Welcome

All Members meeting
October 22nd, 2023

Wifi: **GolfMGC**
Password: **eagle123**

Land Acknowledgement

Introduction and Objectives

Day's Objective:

Opportunity to reset the stage for OHT work,
fostering bold and disruptive ideas for significant healthcare system transformation,
to improve the health and wellbeing of the HPA community

Our Strategy Pillars:

1. Access and movement thru system - right care, right time, right provider
2. Health promotion, prevention, and patient-self management - integrated early interventions at home and in the community
3. Recruitment, retention, and well-being of health care staff, and advance leadership and workforce integration
4. Advance collaboration through a strong HPA OHT structure, systems, and processes

Agenda – Flow of the day

- Introduction, Objectives & Icebreaker
- Reflections from the Field
- Current State – Where we Are
- Break – Networking
- Where we go from here
- Next Steps and Closing Comments

Setting the context

How to start a movement

Start with Why

Circles of Influence & Concern

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ONTARIO HEALTH TEAM

Reflections from the Field

Dr. Anne Wojtak

Reflections on the development of our Ontario Health Team

October 22, 2024

Dr. Anne Wojtak,

Co-Lead, East Toronto Health Partners

About East Toronto Health Partners

- **100+** community, primary care, home care, hospital and social services organizations
- **100+** patient, caregiver and community advisors and community health ambassadors
- **350,000+** people who live or get care here
- **21 neighbourhoods,** including five **high-priority, equity-deserving** communities

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What we've achieved as an OHT

Demonstrated successful integrated response to COVID-19

- Delivered **630,000+ COVID-19 vaccines** from December 2020 to June 2022
- Significant focus on supporting **equity-deserving communities**

↑ Increased primary care capacity

- Launched Health Access Taylor-Massey (HATM), our second primary care hub in an equity-deserving neighbourhood
- HATM has provided **2,700 unique patients** with **access to team-based primary care** since Oct 2022

↑ Increased access to home- and community-based care

- Launched MGH2Home, enhanced care program that delivers care at home through **"one-team" approach** in April 2023; Launching a home care leading project in 2024

↑ Increased access to cancer screening

- Piloted **digital primary care flag** that enabled us to identify and contact **12,000 patients** overdue for cancer screening through OH-funded test of change
- Supported through training and capacity-building of **90+ community health ambassadors**

↑ Increased access to youth mental health

- Opened our 2nd **Youth Mental Health Hub** in an equity-deserving community in July 2023

How we have accelerated our OHT

✓ We are building on 20+ years of partnership

- **Partners in East Toronto** already had a formal network and **were moving towards integration before the OHTs.**
- An existing leadership structure was in place – a 'network of networks' model with sectoral representation

✓ Significant investments beyond OHT implementation funding

- Ontario Health has provided $750K to all OHTs
- For the past 4 years, **Michael Garron Hospital provided another ~$1.5M** annually to seed ETHP innovations and advance integration activities ("community surge")

How we have accelerated our OHT

✓ Having one of the first organized Primary Care Networks

- Helps us engage **270+ family practitioners** in the development of integrated care in East Toronto and co-leads solutions for **improving primary care capacity and access**
- **Requires continued investment, governance, and accountability structures**

✓ Distributed Leadership and Community Mobilization

- **Shared leadership** with several shared ETHP-partner roles and project managers across multiple partners
- Investment in **community engagement** and co-design, with a focus on **representation from equity-deserving neighbourhoods**
- Continued investment in **community health ambassadors**

Aligning OHT and primary care maturity to co-lead system change

Collaborative partnerships and supports to improve coordination/integration of care delivery

Formalized partnerships, structures and governance – design and implementation of integrated delivery models

Integrated accountability, leadership, structures, governance, and resource allocation.
System-level design and delivery of integrated health and social care

OHT development

Organized primary care

Primary care is at the core of integrated health and social care systems.

Maturity for OHTs and organized primary care leadership (e.g. Primary Care Networks) are linked. One cannot happen without the other.

Increased Intensity of Coordination, Integration and Collaborative Partnerships

Increased Client and Citizen Engagement and Community Mobilization

Increasing Level of System Change and Impact

Increasing Investments Re-directed into OHTs

rpa-ontario.ca

ETHP current Governance: A ‘network of networks’ model with different sectors having a representative organization at the leadership table

Leadership Team

+ 2 Members from our Community Advisory

Partners*

Network of patient, caregiver and community advisors and community health ambassadors

See a full list of ETHP member organizations at ethp.ca/partner-organizations

- **December 2019** — Official OHT designation; signing of joint venture agreement
- **July 2021** — External review of our governance and structure *‘what will it take to accelerate integration?’*
- **September 2022** — Moved to a ‘dyad’ OHT leadership
- **January 2023** — Expanded the number of sectors at the leadership table
- **April 2023** — Launched a new portfolio operational structure with distributed leadership across partners for OHT initiatives
- **July 2023** — Started consultations with partners about OHT governance and the future state
- **January 2024** — Moved to a ‘triad’ structure of OHT leadership
- **September 2024** — Launched a Governance Planning task group

Key considerations for future governance

Inclusivity / Representation

More diverse and **inclusive** partner representation including by geography, populations, and sectors	Partners who are helping lead the work need more **voice in decision-making**
Stronger focus on **geographic representation,** e.g. **neighbourhood** action tables	Staggered **term limits** to enable more inclusive representation over time

Trust / Accountability

Representation needs to **agnostic of organizations and sectors**; and accountable to partners and community	Representatives need to be **trusted** and seen to be **working for the community and the collective;** ***Board Chair is key***
Commitment to **hold each other accountable** to act in the best interests of the community and the collective	**Radical transparency** (i.e. budget and resource allocation, decision-making)

Key considerations for future governance

Engagement

- New ETHP governance needs to engage with **partner Boards**
- Connect **smaller partners** together, engaging them and providing value through the OHT
- **More frequent meetings and touchpoints, pulse checks** with partners and community
- **Use Integrated Care Pathway development** as testing ground for new governance and deep engagement

Identity / Role Clarity

- More consistent use of ETHP **branding;** OHT seen as **less connected to the hospital**
- Define the **role of the OHT** - connector, convener, aligner, data, support, info sharing
- Define when something is an **OHT initiative vs a partner-led initiative**
- A more intentional **sign-on process for partners;** define roles and responsibilities

A few reflections

Effective governance is needed at every level of our work

Micro-level governance is as important, if not more important than system-level (macro) governance

Governance must align with the OHT's goals for population health (form follows function) and evolve with an OHT's phases of development

System level governance is new to *everyone* – we cannot underestimate the level of change and support required to get us there

Where to next….

- Advancing i12 priorities (e.g. integrated care pathways, setting up a structure to support home care delivery)
- Partnering with our PCN on long-term HHR capacity planning for access and attachment
- Updating our OHT governance to reflect where we are, and where we are going
- 10+ year strategic planning development focused on population health and demographic shift in East Toronto

Leadership, governance, and the challenges of the ‘in-between’

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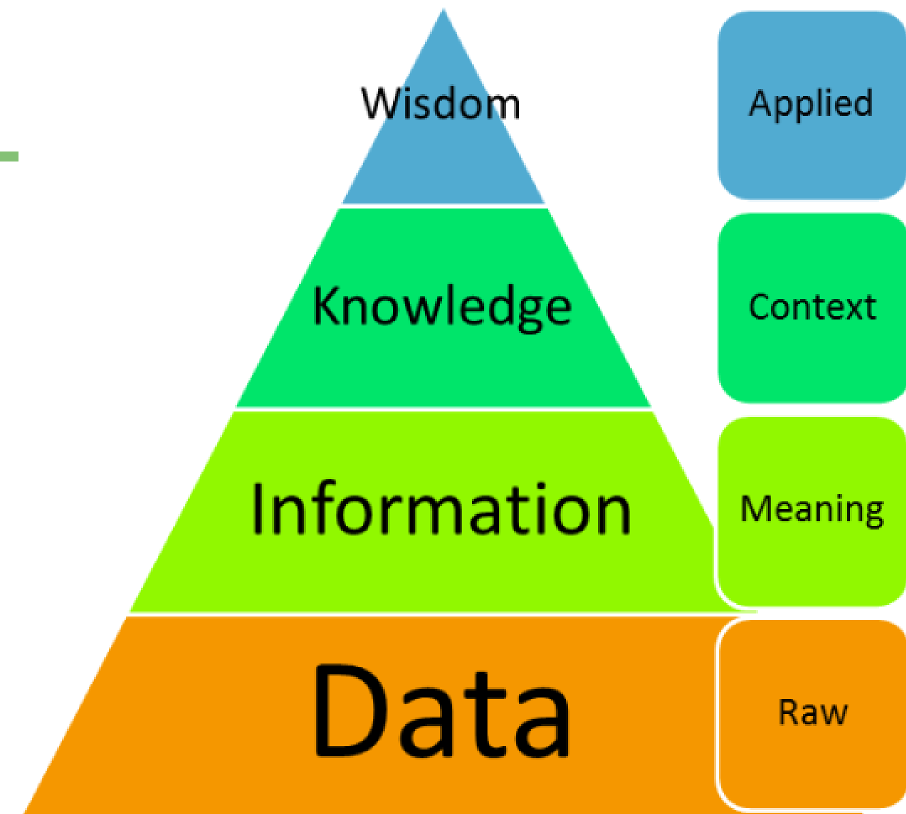
Current State – Where we are? Health Data Summaries

Angela Schyff & Samer Abou-Sweid

Approach to Data

Data → Information → Knowledge → Wisdom



Guide to decisions and actions:

- Understand past performance to plan future
- Appreciate trends over time – improving or deteriorating
- Benchmark across OHTs – who to learn from
- Measure progress and revise strategies accordingly

Comprehensive Population Health view:

- Consider Demographics and Socioeconomic factors on population Health
- View as health system performance, even if it's institution or sector specific
- Celebrate the success, and collectively focus on the gaps
- Addressing gaps in the system to free up resources across the sector

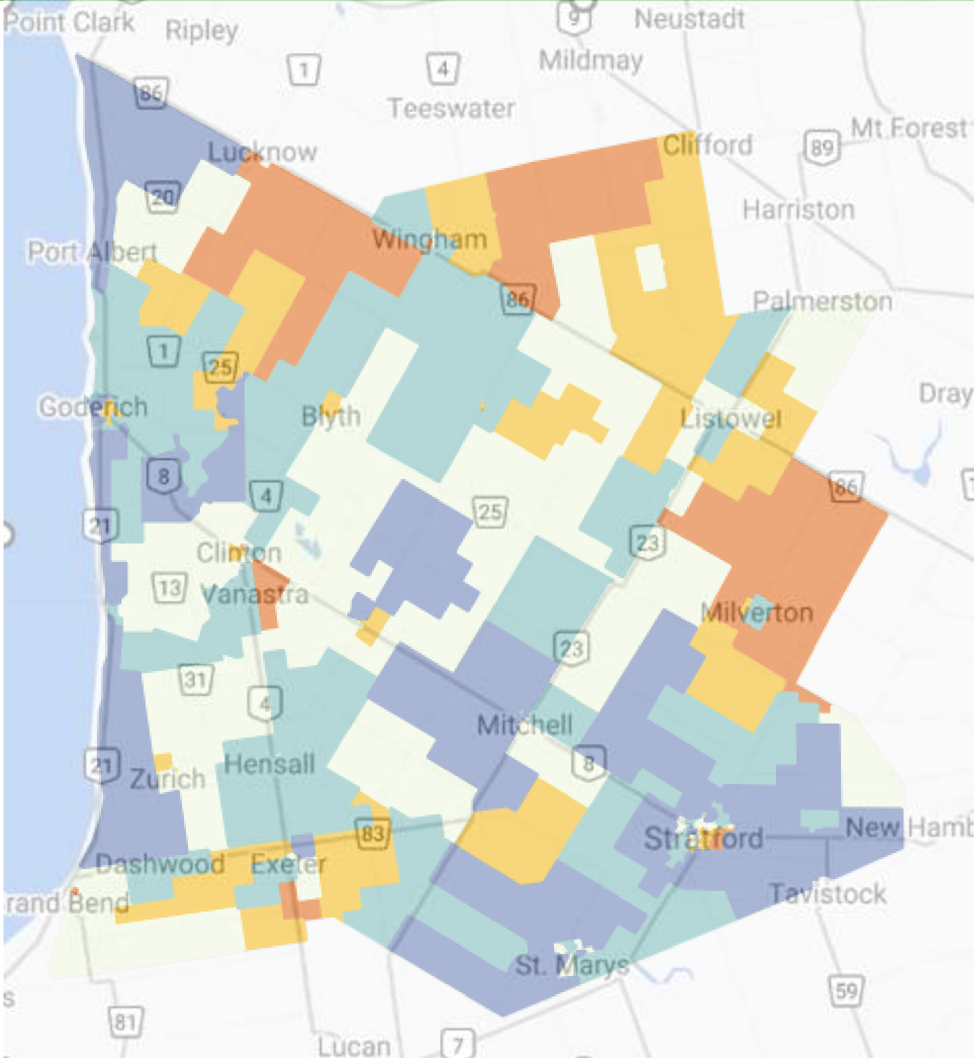
Where we are – Demographics/Socioeconomic

