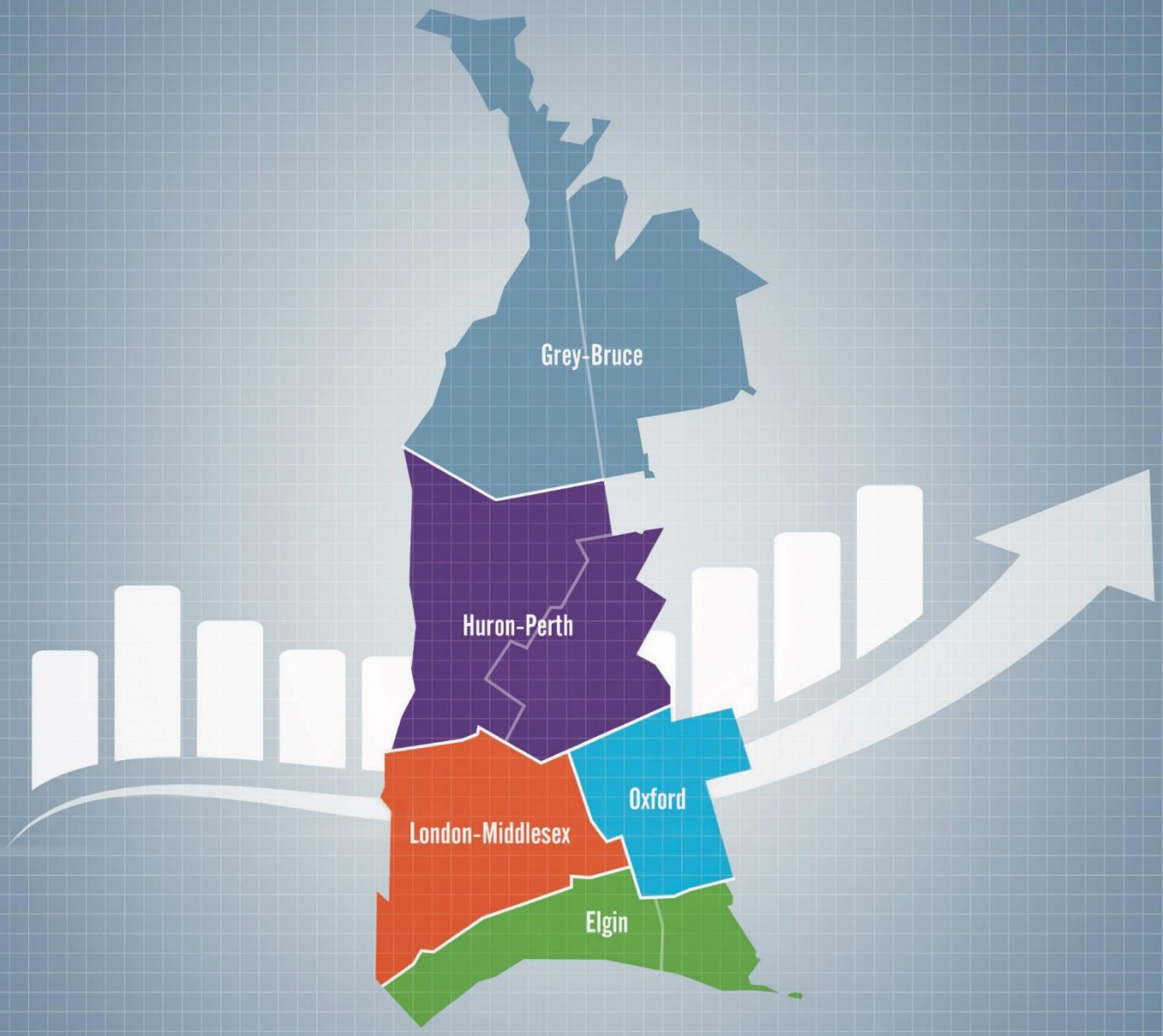
South West **LHIN**



REPORT ON PERFORMANCE

Technical Specifications

Quality care, improved health, better value

Ontario
South West Local Health Integration Network

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Icon Legend

The following icons are used throughout the document to show alignment to Integrated Health Service Plan (IHSP) Big Dots or IHSP Priorities:

	Big Dot or Big Dot Component
	Primary Health Care Priority Measure
	Home, Long-Term Care and Community Care Priority Measure
	Preventing and Managing Chronic Conditions Priority Measure
	Mental Health and Addiction Services Priority Measure
	Hospital-Base Care Priority Measure
	Rehabilitative Services Priority Measure
	Hospice Palliative Care Priority Measure

The following icons are used throughout the document to show alignment to factors that prioritized measures as important for inclusion in IHSP performance monitoring:

	Ministry-LHIN Accountability Agreement (MLAA) Measure
	Shared System Measure
	Service Accountability Agreement (SAA) Measure
	Quality Improvement Plan (QIP)

The Big Dots

1. Self-Reported Health Status

Definition	Percentage of South West LHIN respondents aged 12 and over who rated their general health as “Excellent” or “Very Good”.		
South West LHIN Data Source	Canadian Community Health Survey, LHINs Share File.		
Calculation	Numerator	Weighted # of South West LHIN respondents aged 12 and over who rated their health as “Excellent” or “Very Good”	x 100
	Denominator	Weighted number of survey respondents	
Inclusions	• N/A		
Exclusions	• Residents outside of South West LHIN.		
Timing/Frequency of Release	• Data is updated every 2nd year beginning in 2015/16 and represents survey responses in the year of response. Data lag is approximately 1½ years from the original survey date.		
Levels of Geography for Comparison	• Data are currently available at the Sub-Region, LHIN and provincial levels.		
Limitations	• Survey is conducted and shared every 2 years. • Longitudinal survey closed in 2014; findings after 2014 cannot be linked over time. • Information may be up to two years old by the time it is received at the LHIN. • Responses must be weighted or bootstrapped by the LHIN population weights calculated and sent by Statistics Canada.		

2. Faster Access to Care in the Community

Definition	Proportion of key indicators reflecting reduced wait times for key community services across the health care system in the South West LHIN.
South West LHIN Data Source	*Wait Time for Mental Health Case Management:* ConnexOntario. *Personal Support Worker (PSW) Within 5 Days:* Health Analytics Branch, MOHLTC.. *Timely Access to a Primary Care Provider :* Health Care Experience Survey, MOHLTC.
Calculation	*Wait Time for Mental Health Case Management* 1. Establish IHSP goal by subtracting the IHSP target wait time (21 Days) from the baseline wait time (29 days). 2. Determine current wait time for MH Case Management (see pg.14). 3. Subtract current wait time from baseline wait time to determine the current difference. 4. Divide current difference (Step 3) by IHSP goal (Step 1) to determine progress made toward the target wait time in the current quarter.

