Quarterly Performance Measurement Report

August 2024

Table of Contents

Summary : Latest Month Report

#	Indicator	Unit of Measure	Reporting Period	Proposed Target	Current Performance (lower is better)	Status	Change since last report
1	Caregiver distress among home care clients	%	Mar 2024	<= 56%	52.5%		Improvement from 53.3%
2	Hospitalization rate for conditions that can be managed outside hospital (asthma, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, angina and epilepsy)	Rate per 100,000 population	Apr 2024	<= 20.4 monthly (61.2 quarterly) (244.8 annually)	21.5		Improvement from 22.0
3	Total ALC (Acute and Non-Acute)	%	May 2024	<=16.7%	15.3%		Improvement from 16.7%
4	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	%	Jun 2024	<=10.0%	15.1%		Slippage from 11.8%

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

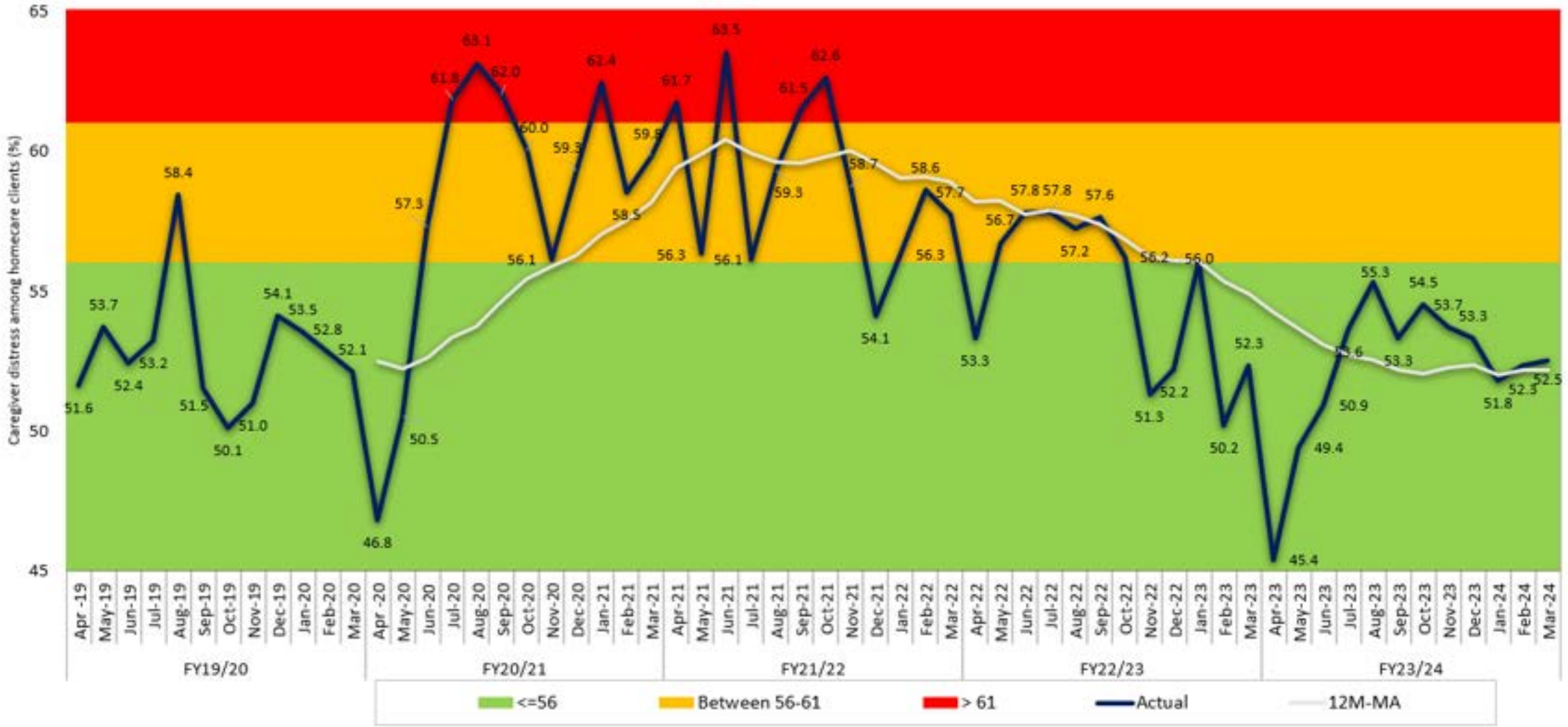
Data Availability

Indicator	Status - FY2024/25 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

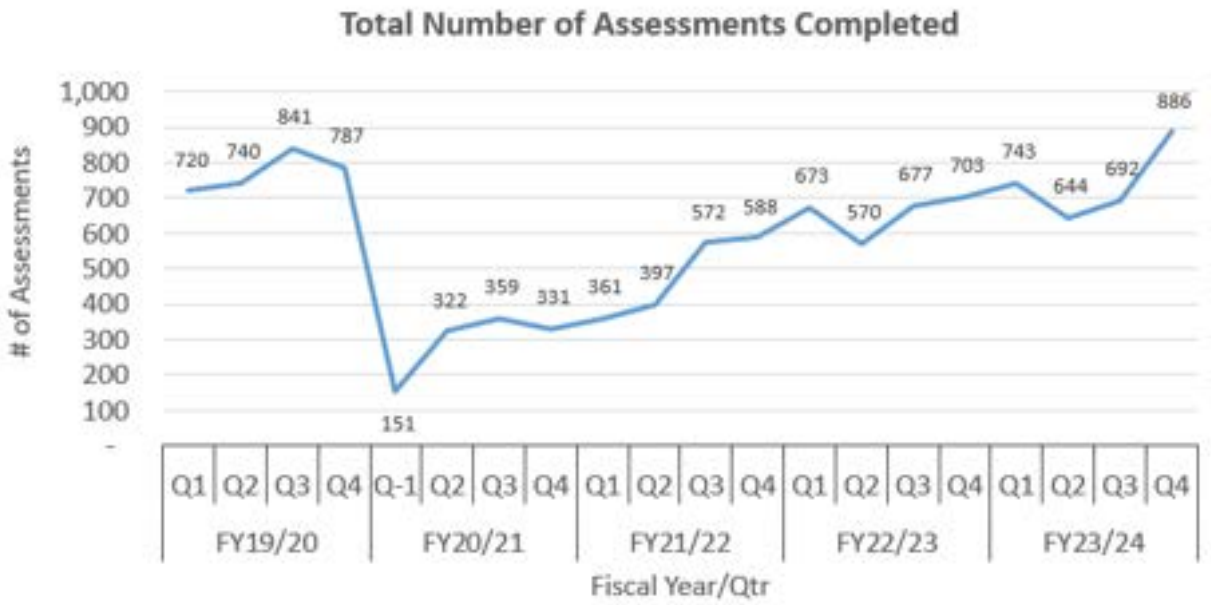
Caregiver Distress Among Homecare Clients (%): April 2019 to March 2024



- 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	FY19/20	FY20/21	FY21/22	FY22/23	FY23/24
Q-1	720	151	361	673	743
Q-2	740	322	397	570	644
Q-3	841	359	572	677	692
Q-4	787	331	588	703	886
Total	**3,088**	**1,163**	**1,918**	**2,623**	**2,965**



- 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.
- In FY2023/24 the number of assessments completed rose to 2,965, which is a significant jump from 22/23. In Q-4 the number of assessments completed exceeded pre-pandemic volumes.

Contributing Factors

Factors contributing to our current performance results:

- WW robustly utilizes the **Let's go Home program (LEGHO)** program to support patients being discharged from hospital to provide short term wrap around care.
- GRH in collaboration with the Alzheimer's Society WW launched the **DREAM program** in January 2024 which could have contributed to the decrease in caregiver distress.
- The support of the **community paramedic program** may also have reduced caregiver stress.
- In collaboration with partners, the KW4 OHT 2024 **wellness calendar** for older adults in the KW4 Region has been completed and distributed to stakeholders. Paramedics report this as a useful tool for patient care. Working group in process of implementing a new calendar for 2025/2026.
- 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 helping with more efficient and seamless access to services that could decrease caregiver distress.
- A **delirium collaborative** has been developed and will provide education for caregivers on how to recognize signs of delirium earlier on, which may contribute to decreasing caregiver distress. On March 13, 2024, the delirium toolkit was distributed to each acute care site emergency departments, community partners and ICT. A webinar was hosted and had over 300 registrants with positive feedback. Moving forward, the Collaborative have met with colleagues at OH who are leading the implementation of the DASH Campaign.
- The **ICT model** of care, which provides support for patients and families may result in decreasing caregiver distress.
- The **Geriatric Medically Complex Clinic** (GMCC) has stabilized the health human resources in the clinic, reducing wait time to see a geriatrician which could have contributed to the reduction in caregiver distress. A Geriatric Specialist will be taking a temporary LOA, effective June 2024, which could impact the wait list.
- Role of function of **intensive geriatric service worker** (IGSW) continues to support families and caregivers
- Home and Community Care Support Services (HCCSS) is seeing a noticeable increase in service provider capacity for personal support services. HCCSS WW has recently launched the provincial PSS framework.
- The short stay respite and convalescent care programs in long term care remain paused in Waterloo Wellington (WW), provincially other short stay respite and convalescent care has restarted.
- Face-to-face visits continue to be the standard based on clinical assessment supplemented by virtual visits as clinically appropriate.

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*

Moving Forward

Initiatives currently underway, or planned for the near future, that will impact our performance on a go-forward basis:

- Delirium Collaborative
  - The KW4 OHT Frail Elderly Collaborative in partnership with the Waterloo Wellington Older Adult Strategy is developing educational materials for patients, families, and clinical teams to assist with **recognizing early signs of delirium** to initiate interventions and supports sooner.

- Integrated Care Team (ICT) Expansion Project
  - The ICT has been running since winter 2022 and has received provincial and national recognition for their tremendous success. Despite this, in May 2024, the team was told that funding would be cut by 45% as OH West would no longer support clinical administration and specialists' fees. OH West committed to work with the OHT to find other resources and has urged the ICT to continue their work. We continue to await confirmation of funding for fiscal 2024/25 - both the amount and the funding letter for this program.

- St Mary's Hospital to Home Program
  - St Mary's has launched a **hospital to home model program** to reduce ALC. The program was implemented as a 21-day program and now launching a 16-week program.