Growing and aging population:

- Higher median age than ON (42.4 vs 41.6yrs)
- Population growth by 33% by 2043
- 65yr+ increasing from 22% to 27% by 2043

Material Deprivation:

- Better on Material Deprivation scale than most OHTs
- Lower income than ON average, but one of the lowest unemployment
- 87% of United Way/SRPC 2023 survey respondents sacrificed food for other expenses



LEGEND:
1 - Least Marginalized to
5 - Most Marginalized

MARGINALIZATION QUINTILES
1
2
3
4
5

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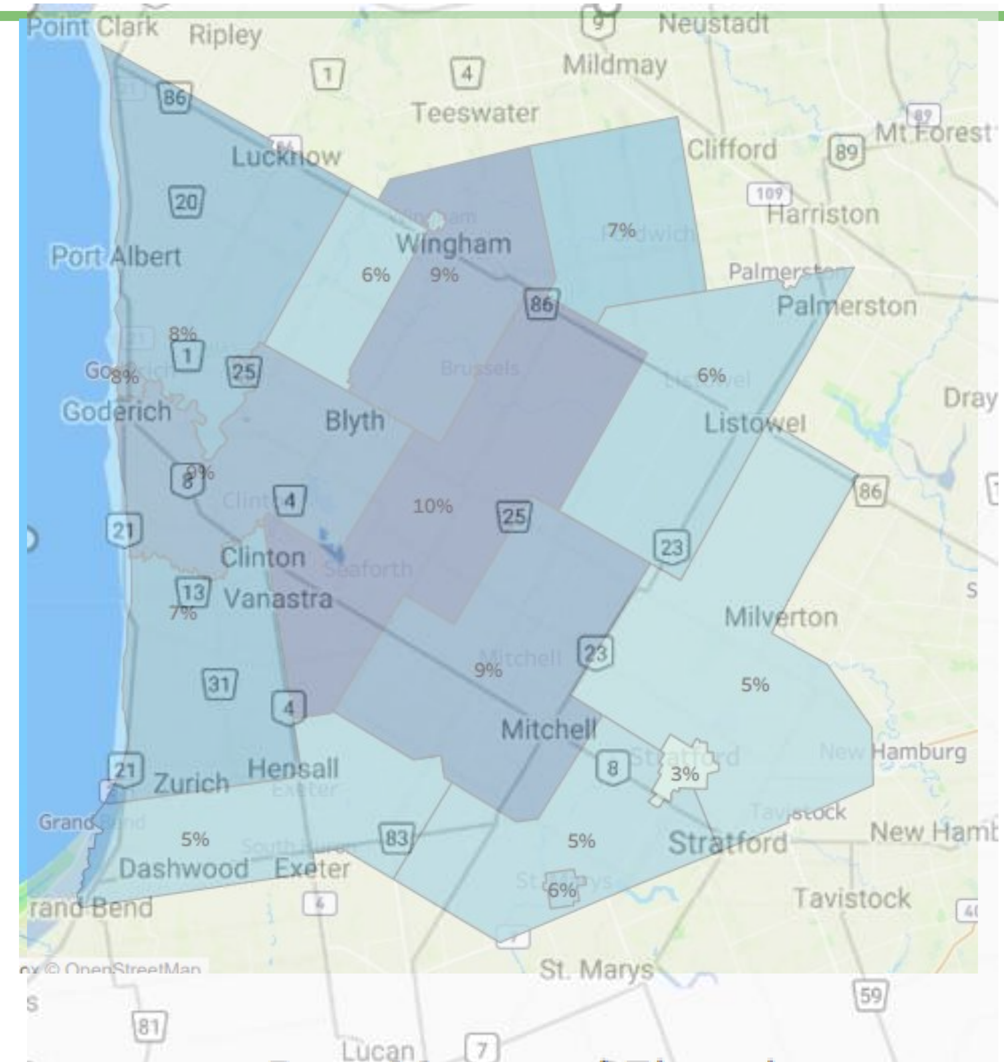
Where we are – Population Health

HPA-OHT is better performer than other OHTs:

- End of Life care
- Care of Frail/Older Adults
- Days in Acute Care
- Cost per Month

Areas for improvement:

- Access to primary care:
    - ED visits managed elsewhere (41.4 vs 10.1 ON avg - rate by 1,000 person years)
    - 7-day physician follow-up after hospital discharge
- Access for MH&A services:
    - 1st contact in ED for MH&A (44.1 vs 38.3 – overall rate per 100)
    - Outpatient visit within 7day MH&A hospital discharge



Best Managed Elsewhere ..

3% 10%

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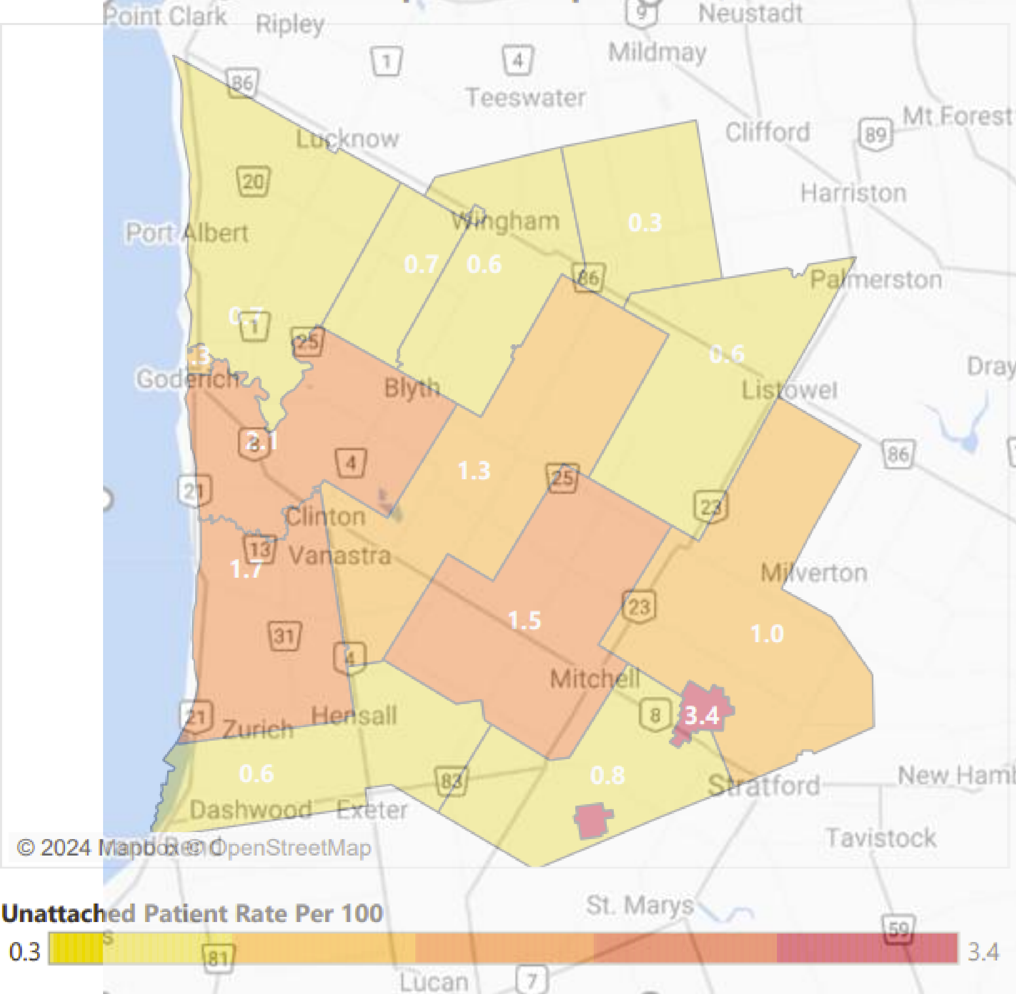
Where we are – Health Outcomes Trends

Primary Care Access and unattached:

- ED best managed elsewhere - decreasing slightly for overall population and 65yrs+
- No access to primary care - increasing in number (6,200 to 8,200)

Community Services:

- ALC, while better than ON average, still high 15.3%.
  Comparable OHTs achieving better performance (9.6%, 12%)
- ALC trend 2018/19 – 2023/24
  - Discharge volume to LTC beds increasing
  - Discharge volume to CCC, Rehab & Ontario Health atHome all decreasing

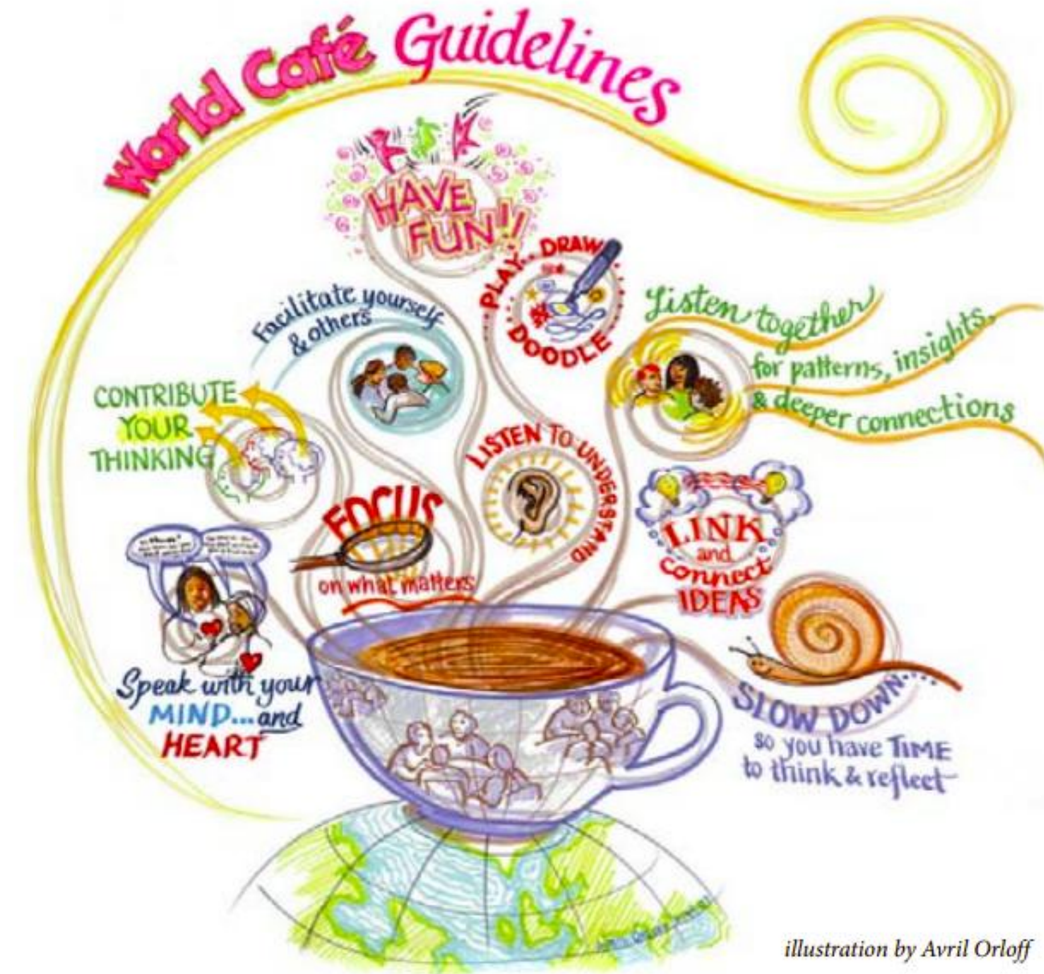


Questions

World Café – Where we are? (35mins)

1. Understand the context - Data and Strategy Pillars
2. Select Facilitator & Note Taker
3. Answer 3 questions:
    1. Success - categorize under 4 Strategy Pillars
    2. Challenges - categorize under 4 Strategy Pillars
    3. What lead to each success or challenge?
4. Switch Tables clock-wise - all but 2 participants (Facilitator, Note taker)
5. Repeat Exercise
6. Report Back

Café Etiquette



Play! Experiment! Improvise!

