New Data on Improvement Indicators for OHTs

HSPN Monthly Webinar
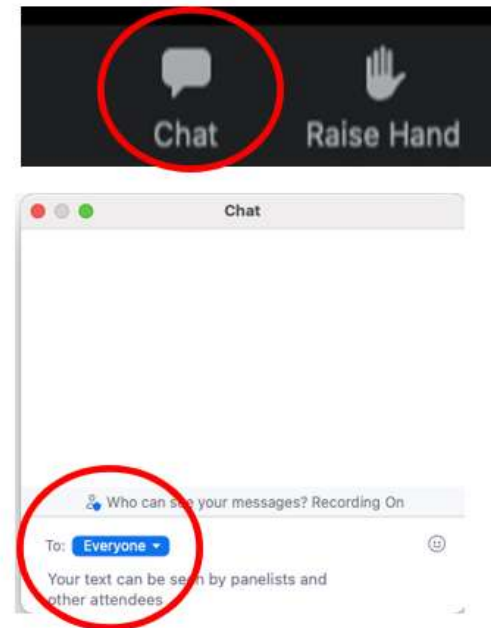
January 23, 2024

Welcome & thank you for joining us!

Please let us know who you are by introducing yourself (name & OHT or <u>other</u> org)

➤Open Chat

➤Set response to <mark>**everyone**</mark> in the chat box

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Land Acknowledgement

We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

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Poll 1

Poll 1: First time ?

Poll | 1 question | 169 of 231 (73%) participated

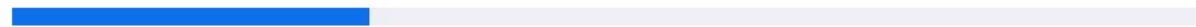1. Have you joined us for an HSPN webinar previously? (Single Choice)
*

169/169 (100%) answered

Yes. I have participated previously.   (119/169) 70%

No. This is my first event.   (50/169) 30%

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HSPN Health System Performance Network

Today's event
OHT Improvement Indicators

Presenters

Dr. Walter Wodchis
Principal Investigator
HSPN

Vijay Kunam
Research Associate
HSPN

Central OHT Evaluation Team

Co-Leads

Dr. Walter P. Wodchis

Dr. Kaileah McKellar

Team Members

Dr. Gaya Embuldeniya

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Priyanka Gayen

Trisha Martin

Vijay Kunaratnam

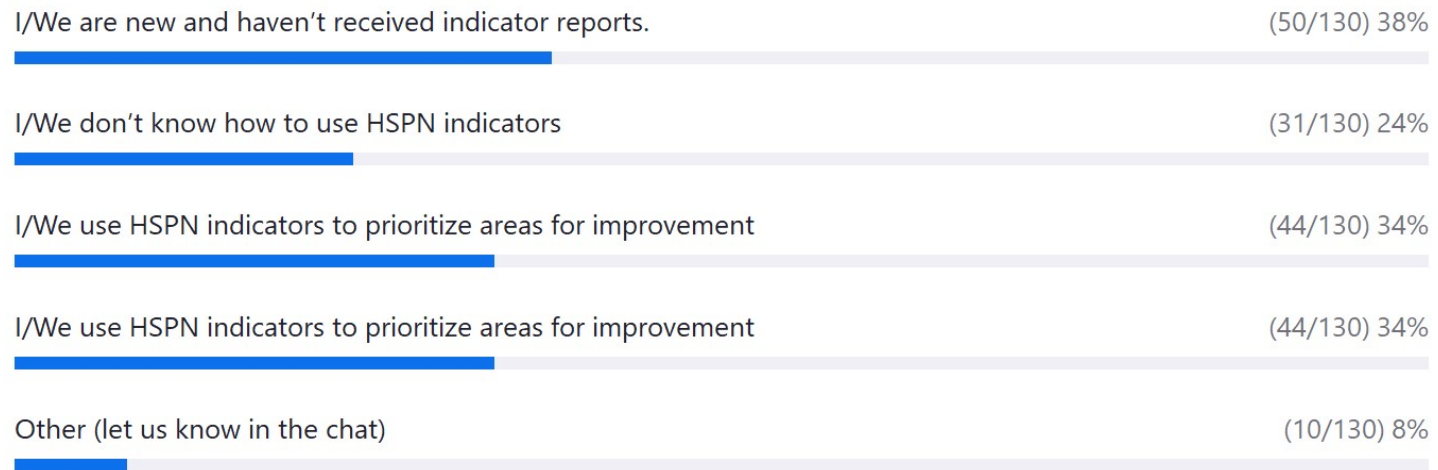Emily Charron

Victor Rentes

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Poll 2

Poll 2: Use of HSPN Reports

Poll | 1 question | 130 of 260 (50%) participated

1. How have you used HSPN indicator reports ? (Select all that apply) (Multiple Choice) *
130/130 (100%) answered

I/We are new and haven't received indicator reports.   (50/130) 38%

I/We don't know how to use HSPN indicators   (31/130) 24%

I/We use HSPN indicators to prioritize areas for improvement   (44/130) 34%

I/We use HSPN indicators to prioritize areas for improvement   (44/130) 34%

Other (let us know in the chat)   (10/130) 8%

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How are indicators reported ?

Individual OHT reports
(Provincial report available online)

1 Powerpoint Presentation & 4 Excel Spreadsheets

OHT Indicators & Population Segmentation

"Your OHT" OHT Results

January 2024

How to use this report - 1

This report contains two main sections:

Part 1:   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).

Part 2:   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.

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HSPN
Health System
Performance
Network

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

1.- Outpatient visits within 7d of MHA hospital discharge
2.- ED as first point of contact for MHA
3.- Frequent (4+) ED visits for MHA
4.- Repeat ED visits within 30d for MHA
5.- 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

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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

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Spider Diagrams for Total Population Indicators
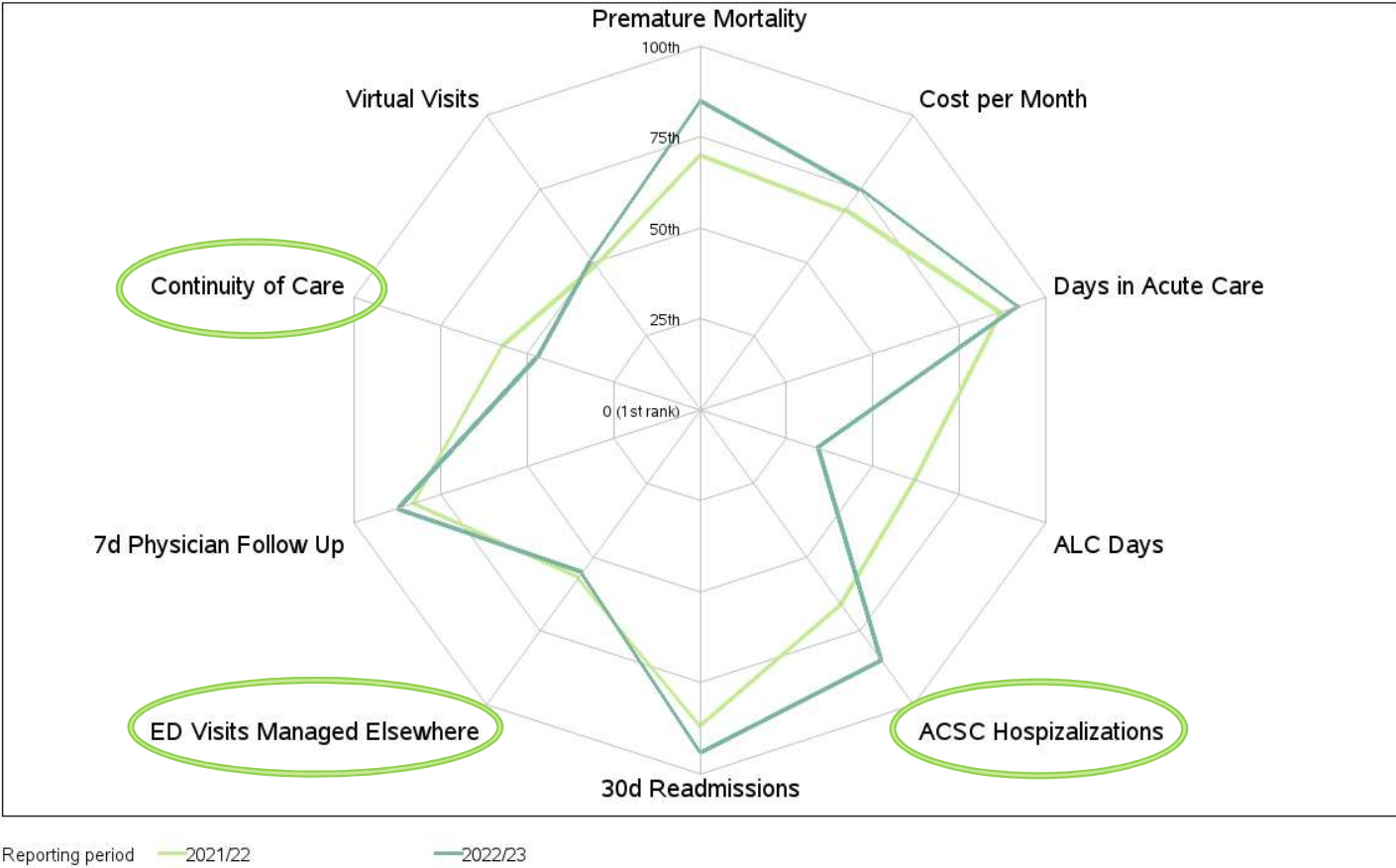
Spider Diagrams for MHA Indicators
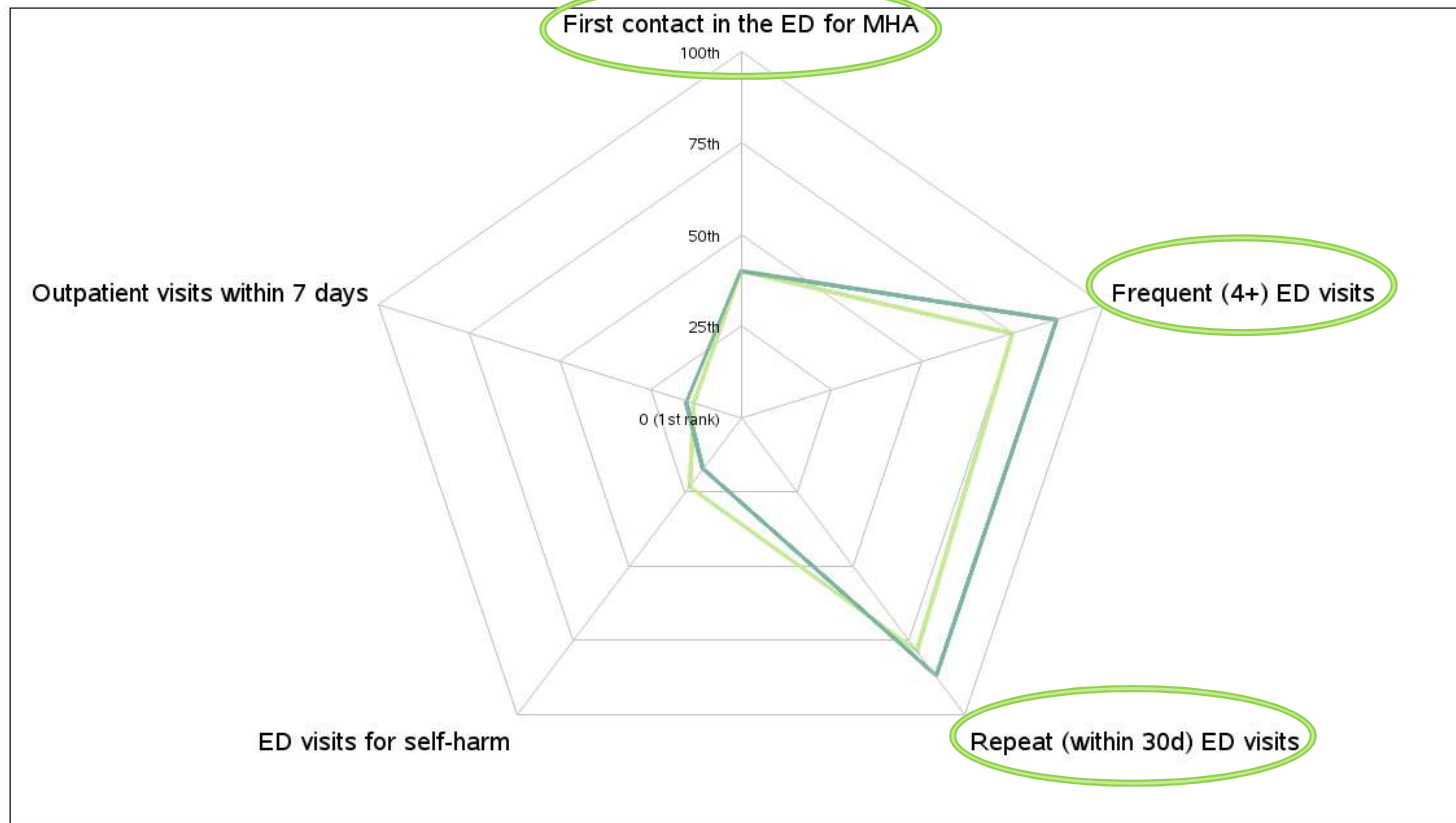
Spider **Diagrams for frail/older adults**
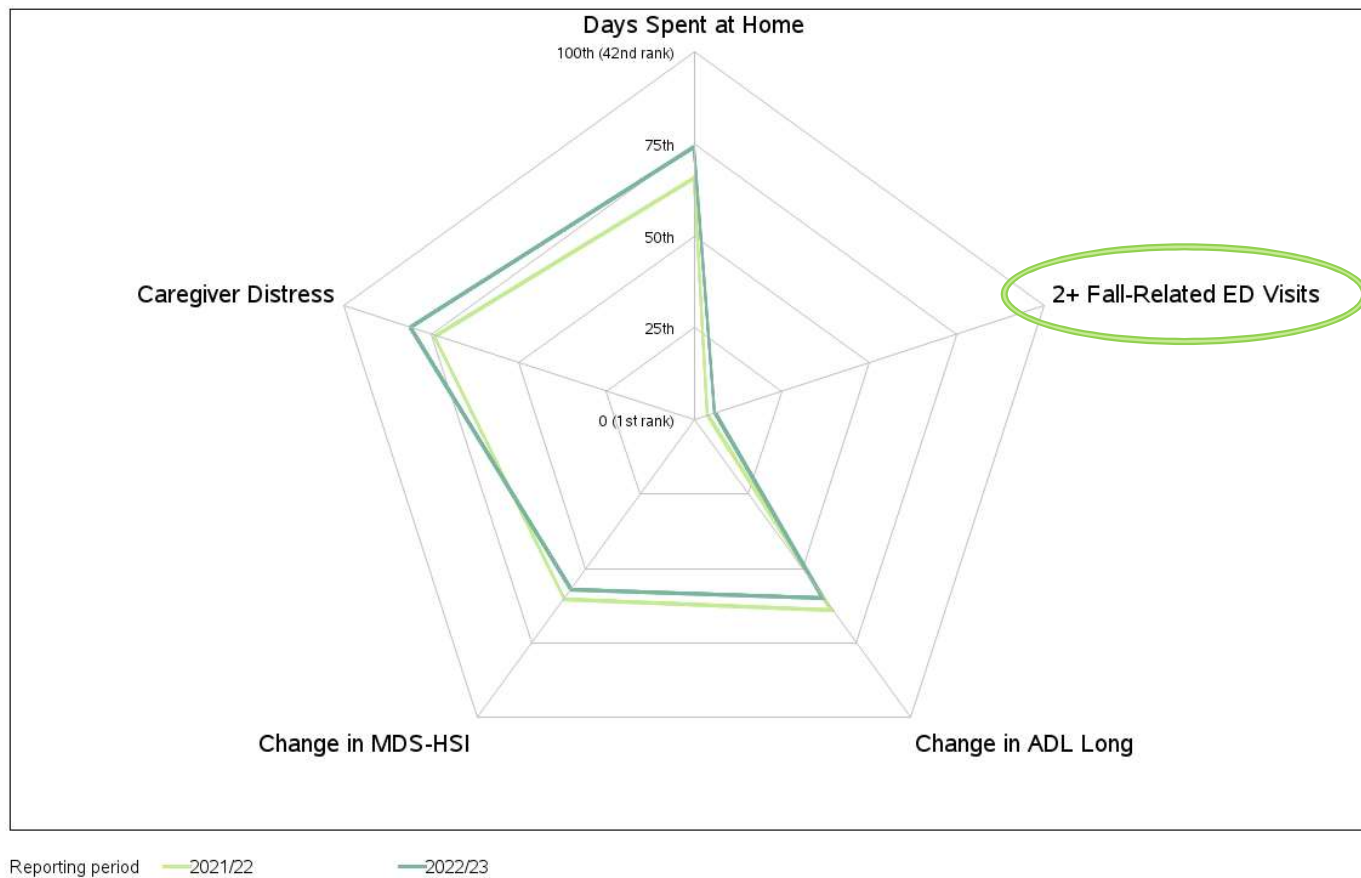
Spider Diagrams for end-of-life Indicators