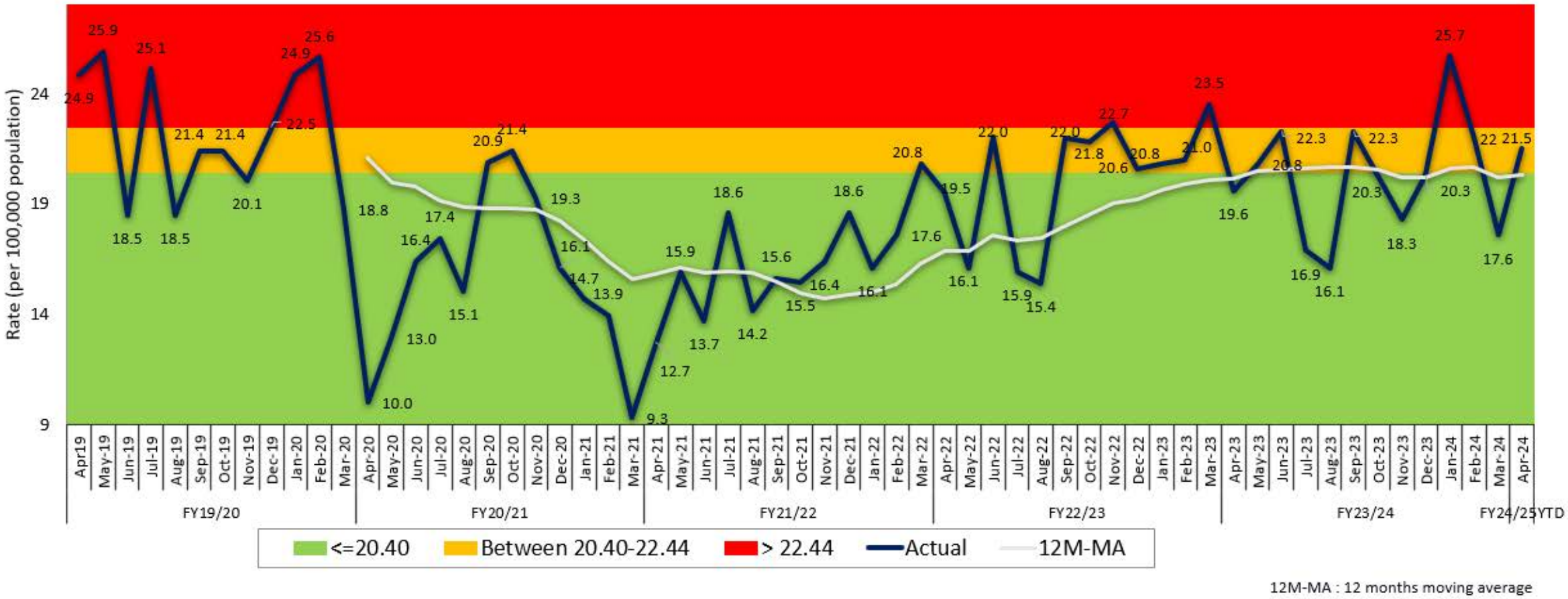
- Building HCCSS WW Capacity
  - HCSS continues to maximize/expand community clinics locally and across the province. **Optimization of direct care therapy to support patients waiting for service has demonstrated effectiveness in supporting ALC patients** to return home.

- Principles of sfCare across sectors:
  - Hospital partners have promoted the exchange of knowledge related to principles of senior friendly care (sfCare) across sectors. Leading practices in Community Based Early Identification, Assessment & Transition: Preventing Alternate Level of Care supports facilitating proactive identification and promoting practices in care and self-management that prevent, slow or reverse declines in the physical and mental capacities of older adults, care plan development and ongoing re-assessment, delivery of interventions and sfCare, and proactive transitions.

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 Apr 2024



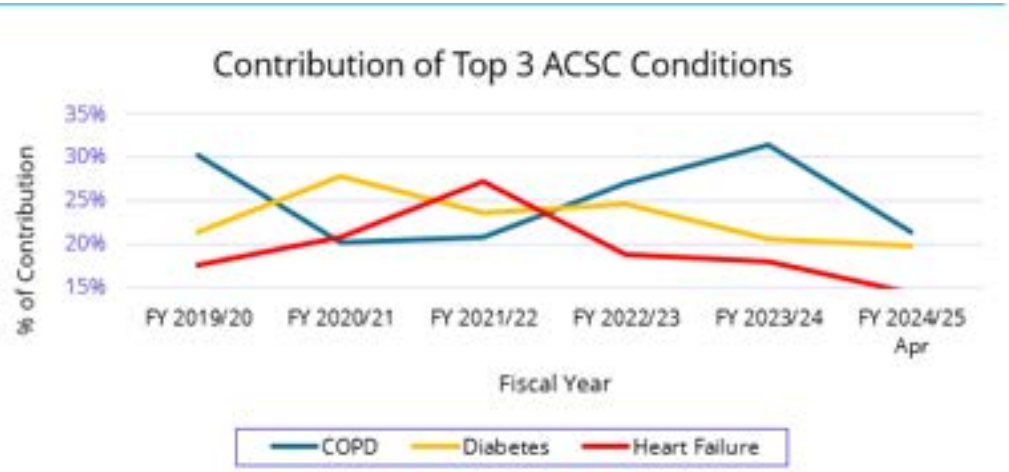
12M-MA : 12 months moving average

- Rate of ACSC best managed elsewhere decreased during the pandemic.
- This could potentially be an artificial decrease based on patients deferring to seek face-to-face care or having the option of virtual care.
- Since Q3 FY2021/22, we can see an upward trend in the rates.

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 FY2024/25 Apr(YTD)

Diagnosis	FY 2019/20	FY 2020/21	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25Apr
COPD	30.2%	20.3%	20.8%	27.0%	31.5%	21.4%
Diabetes	21.3%	27.9%	23.7%	24.7%	20.6%	19.8%
Heart Failure	17.7%	20.9%	27.2%	18.7%	18.1%	14.3%
Angina	2.5%	3.0%	1.9%	1.8%	1.7%	0.8%
Asthma	11.8%	5.2%	9.7%	13.3%	10.9%	23.0%
Epilepsy	12.5%	16.8%	12.4%	11.1%	12.3%	14.3%
Hypertension	4.0%	5.9%	4.3%	3.3%	5.0%	6.3%



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%
- 70.4% in FY2022/23, with the most prevalent being 'COPD' at 27.0%
- 70.2% in FY2023/24, with the most prevalent being 'COPD' at 31.5%

In FY 2024/25 (APR), 'Asthma' became the top ACSC Condition at 23.0%.

- **COPD** had a decrease of 9.9% points in FY2020/21, a slight increase of 0.5% points in FY2021/22, a significant increase of 6.2% points in FY2022/23, an increase of 4.5% points in FY2023/24, **and a decrease of 10.1% points in FY2024/25 Apr YTD**

- **Diabetes** had a significant increase of 6.6% points in FY2020/21, a decrease of 4.2% points in FY2021/22, a slight increase of 1.0% points in FY2022/23, a decrease of 4.1% points in FY2023/24, **and a slight decrease of 0.8% points in FY2024/25 Apr(YTD)**

- **Heart Failure** had an increase of 3.2% points in FY2020/21, 6.3% points in FY2021/22, a significant decrease of 8.5% points in FY2022/23, a slight decrease of 0.6% points in FY2023/24 **, and a decrease of 3.8% points in FY2024/25 Apr(YTD)**

Average Monthly Ambulatory Care Sensitive Conditions Best Managed Elsewhere (ACSC) (%) By Neighbourhood

	FSA Description	Population 0-75 years	Ambulatory Care Sensitive Conditions Best Managed Elsewhere (ACSC) (Rate/100K) – All 7 Conditions (asthma, diabetes, COPD, heart failure, hypertension, angina and epilepsy)					Ambulatory Care Sensitive Conditions Best Managed Elsewhere (ACSC) (Rate/100K) - COPD					Ambulatory Care Sensitive Conditions Best Managed Elsewhere (ACSC) (Rate/100K) - Diabetes					Ambulatory Care Sensitive Conditions Best Managed Elsewhere (ACSC) (Rate/100K) - Heart Failure				
			2019-20	2020-21	2021-22	2022-23	2023-24	2019-20	2020-21	2021-22	2022-23	2023-24	2019-20	2020-21	2021-22	2022-23	2023-24	2019-20	2020-21	2021-22	2022-23	2023-24
Kitchener	Kitchener(East)-N2A	30,030	19.7	16.4	19.7	23.3	29.4	7.8	4.2	4.2	5.8	9.2	2.8	1.9	4.2	6.9	5.8	2.8	4.7	5.8	3.1	8.6
	Kitchener Northeast-N2B	15,470	29.1	20.5	23.2	31.8	31.8	10.8	4.8	3.2	14.0	12.9	3.8	5.9	6.5	5.4	10.8	7.0	6.5	7.0	5.9	2.2
	Kitchener(Southcentral)-N2C	16,175	26.8	19.1	25.8	25.2	35.5	6.2	4.6	6.2	8.2	12.9	4.1	6.2	7.2	3.6	3.6	6.2	3.6	2.6	5.7	9.3
	Kitchener(Southwest)-N2E	38,405	17.4	12.2	15.0	16.3	19.1	3.5	2.2	2.6	2.6	6.9	4.1	2.4	4.6	5.6	3.9	3.5	2.2	3.3	3.0	4.1
	Kitchener(Central)-N2G	13,305	37.6	33.8	40.1	37.6	49.5	13.2	9.4	7.5	8.8	18.2	8.1	8.8	13.8	8.8	8.1	9.4	4.4	10.6	8.1	8.8
	Kitchener(NorthCentral)-N2H	20,965	27.4	27.8	29.8	34.6	30.6	10.7	8.7	13.9	14.7	10.3	6.0	8.3	7.9	9.9	6.4	2.8	3.6	3.6	3.2	4.4
	Kitchener(Northwest)-N2M	33,960	27.5	21.8	28.0	33.4	33.6	12.0	4.7	6.9	10.8	12.5	3.7	8.6	4.2	6.6	6.6	5.2	4.4	10.3	5.9	2.9
	Kitchener(West)-N2N	24,895	15.1	13.7	13.1	17.7	19.1	3.7	1.7	1.7	5.0	4.4	3.3	3.3	1.7	3.3	2.0	1.3	3.7	4.7	4.4	4.7
	Kitchener(Southeast)-N2P	23,990	9.7	5.9	7.6	10.8	11.5	2.8	0.7	1.4	2.4	2.8	1.7	1.4	1.4	1.7	2.4	1.7	0.7	3.1	1.0	2.8
	Kitchener(South)-N2R	18,165	6.0	6.0	7.3	11.9	14.2	0.0	0.9	0.5	0.5	1.8	0.9	0.5	0.9	3.7	2.3	0.9	1.4	1.4	1.8	0.9
Waterloo	Waterloo(Southeast)-N2J	18,660	26.3	14.7	17.9	31.3	21.4	8.9	3.1	2.7	9.8	9.4	6.7	4.0	1.8	6.3	2.7	4.5	3.1	6.7	8.9	5.8
	Waterloo(East)-N2K	27,775	12.9	5.4	10.8	14.4	9.6	2.7	0.9	1.5	2.1	2.1	2.7	0.9	3.0	2.4	2.4	3.3	2.1	3.3	4.8	2.1
	Waterloo(South)-N2L	34,975	15.0	8.8	15.5	17.6	11.7	3.8	0.7	3.3	3.8	3.1	5.7	3.6	5.0	6.0	3.1	1.4	1.7	3.8	3.8	1.9
	Waterloo(Southwest)-N2T	19,365	12.0	8.6	10.3	9.9	11.6	3.0	0.4	0.9	1.3	2.2	5.6	3.9	2.2	1.7	1.7	0.9	2.6	2.6	2.2	2.2
	Waterloo(Northwest)-N2V	18,565	12.6	6.7	10.3	10.3	7.6	0.4	1.3	0.4	1.8	0.4	4.5	1.8	2.7	2.7	3.6	1.8	0.9	4.5	2.7	0.9
Rural	Wellington County & Rural Waterloo Region-N0B (extends beyond KW4)	80,585	3.0	1.8	3.6	3.4	3.5	0.7	0.1	0.5	0.7	0.9	0.3	0.7	1.0	1.0	1.1	0.8	0.4	1.0	0.5	0.4
	New Hamburg(Baden)-N3A	15,490	7.5	8.1	9.7	15.1	10.8	3.2	2.7	1.1	4.8	4.3	2.2	2.2	3.2	3.8	2.2	0.5	1.6	1.6	2.2	1.1
	Elmira-N3B	12,110	16.5	9.6	11.7	8.3	17.9	3.4	0.0	3.4	0.7	2.8	3.4	4.1	1.4	2.8	6.9	4.1	1.4	1.4	1.4	2.1