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Strategy Pillars

Strategic Priority 1	Optimize access and movement through the healthcare system to achieve the right care, at the right time, by the right provider
Strategic Priority 2	Emphasize and support health promotion, prevention, and patient-self management and deliver robust and integrated early health care interventions, at home and in the community for citizens
Strategic Priority 3	Ignite recruitment, retention, and well-being strategies of health care staff as well as advance leadership and workforce integration
Strategic Priority 4	Advance collaboration through a strong HPA OHT structure, systems, and processes

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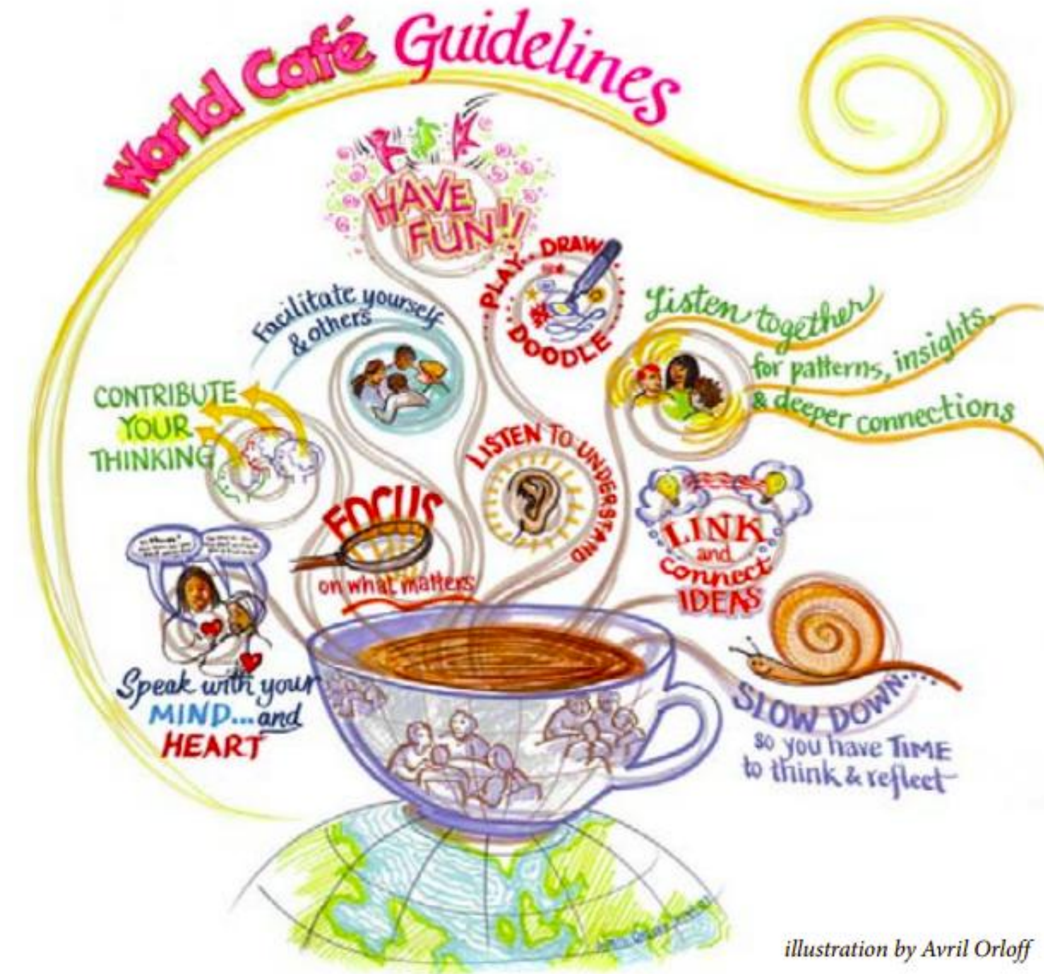
Future State – Where we go from here?

World Café – Where we go from here (60 mins)

1. Understand the context – Be Bold
2. Select Facilitator & Note Taker
3. Answer 3 questions:
   1. Gap Analysis
   2. What are the critical few areas/initiatives to focus on?
   3. What do we stop doing?
4. Switch Tables clock-wise - all but 2 participants (Facilitator, Note taker)
5. Repeat Exercise
6. Report Back & Discussion (20 mins)

Café Etiquette



Play! Experiment! Improvise!

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Thank you
&
Next Steps

APPENDIX

Data Summary Overview

1) Community Demographics & Wellbeing - Determinants of Health (slides 3-9)

- Reports: United Way/Social Research & Planning Council (2023), Catchment Analysis HPA hospitals (2024), Material Deprivation-HSPN 2023, LHIN/Western University Health Inequities Report (2016)
- Data sets: Disparity in income/education/age, Diversity, Deprivation quintile benchmark across OHTs
- Purpose: Material Deprivation and Socioeconomic differences within our OHT and across the province have an impact on population health. Need to understand causation and trends.

2) Health Outcomes – Provincial Benchmarking (slides 10-15)

- Reports: HSPN Report – Spider Diagrams – 2022 & 2023 (full report www.hspn.ca)
- Data sets: Population Health, MH&A, Older/Frail Adult care, Palliative/EOL care (25 KPIs)
- Purpose: Indicators reflect our OHT's population health and our collective healthcare system performance, not a specific institution or organization. Helpful in identifying key areas our OHT is lagging in the province and highlights comparable OHTs who perform better on each KPI

3) Health Outcomes – Annual Trend and Catchment Analysis (slides 16-22)

- Reports: IDS, OHT Dashboards (cQIP, Community Care, Primary Care, Home Care) - 2018/19 – 2023/24
- Data Sets: ED utilization, ALC, Home Care, Primary Care Unattached
- Purpose: Indicators reflect our OHT's population health and our collective healthcare system performance, not a specific institution or organization (e.g. accessing the hospital ED for services better received elsewhere or being in an ALC bed rather than receiving the required care in a more suitable setting is a reflection on the collective system not just the hospital). Need to understand root causes and address the gaps in the system to free up resources. Also, understanding trends over time indicates whether we are improving or deteriorating.

Data Set 1) Community Demographics & Wellbeing - Determinants of Health

- Reports: United Way/SRPC Report (2023), Catchment Analysis HPA hospitals (2024), Material Deprivation-HSPN 2023, LHIN/Western University Health Inequities Report (2016)

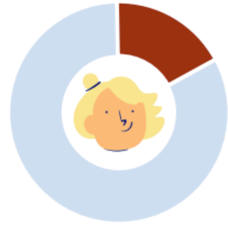
- Data sets: Disparity in income/education/age, Diversity, Deprivation quintile benchmark across OHTs

- Purpose: Material Deprivation and Socioeconomic differences within our OHT and across the province have an impact on population health. Need to understand causation and trends.

HPA Demographics – Population Age and Growth

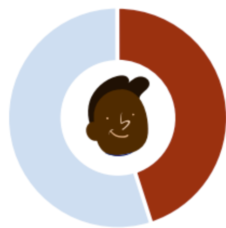
Median Age in Perth ► 42.4 years

Median Age in Province ► 41.6 years



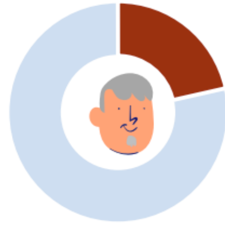
17%

0-14 Years



59%

15-64 years

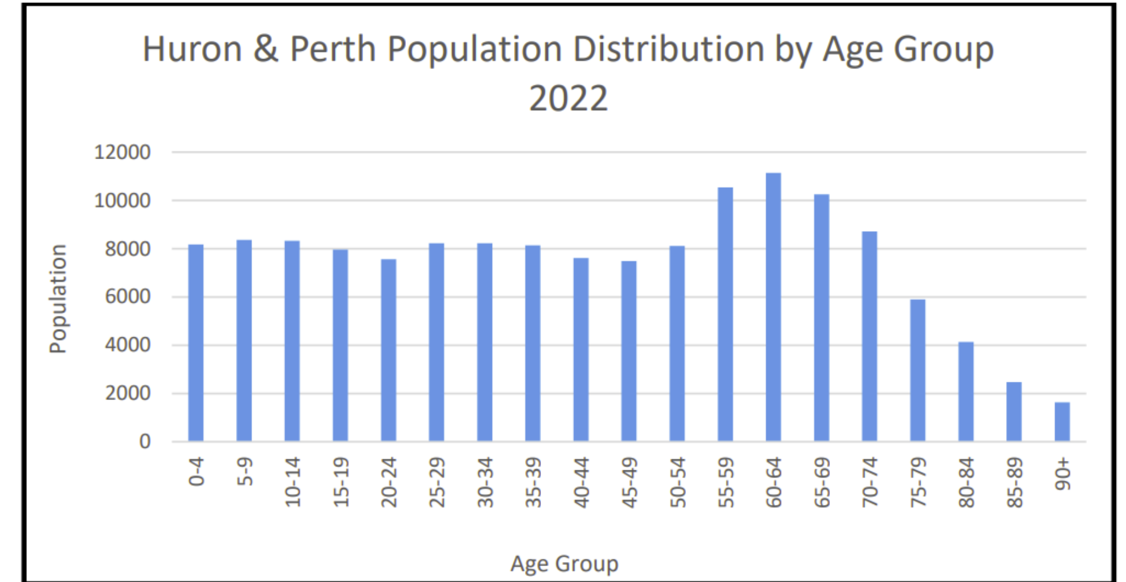


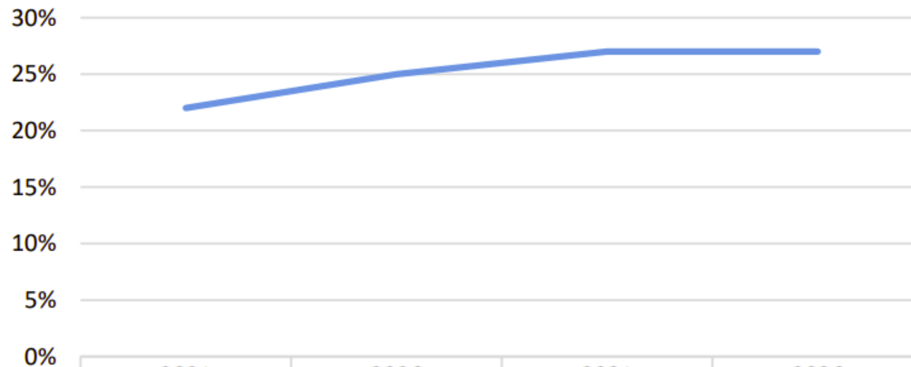
21%

65 to 84 years

3%

85 years+





	2021	2026	2031	2036
% of 65+ in Huron Perth	22%	25%	27%	27%

	2023	2028	2033	2038	2043
Huron Perth Population Projection	153,587	166,251	178,234	190,719	203,849