OHT 06s performance across all end-of-life indicators
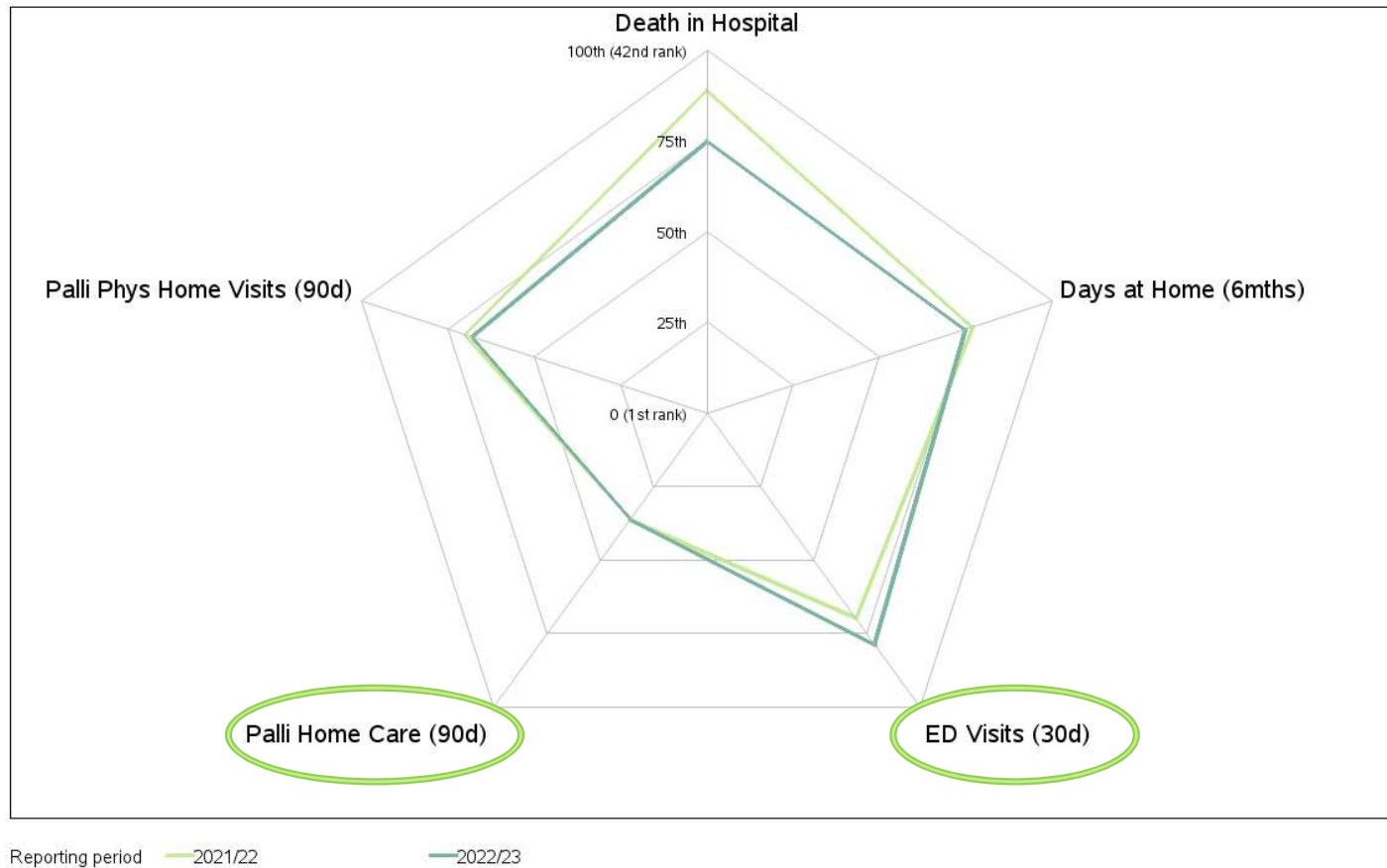
Spider Diagrams Vary by OHT
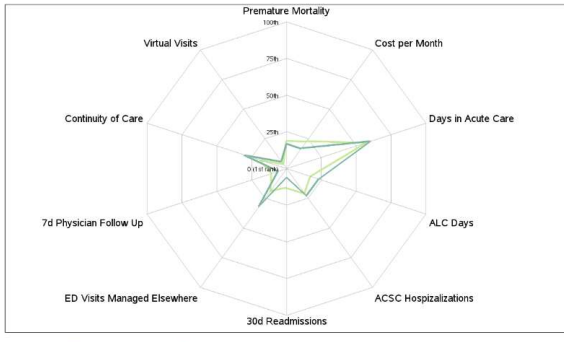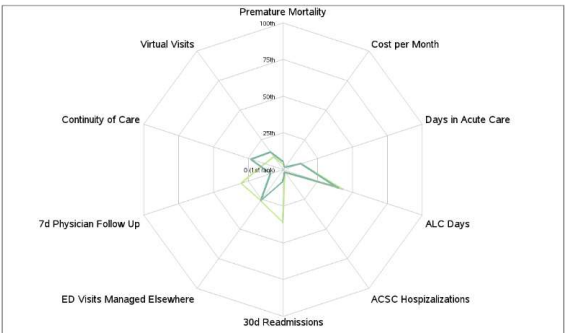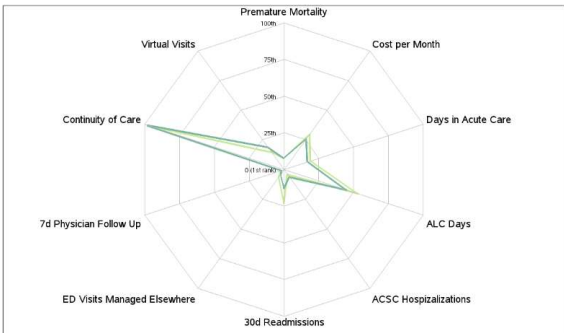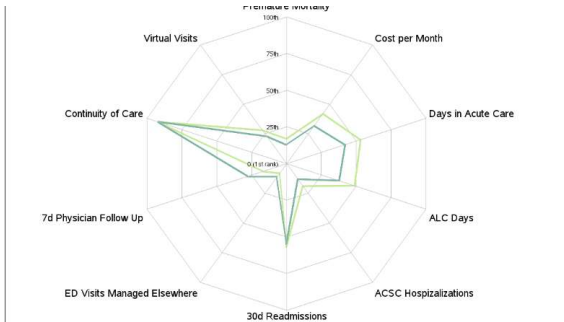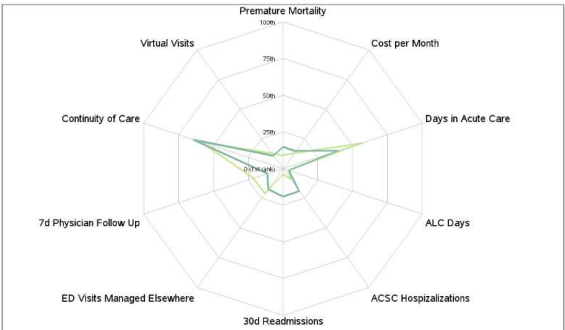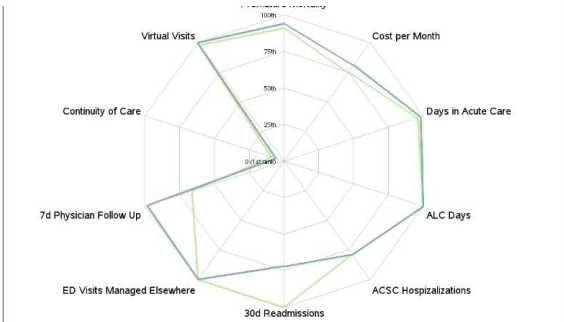
Part 2:

12 Select Indicators with 4 Stratifications

Introduction to Part 2:

Selecting 12 indicators and defining stratification / segmentation approaches

How did we select 12 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.

