Ontario Health Care System Scorecard

Promoting Accountability, Improving Performance

Strategic Alignment Branch
Health System Strategy Division
Ministry of Health and Long-Term Care

February 23rd , 2011

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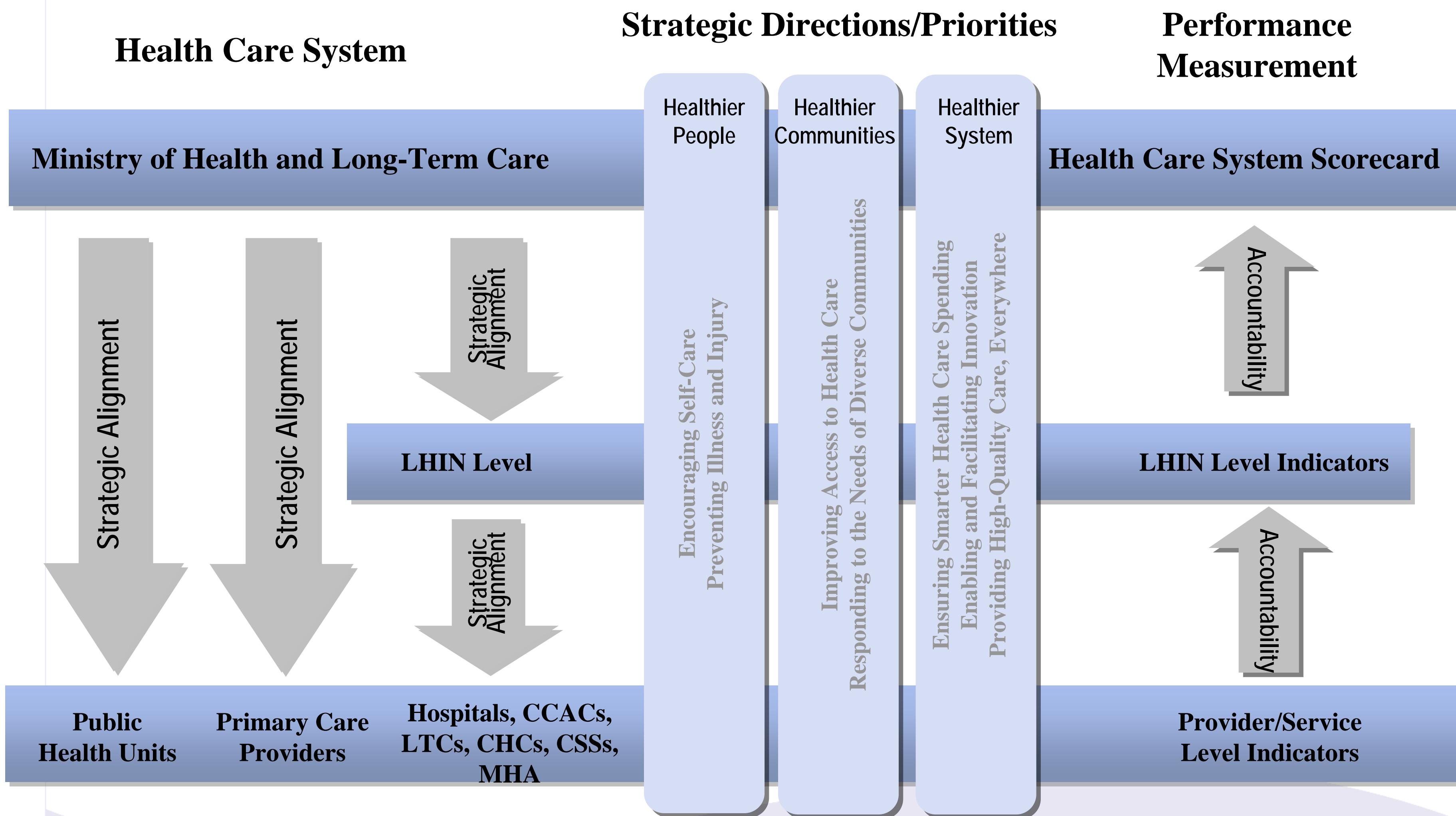
Presentation Outline

- Challenges and Opportunities
- Scorecard Functions
- Performance Management and Measurement Framework
- Balancing the Indicators across Different Domains and Sectors
- Key Features of the Development Process
- Limitations and Challenges
- Main Uptake and Applications of the Scorecard
- Some Examples from the Report
- Opportunities for Filling the Gaps

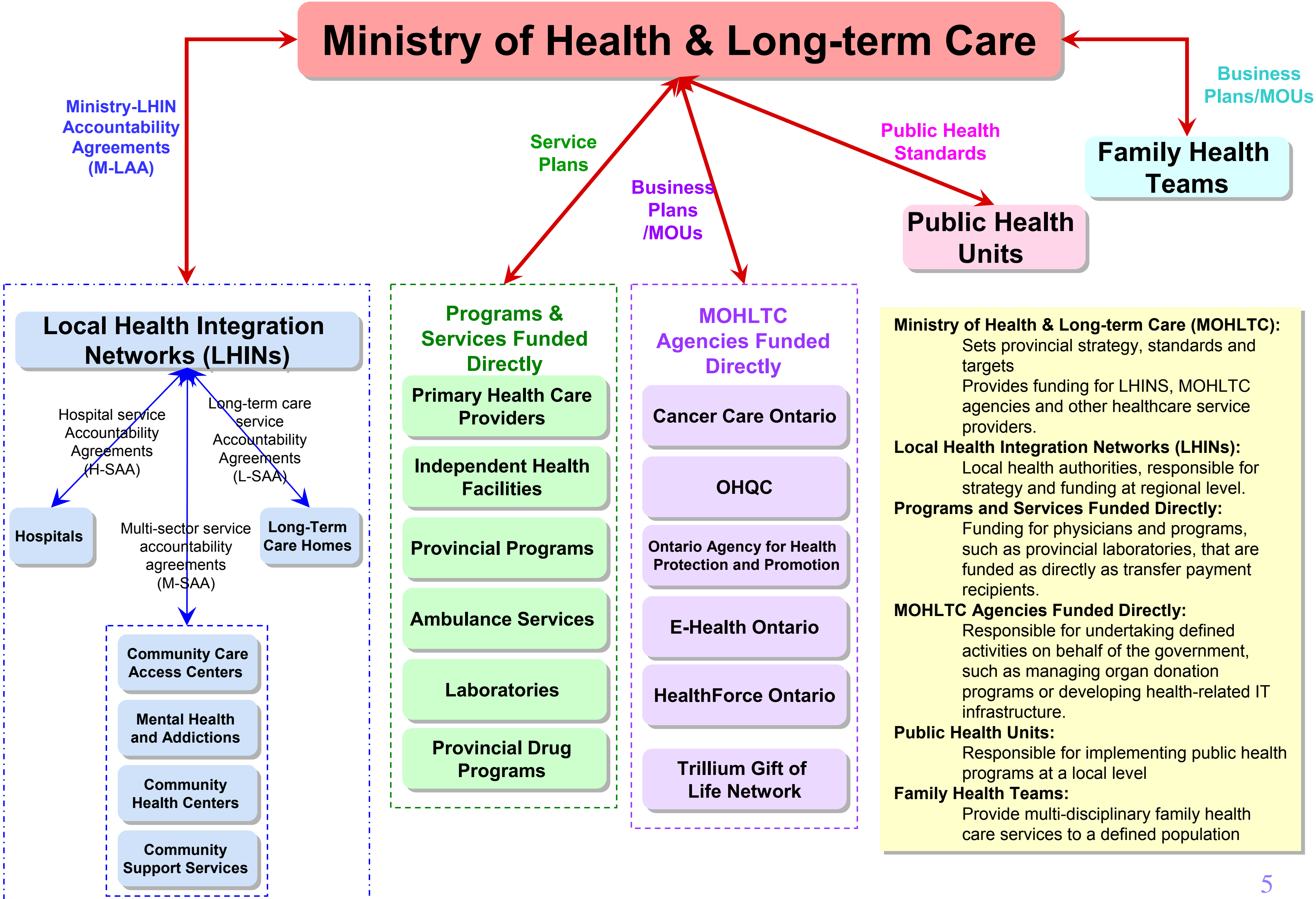
Challenges in Ensuring that Diverse Health System Players Align with Ministry Priorities and Deliver Results

- An affordable health care system demands continuous improvements in efficiency and effectiveness
- It is difficult to maintain accountability for expenditures and results in a system in which authority is devolved and decision-making is widely dispersed
- It is difficult to drive government priorities and right changes through a complex adaptive system, such as the health care system

Accountability and Alignment in Ontario's Health Care System



Accountability Relationships in Ontario's Health Care System



Ministry of Health & Long-term Care (MOHLTC):
Sets provincial strategy, standards and targets
Provides funding for LHINS, MOHLTC agencies and other healthcare service providers.

Local Health Integration Networks (LHINs):
Local health authorities, responsible for strategy and funding at regional level.

Programs and Services Funded Directly:
Funding for physicians and programs, such as provincial laboratories, that are funded as directly as transfer payment recipients.

MOHLTC Agencies Funded Directly:
Responsible for undertaking defined activities on behalf of the government, such as managing organ donation programs or developing health-related IT infrastructure.

Public Health Units:
Responsible for implementing public health programs at a local level

Family Health Teams:
Provide multi-disciplinary family health care services to a defined population

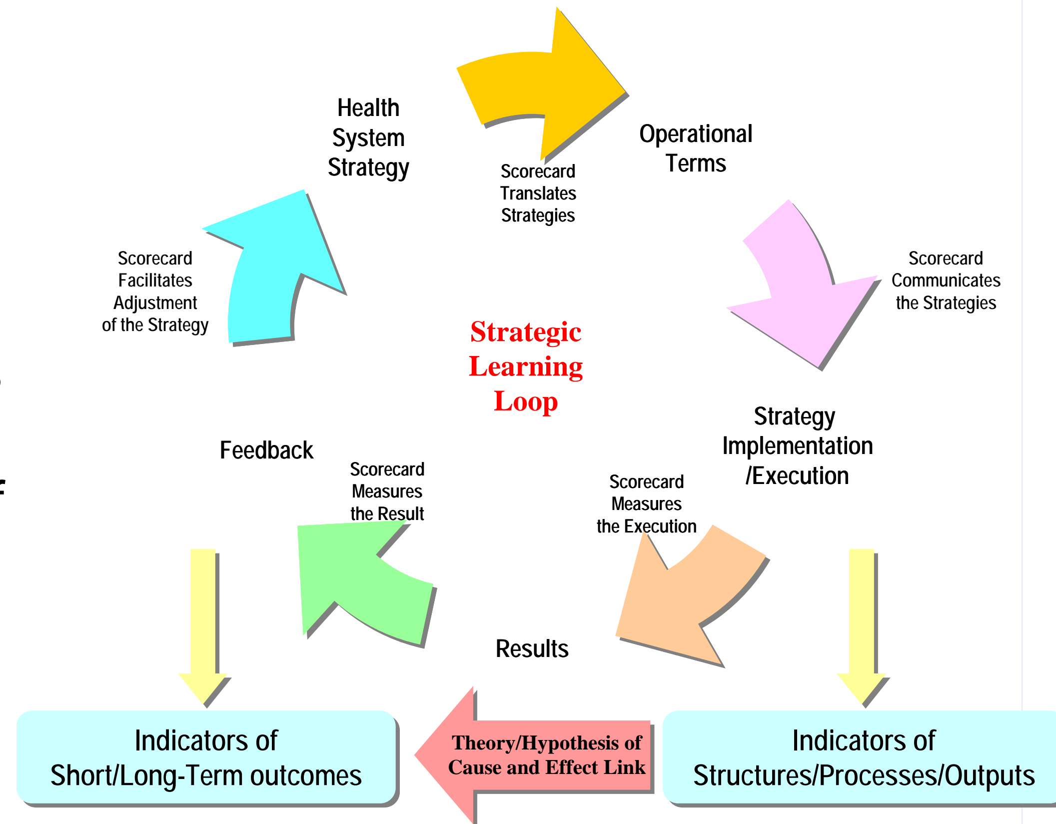
Considerations and Opportunities for Improving the Quality of Health Care

- Establishing clear accountability to help focus efforts and investments on the achievement of specific outcomes is crucial in improving health care at the organizational and health system level
- We need the tools of modern controllership (reporting and evaluation of results) as a mechanism for accountability to align LHINs and providers with ministry priorities and focus on results
- There is some evidence that a scorecard based on strategy is a useful tool for improving system performance management & accountability
- System participants have an appetite for performance expectations that are clear, actionable, authoritative and scientifically rigorous to drive their performance

Health Care System Scorecard Function (1)

To align performance at various levels of the system with ministry priorities

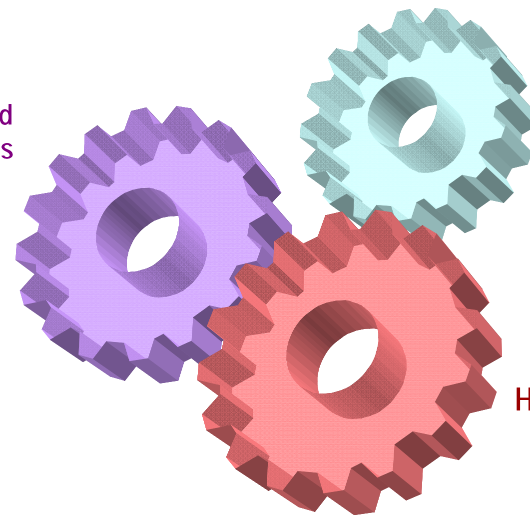
- It acts as the principal means for translating and operationalizing strategy into understandable and actionable terms.
- It communicates the strategy with the front-line institutions/providers and helps them understand their contribution to the achievement of system goals.
- It facilitates the refinement and validation of strategies by providing feedback and learning for robust strategy and priority setting.



Health Care System Scorecard Function (2)

To support stronger accountability through multiple levels of the system and to central agencies

- It guides and facilitates the establishment of accountability measures, targets, and meaningful performance objectives for institutions and providers accountable to the ministry.
- It is a tool for driving focus on ministry priorities down into the system by cascading indicators.
- It shows where challenges lie and when performance improvements are needed.



