

OHT Indicators & Population Segmentation

KW4 OHT Results

January 2024

How to use this report - 1

This report contains two main sections:

- The first section provides your OHT's ranking on 10 overall OHT improvement indicators and 5 improvement indicators for 3 common target populations (mental health, frail older adults, and end of life/palliative care)
- The second section provides your OHT results for 12 indicators stratified by 4 useful sub-groupings (material deprivation, primary care model, CIHI Pop Health Grouper and BC Health System Matrix). The 12 indicators were identified as being most important to OHTs at this time.

How to use this report - 2

1. Have a look at the spider diagram to see which indicators your OHT appears to be close to the centre. Here you are doing well as compared to other OHTs.
2. Use the spider diagrams to see which indicators your OHT appears further to the outside. Many other OHTs are doing better than your OHT on this indicator. Is this an area that is important to your OHT? (You can use the provincial report to see which OHTs are ahead of you).
3. For the indicators that OHTs identified as being most important, you can then look to the second part of the report to find subgroups (by primary care model, material deprivation or health grouping) where you have the greatest opportunity for improvement. These subgroups may point to some conditions that you need to look beyond historical approaches to improvement. You may need additional outreach for low-users or non-rostered patient groups and additional social resources to meet the needs of individuals in high material deprivation (Q4 & Q5).

List of Acronyms

- ACSC: Ambulatory Care Sensitive Condition
- ADL: Activities of Daily Living
- ALC: Alternate Level of Care
- CIHI: Canadian Institute for Health Information
- ED: Emergency Department
- MHA: Mental Health and Addictions
- MDS-HSI: Minimum Data Set Health Status Index

Part 1:

Overall and Population- specific HSPN Improvement Indicators

HSPN OHT Improvement Indicators

Total Population

- Premature Mortality
- Cost per Month
- Days in Acute Care
- ALC Days
- ACSC Hospitalizations
- 30D Readmission
- ED Visit managed elsewhere
- 7D Physician Follow up
- Continuity of Care
- Virtual Visits

Mental Health & Addictions Care

- Outpatient visits within 7d of MHA hospital discharge
- ED as first point of contact for MHA
- Frequent (4+) ED visits for MHA
- Repeat ED visits within 30d for MHA
- Rate of ED visits for deliberate self-harm

Older/Frail Adults

- 2+ fall-related ED visits (among frail)
- Days at home (among frail)
- Change in ADL long form
- Caregiver distress
- Change in MDS-HSI

Palliative & End-of-Life Care

- Deaths in hospital
- ED visit in the last 30d of life
- Palliative - physician home visits in the last 90d of life
- Palliative home - care in the last 90d of life
- Days at home in the last 6mons of life

Spider Diagrams

- Illustrates your OHTs annual rank amongst all OHTs across 10 total population indicators, 5 MHA indicators, 5 older/frail adult indicators, and 5 end of life indicators (2021/22 to 2022/23).
- The light grey lines (resembling a spider web) highlight the rank, where closest to the centre indicates the best rank amongst all OHTs.
- Data points furthest from the centre indicate worst rank in comparison to other OHTs.
- Each indicator is oriented so that best performance is closest to the centre whether best is represented by high (e.g., physician follow-up) or low (e.g., premature mortality) absolute scores.
- Spider diagrams measures performance relative to other OHT's each year.
 - ***Your OHT could have performed better in 2022/23 compared to 2021/22, but if on average the other OHT's also performed better, your point on your spider diagram may be further away from the centre.***

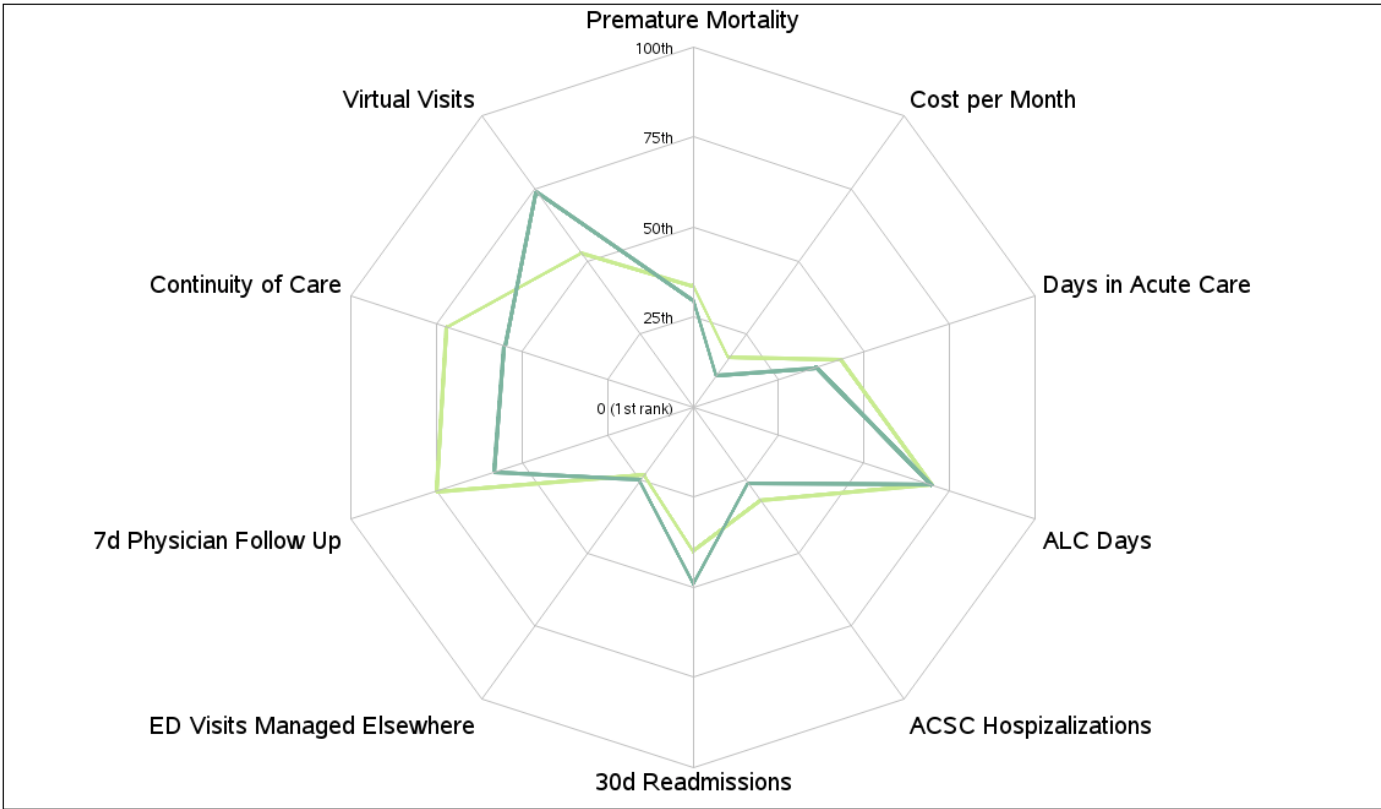
Spider Diagram Interpretation

“Try to be SMALL”

... on target is better

Spider Diagrams for Total Population Indicators

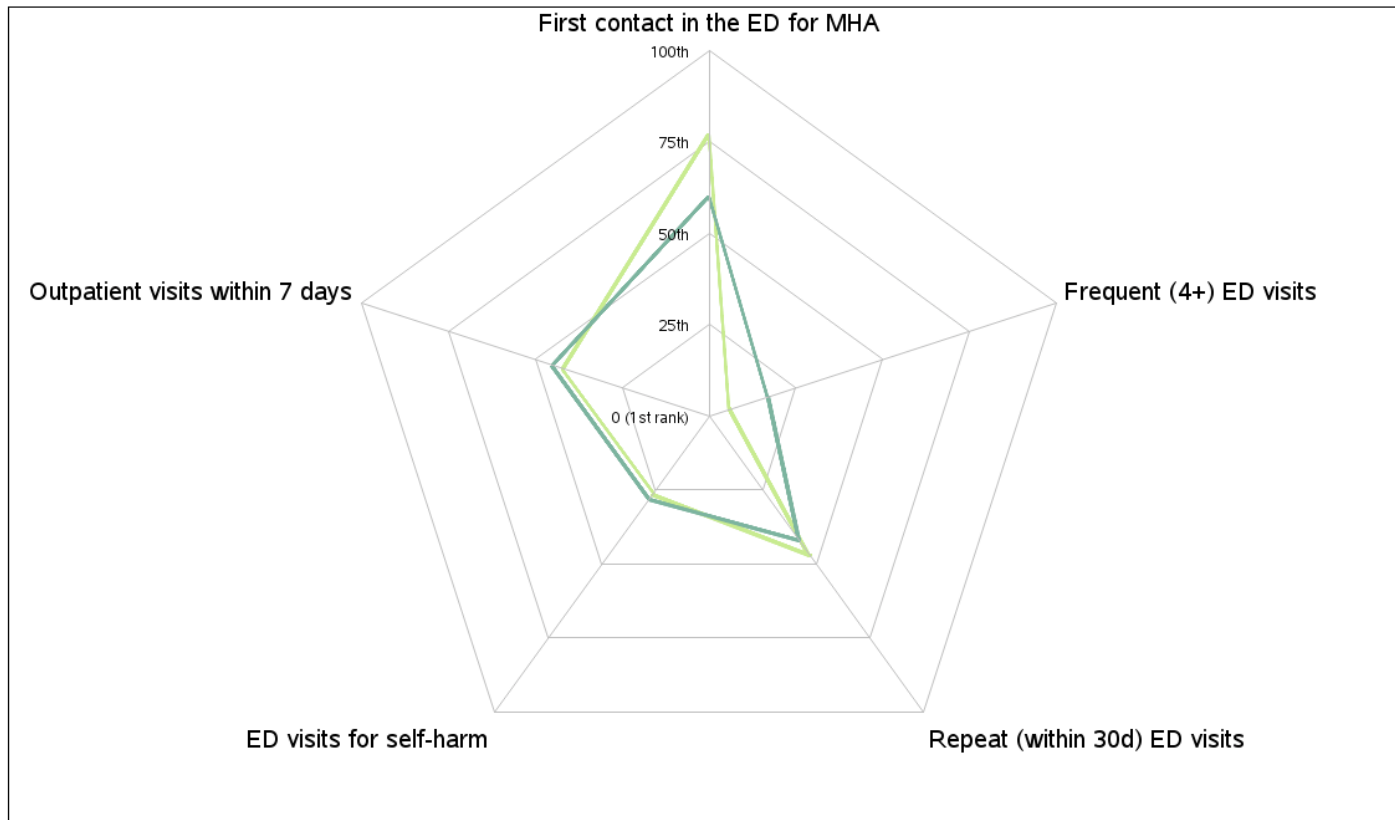
OHT 42s performance across all total population indicators



Reporting period 2021/22 2022/23

Spider Diagrams for MHA Indicators

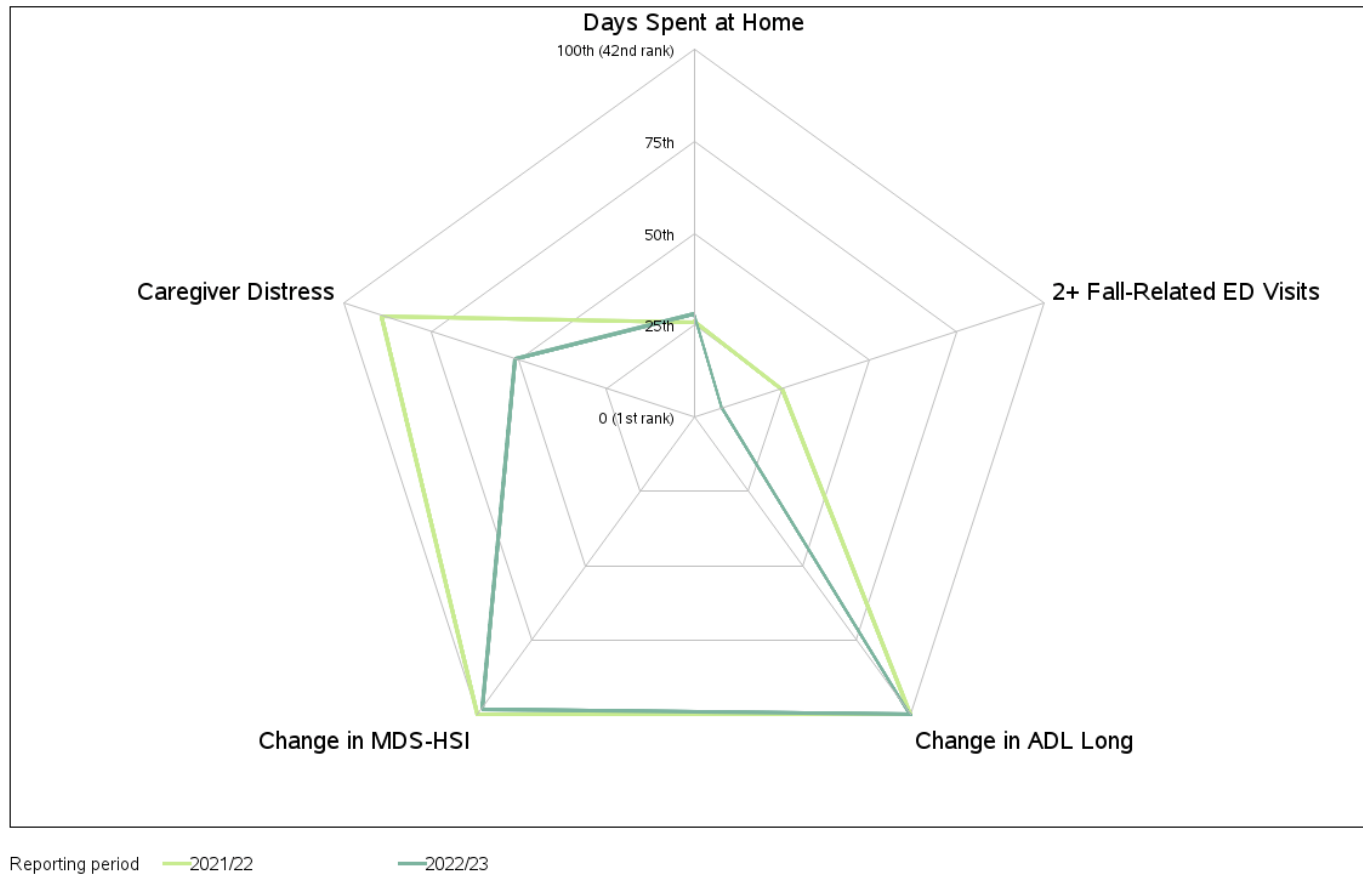
OHT 42s performance across all MHA indicators



Reporting period 2021/22 2022/23

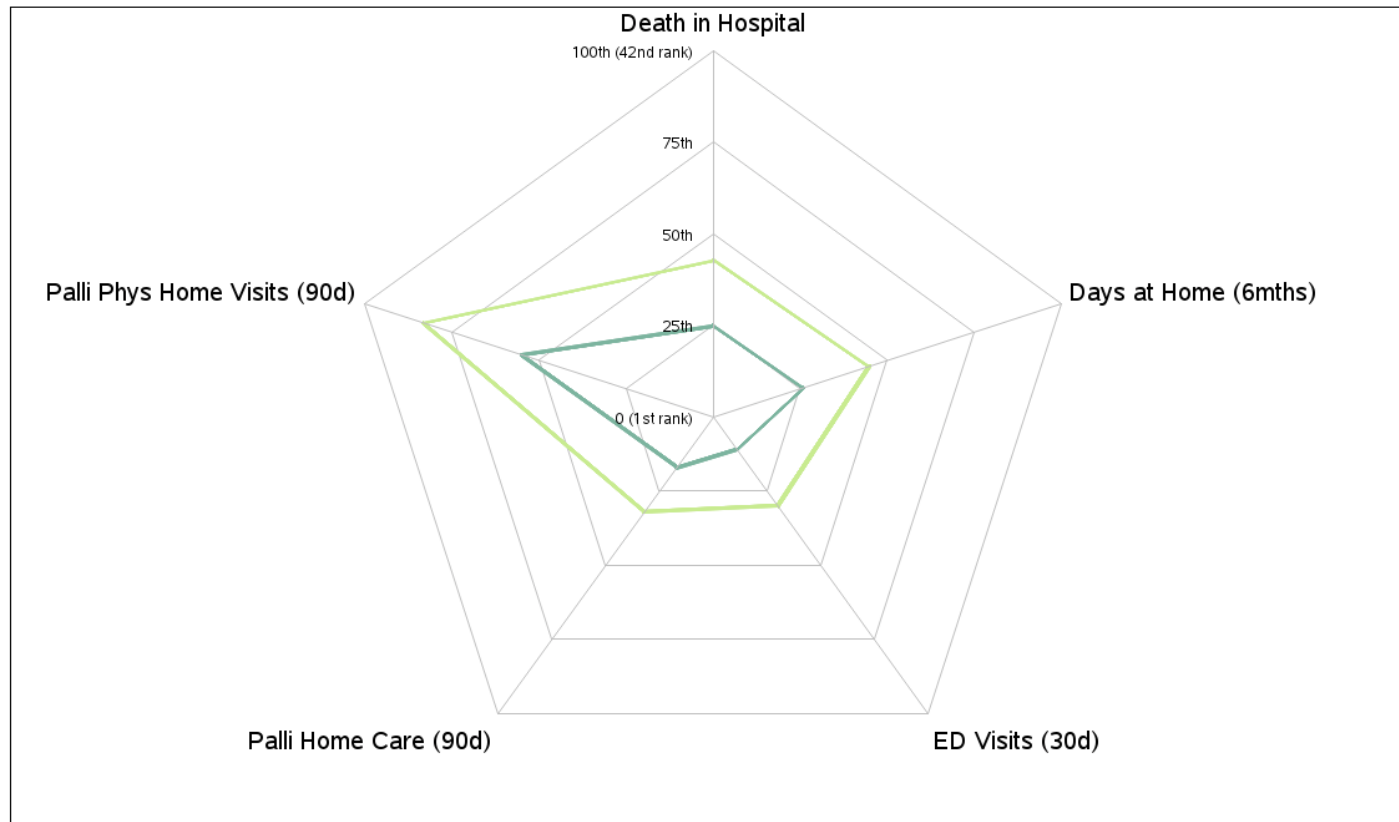
Spider Diagrams for frail/older adults

OHT 42s performance across all frail/ older adult indicators



Spider Diagrams for end-of-life Indicators

OHT 42s performance across all end-of-life indicators



Reporting period 2021/22 2022/23

Introduction to Part 2:

Selecting indicators and defining stratification / segmentation approaches

How did we select indicators for this report?

- Surveys were distributed to an OHT representative identified by the OHT evaluation lead contact as *best suited to answer a survey about the HSPN Improvement Indicators*.
- The survey had 3 multiple choice questions, 3 open text comments and 6 sets of indicators and stratifications to rank.
- A total of 56 OHTs were invited of whom, 42 responded (75%).
- Most respondents held positions as (executive) director of the OHT or OHT operations or lead for analysis or population health.
- OHTs were asked whether we should base a report on a complete set of indicators for one topic or to select a few indicators from different indicator sets. OHTs overwhelming preferred the latter approach and provided rankings of the indicators according to the "priority and usefulness for your OHT". We selected up to 3 indicators from each grouping. For the selected indicators, at least 25% of OHTs selected the indicator as top 2 of 10 from overall indicators or at least 45% of OHTs selected the indicator as top 2 of 5 from population-specific indicators.

Top Chosen Indicators:

Total Population

1. ACSC Hospitalization
2. ED Visit managed elsewhere
3. Continuity of Care

MHA

1. Frequent (4+ ED visits for MHA)
2. Repeat ED visit for MHA (within 30 days)
3. ED as first point of contact for MHA

CQIP

1. ALC
2. Pap
3. Mammogram

Older/Frail Adults

1. Repeat fall-related ED visits among those identified as frail

Palliative & End-of-Life Care

1. Proportion of decedents with home care visits in last 90 days of life
2. Proportion of decedents with 1+ ED visit in last 30 days of life

Indicator Definitions

Indicator	Definition	Quadruple Aim
ED visits best managed elsewhere	Number of low-acuity, unscheduled visits to emergency departments for conditions that could be treated in a primary care setting among persons aged 1 to 74 years of age	Patient Experience (access) & Cost/Efficiency
Hospitalizations for ACSCs	Number of hospital admissions for ambulatory care sensitive conditions (including grand mal status and other epileptic convulsions, chronic obstructive pulmonary disease, asthma, congestive heart failure and pulmonary edema, hypertension, angina, diabetes, and lower respiratory illness) among persons aged 0 to 74 years of age	Health Outcomes
Continuity of care	Average proportion of an attributed person's physician visits that was with their most regularly seen doctor	Patient Experience
Frequent (4+) emergency department visits for help with MHA	Proportion of individuals with an unscheduled emergency department visit that had 4 or more emergency department visits within a 365-day period	Patient Experience & Cost/Efficiency (Health Service Use)
Repeat emergency visits for MHA (within 30 days)	Proportion of unscheduled emergency department visits for care for MH conditions with a second unscheduled emergency department visit for MH or substance abuse within 30 days	Patient Experience & Cost/Efficiency
First contact in the emergency department for MHA	Proportion of incident unscheduled emergency department visits for MHA-care where the patient had no prior MHA-related contact (hospitalization, emergency department or physician visit)	Patient Experience (Timely Access) & Cost/Efficiency
ALC days	Proportion of days in acute inpatient care that were spent in alternate level of care (ALC)	Patient Experience & Cost/Efficiency
PAP Screening	Proportion of screen eligible patients (women 23-69 years of age) up to date with Papanicolaou (Pap) tests	Patient Experience (access)
Mammogram	Proportion of screen-eligible patients (women 52-69 years of age) up to date with a Mammogram	Patient Experience (access)
Repeat fall-related emergency visits, among those identified as frail	Proportion of older adults >65 years of age identified as being frail that had 2 or more unscheduled emergency department visit for fall-related injuries	Health outcome
Proportion of decedents receiving palliative home care in the last 90 days of life	The proportion of decedents that had one or more palliative home care services (excluding care management and placement services) in their last 90 days of life	Patient Experience (access) & Health Outcome
Proportion of decedents with 1 or more emergency department visits in the last 30 days of life	The proportion of decedents that had one or more unplanned emergency department visits in their last 30 days of life	Patient Experience (access) & Cost/Efficiency

Stratification / Segmentation

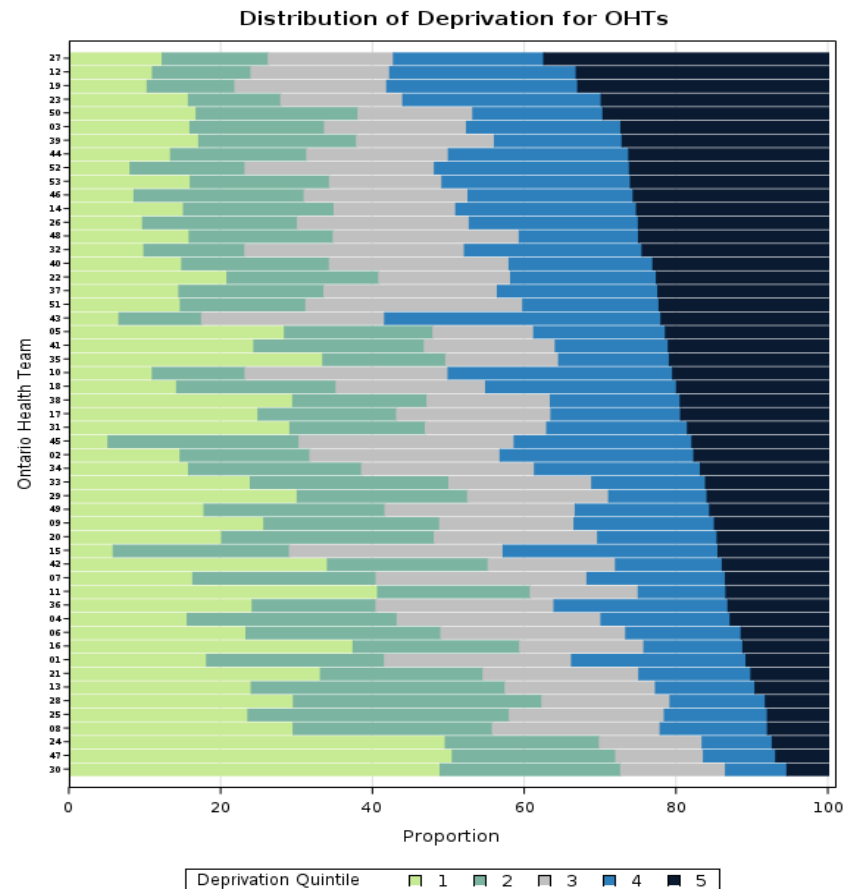
- For the top chosen indicators, we report on the OHT-specific results by four Stratifications or four ways to Segment the population:
 1. Neighbourhood Material Deprivation Quintile
 2. Primary Care Patient Enrolment Model
 3. CIHI Pop Grouper Health Profile Categories (HPCs)
 4. BC Health System Matrix Segments

Material Deprivation Quintile

We use the Material Deprivation Score from the Ontario Marginalization Index to assess equity in OHT indicators across socioeconomic status.

