

Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

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Indicator Technical Specifications 2017/18 Quality Improvement Plans



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This document specifies indicator definitions, reporting periods, and other information for hospitals, primary care organizations, Community Care Access Centres (CCACs), and Long-Term Care (LTC) homes to use in their 2017/18 Quality Improvement Plans (QIPs).

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Introduction: Quality Issues

This document specifies indicator definitions, calculations, reporting periods, and other technical information for hospitals, primary care organizations, Community Care Access Centres (CCACs), and long-term care (LTC) homes to use in their 2017/18 quality improvement plans (QIPs).

The indicators described within this document were carefully chosen as representative of corresponding quality issues by Health Quality Ontario and a number of collaborators.* These key quality issues reflect organizational and sector-specific priorities, as well as system-wide, transformational priorities where improved performance is co-dependent on collaboration with other sectors. Achieving system-wide change on these issues requires every sector and every organization to prioritize quality improvement.

Each sector has its own list of recommended priority and additional indicators to measure performance on these key quality issues. A summary of the quality issues and indicators for the 2017/18 QIPs is presented in Figure 1.

- Review the **priority indicators** recommended for your sector and determine which are relevant for your organization. To support this process, your organization should review its current performance against provincial data and benchmarks for all priority indicators; organizations scoring poorly in comparison with provincial averages/benchmarks are strongly encouraged to select these indicators in their QIP. If your organization elects not to include a priority indicator in the QIP (for example, because performance already meets or exceeds the benchmark or is theoretical best), the reason should be documented in the comments section of the QIP Workplan.
- **Additional indicators** also measure important areas for quality improvement and can be included in your QIP to reflect your organization's specific quality improvement goals and opportunities.
- You may also choose to add **custom indicators** to reflect local initiatives or to modify the existing indicators to be more consistent with measurements used in your organization.

We encourage you to review the issues and indicators for other sectors as well as your own. While each sector has their own set of issues and indicators, many of these cannot be addressed without collaboration with other organizations. To support this, organizations should familiarize themselves with the work of peer organizations across the province or organizations in their region to identify opportunities for alignment or collaboration. To download individual QIPs or to search the QIP database, please visit the QIP Navigator website (<https://qipnavigator.hqontario.ca/>).

Health Quality Ontario also reports on other indicators that are not included as priority or additional indicators in the QIP program - for example, the indicators measured in our yearly report, [Measuring Up](#). Definitions and technical specifications for all indicators reported on by Health Quality Ontario are included in our [indicator library](#).

Please note that indicator results that are based on small numbers (numerators < 5; denominators < 30) should be interpreted with caution because of potentially unstable rates or potential risk to patient

privacy. Because of these risks, results could be suppressed when the data are provided by external organizations (e.g., Ministry of Health and Long-Term Care, QIP Navigator). For more information on data suppression, please contact Health Quality Ontario at QIP@hqontario.ca.

**Health Quality Ontario thanks the following groups for contributing to the identification and definition of the issues and indicators for the 2017/18 QIPs: Health Quality Ontario's Patient, Family and Public Advisory Council; the Quality Improvement Plan Advisory Committee; the Association of Family Health Teams of Ontario; the Association of Ontario Health Centres; the Ontario Long-Term Care Association; the Ontario Association of Non-Profit Homes & Services for Seniors; the Ontario Association of Community Care Access Centres; the Registered Nurses' Association of Ontario; the Ontario Palliative Care Network; Cancer Care Ontario; the Institute for Clinical Evaluative Sciences; the Canadian Institute for Health Information; the Ministry of Health and Long-Term Care; and Ontario's Local Health Integration Networks.*

Figure 1. Quality issues and indicators for the 2017/18 QIPs.

Issue		Hospital	Primary Care	Home Care	Long-Term Care
Effective	Effective transitions	- Readmission for select conditions (A) - Readmission for one of congestive heart failure, chronic obstructive pulmonary disease, or stroke (QBP) (P) - Readmission within 30 days for mental health and addiction (A) - Patient received enough information on discharge (P) - Discharge summaries sent within 48 h of discharge (A)	- Hospital readmissions for select conditions (A) 7-day post-discharge follow-up (physician) (P) 7-day post-discharge follow-up (any provider) (A)	- Hospital readmissions (P) - Unplanned ED visits (P)	Potentially avoidable ED visits (P)
	Coordinating care	- Narrative - Identify complex patients (Health Links) (A)	- Narrative - Identify complex patients (Health Links) (A)	- Narrative - Identify complex patients (Health Links) (A)	Narrative
	Population health	Narrative	- Narrative - Glycated hemoglobin testing (A) - Colorectal and cervical cancer screening (A)	Narrative	Narrative
Patient-centred	Palliative care	Home support for discharged palliative patients (P)		End of life, died in preferred place of death (A)	
	Person experience	- Narrative - Patient experience (P)	- Narrative - Patient involvement (P)	- Narrative - Client experience (P)	- Narrative - Resident experience (P)
Efficient	Access to right level of care	- Narrative - Alternative level of care rate (P)	Narrative	Narrative	Narrative
Safe	Safe care	Pressure ulcers (A), use of physical restraints in mental health patients (A)		Falls for long-stay clients (P)	Pressure ulcers, (A) restraints (A), falls (A)
	Medication safety	- Medication reconciliation (admission) (P) - Medication reconciliation (discharge) (P)	Medication reconciliation (A)		Potentially inappropriate prescribing of antipsychotic medications (P)
	Workplace safety	Narrative	Narrative	Narrative	Narrative
Timely	Timely access to care/services	ED length of stay (complex) (P)	Timely access to primary care (patient perception) (P)	Wait time for home care (personal support worker, nurse) (P)	
Equitable	Equity	Narrative	Narrative	Narrative	Narrative

Legend: (P): Priority indicator (A): Additional indicator (QBP): Indicator related to quality-based procedures

I. Hospital Indicators

New indicators are identified via a “**NEW**” icon.