- For the selected indicators, at least 25% of OHTs selected the indicator as top 2 of 10 from overall indicators or at least 40% of OHTs selected the indicator as top 2 of 5 from population-specific indicators.

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Do you think it would be better to have a report that provides full set of indicators for one of the existing sets or should we create a report that selects a few indicators from different existing sets of indicators?

Provide a report for frail older adults only.

Provide a report for mental health only.

Provide a report for overall indicators only.

Provide a report for cQIP indicators only.

Provide a report that includes a limited number of indicators from each of the above.

0   0.1   0.2   0.3   0.4   0.5   0.6   0.7

■Percent

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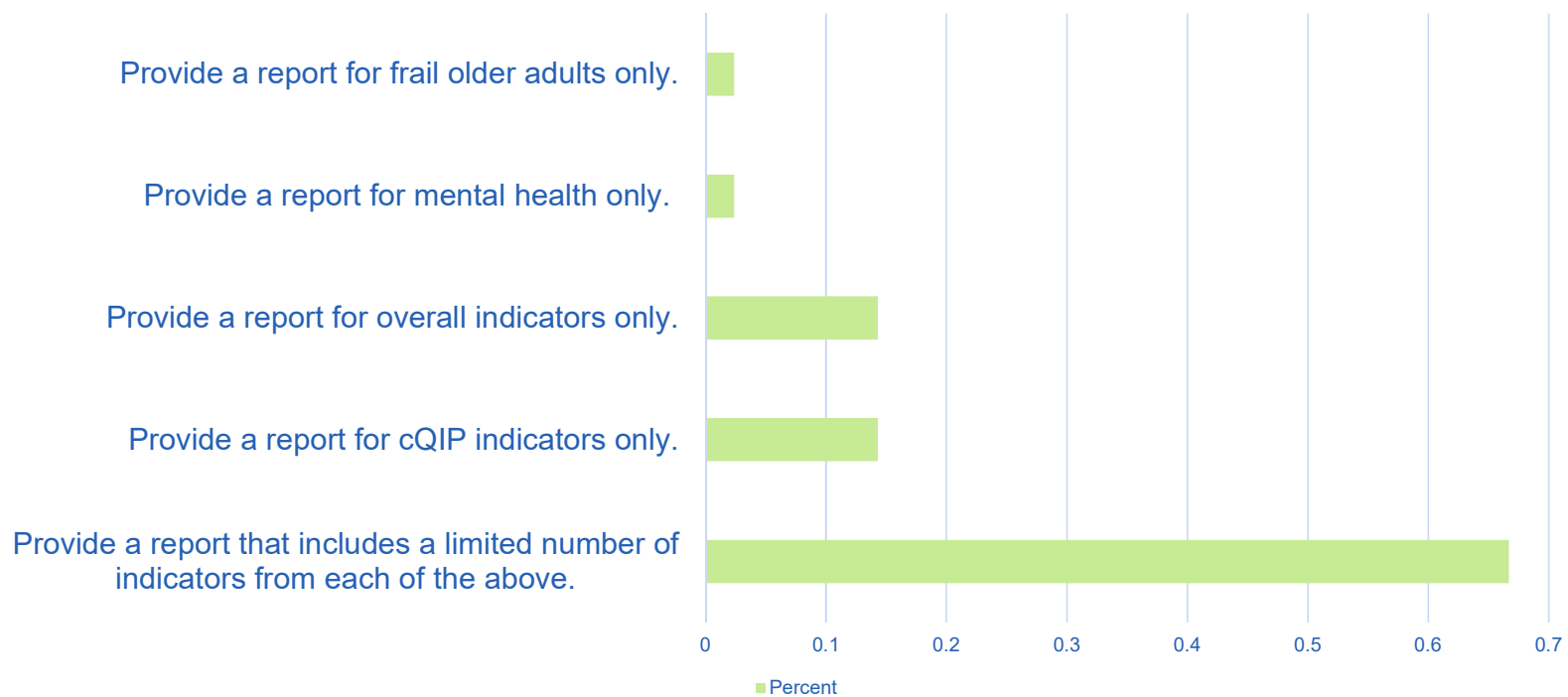
Comments

"Is it possible to have a report for each of those 5 reports? As OHTs continue to shift towards population health management, we have expanded from our first priority population (palliative care) to include all three available there (MH&A and older adults) as well."

"These reports help to inform the starting point of how we're performing, and where we might need to focus on for each of these priority populations."

"The reports provide added value over the excel files, as not everyone can analyze large quantities of data …I recognize that the knowledge of both how to analyze the data in the excel files and the knowledge with which to interpret what the data means and how to use that, is a competency that may not be widely available across OHT organizations."

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Comments

"Hence, we will likely have to select the last option, a report with a limited number of indicators, in order to be sure we're looking at the insights for all of our target populations. However, that option makes us wonder what analysis will not be available in this combined report, which the detailed reports have provided additional insights for. Perhaps if there was guidance on the types of additional information that could be analyzed using the excel files, that might help OHTs know what is available to them with self-run analysis."

Comments

"We have found the condensed slides extremely helpful when preparing data to share with partners but would ideally also have the PDF format with fulsome explanations. It would be helpful to get some of the raw data as well to do an independent analysis/segmentation. For future reference is there a central location where these data files are stored that can be access by all OHTs? As new team members are onboarded it would be nice to have a central site to retrieve data from."

Please rank order the 10 overall indicators from highest (1) to lowest (10) priority usefulness for your OHT.

Legend: 1 (Most important), 2, 3, 4, 5, 6, 7, 8, 9, 10 (Least important)

Categories (top to bottom):
- ED Visits Best Managed Elsewhere
- Continuity of Care
- ACSC Hospitalizations
- 30-Day Readmissions
- Average Days in Acute Inpatient Care
- ALC Days
- Physician Visits After Hospital Discharge
- Premature Mortality
- Cost per Month Alive
- Virtual Physician Encounters

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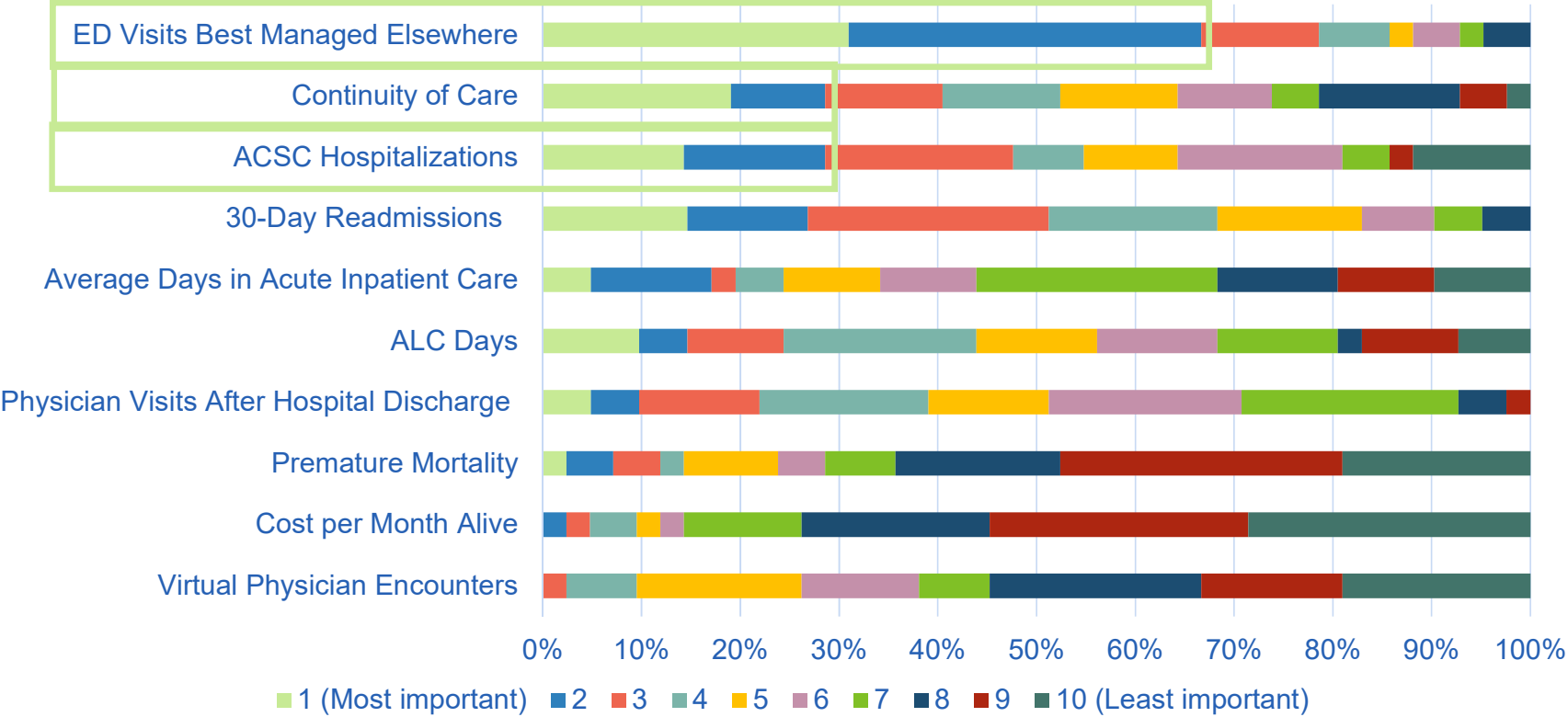
Please rank order the 5 indicators for mental health and addictions (MHA) from highest (1) to lowest (5) priority and usefulness for your OHT.

Indicators (top to bottom):
- Frequent (4+) ED visits for help with MHA
- Repeat ED visits for MHA (within 30 days)
- First contact in the ED for MHA
- 7-day follow-up with a physician after hospitalization for MHA
- Rate of ED visits for deliberate self-harm

Legend:
■ 1 (Most important) ■ 2 ■ 3 ■ 4 ■ 5 (Least important)

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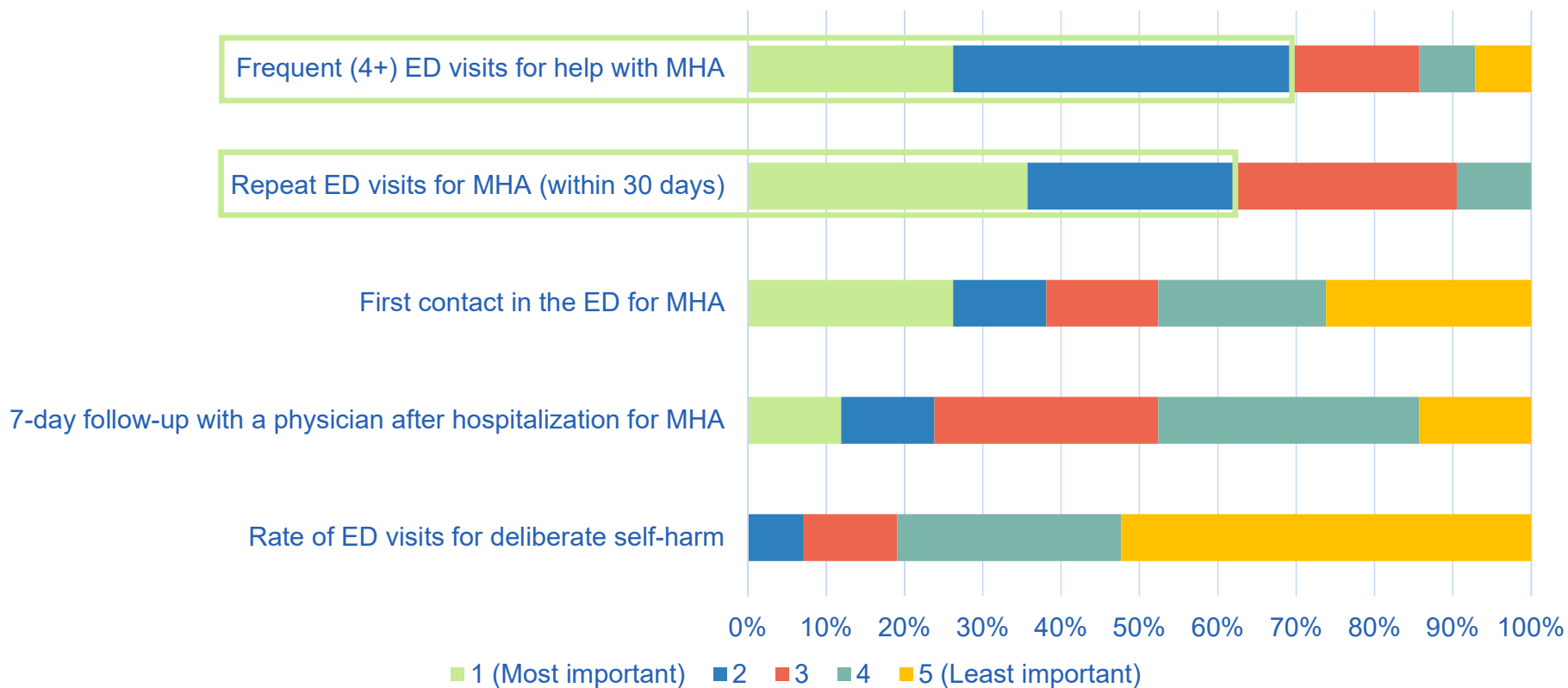
Please rank order the 5 indicators for frail older adults from highest (1) to lowest (5) priority and usefulness for your OHT.