- The average monthly rate of ACSC best managed elsewhere varies by neighbourhood. In 2023/24, the rate per 100K population ranged from a high of 49.5 (Kitchener Central - N2G) to a low of 3.5 (Wellington County & Rural Waterloo Region - N0B).

Contributing Factors

Factors contributing to our current performance results:

COPD:

- SMGH airway clinic **volumes April 2023 to March 2024 rose 14% over previous years annua**l volumes. So far in in **2024/25,** volumes are up **17% over 2023/24,** spread across both our diagnostic and education appointment types.
- In the fall winter 23/24 SMGH launched a rapid respirology clinic 1 day a week as a means for a rapid respirologist assessment for those patients who could not wait for a regular appointment but were not sick enough for an ED visit. This clinic sees 4-6 patients every week for things like thoracentesis, pleural effusion management and other disease progressions.
- Referrals at SMGH's community airway clinics operating in the regions CHCs (Woolwich, Kitchener, Guelph, Langs/Cambridge) remain strong. The team continues to identify incorrectly classified lung conditions with the onsite spirometry they provide
    - With the relocation of the Wellesley site of WCHC, we will be able to see 25-33% more patients per day at the Wellesley site community Respiratory Clinic days due to better ventilation and space options
    - These sites are at maximum capacity with waitlists at some sites. Funding for this program have not increased since it's original start. SMGH is working with the CHC leads to create a funding request to expand the services.
- SMGH restarted contracted RRT services with University of Waterloo for asthma education/self-management appointments to reduce student impact on regional acute healthcare resources as many of this group do not have local primary care options.
- In 23/24 SMGH shifted their smoking cessation classes to a more group-based counselling model with some options for individuals if required. This was due to an increase in referrals from primary care and the regional cancer center. The adaptation has been positive and allowed SMGH to work cooperatively with the cardiac rehab program to increase access to these services for the cardiac population and maintain very short or no waitlists for the service.
- The KW respirology group continues to support the Wellington area with onsite clinics at the MFFHT and virtual assessments of patients form these regions to avoid unnecessary trips for patients. Some of these are subsequently seen in the rapid respirology clinic to avoid hospital admissions to deal with outpatient treatable conditions.

Heart Failure:

- **Remote Care Monitoring** initiatives, in place at SMGH since March 2022, for Congestive Heart Failure has had a significant positive impact (i.e., decrease in heart failure hospitalizations). 56 kits were handed out from April to the end of Augus 2024.
- **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 case 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, Oscar PRO and Accuro QHR EMRs. 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

Diabetes:

- The Regional Coordination Centre has seen a steady increase in the volume of self-referral data in KW4. This could be due to the self-referral to diabetes education program (DEP) awareness campaign that occurred through the Neighborhood Integrated Care Team Project.
- The impact of the Diabetes Fit program sessions, rolled out in collaboration with YMCA, was evaluated through pre and post-surveys on lifestyle, quality of life, and social connections, along with data collection on physical functioning measures before and after the program, and participant satisfaction post-program. The results show an overall improvement in physical functioning and quality of life of the participants.

Courtesy of:

- *Danny Veniott, Program Manager - Respiratory Therapy, Airway Clinics, SMGH and Angie Fraser, Program Manager, Inpatient Cardiac Surgery, SMGH*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

COPD:

- The **Relocation of the Airway Clinic** to the Boardwalk has been a very positive experience for patients and staff. Despite year over year increases in visits the extra space is allowing the clinic to function without physical limitation
- **SMGH is fully operational at Community Healthcare Clinic hosted COPD and Asthma education/self-management programs** operated through Woolwich, Lang's, Community Healthcaring KW, and Guelph CHC's and including some of their remote program sites
    - Work will be starting to develop a business case to request increased funding from OH for the program to maintain and perhaps expand the service to additional sites
    - The spirometers at each site were upgraded recently to reflect updated standards and for reliability reasons
- **SMGH has restarted its asthma education self-management program at University of Waterloo**
- **In-person COPD appointments continue to increase**. SMGH also continues to offer **telephone or virtual options** when required or requested
- The COPD program continues 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 continue 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. care. **This program is now available ongoing as part of SMGH's base program** for patients who have barriers to in person participation. Referrals for COPD activation had risen over the past 6 months with increased communication and awareness of remote access to the program.
- With the planned SMGH GRH merger, the two organizations are looking at respiratory services to see if better streamlining or coordination is obtainable to reduce duplication and improve access.
- SMGH is looking at launching a specialized clinic for pulmonary fibrosis to better support this patient population, similar to their cystic fibrosis clinic structure.

Courtesy of:

- *Danny Veniott, Program Manager - Respiratory Therapy, Airway Clinics, SMGH*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

Heart Failure:

- <u>Remote Care Monitoring (RCM) and Surgical Transition Program:</u>
  - KW4 OHT, in collaboration with SMGH and Primary Care developed and submitted a proposal for **Heart Function Clinic Virtual sustainment and expansion**
    - 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.
  - 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, and connecting to Cardiac Rehab Programming in Waterloo for ongoing Heart failure stream care and monitoring with the interdisciplinary team).
    - 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)
  - **SMGH received confirmation in August 2024 that funding for the RCM project for FY 24/25 has been approved, reinforcing the success of this initiative.**

- <u>Integrated care pathway for senior with congestive heart failure</u>
  - KW4 OHT in collaboration with member organizations and the community designed a patient persona, journey map and **integrated care pathway for senior with congestive heart failure.** The goal of this pathway is to provide a clear community-based care pathway that adopts a chronic disease management approach, improves communication, increases access to information, offers more comprehensive and holistic care, improves the patient's quality of life, engages patients and care partners as members of the care team, better integrates services across sectors, creates a community support around the patients, and integrates palliative care earlier in the patient's care journey. Currently we are exploring new opportunities to support seniors with heart failure in the heart function clinic through community resources. This will include identifying ways to enhance access to community-based services, such as transportation, home care, and social support, to help seniors manage their health more effectively.
  - The CSS navigator pilot project has also been established, which is focused on connecting patients to the community resources they need to achieve holistic care based on a referral from their primary care clinician. Patients with heart failure form a part of the population served through the CSS navigator.

- <u>Clinical Pathway Development and SCOPE</u>
  - 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:

- *Angie Fraser, Program Manager, Inpatient Cardiac Surgery, SMGH*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

Heart Failure:

- The KW4 CHF QBP No-loss Provision Working Group continues to work on a collaborative approach in diagnosis and management of heart failure (HF) patients in the region. Several initiatives have been successfully implemented in our region since its inception back in early 2022. Ongoing work includes:
  - Improving access to IV lasix in outpatient settings
  - Improving data collection for HF patients regarding readmission rates, primary care access, and mortality rates
  - Improving regional buy-in and involvement of other regional hospitals like Guelph General Hospital and Cambridge General Hospital in our HF initiatives
  - Clarifying cut-offs for biomarkers (NT proBNP and BNP) and exploring ways to standardize the availability of the two biomarkers (currently different for inpatients and outpatients and among different facilities)
  - Continuing work to establish a CHF pathway in the community to allow access to allied health supports based on the unique needs of HF patients and family
  - Improving access to primary care for this vulnerable population

Prevention:

- St Mary's General Hospital **launched a new program in April of 2024 called the PREvent Clinic**, for patients with increased cardiovascular risk identified by the Emergency Department, Urgent Care Clinic, or Primary Care Provider. Through a 16-week program, the clinic would focus on medical optimization of risk factors including hypertension, dyslipidemia, to a lesser extent diabetes, and smoking cessation as well as supporting education, dietary counseling and exercise prescriptions. This clinic has been made possible through an expanded partnership between SMGH and Manulife allowing more proactive illness prevention in the community as well as avoidance of hospital admission. The clinic has had 20 patients thus far with reach out to community partners to spread awareness. The Prevent Clinic has onboarded a Social Worker who will be seeing unattached patients at the RAP-Clinic along with a Nurse Practitioner specializing in Primary Care.