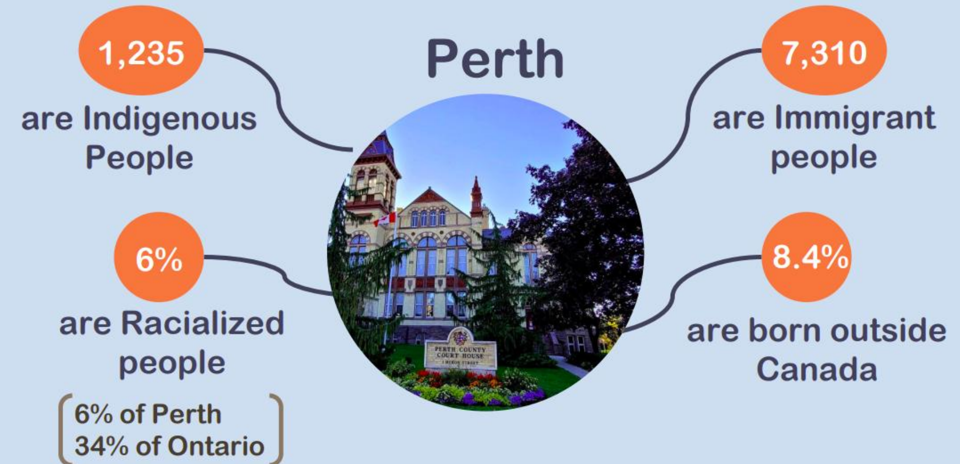
HPA Demographics – Diversity, Education, Health

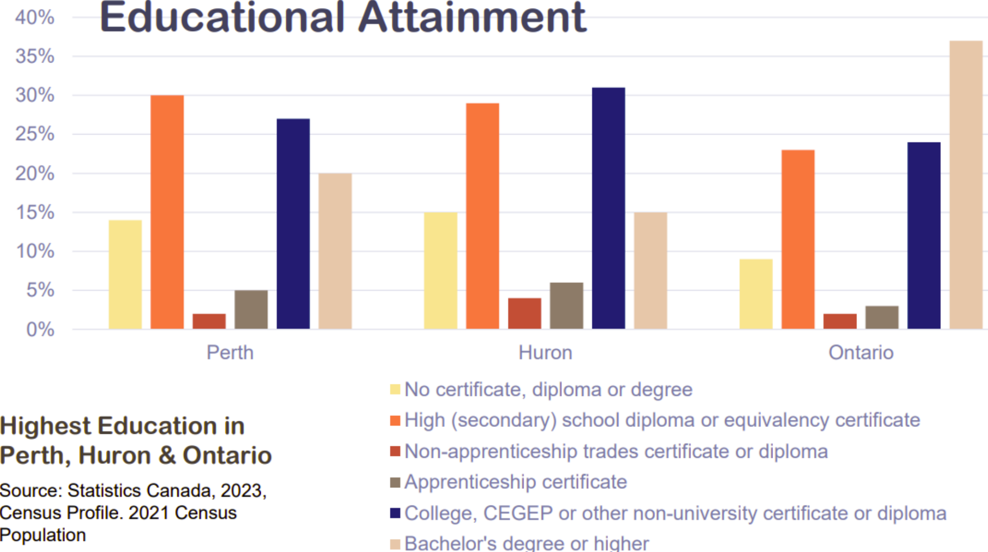
Ontarians relocating is contributing to growth

Population Growth by Central Populations

Source: Statistics Canada, Census 2016 and 2021. Census subdivisions. Population and dwellings section.

Region	2016	2021	Percent Change
PERTH	**76,812**	**81,565**	***6.20%***
North Perth	13,130	15,538	*18.30%*
Perth East	12,227	12,595	*2.60%*
Perth South	3,805	3,776	*(-0.80%)*
St.Marys	7,265	7,386	*1.70%*
Stratford	31,470	33,232	*5.60%*
West Perth	8,865	9,038	*2.00%*



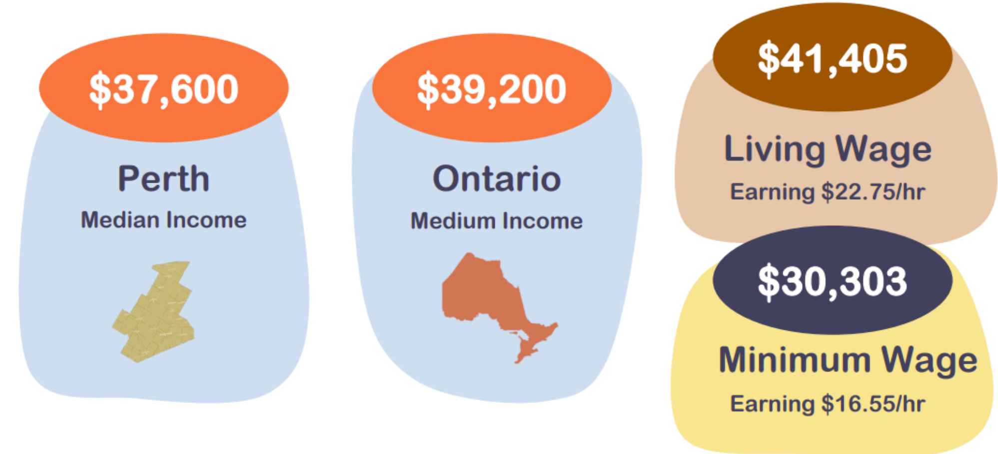


Highest Education in Perth, Huron & Ontario

Source: Statistics Canada, 2023, Census Profile. 2021 Census Population

Health Conditions and Behaviours	Perth District Health Unit	Huron County Health Unit	Ontario
Overweight or obese	61%	63%	53%
Arthritis	21%	23%	17%
Diabetes	8%	6%	7%
High blood pressure	23%	23%	18%
Pain or discomfort; moderate or severe	17%	16%	14%
Chronic obstructive pulmonary disease	4%	8%	4%
Current smoker; daily or occasional	20%	22%	19%
Heavy drinking	17%	18%	17%
Leisure-time physical activity; moderately active or active	49%	58%	54%
Fruit and vegetable consumption; 5 times or more per day	42%	53%	39%

HPA Demographics – Employment, Income, Poverty



Historically, Perth-Huron Has One of the Lowest Unemployment Rates in Ontario

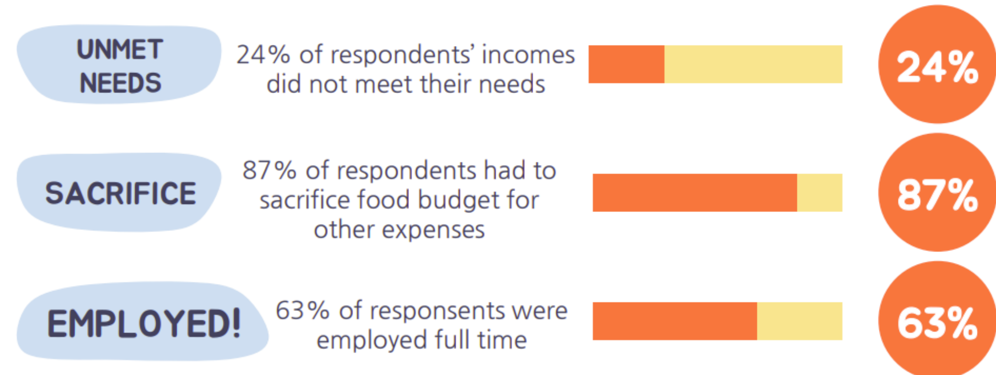
Housing Poverty and Unaffordability

14% of tenant households are in **core housing need**

14% of tenants live in **subsidized housing**

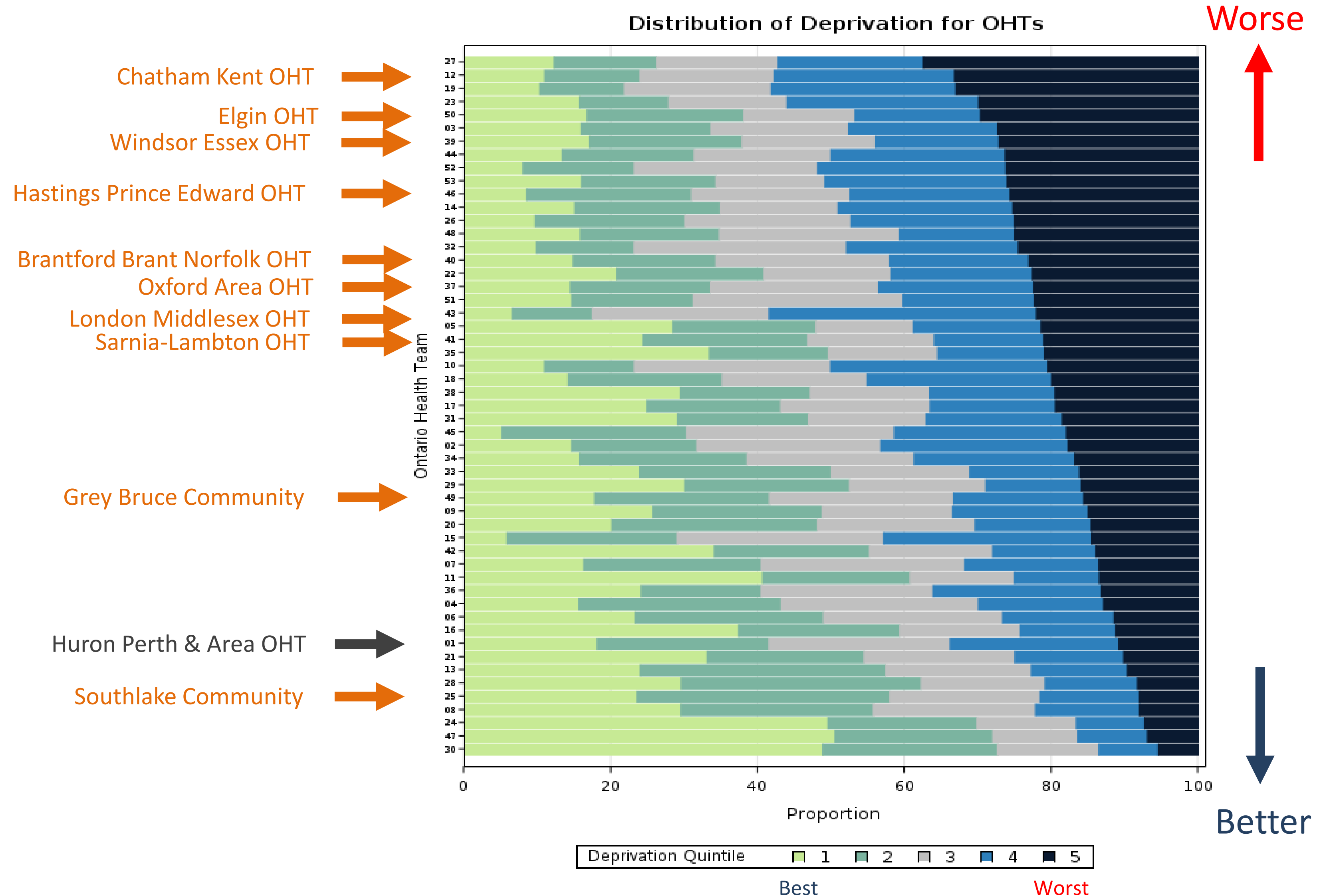
Core Housing: Housing in some combination of unaffordable, inadequate and unsuitable