	Personal Support Worker (PSW) Within 5 Days 5. Establish IHSP goal by subtracting the IHSP target performance (determined by Ministry-LHIN Accountability Agreements) from the baseline performance. 6. Determine current quarterly performance for 5 day wait time for personal support worker services (see pg. 11). 7. Subtract current performance from baseline performance to determine the current difference. 8. Divide current difference (Step 3) by IHSP goal (Step 1) to determine progress made towards target performance in the current quarter, expressed as a percentage out of 100. *Timely Access to a Primary Care Provider* 9. Establish IHSP goal by subtracting the IHSP target performance (47%) from the baseline performance (38.6%). 10. Determine current quarterly performance for same/next day access to a primary care provider when sick (see pg. 10). 11. Subtract current performance from baseline performance to determine the current difference. 12. Divide current difference (Step 3) by IHSP goal (Step 1) to determine progress made towards target performance in the current quarter, expressed as a percentage out of 100. *Calculating the Big Dot* 13. Determine composite progress to date by summing the values obtained from Steps 4, 8 and 12 above, across the three component indicators. 14. Divide composite progress to date (Step 13) by 3 to express composite progress to date as a percentage out of 100.
Inclusions	• See pg. 14 (*Wait Time for Mental Health Case Management*), pg. 11 (*Personal Support Worker Within 5 Days*) and pg. 10 (*Timely Access to a Primary Care Provider*) for detailed inclusions.
Exclusions	• See pg. 14 (*Wait Time for Mental Health Case Management*), pg. 11 (*Personal Support Worker Within 5 Days*) and pg. 10 (*Timely Access to a Primary Care Provider*) for detailed inclusions.
Timing/Frequency of Release	• Data is updated quarterly; timely access to a primary care provider is lagged one quarter behind the reporting quarter.
Levels of Geography for Comparison	• Data is provided at the South West LHIN level.
Limitations	• Each of the three component indicators are comprised of measures expressed in differing units: average wait time for mental health case management is expressed in days while PSW support and timely access to a primary care provider are expressed as a percentage of residents who received care in a timely manner. The component calculations described above are used to convert each indicator to a common denominator, where progress is expressed as a percentage towards achievement of target wait times. • The data on timely access to a primary care provider is lagged one quarter behind the others two wait time measures. • This big dot is restricted to exploring faster access to specific pockets of community based health care and service delivery. It does not necessarily reflect or imply faster access across the health care system.

3. Satisfaction with Health Care in the Community

Definition	Percentage of adults age ≥16 residing in the South West LHIN's geographic boundaries who are very or somewhat satisfied with health care in their community.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Health Care Experience Survey (HCES); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

4. Value Realized by Reducing Hospital Visits and Days

Definition	Savings realized by reducing unnecessary visits and admissions to the hospital.
South West LHIN Data Source	*Readmissions Within 30-Days for Selected HIG Conditions:* See pg. 14. *Emergency Visits Best Managed Elsewhere:* See pg. 10. *Hospitalizations for Ambulatory Care Sensitive Conditions:* See pg. 14.
Calculation	*Value Realized by Reducing Excess Readmissions* 1. Determine the baseline average number of readmissions per quarter for select HIG conditions in the South West LHIN, using the actual number of readmissions reported for LHIN residents in the most recent 4 quarters of available data. 2. Determine the baseline number of readmissions expected in the South West LHIN given the clinical complexity of hospitalized residents, using the most recent 4 quarters of data. 3. Take the actual number of readmissions and subtract the expected number of readmissions to determine the average number of 'excess' readmissions per quarter at baseline. 4. Multiply Step 3 – baseline excess readmissions by the baseline average length of stay for readmission in the South West LHIN (9.1 days) and the baseline estimated direct cost per hospital day stayed in the South West LHIN ($1,112) to determine the baseline excess cost spent on readmissions each quarter at the beginning of IHSP4 ($151,788). 5. IHSP goal for readmissions is for the actual number of readmission each quarter to equal the expected number of readmissions, equating to 0 excess readmissions. 6. Total Targeted IHSP Savings = baseline excess cost (Step 4) multiplied by 12 quarters of potential savings: $1,821,456. 7. Determine the current actual number of readmissions for select HIG conditions in the South West LHIN in the time period of interest. 8. Determine the current number of readmissions expected in the South West LHIN in the time period of interest, given the clinical complexity of hospitalized residents. 9. Take the actual number of readmissions and subtract the expected number of readmissions. 10. Multiply Step 9 – the number of 'Excess readmissions' seen in the quarter of interest - by the baseline average length of stay for readmission in the South West LHIN (9.1 days) and the baseline estimated direct cost per hospital day stayed in the South West LHIN ($1,112) to determine the current excess cost spent on readmissions in the time period of interest. 11. Take the cost determined in Step 10 and subtract this current cost spent on excess readmissions from the baseline cost of excess readmissions calculated in Step 4 ($151,788).

12. Determine cumulative value added to date by taking the current cost determined in Step 11 and where relevant, add to any previous costs calculated from previous quarter's cost determined between fiscal 2016 - fiscal 2018.
13. Calculate cumulative progress made towards the IHSP goal to date by taking the cumulative value calculated in Step 12 and dividing by Total Targeted IHSP Savings (Step 6).

Value Realized by Reducing Emergency Visits Best Managed Elsewhere

14. Determine the baseline average number of ED visits best managed elsewhere per quarter in the South West LHIN, using the number of ED visits best managed in alternative primary care settings in the most recent 4 quarters of available data.
15. Multiply Step 14 – baseline avoidable ED visits by the baseline estimated direct cost per ED visit in the South West LHIN ($180) to determine the baseline excess cost spent on avoidable ED visits each quarter at the beginning of IHSP4 ($1,662,660).

16. Determine IHSP goal for avoidable ED visits (3 year step-down to ideal target)
17. Total Targeted IHSP Savings = Target ED visits/quarter (Step 16) multiplied by direct cost/ED visit ($180) multiplied by 12 quarters of potential savings ($2,477,520).

18. Determine the current number of avoidable ED visits in the South West LHIN in the time period of interest.
19. Multiply Step 18 – the number of avoidable ED visits seen in the quarter of interest - by the baseline estimated direct cost per ED ($180) to determine the current excess cost spent on avoidable ED visits in the time period of interest.
20. Take the cost determined in Step 19 and subtract this current cost spent on excess ED visits from the baseline cost of excess ED visits calculated in Step 15 ($1,662,660).

21. Determine cumulative value added to date by taking the current cost determined in Step 20 and where relevant, add to any previous costs calculated from previous quarter's cost determined between fiscal 2016-fiscal 2018.
22. Calculate current progress made towards IHSP goal to date by taking the cost calculated in Step 21 and dividing by Total Targeted IHSP Savings (Step 17).

Value Realized by Reducing Avoidable Hospitalizations

23. Determine the baseline average number of avoidable admissions for ambulatory care sensitive conditions (ACSC) reported for LHIN residents using the most recent 4 quarters of available data.
24. Multiply Step 23 – baseline avoidable hospitalizations by the baseline average length of stay for an ACSC admission in the South West LHIN (5.2 days) and the baseline estimated direct cost per hospital day stayed in the South West LHIN ($1,112) to determine the baseline excess cost spent on avoidable hospitalizations each quarter at the beginning of IHSP4 ($5,001,776).