Repeat fall-related ED visits among those identified as frail

Change in Activities of Daily Living (ADL) Long score among home care clients

Proportion of home care clients with caregiver distress

Days spent at home among those identified as frail

Change in MDSHSI (Health Status) score among home care clients

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

■ 1 (Most important) ■ 2 ■ 3 ■ 4 ■ 5 (Least important)

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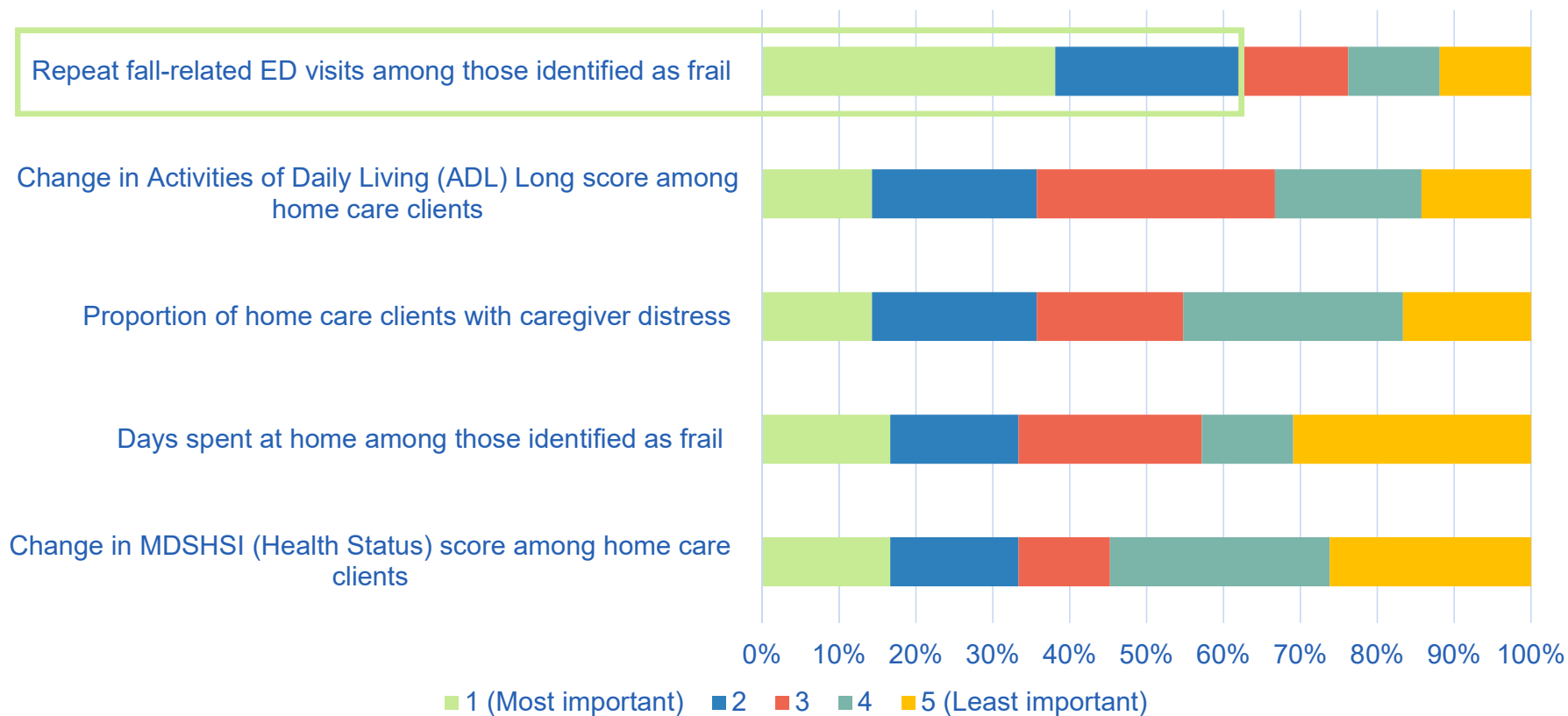
Please rank order the 5 indicators for palliative/end-of-life from highest (1) to lowest (5) priority and usefulness for your OHT.

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

Proportion of decedents with 1+ ED visits in the last 30 days of life

Days spent at home in the last 6 months of life

Deaths in hospital

Proportion of decedents with palliative physician home visits in the last 90 days of life

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

■ 1 (Most important) ■ 2 ■ 3 ■ 4 ■ 5 (Least important)

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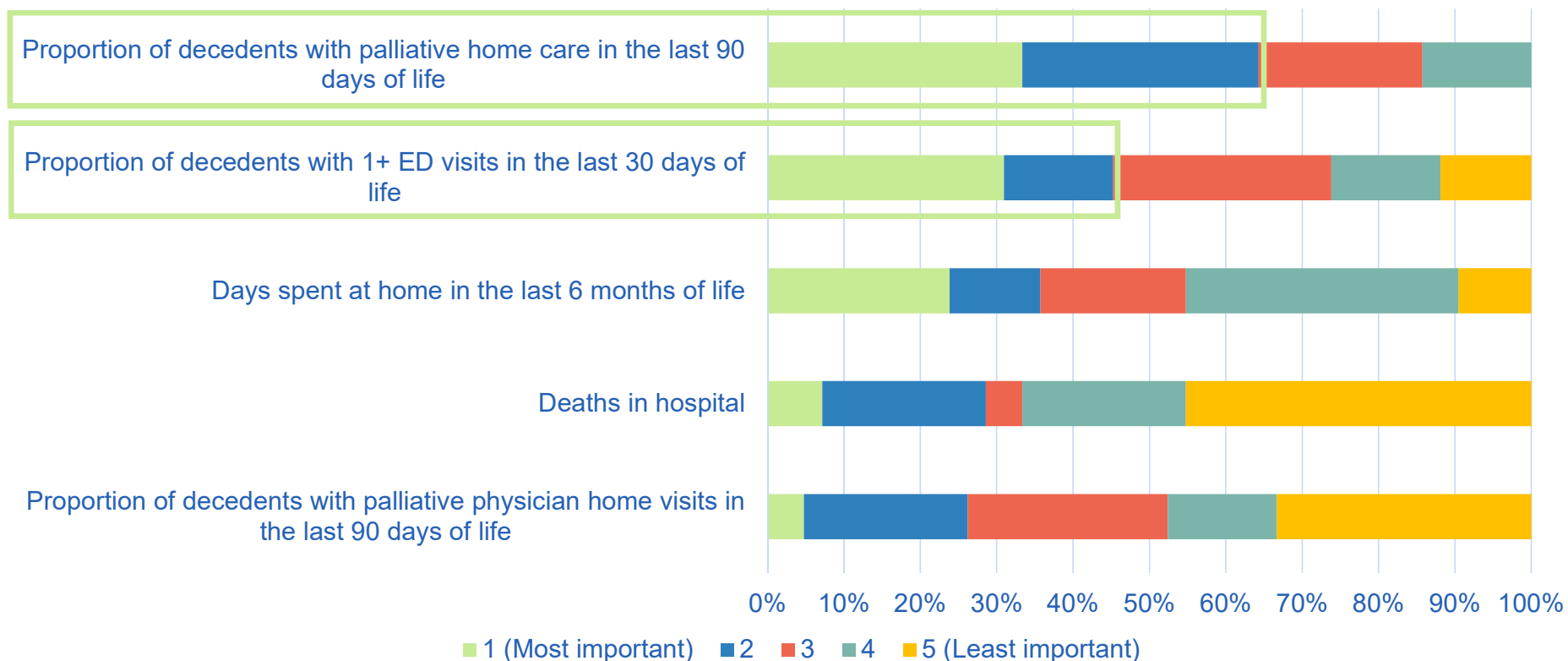
Please rank order the 5 indicators for cQIP from highest (1) to lowest (5) priority and usefulness for your OHT.

Legend: 1 (Most important), 2, 3, 4, 5 (Least important)

Categories: Rate of ED visits as first point of contact for MHA, ALC Days, Up-to-date Pap test, Up-to-date Mammogram, Up-to-date Colorectal screening

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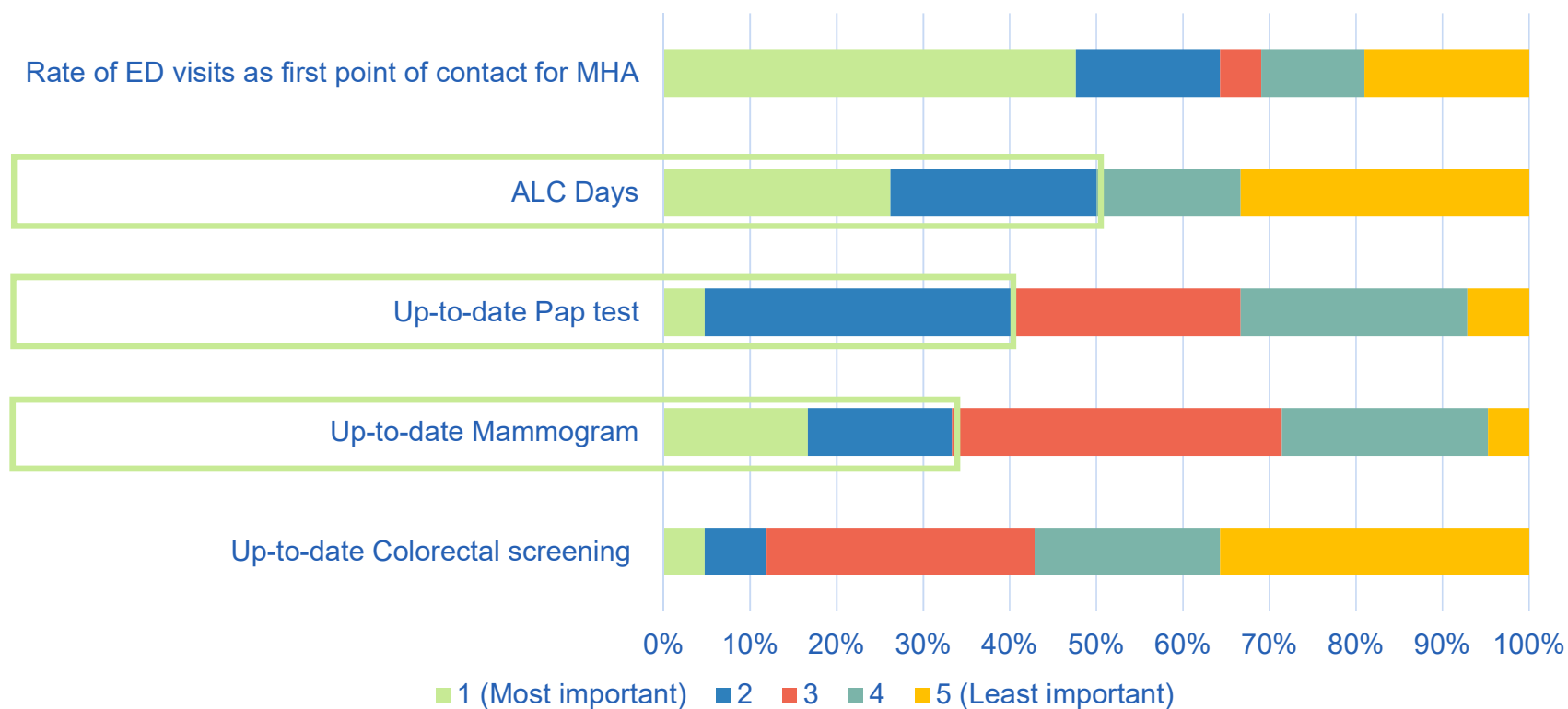
Top Chosen Indicators:

Total Population	MHA	CQIP	Older/Frail Adults	Palliative & End-of-Life Care
1. ED Visits best managed elsewhere 2. ACSC Hospitalization 3. Physician Continuity of Care	-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	•1. ALC -2. Cervical Cancer Screening •3. Breast Cancer Screening	1. Repeat fall-related ED visits among those identified as frail	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

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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

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Chat time

What are your indicators of interest? … in this set or otherwise?