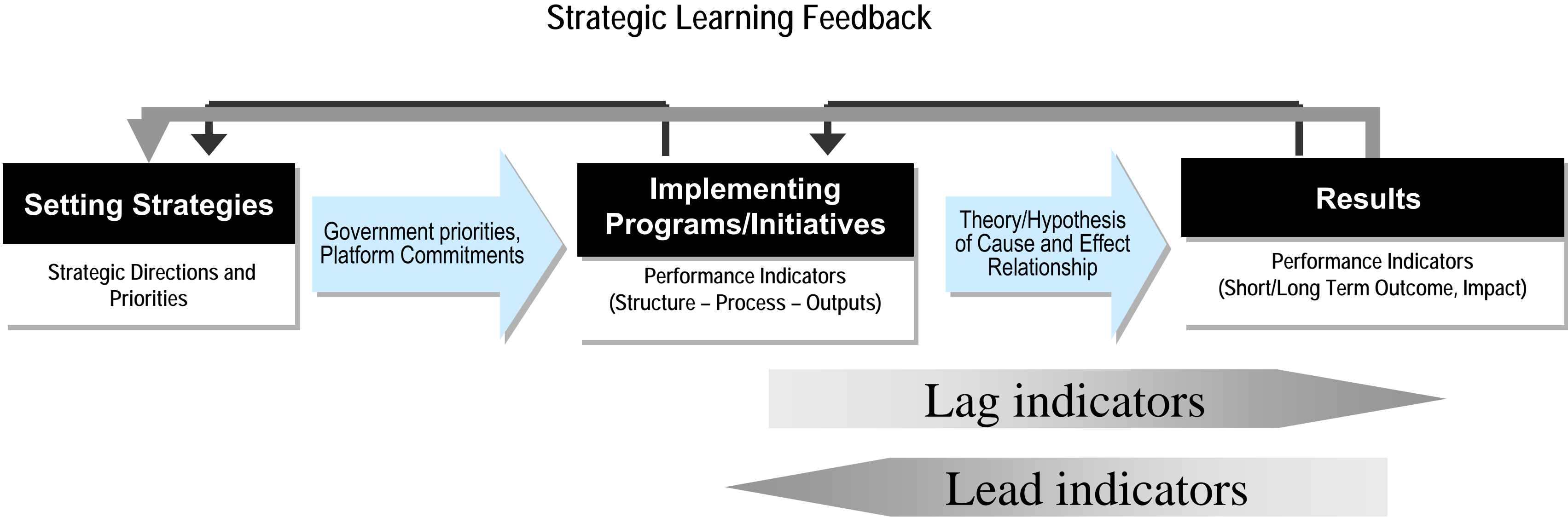
Audiences based on the Primary Purpose:
Accountability and Alignment

- **Primary Audience**: MOHLTC policy and decision makers, LHINs policy and decision makers, and health system program planners.
- **Secondary Audience**: hospitals and other health care organizations administrators, health system researchers; MOHLTC agencies, health care providers, and professional associations
- **Tertiary Audience**: the general public

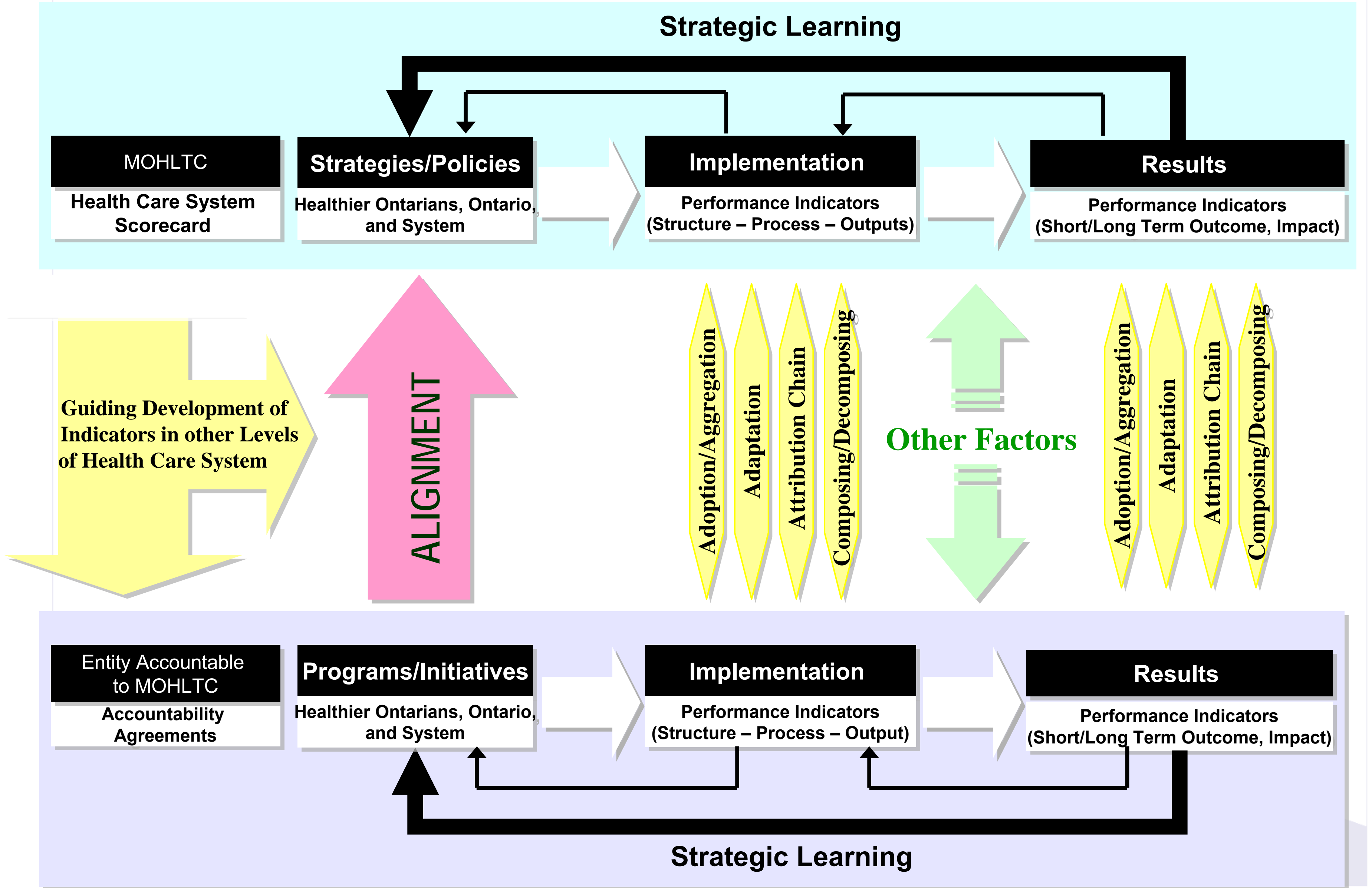
Scope and boundaries based on the Primary Purpose:
Accountability and Alignment

- The MOHLTC and the entities that are accountable to MOHLTC, either directly or indirectly.
- The health care system, not the health system as broadly defined; as such, it relates to the provision of health care by MOHLTC and other entities accountable to it.

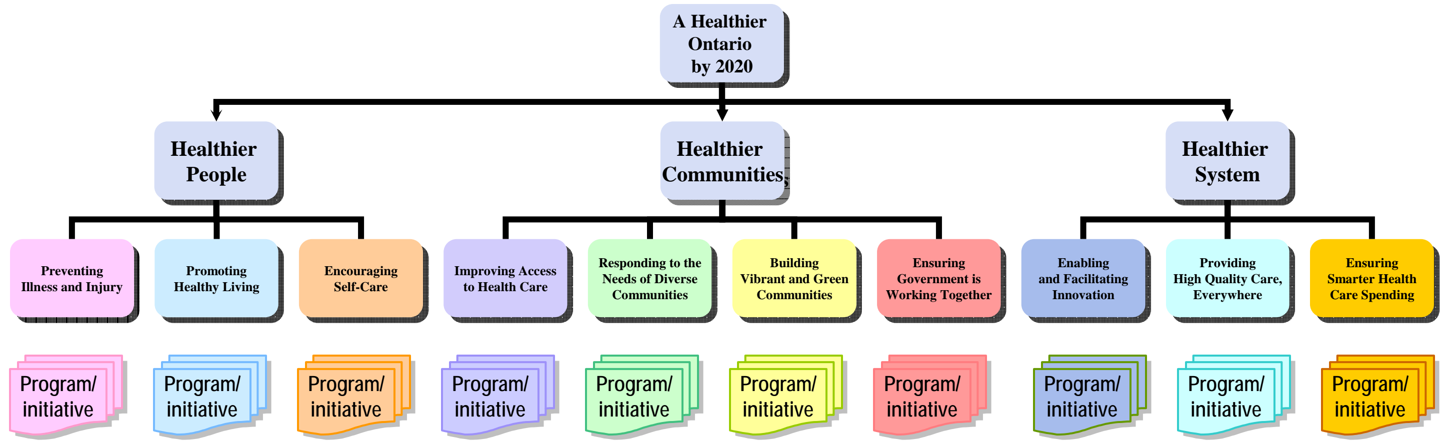
Health Care System Scorecard
Performance Measurement and Management Framework



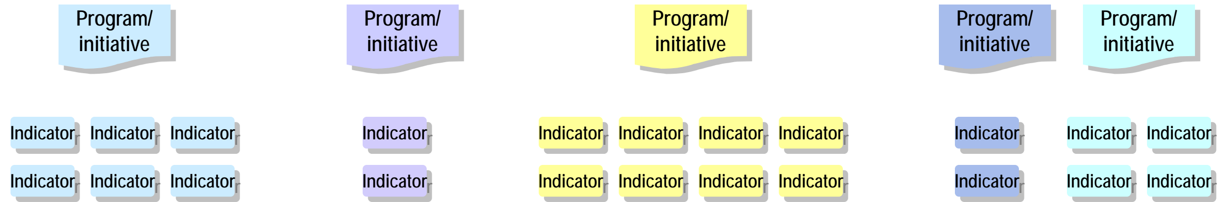
The Framework Promotes Alignment and Accountability across the Health Care System



Health Care System Scorecard Development Process

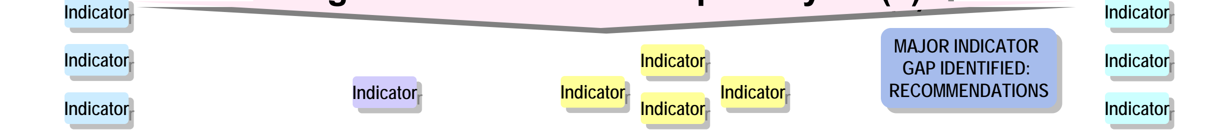


Program selection process based on consultation with Deputy Minister's Office, Steering Committee, and defined criteria



Literature Review

Delphi Method

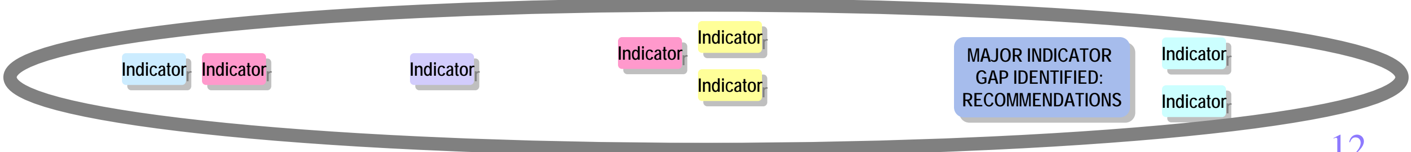


Indicator selection process based on the defined criteria by the Technical Expert Panel

Rating and Ranking

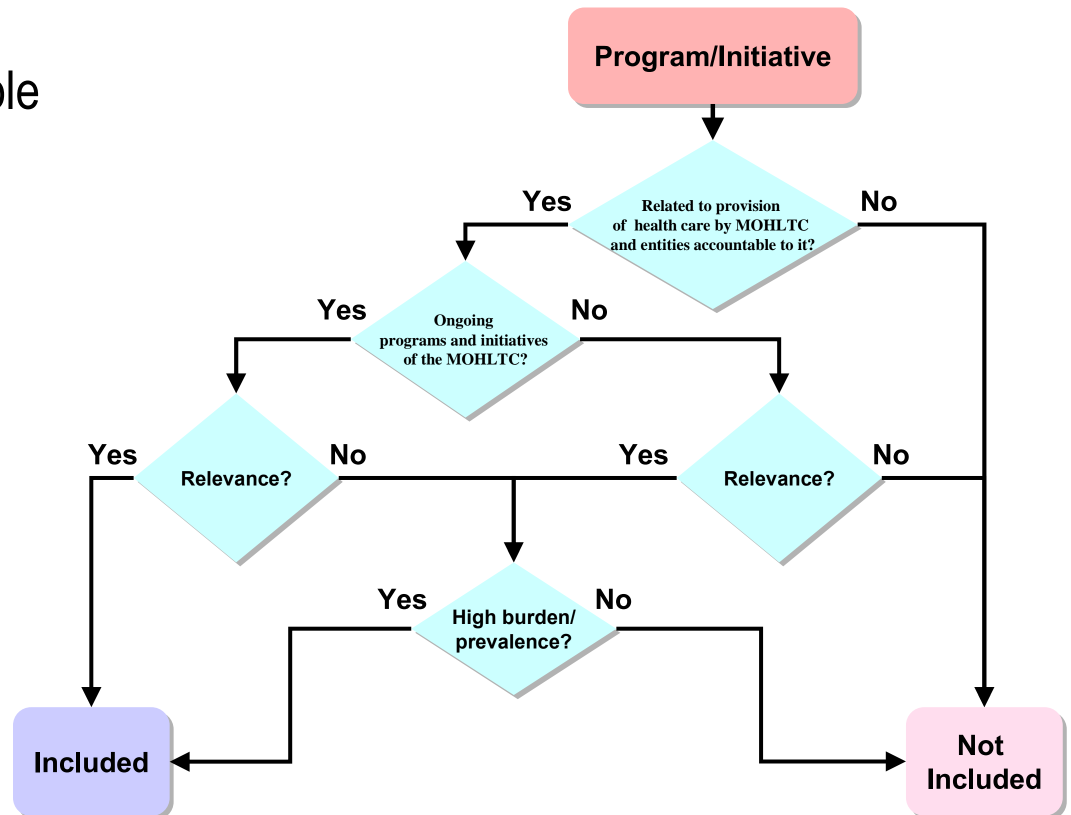
Indicator validation process based on consultation with the Program Areas

Scorecard



Programs and Initiatives Selection Criteria

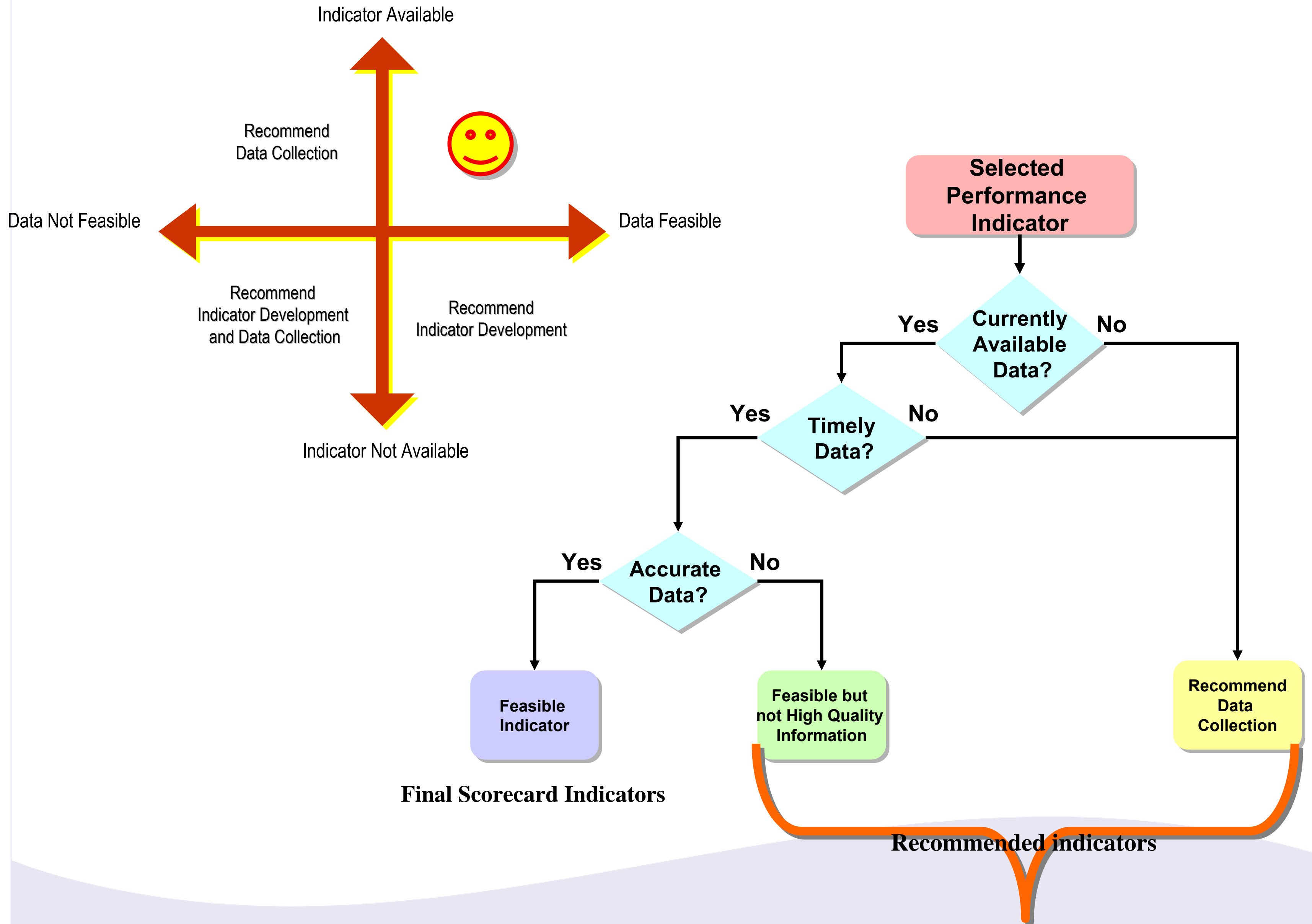
- Related to the provision of health care: the indicator relates to the provision of healthcare by the Ministry or bodies accountable to it.
- Ongoing programs and initiatives of the MOHLTC
- Relevant :any of the following conditions
    - Platform commitments
    - Strategic directions (Operational Plan)
    - Minister's priorities
    - Opportunity for improvement
- Reflective of high burden and high prevalence events