Indicators

- Proportion of the population aged 25 to 64 without a high-school diploma
- Proportion of families who are lone parent families
- Proportion of total income from government transfer payments for population aged 15+
- Proportion of the population aged 15+ who are unemployed
- Proportion of the population considered low-income
- Proportion of households living in dwellings that are in need of major repair



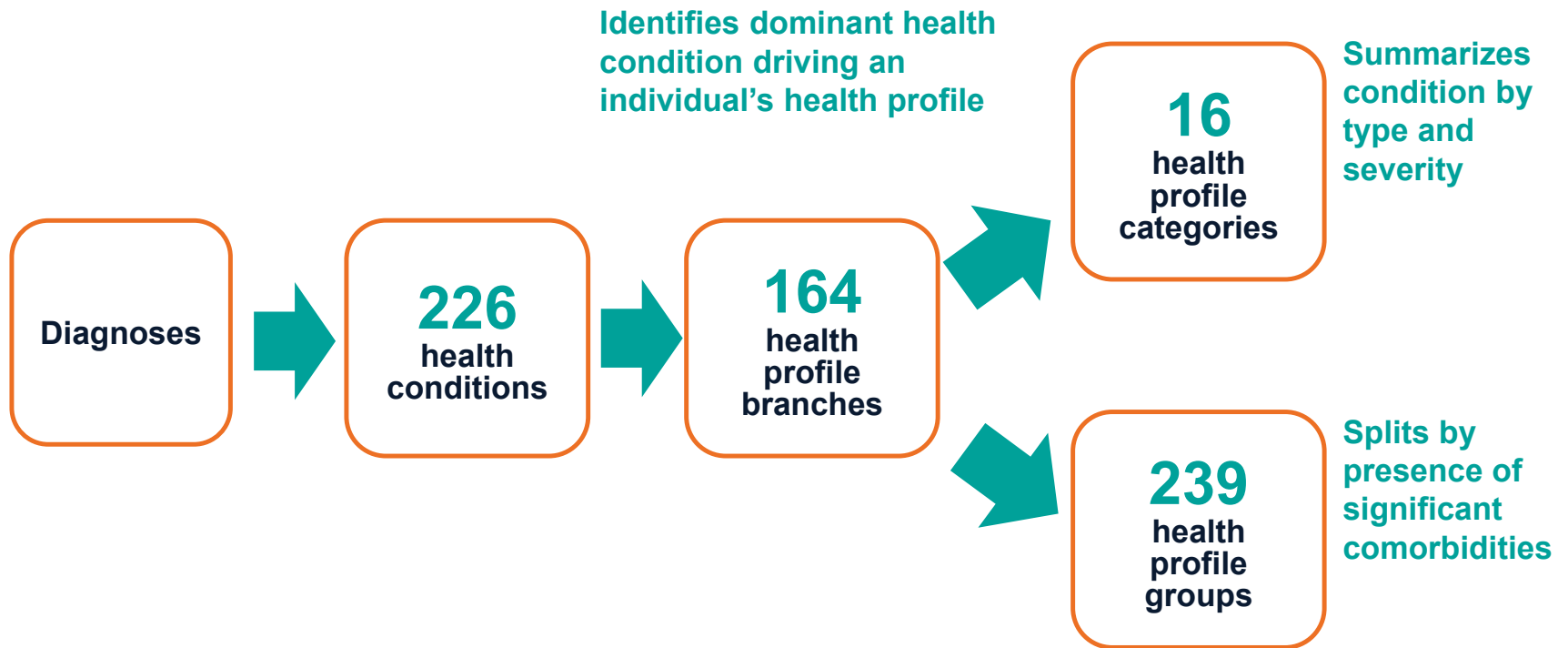
Proportion of OHT population according to Neighbourhood Material Deprivation Ontario Health Teams. OHT Attributable Populations:

Primary Care Patient Enrolment Models

- Family Health Teams (FHTs): Capitation-based models with additional interprofessional teams
- Capitation Based Models (CAP): Family Health Network (FHN), Family Health Organizations (FHO), and Other (mostly this is the Rural and Northern Model)
- Family Health Groups (FHGs): Partly capitation with after-hours coverage
- Comprehensive Care Model (CCM): Fee for service with rostered patients
- Not rostered / Not attached

CIHI Population Grouping Methodology

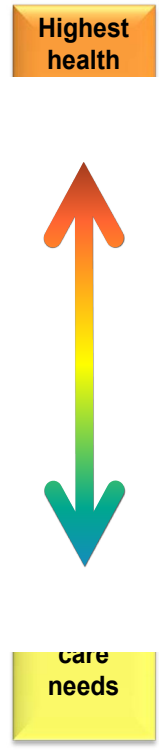
From health conditions to health profile categories (HPCs)



BC Health System Matrix Segment

BC's Population Segmentation: 14 Health Status Groups

Broad Category	Population Segment representing 'highest' need for care in year	
Towards the End of Life	End of Life	In a palliative care or end of life program
	Frail in Residential Care	Living in Licenced residential care
	Frail with High Complex Chronic Conditions	High chronic conditions with supports for activities of daily living
	Frail living in the community	With supports for activities of daily living, without high chronic conditions
Living with Illness and Chronic Conditions	High Complex Chronic Conditions, not Frail	High chronic conditions, without supports for activities of daily living
	Cancer	Population with cancer diagnosis and treatment
	Severe Mental Illness and Substance Use	Hospitalized for MH or SU in 5 year period
	Medium Complex Chronic Conditions	Specific Medium Chronic Conditions or comorbidities
	Low Complex Chronic Conditions	Specific Low Chronic Conditions
Getting Better	Children and Youth Major Conditions	Significant time-limited health needs, without chronic conditions. Includes Newborns with health conditions
	Adults Major Conditions	health conditions
Staying Healthy	Healthy	Healthy, low users, with minor episodic health care needs
	Maternity and Healthy Newborns	Maternity, Obstetrics and newborns
	Non-users	People who used no health care in year



Using Population Segmentation to Provide Better Health Care for All: The “Bridges to Health” Model

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The model discussed in this article divides the population into eight groups: people in good health, in maternal/infant situations, with an acute illness, with stable chronic conditions, with a serious but stable disability, with failing health near death, with advanced organ system failure, and with long-term frailty. Each group has its own definitions of optimal health and its own priorities among services. Interpreting these population-focused priorities in the context of the Institute of Medicine's six goals for quality yields a framework that could shape planning for resources, care arrangements, and service delivery, thus ensuring that each person's health needs can be met effectively and efficiently. Since this framework would guide each population segment across the institute's "Quality Chasm," it is called the "Bridges to Health" model.

Keywords: Health care reform, community health planning, health services needs and demand, person-focused health.

CROSSING THE QUALITY CHASM (IOM 2001A) ENVISIONED AN approach to health that focuses on the individual person or patient and met six specific aims for care: it must be safe, effective, efficient, patient centered (i.e., meets the patient's desires and preferences within the care delivery environment), timely, and equitable.

Address correspondence to: Joanne Lynn, Office of Clinical Standards and Quality, CMS, 7500 Security Blvd., Baltimore, MD 21244-1850 (email: Joanne.lynn@cms.hhs.gov).

The Milbank Quarterly, Vol. 85, No. 2, 2007 (pp. 185–208)
No claim to original U.S. government works.
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Health System Matrix 6.1, BC Ministry of Health 2015



Time Periods for Assigning Stratifications

Assignment to subgroups is based on information on April 1st of the indicator year:

- OHIP address for the individual is used to assign to Material Deprivation Category using the dissemination area and 2021 Census
- Primary care models based on enrolment as at April 1
- CIHI Pop Grouper is based on utilization in the prior fiscal year
- BCHSM classification is based on utilization in prior fiscal year along with conditions diagnosed over different/varying periods of time.

See full technical report for more details :

[\[https://hspn.ca/wp-content/uploads/2022/03/HSPN_SEGMENTATION_TECH_APPENDIX_March_2022.pdf\]](https://hspn.ca/wp-content/uploads/2022/03/HSPN_SEGMENTATION_TECH_APPENDIX_March_2022.pdf)

Part 2:

12 Select Indicators with 4 Stratifications

Rate of ED Visits best managed elsewhere

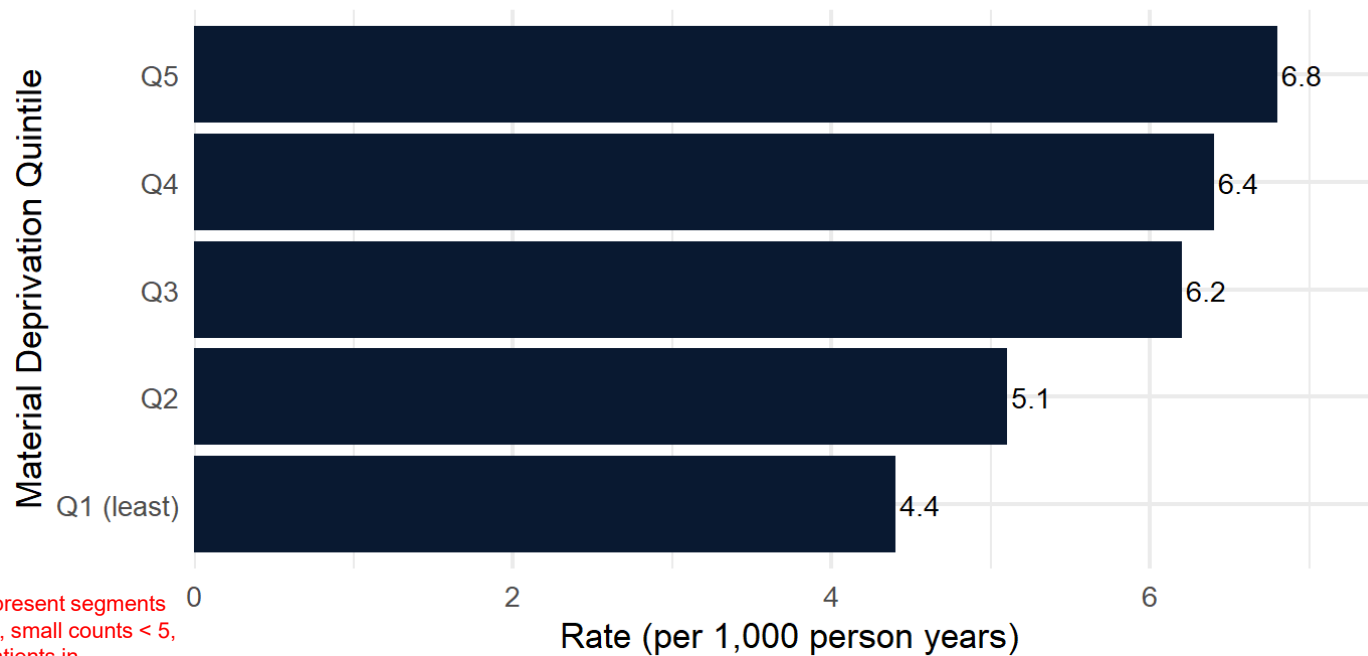
DEFINITION	Quadruple Aim
Rate of low-acuity, unscheduled visits to emergency departments for conditions that could be treated in a primary care setting among persons aged 1 to 74 years of age	Patient Experience (access)

In this graph the horizontal scale represents the rate of ED visits per 1000 patients. This is calculated as the number of patients admitted to ED with a condition that could be managed elsewhere divided by the population in the OHT attributed population who are aged 1 to 74.

Sample Interpretation: In the most deprived communities (Q5), 7 patients per 1000 person years visit the ED for reasons best managed elsewhere. Lower values are preferred on average and indicate better access to care for low acuity conditions in the community.

2022/23 Rate of ED Visits best managed elsewhere by Material Deprivation Quintile

ED Visits best managed elsewhere 2022/23
KW4



Horizontal axis presents rate of ED visits per 1000 person years that could be treated in alternative primary care setting.

- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

*Rate of ED visits per 1000 person years is shown at the end of the bar.

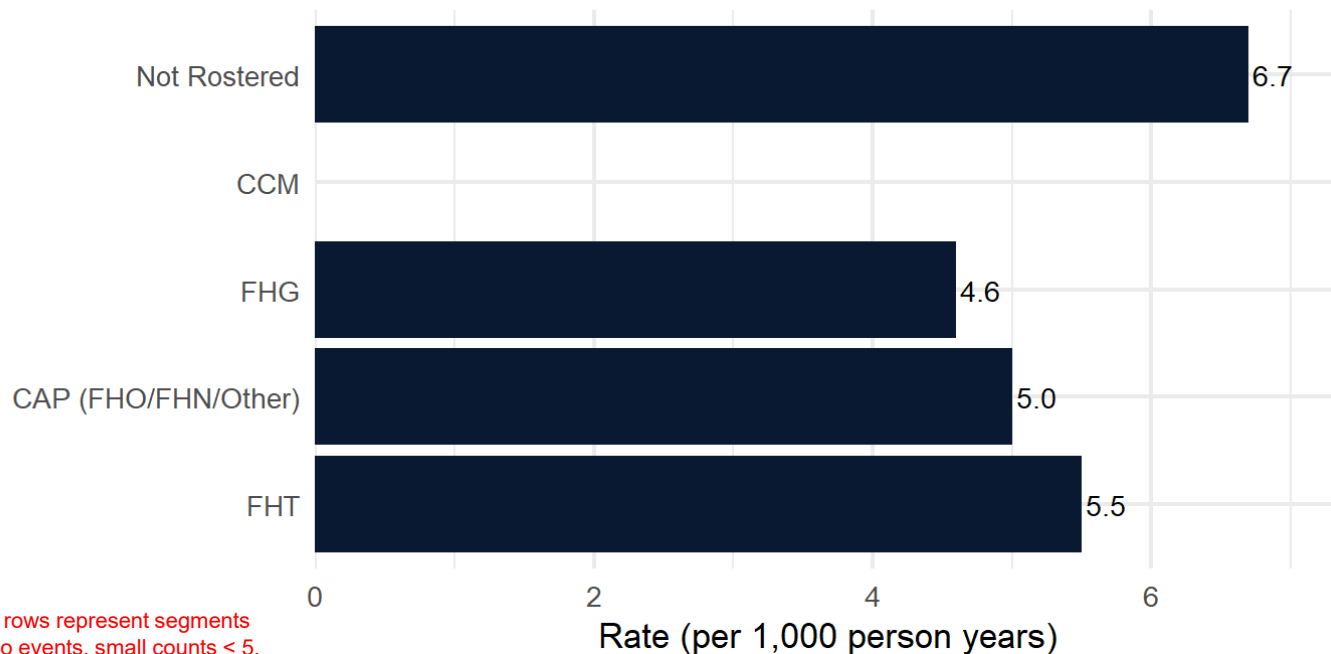
*Data are suppressed for segments with small counts.

*Overall rate per 1000 person years: OHT 42 = 5.5 / Ontario = 10.1.

2022/23 Rate of ED Visits best managed elsewhere by Primary Care Model

ED Visits best managed elsewhere 2022/23
KW4

POPULATION SEGMENT



Horizontal axis presents rate of ED visits per 1000 person years that could be treated in alternative primary care setting.

- OHT and Ontario average indicated in figure footnote.

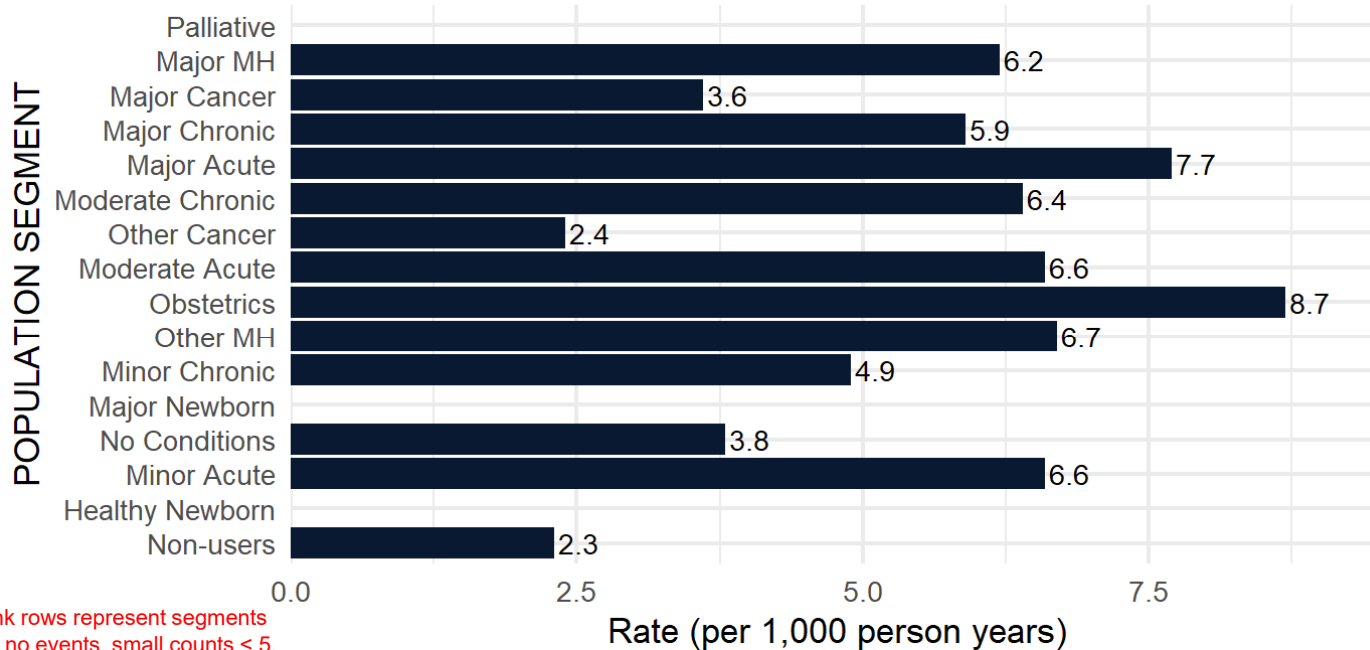
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
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 *Data are suppressed for segments with small counts.
 *Overall rate per 1000 person years: OHT 42 = 5.5 / Ontario = 10.1.

2022/23 Rate of ED Visits best managed elsewhere by CIHI Population Grouping Methodology

ED Visits best managed elsewhere 2022/23

KW4



Horizontal axis presents rate of ED visits per 1000 person years that could be treated in alternative primary care setting.

- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

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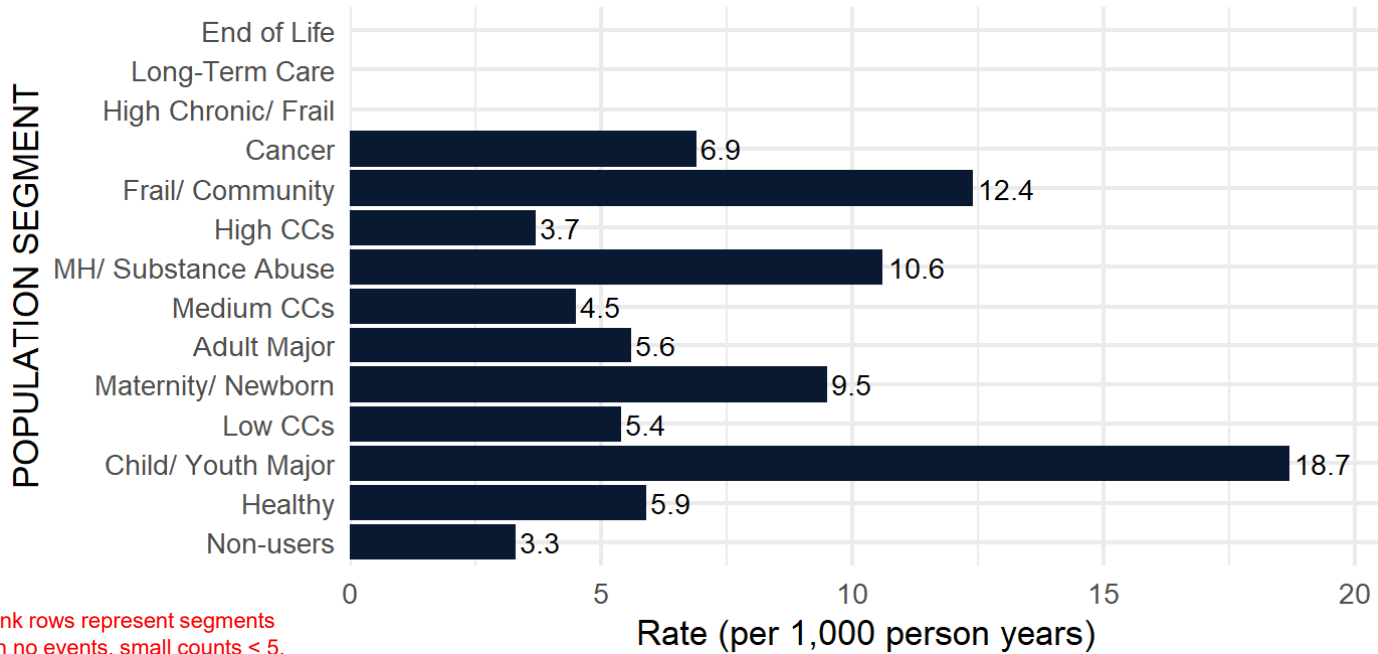
*Data are suppressed for segments with small counts.

*Overall rate per 1000 person years: OHT 42 = 5.5 / Ontario = 10.1.

2022/23 Rate of ED Visits best managed elsewhere by BC Matrix Segment

ED Visits best managed elsewhere 2022/23

KW4



Horizontal axis presents rate of ED visits per 1000 person years that could be treated in alternative primary care setting.

- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
 *Rate of ED visits per 1000 person years is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall rate per 1000 person years: OHT 42 = 5.5 / Ontario = 10.1.

Hospitalizations for ACSCs

DEFINITION	Quadruple Aim
Number of hospital admissions for ambulatory care sensitive conditions (including chronic obstructive pulmonary disease, asthma, congestive heart failure and pulmonary edema, hypertension, angina, diabetes, epilepsy and lower respiratory illness) among persons aged 0 to 74 years of age divided by the OHT population aged 0 - 74.	Health Outcomes

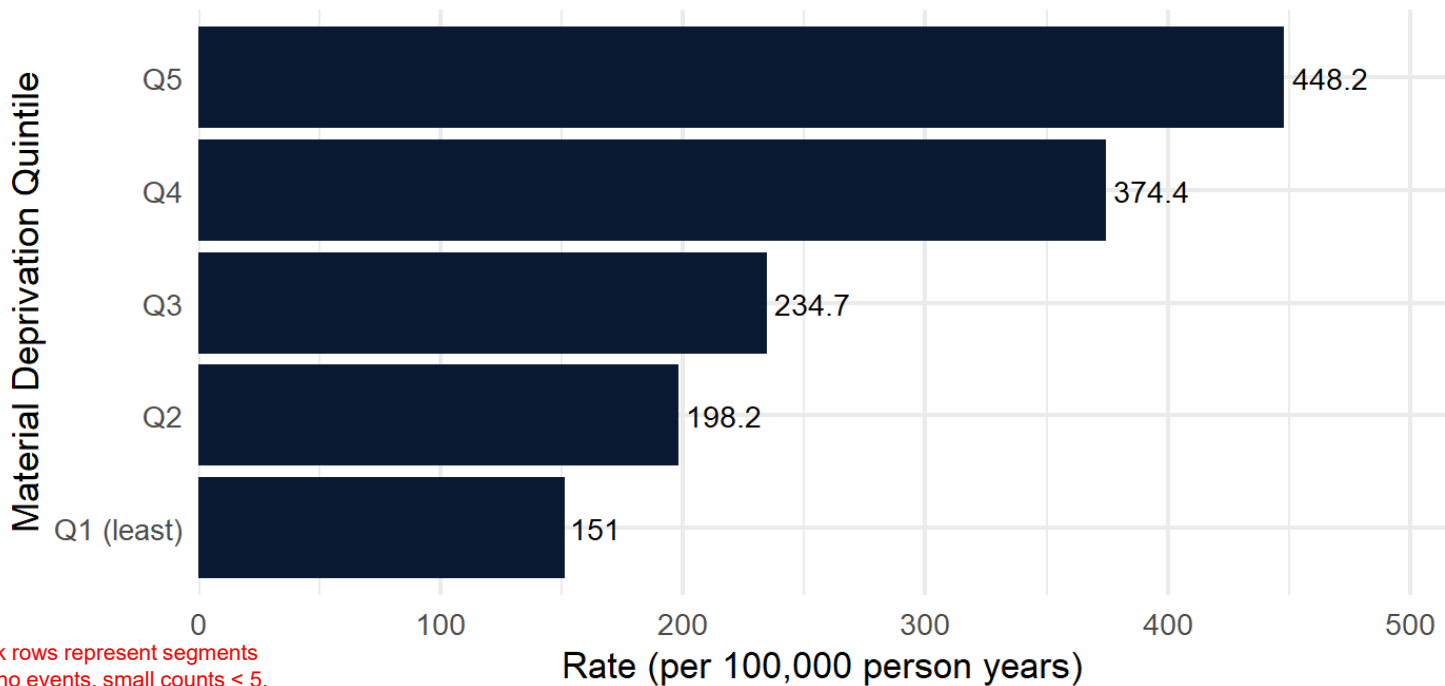
In this graph the horizontal scale represents the rate of ED visits per 1000 patients. This is calculated as the number of patients admitted to ED with a condition that could be managed elsewhere divided by the population in the OHT attributed population who are aged 0 to 74.