25. Determine IHSP goal for avoidable hospitalizations (3 year step-down to target).
26. Total Targeted IHSP Savings = Target ACSC hospitalizations (Step 25) multiplied by the average length of stay at baseline for an ACSC hospitalization (5.2 days) multiplied by the direct cost/hospital day stayed at baseline ($1,112) multiplied by 12 quarters of potential savings ($7,424,602).

27. Determine the current actual number of hospitalizations for ACSC in the South West LHIN in the time period of interest.

	28. Multiply Step 27 – the number of avoidable hospitalizations seen in the quarter of interest - by the baseline average length of stay for an ASCS hospitalization in the South West LHIN (5.2 days) and the baseline estimated direct cost per hospital day stayed in the South West LHIN ($1,112) to determine the current excess cost spent on avoidable hospitalizations in the time period of interest. 29. Take the cost determined in Step 28 and subtract this current cost spent on avoidable hospitalizations from the baseline cost of avoidable hospitalizations calculated in Step 2 ($5,001,776). 30. Determine cumulative value added to date by taking the current cost determined in Step 29 and where relevant, add to any previous costs calculated from previous quarter's cost determined between fiscal 2016-fiscal 2018. 31. Calculate current progress made towards the IHSP goal to date by taking the cost calculated in Step 30 and dividing by Total Targeted IHSP Savings (Step 17). *Calculating the Big Dot* 32. Determine IHSP Target savings by adding the target cost savings from each component indicator in Steps 6, 17 and 26 ($11,723,578). 33. Determine composite savings to date by summing the values obtained from Steps 12, 21 and 30 above, across the three component indicators. 34. Divide composite saving progress to date (Step 33) by IHSP Target saving (Step 32, $11,723,578) to express composite progress to date as a percentage out of 100.
Inclusions	• See pg.14 (*Readmissions Within 30-Days for Selected HBAM Inpatient Grouper (HIG) Conditions*), pg.10 (*Rate of Emergency Visits for Conditions Best Managed Elsewhere*) and pg.14 (*Hospitalization Rate for Ambulatory Care Sensitive Conditions*) for detailed inclusions.
Exclusions	• See pg.14 (*Readmissions Within 30-Days for Selected HBAM Inpatient Grouper (HIG) Conditions*), pg.10 (*Rate of Emergency Visits for Conditions Best Managed Elsewhere*) and pg.14 (*Hospitalization Rate for Ambulatory Care Sensitive Conditions*) for detailed inclusions.
Timing/Frequency of Release	• Data is updated quarterly; data is lagged by one quarter behind the reporting quarter for avoidable ED visits and hospitalizations; two quarters for 30-day readmissions.
Levels of Geography for Comparison	• Data is provided at the South West LHIN level.
Limitations	• The data on 30-day readmissions is lagged one quarter behind the others two avoidable utilization measures. • This big dot is restricted to exploring value added by reducing unnecessary visits in the acute and ambulatory care sectors. It does not necessarily imply value added across the health care system.

Primary Health Care

1. Percentage of Adults Who Were Able to See a Primary Care Provider (PCP) on the Same Day or Next Day When They Were Sick

Definition	Of South West LHIN residents who identified that they had been sick and attempted to see their primary care provider within the last twelve months, what percentage were able to see a doctor or nurse practitioner on the same day or the next day.
South West LHIN Data Source	Health Care Experience Survey (HCES); provided by Health Analytics Branch, MOHLTC.
Calculation	1. Sample a number of Ontarians through telephone surveys. Restrict to respondents residing in postal codes falling within the South West LHIN geographic boundaries. 2. Identify the number of respondents that indicated that within the last 12 months, they had attempted to see a PCP when sick (denominator). 3. Identify the number who were able to see a PCP on the same day or next day (numerator). 4. Divide the numerator by the denominator. Multiply by 100. $\frac{\text{Numerator: Patients who were able to see a PCP on the same day or next day}}{\text{Denominator: Patients who attempted to see a PCP when sick}} \times 100$
Inclusions	• Individuals who saw a primary provider in the past 12 months because they were sick or concerned with a health problem.
Exclusions	• Individuals who refuse to respond.
Timing/Frequency of Release	• Data is updated quarterly but represents 12 months (1 year) of rolling survey responses, lagged by one quarter behind the reporting quarter.
Levels of Geography for Comparison	• Data are currently available at the LHIN and provincial levels.
Limitations	• Sample sizes within each LHIN can be small with each survey cycle. As a result, results represent a rolling fiscal year of data (most recent four quarters).
Notes	• Responses are weighted by Health Analytics Branch, MOHLTC to account for the design characteristics of the survey, and are post-stratified to reflect the population of Ontario. Estimates based on fewer than 10 respondents are suppressed.

2. Rate of Emergency Visits for Conditions Best Managed Elsewhere

Definition	Rate of unscheduled emergency visits that could be treated in alternative primary care settings per 1,000 population age 1-74 years.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	National Ambulatory Care Reporting System (NACRS) • Ontario and LHIN data is provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report). • Sub-region data is retrieved from the Ambulatory Visits Main Table (NACRS); IntelliHealth Ontario, MOHLTC.

3. Percentage of Acute Care Patients Who Have Had a Follow-up With a Physician Within 7-days of Discharge

Definition	Percentage of acute care patients with a hospital stay for specific chronic conditions who saw a physician in an outpatient setting within 7 days of discharge.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Discharge Abstract Database; OHIP Claims Database; provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

Home, Long-Term, and Community Care

4. Percentage of Home Care Clients With Complex Needs Who Received Their Personal Support Visit Within 5 Days of the Date They Were Authorized for Personal Support Services

Definition	Percentage of LHIN Home Care patients with complex needs who received in-home personal support services within the Ontario five day wait time target.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Home Care Database (HCD); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

5. Percentage of Home Care Clients with Complex Needs Who Received Their Nursing Visit Within 5 Days of the Date They Were Authorized for Nursing Services

Definition	Percentage of LHIN Home Care patients with complex needs who received in-home nursing services within the Ontario five day wait time target.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Home Care Database (HCD); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

6. 90th Percentile Wait Time From Community for In-Home Services: Application From Community Setting to First Service (Excluding Case Management)

Definition	This indicator measures the time from when a patient in the community applies for home and community care services until the first in-home service was provided, excluding case management. The 90th percentile is the wait time at which 90% of patients received their service, while the other 10% of patients waited longer.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Home Care Database (HCD); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

7. Percentage of Home Care Clients With an Unplanned, Less Urgent Emergency Department Visit Within the First 30-Days of Discharge From Hospital

Definition	Percentage of LHIN Home Care patients with an unplanned, less-urgent emergency department (ED) visit within the first 30 days of discharge from hospital.
South West LHIN Data Source	Client Health and Related Information System (CHRIS), Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS); retrieved from QIP Navigator, Health Quality Ontario.
Calculation	Numerator / Denominator: Number of LHIN Home Care patients who had an ED visit assessed at a Canadian Triage and Acuity Scale level 4 or 5, within the first 30-days after hospital discharge / All adult Home Care patients discharged from hospital in the time period of interest x 100
Inclusions	• South West LHIN residents aged 18 and older receiving home care services. • ED visit date is within 30-days of the index case discharge date. • Unscheduled ED visit with a C-TAS level of 4 or 5 whose visit did not result in admission to hospital.
Exclusions	• Home care client service for case management. • Records with invalid discharge date, health number and age. • Cases with a discharge disposition = '07' (death) or '08' (cadaver donor). • ED visits with a C-TAS level 4, 5, who visit resulted in admission to hospital.
Timing/Frequency of Release	• Data is updated quarterly. Data lag is three quarters behind the reporting quarter.
Levels of Geography for Comparison	• Data are currently available at the LHIN and provincial levels.
Limitations	• This measure is not adjusted for differences in client demographics, comorbidities or disease severity.
Notes	• Data on this measure for the 13 neighbouring LHINs is available, but currently reported at a de-identified level. The availability of LHIN x LHIN comparative data may lag by up to 5 quarters behind the reporting quarter.

