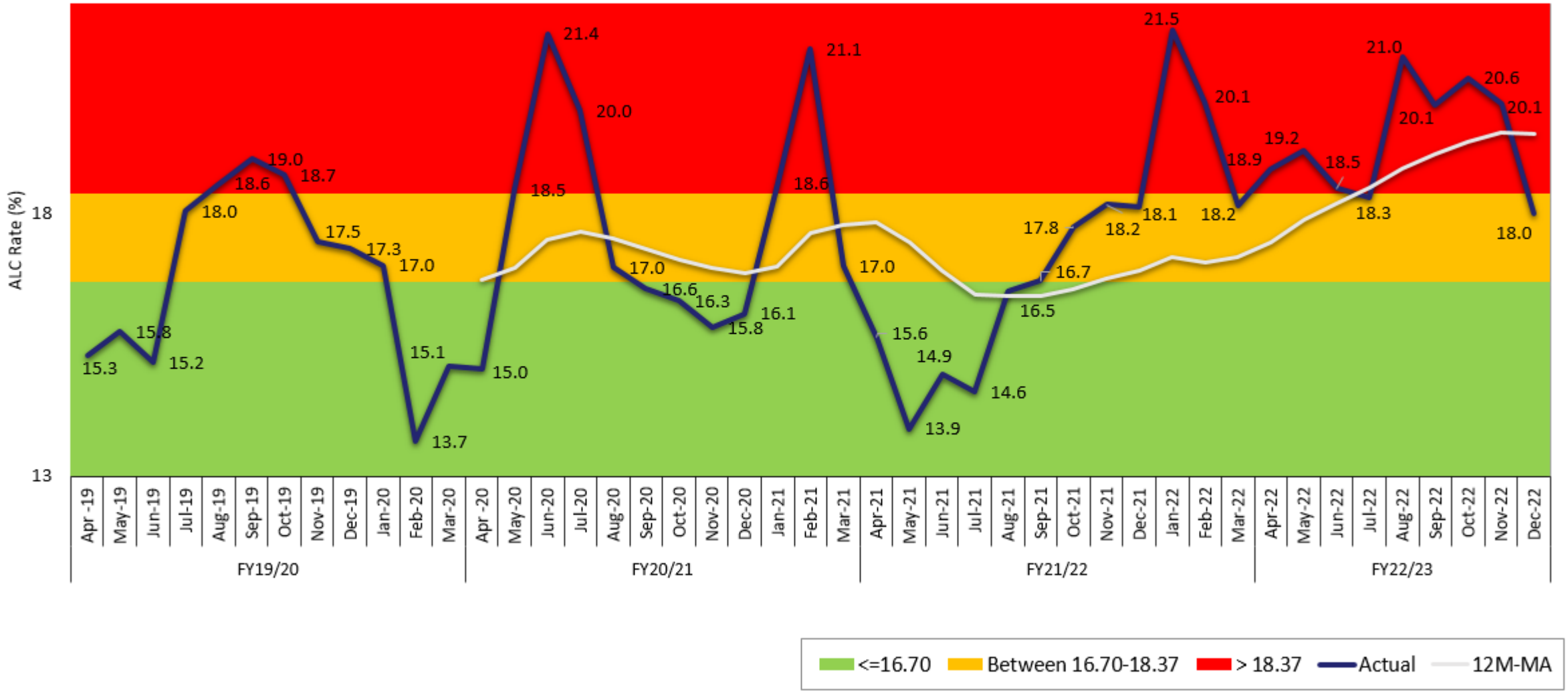
ACSC BME - Moving Forward

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 Dec 2022



- Overall, the KW4 ALC rate has been fluctuating over the past 3 years 9 months, and the total ALC rate shows an increase year over year since the beginning of the pandemic
- FY-YTD Dec 2022, the ALC rate is 19.5% which is 1.8 percentage points higher than the overall average of 17.7%.