Sample Interpretation: In the most deprived communities (Q5), 448 patients per 100,000 person years are hospitalized for ambulatory care conditions. Lower values are preferred on average and indicate a better functioning care in the community/ambulatory settings.

2022/23 Rate of hospitalization for ambulatory care sensitive conditions (ACSC) per 100k by Material Deprivation Quintile

ACSC Hospitalization 2022/23

KW4



Horizontal axis presents rate of hospitalization for ambulatory care sensitive condition per 100k:

- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

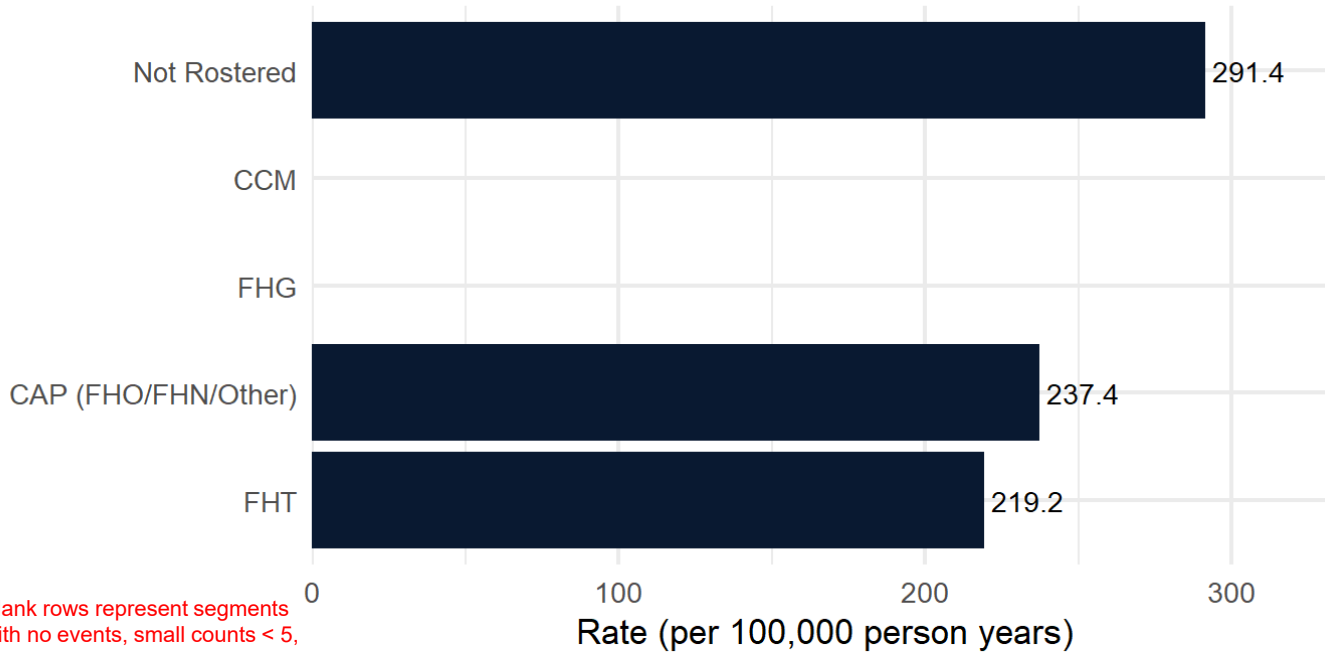
- *Rate of ACSC hospitalization per 100,000 person years is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall rate per 100,000 person years: OHT 42 = 248.9 / Ontario = 300.1.

2022/23 Rate of hospitalization for ambulatory care sensitive conditions (ACSC) per 100k by Primary Care Model

ACSC Hospitalization 2022/23

KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

*Rate of ACSC hospitalization per 100,000 person years is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Overall rate per 100,000 person years: OHT 42 = 248.9 / Ontario = 300.1.

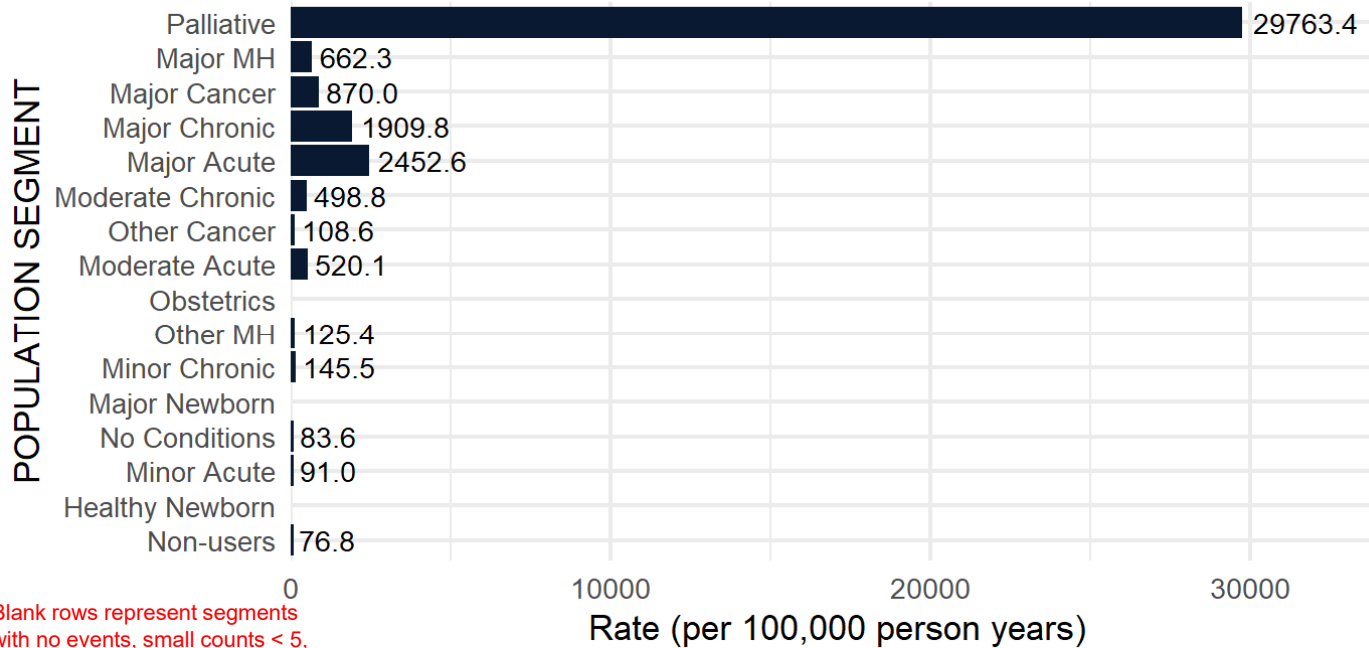
Horizontal axis presents rate of hospitalization for ambulatory care sensitive condition per 100k:

- OHT and Ontario average indicated in figure footnote.

2022/23 Rate of hospitalization for ambulatory care sensitive conditions (ACSC) per 100k CIHI Population Grouping Methodology

ACSC Hospitalization 2022/23

KW4



Horizontal axis presents rate of hospitalization for ambulatory care sensitive condition per 100k:

- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

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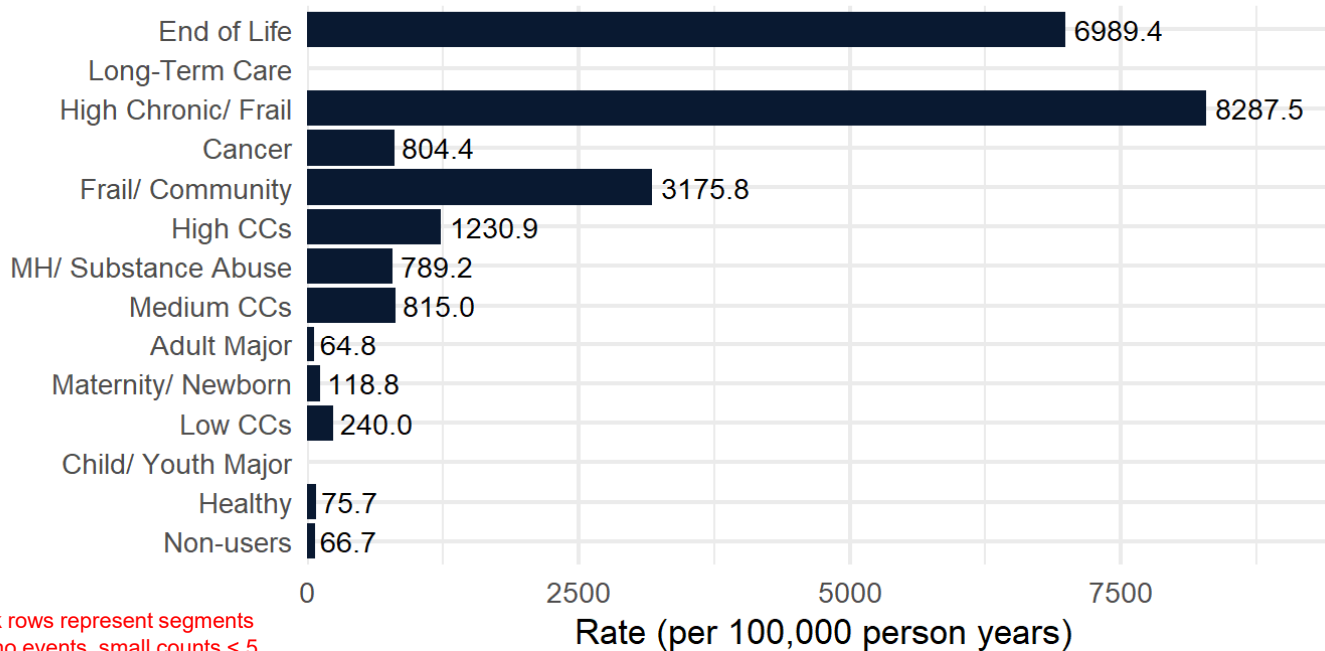
*Overall rate per 100,000 person years: OHT 42 = 248.9 / Ontario = 300.1.

2022/23 Rate of hospitalization for ambulatory care sensitive conditions (ACSC) per 100k by BC Matrix Segment

ACSC Hospitalization 2022/23

KW4

POPULATION SEGMENT



Horizontal axis presents rate of hospitalization for ambulatory care sensitive condition per 100k:

- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

*Rate of ACSC hospitalization per 100,000 person years is shown at the end of the bar.

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*Overall rate per 100,000 person years: OHT 42 = 248.9 / Ontario = 300.1.

Mean (Average) Physician Continuity of Care

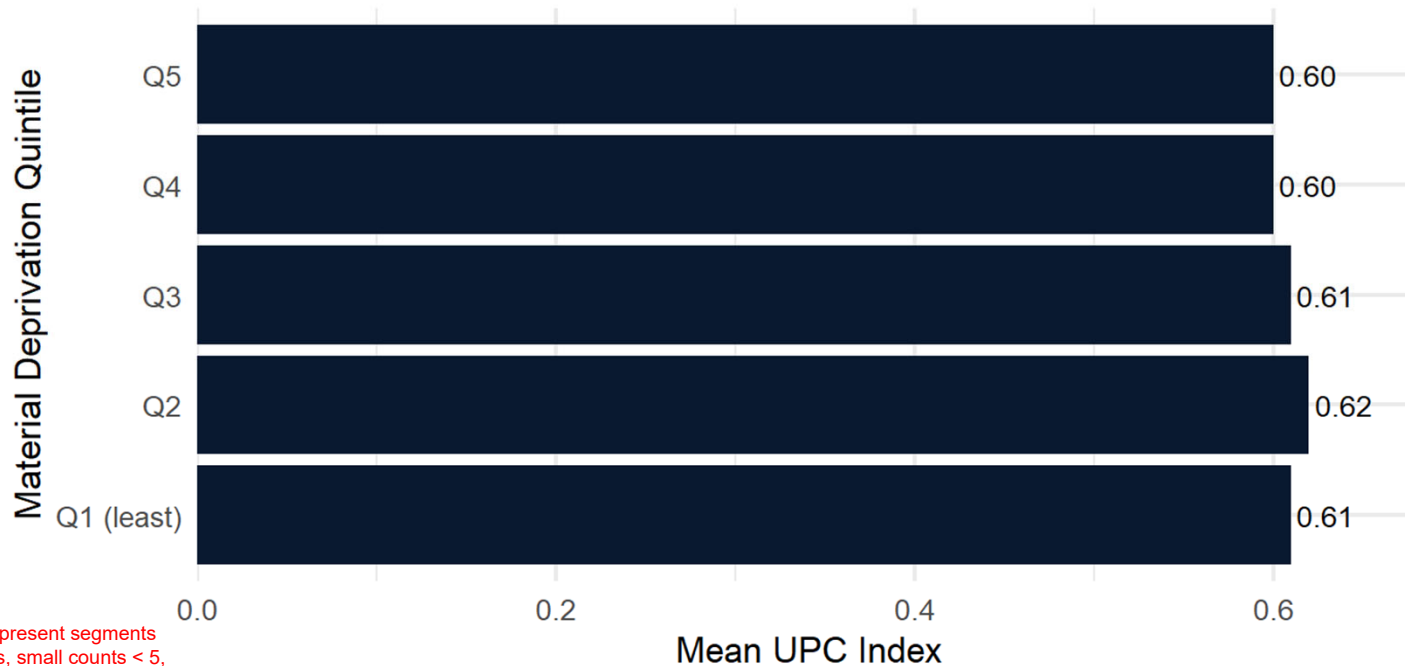
DEFINITION	Quadruple Aim
Average proportion of an attributed person’s physician visits that was with their most regularly seen doctor	Patient Experience

In this graph the horizontal scale represents the average Continuity of Care (CoC) amongst all patients attributed to this OHT where CoC is measured as the proportion of all physician visits that are with the doctor that they see the most often.

Sample Interpretation: In the most deprived communities 60% of patients' visits to the doctor were to the same doctor. Higher numbers indicate greater continuity of care and are an indicator of relationship continuity. Higher values are preferred on average. Specialist direct referrals to other specialists without involvement of a persons' most regularly seen doctor are one of the main ways continuity is decreased.

2022/23 Mean continuity of care (measured by the Usual Provider of Care Index) by Material Deprivation Quintile

Continuity of care (UPC Index) 2022/23
KW4



Horizontal axis presents the mean continuity of care (measured by the Usual Provider of Care Index):

- OHT and Ontario average indicated in figure footnote.

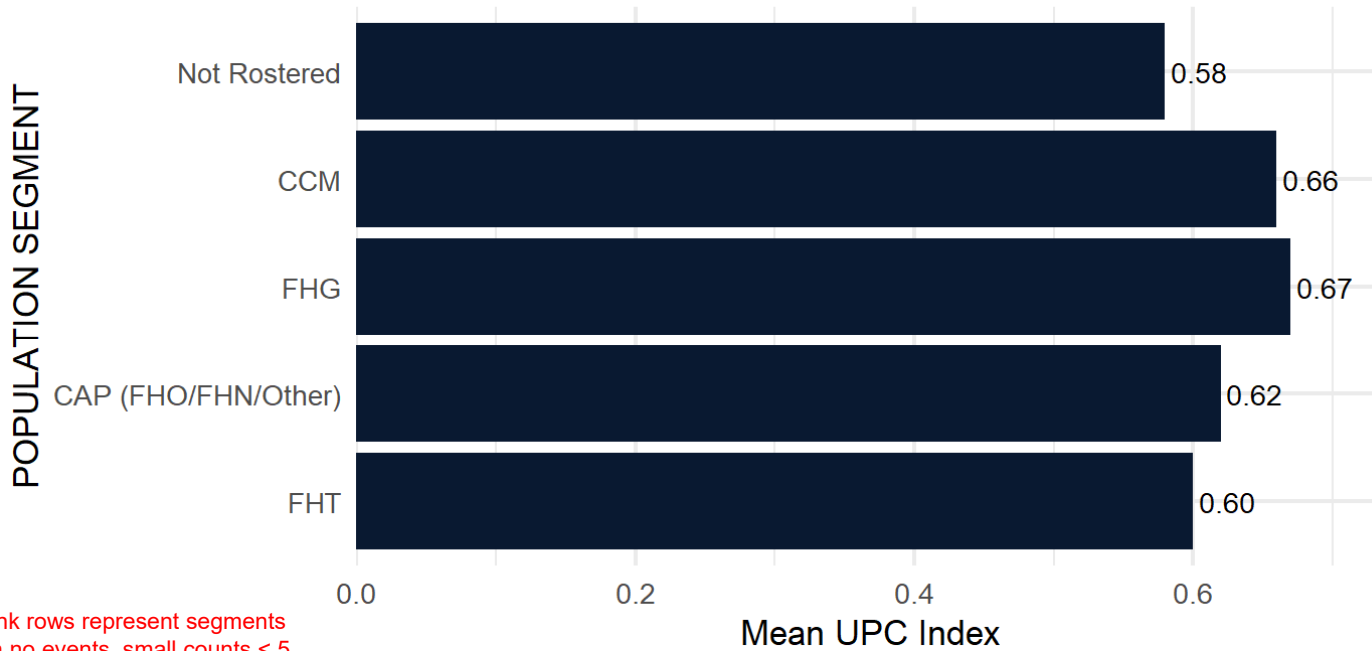
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

- *Mean continuity of care (measured by the UPC index) is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall mean UPC: OHT 42 = 0.61 / Ontario = 0.61.

2022/23 Mean continuity of care (measured by the Usual Provider of Care Index) by Primary Care Model

Continuity of care (UPC Index) 2022/23
KW4



Horizontal axis presents the mean continuity of care (measured by the Usual Provider of Care Index):

- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

*Mean continuity of care (measured by the UPC index) is shown at the end of the bar.

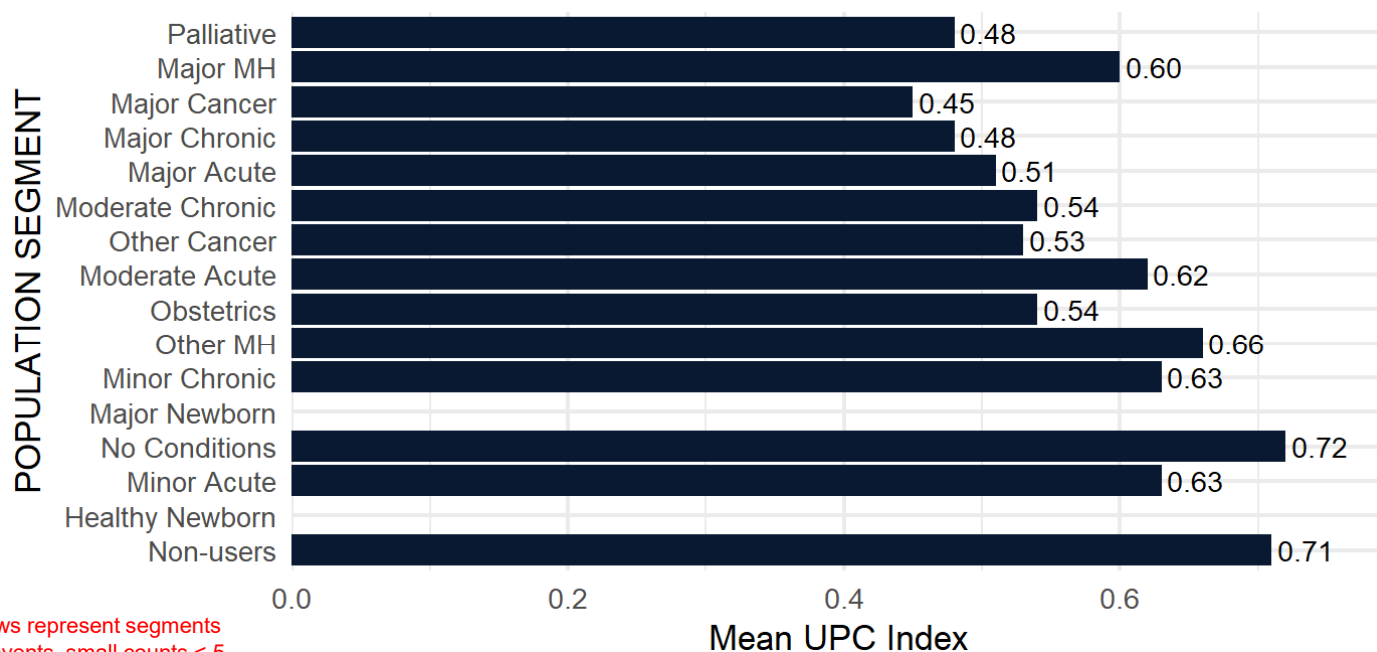
*Data are suppressed for segments with small counts.

*Overall mean UPC: OHT 42 = 0.61 / Ontario = 0.61.

2022/23 Mean continuity of care (measured by the Usual Provider of Care Index) by CIHI Population Grouping Methodology

Continuity of care (UPC Index) 2022/23

KW4



Horizontal axis presents the mean continuity of care (measured by the Usual Provider of Care Index):

- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

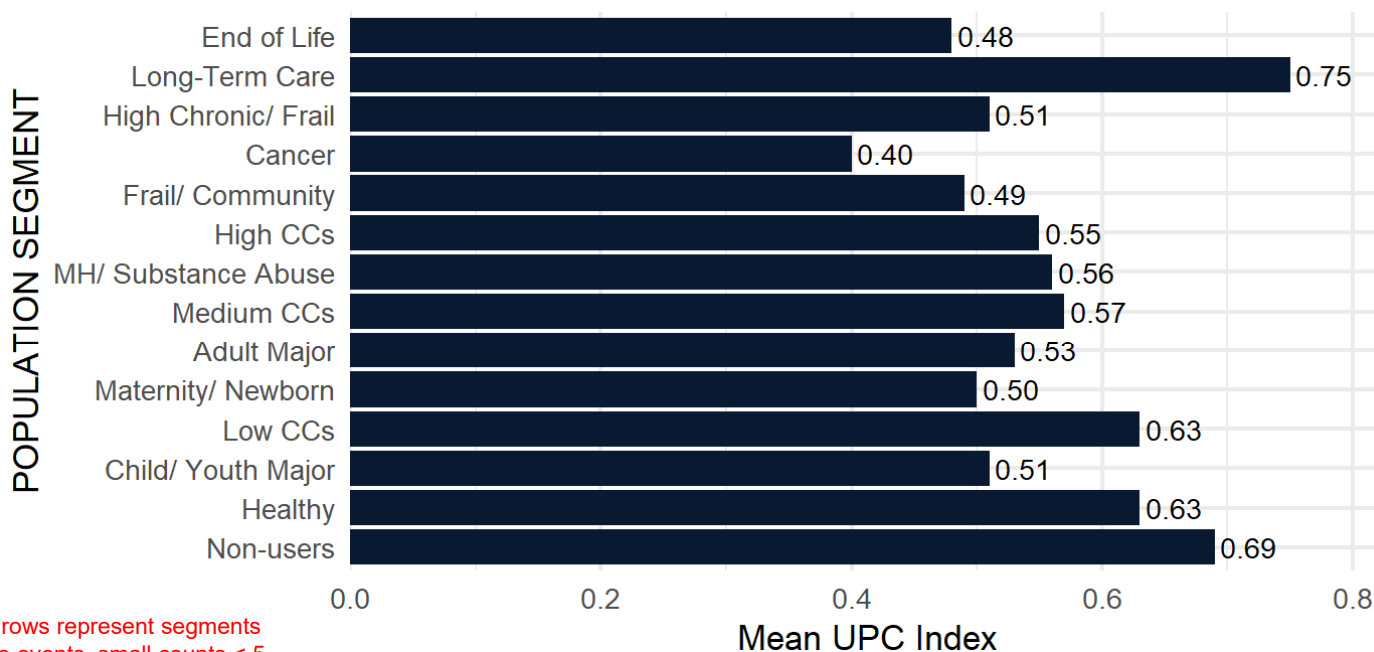
*Mean continuity of care (measured by the UPC index) is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Overall mean UPC: OHT 42 = 0.61 / Ontario = 0.61.