Hospital Priority Indicators

Indicator Name	Risk-adjusted 30-day all-cause readmission rate for patients with congestive heart failure (quality based procedures cohort)
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Definition	The measuring unit of this indicator is an admission for congestive heart failure, as defined for quality-based procedures (QBP). Results are expressed as the risk-adjusted all-cause 30 day non-elective readmission rate among patients admitted to Ontario acute care facilities.
Unit of Measurement	Rate
Calculation Methods	Numerator/ denominator
Numerator	Number of admitted patients with congestive heart failure discharged with a readmission within 30 days.
Denominator	Total number of congestive heart failure index discharges from hospital <i>Inclusions:</i> - Ontario residents with a valid health card number - Age >= 20 years - Most responsible diagnosis of congestive heart failure <i>Exclusions:</i> - Surgical cases - Records with missing admission or discharge dates - Records where patient had an acute transfer out, or where discharge disposition is sign out or death
Risk adjustment	Age, gender, Charlson co-morbidity index, case mix, previous inpatient admissions within 30, 60 or 90 days as a general proxy for patient complexity, calendar year
Current performance: reporting period	January 2015 – December 2015
Data source	Discharge Abstract Database (DAD). Data provided to HQO by Ministry of Health and Long-term Care (MOHLTC)
How to access data	To access your organization’s data for the reporting period, refer to Health Quality Ontario’s QIP Navigator . Data will be available in February 2017.
Comments	This indicator provides an opportunity to incorporate QBP indicators into the QIP for specific QBP Cohorts. The expectation is that hospitals will consider including within their QIP one of the QBP readmission indicators, but hospitals are not expected to include all three. Organizations are encouraged to consider QBP process measures and change ideas to reduce readmissions for one of these select groups. QBP Baseline

	Reports are accessible through the password-protected Health Data Branch web portal: https://hsimi.on.ca/hdbportal/ .
Indicator Name	Risk-adjusted 30-day all-cause readmission rate for patients with chronic obstructive pulmonary disease (quality based procedures cohort)
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	The measuring unit of this indicator is an admission for chronic obstructive pulmonary disease (COPD), as defined for the QBP. Results are expressed as risk-adjusted all-cause 30-day non-elective readmission rate among patients admitted to Ontario acute care facilities.
Unit of Measurement	Rate
Calculation Methods	Numerator/ denominator
Numerator	Number of admitted patients with chronic obstructive pulmonary disease discharged with a readmission within 30 days.
Denominator	Total number of chronic obstructive pulmonary disease index discharges from hospital. <i>Inclusions:</i> • Ontario residents with a valid health card number • Age ≥ 35 • Most responsible diagnosis of chronic obstructive pulmonary disease <i>Exclusions:</i> • Major clinical category partition of Intervention • Most responsible diagnosis of Panlobular emphysema, Centrilobular emphysema, or Macleod's syndrome • Missing admission date, discharge date, or age • Records where patient had an acute transfer out, or where discharge disposition is sign out or death
Risk adjustment	Age, gender, Charlson co-morbidity index, case mix, previous inpatient admissions within 30, 60 or 90 days as a general proxy for patient complexity, Health-Based Allocation Model (HBAM) Inpatient Grouper (HIG) case mix, calendar year
Current performance: reporting period	January 2015 – December 2015
Data source	Discharge Abstract Database (DAD). Data provided to HQO by Ministry of Health and Long-term Care (MOHLTC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017.
Comments	This indicator provides an opportunity to incorporate QBP indicators into the QIP for specific QBP Cohorts. The expectation is that hospitals will consider including within their QIP one of the QBP readmission indicators, but hospitals are not expected to include all three. Organizations are encouraged to consider QBP process measures and change ideas to reduce readmissions for one of these select groups. QBP Baseline Reports are accessible through the password-protected Health Data Branch web portal: https://hsimi.on.ca/hdbportal/ .

Indicator Name	Risk-adjusted 30-day all-cause readmission rate for patients with stroke (quality based procedures cohort)
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	The measuring unit of this indicator is an admission for stroke, as defined for the QBP. The result is risk-adjusted all-cause readmission rate among patients admitted to Ontario acute care facilities.
Unit of Measurement	Rate
Calculation Methods	Numerator/ denominator
Numerator	Number of admitted patients with stroke discharged with a readmission within 30 days.
Denominator	Total number of stroke index discharges from hospital. <i>Inclusions:</i> • Ontario residents with a valid health card number • Age >= 18 years • Most responsible diagnosis of stroke or transient ischemic attack <i>Exclusions:</i> • Most responsible diagnosis of transient global amnesia or cerebral infarction due to cerebral venous thrombosis • Records with stroke as a post-admit complication • Missing admission date, discharge date or age • Records where patient had an acute transfer out, or where discharge disposition is sign out or death
Risk adjustment	Age, gender, Charlson co-morbidity index, case mix, previous inpatient admissions within 30, 60 or 90 days as a general proxy for patient complexity, Health-Based Allocation Model (HBAM) Inpatient Grouper (HIG) case mix, calendar year
Current performance: reporting period	January 2015 – December 2015
Data source	Discharge Abstract Database (DAD). Data provided to HQO by Ministry of Health and Long-term Care (MOHLTC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017.
Comments	This indicator provides an opportunity to incorporate QBP indicators into the QIP for specific QBP Cohorts. The expectation is that hospitals will consider including within their QIP one of the QBP readmission indicators, but hospitals are not expected to include all three. Organizations are encouraged to consider QBP process measures and change ideas to reduce readmissions for one of these select groups. QBP Baseline Reports are accessible through the password-protected Health Data Branch web portal: https://hsimi.on.ca/hdbportal/ .

Indicator Name	Home support for discharged palliative patients
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percent of palliative care patients discharged home from hospital with the discharge status “Home with Support”
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Out of denominator (see below), number of inpatient acute care discharges who are discharged “home with support” (DAD Discharge disposition = 04)
Denominator	The number of home discharges in the reporting period with a hospital admission that indicates that the patient is receiving palliative care. <i>Inclusions:</i> 1) Any diagnosis code with a palliative care indication: ICD 10 Code Z51.5 or ICD 9 Code V66.7 or 2) Main patient service of palliative care (PATSERV = 058) And Discharge destination is home (Discharge disposition = 4 (home with support) or 5 (home without support)) <i>Exclusions:</i> Same day surgery
Risk adjustment	None
Current performance: reporting period	April 2015 – March 2016
Data source	Discharge Abstract Database (DAD). Data provided to HQO by Cancer Care Ontario (CCO)
How to access data	To access your organization’s data for the reporting period, refer to Health Quality Ontario’s QIP Navigator . Data will be available in February 2017.
Comments	For this indicator, “palliative care patient” is defined as an individual who was admitted as an inpatient with a palliative care indication. The indicator is reported at the level of admissions rather than unique patients, thus could capture multiple admissions per patient. For this indicator, ‘Discharged home with support’ and ‘Discharged home without support’ are derived from the following definitions from the CIHI DAD database: Home with Support (Discharge Disposition = 04): Discharged to home or a home setting with support services (senior’s lodge, attendant care, home care, meals on wheels, homemaking, supportive housing, et cetera) a. Example of discharged to a home setting with support: A facility where supervisory care is not required on a continuing basis. A patient is discharged and is able to function independently within a group setting. Community services would be brought in to provide support, when necessary. b. Example of discharged home with support services: A patient is