8. Alternate Level of Care (ALC) Rate

Definition	The proportion of total inpatient days in acute and post-acute care settings that are spent as Alternate Level of Care (ALC) in a specified time period.
South West LHIN Data Source	Cancer Care Ontario, Wait Time Information System (WTIS) – Alternate Level of Care; MOHLTC Health Data Branch – Bed Census Summary (BCS); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).
Calculation	Numerator / Denominator: Total number of ALC days in a given time period (WTIS) / Total number of patient days in the same time period (BCS) x 100
Inclusions	• Acute and Post-Acute facilities submitting both ALC and BCS data.
Exclusions	• Alexandra Marine and General Hospital and Four Counties Health Services do not report ALC data to WTIS. • Facilities that did not report inpatient days to the BCS for a given month/quarter. • ALC cases discontinued due to 'Data Entry Error'. • ALC Days is excluded for the portion of the time when Inpatient Service is equivalent to "Discharge Destination for Post-Acute Care". • ALC cases identified by the facility for exclusion. • Patient days contributed by inpatients in the emergency department (Bed Type = Emergency).
Timing/Frequency of Release	• Data is updated quarterly.
Levels of Geography for Comparison	• Data are currently available at hospital, facility, sub-region, LHIN and provincial levels.
Limitations	• Not all acute and post-acute care hospitals submit information to WTIS. Currently, 97% of inpatient beds in the province report ALC Information to the WTIS. • Although WTIS-ALC data are near-real time BCS data may be lagged up to 2 months. • BCS data are collected at the facility level, whereas WTIS-ALC data are collected at the hospital site/inpatient service level. A linking table is maintained to assist with linking the two data sources together.
Notes	• The day of ALC designation is counted as an ALC day but the date of discharge or discontinuation is not counted as an ALC day. • For cases with an ALC designation date on the last day of a reporting period and no discharge/discontinuation date, then ALC days = 1. • The ALC Rate indicator methodology makes the assumption that the Inpatient Service data element (as defined in the WTIS) is comparable to the Bed Type data element (as defined in the BCS).

9. Percentage of Alternate Level of Care (ALC) Days

Definition	Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment and is designated at an Alternate Level of Care (ALC).
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Discharge Abstract Database (DAD); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

Preventing and Managing Chronic Conditions

10. Hospitalization Rate for Ambulatory Care Sensitive Conditions

Definition	Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care may prevent or reduce the need for admission to hospital, per 100,000 population age less than 75.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Population Estimates and Projections, Statistics Canada & Ontario Ministry of Finance; Discharge Abstract Database (DAD) • Ontario and LHIN data is provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report). • Sub-region data is retrieved from the Inpatient Discharge Main Table (DAD); IntelliHealth Ontario, MOHLTC.

11. Readmissions Within 30 Days for Selected HBAM Inpatient Grouper (HIG) Conditions

Definition	Risk-adjusted rate of readmission for patients with an acute inpatient hospital stay for select chronic conditions, who, after discharge have a subsequent non-elective readmission within 30 days.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Discharge Abstract Database (DAD); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

Mental Health and Addiction Services

12. Average Wait Time for Mental Health Case Management

Definition	The average number of days South West LHIN residents wait from referral to the provision of mental health case management services in the community, as reported by the agency providing the service. Mental Health Case Management refers to provision of case management services to seriously mentally ill service recipients. At a minimum case managers provide: individualized assessment and planning; service coordination; supportive counselling;

	monitoring and evaluation of services to recipients; systems advocacy and resource coordination; and/or Community Treatment Order (CTO) coordination. It does not include clinical counselling, psychotherapy and other clinical treatment interventions, case management and treatment services for specialized populations (dual diagnosis, psychogeriatric etc.), and mental health and addictions workers involved only in the provision of information and referral services.
South West LHIN Data Source	Ontario, LHIN and sub-region data is provided by ConnexOntario; Wait time for Mental Health Services.
Calculation	1. Calculate expected wait time for each referred case. 2. Add together the expected wait times from each referral source. 3. Divide by the number of total number of referral sources.
Inclusions	• Closed Referrals.
Exclusions	• Mental Health Case Management programs funded through hospital global budgets • Residents still waiting for service initiation.
Timing/Frequency of Release	• Data is updated quarterly.
Levels of Geography for Comparison	• Data are currently available at the sub-region, LHIN and provincial levels.
Limitations	• Wait time reflects the time to the next available treatment slot and is reported by the agency providing the service, which may differ from the actual wait time experienced by service recipients. • Service agencies may have different processes for determining service need and availability, which may result in differences in how wait times are defined and calculated across organizations. • The wait time values may be based on a small number of programs and data points. • Organizations are to report availability information regularly to ConnexOntario. However, some organizations may not provide updated information when scheduled.

13. Repeat Unscheduled Emergency Visits Within 30 Days for Mental Health Conditions

Definition	Percent of unscheduled repeat emergency visits for mental health or substance abuse, within 30 days following an emergency visit for a mental health condition.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	National Ambulatory Care Reporting System (NACRS); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

14. Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions

Definition	Percent of unscheduled repeat emergency visits for mental health or substance abuse, within 30 days following an emergency visit for a substance abuse condition.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	National Ambulatory Care Reporting System (NACRS); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

15. Mental Health and Substance Abuse Hospitalization Rate

Definition	The rate of hospital admission for mental health, substance abuse and behavioral disorders per 10,000 South West LHIN residents aged 18 and older.
South West LHIN Data Source	Ontario Mental Health Reporting System (OMHRS), retrieved from the Inpatient Adult Mental Health Table; IntelliHealth Ontario, MOHLTC.
Calculation	1. Determine the number of admissions for mental health, substance abuse, and behavior disorders in the time period of interest (Most Responsible Diagnosis ICD10 Codes: F00-F99 numerator). 2. Estimate the number of South West LHIN residents from census population projections (denominator) aged 18 and over. 3. Divide numerator by the denominator. 4. Multiply by 10,000.
	Numerator / Denominator: $\frac{\text{Number of admissions for most responsible mental and behavioral diagnosis in the period of interest (F00-F999)}}{\text{South West LHIN population estimate aged 18 and over}} \times 10{,}000$
Inclusions	• Residents of South West LHIN. • Age 18 and older at the time of admission. • Main Problem ICD-10 Diagnosis Chapter V (F00-F99).
Exclusions	• N/A
Timing/Frequency of Release	• Data is updated quarterly and lagged by two quarters behind the reporting quarter.
Levels of Geography for Comparison	• Data are currently available at the sub-region, LHIN and provincial levels.
Notes	• Data for Elgin County has been excluded prior to Q2 2015/16 due to known coding errors with patient's geography of residence, captured at the time of admission.