Subsidized Housing: any housing made financially accessbile to low-income households



Material Deprivation Quintile

- HPA compared to benchmark OHTs
- Used to assess equity in OHT indicators across socioeconomic status
- Factors contributing to lower quintile:
  - 25-64yrs without high-school diploma
  - Lone parent families
  - total income from government transfer payments - ages 15+
  - Unemployment - ages 15+
  - Low-income families
  - Households living in dwellings in need of major repair



Proportion of OHT population according to Neighbourhood Material Deprivation

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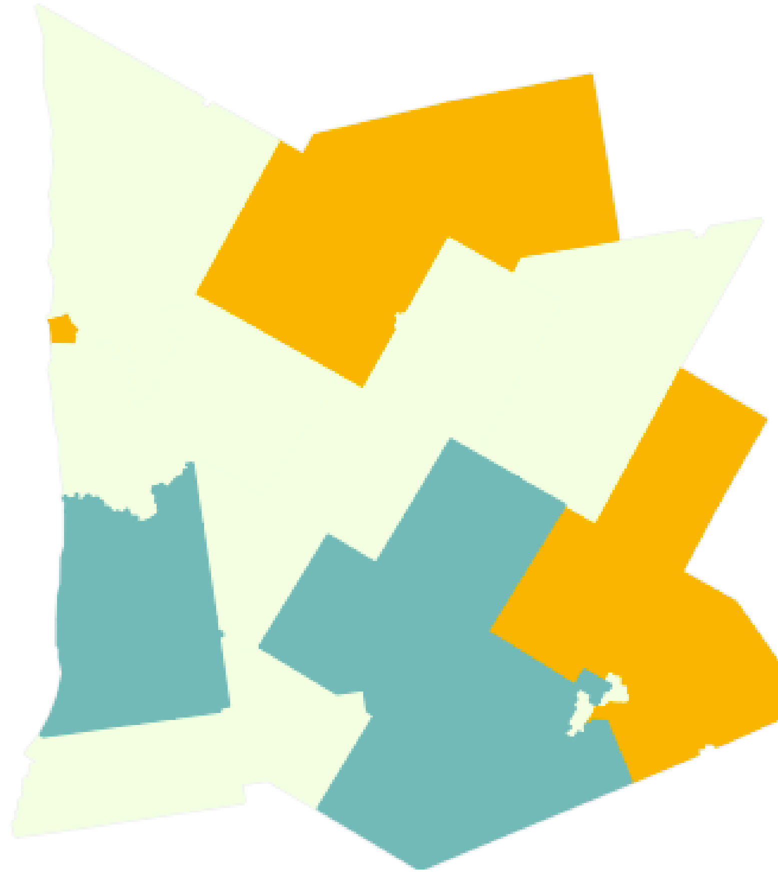
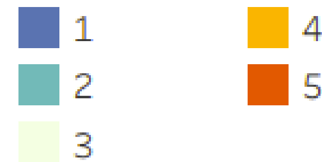
Material Deprivation within HPA (Material Resources)

Quintiles by Aggregated Dissemination Area



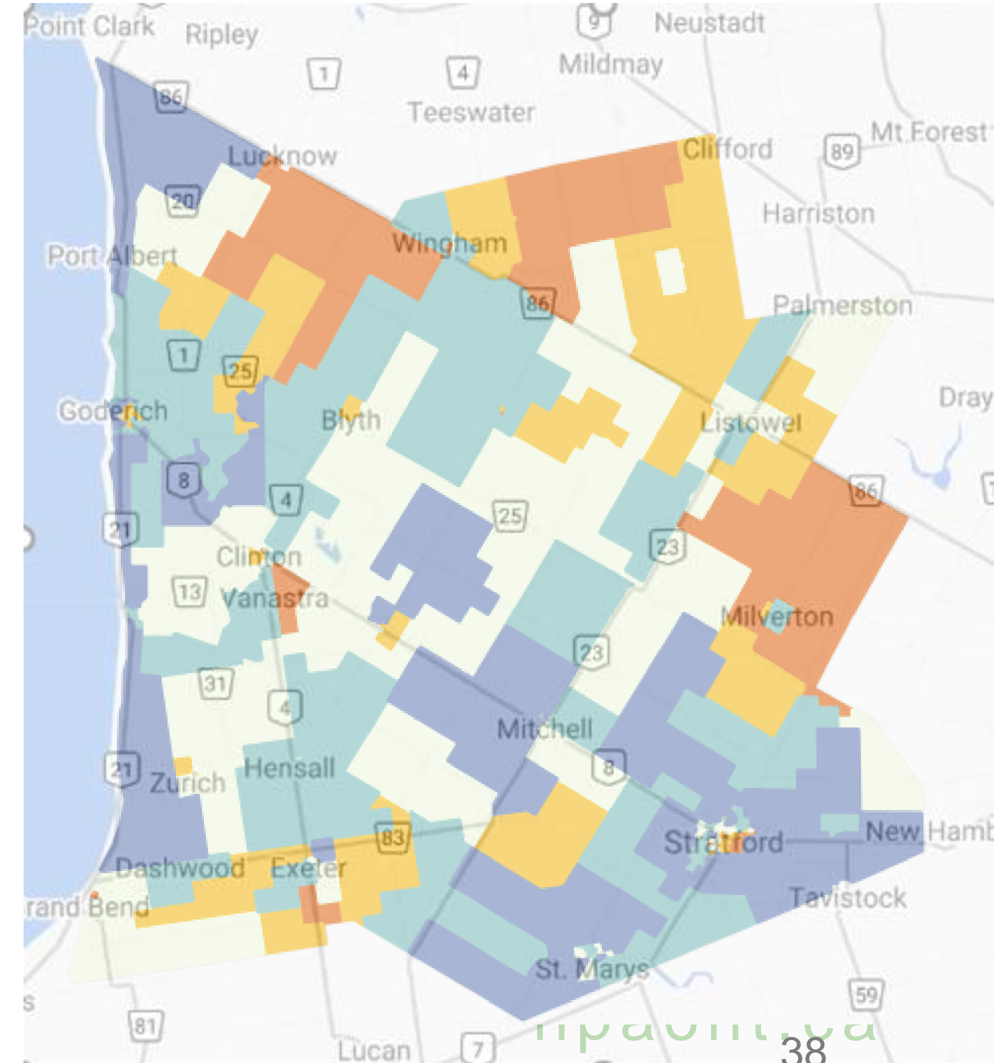
MARGINALIZATION QUINTILES



LEGEND:

1 - Least Marginalized to
5 - Most Marginalized

Quintiles by Dissemination Area



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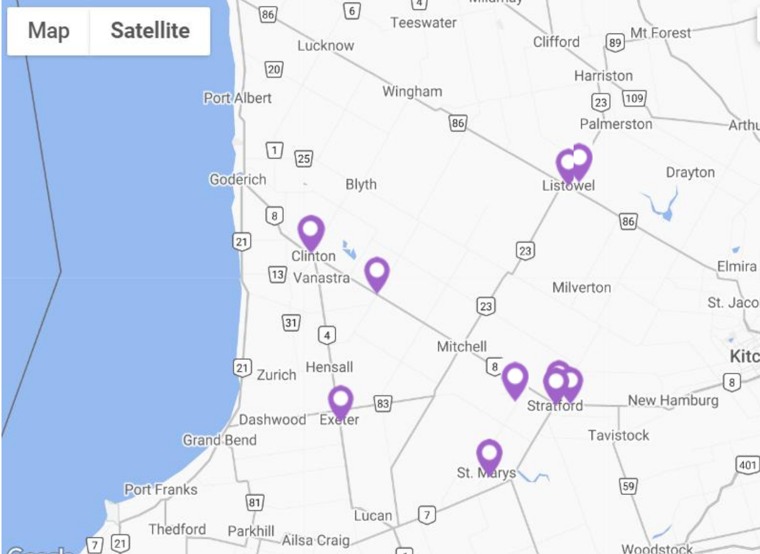
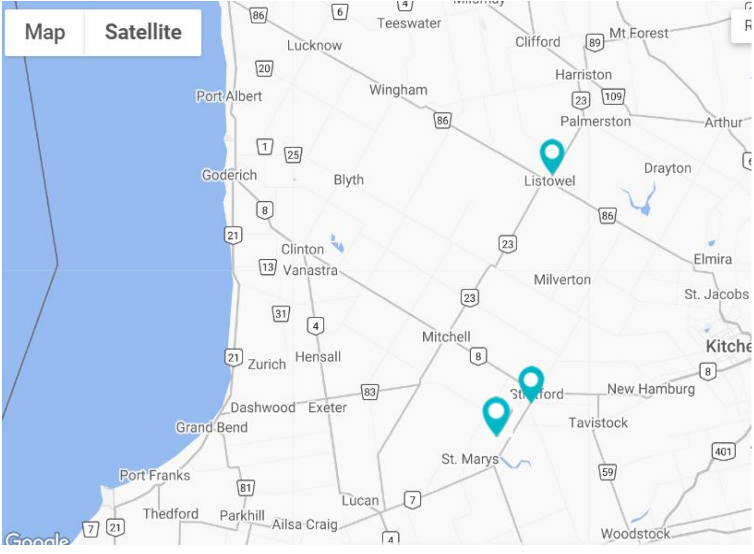
Health Care Services By Geography & Sector

(Only Partners/Collaborating Partners listed, Limited to organizational locations not program/service locations)