	discharged home with the support of home care workers who are providing daily dressing changes and wound care. Home without Support (Discharge Disposition = 05): Discharged home (patient functions independently with no support service from an external agency required) Nursing homes are not considered private residences (home) since there are support services at some level required.
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Indicator Name NEW	Patient experience: Did you receive enough information when you left the hospital?
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of respondents who responded positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100% Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey—Inpatient Care (CPES) Question 38: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? • Completely • Quite a bit • Partly • Not at all For patient experience questions, a “Top-box” method is recommended. “Top box” refers to the respondents who choose the only the most positive response. <u>Top-box Instructions</u>: Add the number of respondents who responded “Completely” and divide by number of respondents who registered any response to this question (do not include non-respondents).
Numerator	Number of respondents who responded “Completely”
Denominator	Number of respondents who registered any response to this question (do not include non-respondents).
Risk adjustment	None
Current performance: reporting period	Average of all survey responses collected during Q1 FY 2016/17 i.e. April 2016 - June 2016

Data source	Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey—Inpatient Care (CPES)
How to access data	These data should be accessed from within your own organization.

Indicator Name	Patient experience: Would you recommend inpatient care?
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Patient- centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of respondents who responded positively to the following question from the Canadian Patient Experiences Survey - Inpatient Care (CPES-IC): "Would you recommend this hospital to your friends and family?"
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Adult Inpatient (medical/surgical): From the Canadian Patient Experience Survey—Inpatient Care (CPES-IC): "Would you recommend this hospital to your friends and family?" ☐ Definitely no ☐ Probably no ☐ Probably yes ☐ Definitely yes <u>Top-box Instructions:</u> Add the number of respondents who responded "Definitely yes" and divide by number of respondents who registered any response to this question (do not include non-respondents).
Numerator	Number of survey respondents who answered "Definitely yes" to the following survey question: Would you recommend this hospital to family and friends? - Definitely no - Probably no - Probably yes - Definitely yes
Denominator	Number of survey respondents (exclude non-respondents)
Risk adjustment	None
Current performance: reporting period	Average of all survey responses collected during Q1 FY 2016/17 i.e. April 2016 - June 2016.
Data source	Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey—Inpatient Care (CPES)
How to access data	These data should be accessed from within your own organization.

Indicator Name	Patient experience: Would you recommend emergency department?
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Patient- centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of respondents who responded positively to the following question from the Ontario Emergency Department Patient Experiences of Care Survey (EDPEC): "Would you recommend this emergency department to your friends and family?"
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Emergency Department: Ontario Emergency Department Patient Experience of Care Survey (EDPEC): "Would you recommend this emergency department to your friends and family?" ☐ Definitely no ☐ Probably no ☐ Probably yes ☐ Definitely yes <u>Top-box Instructions:</u> Add the number of respondents who responded "Definitely yes" and divide by number of respondents who registered any response to this question (do not include non-respondents).
Numerator	Number of survey respondents who answered "Definitely yes" to the following survey question: Would you recommend this emergency department to family and friends? - Definitely no - Probably no - Probably yes - Definitely yes
Denominator	Number of survey respondents (exclude non-respondents)
Risk adjustment	None
Current performance: reporting period	Average of all survey responses collected during Q1 FY 2016/17 i.e. April 2016 - June 2016.
Data source	Emergency Department Patient Experiences of Care (EDPEC)
How to access data	These data should be accessed from within your own organization.

Indicator Name	Alternate level of care rate
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Efficient
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data
Unit of Measurement	Rate per 100 inpatient days
Calculation Methods	Numerator/ denominator x 100% Please note that only those facilities (Acute & Post-Acute) submitting both ALC data (to the Wait Time Information System (WTIS)) and Bed Census Summary (BCS) data (through the Health Database Web Portal) are included in ALC Rate calculation. Any master number that does not have inpatient days reported to the BCS for a given month/quarter will be excluded from reporting for that month/quarter
Numerator	Total number of inpatient days designated as ALC in a given time period (i.e. monthly, quarterly, and yearly). Calculation: - Acute ALC days = the total number of ALC days contributed by ALC patients waiting in non-surgical (NS), surgical (SU), and intensive/critical care (IC) beds. - Post-Acute ALC days = ALC days for Inpatient Services CC + RB + MH - CCC ALC days = ALC days for Inpatient Service CC - Rehab ALC days = ALC days for Inpatient Service RB - Mental Health ALC days = ALC days for Inpatient Service MH Exclusions: - ALC cases discontinued due to 'Data Entry Error'. - ALC cases having Inpatient Service = Discharge Destination for Post-Acute Care (*Exception: Bloorview Rehab, CCC to CCC). - ALC cases identified by the facility for exclusion. 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)
Denominator	Total number of inpatient days in a given time period (i.e. monthly, quarterly, and yearly).

	Calculation: - Acute Patient days = the total number of patient days contributed by inpatients in Medical (MED) + Surgical (SURG) + Combined Medical & Surgical (CMS) + Intensive Care and Coronary Care (ICU) + Obstetrics (OBS) + Paediatric (PAE) + Child/Adolescent Mental Health (Children MH) + Acute Addiction (Addiction) + Pediatrics in Nursery (Paed Days in Nursery) + Newborns (Level 1 - General + Level 2 - Intermediate + Level 3 - ICU Neonatal + Not in Regular) - Post-Acute Patient days = the total number of patient days contributed by inpatients in Chronic (Chronic) + General Rehabilitation (Gen. Rehab) + Special Rehabilitation (Spec. Rehab) + Acute Psych (Acute Psy) + Addiction (Addiction) + Forensic (Forensic) + Psychiatric Crisis Unit (Crisis Unit) + Longer Term Psychiatric (Long Term) - CCC Patient days = the total number of patient days contributed by inpatients in complex continuing care (Chronic) beds - Rehab Patient days = the total number of patient days contributed by inpatients in General Rehabilitation (Gen. Rehab) + Special Rehabilitation (Spec. Rehab) - Mental Health Patient days = the total number of patient days contributed by inpatients in Acute Psych (Acute Psy) + Addiction (Addiction) + Forensic (Forensic) + Psychiatric Crisis Unit (Crisis Unit) + Longer Term Psychiatric (Long Term) Exclusions: - Patient days contributed by inpatients in the emergency department (Bed Type = Emergency (Emerg + PARR, Emergency + PARR)).
Risk adjustment	None
Current performance: reporting period	July 2016 – September 2016
Data source	Bed Census Summary (BCS), Wait Time Information System (WTIS). Data provided to HQO by Cancer Care Ontario (CCO)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2017. Alternatively, hospitals can access ALC reports via Access to Care Site at https://share.cancercare.on.ca. Those not registered can contact Access To Care at ATC@cancercare.on.ca.
Comments	Consistent with the Hospital Service Accountability Agreement performance measure