Indicator Selection Criteria

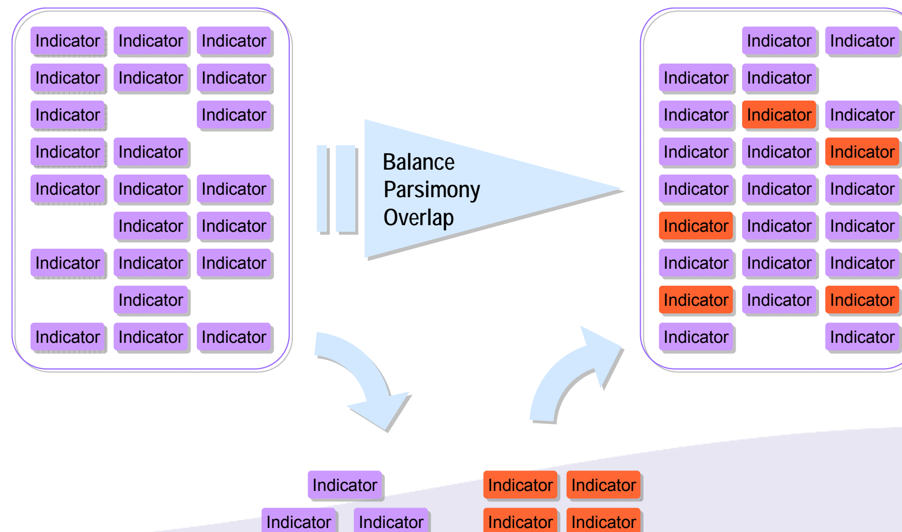
- **Validity:** the indicator measures what it is meant to measure with respect to the targeted phenomenon.
- **Opportunity for Improvement:** the indicator addresses areas where performance improvement is likely to have significant impact on the outcomes.
- **Sensitive:** how significantly the indicator detects changes in the targeted phenomenon it is measuring.
- **Content Validity:** the indicator looks at aspects of performance at the system-level and whole domain, and not at just a specific aspect OR there are parallel indicators that examine the same issue from multiple components of the system.
- **Unidirectional or Potential Target:** the indicator implies a unidirectional performance objective and/or readily lends itself to target setting.

Feasibility Assessment



Assessment of Final Set of Indicators

- **Balanced:** the set of indicators are balanced primarily across
  - MOHLTC strategic directions and key government priorities
  - OHQC's attributes of high-performing healthcare systems
- **Parsimony:** the set of indicators is comprehensive but concise, using as few indicators as possible
- **No overlap:** the set of indicators captures what matters with no overlap



Gap and Balance Analysis: Mapping of Indicators to the Ministry Operational Plan Priorities and to the Attributes of High-Performing Healthcare Systems

Strategic Direction	Healthier People		Healthier Communities		Healthier System		
Priorities / Attributes	Supporting People at Home and Encourage Self-Care	Preventing Illness and Injury	Improving Access to Health Care Across Ontario	Responding to the Needs of Diverse Communities	Ensuring Smarter Health Care Spending	Enabling & Facilitating Innovation	Providing High-Quality Care, Everywhere
Accessibility	Home Care Wait Time		Cancer Surgery Wait Time Cardiac Bypass Wait Time Cataract Surgery Wait Time Joint Replacement Wait Time CT Scans/MRI Wait Time LTC Home Wait Time High-Acuity ED patients Wait Time Low-Acuity ED patients Wait Time Admitted ED patients Wait Time Home Care Wait Time Attached Ontarians Percentage ALC Days ALC Days Mental Health and Substance Abuse Repeat ED Visits	Equity lens was applied to all of the indicators with relevant variable			
Appropriately-resourced		Health Care Workers' Work-Related Injuries			Percentage ALC Days ALC Days Nurses Working in Their Profession		LTC Residents' MAPLe Scores
Efficiency	Home Care Wait Time		High-Acuity EDPatients Wait Time Low-Acuity ED Patients Wait Time Admitted ED Patients Wait Time ALC Days		LTC Residents' MAPLe Scores Hospitalization Rate for Ambulatory Care Sensitive Conditions Percentage ALC Days ALC Days		
Patient-centeredness			Satisfaction with Health Care Confidence in Health Care System				Satisfaction with Health Care Confidence in Health Care System
Effectiveness		HbA1c check in Diabetic Patients Eye Exam in Diabetic Patients LDL-C Check in Diabetic Patients			HbA1c check in Diabetic Patients Eye Exam in Diabetic Patients LDL-C Check in Diabetic Patients Mental Health and Substance Abuse Repeat ED Visits Hospitalization Rate for Ambulatory Care Sensitive Conditions		HbA1c check in Diabetic Patients Eye Exam in Diabetic Patients LDL-C Check in Diabetic Patients Hospitalization Rate for Ambulatory Care Sensitive Conditions LTC ED Visits Mental Health and Substance Abuse Repeat ED Visits
Safety		Health Care Workers' Work-Related Injuries In-Hospital Fractures as results of Falls LTC Fractures Acute and Complex Continuing Care Hospitals Patients with Pressure Ulcers MRSA Rate VRE Rate C. difficile Rate VAP Rate					In-Hospital Fractures as results of Falls LTC Fractures Acute and Complex Continuing Care Hospitals Patients with Pressure Ulcers MRSA Rate VRE Rate C. difficile Rate VAP Rate
Equity	Equity lens was applied to all of the indicators with relevant variable						
Focus on population health		PAP Smear Rate FOBT Rate Mammography Rate STI Rate MMR Vaccination Rate DPT Vaccination Rate Polio Vaccination Rate			PAP Smear Rate FOBT Rate Mammography Rate MMR Vaccination Rate DPT Vaccination Rate Polio Vaccination Rate		Healthy Birth Weight PAP Smear Rate FOBT Rate Mammography Rate MMR Vaccination Rate DPT Vaccination Rate Polio Vaccination Rate
Integration			Percentage ALC Days ALC Days Hospitalization Rate for Ambulatory Care Sensitive Conditions				

Gap and Balance Analysis: Mapping of Indicators to the Ministry Operational Plan Priorities and to the Sectors/Services

Strategic Direction	Healthier People		Healthier Communities		Healthier System		
Priorities / Sectors/Services	Supporting People at Home and Encourage Self-Care	Preventing Illness and Injury	Improving Access to Health Care Across Ontario	Responding to the Needs of Diverse Communities	Ensuring Smarter Health Care Spending	Enabling & Facilitating Innovation	Providing High-Quality Care, Everywhere
Hospitals/Acute Care		In-Hospital Fractures as Results of Falls Acute and Complex Continuing Care Hospitals Patients with Pressure Ulcers MRSA Rate VRE Rate C. difficile Rate VAP Rate	Cancer Surgery Wait Time Cardiac Bypass Wait Time Cataract Surgery Wait Time Joint Replacement Wait Time CT Scans/MRI Wait Time	Equity lens was applied to all of the indicators with relevant variables.	Percentage ALC Days ALC Days		In Hospital Fractures as Result of Falls Acute and Complex Continuing Care Hospitals Patients with Pressure Ulcer MRSA Rate VRE Rate C. difficile Rate VAP Rate
Long-term care		LTC Fractures	LTC Home Wait Time				LTC ED Visits LTC Residents' MAPLe Scores LTC Fractures
Community Care Access Centers	Home Care Wait Time		Home Care Wait Time				
Community Health Centers		STI Rate	Mental Health and Substance Abuse Repeat ED Visits				
Community Support Services							
Rehabilitation							
Palliative Care							
Complex Continuing Care		Acute and Complex Continuing Care Hospitals Patients with Pressure Ulcers					Acute and Complex Continuing Care Hospitals Patients with Pressure Ulcers
Family Health Teams			Attached Ontarians Mental Health and Substance Abuse Repeat ED Visits				
Public Health Units		STI Rates MMR Vaccination Rate DPT Vaccination Rate Polio Vaccination Rate			MMR Vaccination Rate DPT Vaccination Rate Polio Vaccination Rate		MMR Vaccination Rate DPT Vaccination Rate Polio Vaccination Rate
Mental Health and Addiction			Mental Health and Substance Abuse Repeat ED Visits				
Emergency Department			High-Acuity ED Patients Wait Time Low-Acuity ED Patients Wait Time Admitted ED Patients Wait Time Mental Health and Substance Abuse Repeat ED Visits				Mental Health and Substance Abuse Repeat ED Visits
Primary Health Care		STI Rate PAP Smear Rate FOBT Rate Mammography Rate MMR Vaccination Rate DPT Vaccination Rate Polio Vaccination Rate HbA1c Check in Diabetic Patients Eye Exam in Diabetic Patients LDL-C Check in Diabetic Patients	Attached Ontarians Mental Health and Substance Abuse Repeat ED Visits		HbA1c Check in Diabetic Patients Eye Exam in Diabetic Patients LDL-C Check in Diabetic Patients PAP Smear Rate Mammography Rate FOBT Rate		PAP Smear Rate Mammography Rate FOBT Rate Healthy Birth Weight HbA1c check in Diabetic Patients Eye Exam in Diabetic Patients LDL-C Check in Diabetic Patients Hospitalization Rate for Ambulatory Care Sensitive Conditions
System Level (Applicable to more than one sector)		Health Care Workers' Work-Related Injuries	Satisfaction with Health Care Confidence in Health Care System Percentage ALC Days ALC Days		Percentage ALC Days ALC Days Hospitalization Rate for Ambulatory Care Sensitive Conditions Mental Health and Substance Abuse Repeat ED Visits Nurses Working in Their Profession LTC Residents' MAPLe Scores		Mental Health and Substance Abuse Repeat ED Visits Satisfaction with Health Care Confidence in Health Care System

Key Features of the Development Process (1)

- Performance measurement framework based on strategic directions promotes optimal system alignment
- Sharper focus on strategic goals and linkage to priority programs, as the context, results in stronger approach to attribution
- Balancing the needs of the ministry leadership with the need for scientific rigor
- Focusing on the key priorities of the ministry addresses the needs of policy/decision-makers
- Indicators only for care provided by entities accountable to MOHLTC

Key Features of the Development Process (2)

- Consultations with internal (director-level steering committee) and external health system players was key to securing buy-in from stakeholders
- Rigorous scientific approach and critical technical expertise provided by External Expert Panel (Health System Performance Research Network) ensured credibility of the product
- Indicator feasibility assessment conducted in the late phase of the project to allow for indicator and data gap analysis
- Final validation of indicators with ministry program areas/experts, and external stakeholders

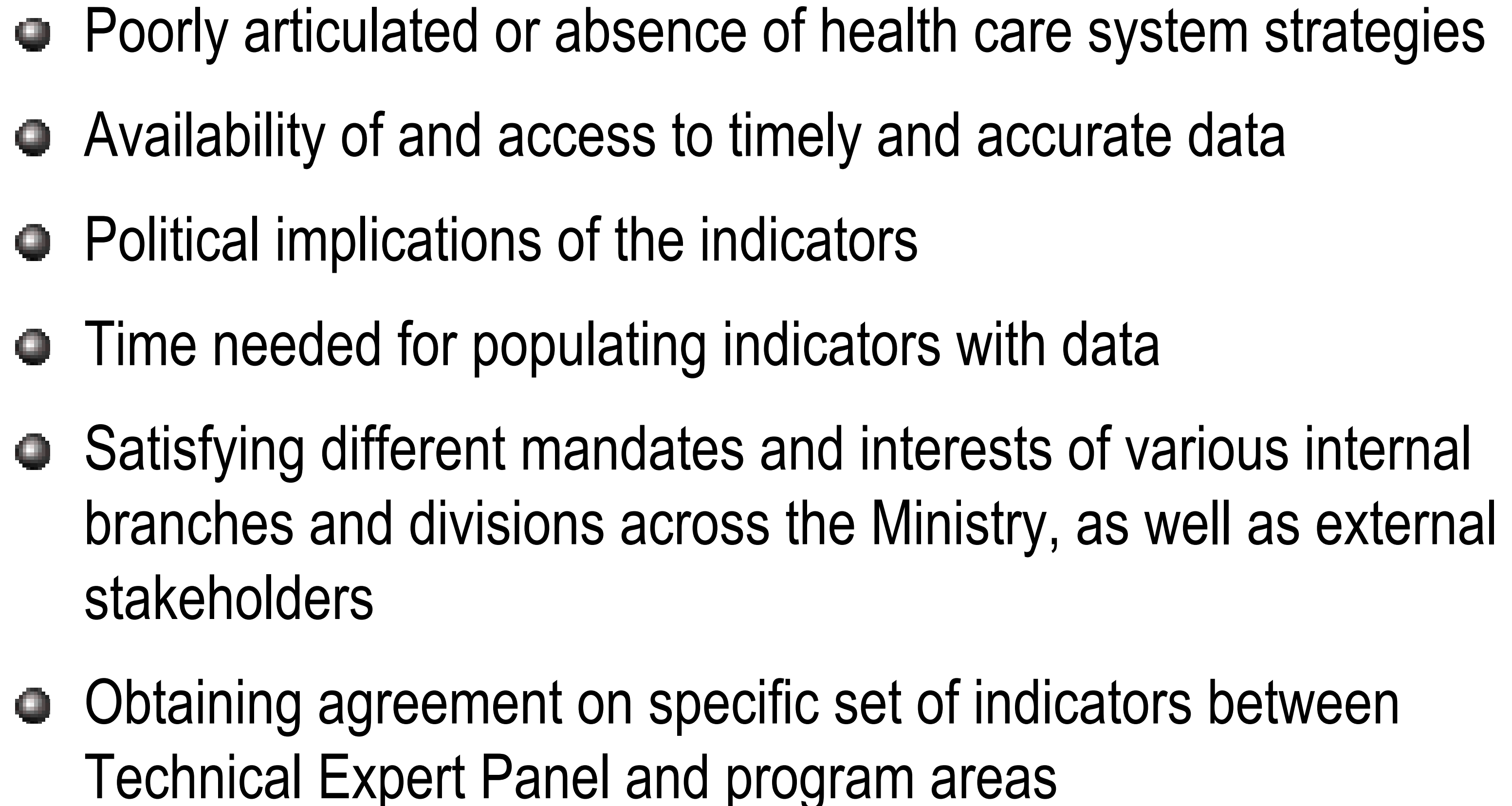
Ontario's Health Care System Scorecard

- A set of 38 evidence-based performance indicators based on strategic directions set out in the Operational Plan
- Finalized in August 2010
- Contains a set of process, output and outcome measures that tracks progress against ministry priorities/objectives to ensures that strategic objectives and expectations are fulfilled
- A dynamic tool which evolves in response to emerging priorities and changing environment (continuous improvement)