Of what use is having a common set of indicators for all OHTs?

What are your thoughts on how we should measure OHT achievements in relation to care and health outcomes for Ontarians?

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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

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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

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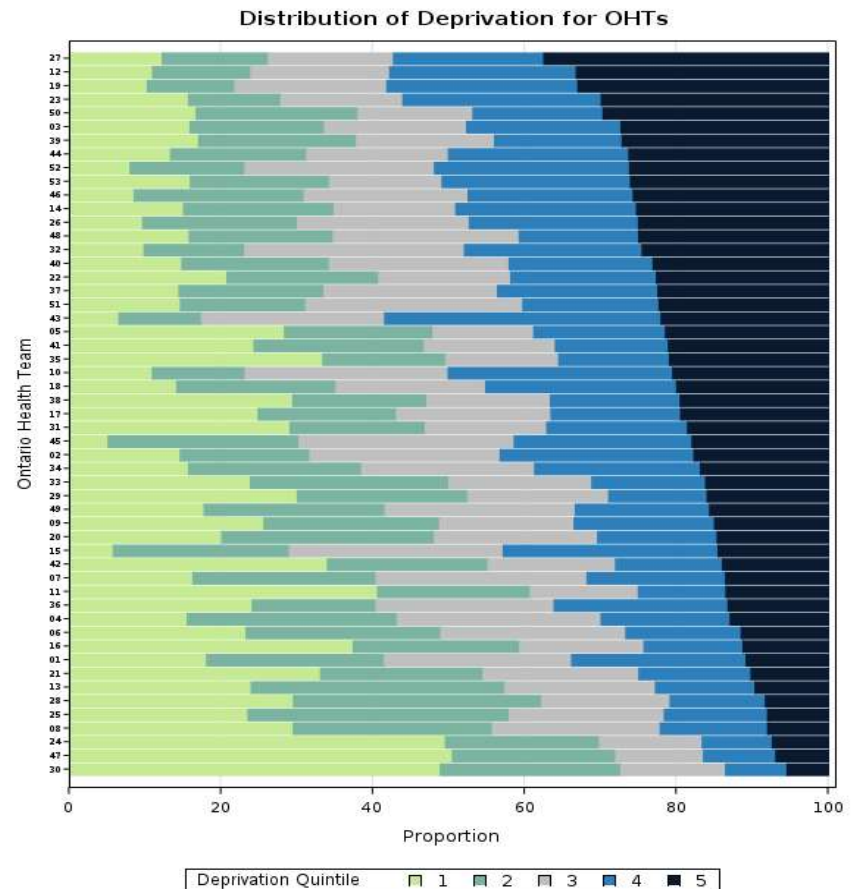
Proportion of OHT population according to Neighbourhood Material Deprivation
Ontario Health Teams. OHT Attributable Populations:

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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)

Identifies dominant health condition driving an individual's health profile

Summarizes condition by type and severity

Diagnoses → **226** health conditions → **164** health profile branches → **16** health profile categories

Splits by presence of significant comorbidities

239 health profile groups
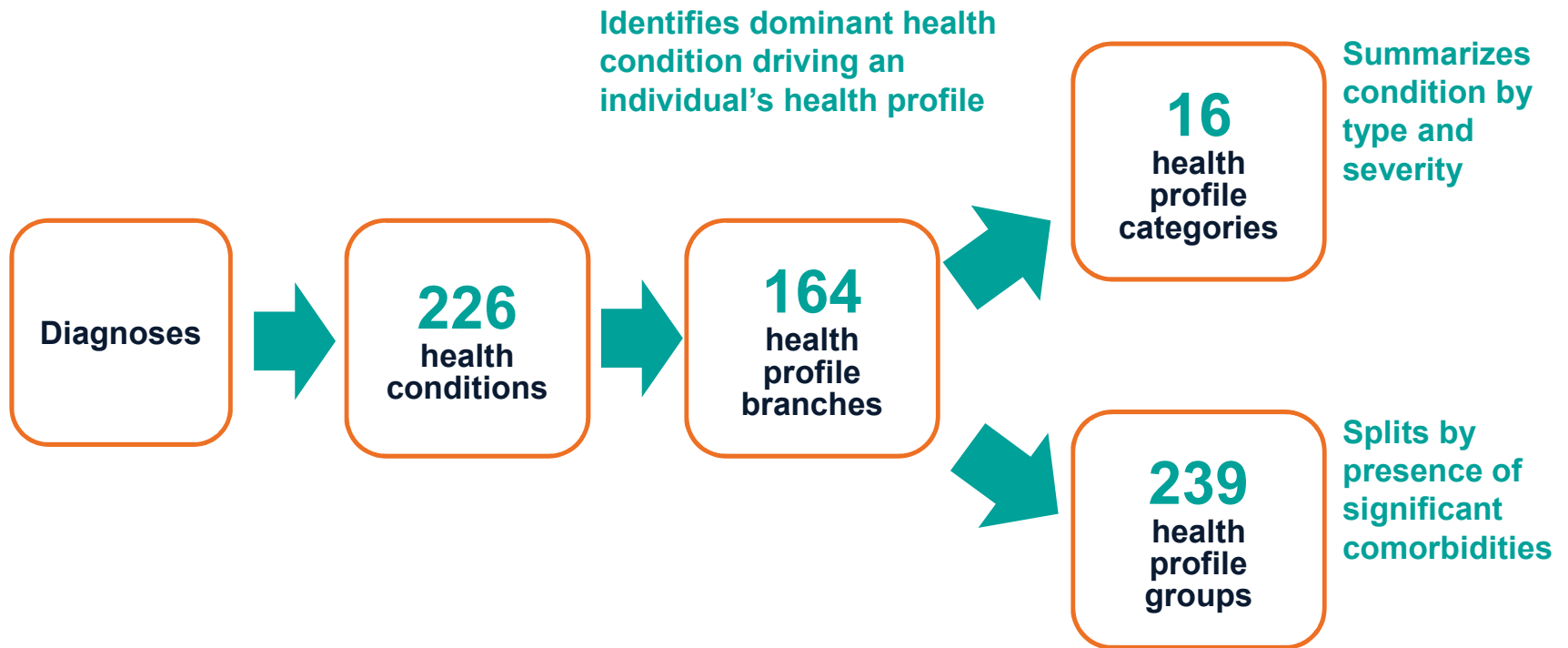
BC Health System Matrix Segment

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	
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

Highest health care needs

Lowest health care needs

Health System Matrix 6.1, BC Ministry of Health 2015

BRITISH COLUMBIA

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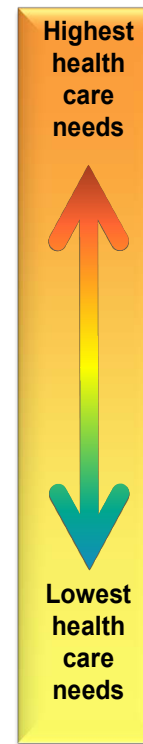
Using Population Segmentation to Provide
Better Health Care for All: The "Bridges
to Health" Model

JOANNE LYNN, BARRY M. STRAUBE,
KAREN M. BELL, STEPHEN F. JENCKS,
and ROBERT T. KAMBIC

Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

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.

C ROSSING 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.

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Poll 3: Which indicators to review?

Poll 3 Which are your top 3 indicators

Poll | 1 question | 167 of 264 (63%) participated

1. Which are your top 3 indicators that we should review today ?
(choose 3) (Multiple Choice)

167/167 (100%) answered

Indicator	Count
ACSC hospitalizations	(25/167) 15%
ED visits best managed elsewhere	(86/167) 51%
Physician continuity of care	(48/167) 29%
ALC Days	(59/167) 35%
Cervical cancer screening	(20/167) 12%
Breast cancer screening	(9/167) 5%
Frequent ED visits for mental health	(53/167) 32%
ED as first contact for mental health	(49/167) 29%
ED visits within 30 days of discharge	(45/167) 27%
Frail Older Adults with repeat fall-related ED visits	(39/167) 23%
Palliative patients with home care in last 90 days of life	(28/167) 17%
Palliative patients with ED visits in last 30 days of life	(22/167) 13%

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

ACSC Hospitalization 2022/23

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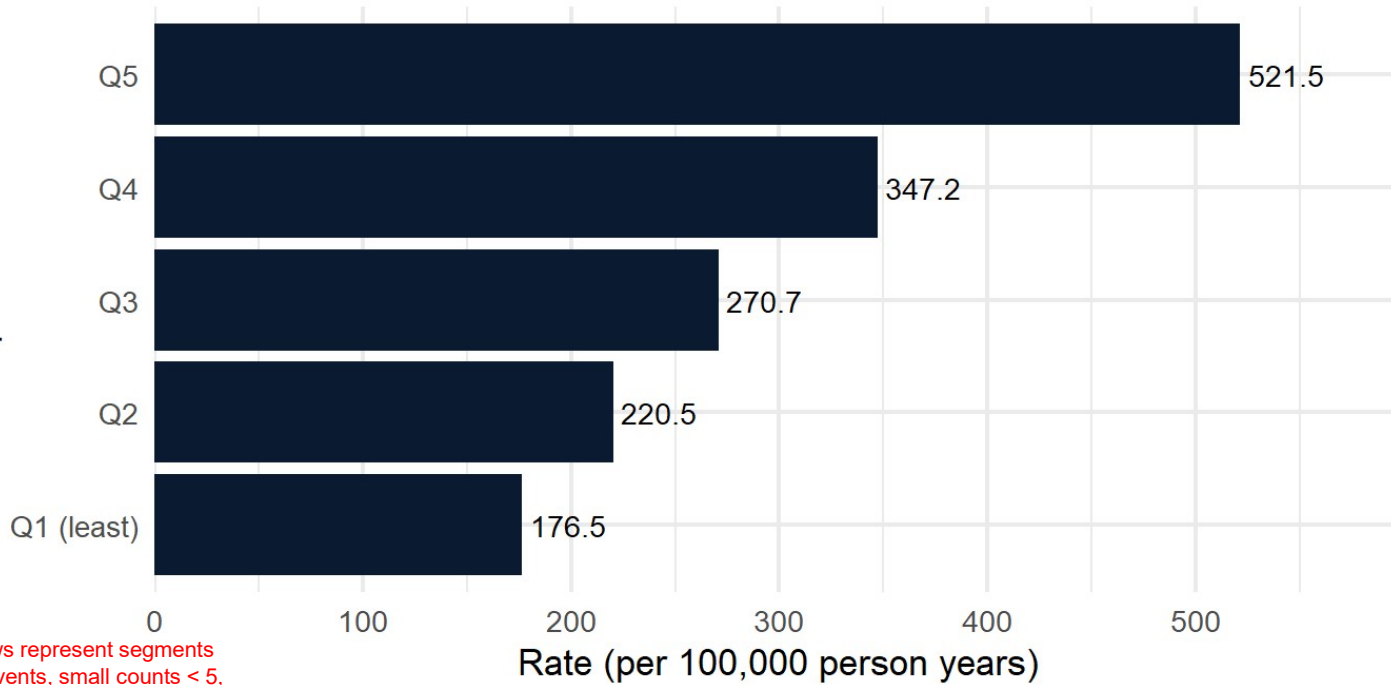
Horizontal axis presents rate of hospitalization for ambulatory care sensitive condition per 100k:

- 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 in Ontario = 300.1.

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IC/ES

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

ED Visits best managed elsewhere 2022/23

Ontario

POPULATION SEGMENT (vertical axis)

Segment	Rate
Not Rostered	11.0
CCM	7.3
FHG	5.5
CAP (FHO/FHN/Other)	8.3
FHT	15.9

Rate (per 1,000 person years) — axis: 0, 5, 10, 15

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

- 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 in Ontario = 10.1.