Indicator Name NEW	90th percentile emergency department length of stay for complex patients
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Timely
Direction of Improvement	Reduce (lower)
Type	Process
Description	The total ED length of stay* where 9 out of 10 complex patients completed their visits. *ED Length of Stay defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED.
Unit of Measurement	Hours
Calculation Methods	Step 1: Calculate ED length of stay in hours for each patient. Step 2: Apply inclusion and exclusion criteria. Step 3: Sort the cases by ED length of stay from shortest to longest. Step 4: The 90th percentile is the case where 9 out of 10 complex patients have completed their visits. <i>Inclusions:</i> - Admitted patients – Disposition Codes 06 and 07 - Non-Admitted Patients – (Disposition Codes 01, 04 – 05 and 08 – 15) with assigned CTAS I, II, or III <i>Exclusions:</i> - ED visits where Registration Date/Time and Triage Date/Time are both blank/unknown (9999) - ED visits where the MIS functional centre is under Emergency Trauma, Observation or Emergency Mental Health Services (as of January 2015 data) - Duplicate cases within the same functional center where all ER data elements have the same values except for Abstract ID number - ED visits where the ED visit Indicator is = '0' - ED visits where patient has left without being seen by a physician during his/her visit (Disposition Code 02 and 03) - ED Length of Stay is greater than or equal to 100000 minutes (1666 hours) - Non-Admitted Patients (Disposition Codes 01 – 05 and 08 – 15) with assigned CTAS IV or V - Non-Admitted Patients (Disposition Codes 01 – 05 and 08 – 15) with missing CTAS
Numerator	n/a
Denominator	n/a
Risk adjustment	None
Current performance: reporting period	January 2016 – December 2016
Data source	NACRS, Canadian Institute for Health Information (CIHI) via Ontario's ER NACRS Initiative (ERNI-Level 1). Data provided to HQO by Cancer Care Ontario (CCO)

How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2016. Alternatively, these data can be gathered by going to iPort Access
Comments	Calculated indicator value is based on ED visits submitted by 126 sites participating in the ER National Ambulatory Care Reporting System (NACRS) Initiative (ERNI) reporting to the NACRS database. Approximately 90% of ED Visits in Ontario are captured by hospital sites participating in ERNI (based on NACRS 13/14 data released July 2014). As of April 2009, patient's stay in a designated Clinical Decision Unit (CDU) will be excluded in the total time spent in ED.

Indicator Name	Medication reconciliation at admission
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Increase (higher)
Type	Process
Description	Total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.
Unit of Measurement	Rate per total number of admitted patients
Calculation Methods	Numerator / denominator
Numerator	Number of admitted patients with medications reconciled
Denominator	Number of patients admitted to the hospital
Risk adjustment	None
Current performance: reporting period	Most recent quarter available
Data source	Data are collected at the organizational-level (in-house).
How to access data	These data should be accessed from within your own organization.
Comments	Note: Medication reconciliation at care transitions has been recognized as best practice and is increasingly becoming a system-wide standard. All hospitals should be working toward comprehensive implementation of medication reconciliation. As such, organizations that were previously reporting medication reconciliation at admission for a unit/service/program or target population in their QIPs should now aim to report current performance and set targets at the organization-level (i.e., for the entire hospital). For specific improvement initiatives, process measures and change idea goals, organizations might still wish to scale their focus to a specific unit/service/program or target population. For more information on implementing and measuring medication reconciliation at admission, refer to the Safer Healthcare Now! Medication Reconciliation in Acute Care Getting Started Kit, which is available online, and visit the medication reconciliation page on the Institute for Safe Medication Practices Canada website. For assistance with monitoring your ongoing medication reconciliation processes, visit the Measures page on the Safer Healthcare Now! Website or contact metrics@saferhealthcarenow.ca.

Indicator Name	Medication reconciliation at discharge
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDDP) was created as a proportion of the total number of patients discharged.
Unit of Measurement	Rate per total number of discharged patients
Calculation Methods	Numerator / denominator
Numerator	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created. Excludes hospital discharge that is death, newborn or stillborn. Any additional exclusions should be documented in the comments section of the QIP.
Denominator	Number of patients discharged from the hospital. Excludes hospital discharge that is death, newborn or stillborn. Any additional exclusions should be documented in the comments section of the QIP.
Risk adjustment	None
Current performance: reporting period	Most recent quarter available
Data source	In house data collection.
How to access data	These data should be accessed from within your own organization.
Comments	Organizations should report current performance and set targets for medication reconciliation at discharge at the organization level (i.e., for the entire hospital). It is recognized, however, that every organization is at a different stage of implementation when it comes to medication reconciliation at discharge, so for specific improvement initiatives, process measures and change idea goals, organizations may wish to scale their focus to a specific unit/service/program or target population. For more information on implementing and measuring medication reconciliation at admission, refer to the Safer Healthcare Now! Medication Reconciliation in Acute Care Getting Started Kit, which is available online, and visit the medication reconciliation page on the Institute for Safe Medication Practices Canada website. For assistance with monitoring your ongoing medication reconciliation processes, visit the Measures page on the Safer Healthcare Now! Website or contact metrics@saferhealthcarenow.ca.