12M-MA : 12 months moving average

ALC Open Cases as of December 2022

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

	Open Cases				% of Cumulative ALC Days											
Facility	Volume (Dec 2022)	Volume (Dec 2021)	%Change (Dec 2022 vs. Dec 2021)	Cumulative ALC Days (Dec 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	34	11	0%	1,518	9%	23%	15%	0.3%	0.6%	0%	20%	1.0%	0%	0.4%	30%	1.0%
Grand River	119	106	8%	5,709	37%	3%	0.4%	3%	1.0%	0%	33%	16%	4%	0.2%	0%	1.0%
Total	153	118	30%	7,227	31%	7%	3%	2.4%	0.9%	0%	30%	13%	3%	0.2%	6%	1.0%

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

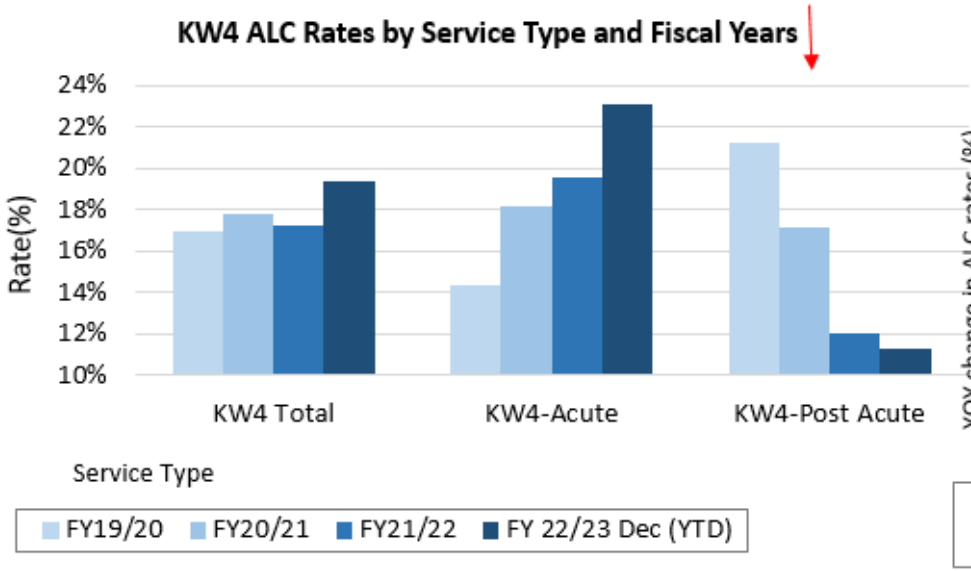
Source - Waterloo Wellington Sub-Region Monthly Alternate Level of Care Performance Summary - Dec 2022

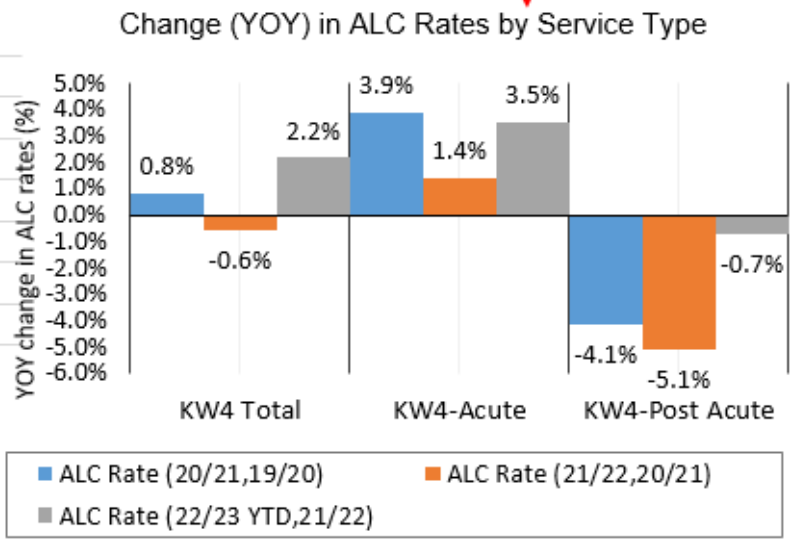
As of Dec 30, 2022:

- There were 153 patients designated ALC on the waitlist in the two KW4 OHT hospitals. This translates into 35 more cases compared to Dec 30, 2021
- These patients have accumulated 7,227 ALC days.
- Of the cumulative ALC Days 31% were attributed to patients waiting for Long Term Care, 30% waiting for Supervised or Assisted Living and 13% were waiting for Convalescent Care

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

Facility	ALC Rate				Year Over Year(YOY) Change in ALC Rates		
	FY19/20	FY20/21	FY21/22	FY 22/23 Dec (YTD)	Between FY 19/20 and 20/21	Between FY 20/21 and 21/22	Between FY 21/22 and 22/23YTD
GRH	16.9%	19.1%	18.3%	20.1%	2.2%	-0.8%	1.9%
Acute	12.8%	20.5%	22.5%	26.1%	7.7%	2.0%	3.6%
Post Acute	21.2%	17.1%	12.0%	11.3%	-4.1%	-5.1%	-0.7%
CCC	24.6%	18.4%	14.2%	11.9%	-6.2%	-4.2%	-2.3%
MH	20.7%	17.6%	10.6%	11.7%	-3.1%	-7.1%	1.1%
Rehab	11.3%	11.5%	10.0%	9.3%	0.2%	-1.5%	-0.7%
SMGH-Acute	17.4%	13.3%	13.7%	16.9%	-4.1%	0.4%	3.2%
KW4 Total	17.0%	17.8%	17.2%	19.4%	0.8%	-0.6%	2.2%
KW4-Acute	14.3%	18.2%	19.6%	23.1%	3.9%	1.4%	3.5%
KW4-Post Acute	21.2%	17.1%	12.0%	11.3%	-4.1%	-5.1%	-0.7%





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 2.2% points between FY21/22 and 22/23 (YTD)
- **had an increase of 2.4% points over the last 3 years and 8 months**

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 3.5% points between FY21/22 and 22/23 (YTD)
- **had an increase of 8.8% points over the last 3 years and 8 months**

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 0.7% points between FY21/22 and 22/23 (YTD)
- **had a decrease of 9.9% points over the last 3 years and months**

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 was submitted and approved 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.
  - 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

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

Alternate Level of Care (ALC) – Moving Forward

Moving Forward:

- Transitional Care Beds
  - HCCSS WW is **expanding transitional care options** for community and hospital patients. Through partnerships, 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. This quarter, there was an expansion of transitional care beds in Highland Place to 33 beds including memory care beds. Highland Place transitional care beds service high level of care needs untypical in most Retirement Homes and are open to community/hospital patients for respite and transitional care.

- Emergency Department (ED) Diversion Program
  - HCCSS WW has expanded the ED diversion program to include SMGH and CMH

- 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**.

- 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.

Courtesy of Lee-Ann Murray, Director of Patient Services, Home and Community Care Support Services Waterloo Wellington and the KW4 OHT Frail Elderly Reference Group co-Leads

Alternate Level of Care (ALC) – Moving Forward

Moving Forward:

- Ontario Bill 7
  - Across the province HCCSS have fully implemented Bill 7 to support access to care in the right place including ensuring patients who are designated ALC and are awaiting Long Term Care Home placement have shorter wait list homes on their facility choice list.

- 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 the KW4 OHT Frail Elderly Reference Group co-Leads