2022/23 Mean continuity of care (measured by the Usual Provider of Care Index) by BC Matrix Segment

Continuity of care (UPC Index) 2022/23
KW4



Horizontal axis presents the mean continuity of care (measured by the Usual Provider of Care Index):

- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

*Mean continuity of care (measured by the UPC index) is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Overall mean UPC: OHT 42 = 0.61 / Ontario = 0.61.

Alternate Level of Care (ALC) days

DEFINITION	Quadruple Aim
Proportion of days in acute inpatient care that were spent in alternate level of care (ALC)	Patient Experience & Efficiency

In this graph the horizontal axis measures the total number of hospital inpatient days amongst all patients in your OHT attributable population and the colours represent how many of those days are acute versus alternate level of care. In this graph the size of the bright green matters because it shows where the largest number of ALC days are incurred.

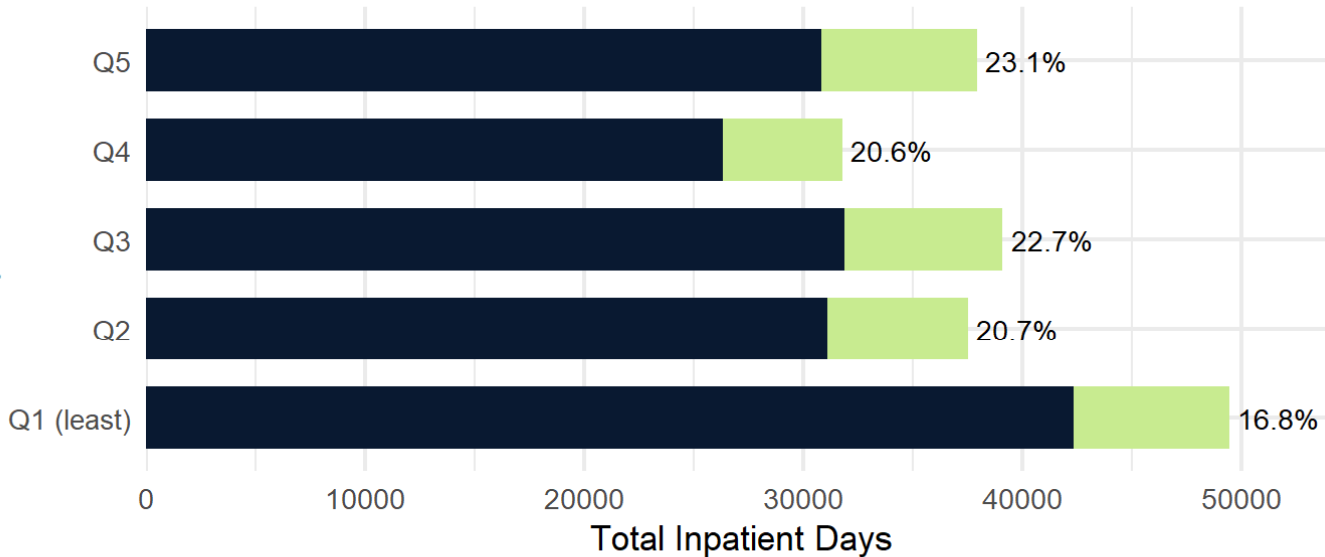
Sample Interpretation: The proportion of inpatient days designated as ALC days in the most deprived communities (Q5) is 23.1%. Lower values are preferred on average and indicate good discharge processes and partnerships between hospital and community settings to accelerate transfer of care to community.

2022/23 ALC Days (percent of acute days) in acute hospitals by Material Deprivation Quintile

ALC Days 2022/23

KW4

Material Deprivation Quintile



Horizontal axis presents total inpatient days:

- Bright green indicates ALC days;
- Dark blue represents non-ALC inpatient days;
- Percentage to the right is the proportion of inpatient days designated as ALC.
- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ Other Inpatient Days ■ ALC Days

Notes:

*Proportion of inpatient days designated as ALC is shown at the end of the bar.

*Data are suppressed for segments with small counts.

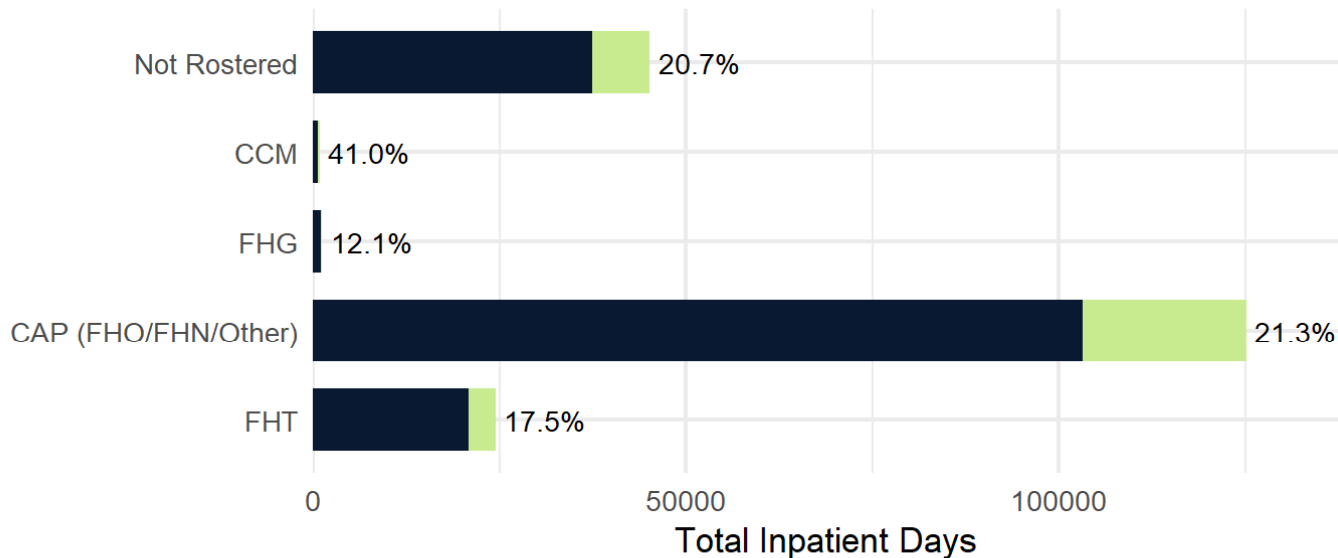
*Overall ALC Days: OHT 42 = 20.7% / Ontario = 18.8%.

2022/23 ALC Days (percent of acute days) in acute hospitals by Primary Care Model

ALC Days 2022/23

KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ Other Inpatient Days ■ ALC Days

Notes:

*Proportion of inpatient days designated as ALC is shown at the end of the bar.

*Data are suppressed for segments with small counts.

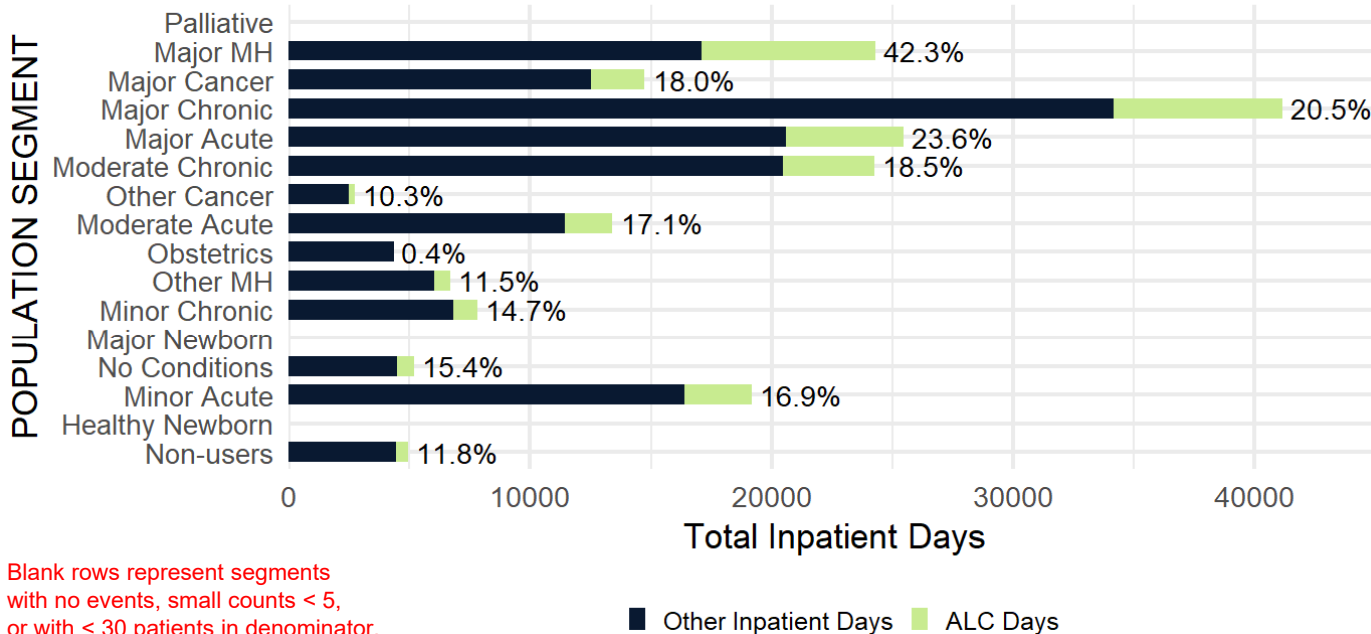
*Overall ALC Days: OHT 42 = 20.7% / Ontario = 18.8%.

Horizontal axis presents total inpatient days:

- Bright green indicates ALC days;
- Dark blue represents non-ALC inpatient days;
- Percentage to the right is the proportion of inpatient days designated as ALC.
- OHT and Ontario average indicated in figure footnote.

2022/23 ALC Days (percent of acute days) in acute hospitals by CIHI Population Grouping Methodology

ALC Days 2022/23
KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
 *Proportion of inpatient days designated as ALC is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall ALC Days: OHT 42 = 20.7% / Ontario = 18.8%.

Horizontal axis presents total inpatient days:

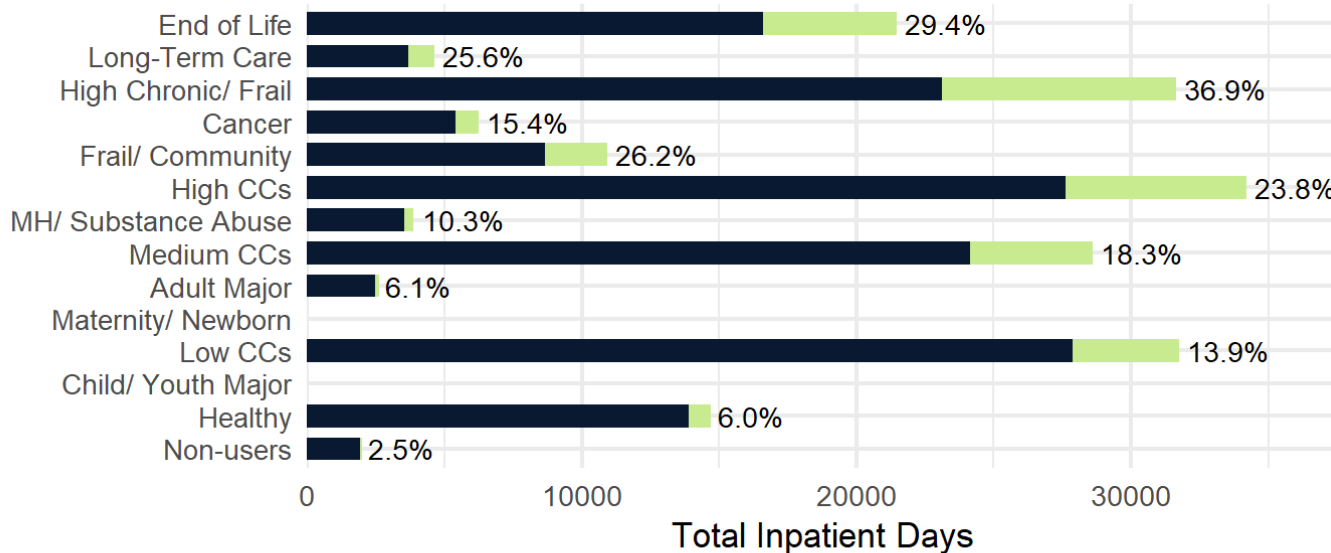
- Bright green indicates ALC days;
- Dark blue represents non-ALC inpatient days;
- Percentage to the right is the proportion of inpatient days designated as ALC.
- OHT and Ontario average indicated in figure footnote.

2022/23 ALC Days (percent of acute days) in acute hospitals by BC Matrix Segment

ALC Days 2022/23

KW4

POPULATION SEGMENT



Horizontal axis presents total inpatient days:

- Bright green indicates ALC days;
- Dark blue represents non-ALC inpatient days;
- Percentage to the right is the proportion of inpatient days designated as ALC.
- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ Other Inpatient Days ■ ALC Days

Notes:

*Proportion of inpatient days designated as ALC is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Overall ALC Days: OHT 42 = 20.7% / Ontario = 18.8%.

Cervical Cancer Screening with Papanicolaou Test

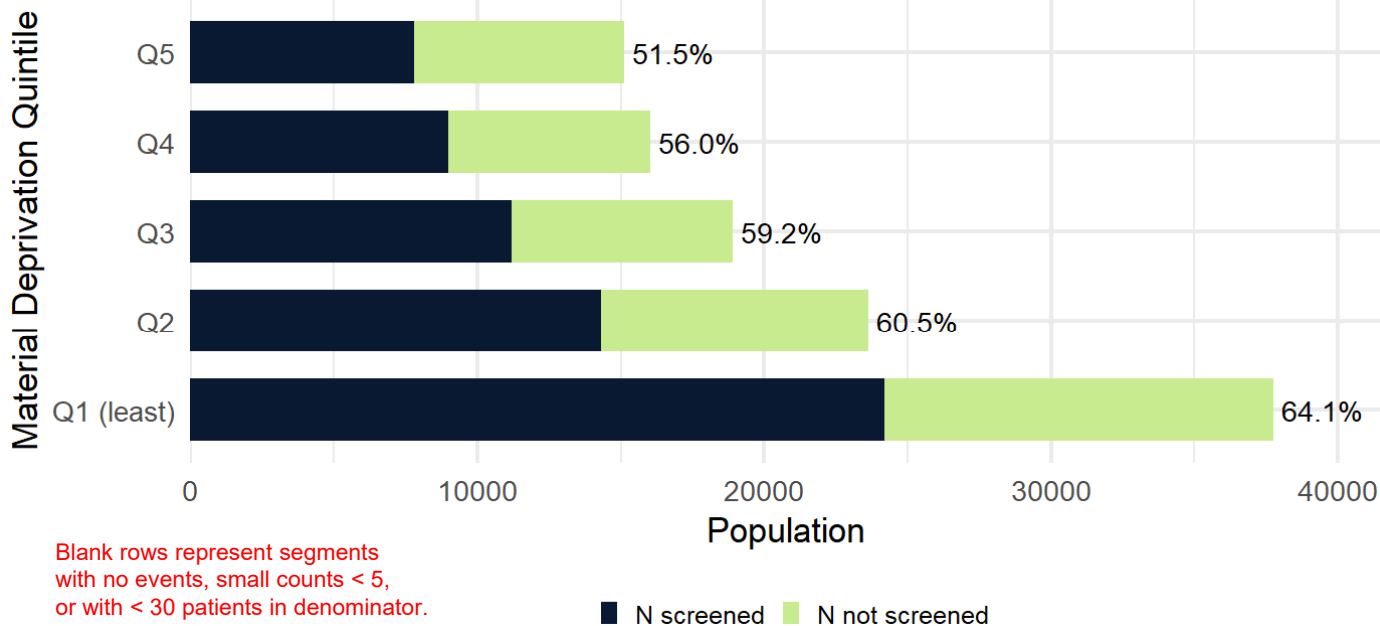
DEFINITION	Quadruple Aim
Proportion of screen eligible patients (women 23-69 years of age) up to date with Papanicolaou (Pap) tests)	Patient Experience (access)

In this graph, the horizontal axis measures the total number of individuals who are eligible to have cervical cancer screening in your OHT attributable population and the colours represent how many of these individuals are, and are not, up to date with their Pap test. In this graph the size of the bright green matters because it shows the population groups where the largest number of tests have not been completed.

Sample Interpretation: 51.5% of patients in the most deprived communities (Q5) were up to date with their cervical cancer screening. Higher values are preferred and support early detection and better survival amongst women diagnosed with cervical cancer.

Percentage of screen-eligible patients (women 23-69 yrs of age) up to date with Papanicolaou (Pap) tests on March 31, 2023 by Material Deprivation Quintile

Up-To-Date Pap Test 2022/23
KW4



Horizontal axis shows the number of women 23-69 years

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- OHT and Ontario average indicated in figure footnote.

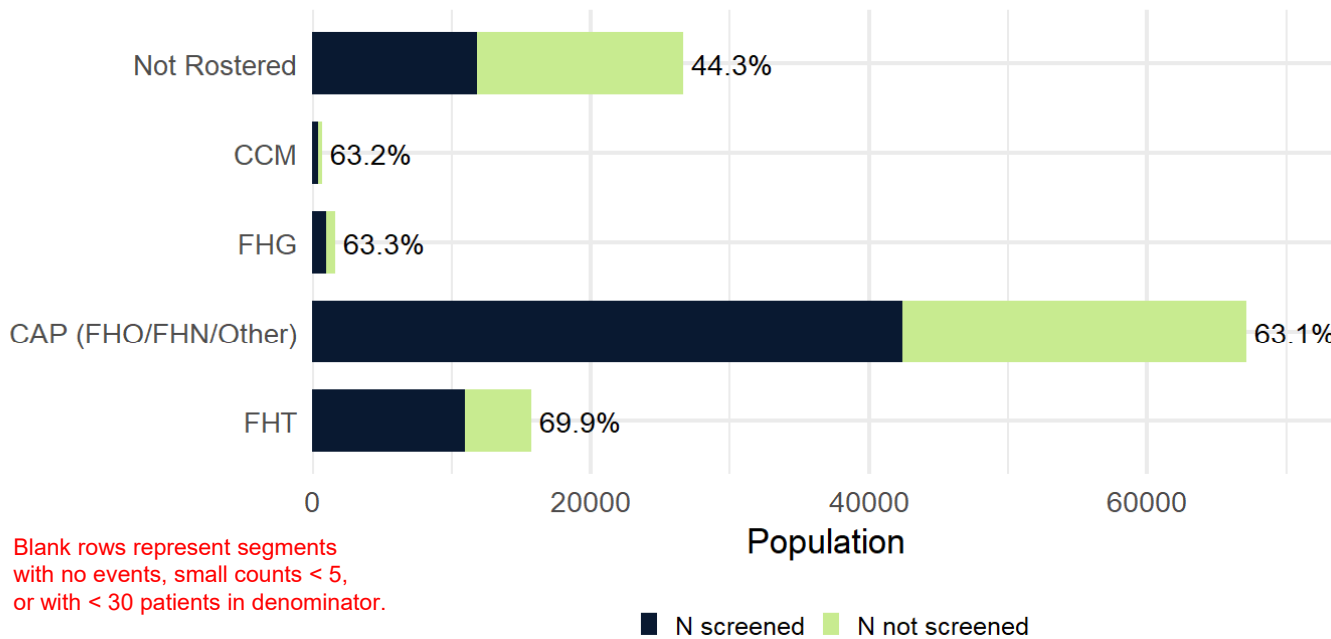
Notes:

- *Proportion of segment screened is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall proportion screened in: OHT 42 = 59.6% / Ontario = 56.0%.

Percentage of screen-eligible patients (women 23-69 yrs of age) up to date with Papanicolaou (Pap) tests on March 31, 2023 by Primary Care Model

Up-To-Date Pap Test 2022/23
KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

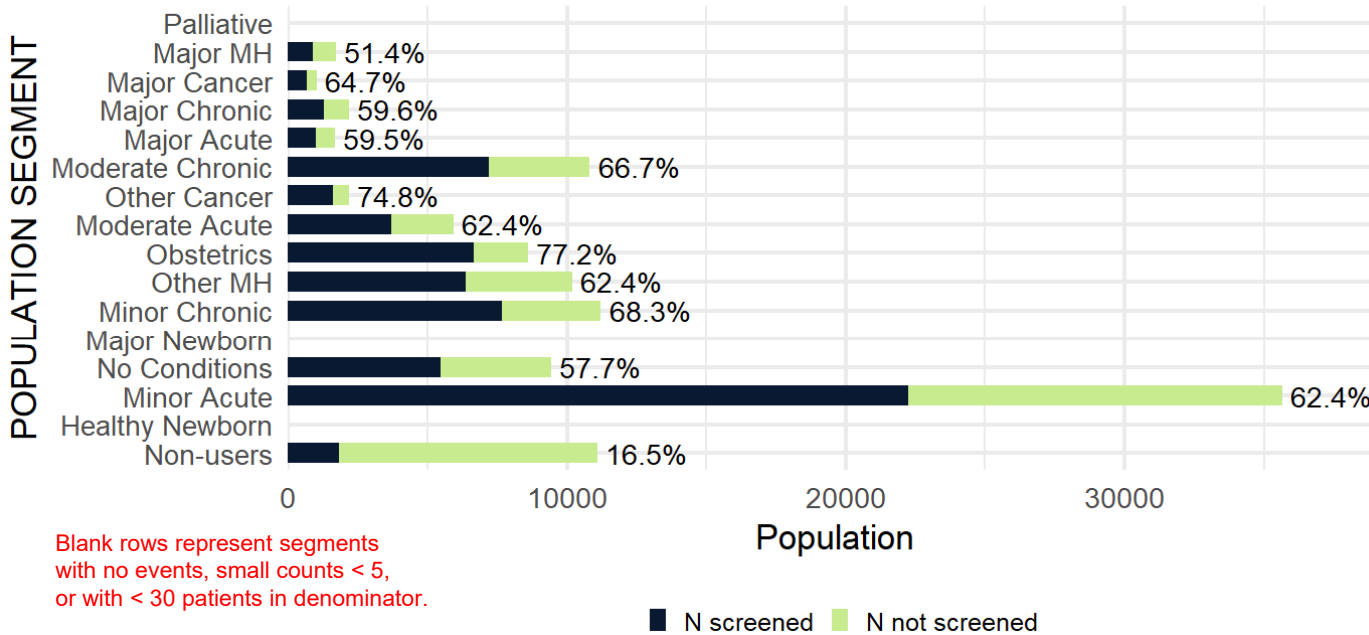
Notes:
 *Proportion of segment screened is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall proportion screened in: OHT 42 = 59.6% / Ontario = 56.0%.

Horizontal axis shows the number of women 23-69 years

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- OHT and Ontario average indicated in figure footnote.