Hospital Additional Indicators

Indicator Name	Readmission within 30 days for selected Health Based Allocation Model Inpatient Grouper (HIG)
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) who are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100% The numerator is the sum of all readmissions for all index cases in the reporting period. To obtain observed readmissions: • Index cases (denominator) must be identified first. • For each index case, identify whether there is a non-elective readmission to any facility within 30 days of discharge. The hospitalization readmission is counted if: • Readmission date is within 30 days of the index case discharge; • DAD field "admission category" is urgent (non-elective readmission). The hospitalization readmission is excluded if: • Readmission case is coded as an acute transfer by the receiving hospital (unless the readmission was coded as a transfer from the same hospital). • There is missing or invalid data for discharge date, admission date, health number, age and gender The denominator is the sum of all index cases (discharges in the reporting period for selected HIGs). To Identify index cases: • The index hospitalization is counted if: ○ Discharge date falls in the reporting period; ○ HIG Group and patient age restrictions match those listed in the appendix; ○ Inpatient HIG atypical code is '00' (typical cases), '01' (transfer in cases), '09' (short stay outlier cases), '10' (long stay outlier cases), or '11' (transfer in long stay cases).

	- The index hospitalization is excluded if: - The case is coded as a transfer to another acute inpatient hospital.																										
Numerator	Sum of all readmissions for all index cases in the reporting period. <i>Inclusions:</i> The hospitalization readmission is counted if: - Readmission date is within 30 days of the index case discharge; - DAD field "admission category" is urgent; - Admission is not coded as an acute transfer by receiving hospital (unless the readmission was coded as a transfer from the same hospital). <i>Exclusions:</i> - Records with missing or invalid discharge/admission date, health number, age and gender.																										
Denominator	Sum of all index cases (discharges in the reporting period for selected HIGs). Includes patients with: - Acute Myocardial Infarction (age 45+) - Cardiac conditions other than heart attack (age 40+) - Congestive heart failure (age 45+) - Chronic obstructive pulmonary disease (age 45+) - Pneumonia - Diabetes - Stroke (age 45+) - Gastrointestinal disease - Cases where the Inpatient HIG atypical code is either '00' (typical cases), '01' (transfer in cases), '09' (short stay outlier cases), '10' (long stay outlier cases), or '11' (transfer in long stay cases). <table> <thead> <tr> <th><u>HIG</u></th><th><u>HIG description</u></th></tr> </thead> <tbody> <tr> <td colspan="2">Acute Myocardial Infarction (Age ≥ 45)</td></tr> <tr> <td>193a</td><td>Myocardial Infarction/Shock/Arrest with Coronary Angiogram</td></tr> <tr> <td>193b</td><td>Myocardial Infarction/Shock/Arrest with Coronary Angiogram with Comorbid Cardiac Conditions</td></tr> <tr> <td>194a</td><td>Myocardial Infarction/Shock/Arrest without Coronary Angiogram</td></tr> <tr> <td>194b</td><td>Myocardial Infarction/Shock/Arrest without Coronary Angiogram with Comorbid Cardiac Conditions</td></tr> <tr> <td colspan="2">Stroke (Age ≥ 45)</td></tr> <tr> <td>25</td><td>Hemorrhagic Event of Central Nervous System</td></tr> <tr> <td>26</td><td>Ischemic Event of Central Nervous System</td></tr> <tr> <td>28</td><td>Unspecified Stroke</td></tr> <tr> <td colspan="2">COPD (Age ≥ 45)</td></tr> <tr> <td>139c</td><td>Chronic Obstructive Pulmonary Disease with Lower Respiratory Infection</td></tr> <tr> <td>139d</td><td>Chronic Obstructive Pulmonary Disease without Lower Respiratory Infection</td></tr> </tbody> </table>	<u>HIG</u>	<u>HIG description</u>	Acute Myocardial Infarction (Age ≥ 45)		193a	Myocardial Infarction/Shock/Arrest with Coronary Angiogram	193b	Myocardial Infarction/Shock/Arrest with Coronary Angiogram with Comorbid Cardiac Conditions	194a	Myocardial Infarction/Shock/Arrest without Coronary Angiogram	194b	Myocardial Infarction/Shock/Arrest without Coronary Angiogram with Comorbid Cardiac Conditions	Stroke (Age ≥ 45)		25	Hemorrhagic Event of Central Nervous System	26	Ischemic Event of Central Nervous System	28	Unspecified Stroke	COPD (Age ≥ 45)		139c	Chronic Obstructive Pulmonary Disease with Lower Respiratory Infection	139d	Chronic Obstructive Pulmonary Disease without Lower Respiratory Infection
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	Pneumonia (All ages) 136 Bacterial Pneumonia 138 Viral/Unspecified Pneumonia 143 Disease of Pleura Congestive Heart Failure (Age ≥ 45) 196 Heart Failure without Coronary Angiogram Diabetes (All ages) 437a Diabetes, Other 437b Diabetes with renal complications 437c Diabetes with ophthalmic, neurological, or circulatory complications 437d Diabetes with multiple complications Cardiac (Age ≥ 40) 202 Arrhythmia without Coronary Angiogram 204a Unstable Angina/Atherosclerotic Heart Disease without Coronary Angiogram 204b Unstable Angina/Atherosclerotic Heart Disease without Coronary Angiogram with Comorbid Cardiac Conditions 208a Angina (except Unstable)/Chest Pain without Coronary Angiogram 208b Angina (except Unstable)/Chest Pain without Coronary Angiogram with Comorbid Cardiac Conditions Gastrointestinal HIGs (All ages) 231 Minor Upper Gastrointestinal Intervention 248 Severe Enteritis 251 Complicated Ulcer 253 Inflammatory Bowel Disease 254 Gastrointestinal Hemorrhage 255 Gastrointestinal Obstruction 256 Esophagitis/Gastritis/Miscellaneous Digestive Disease 257 Symptom/Sign of Digestive System 258 Other Gastrointestinal Disorder 285 Cirrhosis/Alcoholic Hepatitis 286 Liver Disease except Cirrhosis/Malignancy 287 Disorder of Pancreas except Malignancy 288 Disorder of Biliary Tract <i>Exclusions:</i> - Records with missing valid data on discharge/admission date, health number, age and gender; - Index cases coded as transfers to another acute inpatient hospital, deaths, and sign-outs; - Cases with Discharge disposition = '07' (death).
Risk adjustment	Risk adjusted

Additional specifications	For a list of included HIGs, and inclusion/exclusion criteria, refer to the Ministry's Resource for Indicator Standards website .
Current performance: reporting period	July 2015 – June 2016
Data source	Discharge Abstract Database (DAD). Data provided to HQO by Ministry of Health and Long-term Care (MOHLTC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017. Alternatively, refer to the Ministry's Health Data Branch Web Portal for your organization's rates (click on 'Hospitals', then 'Quality Improvement Plans').
Comments	A variation of this indicator is calculated for enrolled patients and reported at the primary care practice level for the Primary Care Quality Improvement Plan. Patients are included in the numerator and denominator if CAPE (Client Agency Program Enrollment) records show they are enrolled at the time of discharge for the index case. The group billing number from CAPE identifies the group the patient is enrolled with for practice level results.