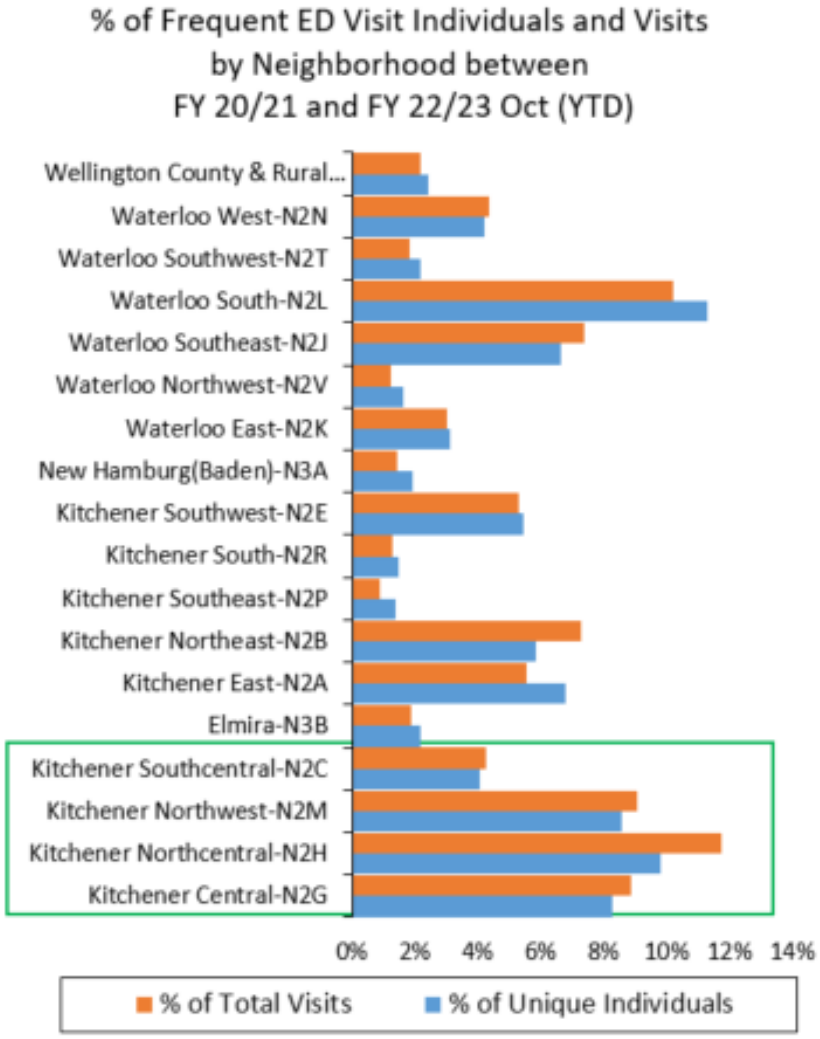
Frequent Emergency Department Visits for Help with Mental Health and Addictions

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

- 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 Neighbourhood in FY 2020/21 to FY 2022/23 Oct (YTD)

>=4 Visits												
FSA	Population (2021 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	**91,210**	**18%**	**88**	**82**	**56**	**708**	**622**	**447**	**226**	**1,777**	**31%**	**34%**
Kitchener Central-N2G	14,580	3%	22	25	14	180	179	105	61	464	8%	9%
Kitchener Northcentral-N2H	22,455	5%	27	28	17	252	216	147	72	615	10%	12%
Kitchener Northwest-N2M	36,495	7%	27	18	18	206	147	122	63	475	9%	9%
Kitchener Southcentral-N2C	17,680	4%	12	11	7	70	80	73	30	223	4%	4%
Other KW4 Neighbourhoods	**405,360**	**82%**	**146**	**156**	**94**	**928**	**1,037**	**653**	**396**	**2,618**	**54%**	**50%**
Total	**496,570**	**100%**	**234**	**238**	**150**	**1,636**	**1,659**	**1,100**	**622**	**4,395**	85%	84%
							All FSAs:3FYs		736	5,244	100%	100%