Percentage of screen-eligible patients (women 23-69 yrs of age) up to date with Papanicolaou (Pap) tests on March 31, 2023 by CIHI Population Grouping Methodology

Up-To-Date Pap Test 2022/23 KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

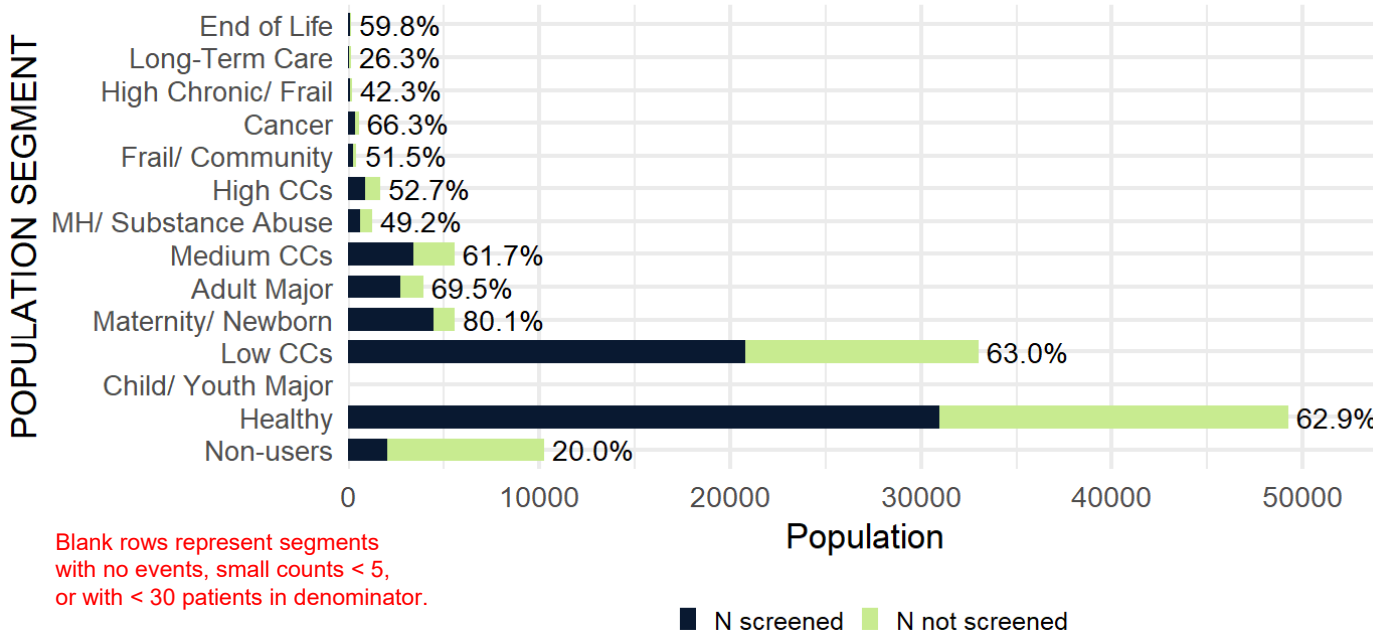
- *Proportion of segment screened is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall proportion screened in: OHT 42 = 59.6% / Ontario = 56.0%.

Horizontal axis shows the number of women 23-69 years

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- OHT and Ontario average indicated in figure footnote.

Percentage of screen-eligible patients (women 23-69 yrs of age) up to date with Papanicolaou (Pap) tests on March 31, 2023 by BC Matrix Segment

Up-To-Date Pap Test 2022/23
KW4



Horizontal axis shows the number of women 23-69 years

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- OHT and Ontario average indicated in figure footnote.

Notes:
 *Proportion of segment screened is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall proportion screened in: OHT 42 = 59.6% / Ontario = 56.0%.

Breast Cancer Screening with Mammogram

DEFINITION	Quadruple Aim
Proportion of screen-eligible patients (women 52-69 years of age) up to date with a Mammogram	Patient Experience (access)

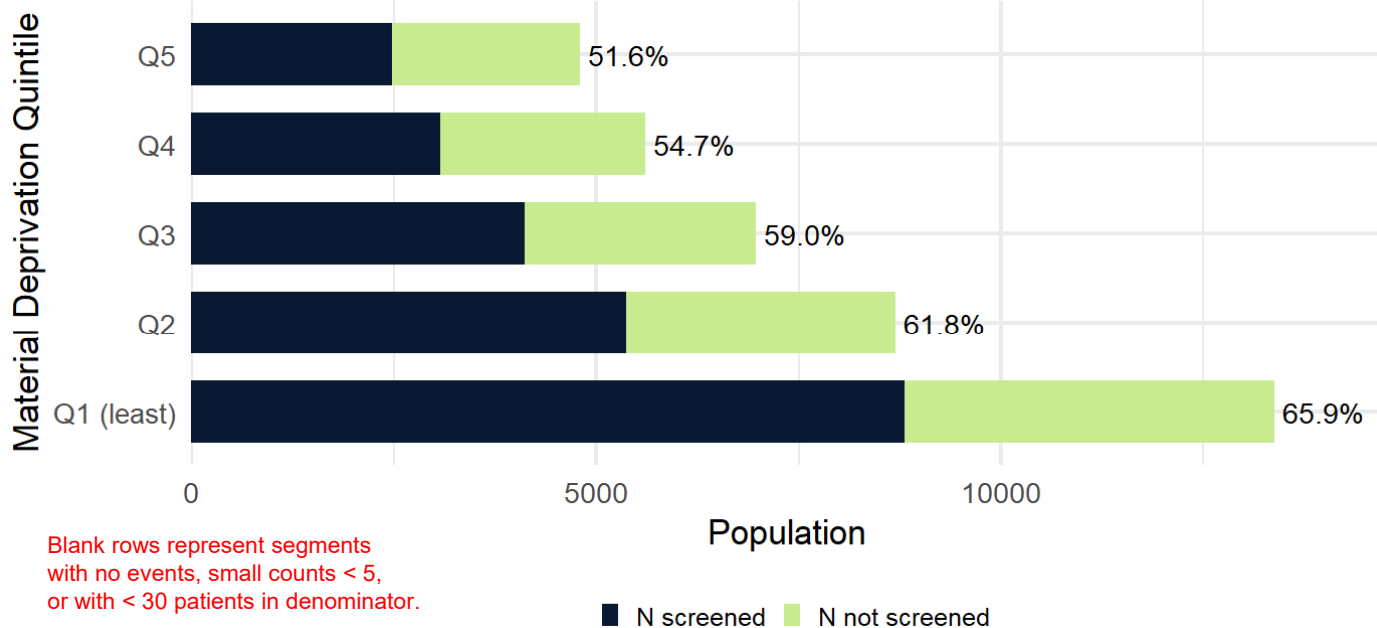
In this graph, the horizontal axis measures the total number of individuals who are eligible to have breast cancer screening in your OHT attributable population and the colours represent how many of these individuals are, and are not, up to date with their Mammogram screening. In this graph the size of the bright green matters because it shows the population groups where the largest number of tests have not been completed.

Sample Interpretation: 51.6% of patients in the most deprived communities (Q5) were up to date with their Mammogram screening. Higher values are preferred and support early detection and better survival amongst women diagnosed with breast cancer.

Percentage of screen-eligible patients (women 52-69 years of age) up to date with a Mammogram on March 31, 2023 by Material Deprivation Quintile

Up-To-Date Mammogram 2022/23

KW4



Horizontal axis shows the number of women 52-69 years:

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- OHT and Ontario average indicated in figure footnote.

Notes:

*Proportion of segment screened is shown at the end of the bar.

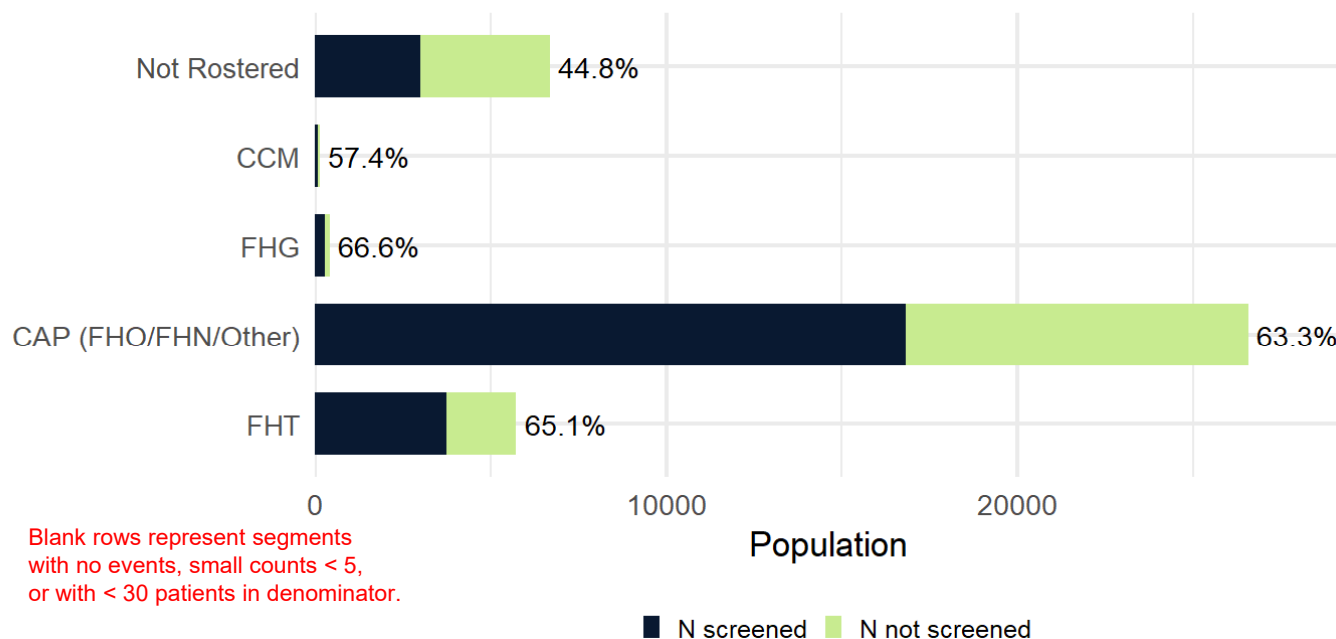
*Data are suppressed for segments with small counts.

*Overall proportion screened in: OHT 42 = 60.4% / Ontario = 56.0%.

Percentage of screen-eligible patients (women 52-69 years of age) up to date with a Mammogram on March 31, 2023 by Primary Care Model

Up-To-Date Mammogram 2022/23
KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
 *Proportion of segment screened is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall proportion screened in: OHT 42 = 60.4% / Ontario = 62.3%.

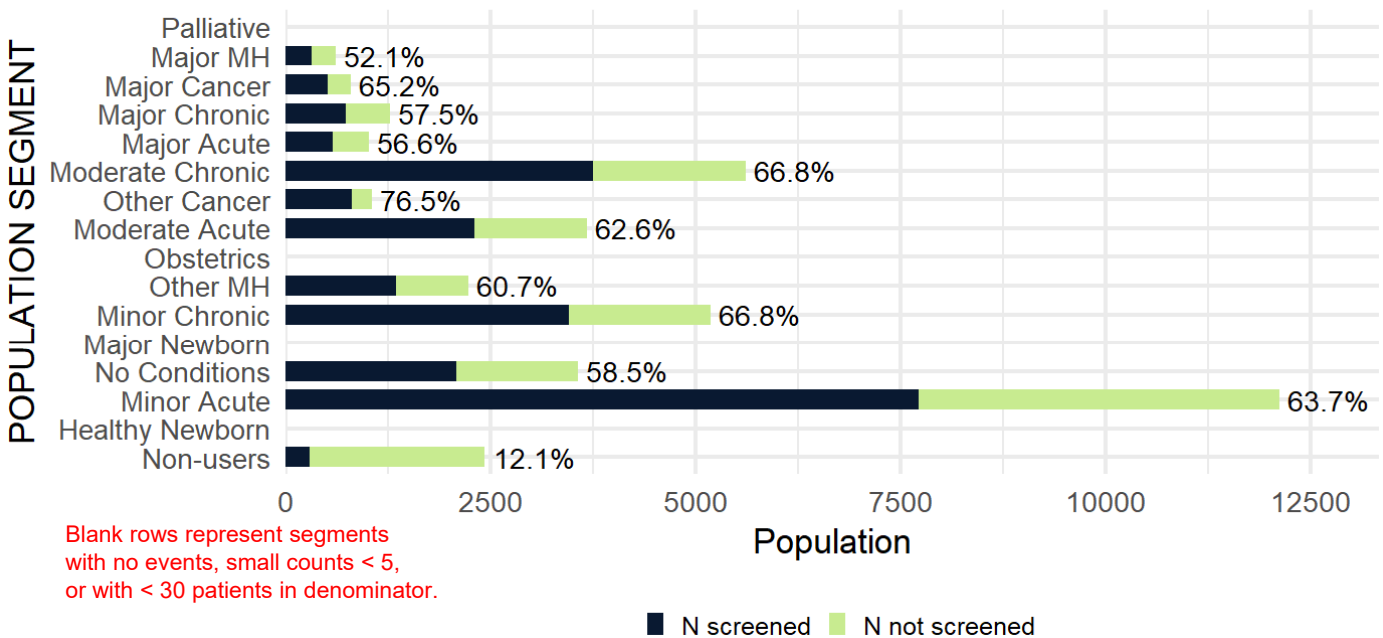
Horizontal axis shows the number of women 52-69 years:

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- OHT and Ontario average indicated in figure footnote.

Percentage of screen-eligible patients (women 52-69 years of age) up to date with a Mammogram on March 31, 2023 by CIHI Population Grouping Methodology

Up-To-Date Mammogram 2022/23

KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
 *Proportion of segment screened is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall proportion screened in: OHT 42 = 60.4% / Ontario = 62.3%.

Horizontal axis shows the number of women 52-69 years:

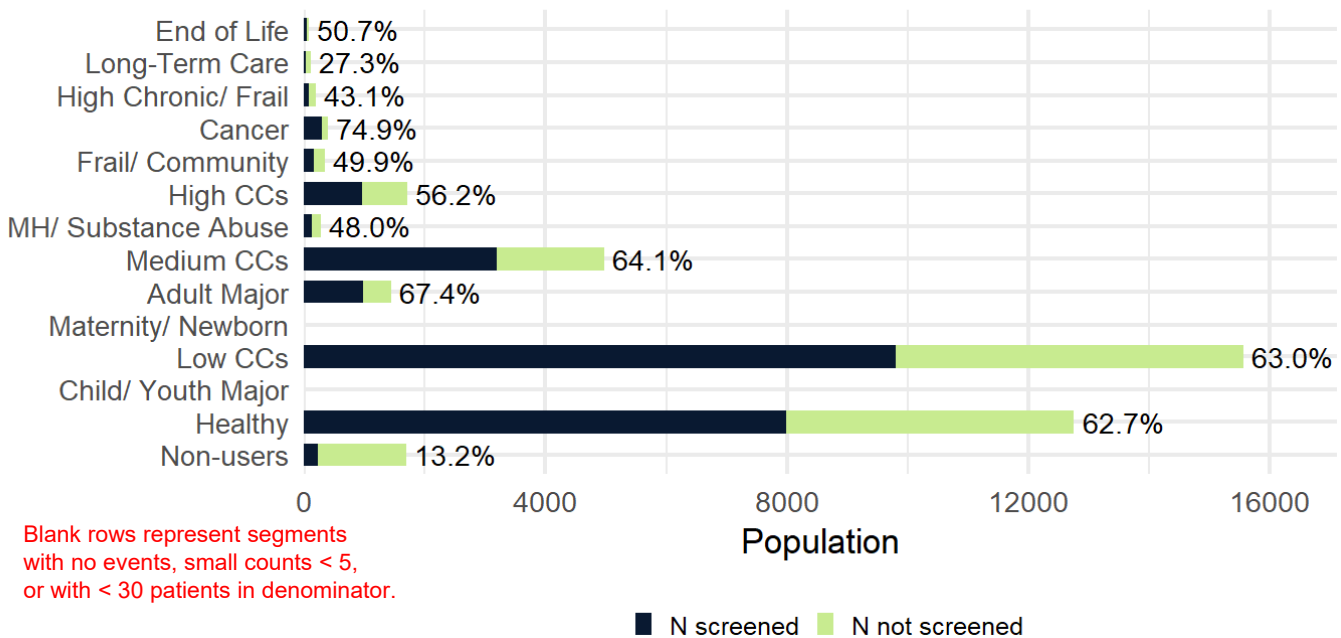
- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- OHT and Ontario average indicated in figure footnote.

Percentage of screen-eligible patients (women 52-69 years of age) up to date with a Mammogram on March 31, 2023 by BC Matrix Segment

Up-To-Date Mammogram 2022/23

KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
 *Proportion of segment screened is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall proportion screened in: OHT 42 = 60.4% / Ontario = 62.3%.

Horizontal axis shows the number of women 52-69 years:

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- OHT and Ontario average indicated in figure footnote.

Frequent (4+) emergency department visits for help with MHA

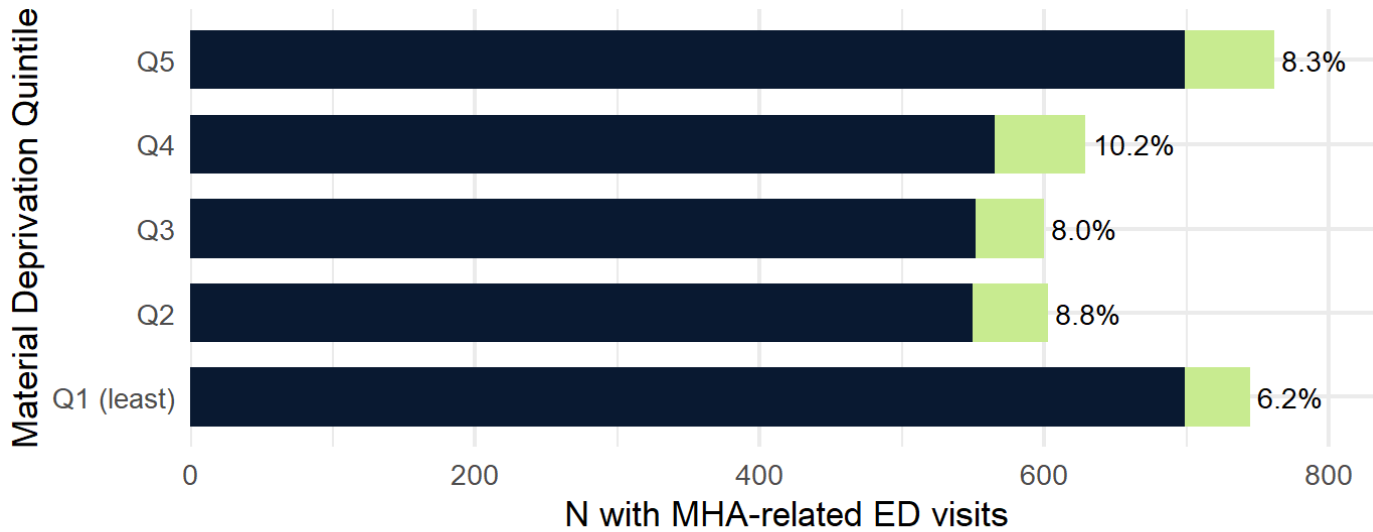
DEFINITION	Quadruple Aim
Proportion of individuals with an unscheduled emergency department visit that had 4 or more emergency department visits for an MHA reason within a 365-day period	Patient Experience (Timely Access) & Cost/Efficiency

In this graph, the horizontal axis counts the total number of individuals in your OHT attributed population who were admitted to ED for an MHA-related reason. The colours represent how many had less than 4 or at least 4 or more ED visits for an MHA-related reason. In this graph the size of the bright green matters because it shows the population groups where the largest number of ED visits were incurred.

Sample Interpretation: 8.3% of patients in the most deprived communities (Q5) had 4 or more unscheduled ED visits related to MHA. Lower values are preferred and indicate that people with mental health and addictions are able to access care in the community.

2022/23 Number of patients with Frequent (4+) ED visits for MHA by Material Deprivation Quintile

Frequent (4+ ED visits for MHA) 2022/23
KW4



Horizontal axis presents number of patients with MHA-related ED visits.

- Bright green indicates number of patients with 4 or more MHA-related ED visits;
- Dark blue represents number of patients with at least one MHA-related ED visit;
- Percentage to the right is the proportion of the attributable population that had 4+ ED visits within a year;
- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N with MHA-related ED visit ■ N with 4+ MHA-related ED visits

Notes:

*The proportion of the attributable population that had 4+ ED visits for MHA is shown at the end of the bar.

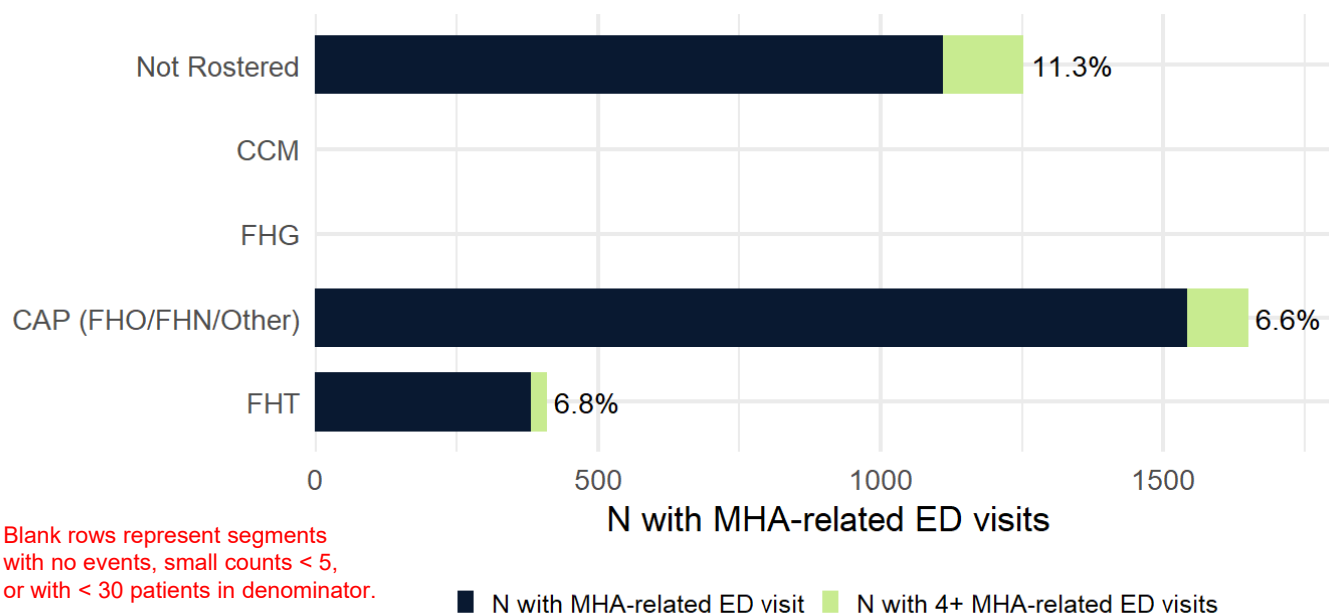
*Data are suppressed for segments with small counts.

*Proportion with 4+ ED visits: OHT 42 = 8.5% / Ontario = 10.3%.

2022/23 Number of patients with Frequent (4+) ED visits for MHA by Primary Care Model

Frequent (4+ ED visits for MHA) 2022/23
KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

*The proportion of the attributable population that had 4+ ED visits for MHA is shown at the end of the bar.

*Data are suppressed for segments with small counts.

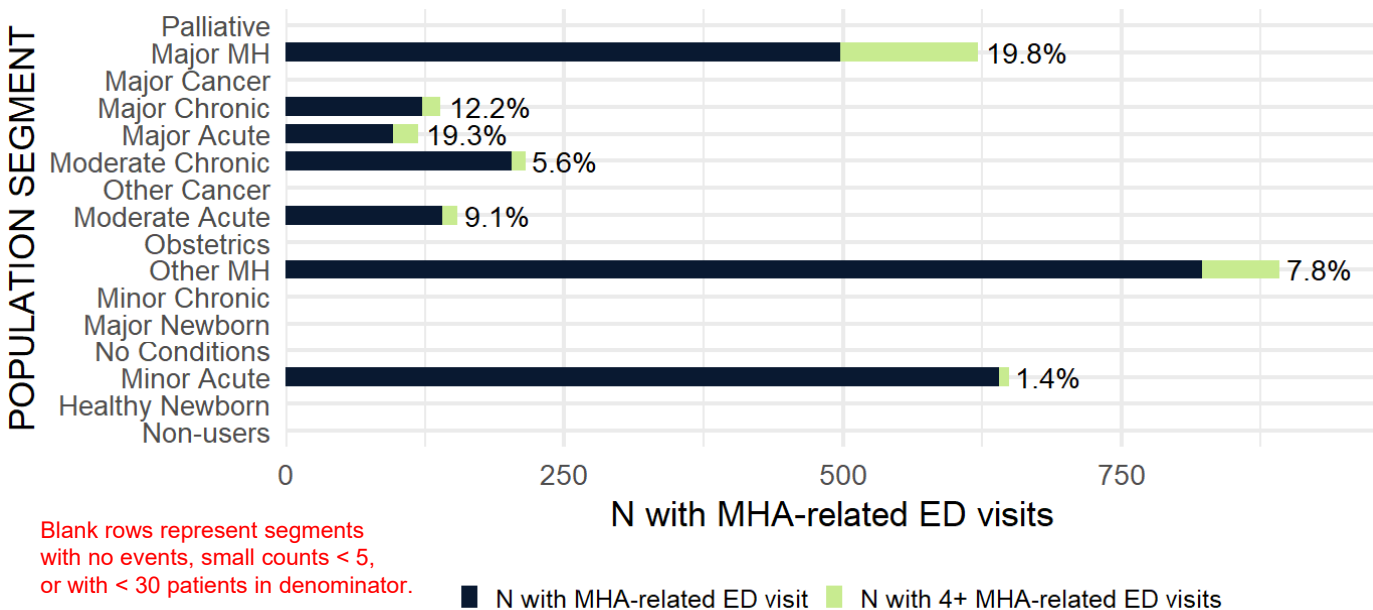
*Proportion with 4+ ED visits: OHT 42 = 8.5% / Ontario = 10.3%.