Unattached Patients:

- The Rapid Access Primary Care Clinic (RAP-Clinic) is a cross-organization effort being led by Community Healthcaring KW. This pilot clinic is focusing on providing access to episodic primary care for unattached patients who frequently use the ED as their first point of access. The pilot has created a proof-of-concept clinic that has shown early signs of success. The SMGH and GRH Emergency Departments are active referral partners, and the Waterloo Regional Nurse-Practitioner Led Clinic is exploring providing virtual NP support as well as attaching unattached patients where possible. This pilot builds on a proposal created for the Expanding Team Based Care Expression of Interest. The sectors involved include KW4 OHT primary care, hospitals, community service providers.
- The Cardiac Rehab/Prevent team will be working on-stie at the RAP-Clinic supporting prevention and primary care in a new collaboration and innovative approach.

Diabetes:

- KW4 OHT in collaboration with member organizations and the community have designed a patient persona, journey map and **integrated care pathway for Diabetes.** 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.
- The OHT is continuing to work with the Regional Coordination Centre to create awareness about **Self-referral to Diabetes Education Programs** with a focus on the priority neighborhoods. These programs equip patients with the proper education, tools and support in managing Diabetes. The Regional Coordination Centre is also working towards providing self-referral forms in top languages spoken by newcomers to the region and will continue to report on volumes of self-referral data.
- The OHT collaborated with the House of Friendship to circulate the Self-referral to Diabetes Education Program posters through their food distribution programs at community centres.
- The OHT collaborated with the YMCA of Three Rivers to roll out two sessions of **Diabetes Fit Program**, a health management program that is focused on leveraging lifestyle modifications to diet and exercise as a way to improve the overall quality of life in patients with Pre-diabetes and Type 2 Diabetes. The YMCA continues to offer the Diabetes Fit program as part of their regular programming to residents of KW4.
- The OHT is supporting improved access to diabetes care for high-risk patients in KW4 through timely access to endocrinologists and diabetes education programs for patient referrals meeting urgent criteria.
- The OHT is supporting diabetes prevention and management with Indigenous older adults. This includes participating in a Working Group comprised of Certified Diabetes Educators (CDEs), Indigenous Older Adults and health and social service professionals who intersect with these groups to identify knowledge gaps in local diabetes health care management for Indigenous Older Adults and produce education materials that will situate CDEs to be a key stakeholder in enabling Indigenous older adults to live a safer and connected life.

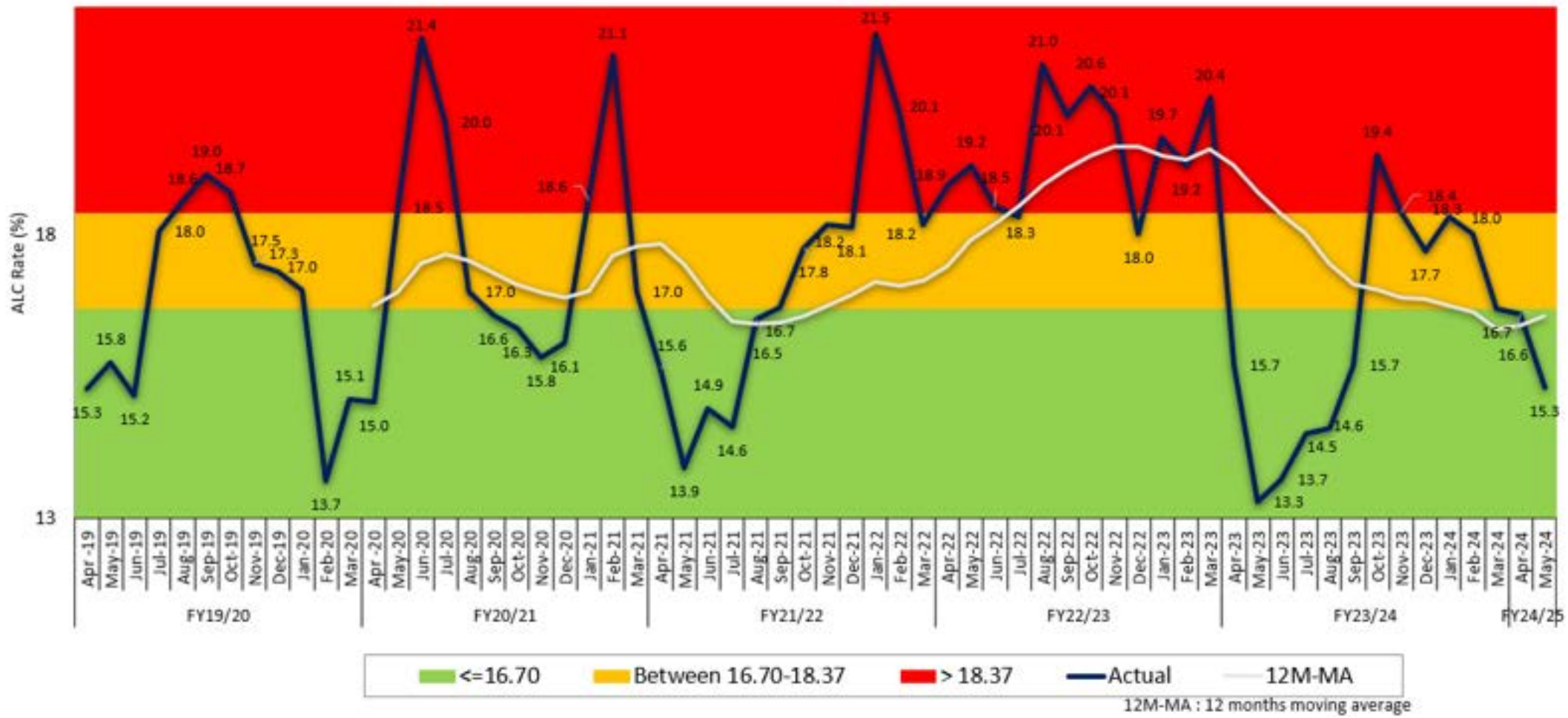
Courtesy of:

- *Danny Veniott, Program Manager - Respiratory Therapy, Airway Clinics, SMGH and Angie Fraser, Program Manager, Inpatient Cardiac Surgery, SMGH*

KW4 Ontario Health Team

Alternative Level of Care (ALC)

Total ALC (Acute and Non-Acute) Rate (%) - April 2019 to May 2024



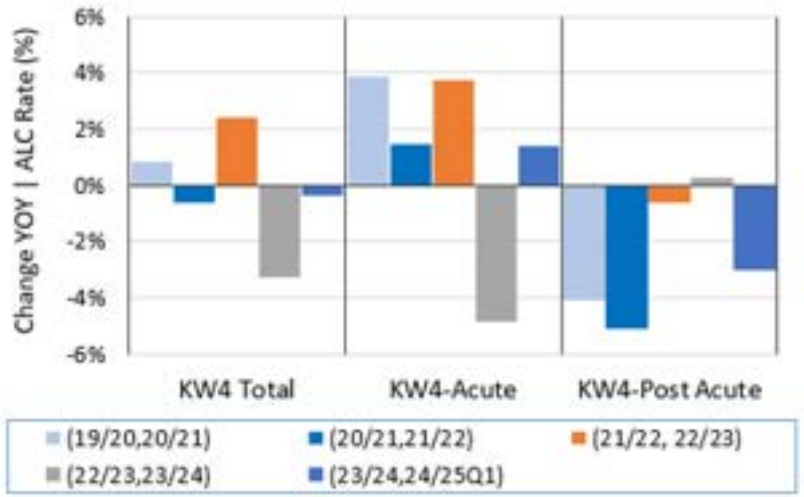
- Overall, the KW4 ALC rate has fluctuated over the past 5¼ years.
- There was an upward trend since the beginning of the pandemic and then a downward trend beginning in the third quarter of FY2022/23.
- FY 2024/25 May YTD, the average ALC rate was 16.0% which is below our target of 16.7%.

ALC Rate by Facility, Service Type, and Fiscal Year FY19/20 to FY24/25 May

Facility	ALC Rate						Year Over Year (YOY) Change in ALC Days				
	FY19/20	FY20/21	FY21/22	FY22/23	FY23/24	FY24/25Q1	Between FY 19/20 and 20/21	Between FY 20/21 and 21/22	Between FY 21/22 and 22/23	Between FY 22/23 and 23/24	Between FY 23/24 and 24/25Q1
GRH	16.9%	19.1%	18.3%	20.4%	17.4%	16.6%	2.2%	-0.8%	2.1%	-2.9%	-0.8%
Acute	12.8%	20.5%	22.5%	26.4%	21.4%	22.3%	7.7%	2.0%	3.9%	-4.9%	0.9%
Post Acute	21.2%	17.1%	12.0%	11.4%	11.7%	8.7%	-4.1%	-5.1%	-0.6%	0.3%	-3.0%
CCC	24.6%	18.4%	14.2%	12.7%	12.0%	10.6%	-6.2%	-4.2%	-1.5%	-0.7%	-1.3%
MH	20.7%	17.6%	10.6%	10.9%	12.1%	7.4%	-3.1%	-7.1%	0.4%	1.2%	-4.7%
Rehab	11.3%	11.5%	10.0%	9.9%	10.1%	7.9%	0.2%	-1.5%	-0.1%	0.2%	-2.3%
SMGH-Acute	17.4%	13.3%	13.7%	17.1%	12.8%	12.9%	-4.1%	0.4%	3.4%	-4.3%	0.2%
KW4 Total	17.0%	17.8%	17.2%	19.6%	16.3%	16.0%	0.8%	-0.6%	2.4%	-3.3%	-0.4%
KW4-Acute	14.3%	18.2%	19.6%	23.3%	18.5%	19.9%	3.9%	1.4%	3.7%	-4.9%	1.4%
KW4-Post Acute	21.2%	17.1%	12.0%	11.4%	11.7%	8.7%	-4.1%	-5.1%	-0.6%	0.3%	-3.0%

KW4 ALC Rates by Service Type and Fiscal Years

Change (YOY) in ALC Rates by Service Type



KW4 Total ALC Rate:
- increased 0.8% points between FY19/20 and 20/21
- decreased 0.6% points between FY 20/21 and 21/22
- increased 2.4% points between FY21/22 and 22/23
- decreased 3.3% points between FY22/23 and 23/24
- decreased 0.4% points between FY23/24 and 24/25Q1
- **decreased 1.0% points over the last 5¼ 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
- decreased 4.9% points between FY22/23 and 23/24
- increased 1.4% points between FY23/24 and 24/25Q1
- **increased 5.6% points over the last 5 ¼ years.**

KW4 Post Acute ALC Rate:
- decreased 4.1% points between FY19/20 and 20/21
- decreased 5.1% points between FY 20//21 and 21/22
- decreased 0.6% points between FY21/22 and 22/23
- increased 0.3% points between FY22/23 and 23/24
- decreased 3.0% points between FY23/24 and 24/25Q1
- **decreased 12.5% points over the last 5 ¼ years.**

Source: ALC Rate Quarterly Release CCO-WTIS

FY24/25Q1 has only April and May data

Contributing Factors

Factors contributing to our current performance results:

- Home with HCCSS Services
  - Provincial commitment to provide education on ALC designation and operational direction - Home First.
  - **Weekly oversight and escalation of ALC to home** with Ontario Health At Home, Waterloo Wellington in collaboration with the hospital partners.
  - **Increased capacity of Personal Support Services (PSS)** and no waiting list for PSS in KW4.