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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

Ontario

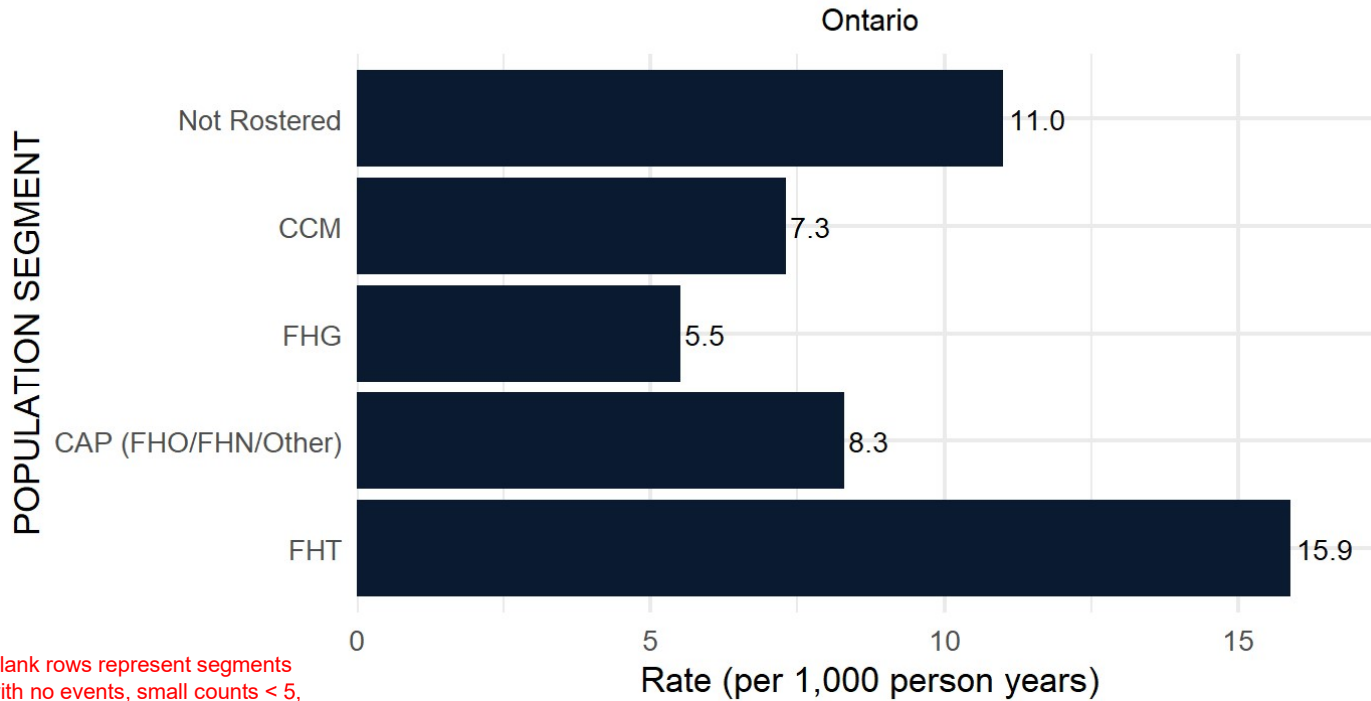| POPULATION SEGMENT	Mean UPC Index
End of Life	0.50
Long-Term Care	0.74
High Chronic/ Frail	0.50
Cancer	0.40
Frail/ Community	0.50
High CCs	0.55
MH/ Substance Abuse	0.56
Medium CCs	0.57
Adult Major	0.53
Maternity/ Newborn	0.50
Low CCs	0.62
Child/ Youth Major	0.52
Healthy	0.63
Non-users	0.70

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 in Ontario = 0.61.

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

- Indicator calculated for individuals with 2+ visits,
- Ontario average indicated in figure footnote.

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

ALC Days 2022/23

Ontario

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

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.
- Ontario average indicated in figure footnote.

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 in Ontario = 18.8%.

HSPN

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

ALC Days 2022/23

Ontario

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.
- Ontario average indicated in figure footnote.

Chart data (Population Segment, percentage):
- Palliative — 24.2%
- Major MH — 40.0%
- Major Cancer — 12.5%
- Major Chronic — 19.6%
- Major Acute — 20.5%
- Moderate Chronic — 13.9%
- Other Cancer — 13.7%
- Moderate Acute — 15.2%
- Obstetrics — 0.3%
- Other MH — 10.9%
- Minor Chronic — 13.5%
- Major Newborn
- No Conditions — 15.9%
- Minor Acute — 12.6%
- Healthy Newborn
- Non-users — 15.2%

X-axis: Total Inpatient Days (0, 500000, 1000000, 1500000, 2000000)
Y-axis: POPULATION SEGMENT

Legend: ■ Other Inpatient Days ■ ALC Days

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.
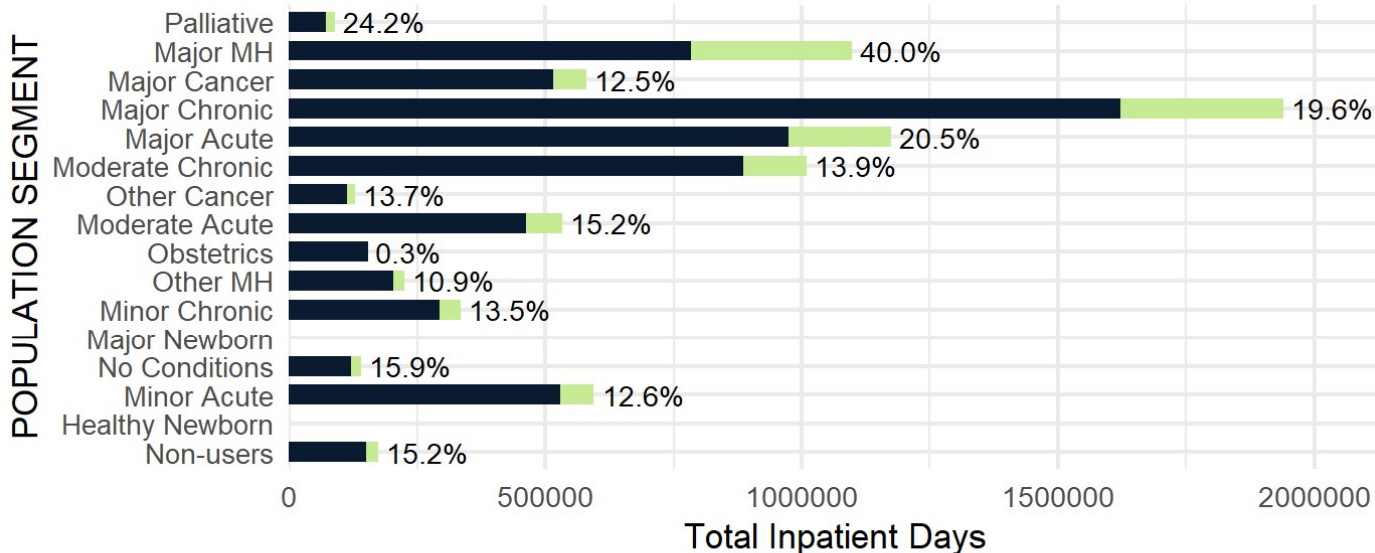*Data are suppressed for segments with small counts.
*Overall ALC Days in Ontario = 18.8%.

HSPN

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

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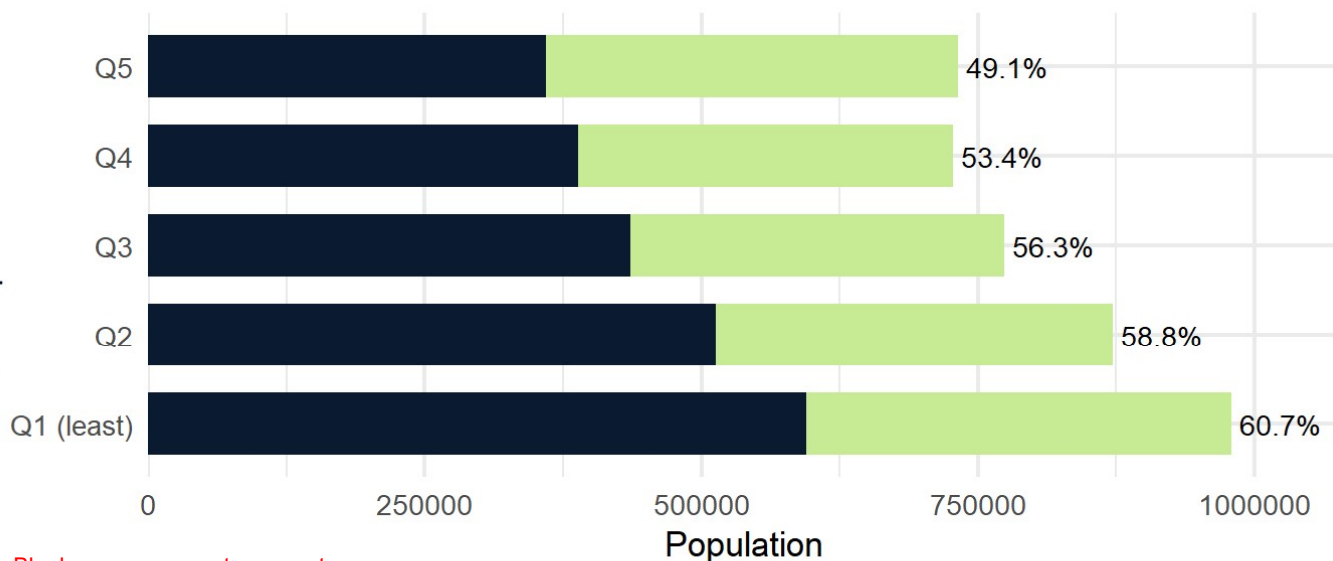
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

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 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.
- Ontario average indicated in figure footnote.

HSPN

IC/ES

46

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

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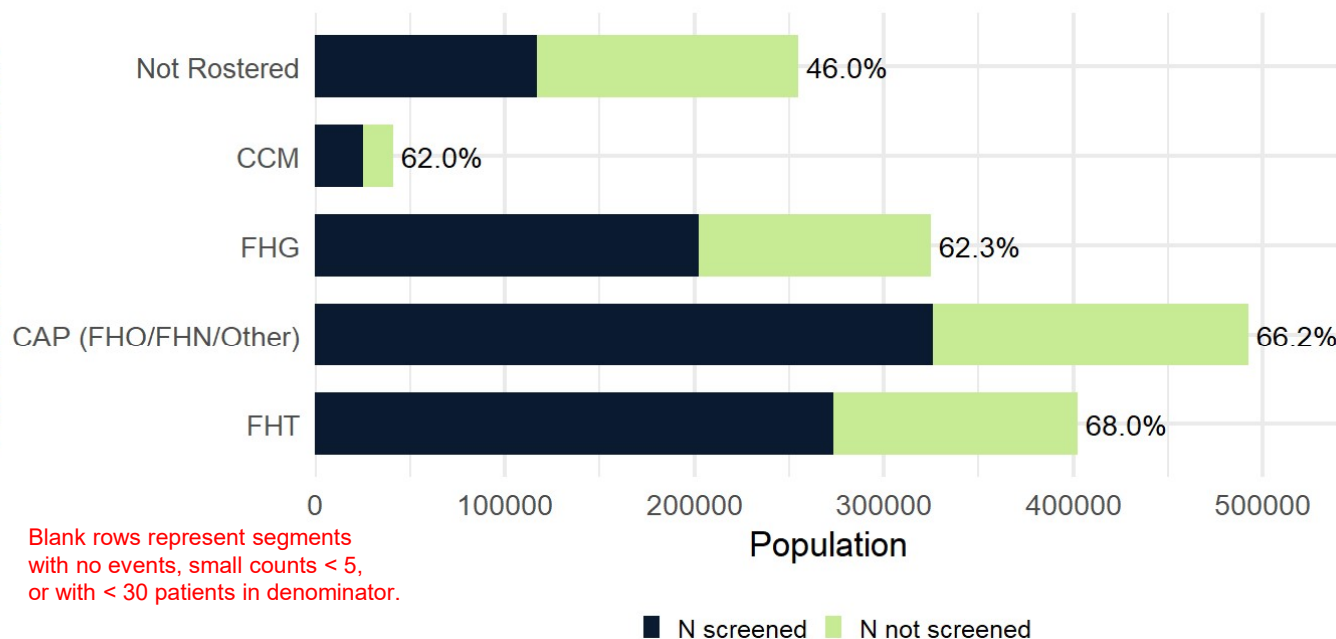
Horizontal axis shows the number of women 52-69 years:

- 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.
- Ontario average indicated in figure footnote.

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 Ontario = 62.3%.