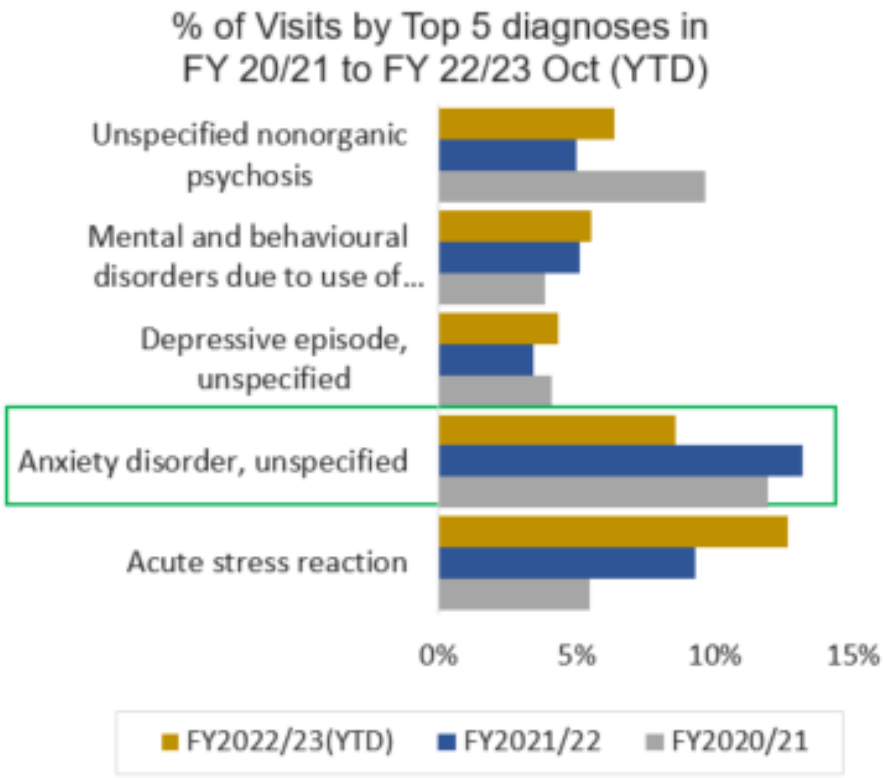
Between FY20/21 to 22/23 Oct YTD, 736 unique individuals had four or more ED visits for help with MH&A, totaling 5,244 visits in KW4 Facilities.

As per the 2021 census:

- Our four priority neighbourhoods (N2C, N2G, N2H, N2M) account for only 18% of KW4's population but 34% of the visits and 31% of the individuals
- The other fourteen KW4 neighbourhoods account for 82% of KW4's population but 50% of the visits and 54% of the individuals
- Although the Waterloo South neighborhood (N2L) appears to have a high percentage of visits (10%) and individuals (11%) this is in line with the % of the people who reside there (8%) and therefore this neighbourhood does not appear to be disproportionately represented

Unique # of Patients and # of ED Visits by Top 5 Diagnoses in FY2020/21 to FY2022/23 Oct (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%	9.9%	5.5%	9.3%	12.6%	8.4%	8.7%
Anxiety disorder, unspecified	12.9%	14.5%	9.9%	11.9%	13.2%	8.5%	12.8%	11.5%
Depressive episode, unspecified	5.4%	3.6%	4.4%	4.1%	3.4%	4.3%	4.5%	3.9%
Mental and behavioural disorders due to use of alcohol, acute intoxication	4.3%	5.4%	5.5%	3.9%	5.1%	5.5%	5.0%	4.7%
Unspecified nonorganic psychosis	11.5%	6.2%	6.6%	9.6%	5.0%	6.4%	8.3%	7.1%
Total	40.6%	39.1%	36.3%	35.0%	36.0%	37.3%	39.0%	36.0%