- ALC Rounds
  - St Mary's General Hospital in collaboration with Ontario Health At Home, Waterloo Wellington has implemented **including community partner CSS in ALC rounds** to provide support to patients and families and to help problem solve discharge barriers and exploring opportunities to prevent ALC designations.

- Hospice
  - **Additional beds were added to Hospice Waterloo Region**. This increase to 11 beds allows for the provision of additional palliative care for those at end of life and supports for their families.

- Emergency Department (ED) Diversion Program
  - ED diversion remains a focus of hospitals to 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.

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

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Alternate Destination – Hospice</u>
  - On August 31, 2023, Region of Waterloo Paramedic Services received approval from the Ministry of Health, for the **Alternation Destination (Hospice) project** under the ministry's Patient Care Model initiative for eligible 9-1-1 palliative care and end of life patients. KW4 OHT was a proponent for this model and offered a letter of support. Under this model, palliative care patients calling 9-1-1 will have the option to be treated on-scene for pain and symptom management, including pain or dyspnea, hallucinations or agitation, terminal congested breathing, and nausea or vomiting. Following treatment on-scene, patients have the option for paramedics to coordinate the patient's follow-up care directly with the patient's primary palliative care provider; or if treatment on-scene is not managing the symptoms and the patient is registered in the Alternate Destination Hospice project, the patient can be moved directly to Hospice for end-of-life care. This **ensures that paramedics have more options to provide safe and appropriate treatment for patients while helping to protect hospital capacity**. Meetings to move this initiative forward among the many partners are ongoing.

- <u>Emergency Department (ED) Diversion Program</u>
  - The KW4 OHT Frail Elderly Collaborative in partnership with the Waterloo Wellington Older Adult Strategy is **developing education tools** built on the RGP Toronto materials **to assist with education and knowledge transfer in assessing and recognizing delirium early in the Emergency Department** with treatment and care options. **Education tools launched in March 2024**

- <u>Let's Go Home (LEGHO)</u>
  - This program continues to offers up to **6 weeks of Community Support Services**, customized to the unique needs of vulnerable patients, and at no cost to the patient, supporting their stabilization in the community post discharge.
  - The program has been well received by hospitals and has been of great benefit to patients.

- <u>Integrated Care Team (ICT) Expansion Project</u>
  - A proposal has been put forth to the ministry for base funding for this project. To date partial funding has been received with ongoing efforts underway to secure additional funding.

- <u>Community Navigation Team</u>
  - The **Community Navigation pilot initiative**, being led by Community Care Concepts, supports primary care providers in connecting patients with community social services. This program builds off learnings from LEGHO, SCOPE, and the CCP ICT and connects in with these initiatives as appropriate. The Navigation Team is leveraging the Ocean eReferral platform to provide team-based resources to clinicians in Family Health Organizations (FHOs). The Navigation Team connects patients with community-based supports for upstream preventative care. The team has expanded to support over 30 primary care providers located The Boardwalk and is planning the next steps for this program.

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

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Long Term Care (LTC)</u>
  - In collaboration with LTC partners, Ontario Health At Home, Waterloo Wellington is supporting the opening of **additional LTC beds at the Village of Winston Park. Additional beds at the Elliott expected to come online in fall 2024.**

- <u>SCOPE (Seamless Care Optimizing the Patient Experience)</u>
  - 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.

- <u>ALC Leading Practices</u>
  - **Self assessments have been completed by hospitals and community organizations** for ALC leading best practices and in collaboration with OH West **will develop plans for implementation** by individual organizations. Updates to the implementation of plans to be provided to OH-West.

- <u>Transitional Care Beds (TCU)</u>
  - Ontario Health At Home, Waterloo Wellington continues to operate a 30 bed TCU that focuses on supporting ALC patients and patients in the community at risk of admission to hospital. TCU operates 5 beds in Guelph Wellington area at Stone Lodge Retirement Residence and 25 at Highland Place in Kitchener. Collaborative discussions with OH and hospital partners related to supporting additional populations for TCU (i.e., rehab populations, persons unable to return home due to external factors, MAiD support) continue.

- <u>Integrated Dementia Resource Team - DREAM (Dementia, Resource, Education, Advocacy, Mentorship)</u>
  - This initiative is aimed at people living with dementia with the goal of preventing hospital admissions, decreasing caregiver burden, reducing repeat visits, and decreasing ALC.
  - Guelph and GRH are included in the pilot, with the goal to scale to all 7 hospitals in WW if the pilot is successful.
  - As part of this initiative, the Alzheimer's Society would embed a resource (RPN/social worker trained in behaviour prevention) in the Emergency Department Monday to Friday, 8:00-4:00. This resource will help to identify community resource, help with access, and support transition from hospital to home through the Alzheimer's Society respite program. Activation/therapeutic support (not personal care) would be provided for up to 12 hours per week or 40 hours per month to relieve caregiver burden.
  - This Team will also support the individual with dementia in the emergency department and support capacity building with staff within the emergency department.

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

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Waterloo Focus Community Meeting</u>
  - Waterloo Region is engaged in a Community focus meeting and monthly updates with scorecards and target progress. The updated scorecards for CMH, GRH and SMGH provide ALC targets. There is also an action plan to support improvements in ALC.

- <u>Delirium Resource Toolkit Program</u>
  - This initiative involves the **rollout of delirium resource toolkit** for caregivers, clients and patients in various settings (i.e., Emergency Department) to assist with recognizing the early signs of delirium so that interventions and supports can be initiated sooner. The Delirium Collaborative is developing their next work plan taking into consideration the results of the Delirium Resource Toolkit evaluations requesting:
    - education on how to support older adults in acute care experiencing a delirium and how to prevent.
    - education re: Falls prevention and Delirium

- <u>St. Joseph's Home Care Hospital to Home Program</u>
  - SMGH has launched the **St. Joseph's Home Care Hospital to Home Program** to help adults who no longer require hospital care to continue their recovery, healing, and rehabilitation at home, while other longer-term community-based services are arranged. By March 31, 2025, SMGH is aiming to have seen a 10% decrease in ALC LOS for patients in the categories of Home with CCAC and Retirement Home with Supports through this initiative.

- <u>Integrated Transitional Care Team Program</u>
  - GRH has launched an initiative to provide complex transitional care within a patient's home instead of an inpatient unit through the **Integrated Transitional Care Team**. This team is composed of a GRH Transitional Care Navigator (TCN), HCCSS Care Coordinators, and leads from both Bloom Care Solutions and Community Support Services (CSSs) will collaboratively design an Integrated Transitional Care Plan while the patient is in the inpatient setting. The program can last for up to 3 months in duration and patients can be discharged to existing HCCSS and/or CSS or assisted living options.

- <u>Access to Home Support Services Program</u>
  - The City of Waterloo is implementing Year 2 of the 'Improving Access to Home Support Services in Waterloo' initiative to increase the ability of low income, newcomer, or otherwise vulnerable seniors to age in place. This is a three-year initiative, focusing on service expansion with transportation, snow clearing, yard maintenance, and volunteer liaison/service navigation.
- <u>Indigenous Knowledge Transfer</u>
  - The Indigenous relations working group hosted an information sharing circle inclusive of indigenous older adults living with diabetes, primary care and community partners on June 12, 2024.
  - **The Indigenous Older Adult Diabetes Collaborative is developing a work** plan that will have a focus on the learnings shared at the Indigenous Sharing Circle.
  - **Indigenous learning module**; Caring for Indigenous Older Adults in Waterloo Wellington is available for partners to host on their learning platforms. This is currently being added to the SMGH and GRH learning platforms.

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

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Palliative Care Health Service Delivery Framework Program</u>
  - Ontario Health has provided an opportunity for a **Palliative Care Coach** to implement the Palliative Care Health Service Delivery Framework. Specific goals for this project include:
    - Building primary-level palliative care competencies of health care providers in community organizations
    - Broader integration and coordination between specialist providers and community organizations
    - The provision of timely, equitable access to high-quality palliative care to patients and their families as close to home as possible.
  - KW4 was approved for one role who will work out of Hospice Waterloo Region. Recruitment for this role is underway.

- <u>Geriatrics Knowledge Exchange</u>
  - Planning is underway for the **annual knowledge exchange in Geriatrics** which will take place on November 6, 2024. This event will share information and resources to enhance the knowledge of Clinicians in the system.