Information Provided in the Scorecard

- Relevant strategic priority, program, attribute of high performing healthcare system, sector and data source
- Trend analysis shows our progress against targets/benchmarks
- LHIN level analysis of the indicators provides comparative information and evidence for local performance improvement planning by learning from best practices
- The equity lens applied to indicators provides information for making decisions to address health care inequities

Limitations and Challenges



- Poorly articulated or absence of health care system strategies
- Availability of and access to timely and accurate data
- Political implications of the indicators
- Time needed for populating indicators with data
- Satisfying different mandates and interests of various internal branches and divisions across the Ministry, as well as external stakeholders
- Obtaining agreement on specific set of indicators between Technical Expert Panel and program areas

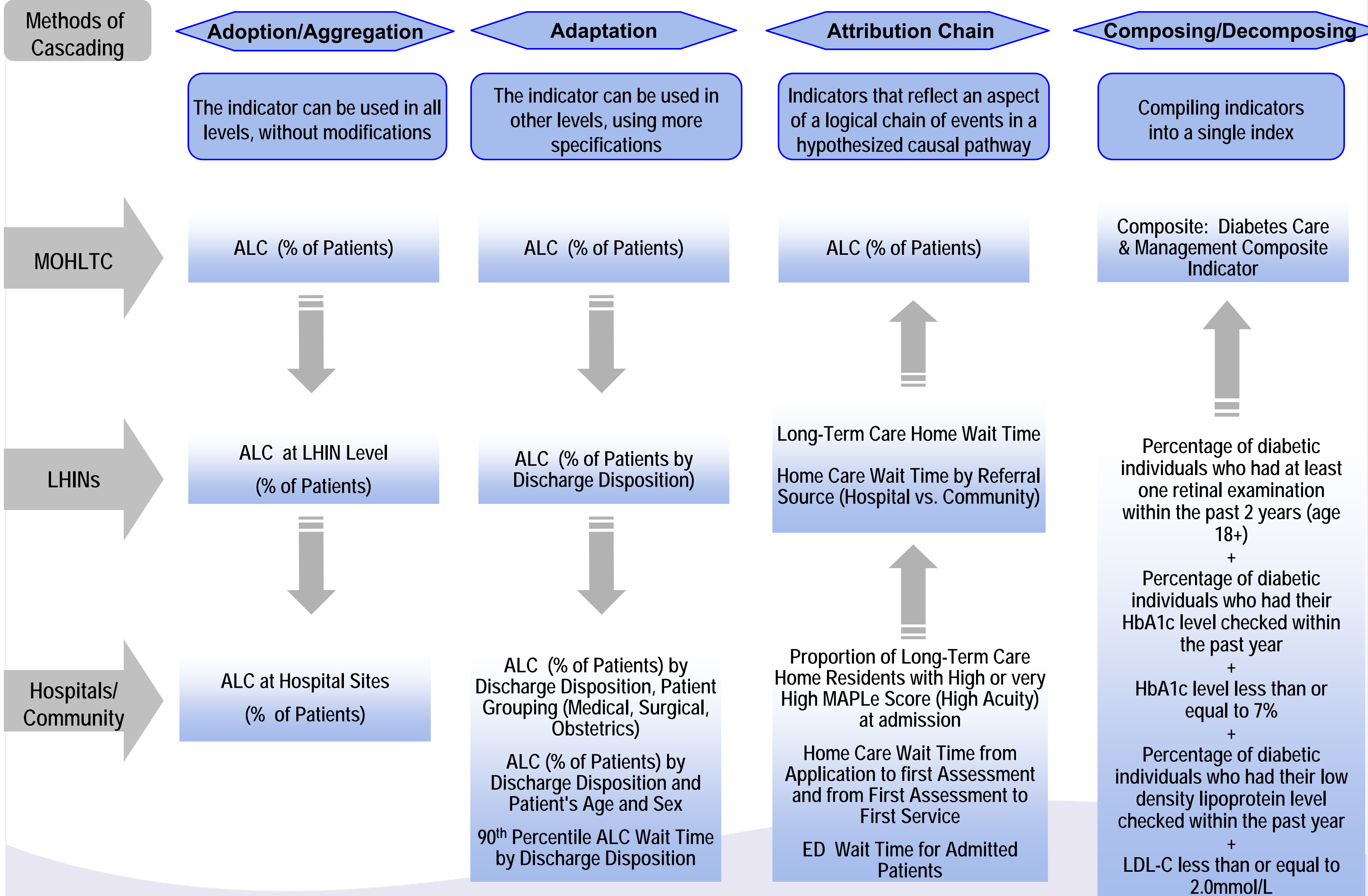
Main Uptake and Applications of the Scorecard

- Strengthening accountability to central agencies
- Guided the selection of the re-negotiated Ministry-LHIN Performance Agreement (MLPA) indicators
- Guiding the development of “An Integrated Approach to LHIN Performance Measurement and Management”

How Performance Measurement Can Help Better Manage Performance

Change in Performance Over Time	Level of Performance Compared to Target or Benchmark: Good	Satisfactory	Poor
Improving	**No action**	**No action** -LTC Residents' MAPLe Scores -Hip and Knee Replacement Wait Time -Confidence in Health Care System -Hospitalization Rate for Ambulatory Care Sensitive Conditions	**Needs attention** -Breast Cancer Screening Rate -Cervical Cancer Screening Rate -Colon Cancer Screening Rate -Nurses Working in Their Profession
No Change	**No action** -Cancer Surgery Wait Time -Cardiac Bypass Wait Time -Cataract Surgery -Gonorrhea Rate	**Needs attention** -High-Acuity ED patients Wait Time -Low-Acuity ED patients Wait Time -MRSA Rate	**Needs action** -MRI Wait Time -Infectious Syphilis Rate
Worsening	**Needs attention** -Chlamydia Rate	**Needs action** -C. difficile Rate	**Needs action** -CT Scan Wait Time -Satisfaction with Health Care -ALC Days

Cascading Indicators to Strengthen Accountability and Alignmen



Health Care System Scorecard Indicators for Different Health Care Sectors

Hospitals/Acute Care

- Patient Safety
  - In Hospital Fractures as a result of Falls
  - Pressure Ulcers
  - MRSA Rates
  - VRE Rates
  - C. diff Rates
  - VAP Rates
- Wait Times
  - Cancer Surgery
  - Cardiac Procedures
  - Cataract Surgery
  - Joint Replacement
  - CT/MRI Scans
- Diabetic HbA1C check, Retinal Eye Exams, LDL-C Check
- ALC days and % ALC days

Family Health Teams

- Attached Ontarians
- Mental Health and Substance Abuse Repeat Emergency Visits

Public Health Units

- Sexually Transmitted Infections (STI)
- MMR Vaccination Rates
- DTP Vaccination Rates
- Polio Vaccination Rates

Long-Term Care Home

- Resident Safety
  - LTC Fractures
  - LTC ED Visits
- LTC Residents' MAPLe Score
- LTC Wait Time

Community Health Centres

- Sexually Transmitted Infections (STI)
- Mental Health and Substance Abuse Repeat Emergency Visits

Complex Continuing Care Hospitals

- Pressure Ulcers

System Level (applies to more than one sector)

- Lost Time Work Related Injuries for Health Care Workers
- Satisfaction with Health Care
- Confidence in Health Care System
- % ALC Days, ALC Days
- Mental Health and Substance Abuse Repeat Emergency Visits
- Working Nurses
- Ambulatory Care Sensitive Conditions-Hospitalizations
- LTC Residents' MAPLe Score

Primary Health Care

- Sexually Transmitted Infections (STI)
- PAP Smear Rates
- FOBT Rates
- Mammography Rates
- Healthy Birth Weight
- Diabetic HbA1C check, Eye Exams, LDL-C Check
- Attached Ontarians
- MMR, DPT and Polio Vaccination Rates
- Mental Health and Substance Abuse Repeat Emergency Visits

Emergency Departments

- Wait Times
  - High Acuity
  - Low Acuity
  - Admitted Cases
- Mental Health and Substance Abuse Repeat Emergency Visits

Mental Health and Substance Abuse

- Mental Health and Substance Abuse Repeat Emergency Visits

Community Care Access Centres

- Mental Health and Substance Abuse Repeat Emergency Visits
- Home Care Wait Time

Indicator: Percentage of non-admitted high acuity patients (Canadian Emergency Department Triage and Acuity Scale (CTAS) I-III) treated within their respective targets (≤ 8 hours) in Emergency Room (ER)
Indicator: Percentage of non-admitted low acuity patients (CTAS IV & V) treated within their targets (≤ 4 hours) in ER
Indicator: Percentage of admitted patients treated within their targets (≤ 8 hours) in ER

Strategic Priority: Improving Access to Health Care
Program/Strategy/Theme: Emergency Department Wait Times

Attribute of Quality Care: Accessibility, Efficiency
Sector: Emergency Department
Data Source: NACRS*, EDRS**

Figure 29: Non-admitted and admitted ER patients treated within their targets by CTAS level (Fiscal Years 2008-09 to 2009-10 Q1-Q4)

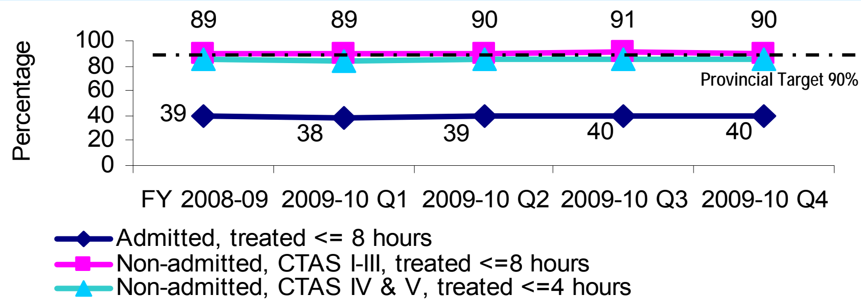


Figure 30: Non-admitted and admitted ER patients treated within their targets by CTAS level by LHIN (Fiscal Year 2008-09)

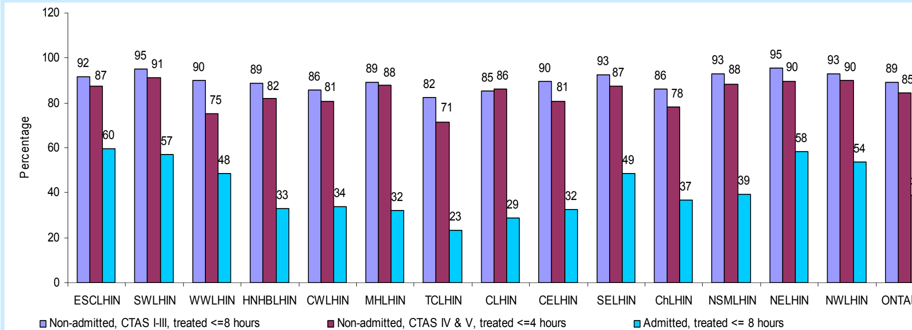


Figure 31: Non-admitted and admitted ER patients treated within their targets by CTAS level by Sex (Fiscal Year 2008-09 to 2009-10 Q1-Q4)

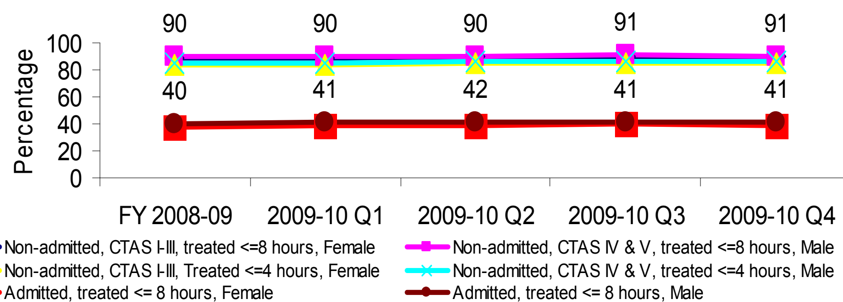
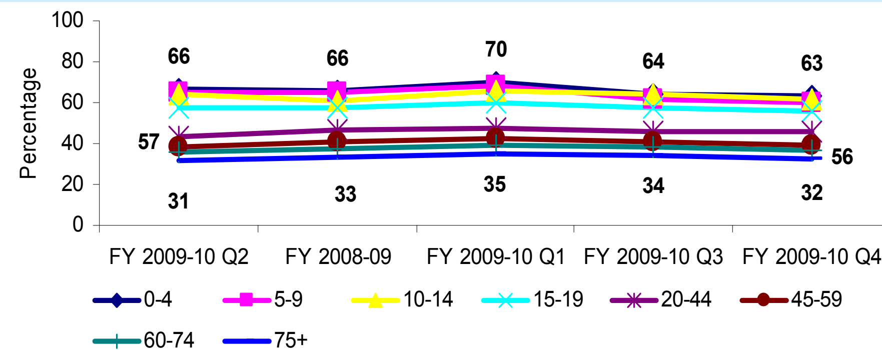


Figure 32: Admitted ER patients treated within their targets by CTAS level by Age (Fiscal Year 2008-09 to 2009-10 Q1-Q4)



- Among non-admitted ER patients with high acuity CTAS (I-III), nearly 90% were treated within their respective targets. The proportion of admitted ER cases treated within their targets has remained stable since 2008-09. Recent data show that there are regional variations in wait time for admitted and non-admitted ER patients. Age specific data shows that a larger proportion of the admitted ER patients in the 5-9 age group were seen within their targeted time frame.

Indicator: 90th percentile wait times between decision to proceed with surgery and the time the procedure is completed for Cancer, Cardiac Bypass, Joint Replacement and Cataract Surgeries

Strategic Priority: Improving Access to Health Care
Program/Strategy/Theme: Surgical Wait Times

Attribute of Quality Care: Accessibility
Sector: Hospitals/Acute Care
Data Source: Wait Time Information System (WTIS)

Figure 33: 90th percentile surgical wait times
(Fiscal Years 2007-08 Q1 to 2009-10 Q4)

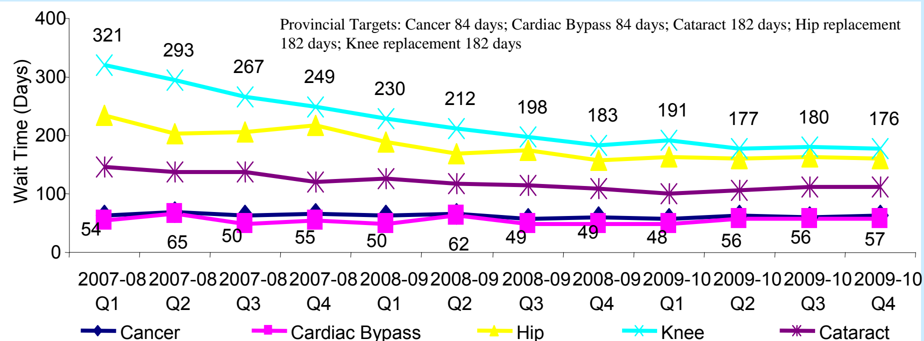


Figure 34: 90th percentile surgical wait times by LHIN
(Fiscal Year 2009-10 Q4)

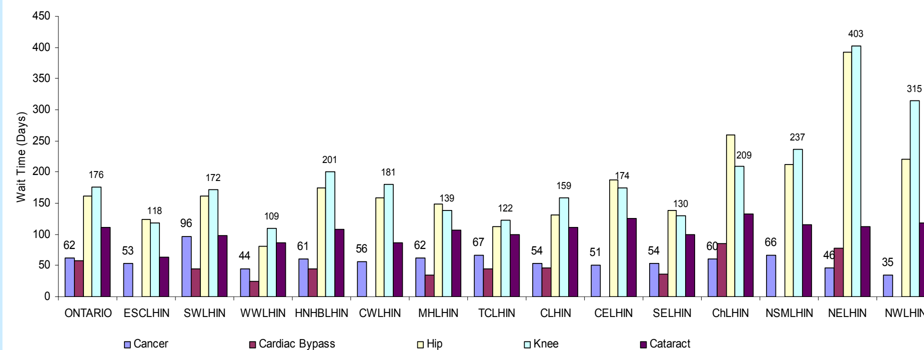


Figure 35: 90th Percentile surgical wait times by Equity Variable

No equity data was available for this indicator.