Indicator Name NEW	Hospital readmission rates for a mental illness or an addiction
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission.
Unit of Measurement	Rate per 100 readmissions
Calculation Methods	Readmission rate equals the number of patients readmitted within 30 days of discharge divided by the number of patients discharged during the study period. OMHRS and CIHI/DAD databases are used to identify index as well as subsequent hospitalizations for mental health and addictions.
Numerator	Number of individuals with any MH&A hospital readmissions* within ($\leq$) 30 days following the incident hospital discharge in the reporting period. For any MHA hospital discharge (denominator), calculate the following readmissions (numerator): 1. Any MHA Admission during follow-up period: - DAD ICD-10-CA Dx10Code1: F04 to F99, - or OMHRS DSM-IV: Any hospital admission (including missing diagnosis except for DSM-IV 290.x. 294.x in AXIS1_DSM4CODE_DISCH1) <i>Exclusions:</i> - Patients without a valid health insurance number - Patients without an Ontario residence

	• Gender not recorded as male or female • Age < 16 or Age > 105 • Invalid date of birth, admission date/time, discharge date/time • Individuals who die within 30 days of discharge (based on RPDB) before a follow-up or outcome occurs (i.e. a person dies before they have been readmitted or is readmitted but dies before they are discharged) • Any non-MH&A hospital readmissions* Notes: • Separately report the number of individuals who died and re-admitted during the follow-up period overall in all years. • Calculate within ($\leq$) 30 days acute care re-admission proportion following the index MH&A hospital discharge date (i.e. Count only one visit per IKN per 30 day follow-up period). • *Reason for re-admission can be for a different MH&A reason than the initial MH&A diagnosis. • Incident discharges are restricted to calendar years but 30 day follow-up for readmission can cross over into the next calendar year.
Denominator	Total number of incident MH&A hospital discharges in the reporting period. Incident = 1st event in a calendar period without any look-back for past events (If multiple hospital visits in CY, use first). Keep only one discharge per IKN (ICES Key Number) per year. MH&A Hospital Discharges: From DAD var DX10CODE1 with any of the following ICD-10-CA codes. From OMHRS: • If var AXIS1_DSM4CODE_DISCH1 complete* use AXIS1_DSM4CODE_DISCH1 • No, use PROV DX1 *Complete = listed diagnosis from below present Exclude OMHRS admissions if AXIS1_DSM4CODE_DISCH1 in: (290.x OR 294.x) Include visits with suspect diagnoses (suspect = T). With any of the following DSM-IV codes/provisional diagnoses: • Overall MHA ▪ ICD-10-CA: F04 to F99 ▪ DSM-IV: Any (including missing diagnoses, excluding 290.x. 294.x in AXIS1_DSM4CODE_DISCH1 which are dementia codes)

	** MH&A diagnostic categories represent reason for the incident hospital discharge. Disposition of hospital discharge: • From DAD where var DISCHDISP = 2,3,4,5,6,12 • From OMHRS where var DISCHREASON = 1,5,6,7,8 • Exclude discharges with a DAD/OMHRS record within 1 day (i.e. are not a true discharge and are a transfer). Note: re-hospitalizations (numerator) do not have to result in discharge home Hospitalizations should be constructed as episodes using the following steps: 1) i) Pull all DAD and OMHRS records between the specified calendar years (CY) being examined for this indicator with an ICD-10-CA primary discharge diagnosis of F04 to F99 or DSM-IV codes, excluding 290.x and 294.x ○ Identify the IKNs found for these records 2) For only the IKNs identified in the previous step, pull all DAD records from 1988 onwards and all OMHRS records for all diagnoses, i.e. not only mental health diagnoses, and create episodes by adjoining OMHRS/DAD records that overlap within (+/-) 1 day. These will be considered part of a single episode. 3) Use discharge diagnoses and other variables from the final discharge of the episode ○ Note, if 2 or more records have the same discharge date as the discharge date of the episode, use an OMHRS discharge diagnoses, if applicable (i.e. if one record is DAD and one is OMHRS, take the OMHRS diagnoses) Inclusions: • 16 - 105 years i.e. Age >=16 and Age <=105 (other stratifications) Exclusions: • Patients without a valid health insurance number • Patients without an Ontario residence • Gender not recorded as male or female • Age < 16 or Age > 105 • Invalid date of birth, admission date/time, discharge date/time • Individuals who die within 30 days of discharge (based on RPDB) before a follow-up or outcome occurs (i.e. a person dies before they have been readmitted or is readmitted but dies before they are discharged) Note: If OMHRS records occurs within 24 hours of discharge/admission from institution then this should be considered as part of the same episode of care.
Risk adjustment	The rates are age and sex adjusted to the 2006 RPDB
Current performance: reporting period	January 2015 – December 2015
Data source	Discharge Abstract Database (DAD), Ontario Mental Health Reporting System (OMHRS), Registered Persons Database (RPDB)

	Data to be provided to HQO by Ministry of Health and Long Term Care (MOHLTC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017.
Comments	See HQO's Indicator Library for limitations and caveats http://www.hqontario.ca/System-Performance/Indicator-Library

Indicator Name NEW	Percent discharge summaries sent from hospital to community care provider within 48 hours of discharge
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100% Calculate number of discharge summaries transcribed, signed and sent within 48 hours of patient's discharge from hospital for the time period.
Numerator	Number of patients discharged from hospitals for whom a discharge summary is sent to primary care provider within 48 hours of discharge (electronically or by fax) for the time period. <i>Inclusions:</i> - Acute and post-acute hospital inpatient discharge summaries sent electronically to primary care provider with access to Hospital Report Manager, Clinical Connect or similar, or by fax to those without electronic access. <i>Exclusions:</i> - Discharges of inpatients who do not have a documented primary care provider. - Discharges from outside the LHIN. - Emergency Department patients. - Newborns, deaths, and delivery summaries.
Denominator	Number of inpatients discharged for the time period. <i>Inclusions:</i> - Acute and post-acute hospital inpatient discharge. <i>Exclusions:</i> - Discharges of inpatients whose primary care provider is not identified. - Emergency Department patients.