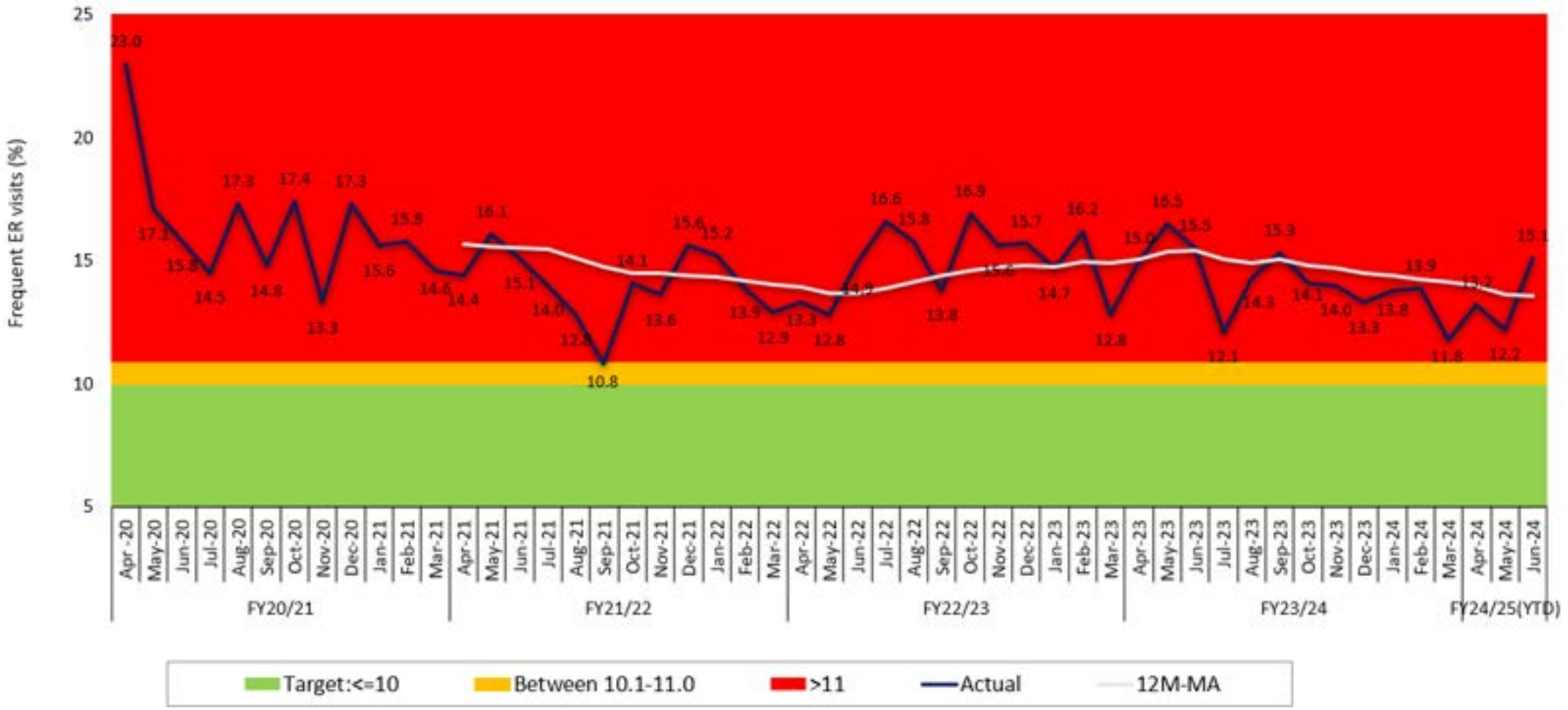
- <u>Frailty Screening Tool</u>
  - In collaboration with OH West and the KW4 Frail Elderly Working Group inclusive of the Waterloo Wellington Older Adult Strategy "Council", communication was sent out to partners to assist with **compiling a comprehensive system understanding and awareness of the frailty screening tools used** across the Waterloo Wellington region.
  - As shared in the Provincial Geriatric Leadership Ontario document *Frailty Screening & Management in the Community* there in an "increased interest across the Ontario Health Care System, in designing care approaches that better address the needs of older adults (individuals aged 65+) living with multiple, and often interacting, complex and chronic health conditions" and/or who may be considered living with frailty and/or at risk of frailty.
  - As a system of care, inclusive of our OH West Access and Flow partners, we recognize and support the implementation and access to more than one specific evidence-informed frailty screening tool. We support the value for the older adult and their health care team of integrated tools whenever the opportunity is presented.

- <u>System Planning for ALC</u>
  - There is a meeting being held on September 10, 2024, with partners who have geriatric medicine and geriatric psychiatry clinics to review wait-times as part of systems planning for ALC

Courtesy of:
- *Lee-Ann Murray, Director of Patient Services, Ontario Health At Home, 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

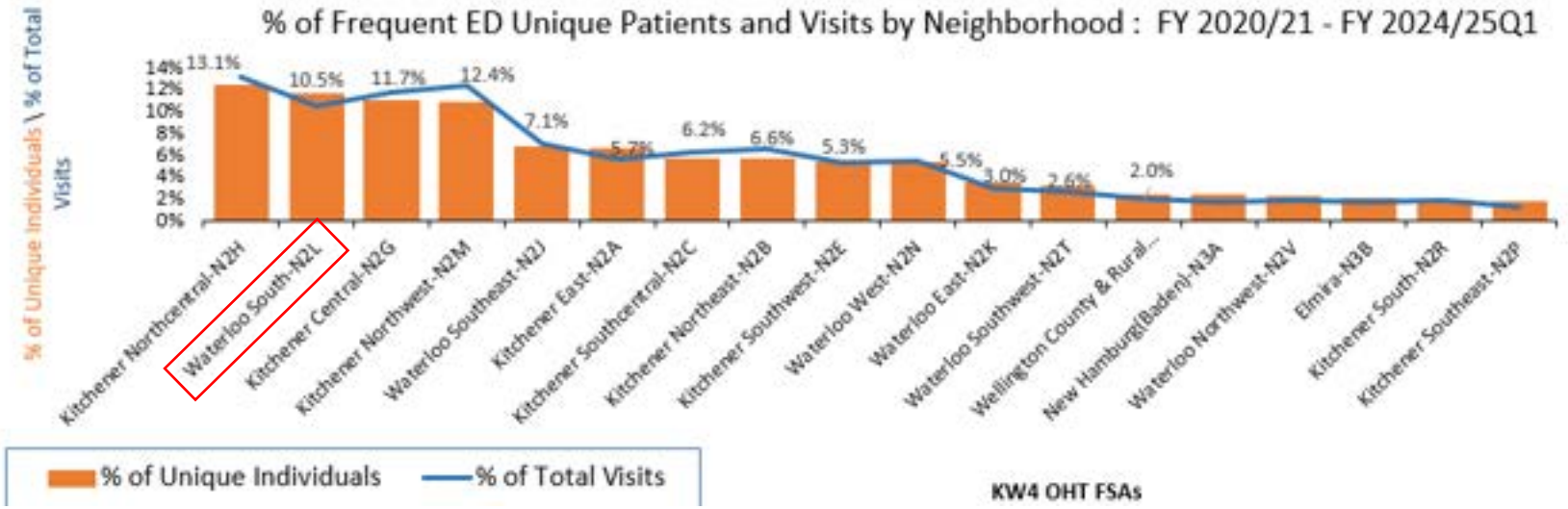
Frequent ER Visits For Help with Mental Health & Addictions (%) - April 2020 to Jun 2024



- Overall, there was been a downward trend in frequent ER visits for help with mental health and addictions in FY 20/21 and 21/22.
- This was followed by an upward trend in FY 22/23 and a downward trend in FY 23/24, however performance was still well above our target.

KW4 OHT: Unique # of Patients and ED Visits by Neighbourhood : FY 20/21 to 24/25Q1

>=4 Visits																
FSA	Population(2021 Census)	% of Population	Unique# of Individuals					# of Visits					4 Fiscal Years			
			FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25Q1	FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25Q1	Total :Unique# of Individuals	Total # of Visits	% of Unique Individuals	% of Total Visits
KW4 Priority Neighbourhoods	**91,210**	**18%**	**88**	**82**	**95**	**103**	**48**	**708**	**622**	**668**	**814**	**360**	**416**	**3172**	**39.8%**	**43.5%**
Kitchener Central-N2G	14,580	3%	22	25	24	29	15	180	179	153	209	133	115	854	**11.0%**	**11.7%**
Kitchener Northcentral-N2H	22,455	5%	27	28	30	33	11	252	216	206	228	55	129	957	**12.3%**	**13.1%**
Kitchener Northwest-N2M	36,495	7%	27	18	30	24	14	206	147	214	216	123	113	906	**10.8%**	**12.4%**
Kitchener Southcentral-N2C	17,680	4%	12	11	11	17	8	70	80	95	161	49	59	455	**5.6%**	**6.2%**
Other KW4 Neighbourhoods	**405,360**	**82%**	**146**	**156**	**140**	**129**	**57**	**928**	**1,037**	**865**	**859**	**426**	**629**	**4119**	**60.2%**	**56.5%**
KW4 OHT FSAs Total	**496,570**	**100%**	**234**	**238**	**235**	**232**	**105**	**1,636**	**1,659**	**1,533**	**1673**	**786**	**1045**	**7291**	79%	74%
Other FSAs/Non-KW4 OHT FSAs													285	2,550	21%	26%

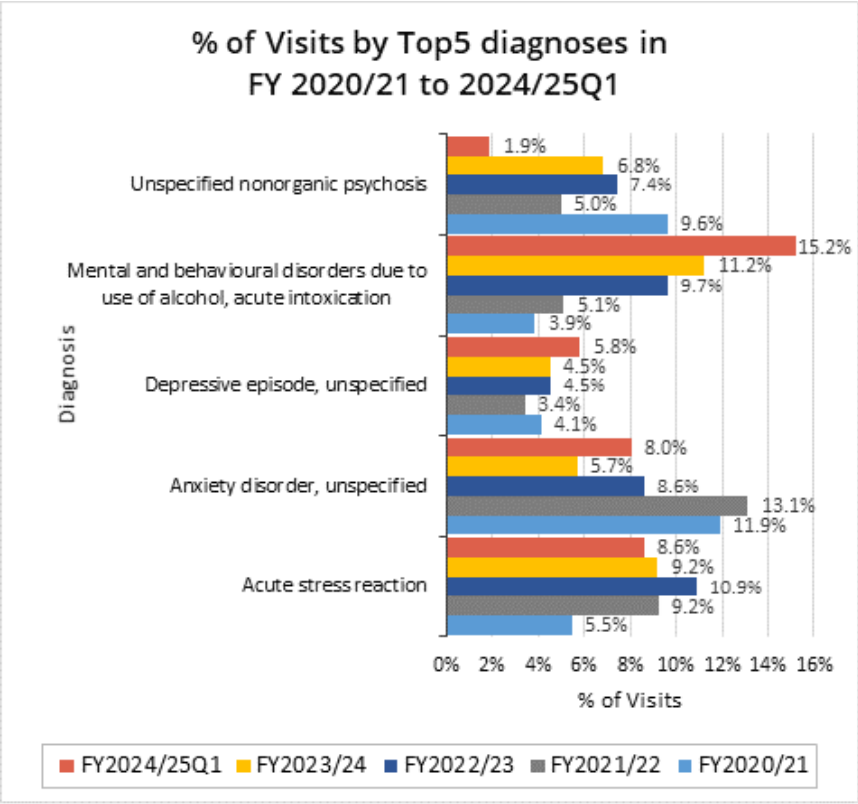


Between FY20/21 and 24/25 Q1; 1045 unique individuals residing in KW4 had four or more ED visits for help with MH&A, totaling 7,291 visits.