Figure 36: 90th Percentile surgical wait times by Equity Variable

No equity data was available for this indicator.

- Access to surgical services has been identified as one of the provincial government's major priorities, and data has been reported as early as 2005, but more systematically as of 2007-08. The 90th percentile wait times for joint replacement and for cataract surgery have decreased since Q1 2008-09. At the same time, wait times for cancer and cardiac bypass surgeries have remained relatively stable. Regional rates show strikingly different rates. Equity data for these indicators were not available.

Indicator: 90th percentile wait times for Computed Tomography (CT) scan and Magnetic Resonance Imaging (MRI)

Strategic Priority: Improving Access to Health Care
Program/Strategy/Theme: CT Scan and MRI Wait Times

Attribute of Quality Care: Accessibility
Sector: Hospitals/Acute Care
Data Source: Wait Time Information System (WTIS)

Figure 37: 90th percentile wait times for CT scan and MRI
(Fiscal Years 2007-08 Q1 to 2009-10 Q4)

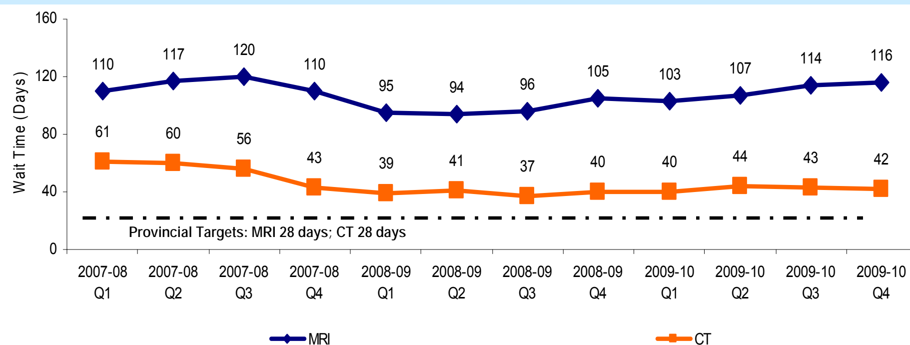


Figure 38: 90th percentile wait times for CT scan and MRI by LHIN
(Fiscal Year 2009-10 Q4)

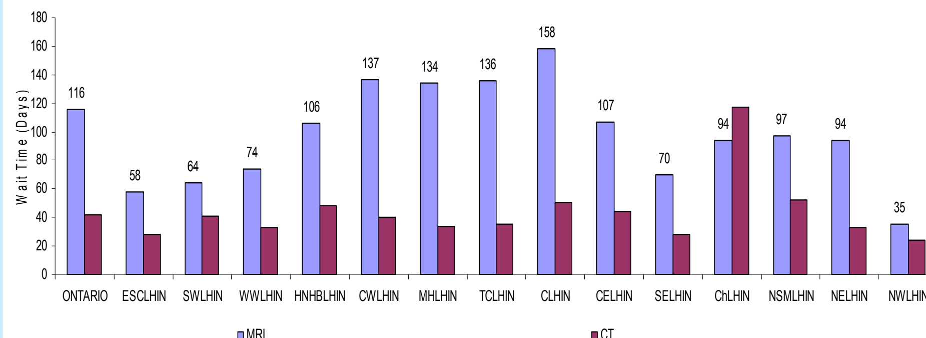


Figure 39: 90th percentile wait times for CT scan and MRI
by Equity Variable

No equity data was available for this indicator.

Figure 40: 90th percentile wait times for CT scan and MRI
by Equity Variable

No equity data was available for this indicator.

- Access to diagnostic services has been identified as one of the major priorities for the government of Ontario. Trend data is available from Q1 2007-08. The 90th percentile wait times for CT scan has dropped by 19 days since Q1 2007-08. However, the wait times for MRI have increased during the same period by 6 days. There are strikingly regional variations for CT scan and MRI. Equity data for these indicators were not available. The observed wait times for all indicators are above the provincial targets.

Indicator: Percentage of Long-Term Care (LTC) home residents with "Method of Assigning Priority Levels" (MAPLe) scores of high or very high (high acuity) at admission

Strategic Priority: Providing High Quality Care Everywhere, Ensuring Smarter Health Care Spending
Program/Strategy/Theme: Long-Term Care

Attribute of Quality Care: Appropriately-Resourced, Efficiency
Sector: Long-Term Care, System Level
Data Source: Home Care Database (HCD)

Figure 41: High or very high MAPLe Scores at LTC Admission (Fiscal Years 2008-09 Q1 to 2009-10 Q4)

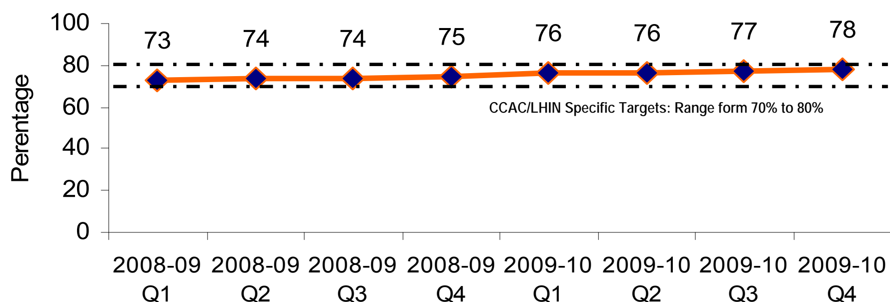


Figure 42: High or very high MAPLe Scores at LTC Admission by LHIN (Fiscal Year 2009-10 Q4)

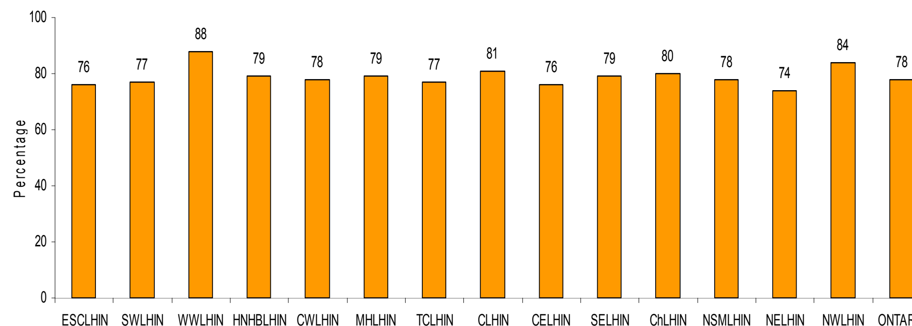


Figure 43: High or very high MAPLe Scores at LTC Admission by Sex (Fiscal Years 2008-09 Q1 to 2009-10 Q4)

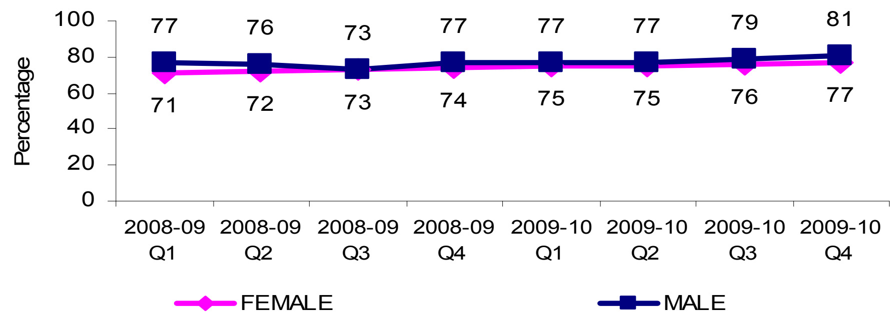
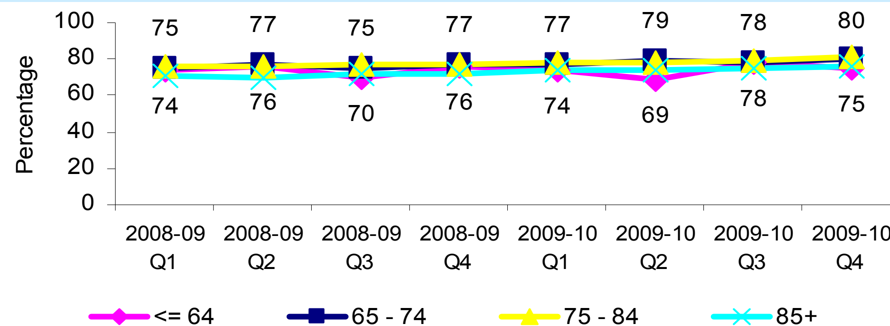


Figure 44: High or very high MAPLe Scores at LTC Admission by Age (Fiscal Years 2008-09 Q1 to 2009-10 Q4)



- The appropriateness of Long-Term Care (LTC) home placements is assessed by the MAPLe score (a measure of acuity). Recent data shows that three out of every four Ontarians placed in LTC homes had a high or very high MAPLe score (high acuity). Further investigation is required for the remaining fourth of residents. There are regional variations in the observed placement rates. The percentage of those with higher acuity placed in LTC homes remained stable for those 64 years of age or younger and slightly increased for other age groups.

Indicator: 90th percentile wait time for Ontarians who received In-Home* Community Care Access Centre (CCAC) Services

Strategic Priority: Improving Access to Health Care, Supporting People at Home and Encourage Self Care
Program/Strategy/Theme: Home Care Wait Times

Attribute of Quality Care: Accessibility, Efficiency
Sector: Community Care Access Centres
Data Source: Registered Person Database, Home Care Database

Figure 53: 90th percentile CCAC Service wait time by referral source (Fiscal Years 2007-08 to 2009-10)

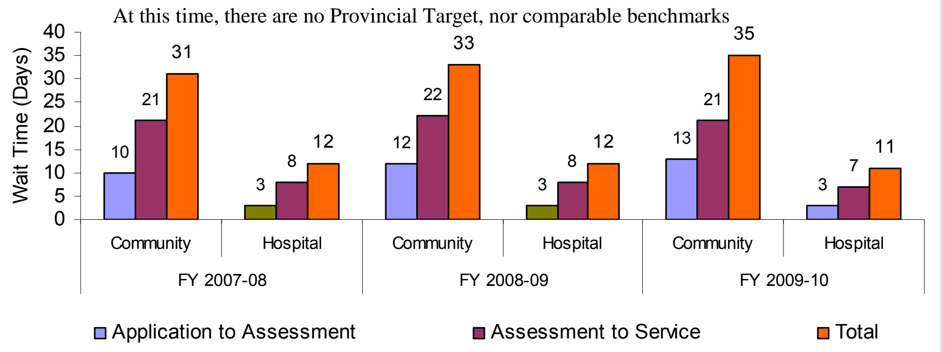


Figure 54: 90th percentile total wait time (Application to First Service) by referral source by LHIN (Fiscal Year 2009-10)

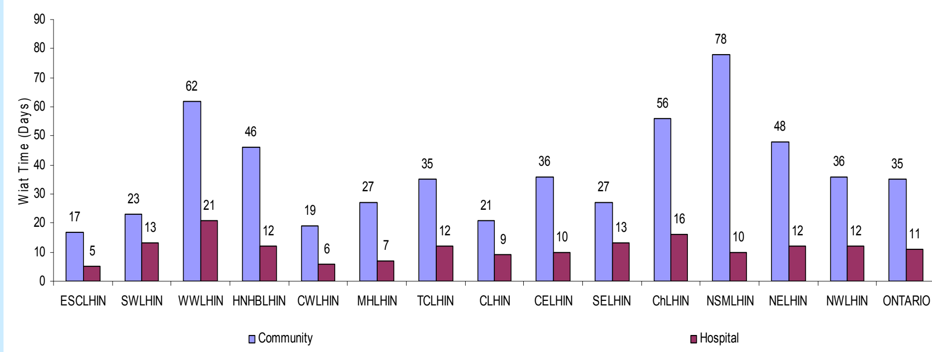


Figure 55: 90th percentile wait time (Application to First Service) by referral source and Sex (Fiscal Years 2007-08 to 2009-10)

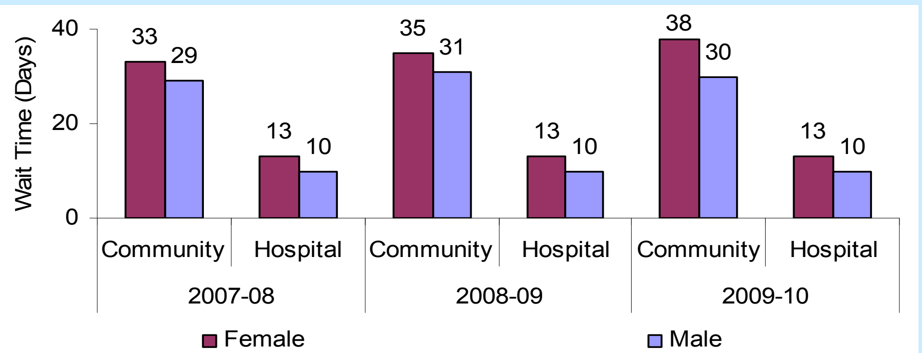
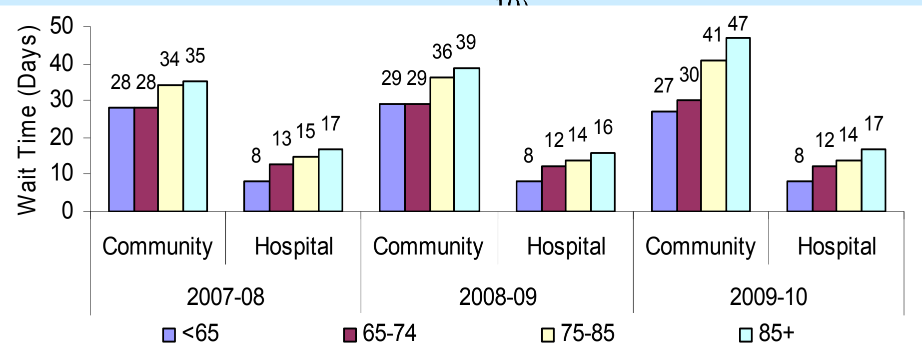


Figure 56: 90th percentile wait time (Application to First Service) by referral source and Age (Fiscal Years 2007-08 to 2009-10)



❖ Access to community care services through Community Care Access Centres (CCAC) is measured using wait time "from application to first assessment" and "from assessment to first service". Among Ontarians who received in-home* CCAC services, those referred from hospitals had the shorter wait time when compared to those referred from the community. There are strikingly different regional wait time patterns. Female service recipients and those 75 years of age and older had longer wait times.