Hospital-Based Care

16. 90th Percentile Emergency Department (ED) Length of Stay for Complex Patients

Definition	The total emergency department (ED) length of stay (LOS) where 9 out of 10 complex patients completed their ED stay.
Technical Specification	*Link to Technical Specification - See Pg. 5*
South West LHIN Data Source	National Ambulatory Care Reporting System (NACRS) via Ontario's ER NACRS Initiative. Retrieved from ER Performance Summary Report, iPort; Access to Care, Cancer Care Ontario.

17. 90th Percentile Emergency Department (ED) Length of Stay for Minor/Uncomplicated Patients

Definition	The total emergency department (ED) length of stay (LOS) where 9 out of 10 minor/uncomplicated patients completed their ED Stay.
Technical Specification	*Link to Technical Specification - See Pg. 8*
South West LHIN Data Source	National Ambulatory Care Reporting System (NACRS) via Ontario's ER NACRS Initiative. Retrieved from ER Performance Summary Report, iPort; Access to Care, Cancer Care Ontario.

18. Percentage of Priority 2, 3 & 4 Cases Completed Within Access Target for CT Scan

Definition	Percentage of cases completed within Ontario wait time targets for computed tomography (CT) scans by priority.
Technical Specification	*Link to Technical Specification - See Pg. 20*
South West LHIN Data Source	Wait Time Information System (WTIS). Retrieved from DI Targets and Benchmark Summary Report (Completed Cases), iPort; Access to Care, Cancer Care Ontario.

19. Percentage of Priority 2, 3 & 4 Cases Completed within Access Target for MRI Scan

Definition	Percentage of cases completed within Ontario wait time targets for magnetic resonance imaging (MRI) scans by priority.
Technical Specification	*Link to Technical Specification - See Pg. 17*
South West LHIN Data Source	Wait Time Information System (WTIS). Retrieved from DI Targets and Benchmark Summary Report (Completed Cases), iPort; Access to Care, Cancer Care Ontario.

20. Percentage of Priority 2, 3 & 4 Cases Completed within Access Target for Hip Replacement

Definition	Percentage of cases completed within Ontario wait time targets for hip joint replacements by priority.
Technical Specification	*Link to Technical Specification - See Pg. 11*
South West LHIN Data Source	Wait Time Information System (WTIS). Retrieved from Surgery Targets and Benchmark Summary Report (Completed Cases), iPort; Access to Care, Cancer Care Ontario.

21. Percentage of Priority 2, 3 & 4 Cases Completed within Access Target for Knee Replacement

Definition	Percentage of cases completed within Ontario wait time targets for knee joint replacements by priority.
Technical Specification	*Link to Technical Specification - See Pg. 14*
South West LHIN Data Source	Wait Time Information System (WTIS). Retrieved from Surgery Targets and Benchmark Summary Report (Completed Cases), iPort; Access to Care, Cancer Care Ontario.

22. Health Based Allocation Model (HBAM) Variance

Definition	HBAM Variance is the sum of the differences between actual total cost and expected total cost for each of Acute and Day Surgery, Emergency Department, Complex Continuing Care, Rehabilitation, and Inpatient Mental Health modules for all HBAM hospitals in the South West LHIN. Expected total cost is the product of (expected unit cost * expected service level).
South West LHIN Data Source	The HBAM performance indicator is based on the HBAM Results reports published annually to the Health Capital Data Branch website. The HBAM Results report includes actual and expected cost and service activity for each of the HBAM modelled components, e.g. acute and day surgery, emergency department, complex continuing care. The actual costs are taken from the Ontario Cost Distribution Methodology year-end tables and the actual service activity is pulled from the clinical database associated with the HBAM component.
Calculation	Sum of variance for each of Acute & Day Surgery, Emergency Department, Complex Continuing Care, Inpatient Rehabilitation, and Inpatient Mental Health calculated by: Actual Unit Cost x Actual Service Level (i.e. total actual cost) Subtract (-) Expected Unit Cost x Expected Service Level (i.e. total expected cost) The difference is the variance between the total cost incurred by the hospital and the cost that the HBAM model assigns and may be expressed in dollars or as a per cent of total expected cost. A positive variance (actual costs > expected costs) will not be recognized in the HBAM funding formula, i.e. will not increase the hospital's HBAM funding share. A positive variance can be the result of the hospital unit cost in excess of the standard unit cost (provincial average cost adjusted for major hospital cost variance factors such as number of tertiary cases) or the hospital could be "over-serving" after population and market share factors are considered, or both.
Inclusions	• Acute & Day Surgery, Emergency Department, Complex Continuing Care, Inpatient Rehabilitation, Inpatient Mental Health.
Exclusions	• Home and Community Care.
Timing/Frequency of Release	• Data is updated annually, and lagged by one fiscal year.
Levels of Geography for Comparison	• Data is currently available at the organizational (HBAM hospitals only), health sector, LHIN and provincial levels.
Limitations	• Expected service level modelling only applies to Acute & Day Surgery, Emergency Departments, and Inpatient Rehabilitation; expected service levels = actual service levels for Complex Continuing Care and Inpatient Mental Health.

	• Expected unit cost modelling only applies to Acute & Day Surgery, Emergency Departments, Inpatient Rehabilitation, and Complex Continuing Care; expected unit costs = actual unit costs for Inpatient Mental Health.

23. Hospital Standardized Mortality Ratio (HSMR)

Definition	The ratio of the actual number of acute in-hospital deaths to the expected number of in-hospital deaths, for select conditions.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Discharge Abstract Database (DAD); retrieved from CIHI Portal, Canadian Institute for Health Information.

Rehabilitative Services

24. Length of Stay Efficiency for Inpatient Rehabilitation

Definition	Average change in FIM Total Function Score from admission to discharge, given the patient's length of stay in inpatient rehabilitation.
Technical Specification	*Link to Technical Specification - See Detailed View*
South West LHIN Data Source	National Rehabilitation Reporting System (NRS); retrieved from the Inpatient Rehabilitation Table; IntelliHealth Ontario, MOHLTC.

Hospice Palliative Care

25. Percentage of Palliative Care Clients Discharged From Hospital With Home Support

Definition	Percentage of palliative care patients discharged home from hospital with support services from an external agency (Home Care) in place.
Technical Specification	*Link to Technical Specification - See Pg. 10*
South West LHIN Data Source	Discharge Abstract Database (DAD) • Ontario and LHIN data is provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report). • Sub-region data is retrieved from the Inpatient Discharge Main Table (DAD); IntelliHealth Ontario, MOHLTC.

Safety

26. Falls: Percentage of Adult Long-Stay Home Care Patients Who Record a Fall on Their Follow-Up (RAI-HC) Assessment

Definition	Percentage of adult long-stay Home Care patients who have a fall on their follow-up of the Resident Assessment Instrument (RAI) for home care.
Technical Specification	*Link to Technical Specification - See Pg. 63*
South West LHIN Data Source	Home Care Database (HCD); retrieved from Health Shared Services Ontario (HSSO)'s reporting site.