- Our four priority neighbourhoods (**N2C, N2G, N2H, N2M**) account for only 18% of KW4's population but 43.5% of the visits and 39.8% of the individuals from KW4
- The other fourteen KW4 neighbourhoods account for 82% of KW4's population but 56.5% of the visits and 60.2% of unique individuals.
- Although the Waterloo South Neighbourhood (N2L) appears to have a high percentage of visits (10.5%) 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.
- 26% of the visits to a hospital located within KW4 and 21% of the individuals reside outside KW4 OHT neighbourhoods.

Unique # of Patients and # of ED Visits by Top 5 Diagnoses in FY2020/21 to 24/25Q1

Diagnosis	% of Unique Individuals					% of Visits					Total % of Unique Individuals	Total % of Visits
	FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25Q1	FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25Q1		
Acute stress reaction	6.5%	9.4%	11.2%	9.8%	10.7%	5.5%	9.2%	10.9%	9.2%	8.6%	11.2%	10.9%
Anxiety disorder, unspecified	12.9%	14.4%	9.4%	6.5%	6.6%	11.9%	13.1%	8.6%	5.7%	8.0%	11.7%	11.0%
Depressive episode, unspecified	5.4%	3.6%	4.5%	4.1%	8.3%	4.1%	3.4%	4.5%	4.5%	5.8%	5.5%	5.4%
Mental and behavioural disorders due to use of alcohol, acute intoxication	4.3%	5.4%	6.3%	9.8%	15.7%	3.9%	5.1%	9.7%	11.2%	15.2%	9.1%	11.0%
Unspecified nonorganic psychosis	11.5%	6.1%	7.3%	8.2%	2.5%	9.6%	5.0%	7.4%	6.8%	1.9%	9.2%	8.3%
Total	40.6%	39.0%	38.8%	38.4%	43.8%	35.0%	35.9%	41.1%	37.5%	39.6%	46.7%	46.6%

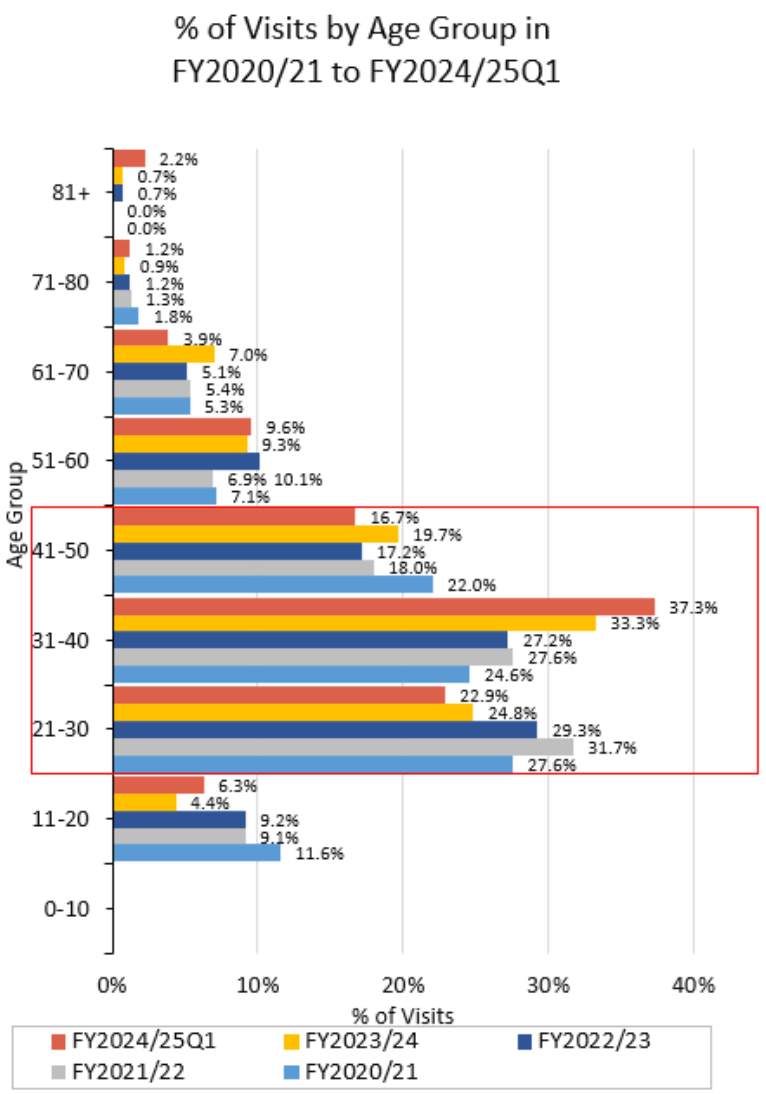


Diagnoses:

- The top 5 diagnoses codes accounted for 46.6% of visits for 46.7% of the individuals, with the most prevalent diagnosis being 'Anxiety Disorder, unspecified' at 11.7% for the last 4¼ fiscal years.
- 'Mental and behavioural disorders due to use of alcohol, acute intoxication' was the most prevalent diagnosis in the latest two quarters.

Unique # of Patients and ED Visits by Age Group in FY2020/21 to 24/25Q1

Age Group	% of Unique Unique Individuals					% of Visits					Total % of Individuals	Total % of Visits	Average Visits per Person				
	FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25Q1	FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25Q1			FY2020/21	FY2021/22	FY2022/23	FY2023/24	FY2024/25Q1
0-10																	
11-20	14.4%	11.2%	11.5%	6.3%	8.9%	11.6%	9.1%	9.2%	4.4%	6.3%	10.0%	7.5%	5.6	5.8	5.4	5.6	5.2
21-30	27.7%	32.5%	25.9%	23.7%	24.2%	27.6%	31.7%	29.3%	24.8%	22.9%	26.6%	27.2%	0.4	5.9	8.5	4.7	6.9
31-40	24.5%	25.6%	24.1%	29.8%	32.3%	24.6%	27.6%	27.2%	33.3%	37.3%	27.1%	30.0%	0.6	6.6	7.9	3.5	8.5
41-50	18.7%	15.2%	17.8%	19.6%	16.9%	22.0%	18.0%	17.2%	19.7%	16.7%	18.0%	19.1%	0.4	10.1	7.0	3.4	7.2
51-60	7.2%	7.6%	11.9%	12.1%	9.7%	7.1%	6.9%	10.1%	9.3%	9.6%	10.1%	8.6%	0.6	6.5	4.0	3.2	7.3
61-70	5.4%	6.1%	5.9%	6.1%	4.0%	5.3%	5.4%	5.1%	7.0%	3.9%	5.8%	5.8%	0.3	6.0	6.3	3.2	7.0
71-80	2.2%	1.8%	1.7%	1.4%	1.6%	1.8%	1.3%	1.2%	0.9%	1.2%	1.7%	1.2%	0.3	7.0	5.0	3.4	5.5
81+	0.0%	0.0%	1.0%	1.0%	2.4%	0.0%	0.0%	0.7%	0.7%	2.2%	0.7%	0.6%			0.0	2.8	6.7
Total	100.0%	100.0%	100.0%	100.0%	24.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1.2	6.9	5.5	3.7	7.3



Age Groups

- The top three age groups listed below accounted for 76.3% of the visits and 71.7% of the individuals from April 2020 to June 2024:
  - 21-30 at 27.2% visits and 26.6% of unique individuals
  - 31-40 at 30.0% visits and 27.1% of unique individuals
  - 41-50 at 19.1% visits and 18.0% of unique individuals

Contributing Factors

Factors contributing to our current performance results:

- **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. As of August 13, 2023, Waterloo Region Paramedics received just under 600 suspected opioid overdose/drug poisoning related calls in KW4 this calendar year and there have been 40 suspected opioid-related deaths.
- 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 December 4, 2023, 6,217 KW4 residents are registered with the Health Care Connect Program waiting for connection to a provider.
- **Waitlist for mental health services** are continuing to grow with minimal investment in the last 10-years. Investments in clinical services have not kept pace with the rapid growth of people to our region , many of whom have arrived with considerable adversities in their past , and complex health and mental health care needs. In many areas (i.e., community psychiatry), our region has been historically under resourced.
- 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.
- There is an ongoing **lack of intensive team-based outpatient treatment resources** - most patients who present frequently to the ED have multiple and complex medical, mental health, addictions, and social needs that are not well addressed with either acute inpatient or office-based outpatient services.
- **Resources for individuals with borderline personality are limited**. They constitute a significant percentage of individuals visiting the emergency department. Expanded services and resources to connect individuals with treatment are needed to meet the current demand. CMHA, who is funded to deliver a DBT program, which is the gold standard of treatment for people with BPD, have a waiting list of 2 years or more.
- The **retention and recruitment of health care professionals** over the last couple of years 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 Advisory Group*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>Ontario Structured Psychotherapy (OSP) Program:</u>
  - Members of the KW4 OHT will continue the roll-out of **Ontario Structured Psychotherapy** (OSP), which 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 were 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.
  - The goal in 2024/25 is to:
    - Provide referral presentations/resources to 15 Waterloo-based social service/health agencies
    - Increase the number of Waterloo Region residents referred to OSP to 150% of the caseload for two FTE's
    - Increase views of OSP referral page by 100% from 40 views per month to 80 views per month
    - Enable a positive experience with 80% of patients indicated they were very satisfied or satisfied with their experience with the OPS program
    - Improve patient outcomes with 70% of patients enrolled in the OSP program reporting lower PHQ-9/GAD-7 scores after completing the program
  - The current Guelph service provider for OSP has opted out of the program. There is some discussion about Guelph FHT considering taking it on.
  - The government is moving towards volume/referrals for funding which might be a challenge.
  - There is a need to ensure referrals keep flowing from Primary Care, Hospitals, and Community agencies to ensure the case for support represents capacity and demand in our community.