	Newborns, deaths, and delivery summaries
Risk adjustment	None
Current performance: reporting period	Most recent 3 month period.
Data source	In house data collection
How to access data	In house data collection
Comments	Recommend organizations consider pilot testing this indicator in one program or unit for 2017/18 QIP. Timely distribution of discharge summaries is predicated on the following core elements: - Physicians (or delegate) dictate discharge summary as close to patient's discharge time (preferably before) as possible - Transcription to occur within 24 hours of dictation - Activate 'auto-authentication' to ensure one-step distribution of the discharge summary upon signature (note: will be e-HR specific and may require Medical Advisory (or similar) approval) - Improvement efforts may focus on (1) getting discharge summaries prepared and signed in a timely manner, and (2) signed discharge summaries distributed in a timely manner.

Indicator Name NEW	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Identify patients with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach The complex patient target population should: - Overlap substantially with high cost users, recognizing that not all high cost users are high needs patients (and vice versa); - Include patients with high needs and/or complex conditions; and, - Include patients with four or more chronic/high cost conditions, including a focus on individuals living with mental health and addictions, palliative patients, and the frail elderly. However, recognizing nuances exist across communities, LHINs and Health Links are encouraged to adapt the patient identification criteria to their local context and population needs.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Total number of patients who were offered access to the Health Link approach

Denominator	Total number of patients identified through clinical level assessments and/or data-driven case-finding methods sourced as meeting HLs criteria <i>Exclusions:</i> Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Risk adjustment	None
Current performance: reporting period	Most recent 3 month period.
Data source	In house, manual data collection (health record, EMR, other)
How to access data	In house data collection.
Comments	In late 2015, Health Quality Ontario completed a review of the best available information about Health Links and analysis of innovations related to Coordinated Care Management. The innovations framework includes detailed information to help organizations identify patients with multiple conditions and complex needs through clinical level assessments and data driven case finding methods at any point in the patient's healthcare journey. Patients identification approaches: Use <i>clinical level patient identification mechanisms</i> to support identification of patients during a service encounter. For example, as each patient presents to a health or wellness organization or program to receive care, the provider may identify that the patient may benefit from a Health Links/Coordinated Care Management approach. To further support clinical decision making, the provider may then administer a standardized risk assessment tool, if indicated. Use <i>data driven case finding mechanisms</i> to support prospective identification of patients with multiple conditions and complex needs using utilization data to identify complex patients. For example, triggers such as the number of visits to the emergency department, number/length of admissions to hospital within a specified time frame, or patients with specific diagnoses or conditions can be built into the electronic medical record or can be managed by targeted data extraction and analysis methods, to support the identification of potential Patients with multiple conditions and complex needs. <u>Note:</u> A single, cross-sectorial clinical level risk assessment tool/method with adequate sensitivity and specificity to capture every patient who would benefit from a Health Links/Coordinated Care Management approach was not identified. However, the following risk assessment tools were highlighted by Health Links during the environmental scan, and are presented here for consideration based on the practice setting. The decision to implement/administer one of these tools must be considered alongside other contextually relevant information. - LACE (Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits) - PRA (Predictive Repetitive Admission) - DIVERT Scale (Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale)

	For more technical details, please refer to Identify Patients: Use a Combination of Clinical and Data Driven Strategies <u>Note</u>: Once a patient who has multiple conditions or complex needs has been identified, the organization should connect to the processes established by the local Health Link.
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Indicator Name	Pressure ulcers for complex continuing care patients
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Percent of patients (residents) receiving complex continuing care with a newly occurring Stage 2 or higher pressure ulcer in the last three months
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of complex continuing care (ccc) patients (residents) that developed a new stage 2 or higher pressure ulcer in the three-month period
Denominator	Total number of patients (residents) receiving complex continuing in the three month period
Risk adjustment	None
Current performance: reporting period	July 2016 – September 2016
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017. Alternatively, refer to CIHI's CCRS eReports for your organization's rates.
Comments	This indicator represents a rolling four-quarter average.

Indicator Name	Physical restraints in mental health
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Process
Description	The number of hospital patients who were physically restrained at least once in the 3 days prior to a full admission assessment, divided by all patients with a full admission assessment in the reporting period.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of patients who were physically restrained in the 3 days prior to a full admission assessment in the reporting period. <i>Inclusions:</i> The number of full admission assessments with physical restraint use (any of M1a ≥ 1 or M1b ≥ 1 or M1c ≥ 1) coded on the RAI-MH • M1a: The number of full admission assessments for the 12 month period (inclusive) with M1a "Mechanical Restraint" use coded within the last 3 days • M1b: The number of full admission assessments for the 12 months period with M1b "Chair Prevents Rising" use coded within the last 3 days • M1c: The number of full admission assessments for the twelve months period with M1c "Physical/Manual Restraint by Staff" coded within the last 3 days
Denominator	The number of patients with a full admission assessment in the reporting period (i.e. Total number of full admission assessments)
Risk adjustment	None
Current performance: reporting period	October 2015 – September 2016
Data source	Ontario Mental Health Reporting System (OMHRS). Data provided to HQO by Canadian Institute for Health Information (CIHI)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017. Alternatively, access your data from the CIHI OMHRS Quarterly Comparative reports.

Information for hospitals with complex continuing care and rehabilitation services

Hospitals that have beds devoted to complex continuing care (CCC) and rehabilitation services should consider including quality improvement measures specific to the adult CCC and rehabilitation patient populations. The Ontario Hospital Association's CCC and rehabilitation Provincial Leadership Council have identified a set of measures appropriate for inclusion in the QIP. To access more information, see the [Ontario Hospital Association's website](#).

The Rehabilitative Care Alliance is a province-wide collaborative that was established in April 2013 by Ontario's Local Health Integration Networks (LHINs) to build on the work of the Rehabilitation and Complex Continuing Care Expert Panel. They have developed a Rehabilitative Care System Evaluation Framework, including a list of indicators that may be appropriate for inclusion in the QIP. For more information, visit their website at <http://www.rehabcarealliance.ca>.