Horizontal axis presents number of patients with MHA-related ED visits.

- Bright green indicates number of patients with 4 or more MHA-related ED visits;
- Dark blue represents number of patients with at least one MHA-related ED visit;
- Percentage to the right is the proportion of the attributable population that had 4+ ED visits within a year;
- OHT and Ontario average indicated in figure footnote.

2022/23 Number of patients with Frequent (4+) ED visits for MHA by CIHI Population Grouping Methodology

Frequent (4+ ED visits for MHA) 2022/23
KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N with MHA-related ED visit ■ N with 4+ MHA-related ED visits

Notes:

*The proportion of the attributable population that had 4+ ED visits for MHA is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Proportion with 4+ ED visits: OHT 42 = 8.5% / Ontario = 10.3%.

Horizontal axis presents number of patients with MHA-related ED visits.

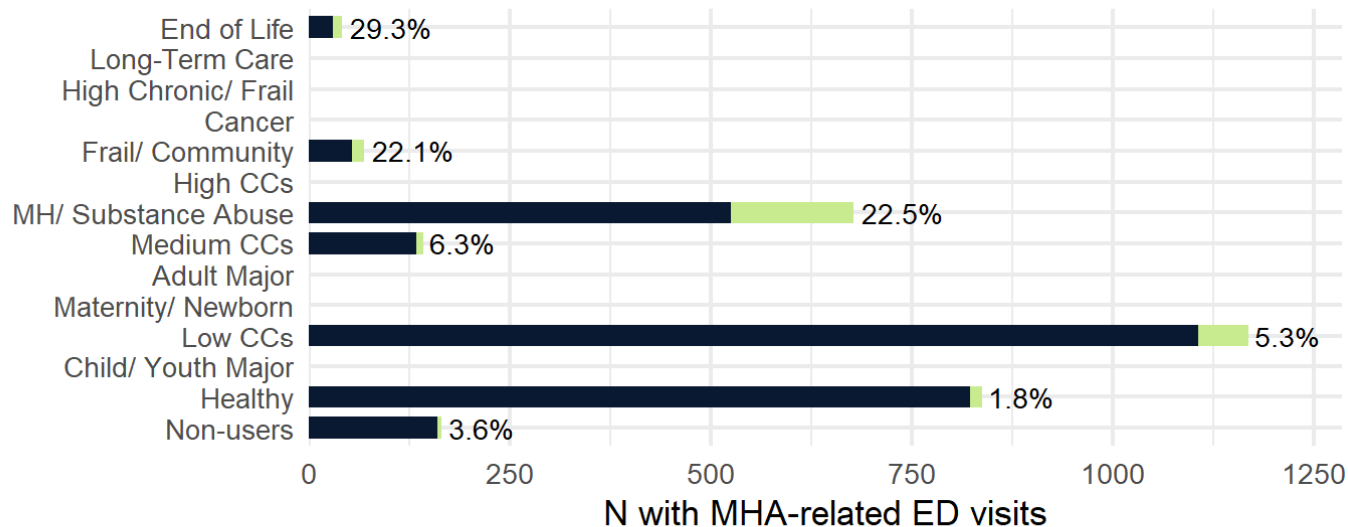
- Bright green indicates number of patients with 4 or more MHA-related ED visits;
- Dark blue represents number of patients with at least one MHA-related ED visit;
- Percentage to the right is the proportion of the attributable population that had 4+ ED visits within a year;
- OHT and Ontario average indicated in figure footnote.

2022/23 Number of patients with Frequent (4+) ED visits for MHA by BC Matrix Segment

Frequent (4+ ED visits for MHA) 2022/23

KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N with MHA-related ED visit ■ N with 4+ MHA-related ED visits

Notes:

*The proportion of the attributable population that had 4+ ED visits for MHA is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Proportion with 4+ ED visits: OHT 42 = 8.5% / Ontario = 10.3%.

Horizontal axis presents number of patients with MHA-related ED visits.

- Bright green indicates number of patients with 4 or more MHA-related ED visits;
- Dark blue represents number of patients with at least one MHA-related ED visit;
- Percentage to the right is the proportion of the attributable population that had 4+ ED visits within a year;
- OHT and Ontario average indicated in figure footnote.

Repeat emergency visits for MHA (within 30 days)

DEFINITION	Quadruple Aim
Proportion of unscheduled emergency department visits for care for MH conditions with a second unscheduled emergency department visit for MH or substance abuse within 30 days	Patient Experience (Health Service Use)

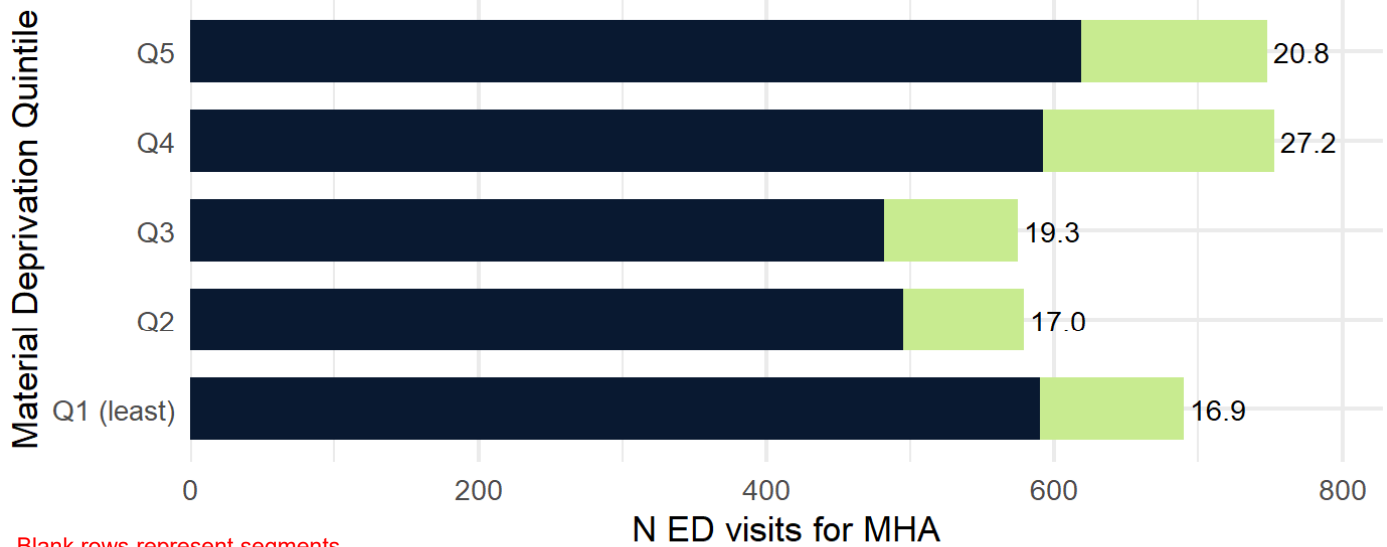
In this graph, the horizontal axis counts the total number of individuals in your OHT attributed population who were discharged from an ED with an MHA-related reason. The colours represent how many did and did not return to the ED for an MHA-related reason within 30 days. In this graph the size of the bright green matters because it shows the population groups where the largest number of ED visits were incurred.

Sample Interpretation: Amongst individuals living in the neighbourhoods with the highest material deprivation who present to ED with an MHA concern, 20.8% had a repeat ED visit for MH or substance abuse within 30 days. Lower values for this indicator are preferred and indicate that good follow-up care was provided for an individual after their first presentation.

2022/23 Rate of ED visit for MHA within 30 days by Material Deprivation Quintile

Rate of ED visits for MHA within 30 Days 2022/23

KW4



Horizontal axis shows the number of ED visits for MHA:

- Bright green indicates number of ED visits within 30 days
- Dark blue represents the number of ED visits for MHA
- Number to the right is the rate of repeat ED visits in the attributable population

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

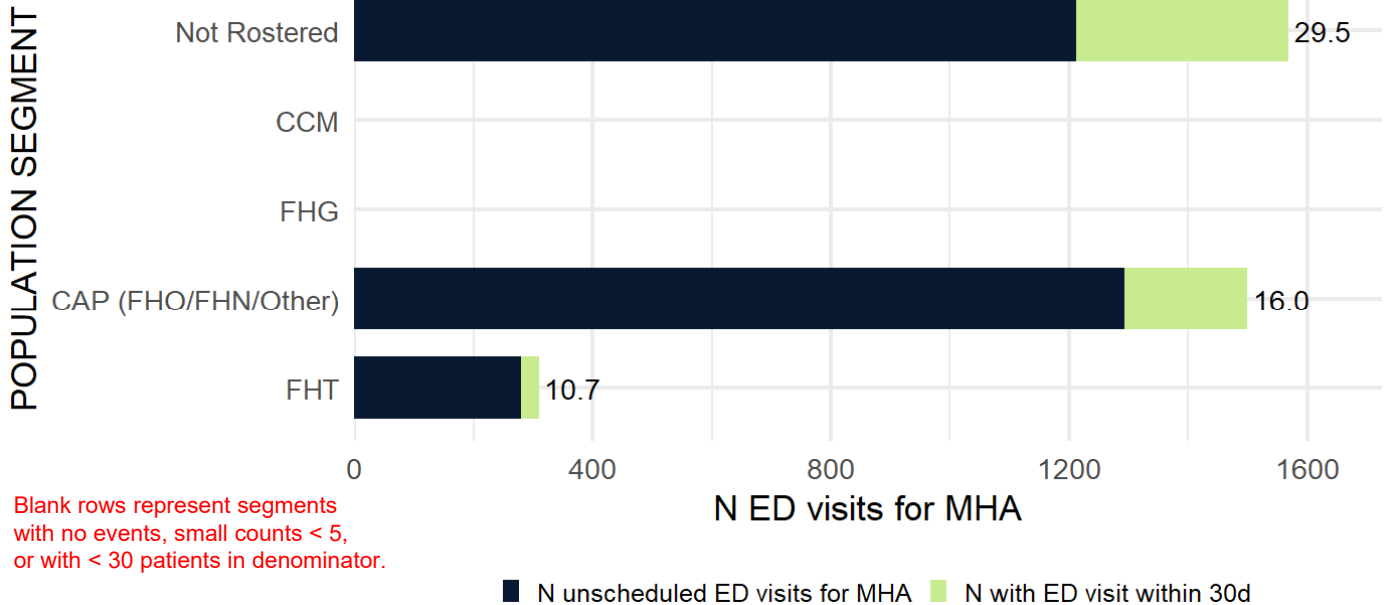
■ N unscheduled ED visits for MHA ■ N with ED visit within 30d

Notes:

- *Rate of repeat ED visit for MHA within 30 days is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall rate per 100 in: OHT 42 = 21.3 / Ontario = 24.0.

2022/23 Rate of ED visit for MHA within 30 days by Primary Care Model

Rate of ED visits for MHA within 30 Days 2022/23
KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Horizontal axis shows the number of ED visits for MHA:

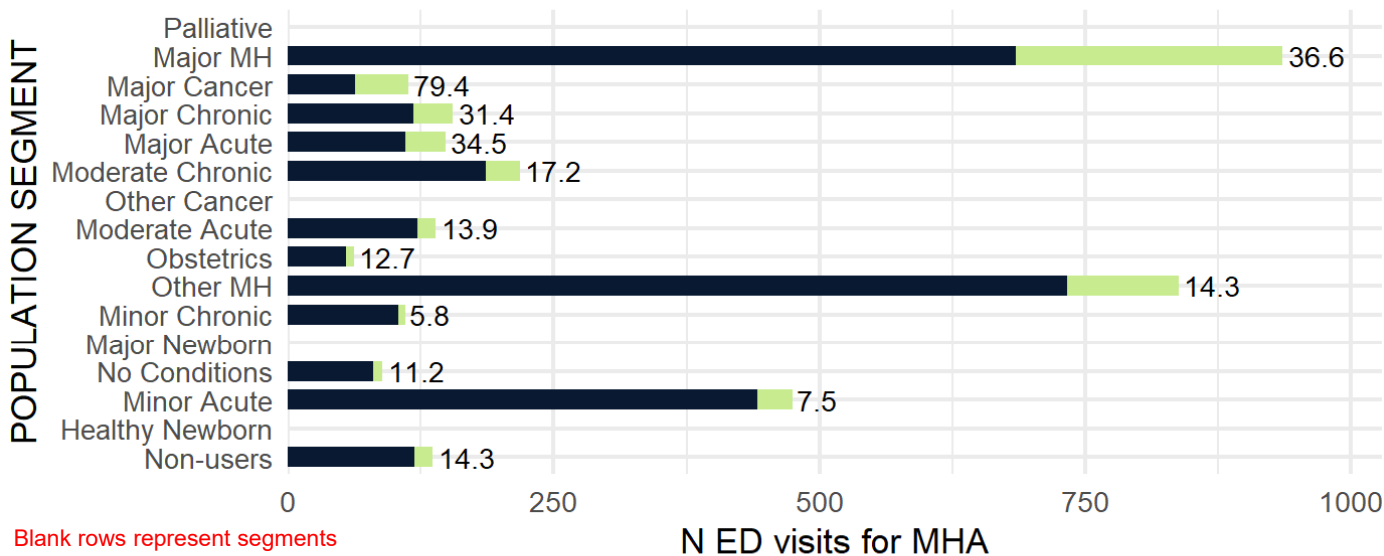
- Bright green indicates number of ED visits within 30 days
- Dark blue represents the number of ED visits for MHA
- Number to the right is the rate of repeat ED visits in the attributable population

Notes:
 *Rate of repeat ED visit for MHA within 30 days is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall rate per 100 in: OHT 42 = 21.3 / Ontario = 24.0.

2022/23 Rate of ED visit for MHA within 30 days by CIHI Population Grouping Methodology

Rate of ED visits for MHA within 30 Days 2022/23

KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N unscheduled ED visits for MHA ■ N with ED visit within 30d

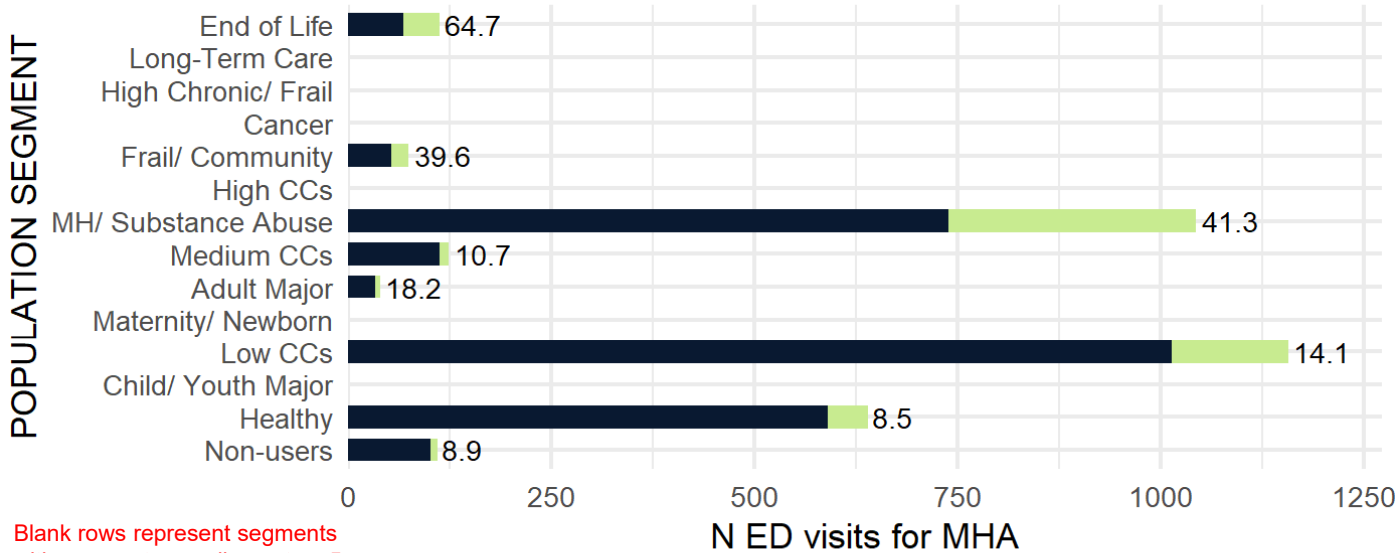
Notes:
 *Rate of repeat ED visit for MHA within 30 days is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall rate per 100 in: OHT 42 = 21.3 / Ontario = 24.0.

Horizontal axis shows the number of ED visits for MHA:

- Bright green indicates number of ED visits within 30 days
- Dark blue represents the number of ED visits for MHA
- Number to the right is the rate of repeat ED visits in the attributable population

2022/23 Rate of ED visit for MHA within 30 days by BC Matrix Segment

Rate of ED visits for MHA within 30 Days 2022/23
KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N unscheduled ED visits for MHA ■ N with ED visit within 30d

Notes:

*Rate of repeat ED visit for MHA within 30 days is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Overall rate per 100 in: OHT 42 = 21.3 / Ontario = 24.0.

Horizontal axis shows the number of ED visits for MHA:

- Bright green indicates number of ED visits within 30 days
- Dark blue represents the number of ED visits for MHA
- Number to the right is the rate of repeat ED visits in the attributable population

First contact in the emergency department for MHA

DEFINITION	Quadruple Aim
Proportion of incident unscheduled emergency department visits for MHA-care where the patient had no prior MHA-related contact (hospitalization, emergency department or physician visit)	Patient Experience (Timely) Cost/Efficiency

In this graph, the horizontal axis counts the total number of individuals in your OHT attributed population who were admitted to ED for an MHA-related reason. The colours represent how many had already been identified as having an MHA condition versus those presenting for the first time. In this graph the size of the bright green matters because it shows the population groups where the largest number of ED visits was the location for the first presentation for mental health.

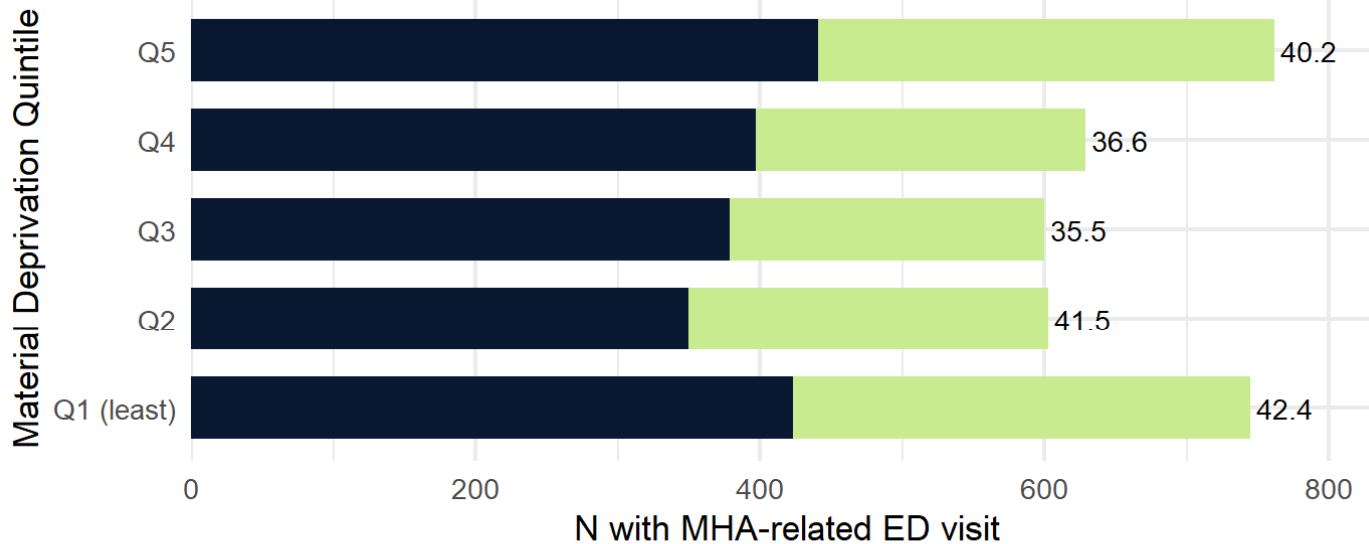
Sample Interpretation: Amongst individuals who lived in the most deprived neighbourhoods (Q5 deprivation) and presented to the emergency department for an MHA concern, 40.2% were presenting for the first time to the health system with an MHA concern. Generally lower values are preferred indicating that people with MHA concerns are identified in the community prior to an urgent care event.

2022/23 Rate of Emergency Department visits as first point of contact for Mental Health and Addictions-related care by Material Deprivation Quintile

ED as first contact for MHA 2022/23

KW4

Horizontal axis shows the total number of individuals with Mental-Health and Addictions-related ED visit



- Bright green indicates number of individuals for whom first contact for MHA was at an ED;
- Dark blue represents number of individuals with previous contact for MHA;
- Number to the right is the rate of each segment with ED as first point of contact for MHA.
- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N with first contact elsewhere ■ N with first contact in ED

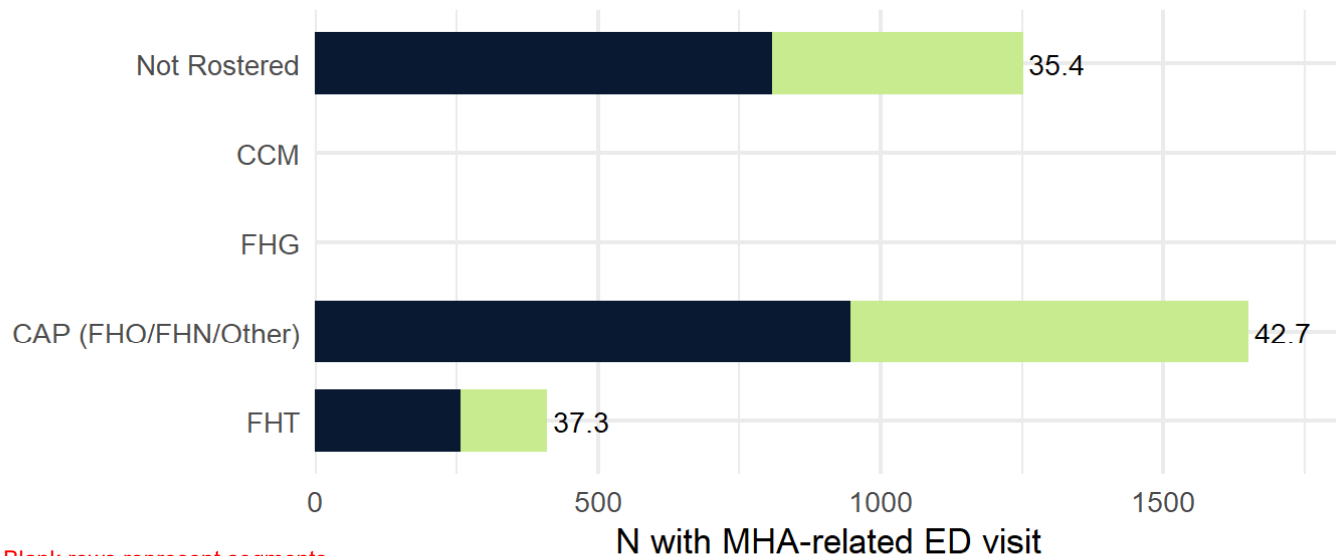
Notes:

- *Rate of ED as first point of contact for MHA is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall rate per 100 in: OHT 42 = 39.3 / Ontario = 38.3.