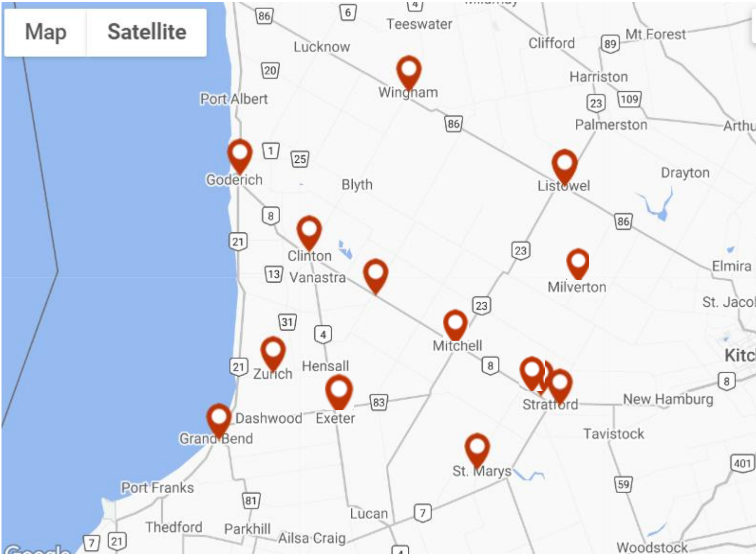


Community Support

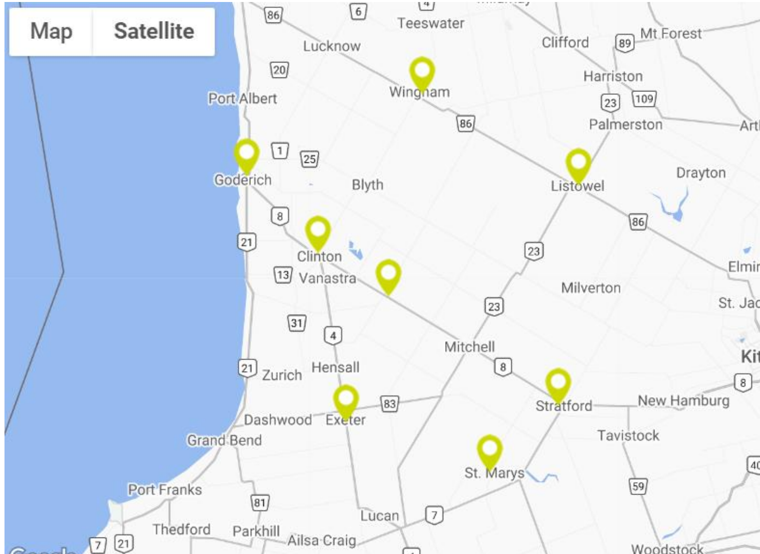
MH&A



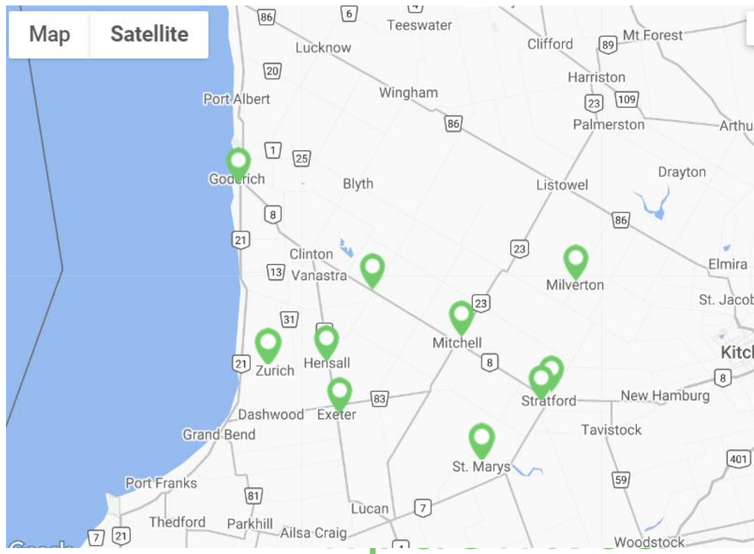
Home Care



Primary Care



Hospitals



LTC

Data Set 2) Health Outcomes – Provincial Benchmarking

- Reports: HSPN Report – Spider Diagrams – 2022 & 2023 (full report www.hspn.ca)
- Data sets: Population Health, MH&A, Older/Frail Adult care, Palliative/EOL care (25 KPIs)
- Purpose: Indicators reflect our OHT's population health and our collective healthcare system performance, not a specific institution or organization. Helpful in identifying key areas our OHT is lagging in the province and highlights comparable OHTs who perform better on each KPI

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

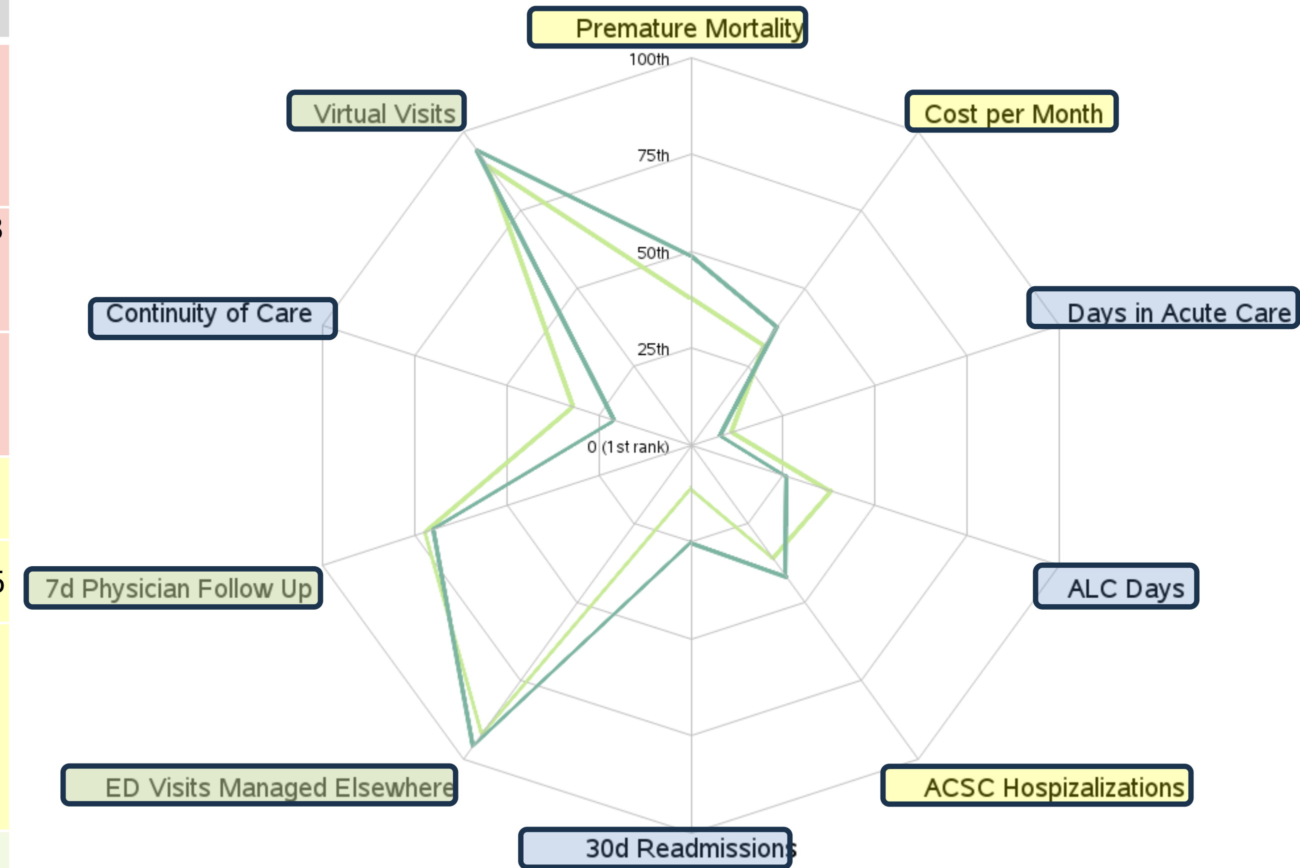
Palliative & End-of-Life Care

- 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 for Total Population Indicators

Interpretation & benchmark to better performing OHTs:

Indicator Name	Indicator Definition	Desired Direction	HPA	Benchmark OHTs
ED Visit Managed Elsewhere	Rate of emergency visits that could be treated in alternative setting like primary care	Lower	41.4	Windsor: 2.1 CK: 10.1 Southlake: 10.3 London: 13.2
Virtual Visits	Proportion of healthcare visits conducted virtually	Higher	47.7	Southlake: 65.3 Windsor: 58.5 London: 56.7
7D Physician Follow-up	Percentage of pts who see a physician within 7 days of hospital discharge for care continuity	Higher	26.0	Southlake: 35.9 Windsor: 34.4 Brantford: 30.7
Premature Mortality	Rate of death before the age of 75 (per 100,000 population)	Lower	420	Southlake: 316 London: 390
Cost per Month	Avg gov't healthcare spend per patient per month for the OHT pop	Lower	384	Southlake: $345
ACSC Hospitaliza-tions	Rate of hospitalizations for ambulatory care-sensitive conditions - often preventable with proper outpatient care for chronic conditions (per100,000 population)	Lower	321	Southlake: 295
ALC Days	Number of days a patient occupies a hospital bed while waiting for another care setting	Lower	15.3	Chatham K: 9.6 Elgin : 12.0 Sarnia L: 13.6
30D Readmission	Percentage of pts readmitted to hospital within 30days of discharge	Lower	13.7	Oxford: 13.2
Continuity of Care	Proportion of pts receiving care from same provider/team	Higher	0.63	Oxford: 0.64
Days in Acute Care	Days pts spend in acute care	Lower	8.0	Elgin: 7.3



Being at the center is best. Furthest (100th) is worst OHT

Top Performer Avg Performer Low Performer (Opportunity)

----- **2021/22 performance compared to other OHTs**

----- **2022/23 performance compared to other OHTs**

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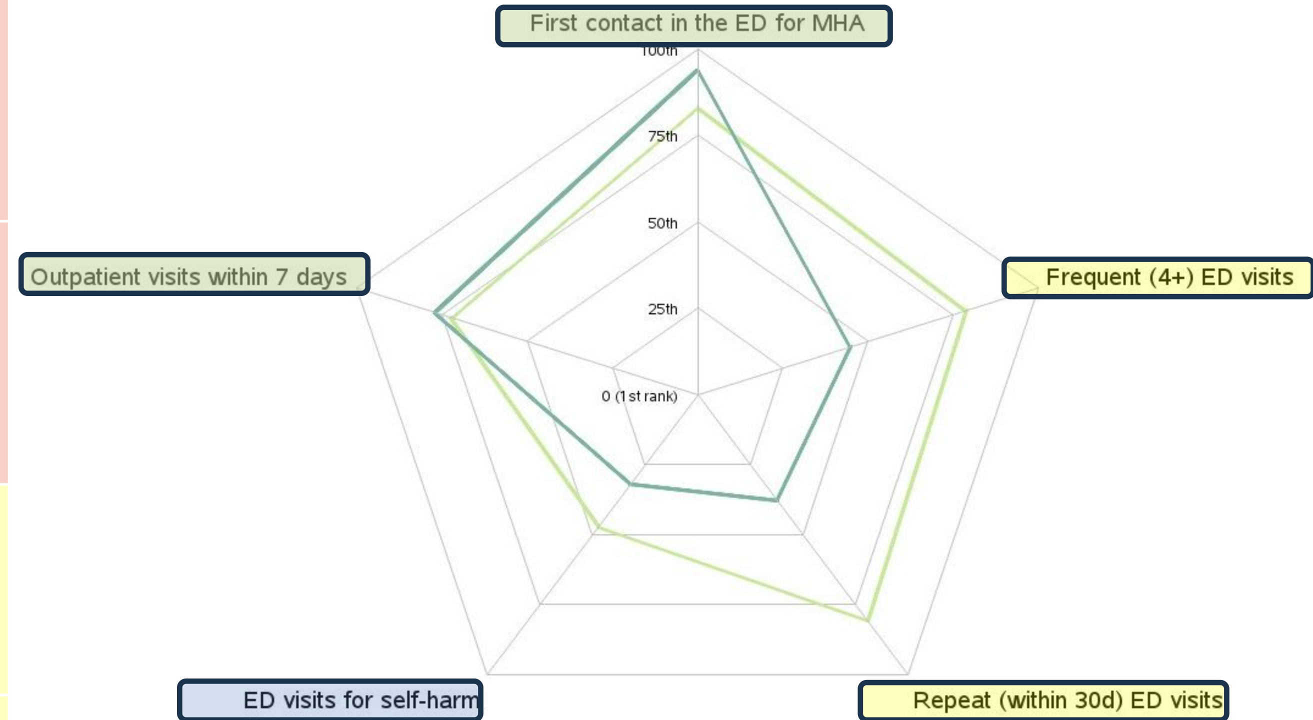
Spider Diagrams for MHA Indicators

Interpretation & benchmark to better performing OHTs:

Indicator Name	Indicator Definition	Desired Direction	S-L	Benchmark OHTs
First contact in the ED for MHA	Percentage of MHA cases where the ED is the first point of contact	Lower	44.1	Windsor: 32.6 Brantford: 34.1 CK: 35.5 London: 36.6
Outpatient Visits within 7d of MHA Hospital Discharge	Percentage of MHA patients who have an outpatient visit within 7 days of hospital discharge	Higher	18.5	Brantford: 28.7 Windsor: 28.4 London: 25.1 Oxford: 25.0
Frequent (4+) ED Visits for MHA	The percentage of patients with MHA issues who visit the ED 4 or more times/year	Lower	9.7	Oxford: 6.5 CK: 8.1 Hastings: 8.6
Repeat ED Visits within 30d for MHA	Percentage of mental health and addiction patients who return to the ED within 30 days of the initial visit	Lower	21.4	Sarnia L: 16.3 Windsor: 17.2 Oxford: 17.6
Rate of ED Visits for Deliberate Self-Harm	The rate of ED visits due to deliberate self-harm (per 100,000 population)	Lower	15.7	Southlake: 15.5