27. Percentage of Long-Stay Patients That Have Had Medication Reconciliation/Management Within the Last 180 Days

Definition	Percentage of long stay patients with an open home care referral at the end of the reporting month whose medications have been reviewed between a patients' care coordinator and physician/pharmacist within the last 180 days.
South West LHIN Data Source	Client Health & Related Information System (CHRIS), retrieved by the South West LHIN.
Calculation	Numerator: Number of long stay patients with an open home care referral at the end of the reporting month whose medications have been reviewed between the patients' care coordinator and physician/pharmacist within the last 180 days Denominator: Number of long stay patients with an open home care referral at the end of the reporting month X100
Inclusions	• Patients who had a Service Recipient Code equal to 93 or 94 with an open home care referral at the end of the reporting month. • A medication review is deemed to be one of the following: 1) Resident Assessment Instrument-Home Care (RAI-HC) where reviewed by physician, or, No Medications Taken (q3 = 0) on a RAI-HC that occurred within 180 days from the end of the reporting month. 2) A patient note exists with a "Note Subject" starting with the text "Medication" within 180 days from the end of the reporting month. 3) MHAN Workload Form with [CheckMedicationReconciliationCompleted] = 'Yes' within 180 days from the end of the reporting month. 4) RRN Workload Form with [CheckMedicationReconciliationCompleted] or [CheckWasMedicationReconciliationInitiated] or

	[CheckMedicationDiscrepancyIdentified] or [CheckDiscrepancyResolvedWithHealthcareProfessional] = 'Yes' within 180 days from the end of the reporting month.
Exclusions	• N/A
Timing/Frequency of Release	• Data is updated monthly.
Levels of Geography for Comparison	• Data is currently available at the sub-region and South West LHIN levels. No comparative data to neighbouring LHINs is available.
Notes	• Quarterly percentage is calculated by dividing the sum of monthly numerators by the sum of monthly denominators.

28. Missed Care: Overall Percentage of Missed Care Visits From South West LHIN Providers

Definition	The proportion of clinical care services that are not delivered in accordance with patients' allocated Care Plans within the South West LHIN.
South West LHIN Data Source	Self-reported data provided by Service Provider Organizations, retrieved from Health Shared Services Ontario (HSSO)'s Members (Provider) Portal.
Calculation	Numerator / Denominator: Any fixed period visits or hourly visit to a patient, authorized by LHIN Home and Community Care services, as part of the patient care plan, that the Service Provider fails to attend and is unable to reschedule in accordance with the patient care plan / All fixed period visits or hourly visits delivered plus the number of visits (fixed period) or hourly visits that are not delivered in accordance with the patient care plan X100
Inclusions	These are examples of "Missed Care": • A visit scheduled for morning care was missed. The patient went without the morning care or a family member provided it. • The patient was scheduled for daily treatments. The Service Provider Organization did not have anyone available to provide the treatment on Tuesday and the patient had to travel to the emergency department for the treatment.
Exclusions	These situations would not be defined as "Missed Care": • A visit scheduled for morning care was missed. The patient called and the Service Provider Organization sent someone to provide the care two hours later than scheduled but still within the patient care plan. • The patient was scheduled for a treatment on Tuesday. The Service Provider Organization did not have anyone available to provide the treatment on Tuesday but after discussion with the physician and the patient the treatment was scheduled for Wednesday which is still within the patient care plan. • Visit scheduled in retirement home for morning care was missed. The retirement home called the Service Provider Organization and the provider said that they could send someone to provide the care two hours later (still within the patient care plan) but the retirement home decided to provide the care themselves. • A Service Provider Organization arrived at a retirement home to provide care as per patient care plan but the retirement home had already provided the care themselves.
Timing/Frequency of Release	Data is updated quarterly.
Levels of Geography for Comparison	Data is available at the service provider and South West LHIN level. No comparative data to neighbouring LHINs is available.

Effectiveness

29. Percentage of Home Care Clients With an Unplanned, Less Urgent Emergency Department Visit Within the First 30 Days of Discharge From Hospital

Definition	Percentage of LHIN Home Care patients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital.
South West LHIN Data Source	Client Health and Related Information System (CHRIS), Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS); retrieved from QIP Navigator, Health Quality Ontario.
Calculation	Numerator: Number of LHIN Home Care patients who had an ED visit assessed at a Canadian Triage and Acuity Scale level 4 or 5, within the first 30-days after hospital discharge x 100 Denominator: All adult Home Care clients discharged from hospital in the time period of interest
Inclusions	• South West LHIN clients aged 18 and older receiving home care services. • ED visit date is within 30-days of the index case discharge date. • Unscheduled ED visit with a C-TAS level of 4 or 5 whose visit did not result in admission to hospital.
Exclusions	• Home care client service for case management. • Records with invalid discharge date, health number and age. • Cases with a discharge disposition = '07' (death) or '08' (cadaver donor). • ED visits with a C-TAS level 4, 5, who visit resulted in admission to hospital.
Timing/Frequency of Release	• Data is updated quarterly. Data lag is three quarters behind the reporting quarter.
Levels of Geography for Comparison	• Data are currently available at the LHIN and provincial levels.
Limitations	• This measure is not adjusted for differences in client demographics, comorbidities or disease severity.
Notes	• Data on this measure for the 13 neighbouring LHINs is available, but currently reported at a de-identified level. The availability of LHIN x LHIN comparative data may lag by up to 5 quarters behind the reporting quarter.

30. Percentage of Home Care Clients who Experienced an Unplanned Readmission to Hospital Within 30 Days of Discharge From Hospital

Definition	Percentage of LHIN Home Care patients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital
Technical Specification	*Link to Technical Specification - See Pg. 57*
South West LHIN Data Source	Discharge Abstract Database (DAD), Home Care Database (HCD), National Ambulatory Care Reporting System (NACRS); retrieved from Health Shared Services Ontario (HSSO)'s reporting site.

31. Number of Care Conferences

Definition	Number of LHIN Home Care patients with complex needs that had a care conference conducted within the last 6 months from the date of the reporting period close.
South West LHIN Data Source	Client Health Related Information System (CHRIS); retrieved by the South West LHIN.
Calculation	Number of unique Home Care patients that had a care conference recorded within the last 6 months from the date of the reporting month close, and were coded as complex at the time the care conference took place.
Inclusions	• Patient had an active "Home Care" referral at the end of the reporting month. • Patient had at least one "Care Conference" in the last 6 months as of the end of the reporting month. • Patient had a Client Care Model (CCM) population of "Complex" on the date that "Care Conference" occurred.
Exclusions	• N/A
Timing/Frequency of Release	• Data is updated annually.
Levels of Geography for Comparison	• Data is available at the sub-region and South West LHIN level. No comparative data to neighbouring LHINs is available.
Notes	• "Care Conference" is a workload activity type in CHRIS. • Annual count number is the sum of monthly numbers.