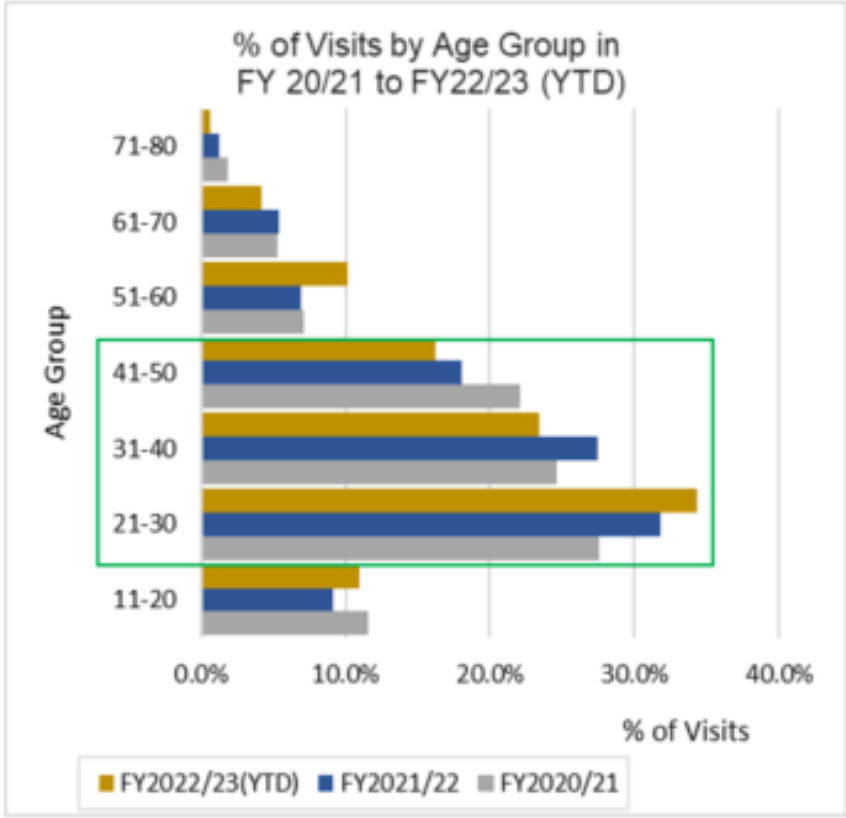


Diagnoses:

- The top 5 diagnoses codes accounted for 36.0% of visits for 39.0% of the individuals, with the most prevalent being 'Anxiety Disorder, unspecified' at 11.5% for the last 3 fiscal years.
- Acute stress reaction 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 Oct (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%	12.6%	11.6%	9.2%	10.9%	12.8%	10.5%	5.6	5.8	6.4
21-30	27.7%	32.6%	29.1%	27.6%	31.8%	34.3%	29.9%	30.9%	6.9	7.0	8.7
31-40	24.5%	25.4%	23.6%	24.6%	27.4%	23.4%	24.6%	25.4%	6.9	7.7	7.3
41-50	18.7%	15.2%	17.6%	22.0%	18.0%	16.2%	17.1%	19.0%	8.1	8.5	6.8
51-60	7.2%	7.6%	11.0%	7.1%	6.9%	10.1%	8.3%	7.8%	6.9	6.5	6.8
61-70	5.4%	6.2%	4.4%	5.3%	5.4%	4.2%	5.4%	5.1%	6.8	6.3	7.0
71-80	2.2%	1.8%	1.1%	1.8%	1.3%	0.6%	1.8%	1.3%	5.8	5.0	4.0
81+	0.0%	0.0%	0.5%	0.0%	0.0%	0.4%	0.1%	0.1%			5.0
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	6.9	7.2	7.4



Age Groups

- The top three age groups listed below accounted for 75.3% of the visits and 71.6% of the individuals in April 2020 to October 2022:
  - 21-30 at 30.9% visits and 29.9%
  - 31-40 at 25.4% visits and 24.6%
  - 41-50 at 19.0% visits and 17.1%
- The age group '21-30' had a decreased number of individuals since FY2021/22 with 3.5% points and a 2.5% increase in frequent visits in FY2022/23(YTD).
- 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 – 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 also 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

KW4 Ontario Health Team

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. This will become 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
  - As part of the NICT project we will be developing **3 patient personas and accompanying high-level journey maps** to identify opportunities for improved integrated care and strategies for implementation to better serve the identified patient personas.
  - **One of these persona will be related to MH&A**.
  - This will be followed by the **creation of integrated care pathways (ICPs)** with the buy-in and support of our partners, and the identification of opportunities for improved integrated care and strategies and suggestions for improved transitions based on the ICPs.
  - We will then use these learnings to inform the development of new integrated funding models.

- 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 Carizon and KW Counselling Services in Kitchener.

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:

- 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 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:

- 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 and GRH Mental Health Families for Awareness, Change and Education (FACE) Committee

KW4 Ontario Health Team

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	<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