Being at the center is best. Furthest (100th) is worst OHT

Top Performer | Avg Performer | Low Performer (Opportunity)

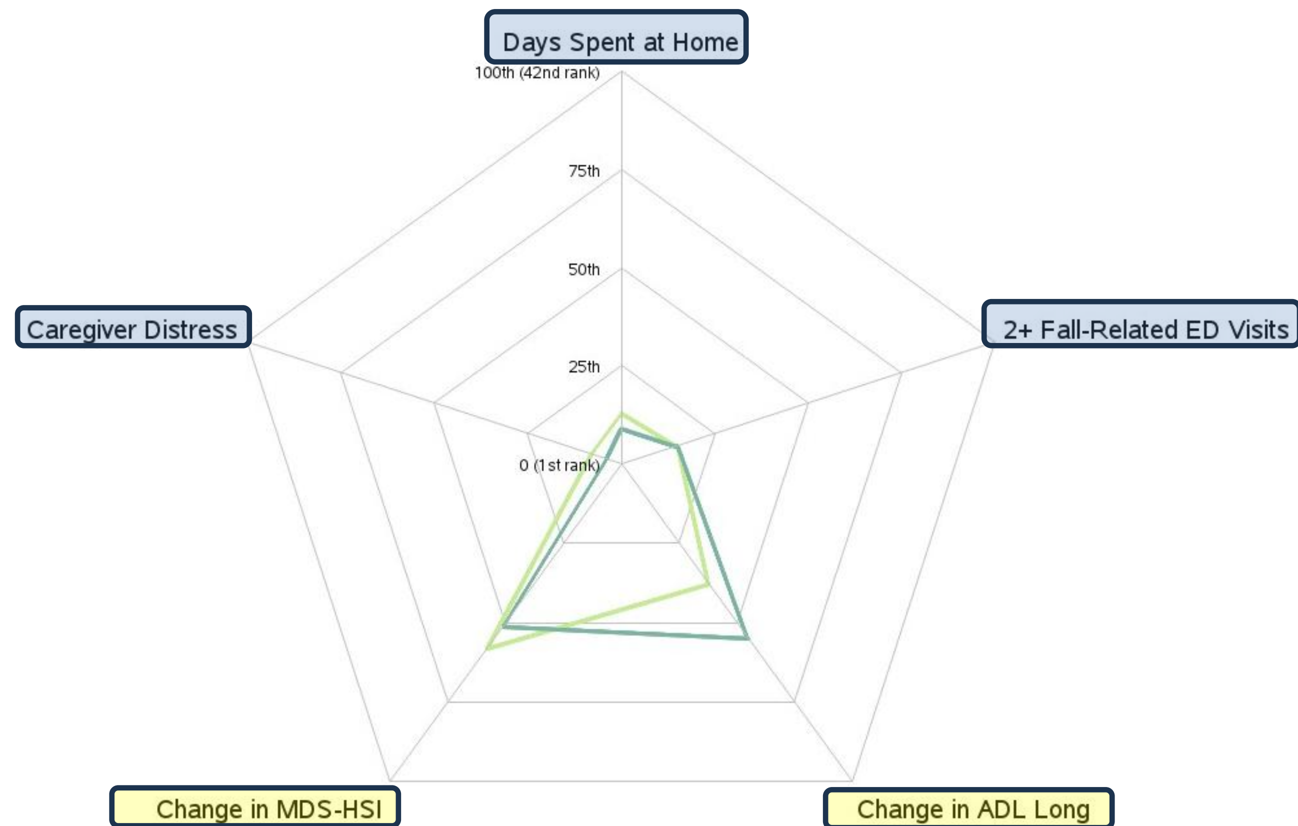
----- **2021/22 performance compared to other OHTs**

----- **2022/23 performance compared to other OHTs**

Spider Diagrams for Frail/Older Adults

Interpretation & benchmark to better performing OHTs:

Indicator Name	Indicator Definition	Desired Direction	HPA	Benchmark OHTs
Change in ADL Long Form	The change in patients' ability to perform Activities of Daily Living - assessed using a comprehensive evaluation tool	Higher	2.36	Sarnia L: 3.37 Brantford: 3.14 Hastings: 3.11 CK: 3.10
Change in MDS-HSI	The change in the summary score of overall health for patients who receive an interRAIHC assessment	Higher -ve value	-0.04	Oxford : -0.06 Brantford: -0.06
2+ Fall-related ED Visits (among frail)	Percentage of frail patients who have 2 or more fall-related ED visits in a year	Lower	2.0	None in benchmark group
Days at Home (among frail)	Number of days frail patients spend at home rather than in a healthcare facility	Higher	355	CK: 356
Caregiver Distress	Percentage of caregivers who report experiencing distress	Lower	37.1	Elgin: 35.7



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Top Performer   Avg Performer   Low Performer (Opportunity)

------ **2021/22 performance compared to other OHTs**

------ **2022/23 performance compared to other OHTs**

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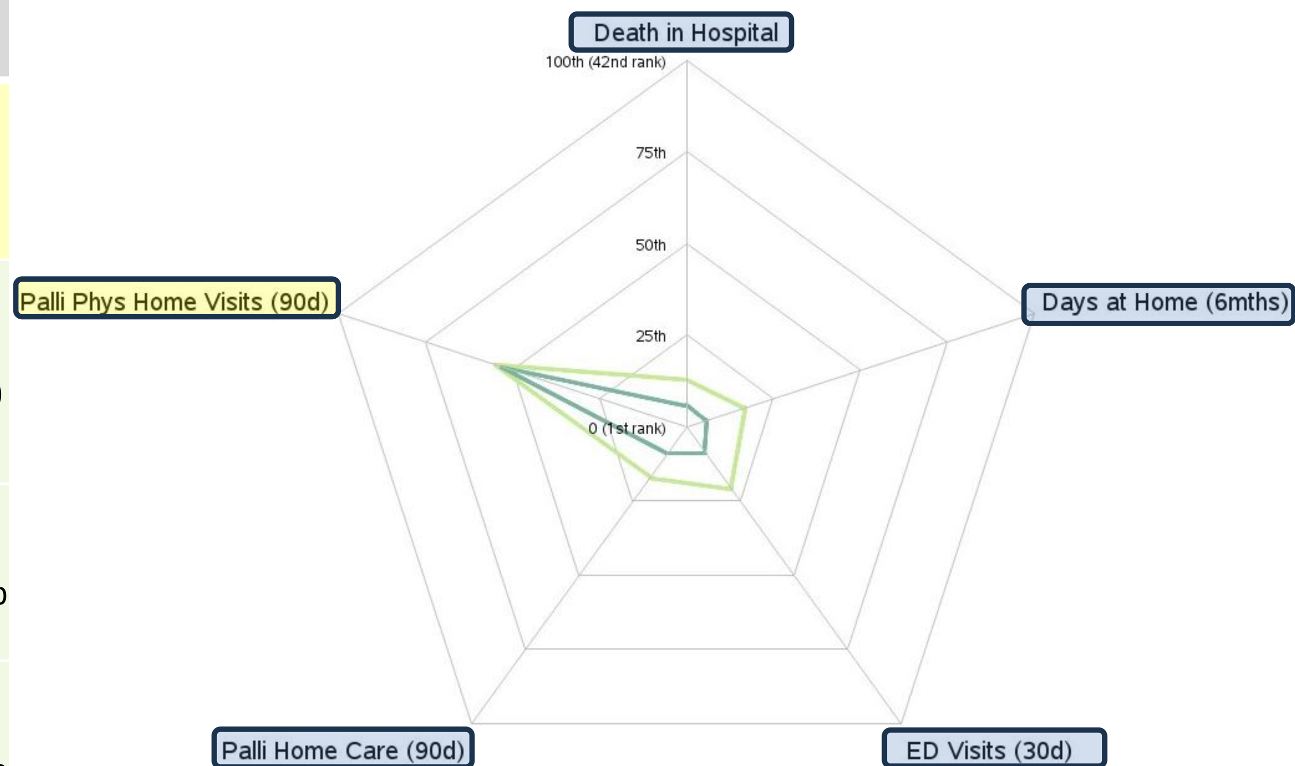
Spider Diagrams for End-of-life Indicators

Interpretation & benchmark to better performing OHTs:

Indicator Name	Indicator Definition	Desired Direction	S-L	Benchmark OHTs
Palliative Home Care in the Last 90 Days of Life	Percentage of patients receiving at least one home-based palliative care visit in the last 90 days of Life	Higher	30.3	None in benchmark group
Palliative Physician Home Visits in the Last 90 Days of Life	Percentage of patients receiving physician home visit or consult for palliative care in the last 90 days of life	Higher	25.2	SL: 30.6 Oxford: 29.5 Southlake: 29.0 GB: 28.9
ED Visit in the Last 30 Days of Life	Percentage of patients who visit the ED in the last 30 days of life.	Lower	50.8	None in benchmark group
Deaths in Hospital	Percentage of deaths occurring in the hospital as opposed to home or other setting	Lower	39.8	None in benchmark group
Days at Home in the Last 6 Months of Life	Number of days a patient spends at home during the last 6 months of life.	Higher	165	None in benchmark group



Being at the center is best. Furthest (100th) is worst OHT

Top Performer | Avg Performer | Low Performer (Opportunity)

----- **2021/22 performance compared to other OHTs**

----- **2022/23 performance compared to other OHTs**

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Data Set 3) Health Outcomes – Annual Trend and Catchment Analysis

- Reports: IDS, OHT Dashboards (cQIP, Community Care, Primary Care, Home Care) - 2018/19 – 2023/24

- Data Sets: ED utilization, ALC, Home Care, Primary Care Unattached

- Purpose Indicators reflect our OHT's population health and our collective healthcare system performance, not a specific institution or organization (e.g. accessing the hospital ED for services better received elsewhere or being in an ALC bed rather than receiving the required care in a more suitable setting is a reflection on the collective system not just the hospital). Need to understand root causes and address the gaps in the system to free up resources. Also, understanding trends over time indicates whether we are improving or deteriorating.

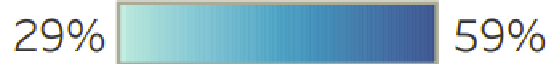
ED avoidance 2018/19-2023/24

All Patients	FY1819	FY1920	FY2021	FY2122	FY2223	FY2324
CTAS 4 & 5 ED Visit Rate	51.5%	47.9%	43.9%	43.5%	44.1%	43.1%
Best Managed Elsewhere Rate	7.7%	6.8%	3.3%	4.0%	6.8%	6.3%
ED Visits Indicating No Access to Primary Care Rate	6%	7%	9%	7%	7.4%	8.0%
ED Visits	98,544	96,171	70,361	84,319	96,852	102,419
ED Visits Indicating No Access to Primary Care	6225	6478	5983	5865	7135	8,238

Transitions in Care for Frail Seniors (Age >=65, 4+ Chronic/High-Cost Conditions)	FY1819	FY1920	FY2021	FY2122	FY2223	FY2324
CTAS 4 & 5 ED Visit Rate	40.0%	37.0%	33.0%	33.0%	34.0%	32.3%
Best Managed Elsewhere Rate	1.5%	1.5%	0.8%	0.9%	1.0%	0.8%
ED Visits Indicating No Access to Primary Care Rate	2.5%	2.3%	2.8%	2.2%	2.3%	2.7%
ED Visits	13,945	14,019	11,816	13,266	14,177	14,907
ED Visits Indicating No Access to Primary Care	347	329	335	298	329	407

ED Utilization Appropriateness by geography

CTAS 4 & 5 ED Visit Rate



Best Managed Elsewhere ..