2022/23 Rate of Emergency Department visits as first point of contact for Mental Health and Addictions-related care by Primary Care Model

ED as first contact for MHA 2022/23
KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N with first contact elsewhere ■ N with first contact in ED

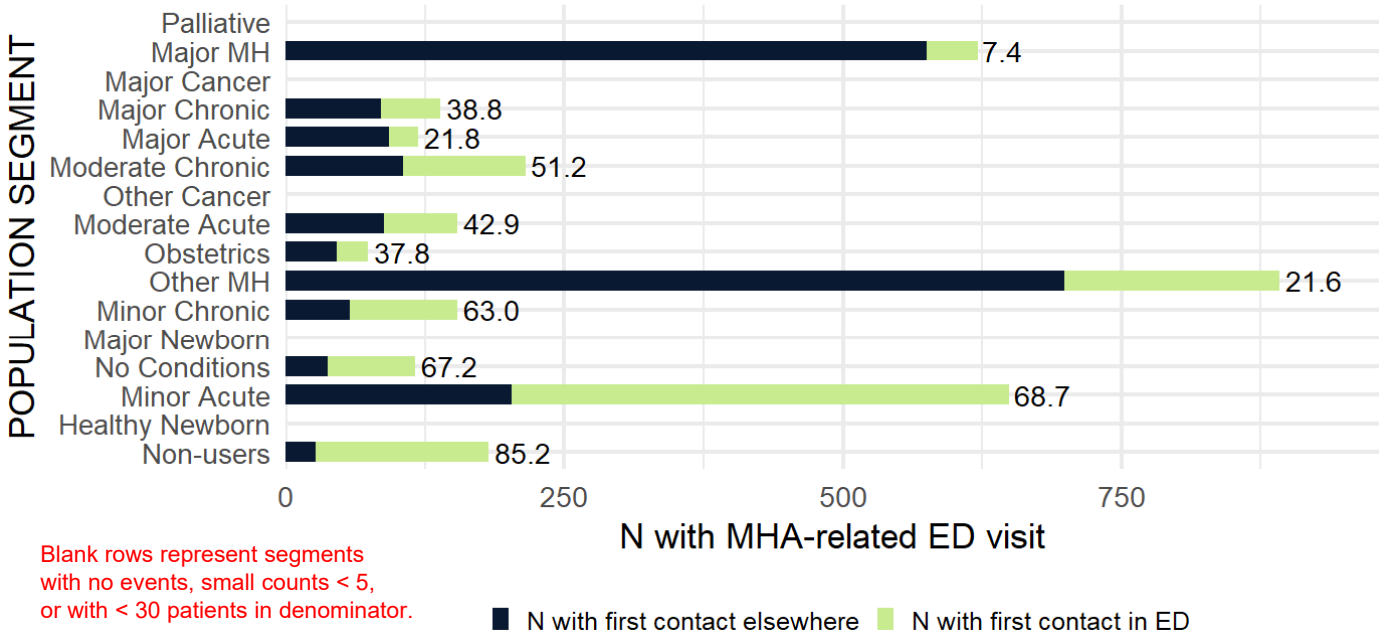
Notes:
 *Rate of ED as first point of contact for MHA is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall rate per 100 in: OHT 42 = 39.3 / Ontario = 38.3.

Horizontal axis shows the total number of individuals with Mental-Health and Addictions-related ED visit

- Bright green indicates number of individuals for whom first contact for MHA was at an ED;
- Dark blue represents number of individuals with previous contact for MHA;
- Number to the right is the rate of each segment with ED as first point of contact for MHA.
- OHT and Ontario average indicated in figure footnote.

2022/23 Rate of Emergency Department visits as first point of contact for Mental Health and Addictions-related care by CIHI Population Grouping Methodology

ED as first contact for MHA 2022/23
KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
 *Rate of ED as first point of contact for MHA is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall rate per 100 in: OHT 42 = 39.3 / Ontario = 38.3.

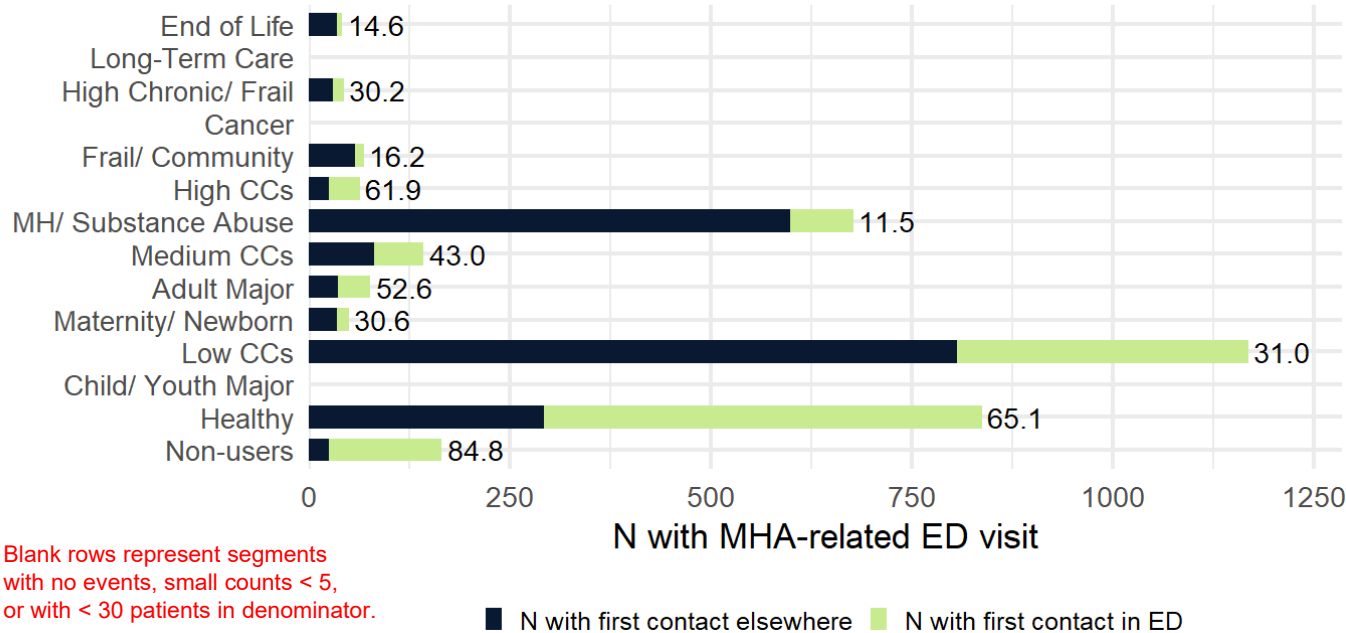
Horizontal axis shows the total number of individuals with Mental-Health and Addictions-related ED visit

- Bright green indicates number of individuals for whom first contact for MHA was at an ED;
- Dark blue represents number of individuals with previous contact for MHA;
- Number to the right is the rate of each segment with ED as first point of contact for MHA.
- OHT and Ontario average indicated in figure footnote.

2022/23 Rate of Emergency Department visits as first point of contact for Mental Health and Addictions-related care by BC Matrix Segment

ED as first contact for MHA 2022/23
KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
 *Rate of ED as first point of contact for MHA is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall rate per 100 in: OHT 42 = 39.3 / Ontario = 38.3.

Horizontal axis shows the total number of individuals with Mental-Health and Addictions-related ED visit

- Bright green indicates number of individuals for whom first contact for MHA was at an ED;
- Dark blue represents number of individuals with previous contact for MHA;
- Number to the right is the rate of each segment with ED as first point of contact for MHA.
- OHT and Ontario average indicated in figure footnote.

Proportion of decedents receiving palliative home care in the last 90 days of life

DEFINITION	Quadruple Aim
The proportion of decedents that had one or more palliative home care services (excluding care management and placement services) in their last 90 days of life	Patient Experience (access) Health Outcome

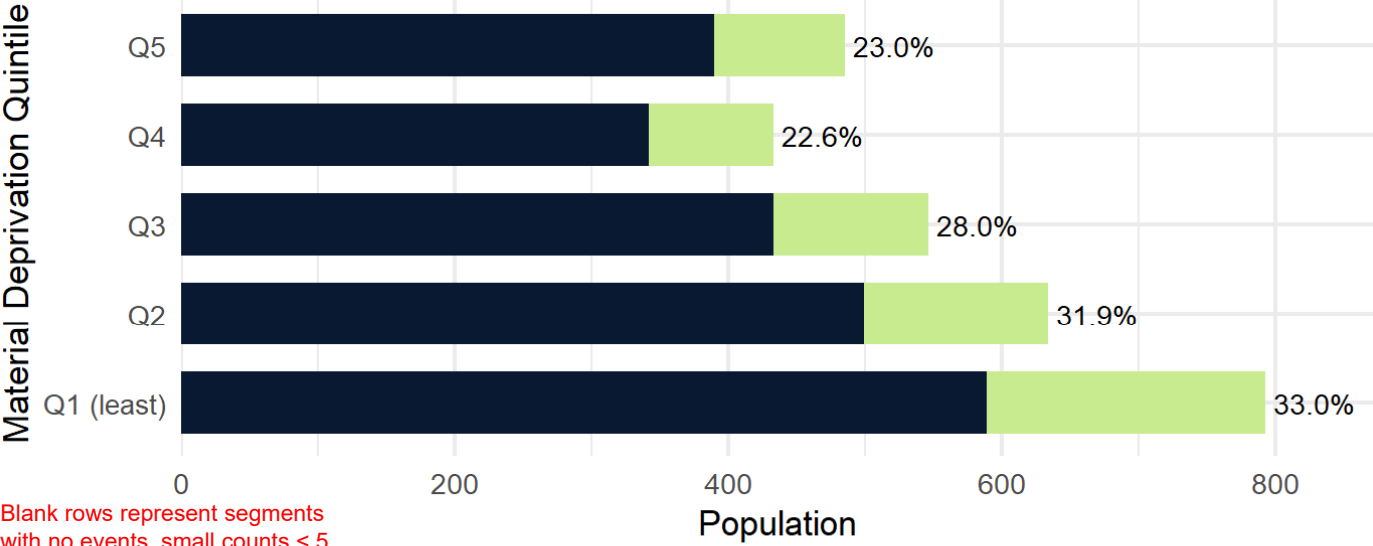
In this graph, the horizontal axis counts the total number of individuals in your OHT attributed population who died within the observation year. The colours represent how many did and did not receive palliative home care visit in the last 30 days of life. In this graph the size of the dark blue matters because it shows the population groups which groups did NOT receive palliative home care.

Sample Interpretation: 23% of patients (of the OHT attributed patients who died in the reporting period) in the most deprived communities (Q5) received homecare in the last 90 days of life. Higher values are preferred and indicate good community-based care near the end of life.

2022/23 Proportion of descendants with home care in last 90 days by Material Deprivation Quintile

Proportion with home care in last 90 days 2022/23

KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N without palliative home care in last 90d ■ N with palliative home care in last 90d

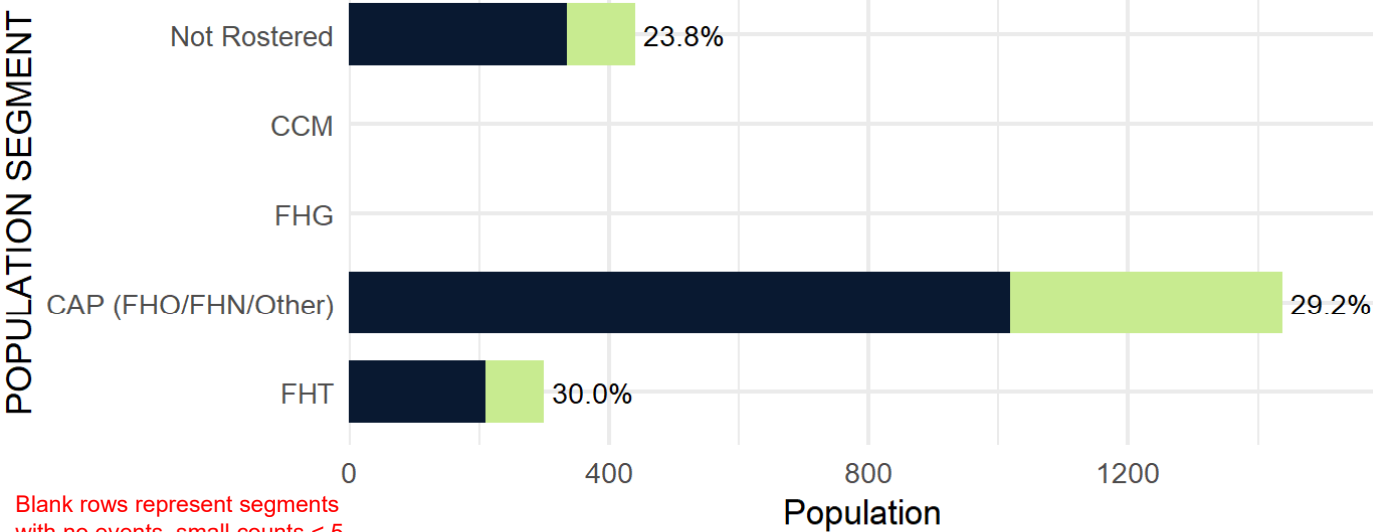
- Notes:
- *Proportion of patients with home care in the last 90 days is shown at the end of the bar.
 - *Data are suppressed for segments with small counts.
 - *Overall proportion with home care in: OHT 42 = 28.1% / Ontario = 18.4%.

Horizontal axis shows the number of OHT attributed patients that died in the reporting period.

- Bright green indicates number of individuals that had one or more palliative home care services in their last 90 days of life.
- Dark blue represents number of individuals without palliative care services.
- Number to the right is the proportion of decedents that had one or more palliative home care service
- OHT and Ontario average indicated in figure footnote.

2022/23 Proportion of descendants with home care in last 90 days by Primary Care Model

Proportion with home care in last 90 days 2022/23
KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N without palliative home care in last 90d ■ N with palliative home care in last 90d

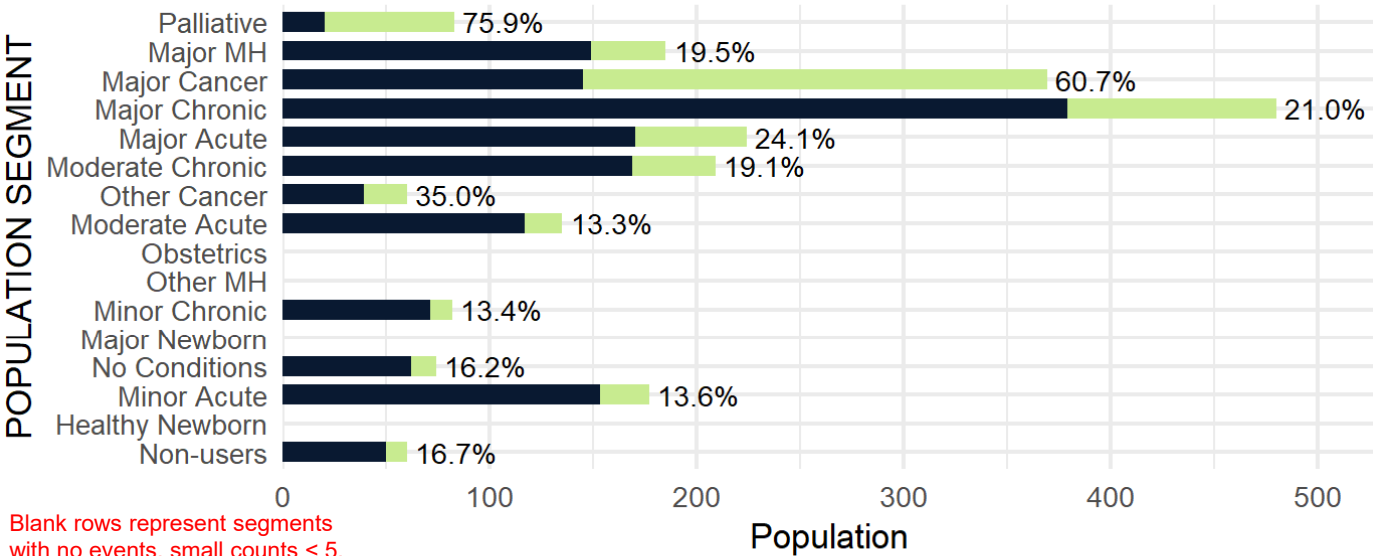
Notes:
 *Proportion of patients with home care in the last 90 days is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall proportion with home care in: OHT 42 = 28.1% / Ontario = 18.4%.

Horizontal axis shows the number of OHT attributed patients that died in the reporting period.

- Bright green indicates number of individuals that had one or more palliative home care services in their last 90 days of life.
- Dark blue represents number of individuals without palliative care services.
- Number to the right is the proportion of decedents that had one or more palliative home care service
- OHT and Ontario average indicated in figure footnote.

2022/23 Proportion of descendants with home care in last 90 days by CIHI Population Grouping Methodology

Proportion with home care in last 90 days 2022/23
KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N without palliative home care in last 90d ■ N with palliative home care in last 90d

Notes:
 *Proportion of patients with home care in the last 90 days is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall proportion with home care in: OHT 42 = 28.1% / Ontario = 18.4%.

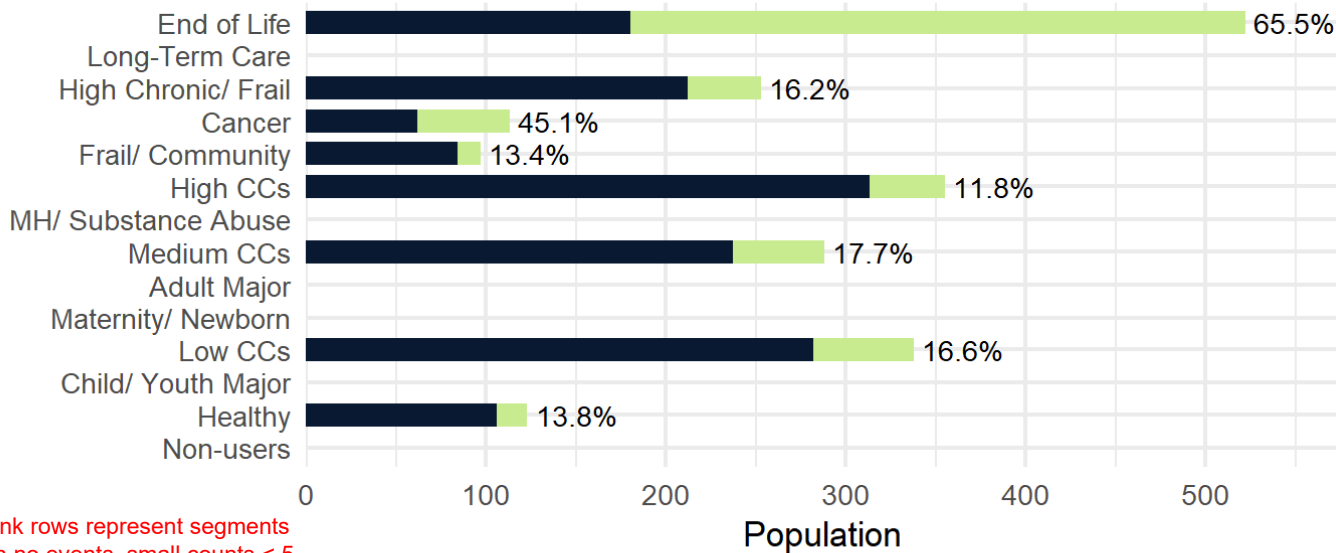
Horizontal axis shows the number of OHT attributed patients that died in the reporting period.

- Bright green indicates number of individuals that had one or more palliative home care services in their last 90 days of life.
- Dark blue represents number of individuals without palliative care services.
- Number to the right is the proportion of decedents that had one or more palliative home care service
- OHT and Ontario average indicated in figure footnote.

2022/23 Proportion of descendants with home care in last 90 days by BC Matrix Segment

Proportion with home care in last 90 days 2022/23
KW4

POPULATION SEGMENT



Horizontal axis shows the number of OHT attributed patients that died in the reporting period.

- Bright green indicates number of individuals that had one or more palliative home care services in their last 90 days of life.
- Dark blue represents number of individuals without palliative care services.
- Number to the right is the proportion of decedents that had one or more palliative home care service
- OHT and Ontario average indicated in figure footnote.

Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N without palliative home care in last 90d ■ N with palliative home care in last 90d

Notes:

- *Proportion of patients with home care in the last 90 days is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall proportion with home care in: OHT 42 = 28.1% / Ontario = 18.4%.

Proportion of decedents with 1 or more emergency department visits in the last 30 days of life

DEFINITION	Quadruple Aim
The proportion of decedents that had one or more unplanned emergency department visits in their last 30 days of life	Patient Experience (access) & Cost/Efficiency

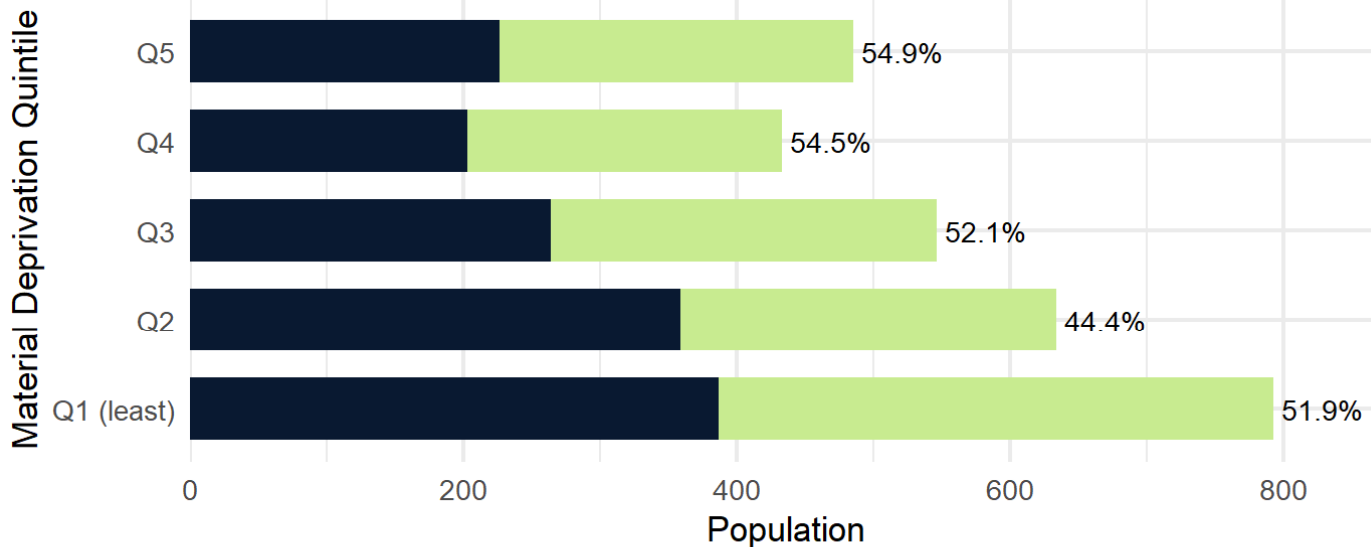
In this graph the horizontal axis counts the total number of individuals in your OHT attributed population who died within the observation year. The colours represent how many did and did not visit an emergency department in the last 30 days of life. In this graph the size of the bright green matters because it shows the population groups where the largest number of ED visits were incurred.

Sample Interpretation: 54.9% of patients (of the OHT attributed patients that died in the reporting period) in the most deprived communities (Q5) had one or more ED visit in their last 30 days of life. Lower values are preferred and indicate good care and symptom management for individuals near the end of life.

2022/23 Proportion of descendants with ED visit in last 30 days by Material Deprivation Quintile

Proportion with ED visit in last 30 days 2022/23

KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N without ED visit in last 30d ■ N with ED visit in last 30d

Notes:

*Proportion of patients with ED visit in the last 30 days is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Overall proportion with ED visit in: OHT 42 = 51.1% / Ontario = 55.0%.

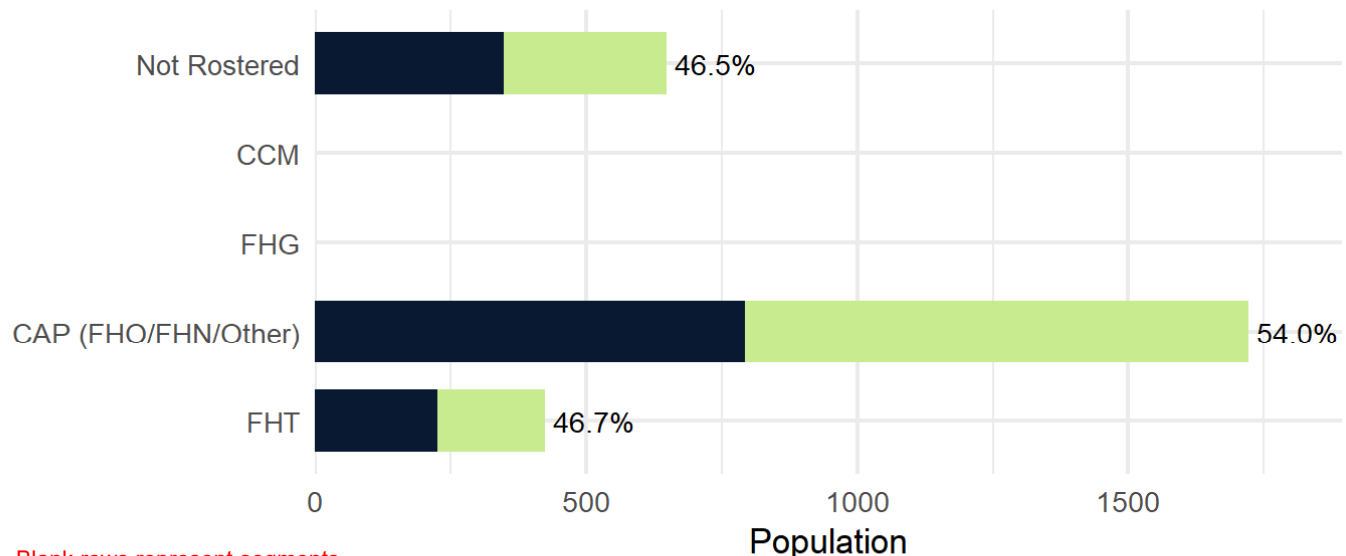
Horizontal axis shows the number of OHT attributed patients that died in the reporting period.