- <u>Transitional Age Youth Clinic</u>
  - In September 2023, Grand River Hospital started a **Transitional Age Youth Clinic for youth aged 17-22** to address the challenges of lack of access to, and follow-up with, ongoing psychiatric care as the youth turn 18 and age out of our clinic.
  - The goal is to have young adult patients, their parents, GRH's clinical team and their primary care physician working together to manage the mental health issues.
  - Access to this clinic will initially be for patients who have already established care with a GRH child/adolescent psychiatrist, attend appointments regularly, and are interested in continuing psychiatric care. Newly referred youth or youth with urgent issues will continue to be seen via usual mechanisms. In the future GRH hopes to be able to extend this to referrals from GRH's adult inpatient or outpatient services, or possibly directly from the primary care physician.
  - Child and Adolescent psychiatry resources are currently very limited. Resources are being focused on inpatient unit which is impacting resources for outpatient work.
  - In the process of implementing a Readiness Assessment

- <u>Expanded Quick Response Services for Mild, Moderate, Episodic/Situation</u>
  - Members of the KW4 OHT are working to **expand quick response services for all ages to 5-days a week and include Triage/Service Navigation Roles.** The Expanded Quick Response services have been extended to 5- days a week for adults from June 2024. Quick Response services for children and youth is scheduled to start in the Fall. Service Navigation has also been included to redirect clients who do not need a Quick Response session. In the past two months, there has been a lot of progress in uptake with an average of 154 and 231 Quick Response sessions in June and July, respectively.
  - The service provides single-session counselling and mental health support service navigation to anyone experiencing mild, moderate, and/or situational challenges that require urgent or timely support by trained mental health staff. Both virtual and in-person sessions are available. Quick Response services are provided through funded and fee for service options to ensure everyone can access the support they need regardless of financial means. The pilot is currently focused on adults only, but Camino is hoping to launch a pilot for children in September.
  - In 2024/25 they aim to:
    - Expand quick response services to 5 days per week
    - Reduce waitlists for ongoing counselling by an average of 10-days from 40 days to 30 days
    - Increase utilization of quick response services by an average of 20 individuals per week from 30 individuals per week to 50 individuals per week
    - Develop a newly developed workshop designed for those on the waitlist for counselling
  - As Quick Response and ICC are serving different acuities, we are triaging people as necessary between the two services to ensure they get the right level of service and support.

Courtesy of:

- *KW4 OHT Mental Health and Addictions Advisory Group*

Moving Forward

Initiatives currently underway, or planned for the near future, that will impact our performance on a go-forward basis:

- Integrated Crisis Centre (ICC)
  - The ICC, a collaboration between Thresholds Homes and Supports and CMHA Waterloo Wellington, opened on Tuesday July 30, 2024, at 298 Lawrence Ave. Kitchener. The hours of operation are Tuesday-Saturday 2:00pm-8:00pm. In the first 5 days of the soft-launch, the centre served 11 unique clients with 14 visits and all the clients were self-directed. As the roll-out continues, the option of paramedic and police drop-off will be explored.
  - The ICC is intended for those individuals aged 18 years or older who are experiencing a mental health or substance-use crisis and do not require more immediate hospital emergency department intervention or substance use withdrawal support.
  - The ICC addresses mental health and/or substance-use crises, which can include: a serious, immediate problem, a situational crisis, psychosis, risk of self-harm, emotional distress, an emotional response to trauma, agitation (or inability to sleep resulting from agitation), severe depression or anxiety, symptoms of moderate withdrawal, or suicidal thoughts.
  - As Quick Response and ICC are serving different acuities, we are triaging people as necessary between the two services to ensure they get the right level of service and support.

- Region of Waterloo and Justice Mental Health Project
  - Members of the KW4 OHT are working to provide long-term housing alongside dedicated holistic direct support for individuals navigating a concurrent disorder and at risk of homelessness upon exiting incarceration through the Region of Waterloo and Justice Mental Health Project. This project aims to have **6 dedicated subsidized apartment units** secured and occupied in 2024/25.

- Supportive Housing Health Initiative
  - Members of the KW4 OHT are planning to launch on-site programming at Supportive Housing locations across the Region of Waterloo through the **Supportive Housing Health Initiative (SHHI) Program**. This team will include Nurse Practitioners, Peer Support Workers, and Addictions Counsellors who provide Primary Care and addictions care.

- Supportive Transitional Indigenous Housing
  - Member of the KW4 OHT are planning to construct **new supportive housing for indigenous/non-indigenous individuals** in need of mental health support. The project aims to be constructed by December 2025.
- Triage Tools
  - The KW4 Mental Health and Addictions Advisory group has **developed two triage tools for physicians**: one for referring adults and refugees and one for referring children and youth. These tools aim to assist physicians in referring patients to the most appropriate community mental health support based on their presenting mental health, addiction, and brain injury needs. The adult and refugee tool can be found here. The children and youth tool can be found here.

- Youth Wellness Hubs
  - Members of the KW4 OHT continue to explore the establishment of **Youth Wellness Hubs** that provide high-quality integrated youth services to support the well-being of young people aged 12 to 25, including mental health and substance use supports, primary health care, community and social supports, and more. The aim of this Community Collaborative is to offer a model that combines recreation, school support, mental health services, and connection, all designed with input from youth and led by the community. In 2024/25, with the assistance of a consultant, the goal is to determine the approach to the wellness hub and establish a framework that meets the needs of Waterloo Region.

Courtesy of:
- *KW4 OHT Mental Health and Addictions Advisory Group*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>9-8-8 Suicide Crisis Helpline Launch</u>
  - On November 30, 2023, a **new Canada-wide three-digit helpline that will provide urgent, mental health support in real-time was launched**. Accessible by text and phone, 9-8-8 will provide quick access to bilingual support from trained responders who can properly assess individuals in need of crisis support and direct them to resources and services across the community. The Centre for Addition and Mental Health (CAMH) is partnering with the Canadian Mental Health Association Waterloo Wellington and Compass Community Services, who have been selected as partners to support the new 988 mental health crisis helpline. Existing distress and crisis lines Here 24/7: 1-844-437-3247 and the Compass Community Services Distress Line: 1-888-821-7760 will also continue to ensure "that every door is the right door" to receiving quality mental health and addictions crisis services.

- <u>7 Bed Step-Up Step-Down Unit</u>
  - Starling Community Services (formerly Lutherwood) recently received sustainable MOH funding for a **7 bed Step-Up Step-Down Unit to help Child and Adolescent Inpatient Psychiatry (CAIP)** kids get back (step down) to their communities, home and school sooner rather than staying in hospital. There is also a "step up" when they are in a community service and need more intensive care. This program will also act as a province-wide resource for kids as well.

- <u>Safe Haven Youth Services</u>
  - Starling Community Services (formerly Lutherwood) just opened a service at Safe Haven Youth Services in Kitchener called **Life Launch expanding from 2 beds to 6.** This service helps kids who have few family supports with a place to live so they can stay in school, get a job, etc. in order to keep them off the street and in a safe setting where they can develop more living skills.

- <u>Homelessness and Addiction Recovery Treatment (HART) hub model</u>
  - On August 20, 2024, the province announced the of banning consumption sites within 200 meters of schools and childcare centers, by March 31, 2025, including the site at 150 Duke Street West in Kitchener which is operated by the Sanguen Health Centre in partnership with Region of Waterloo Public Health
  - The Ministry of Health (MOH) in partnership with the Ministries of Municipal Affairs and Housing (MMAH); Children Community and Social Services (MCCSS), Labour, Immigration, Training and Skills Development (MLITSD) and Ontario Health (OH) is investing up to $378 million to support a three-year demonstration project for the creation of 19 new Homelessness and Addiction Recovery Treatment (HART) Hubs.
  - These hubs, designed to provide comprehensive care including mental health services, addiction support, and housing, will add up to 375 supportive housing units, in addition to recovery and treatment beds across the province.
  - HART Hubs will not offer supervised drug use or needle exchange programs but will focus on recovery and long-term stability.
  - The nine currently provincially-funded sites are being encouraged to submit proposals to transition to HART Hubs.
  - Partners throughout KW4 have been meeting and are planning for the submission process to apply for a HART hub in Waterloo Region. Intent to Apply submissions are due September 20th and finalized proposals are due October 18, 2024.

- <u>Acquired Brain Injury in the Streets</u>
  - 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. The team includes ABI specialists in psychiatry, occupational therapy, behaviour therapy and social work.
  - Specialized brain injury workers screen for brain injury using a low barrier HELPS Brain Injury Screening Tool.
  - During a screening blitz in 2022, Traverse Independence confirmed that a very high percentage of homeless and precariously housed people (73.1 per cent, or 68 of the 93 screened) have suffered from an ABI and would benefit enormously from this service.

Courtesy of:
- *KW4 OHT Mental Health and Addictions Advisory Group*

Moving Forward

<u>Initiatives currently underway, or planned for the near future</u>, that will impact our performance on a go-forward basis:

- <u>MHA System Transformation Team</u>
  - Over the summer the KW4 OHT Mental Health and Addiction Working Group chair has facilitated a collaborative process that includes representation from the Region of Waterloo and CND OHT with the aim of developing common goals and workplans to support the MHA population across the region. The group met twice and have agreed to focus on the Frequent Emergency Department visits for MHA indicator. To move this work forward, data from hospitals in the region, paramedic services, and police services was shared. It was suggested to create a regional system transformation team consisting of senior leadership of Mental Health organizations from both KW4 and CND OHTs, grassroots and community representation. This team will be tasked with identifying initiatives/projects that will positively impact the frequent ED visits for MHA indicator based on the available data. This approach will be useful in optimization of resources, connecting existing work, and measurement of outcomes. The recommendations have gone to the Mental Health and Addictions Working Group of both OHTs for review and approval with a possible kick-off meeting in October 2024.

- <u>Senior's Mental Health</u>
  - Conversations are currently underway to explore opportunities to improve Senior's Mental Health services across Waterloo Wellington, including discussing opportunities for better integration and improved flow.

Courtesy of:
- *KW4 OHT Mental Health and Addictions Advisory Group*

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%