* Including: In-Home, Adult Day Care and Supportive Housing Note: Wait times exclude case management services

Indicator: Percentage of any unplanned and unscheduled mental health and substance abuse Emergency Visits which occur within 30 days of a previous mental or substance abuse Emergency Visit in any Ontario hospital and in any LHIN

Strategic Priority: Providing High Quality Care Everywhere, Ensuring Smarter Health Care Spending, Improving Access to Health Care
Program/Strategy/Theme: Mental Health and Addictions

Attribute of Quality Care: Accessibility, Effectiveness
Sector: Mental Health and Addictions, System Level, ED, CHC*, FHT**
Data Source: National Ambulatory Care Reporting System***

Figure 65: Repeat unplanned and unscheduled Emergency visit rates for Mental Health and Substance Abuse Patients based on Patient LHIN (Fiscal Years 2006-07 to 2008-09)

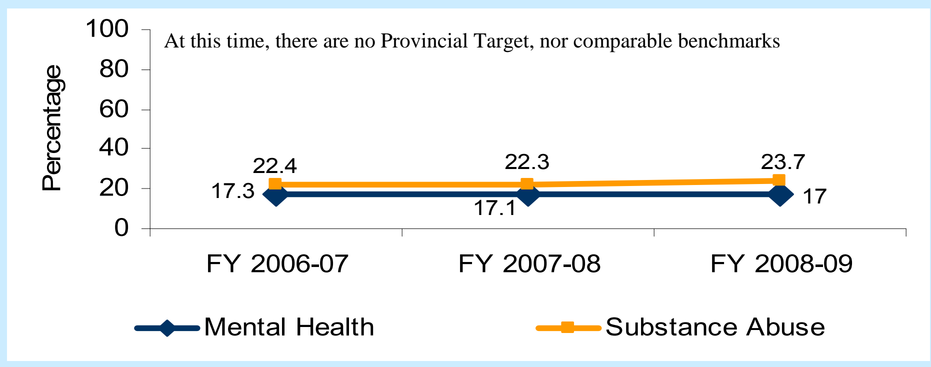


Figure 66: Repeat unplanned and unscheduled Emergency visit rates for Mental Health and Substance Abuse by Patient LHIN (Fiscal Year 2008-09)

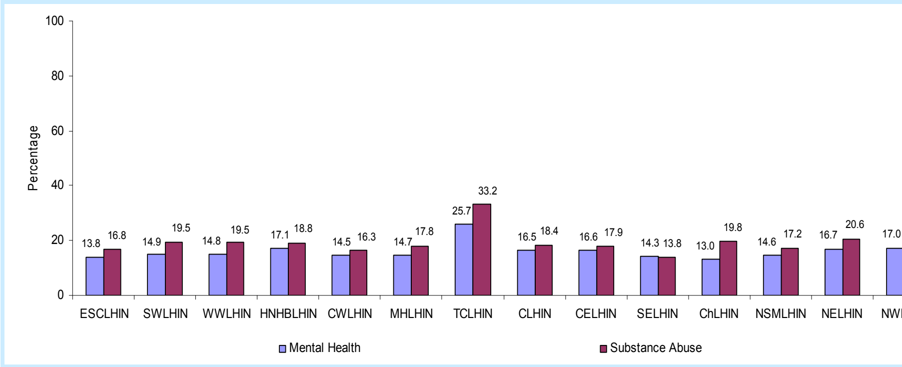


Figure 67: Repeat unplanned and unscheduled Emergency visit rates for Mental Health and Substance Abuse Patients by Patient LHIN by Sex (Fiscal Years 2006-07 to 2008-09)

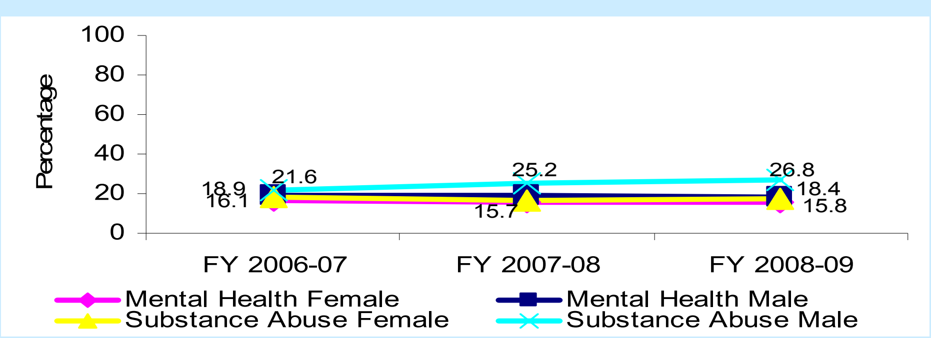
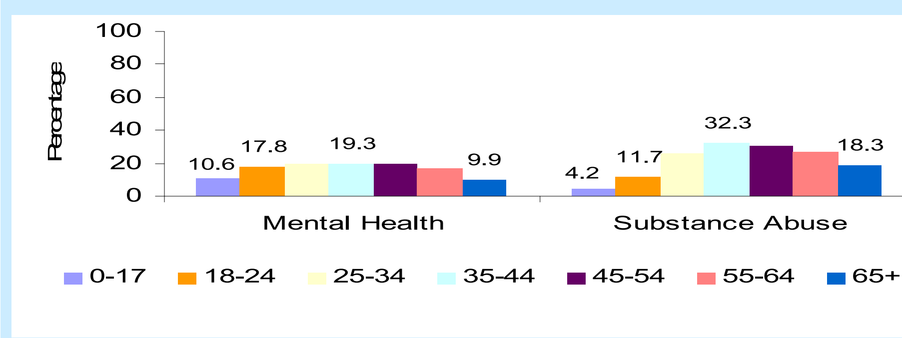


Figure 68: Repeat unplanned and unscheduled Emergency visit rates for Mental Health and Substance Abuse Patients by Patient LHIN by Age (Fiscal Yea 2008-09)



- Repeat unplanned emergency visits impact the Emergency Department (ED) volumes and can contribute to overcrowding. It may also reflect that these patients are not getting the right kind of follow-up care after ED discharge. The rate of unplanned emergency revisits for mental health is stable at about 17% between fiscal 2006-07 to 2008-09 and increased slightly for substance abuse (22.4 to 23.7). Regional analysis of the data shows that a large proportion of the repeat emergency visits occur in the same LHIN as the patient's LHIN. There are slightly different patterns of visits between females and males, and those in different age groups. Income data would be interesting to be include in future iteration of the scorecard.

*Community Health Centres, **Family Health Teams,***NACRS

Indicator: Percentage Alternate Level of Care (ALC) days: Percentage of inpatient days where a physician (or designated other) indicated that a patient occupying an acute care hospital bed no longer required acute care

Strategic Priority: Improving Access to Health Care Services, Ensuring Smarter Health Care Spending
Program/Strategy/Theme: Integration

Attribute of Quality Care: Integration, Efficiency, Access, App-Res*
Sector: System Level, Hospitals/Acute Care
Data Source: Discharge Abstract Database (DAD)

Figure 97: Percentage of inpatient ALC days (Fiscal Years 2004-05 to 2008-09)

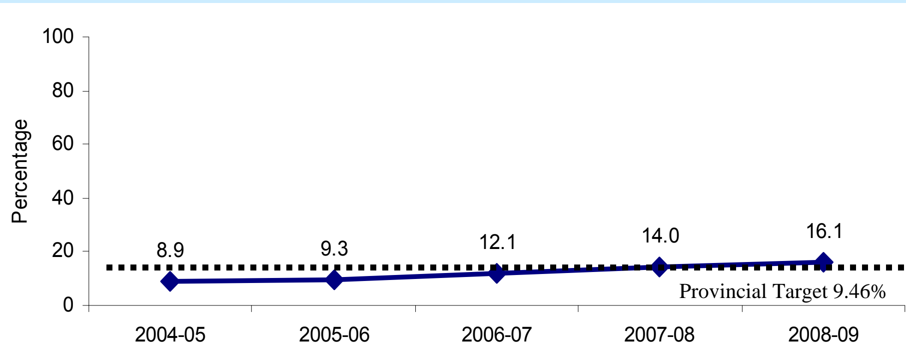


Figure 98: Percentage of inpatient ALC days by LHIN of patient (Fiscal Year 2008-09)

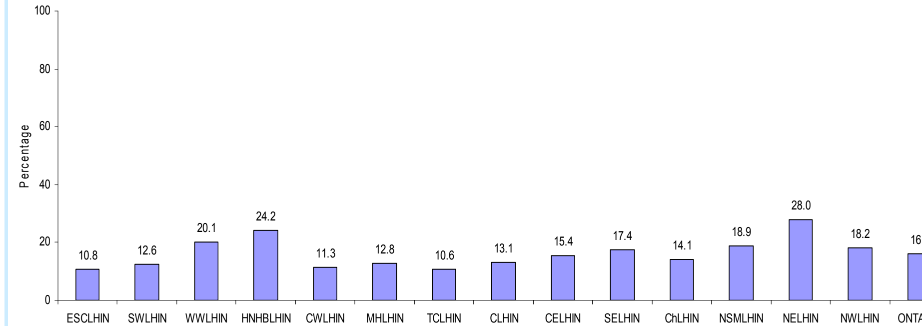


Figure 99: Percentage of inpatient ALC days by Sex (Fiscal Years 2004-05 to 2008-09)

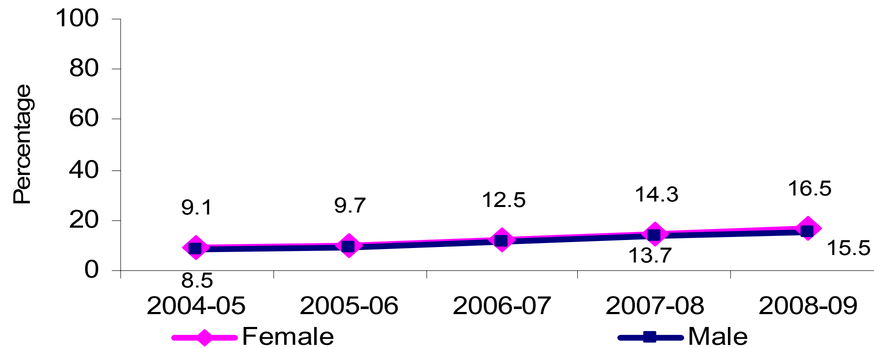
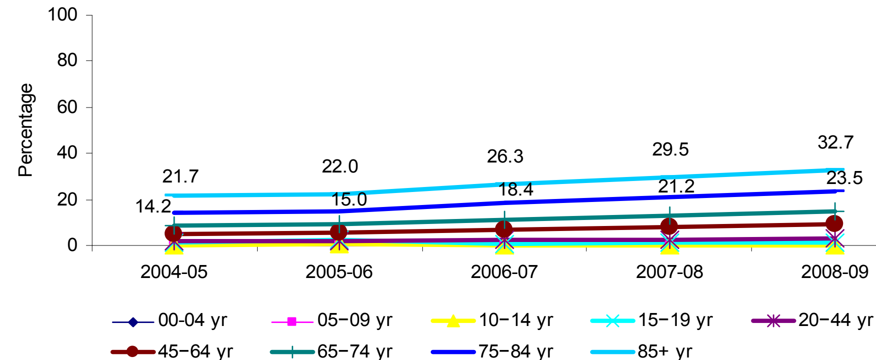


Figure 100: Percentage of inpatient ALC days by Age (Fiscal Years 2004-05 to 2008-09)



❖ Reducing ALC days is a priority of the government of Ontario. ALC data show that the proportion of ALC patients in acute care hospitals has increased dramatically from fiscal 2004-05 to 2008-09 . There are strikingly different regional ALC days rates. There is no difference in percent ALC days by sex. The percentage of ALC among older patients has increased steadily since 2004-05.

*Appropriately Resourced

Indicator: 90th percentile Alternate Level of Care (ALC) days: Number of days for 90 percent of the patients where a physician (or designated other) indicated that a patient occupying an acute care hospital bed no longer required acute care

Strategic Priority: Improving Access to Health Care Services, Ensuring Smarter Health Care Spending, Improving Access to Health Care
Program/Strategy/Theme: Integration

Attribute of Quality Care: Integration, Efficiency, Access
Sector: System Level, Hospitals/Acute Care
Data Source: ALC Interim Upload Tool

Figure 101: 90th percentile ALC days by discharge disposition (Fiscal Year 2009-10 Q4)

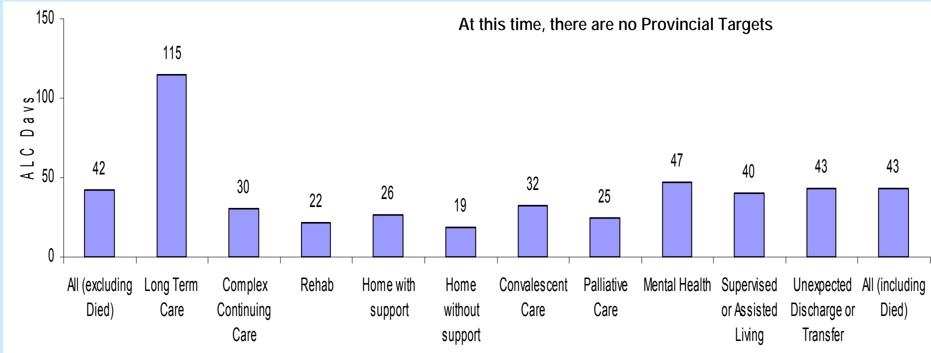


Figure 102: 90th percentile ALC days by LHIN (Fiscal Year 2009-10 Q4)

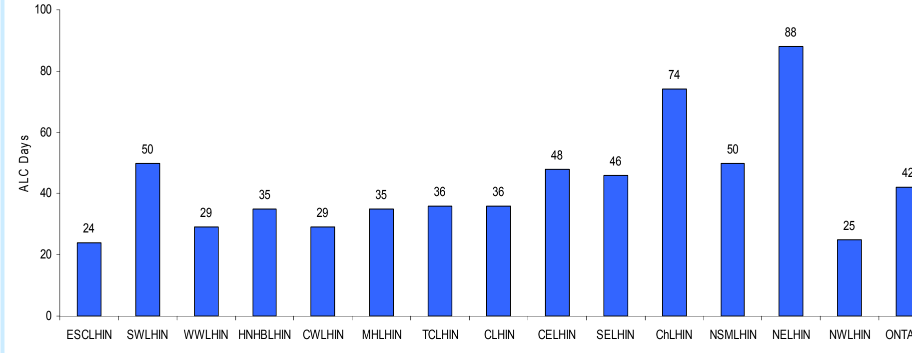


Figure 103: 90th percentile ALC days by discharge disposition by Equity Variable

Equity data for this indicator are not currently collected and reported.

Figure 104: 90th percentile ALC days by discharge disposition by Equity Variable

Equity data for this indicator are not currently collected and reported.

- ALC days are largely influenced by patients' discharge disposition. Recent data show that ALC days for those waiting for placement in LTC homes and mental health care are the longest. There are notable regional differences in 90th percentile ALC days. Equity data for this indicator are not currently collected and reported

Opportunity for Filling the Gaps (1)

- Enhancing capacity to conduct equity analyses for all indicators based on important variables
  - Limitation on the equity variables in not unique to the HCSS
- Filling the gaps
  - Surgical/Imaging Wait Times:
  - the time from referral to see specialist--This component of wait time is as important as the current wait time measure
  - Diabetes Strategy:
    - The actual test results for HbA1c, blood pressure, and LDL
      - Data on these variables are not systematically collected at present time
      - Plans to include them as part of the BDDI have been discussed
  - HealthForceOntario Strategy:
    - The employment gaps for all regulated health professionals for planning and resource allocation purposes
  - Patient Safety:
    - Medication incidents resulting in death or harm,
    - Amenable mortality (causes of death considered amenable to health care).
    - In the LTC and Home care settings, many of the safety indicators have/will become more systematically available
  - eHealth:
    - System level indicators related to eHealth and the use of electronic health records

Opportunity for Filling the Gaps (2)

- Integration:
  - Appropriate system level indicators for integration, specifically, care transitions indicators
- Mental Health & Addictions:
  - Emphasis on data collection and indicator development in the MHA community care sector.
  - Indicators relevant to integration of MH&A services into other primary care and community services (such as inpatient mental health patients in Ontario who received at least one community mental health service contact within 30 days of discharge)
- Informal Caregiver Distress:
  - One of the important indicators that have been under review by CIHI
- Sustainability/Productivity:
  - A major indicator gap, particularly those that can be used for accountability purposes
- Public Drugs:
  - System level indicators related to the publicly financed drugs
- Maternal, Child & Youth Health:
  - Vaccination rates for children 2 years of age or younger. Currently this data is not available in Ontario. Also, the infant mortality rate, for which the available data sources have not been accurate and complete in Ontario in recent years.
- Primary and Ambulatory Care:
  - Enhancement of data gathering in the primary and ambulatory care settings is essential to support assessment of chronic disease prevention and management strategy particularly around avoidable hospitalization and readmissions.