- Bright green indicates number of individuals that had one or more ED visit in their last 30 days of life.
- Dark blue represents number of individuals without ED visit in their last 30 days of life.
- Number to the right is the proportion of decedents that had one or more ED visit in their last 30 days.
- OHT and Ontario average indicated in figure footnote.

2022/23 Proportion of descendants with ED visit in last 30 days by Primary Care Model

Proportion with ED visit in last 30 days 2022/23
KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N without ED visit in last 30d ■ N with ED visit in last 30d

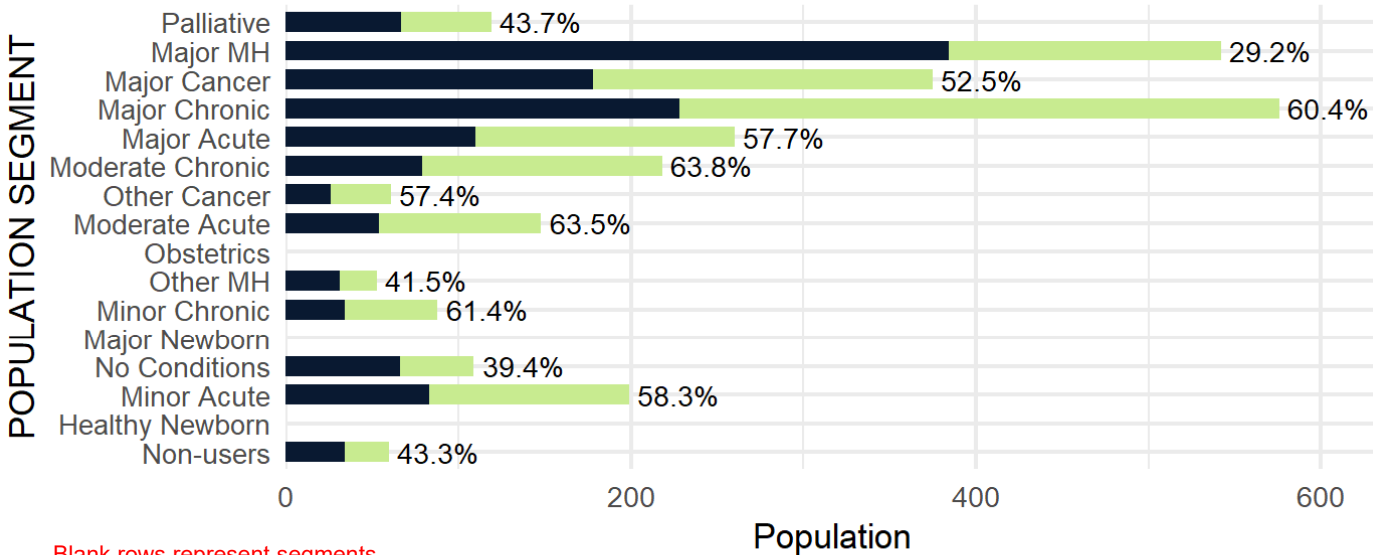
Notes:
 *Proportion of patients with ED visit in the last 30 days is shown at the end of the bar.
 *Data are suppressed for segments with small counts.
 *Overall proportion with ED visit: OHT 42 = 51.1% / Ontario = 55.0%.

Horizontal axis shows the number of OHT attributed patients that died in the reporting period.

- Bright green indicates number of individuals that had one or more ED visit in their last 30 days of life.
- Dark blue represents number of individuals without ED visit in their last 30 days of life.
- Number to the right is the proportion of decedents that had one or more ED visit in their last 30 days.
- OHT and Ontario average indicated in figure footnote.

2022/23 Proportion of descendants with ED visit in last 30 days by CIHI Population Grouping Methodology

Proportion with ED visit in last 30 days 2022/23
KW4



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N without ED visit in last 30d ■ N with ED visit in last 30d

Notes:

*Proportion of patients with ED visit in the last 30 days is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Overall proportion with ED visit in: OHT 42 = 51.1% / Ontario = 55.0%.

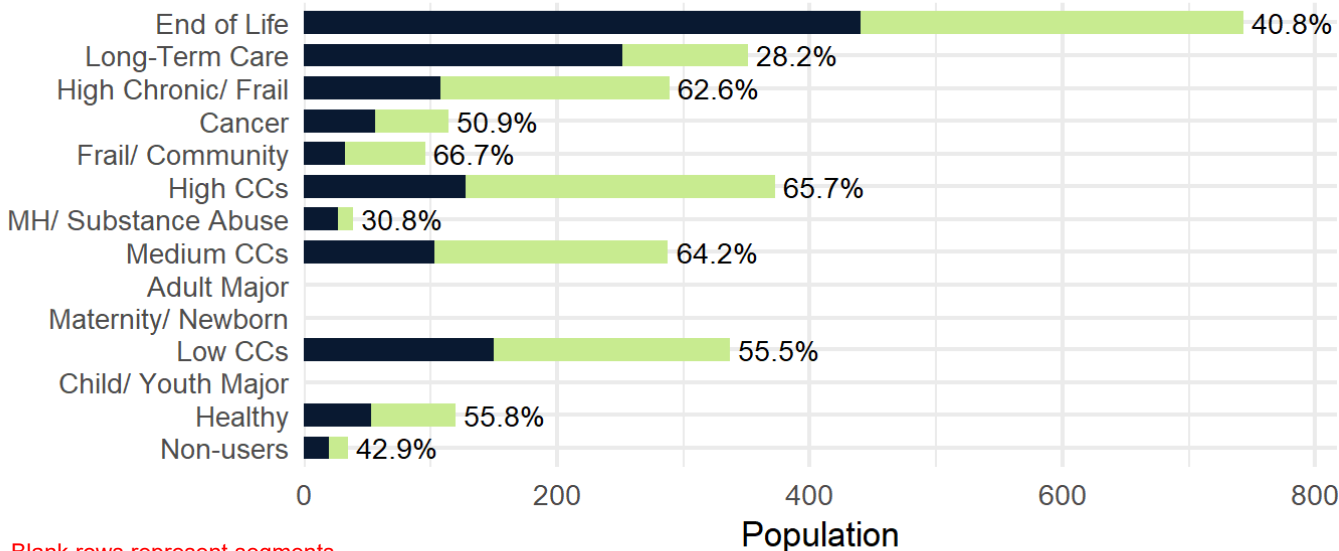
Horizontal axis shows the number of OHT attributed patients that died in the reporting period.

- Bright green indicates number of individuals that had one or more ED visit in their last 30 days of life.
- Dark blue represents number of individuals without ED visit in their last 30 days of life.
- Number to the right is the proportion of decedents that had one or more ED visit in their last 30 days.
- OHT and Ontario average indicated in figure footnote.

2022/23 Proportion of descendants with ED visit in last 30 days by BC Matrix Segment

Proportion with ED visit in last 30 days 2022/23
KW4

POPULATION SEGMENT



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ N without ED visit in last 30d ■ N with ED visit in last 30d

Notes:

*Proportion of patients with ED visit in the last 30 days is shown at the end of the bar.

*Data are suppressed for segments with small counts.

*Overall proportion with ED visit in: OHT 42 = 51.1% / Ontario = 55.0%.

Horizontal axis shows the number of OHT attributed patients that died in the reporting period.

- Bright green indicates number of individuals that had one or more ED visit in their last 30 days of life.
- Dark blue represents number of individuals without ED visit in their last 30 days of life.
- Number to the right is the proportion of decedents that had one or more ED visit in their last 30 days.
- OHT and Ontario average indicated in figure footnote.

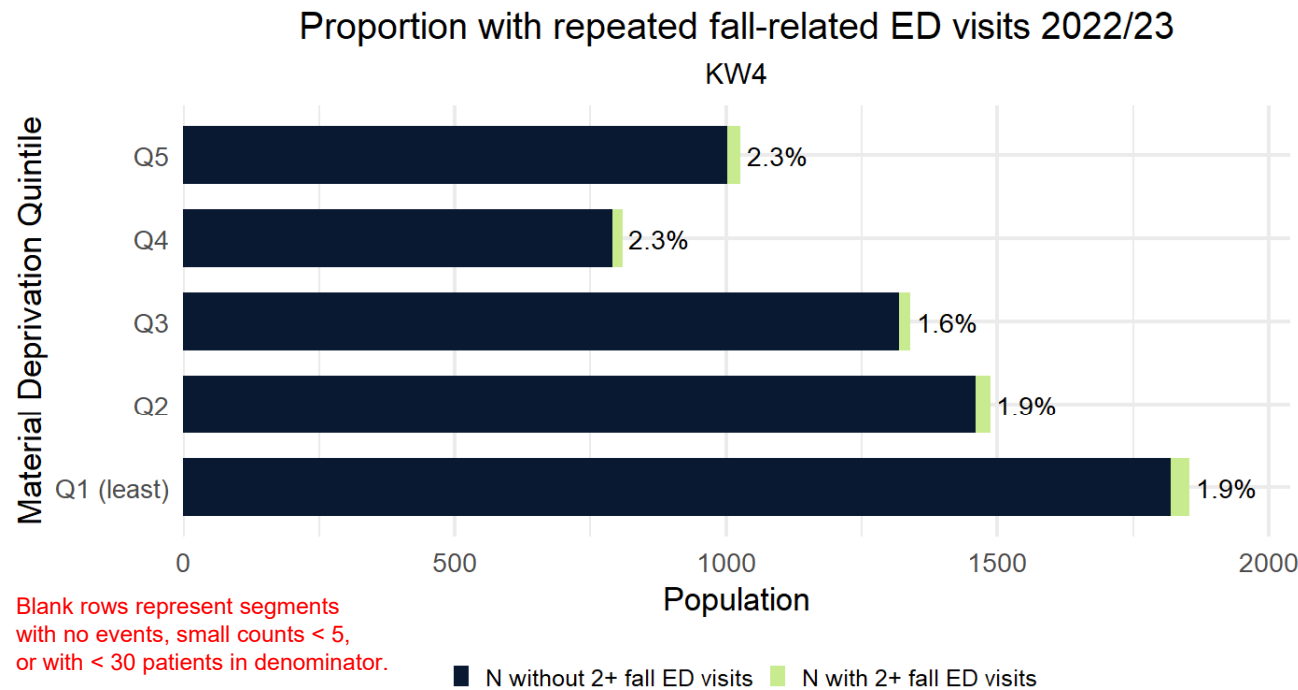
Repeat fall-related emergency visits, among those identified as frail

DEFINITION	Quadruple Aim
Proportion of older adults >65 years of age identified as being frail that had 2 or more unscheduled emergency department visit for fall-related injuries	Health outcome

In this graph, the horizontal axis counts the total number of individuals in your OHT attributed population who were frail while the bright green indicates the number who were admitted to an emergency department two or more times for fall-related injuries. In this graph the size of the bright green matters because it shows the population groups where the largest number of ED visits were incurred.

Sample Interpretation: 2.3% of frail older adults in the most deprived communities (Q5) had two or more ED visits for fall-related injuries. Lower values are generally preferred. While staying active may lead to falls, good community-based fall prevention and high levels of physical activity and health should lead to lower rates of injuries resulting from falls and fewer ED visits for fall-related injuries.

2022/23 Proportion of frail population with repeated fall-related ED visits by Material Deprivation Quintile



Notes:

*Proportion of frail patients with 2 or more fall related ED is shown at the end of the bar.

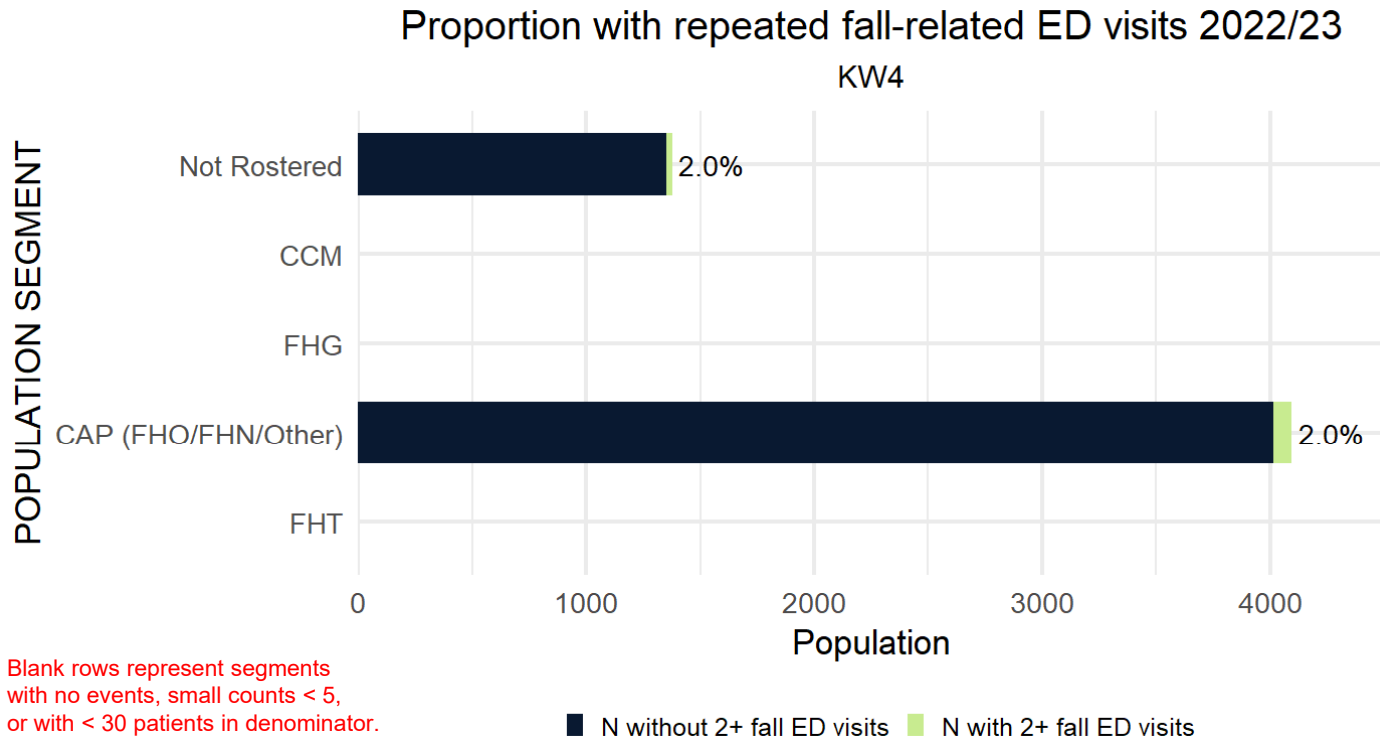
*Data are suppressed for segments with small counts.

*Overall proportion of falls in: OHT 42 = 1.9%/ Ontario = 2.5%

Horizontal axis shows the number of OHT attributed population age 66 years or older that were frail.

- Bright green indicates number of frail patients with 2 or more fall-related ED visit.
- Dark blue indicates the number of frail patients without 2 or more fall-related ED visits.
- Number to the right is the proportion frail patients with 2 or more fall-related ED visits.
- OHT and Ontario average indicated in figure footnote.

2022/23 Proportion of frail population with repeated fall-related ED visits by Primary Care Model



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

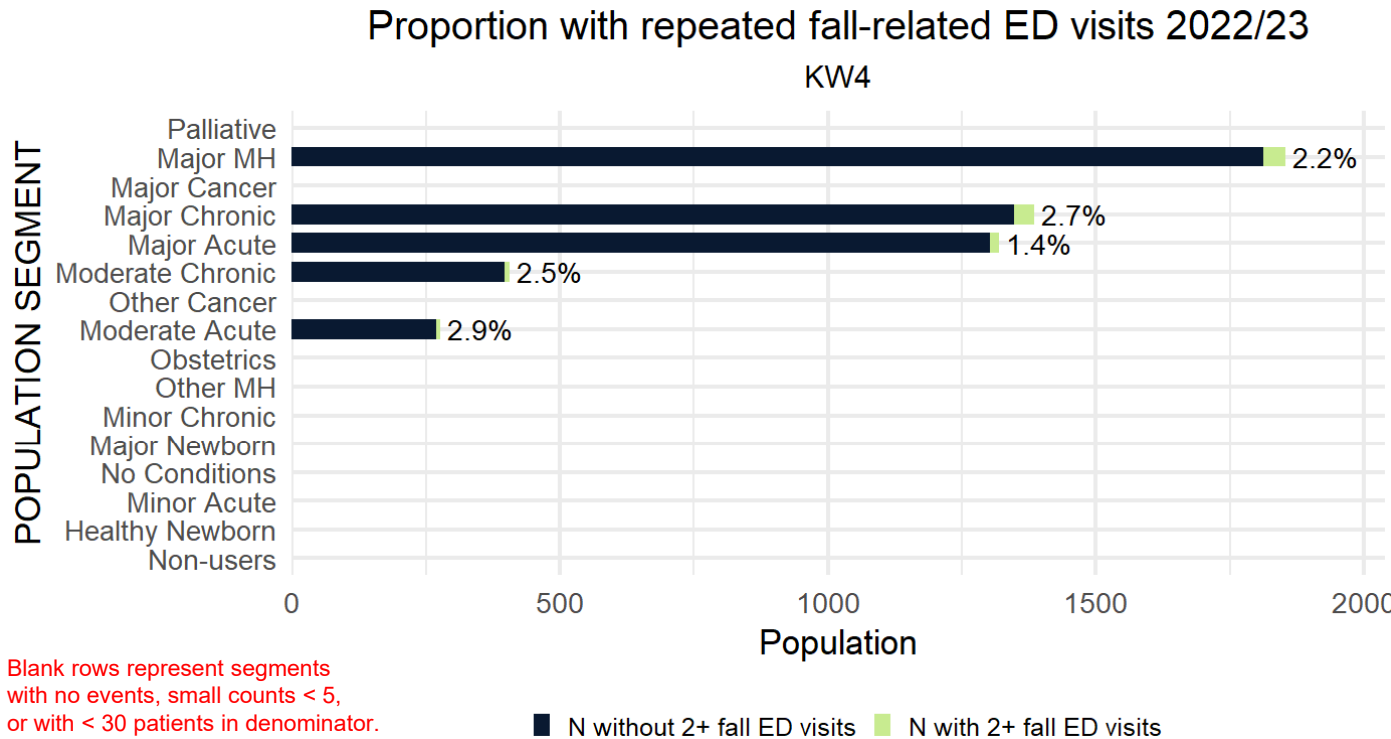
Notes:

- *Proportion of frail patients with 2 or more fall related ED is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall proportion of falls in: OHT 42 = 1.9%/ Ontario = 2.5%.

Horizontal axis shows the number of OHT attributed population age 66 years or older that were frail.

- Bright green indicates number of frail patients with 2 or more fall-related ED visit.
- Dark blue indicates the number of frail patients without 2 or more fall-related ED visits.
- Number to the right is the proportion frail patients with 2 or more fall-related ED visits.
- OHT and Ontario average indicated in figure footnote.

2022/23 Proportion of frail population with repeated fall-related ED visits by CIHI Population Grouping Methodology



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

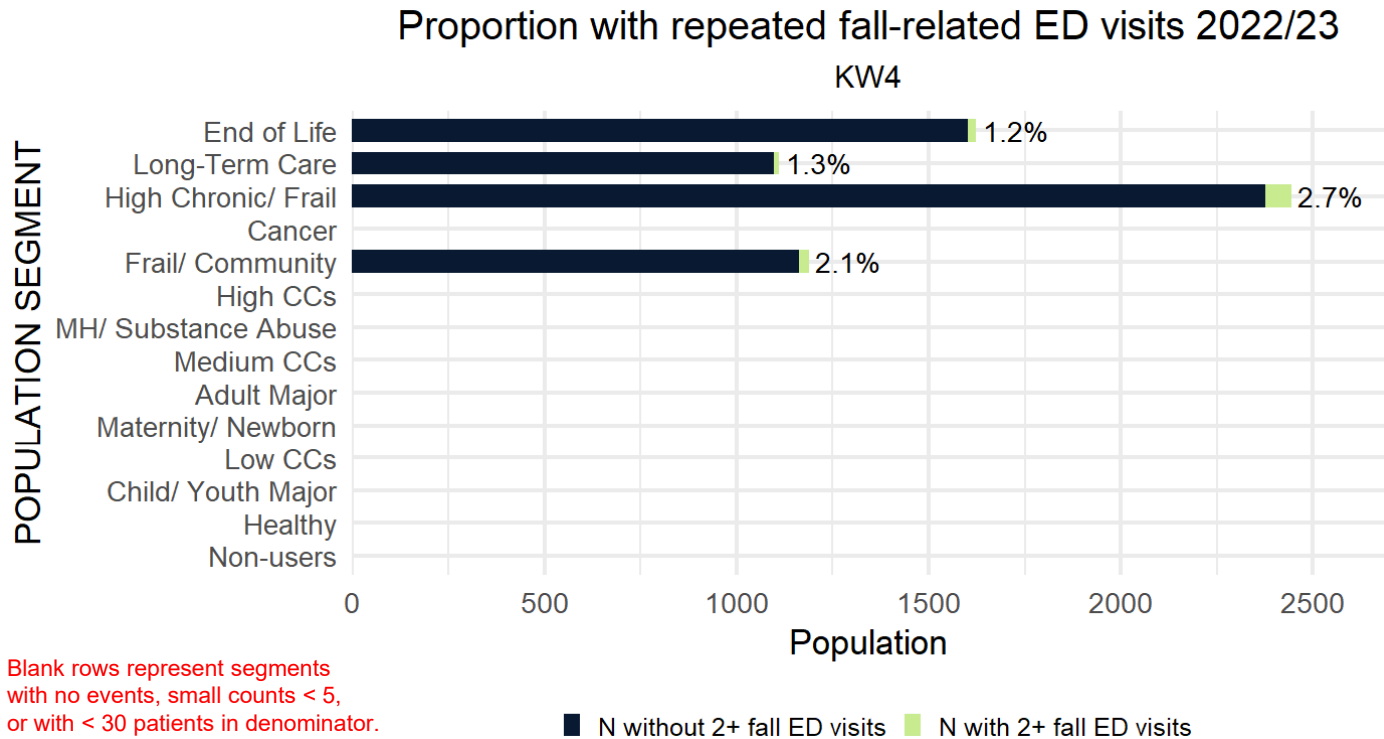
Notes:

- *Proportion of frail patients with 2 or more fall related ED is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall proportion of falls in: OHT 42 = 1.9%/ Ontario = 2.5%

Horizontal axis shows the number of OHT attributed population age 66 years or older that were frail.

- Bright green indicates number of frail patients with 2 or more fall-related ED visit.
- Dark blue indicates the number of frail patients without 2 or more fall-related ED visits.
- Number to the right is the proportion frail patients with 2 or more fall-related ED visits.
- OHT and Ontario average indicated in figure footnote.

2022/23 Proportion of frail population with repeated fall-related ED visits by BC Matrix Segment



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:

- *Proportion of frail patients with 2 or more fall related ED is shown at the end of the bar.
- *Data are suppressed for segments with small counts.
- *Overall proportion of falls in: OHT 42 = 1.9% / Ontario = 2.5%.

Horizontal axis shows the number of OHT attributed population age 66 years or older that were frail.

- Bright green indicates number of frail patients with 2 or more fall-related ED visit.
- Dark blue indicates the number of frail patients without 2 or more fall-related ED visits.
- Number to the right is the proportion frail patients with 2 or more fall-related ED visits.
- OHT and Ontario average indicated in figure footnote.

Notes

- There is an accompanying report with further details about the indicators included in this report.
- For details on specification of BC Health System Matrix and other indicator definitions please see:
Mondor L, Hall RE, and Wodchis WP. Population Segmentation for Ontario Health Teams using the British Columbia Health System Matrix. Toronto, ON: Health System Performance Network. 2021. available at <https://hspn.ca/evaluation/oht/reports/>

Notes

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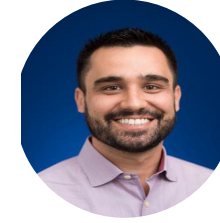
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THANK YOU!



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