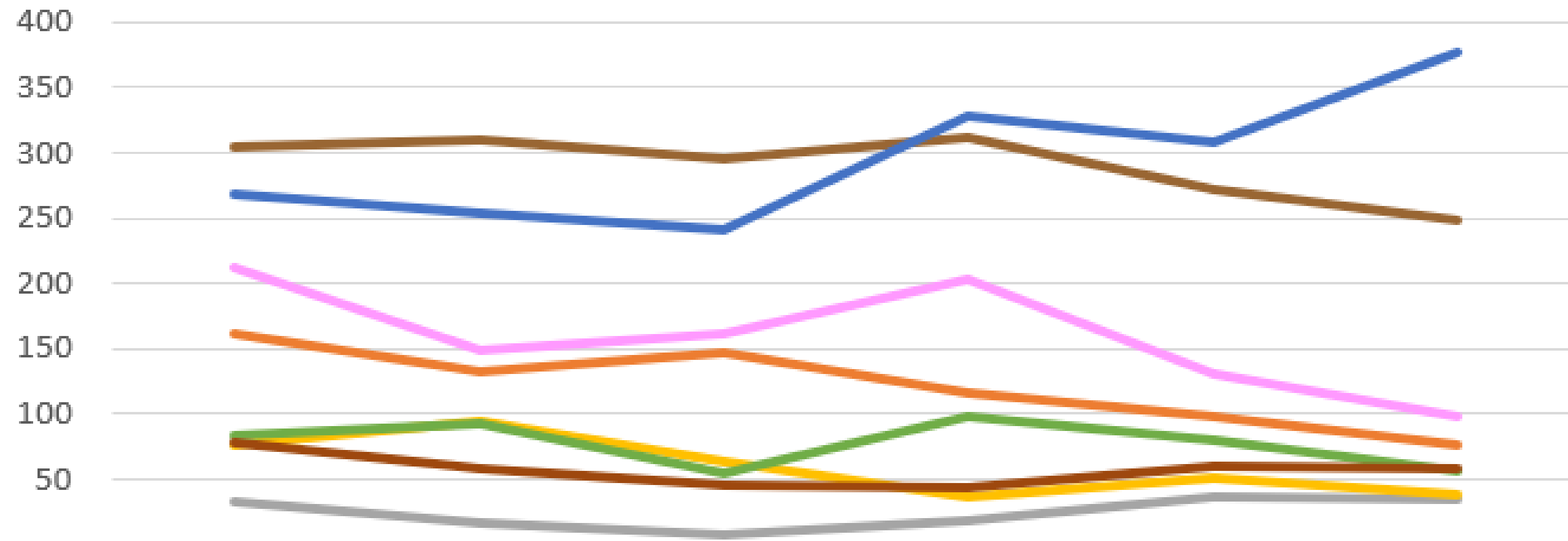
Readmissions 2018/19-2023/24

All Patients	FY1819	FY1920	FY2021	FY2122	FY2223	FY2324
Inpatient Acute Discharges	14,494	14,148	12,381	12,828	13,789	13,976
Urgent Readmissions within 30 Days	1,781	1,791	1,506	1,634	1,753	1,966
% Readmissions	12.3%	12.7%	12.2%	12.7%	12.7%	14.1%

Transitions in Care for Frail Seniors (Age >=65, 4+ Chronic/High-Cost Conditions)	FY1819	FY1920	FY2021	FY2122	FY2223	FY2324
Inpatient Acute Discharges	4,654	4,813	4,149	4,407	5,031	5,261

ALC Analysis

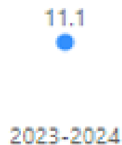
ALC by Discharge Destination HP&A OHT



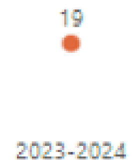
	FY1819	FY1920	FY2021	FY2122	FY2223	FY2324
Complex Continuing Care Bed	304	310	295	311	272	249
Home - with CCAC Services	162	133	147	117	98	77
Home - with Community Services	32	17	7	18	36	35
Home - without Services	77	94	63	36	51	38
Long Term Care Bed (LTC)	269	254	241	329	309	377
Palliative Care Bed	83	93	54	98	80	57
Rehabilitation Bed	213	148	162	203	131	98
Supervised or Assisted Living	79	58	45	43	60	58

Home Care Services

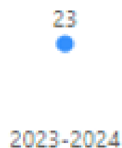
Average Wait Time (in Days) for first Home Care Service from Hospital



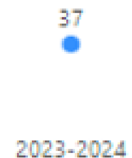
Average Wait Time (in Days) for first Home Care Service from Community



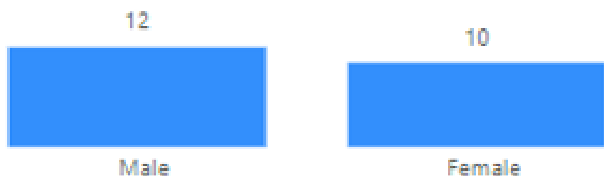
90 th Percentile Wait Time (in Days) for first Home Care Service from Hospital



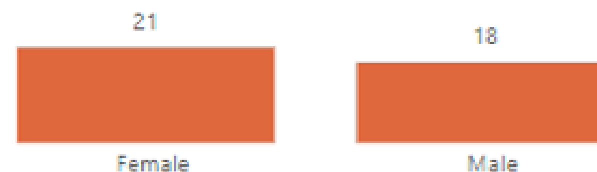
90 th Percentile Wait Time (in Days) for first Home Care Service from Community



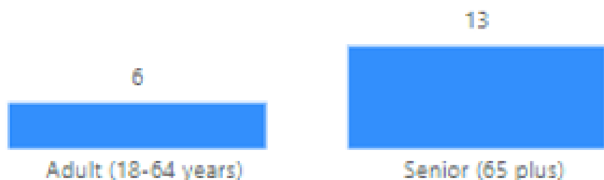
Average Wait Time (in Days) for first Home Care Service from Hospital by Sex



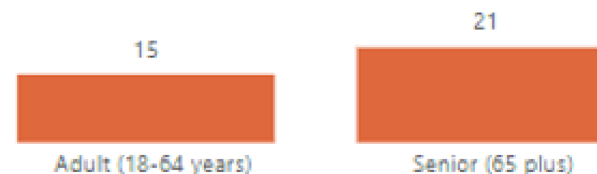
Average Wait Time (in Days) for first Home Care Service from Community by Sex



Average Wait Time (in Days) for first Home Care Service from Hospital by Age

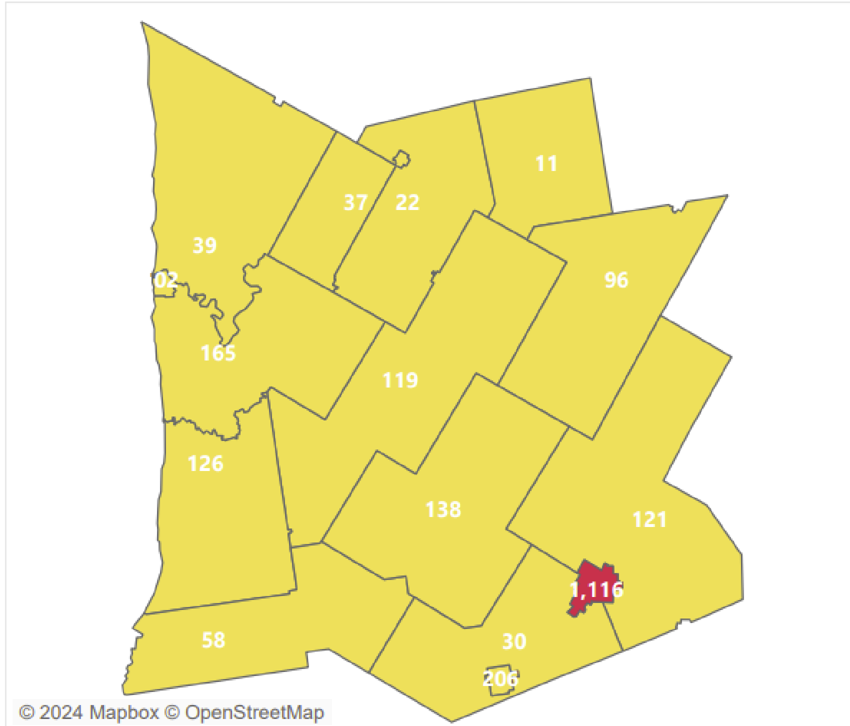


Average Wait Time (in Days) for first Home Care Service from Community by Age



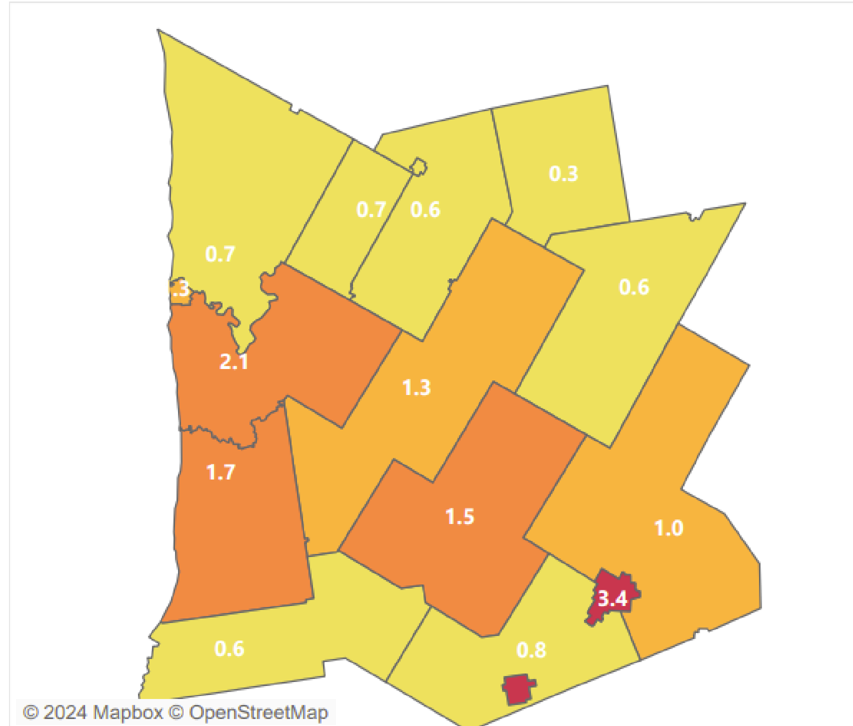
Unattached Patients at time of ED visit

Unattached Patients (CSD)



Distinct Patients

Unattached Patient Rate per 100 Population (CSD)



Unattached Patient Rate Per 100

NAC Census Division Name	NAC Census Subdivision Name	Distinct Patients	Rate
Huron	Central Huron	165	2.1
	Bluewater	126	1.7
	Goderich	102	1.3
	Huron East	119	1.3
	North Huron	37	0.7
	Ashfield-Colborne-Wawanosh	39	0.7
	Morris-Turnberry	22	0.6
	South Huron	58	0.6
	Howick	11	0.3
Perth	Stratford	1,116	3.4
	St. Marys	206	2.8
	West Perth	138	1.5
	Perth East	121	1.0
	Perth South	30	0.8
	North Perth	96	0.6

Note: **Access to Primary Health Care Code** in NACRS (Field 129) identifies if a patient has access to primary health care, either through a Family Physician, Family Health Team, Walk-in Clinic or in other settings. **Unattached Patients** have been defined as those indicating "None" for this field based on their last record in the analytical cohort.

Source: IDS, NACRS