HSPN

IC/ES 47

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

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

Ontario

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 in Ontario = 10.3%.
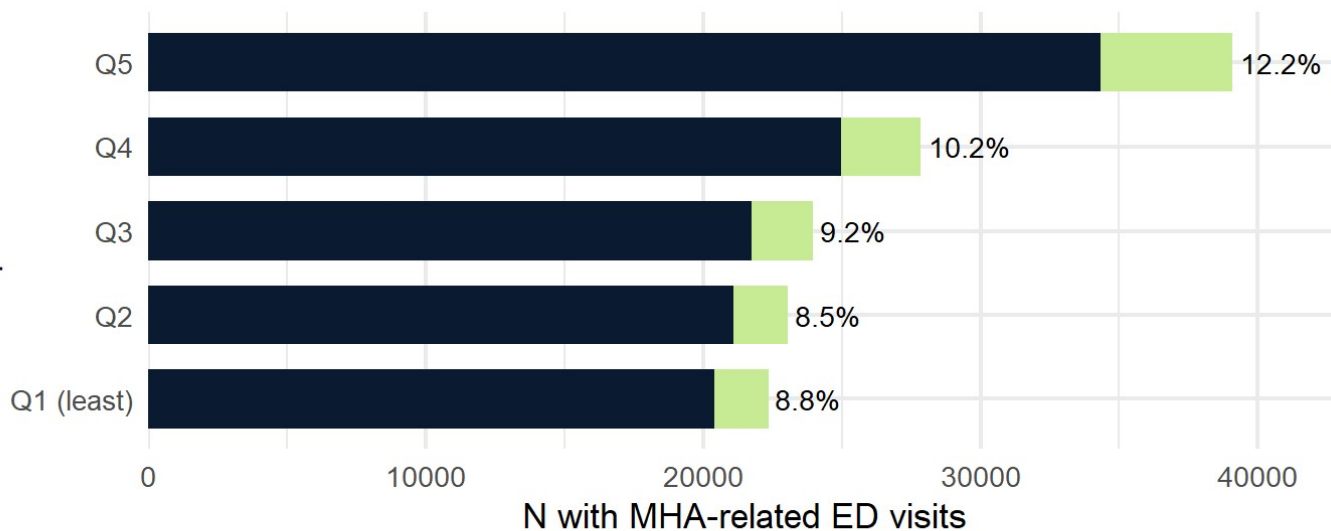
Horizontal axis presents number of patients with MHA-related ED visits.

- 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;
- Ontario average indicated in figure footnote.

HSPN

IC/ES   48

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

Ontario
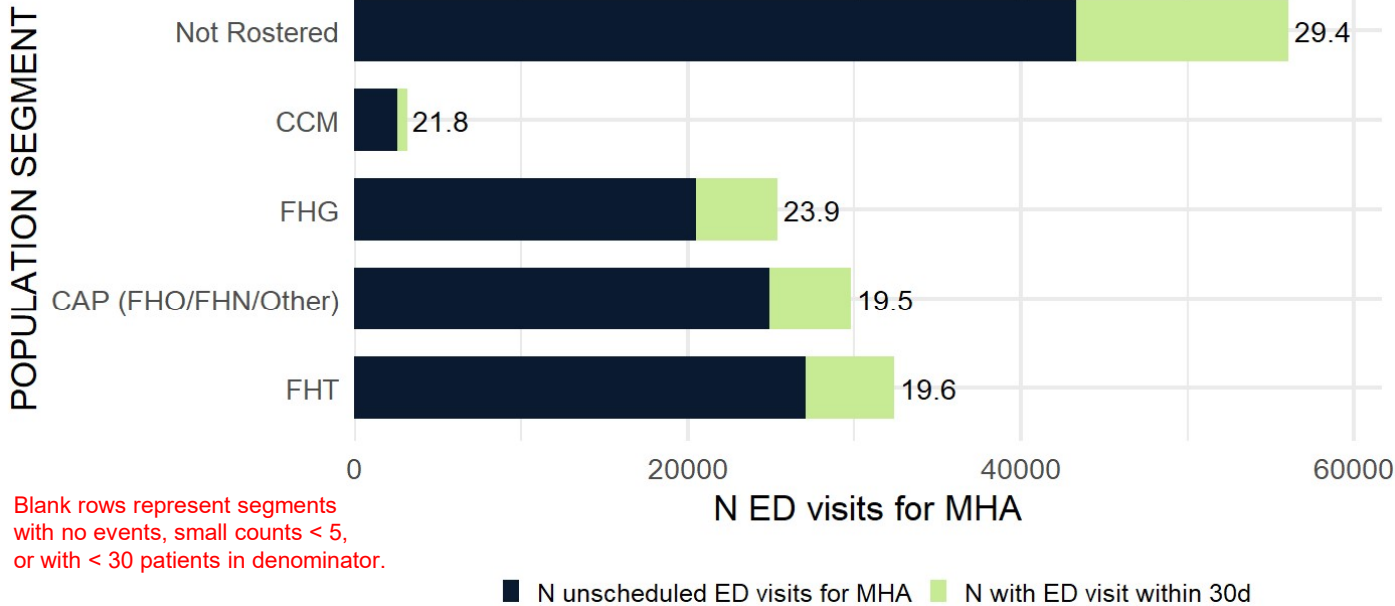
Horizontal axis shows the number of ED visits for MHA:

- 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
- Ontario average indicated in figure footnote.

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 Ontario = 24.0.

HSPN

IC/ES

49

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

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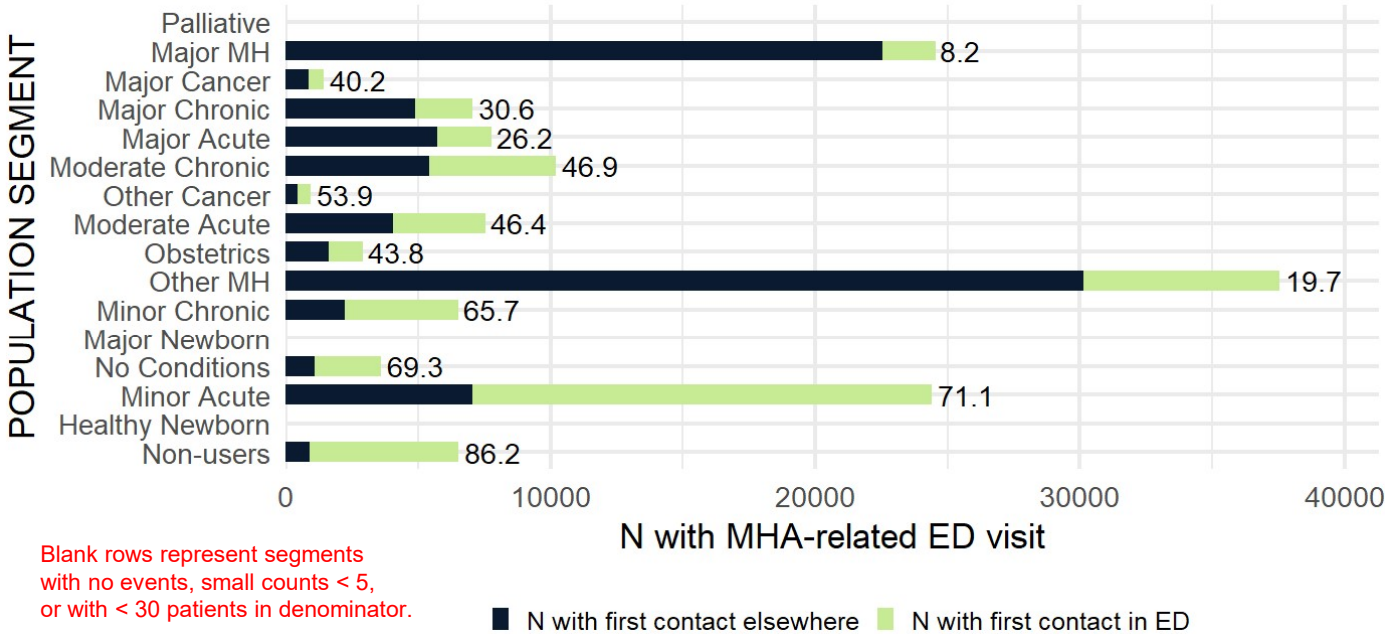
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

■ 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 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.
- Ontario average indicated in figure footnote.

HSPN

IC/ES 50

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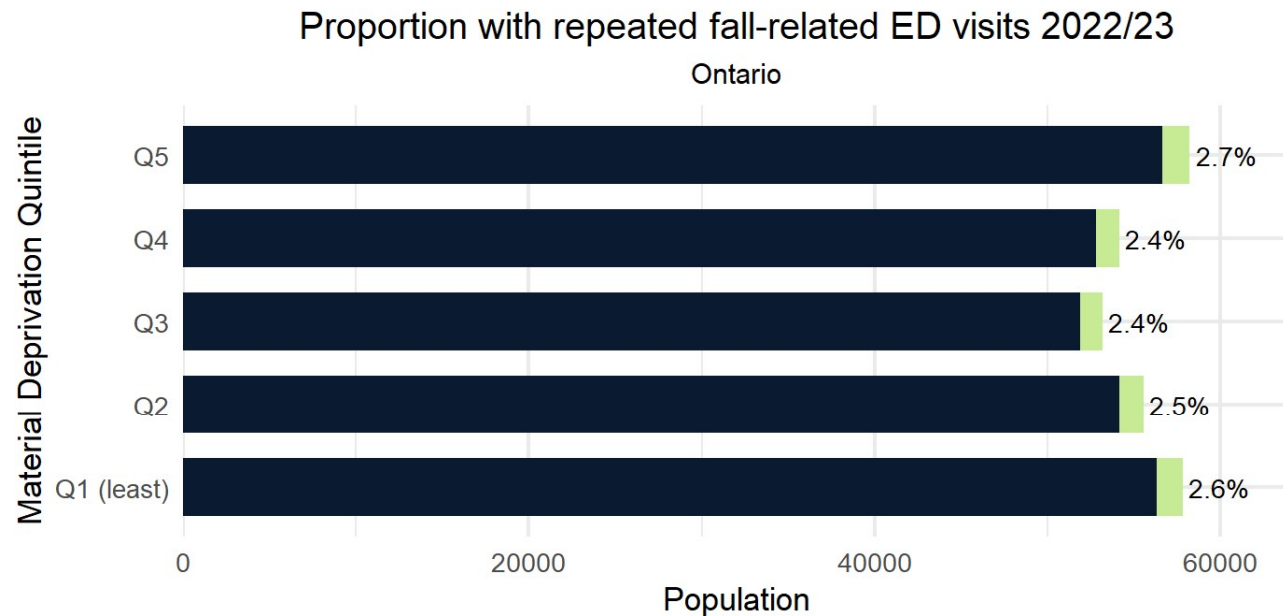
Proportion with repeated fall-related ED visits 2022/23

Ontario

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

■ N without 2+ fall ED visits ■ N with 2+ fall ED visits

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 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.
- Ontario average indicated in figure footnote.

HSPN

IC/ES

51

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

Proportion with home care in last 90 days 2022/23

Ontario

Population segments (POPULATION SEGMENT) with proportions:
- Palliative: 61.6%
- Major MH: 13.6%
- Major Cancer: 39.6%
- Major Chronic: 14.1%
- Major Acute: 15.9%
- Moderate Chronic: 11.2%
- Other Cancer: 22.6%
- Moderate Acute: 10.3%
- Obstetrics:
- Other MH: 4.1%
- Minor Chronic: 9.6%
- Major Newborn:
- No Conditions: 9.0%
- Minor Acute: 9.7%
- Healthy Newborn:
- Non-users: 6.2%

Horizontal axis: Population (0, 5000, 10000, 15000, 20000)

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 Ontario = 18.4%.
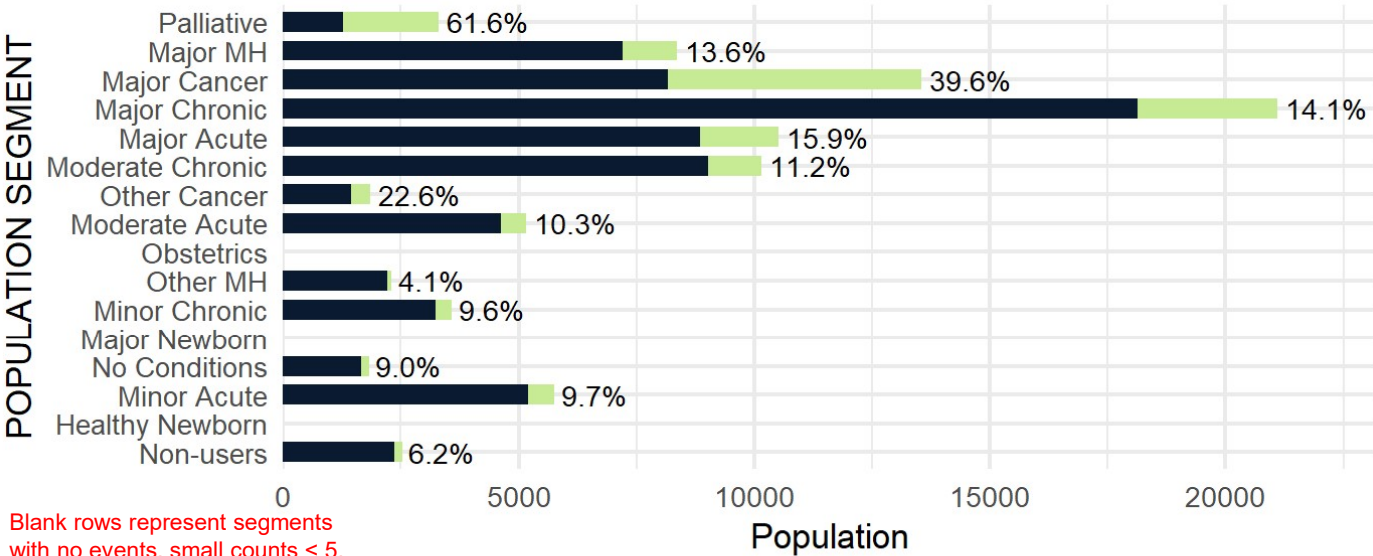
Horizontal axis shows the number of OHT attributed patients that died in the reporting period.