32. Complex Patients: Patients with MAPLe Scores High/Very High Living in the Community Supported by LHIN Home and Community Care

Definition	Percentage of LHIN Home Care patients with MAPLe Scores high/very high living in the community supported by LHIN Home and Community Care services.
Technical Specification	*Link to Technical Specification - See Pg. 70*
South West LHIN Data Source	Home Care Database (HCD), Resident Assessment Instrument for Home Care (RAI-HC) via Long Stay Assessment Software (LSAS), retrieved from Health Shared Services Ontario (HSSO)'s reporting site.
Notes	• *Link to MAPLe Decision Tree – See Pg. 2*

33. Home First Impact: Estimated Number of Hospital Days Saved

Definition	Number of calendar days that South West LHIN Home Care patients are on the "Home First" program.
South West LHIN Data Source	Client Health Related Information System (CHRIS); retrieved by the South West LHIN.
Calculation	Sum of the total number of days that South West LHIN home care patients are on the "Home First" program across the LHIN within the reporting period.

Inclusions	• Patient was on the “Home First” program on the calendar day of interest.
Exclusions	• Patient was on hospital hold on the calendar day of interest.
Timing/Frequency of Release	• Data is updated annually.
Levels of Geography for Comparison	• Data is available at the sub-region and South West LHIN level. No comparative data to neighbouring LHINs is available.
Notes	• “Home First” is considered as a parent program in South West LHIN, the following are its child programs and their respective criteria: “Home First – Intensive Hospital to Home Plan (IH2HP)” a. Active IH2HP Referral Code “Home First – Wait at Home” a. Active Placement with 1 or 1A crisis Priority “Safe at Home – LTC” a. Resident Assessment Instrument (RAI) > 16 b. Service Recipient Code (SRC) IN (93,94,95) c. Active LTC Referral “Home First – High Risk Seniors” a. RAI > 16 b. Age > 65 c. SRC Code IN (93,94,95) d. Method for Assigning Priority Levels (MAPLe) = Very High “Home First – Hospital Avoidance” a. Referral Source i. Hospital ii. OR if Referral Source is not Hospital, a Hospital Hold b. Greater than average of 1 hour/day of combined homemaking for 28 days following “Admit Date” or “Hospital Hold End Date” c. Within 28 days following “Admit Date” or “Hospital Hold End Date” • It is assumed that the sum of days patients were supported through the Home First program are equivalent the sum of days that would have been spent in hospital if the patient was not on the "Home First" program.

34. Health Links: Total Number of Patients Supported by Coordinated Care Plans (CCPs)

Definition	The total number of residents being supported in the South West LHIN by Health Links and receiving a Coordinated Care Plan (CCP) recorded through home care services.
South West LHIN Data Source	Client Health Related Information System (CHRIS); retrieved by the South West LHIN.
Calculation	Sum of the number of unique individuals with a completed coordinated care plan in the time period of interest.
Inclusions	• Clients with an open Health Links referral.
Exclusions	• Clients with duplicate referral records
Timing/Frequency of Release	• Data is updated monthly, and summed quarterly.
Levels of Geography for Comparison	• Data is available at the sub-region and South West LHIN level. No comparative data to neighbouring LHINs is available.
Notes	• Coordinated Care Plans completed within the community by Health Service Providers not affiliated with a Care Coordination, are not reported into CHRIS, and subsequently, are not captured.

Accessible

35. Percentage of Home Care Clients With Complex Needs Who Received Their Personal Support Visit Within 5 Days of the Date They Were Authorized For Personal Support Services

Definition	Percentage of LHIN Home Care patients with complex needs who received in-home personal support services within the Ontario five day wait time target.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Home Care Database (HCD); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

36. Percentage of Home Care Clients Who Received Their Nursing Visit Within 5 Days of the Date They Were Authorized For Nursing Services

Definition	Percentage of LHIN Home Care Clients who received in-home nursing services within the Ontario five day wait time target.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Home Care Database (HCD); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

37. Wait Time – Discharge to Initiation: 90th Percentile Wait Time from Hospital Discharge to Service Initiation (Hospital Setting)

Definition	This indicator measures the time from when a patient is deemed eligible for home care services referred from a hospital setting, is discharged from hospital and receives their first home and community care service, excluding case management. The 90th percentile is the wait time at which 90% of the clients received their service, while the other 10% of clients waited longer.
Technical Specification	*Link to Technical Specification - See Pg. 34*
South West LHIN Data Source	Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI) Home Care Database (HCD); retrieved from Health Shared Services Ontario (HSSO)'s reporting site.

38. 90th Percentile Wait Time From Community for In-Home Services: Application from Community Setting to First Service (Excluding Case Management)

Definition	This indicator measures the time from when a patient in the community applies for home and community care services until the first in-home service was provided, excluding case management. The 90th percentile is the wait time at which 90% of the clients received their service, while the other 10% of clients waited longer.
Technical Specification	*Link to Technical Specification*
South West LHIN Data Source	Home Care Database (HCD); provided by Health Analytics Branch, MOHLTC (Quarterly Stocktake Report).

39. Percent of Palliative /End of Life Patients Who Died in Their Preferred Place of Death

Definition	Percent of palliative/end of life patients receiving LHIN Home and Community Care services who passed away in the time period of interest and died in their preferred place of death.
Technical Specification	*Link to Technical Specification - See Pg. 64*
South West LHIN Data Source	Client Health Related Information System (CHRIS); retrieved from Health Shared Services Ontario (HSSO)'s reporting site.

40. Adult Day Program Occupancy

Definition	Percentage of total available spaces occupied for Adult Day Programs (ADP) offered in the South West LHIN during the reporting period of interest.
South West LHIN Data Source	ADP providers, submitted to the South West LHIN.
Calculation	Numerator / Denominator: Total number of spaces filled by registered clients / Total number of day program spaces funded by the South West LHIN X100
Inclusions	• Participating ADPs funded by the South West LHIN.
Exclusions	• N/A
Timing/Frequency of Release	• Data is updated quarterly.
Levels of Geography for Comparison	• Data is available by provider/program, and for the South West LHIN. No comparative data to neighbouring LHINs is available.
Notes	• Adult day programs provide part-of-the-day supervised programming in a group setting for dependent adults, such as the frail elderly, individuals with Alzheimer's, or individuals with disabilities. Services may include leisure activities, meals and personal care. Performance is assessed against a program's occupancy, which may not reflect client attendance.

Patient-Centered

41. Patient and Caregiver Overall Rating of South West LHIN Services

Definition	Percentage of South West LHIN Home Care patients who responded to the Client and Caregiver Experience Evaluation Survey (CCEE) during the time period of interest, who reported their overall experience with home and community care services as "Excellent", "Very Good", or "Good".
Technical Specification	*Link to Technical Specification - See Pg. 59*
South West LHIN Data Source	Client and Caregiver Experience Evaluation (CCEE) Survey; retrieved from National Research Corporation (NCR) eReports site.