For further information, to provide your comments

or to obtain a copy of the current Scorecard Report,

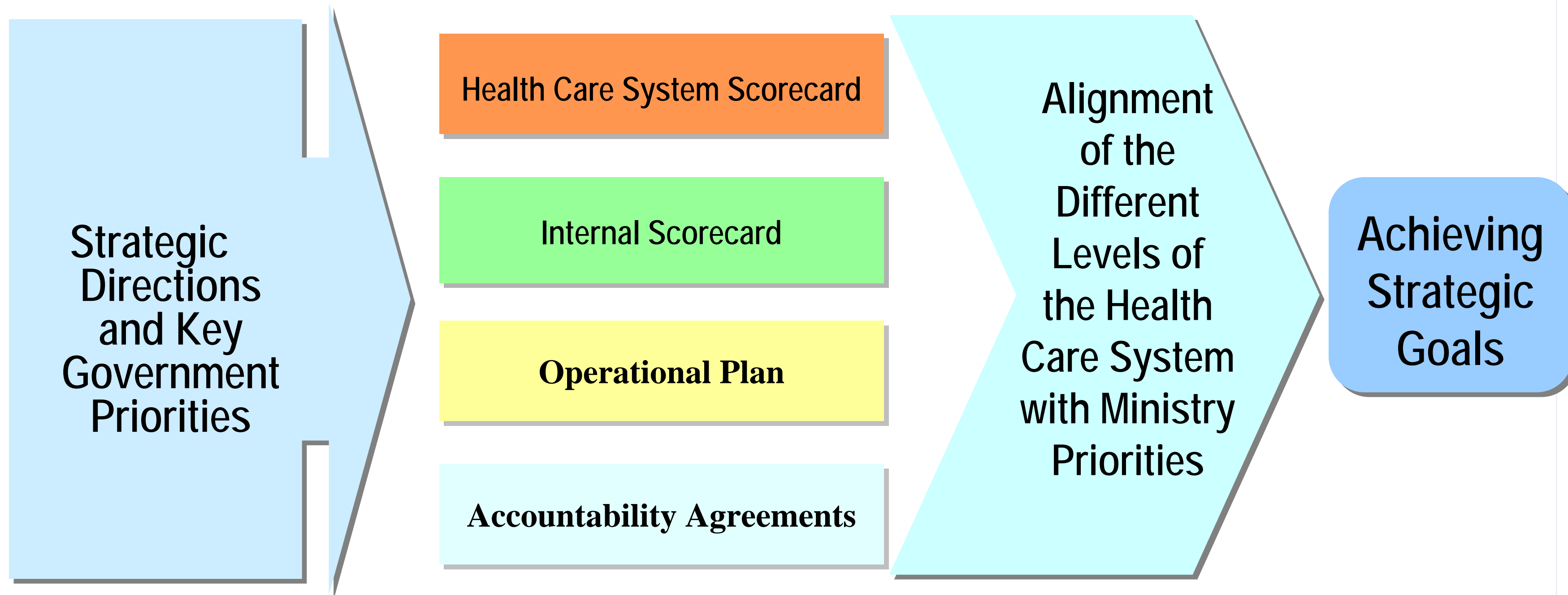
please contact:

Sahba.Eftekhary@ontario.ca

Siamak.Tenzif@ontario.ca

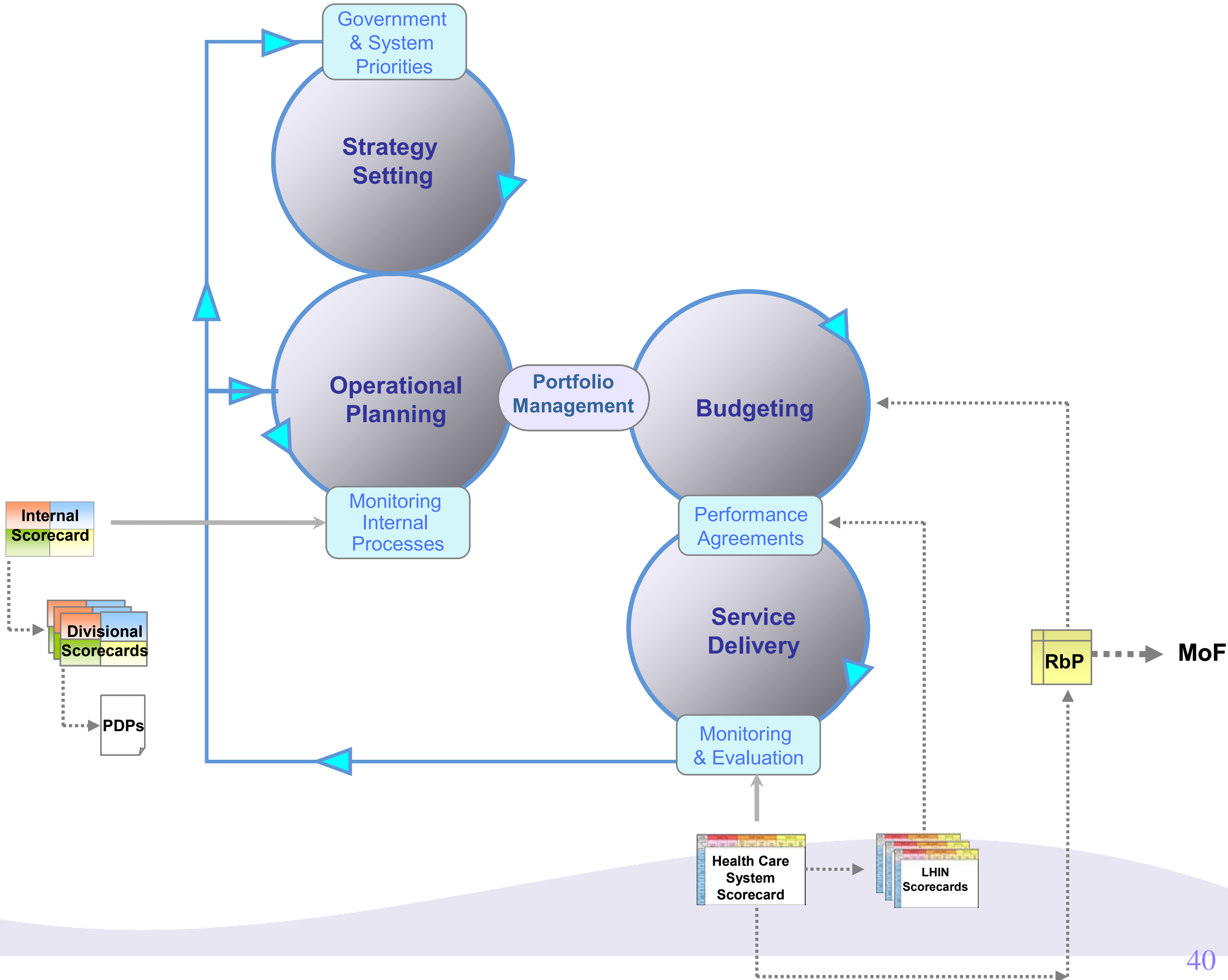
416-326-6501

Accountability and Alignment Tools

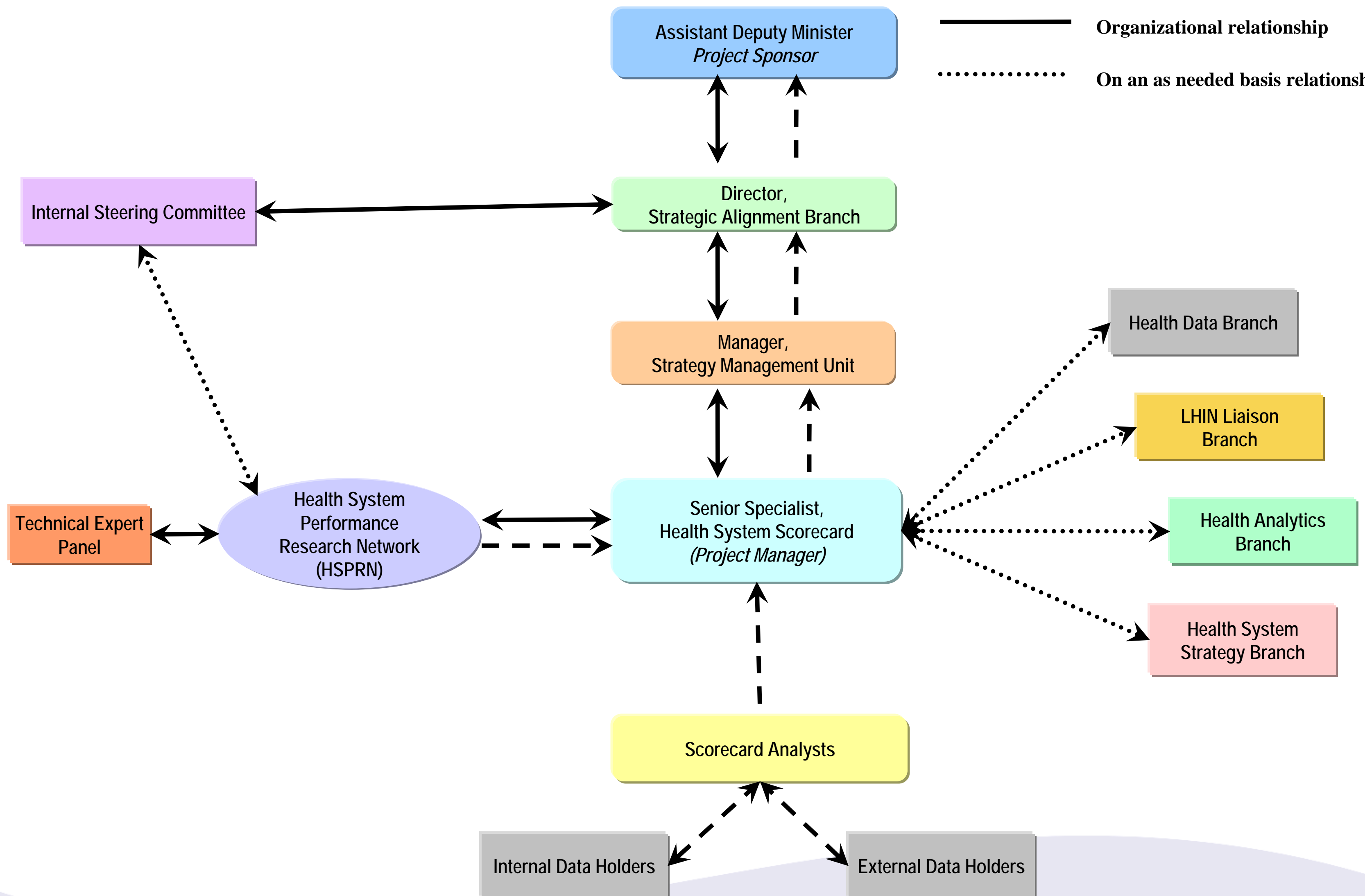


These tools enable the Ministry to identify strategies that are most likely to lead to the greatest strategic success, and thereby improve efficiency in resource allocation.