- 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
- Ontario average indicated in figure footnote.

HSPN

IC/ES   52

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

Proportion with ED visit in last 30 days 2022/23

Ontario

POPULATION SEGMENT	Proportion
Palliative	41.5%
Major MH	40.4%
Major Cancer	54.6%
Major Chronic	63.6%
Major Acute	61.5%
Moderate Chronic	63.0%
Other Cancer	55.1%
Moderate Acute	60.7%
Obstetrics	
Other MH	46.4%
Minor Chronic	58.6%
Major Newborn	
No Conditions	49.3%
Minor Acute	53.2%
Healthy Newborn	
Non-users	50.4%

Population axis: 0, 5000, 10000, 15000, 20000, 25000

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

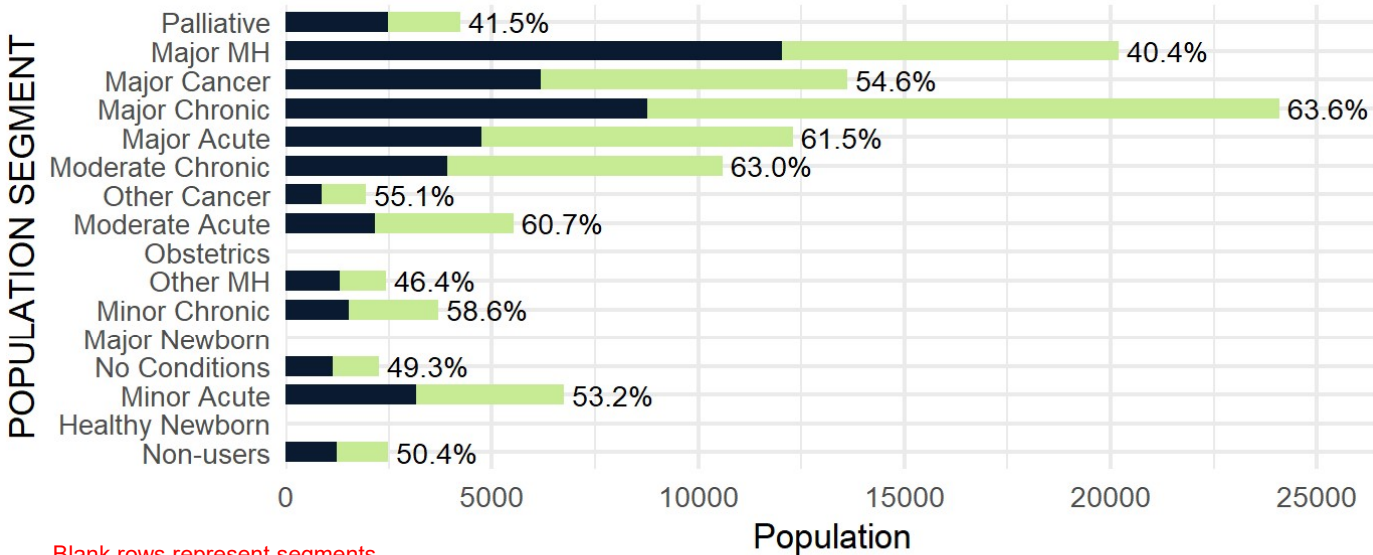■ N without ED visit in last 30d   ■ N with ED visit in last 30d

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 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.
- Ontario average indicated in figure footnote.

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IC/ES   53

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).

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How to use this report - 3

1. Every OHT has received Excel data files with all 27 indicators stratified by 4 approaches for fiscal years 2021/22 and 2022/23.

2. All OHT reports will be posted on the HSPN website on February 15, 2024. Additional provincial reports are forthcoming.

3. HSPN is making a simple online OHT comparator tool available to create charts based on HSPN reported data. (e.g. OHT A and B comparing ED Visits according to primary care model. … how is B doing so much better than A ?
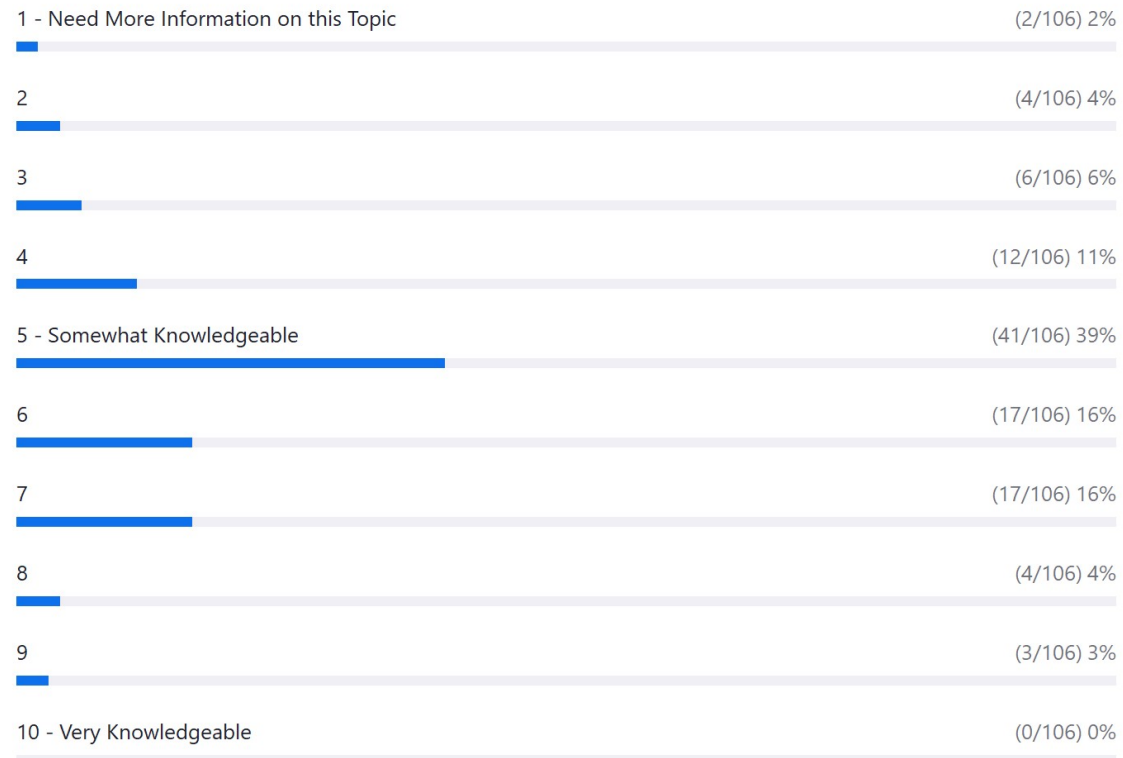
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Poll 4

Poll 4: Knowledge About Today's Topic

Poll | 1 question | 106 of 196 (54%) participated

1. How knowledgeable are you about HSPN reports on OHT Improvement Indicators ? (Single Choice) *

106/106 (100%) answered

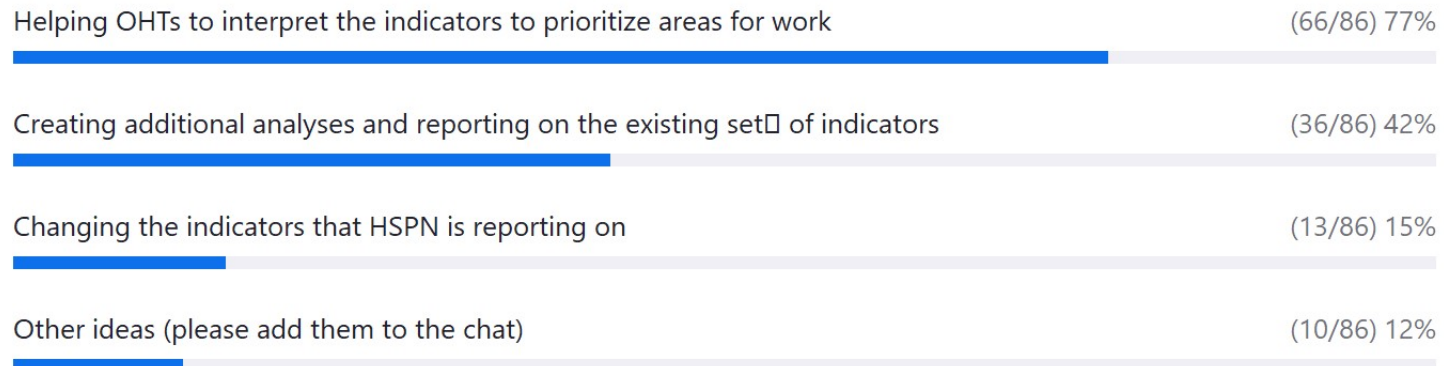|	
1 - Need More Information on this Topic	(2/106) 2%
2	(4/106) 4%
3	(6/106) 6%
4	(12/106) 11%
5 - Somewhat Knowledgeable	(41/106) 39%
6	(17/106) 16%
7	(17/106) 16%
8	(4/106) 4%
9	(3/106) 3%
10 - Very Knowledgeable	(0/106) 0%

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Poll 5

Poll 5: Improvements for HSPN

Poll | 1 question | 86 of 179 (48%) participated

1. HSPN is always looking to evolve our measurement and reporting. What should we be working on ? (select all that apply) (Multiple Choice)

86/86 (100%) answered

Helping OHTs to interpret the indicators to prioritize areas for work   (66/86) 77%

Creating additional analyses and reporting on the existing set☐ of indicators   (36/86) 42%

Changing the indicators that HSPN is reporting on   (13/86) 15%

Other ideas (please add them to the chat)   (10/86) 12%

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Up Next

- HSPN webinar series
  - 4th Tuesday of the Month: 12:00 – 1:30 pm

Upcoming
  - February 27 – Policy Supports for Integrated Care
  - March 26 – Equity in the Ontario Health System

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Can you share some feedback? Scan here! (or click link in chat)
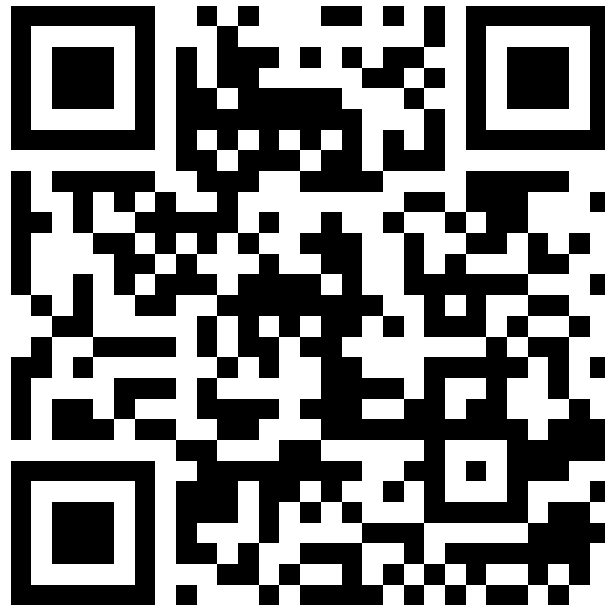
THANK YOU!

@infohspn

hspn@utoronto.ca

The Health System Performance Network

hspn.ca

HSPN

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

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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 2021 and 2022

- 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]