42. Patient and Caregiver Overall Rating of Facilitation by Care Coordinator

Definition	Percentage of South West LHIN Home Care patients who are responded to the Client and Caregiver Experience Evaluation Survey (CCEE) during the time period of interest, who reported they were satisfied with the facilitation provided by the South West LHIN Care Coordinators.
South West LHIN Data Source	Client and Caregiver Experience Evaluation (CCEE) Survey; retrieved from National Research Corporation (NCR) eReports site.
Calculation	Numerator: The sum of the number of positive responses ("Usually", "Always") registered for each of the six questions that form the KPI 5 Score for the "building relationships & trust" rating. (n positive Q20) + (n positive Q21) + (n positive Q22) + (n positive Q28) + (n positive Q29) + (n positive Q30) *Note: the sum of the weighted responses are used. Post-sample weighs are applied to adjust for disproportionate sampling and to ensure that the reported survey results are representative of the population served by LHIN Home & Community Care ——— Denominator: The total number of valid responses registered for all of the questions listed above X100
Inclusions	• All unique active or discharged patients receiving in-home services and discharge patients to placement in one of the following categories during the specified time period (admission final; withdrawn, interim became final; withdrawn, placement by other CCAC; refused bed)
	• Excludes patients who received in-school service only. • Nursing clinic services. • Respite services. • Medical supplies and equipment. • End-of-life patients (SRC 95). • Clients not yet categorized (SRC 99). • In-home patients classified as out of region. • Convalescent care patients. • Home care patients with hospital or death discharges

	• Patients on hold in hospital • Patients with a claim against Home and Community Care or before the Ontario Health Service Appeal and Review Board.
Timing/Frequency of Release	• Weighted results are reported bi-annually.
Levels of Geography for Comparison	• Data is available at the service provider, service, LHIN and provincial levels.
Notes	• The six questions that form the KPI 5 Score for "building relationships & trust" are: **Question 20:** How often did the case manager explain things in a way that was easy to understand? **Question 21:** How often did the case manager listen carefully to you? **Question 22:** How often did the case manager treat you with courtesy and respect? **Question 28:** In the last 2 months of care, how often did home health care providers from this agency explain things in a way that was easy to understand? **Question 29:** In the last 2 months of care, how often did home health care providers from this agency listen carefully to you? **Question 30:** In the last 2 months of care, how often did home health care providers from this agency treat you with courtesy and respect? • Results are weighted to reflect the population of home care patients eligible to be surveyed within each LHIN (i.e., sampled home care patients are standardized to LHIN-specific populations).

43. Patient and Caregiver Overall Satisfaction with Connection to Community Services

Definition	Percentage of South West LHIN Home Care patients who are responded to the Client and Caregiver Experience Evaluation Survey (CCEE) during the time period of interest, who reported they were satisfied with the connection to community services provided by South West LHIN Care Coordinators
South West LHIN Data Source	Client and Caregiver Experience Evaluation (CCEE) Survey; retrieved from National Research Corporation (NCR) eReports site.
Calculation	Numerator: The sum of the number of positive responses ("Yes") registered for each of the two questions that form the KPI 6 Score for the "linking to other services" rating. (n positive Q18_c) + (n positive Q41) **Note: the sum of the weighted responses are used. Post-sample weighs are applied to adjust for disproportionate sampling and to ensure that the reported survey results are representative of the population served by LHIN Home & Community Care ———————————— X100 Denominator: The total number of valid responses registered for all of the questions listed above.
Inclusions	• All unique active or discharged patients receiving in-home services and discharge patients to placement in one of the following categories during the specified time period: Admission final; Withdrawn, interim became final; Withdrawn, placement by other CCAC; Refused bed.
Exclusions	• Excludes patients who received in-school service only. • Nursing clinic services. • Respite services.

	• Medical supplies and equipment. • End-of-life patients (SRC 95). • Clients not yet categorized (SRC 99). • In-home patients classified as out of region. • Convalescent care patients. • Home care patients with hospital or death discharges • Patients on hold in hospital • Patients with a claim against Home and Community Care or before the Ontario Health Service Appeal and Review Board.
Timing/Frequency of Release	• Weighted results are reported bi-annually.
Levels of Geography for Comparison	• Data is available at the service provider, service, LHIN and provincial levels.
Notes	• The two questions that form the KPI 6 Score for "linking to other services" are: **Question 18_c:** If you needed further support, did the CCAC help you to get linked to other services in the community? **Question 41:** If you needed further support, did the CCAC help you to get linked to other services in the community after your CCAC services ended? • Results are weighted to reflect the population of home care patients eligible to be surveyed within each LHIN (i.e., sampled home care patients are standardized to LHIN-specific populations).

44. Patient and Caregiver Complaints per 1,000 Patients – South West LHIN

Definition	The number of patient complaints regarding South West LHIN Home and Community Care services per 1,000 patients
South West LHIN Data Source	Event Tracking Management System (ETMS), retrieved by the South West LHIN.
Calculation	Numerator / Denominator: Number of complaints regarding the South West LHIN in the reporting month / Number of patients receiving home and community care services who had at least one admitted patient day in the reporting month X1,000

Inclusions	• The following event categories are considered complaints regarding South West LHIN Home and Community Care Services
	  • Ability to place in Long-Term Care Home(s)
	  • Amount and/or availability of allocated service(s)
	  • Business processes
	  • Eligibility for, or exclusion of, service
	  • Rights violation
	  • Termination of service

Exclusions	• The event is excluded if the record in ETMS is flagged as deleted.
Timing/Frequency of Release	• Data is updated monthly.
Levels of Geography for Comparison	• Data is available for the South West LHIN. No comparative data to neighbouring LHINs is available.
Notes	• For the purpose of this measure, an event is defined as something that has, or may happen to, or is regarded as happening; a noteworthy episode of some-to-great importance; a term to encompass complaints, compliments, risk events, adverse events, and near misses.

	• For the purpose of this measure, a complaint is defined as an expression of dissatisfaction from external or internal origin, related to service and/or processes where a response and/or resolution is explicitly or implicitly expected. • The quarterly rate is the sum of monthly rates.

45. Patient and Caregiver Complaints per 1,000 Patients – Provider

Definition	Number of patient complaints regarding South West LHIN Home and Community Care Service Providers per 1,000 patients.
South West LHIN Data Source	Event Tracking Management System (ETMS), retrieved by the South West LHIN.
Calculation	Numerator / Denominator: Number of complaints regarding Home and Community Care Service Providers in the reporting month / Number of patients receiving Home and Community Care services who had at least one admitted patient day in the reporting month X1000

Inclusions	• The following event categories are considered as complaints regarding the service providers
	  • Quality of service.
	  • French services.

Exclusions	• The event is excluded if the record in ETMS is flagged as deleted.
Timing/Frequency of Release	• Data is updated monthly.
Levels of Geography for Comparison	• Data is available for the South West LHIN. No comparative data to neighbouring LHINs is available.
Notes	• For the purpose of this measure, an event is defined as something that has, or may happen to, or is regarded as happening; a noteworthy episode of some-to-great importance; a term to encompass complaints, compliments, risk events, adverse events, and near misses. • For the purpose of this measure, a complaint is defined as an expression of dissatisfaction from external or internal origin, related to service and/or processes where a response and/or resolution is explicitly or implicitly expected. • The quarterly rate is the sum of monthly rates.