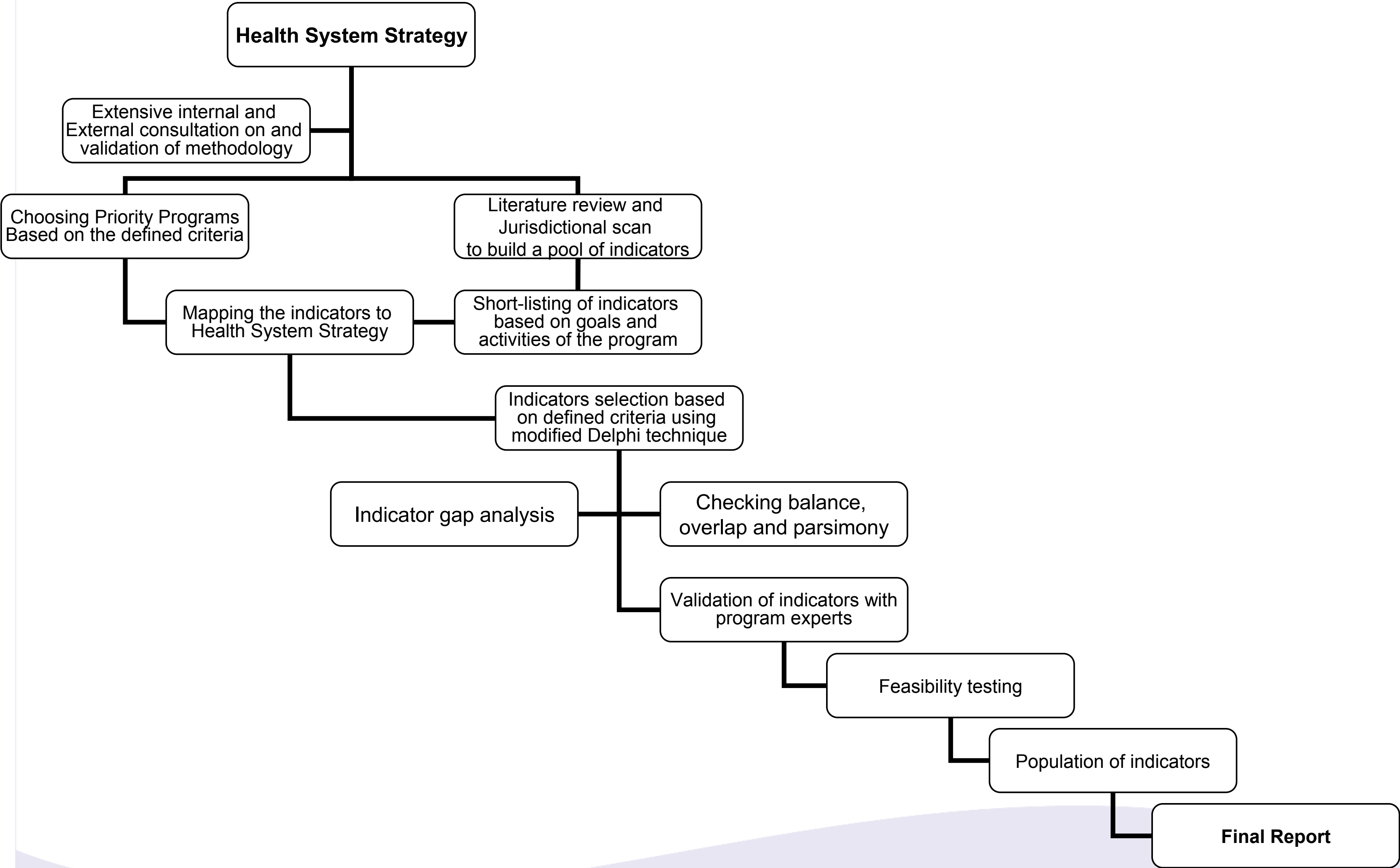
Ministry Business Processes



Governance and Organizational Structure



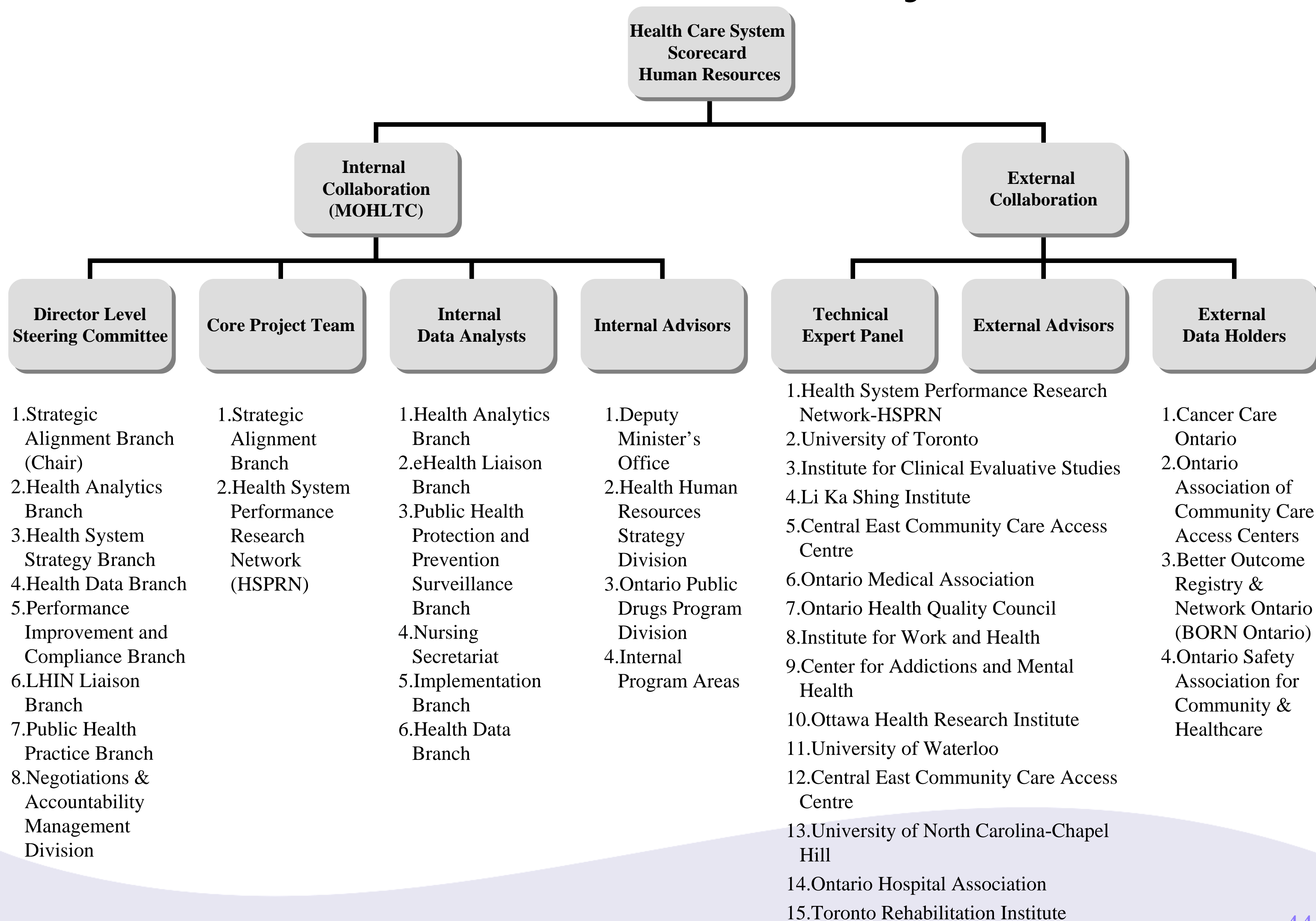
Health Care System Development Process: Summary of the Steps



Collaborations and Consultations throughout the Project

- Project oversight and guidance provided by Director-level Steering Committee
- Consultations with internal and external health system players throughout the development process was key to securing buy-in from health system stakeholders
- Critical technical expertise provided by External Expert Panel (Health System Performance Research Network) for indicator selection process, which ensured the scientific rigor of the final product
- Final validation of indicators with Ministry program areas/experts and external stakeholders, which ensured internal buy-in and support
- Obtaining data from internal and external data holders for populating the indicators

Involvement and Engagement of Various Groups and Individuals in the Ontario Health Care System Scorecard



Consultation and Collaboration Goals of the Health Care System Scorecard

Purpose:

To generate buy-in and promote the adoption of the Health Care System Scorecard as an alignment tool

Planning Phase:

- To raise awareness and understanding of the purpose of the Health Care System Scorecard and the intended objectives of measuring performance in Ontario's Health Care System
- To obtain input, feedback, and recommendation on the approach adopted to develop the scorecard
- To ensure major MOHLTC priorities are identified and captured in the scorecard

Implementation Phase:

- To ensure appropriate engagement and involvement of key policy-makers and stakeholders who will utilize the scorecard as a tool in aligning their strategies.
- To ensure a high level of rigor and accuracy in the final product
- To ensure that that product is available in formats that are usable and meet the needs of identified end-users.
- To ensure the needs of MOHLTC policy-makers and various stakeholders are addressed in the scorecard
- To ensure uptake and utilization of the scorecard both internally and externally

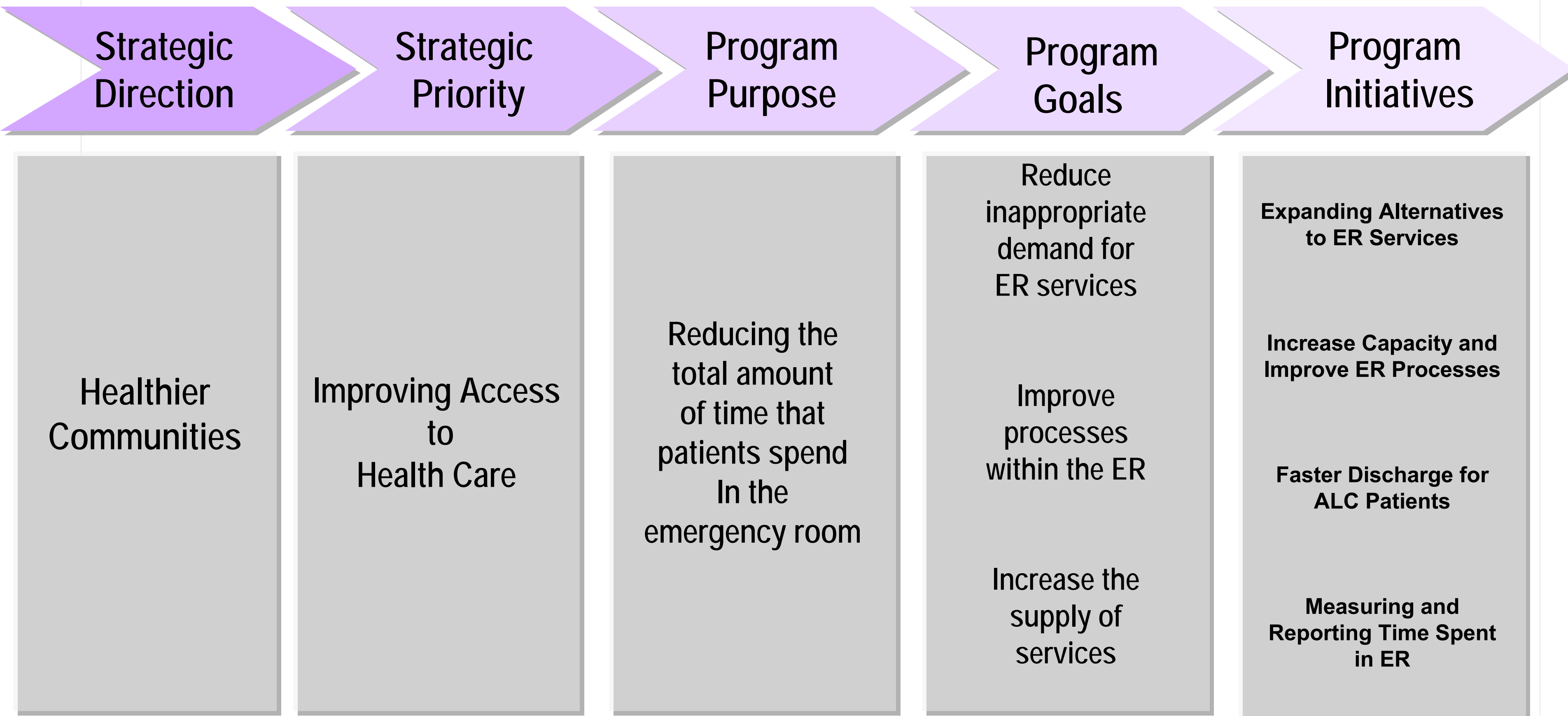
Expert Panel Expertise Gap Analysis Based on the OHQC Attributes of High Performing Healthcare Systems

	Organization /Institution	Accessibility	Appropriately-resourced	Efficiency	Patient-centeredness	Effectiveness	Safety	Equitability	Focus on population health	Integration
Nizar Ladak	North York General Hospital University of Waterloo/Toronto		✓	✓			✓			✓
Geoff Anderson	HSPRN University of Toronto ICES	✓				✓	✓	✓		✓
Walter Wodchis	HSPRN University of Toronto ICES	✓	✓	✓	✓	✓	✓	✓		✓
Louise Lemieux-Charles	HSPRN University of Toronto Institute for Work and Health	✓			✓	✓				✓
Jan Barnsley	University of Toronto ICES	✓			✓	✓		✓	✓	✓
Ian McKillop	HSPRN University of Waterloo/Toronto University Health Research, UWO ICES		✓	✓					✓	✓
Michael Schull	ICES University of Toronto Sunnybrook Research Institute	✓				✓	✓			
Gary Teare	Health Quality Council of Saskatchewan U of Saskatchewan/Toronto ICES Toronto Rehab	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arlene Bierman	HSPRN Li Ka Shing Knowledge Institute University of Toronto ICES	✓			✓	✓		✓	✓	✓
Ross Baker	HSPRN University of Toronto				✓		✓			
Don Ford	Central East Community Care Access Centre									
Doug Manuel	Ottawa Health Research Institute ICES University of Toronto	✓	✓	✓		✓		✓	✓	✓
Astrid Guttmann	HSPRN ICES University of Toronto	✓						✓		
Elizabeth Lin	CAMH ICES University of Toronto	✓			✓			✓	✓	✓
Aura Hanna	Ontario Medical Association				✓					
Lou Reidel	Ontario Hospital Association		✓	✓	✓					
George Pink	U of North Carolina, Chapel Hill University of Toronto		✓	✓						
Jennie Pickard	Central East Community Care Access Centre	✓	✓	✓	✓	✓	✓	✓	✓	✓

Expert Panel Expertise Gap Analysis
Based on the Health Care Sectors/Services

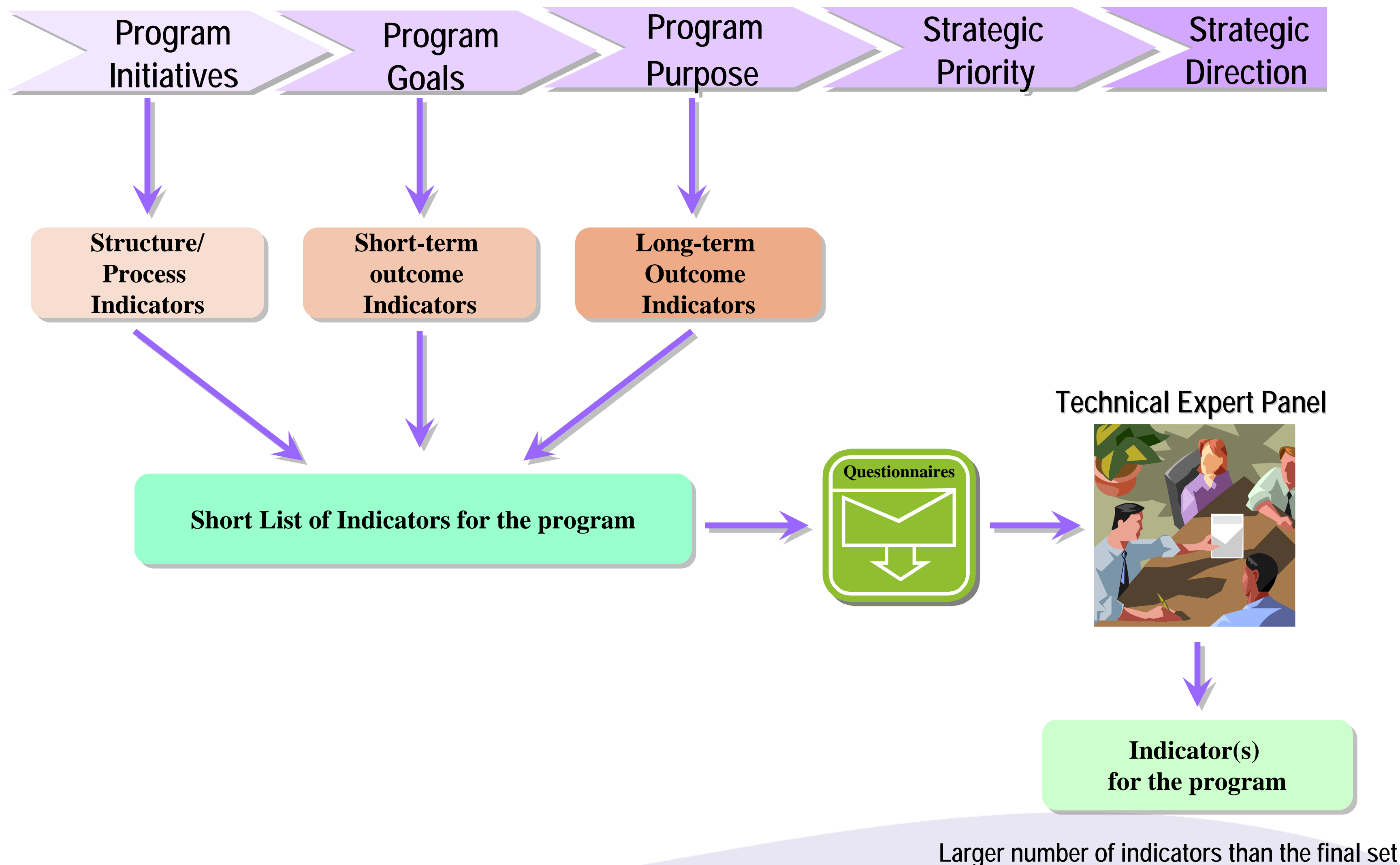
	Organization /Institution	Hospitals/ Acute Care	Long-term care	Community Care Access Centers	Community Health Centers	Community Support Services	Rehab	Palliative Care	Complex Continuing Care	Family Health Teams	Public Health Units	Mental Health and Addiction	Emergency Department	Primary Health Care
Nizar Ladak	North York General Hospital University of Waterloo/Toronto	✓												
Geoff Anderson	HSPRN University of Toronto ICES	✓	✓											✓
Walter Wodchis	HSPRN University of Toronto ICES	✓	✓	✓		✓	✓		✓	✓				✓
Louise Lemieux-Charles	HSPRN University of Toronto Institute for Work and Health													
Jan Barnsley	University of Toronto ICES									✓				✓
Ian McKillop	HSPRN University of Waterloo/Toronto University Health Research, UWO ICES	✓								✓	✓			
Michael Schull	ICES University of Toronto Sunnybrook Research Institute	✓												
Gary Teare	Health Quality Council of Saskatchewan U of Saskatchewan/Toronto ICES Toronto Rehab	✓	✓		✓		✓	✓	✓	✓	✓		✓	✓
Arlene Bierman	HSPRN Li Ka Shing Knowledge Institute University of Toronto ICES													
Ross Baker	HSPRN University of Toronto	✓	✓											
Don Ford	Central East Community Care Access Centre	✓		✓										
Doug Manuel	Ottawa Health Research Institute ICES University of Toronto	✓							✓	✓	✓			✓
Astrid Guttmann	HSPRN ICES University of Toronto	✓										✓	✓	
Elizabeth Lin	CAMH ICES University of Toronto	✓				✓						✓	✓	✓
Aura Hanna	Ontario Medical Association									✓				✓
Lou Reidel	Ontario Hospital Association		✓					✓						
George Pink	U of North Carolina, Chapel Hill University of Toronto	✓	✓		✓									
Jennie Pickard	Central East Community Care Access Centre		✓		✓	✓		✓				✓		✓

Example: Linking Strategic Directions, Priorities, Program and Initiatives in ER Strategy



Source: http://www.health.gov.on.ca/transformation/wait_times/wait_mn.html

Indicator Selection Approach for Each Program/Initiative



Larger number of indicators than the final set