II. Primary Care Indicators

Primary Care Priority Indicators

Indicator Name	7-day post-hospital discharge follow-up rate for selected conditions
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of patients or clients who see their primary care provider within 7 days after discharge from hospital for selected conditions. The percent of enrolled patients with an acute inpatient hospital stay for: • Acute Myocardial Infarction (AMI) • Cardiac Conditions • Congestive heart failure (CHF) • Chronic Obstructive Pulmonary Disease (COPD) • Pneumonia • Diabetes • Stroke • Gastrointestinal Disease
Unit of Measurement	Percentage
Calculation Methods	Numerator/ Denominator x 100%
Numerator	Total number of rostered patients with primary care visit post-acute discharge in a given time period. Selected conditions (select HIGS) are: AMI, stroke, COPD, pneumonia, congestive heart failure, diabetes, cardiac conditions and gastrointestinal disorders. <i>Inclusions:</i> • A physician visit is counted if there is a service claim billed by any primary care physician in the group that the patient is enrolled within 0 to 7 days of their discharge from hospital. • Includes patients rostered at the time of discharge to an Ontario physician in a primary care practice model. Follow up is restricted to professional services provided by any general practitioner, family physician, geriatrician or pediatrician in the practice group to which the patient is rostered. Does not include telephone calls to patients, visits to the family physician in ED, or visits to other non-physician providers. <i>Exclusions:</i> • Hospital discharge records with missing or invalid discharge date, admission date, health number, age and gender;

	- Ontario Health Insurance Plan (OHIP) claims that are negated, duplicates, physician claims from laboratory groups, and claims paid by the Workplace Safety and Insurance Board (WSIB). Steps: Identify enrolled patients with primary care visit within 7 days of discharge to any physician in the group they are enrolled with: - Link discharge records for enrolled patient (see denominator) to the Claims History Database on health number to find services billed by an Ontario primary care physician where the service date of the claim is within 7 days of the hospital discharge date. Negated claims, duplicate claims and lab claims are excluded. - For clients with services, determine if the billing physician is in the group the patient is rostered to: - Link the records of OHIP services 7 days after discharge to the Corporate Provider Database (CPDB) on the billing number of the physician who provided the service. - Extract the group membership(s) for that physician and verify if it matches the group number on the patient's enrollment record. - Patients have a visit within 7 days if they have at least one service from a physician in the group that they were enrolled with at the time of discharge.																				
Denominator	Total number rostered patients discharged from hospital (select HIGs) in a given time period. <i>Inclusions:</i> - Acute inpatients in the specified HBAM Inpatient Grouper (HIGs) enrolled with a primary care physician at the time of discharge; - Cases that are typical, transfer in, short stay, long stay or long stay transfer in per the HIG atypical indicator (i.e. the HIG atypical indicator must be '00', '01', '09', '10', '11'); 3. Included ages are cohort specific: a) patients ≥ 45 for acute myocardial infarction (AMI), stroke, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF); b) patients ≥ 40 for cardiac HIGs, c) all ages for pneumonia, diabetes, and gastrointestinal (GI). <table> <thead> <tr> <th><u>HIG</u></th><th><u>HIG description</u></th></tr> </thead> <tbody> <tr> <td colspan="2">Acute Myocardial Infarction (Age ≥ 45)</td></tr> <tr> <td>193a</td><td>Myocardial Infarction/Shock/Arrest with Coronary Angiogram</td></tr> <tr> <td>193b</td><td>Myocardial Infarction/Shock/Arrest with Coronary Angiogram with Comorbid Cardiac Conditions</td></tr> <tr> <td>194a</td><td>Myocardial Infarction/Shock/Arrest without Coronary Angiogram</td></tr> <tr> <td>194b</td><td>Myocardial Infarction/Shock/Arrest without Coronary Angiogram with Comorbid Cardiac Conditions</td></tr> <tr> <td colspan="2">Stroke (Age ≥ 45)</td></tr> <tr> <td>25</td><td>Hemorrhagic Event of Central Nervous System</td></tr> <tr> <td>26</td><td>Ischemic Event of Central Nervous System</td></tr> <tr> <td>28</td><td>Unspecified Stroke</td></tr> </tbody> </table>	<u>HIG</u>	<u>HIG description</u>	Acute Myocardial Infarction (Age ≥ 45)		193a	Myocardial Infarction/Shock/Arrest with Coronary Angiogram	193b	Myocardial Infarction/Shock/Arrest with Coronary Angiogram with Comorbid Cardiac Conditions	194a	Myocardial Infarction/Shock/Arrest without Coronary Angiogram	194b	Myocardial Infarction/Shock/Arrest without Coronary Angiogram with Comorbid Cardiac Conditions	Stroke (Age ≥ 45)		25	Hemorrhagic Event of Central Nervous System	26	Ischemic Event of Central Nervous System	28	Unspecified Stroke
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	COPD (Age ≥ 45) 139c Chronic Obstructive Pulmonary Disease with Lower Respiratory Infection 139d Chronic Obstructive Pulmonary Disease without Lower Respiratory Infection Pneumonia (All ages) 136 Bacterial Pneumonia 138 Viral/Unspecified Pneumonia 143 Disease of Pleura Congestive Heart Failure (Age ≥ 45) 196 Heart Failure without Coronary Angiogram Diabetes (All ages) 437a Diabetes, Other 437b Diabetes with renal complications 437c Diabetes with ophthalmic, neurological, or circulatory complications 437d Diabetes with multiple complications Cardiac (Age ≥ 40) 202 Arrhythmia without Coronary Angiogram 204a Unstable Angina/Atherosclerotic Heart Disease without Coronary Angiogram 204b Unstable Angina/Atherosclerotic Heart Disease without Coronary Angiogram with Comorbid Cardiac Conditions 208a Angina (except Unstable)/Chest Pain without Coronary Angiogram 208b Angina (except Unstable)/Chest Pain without Coronary Angiogram with Comorbid Cardiac Conditions Gastrointestinal HIGs (All ages) 231 Minor Upper Gastrointestinal Intervention 248 Severe Enteritis 251 Complicated Ulcer 253 Inflammatory Bowel Disease 254 Gastrointestinal Hemorrhage 255 Gastrointestinal Obstruction 256 Esophagitis/Gastritis/Miscellaneous Digestive Disease 257 Symptom/Sign of Digestive System 258 Other Gastrointestinal Disorder 285 Cirrhosis/Alcoholic Hepatitis 286 Liver Disease except Cirrhosis/Malignancy 287 Disorder of Pancreas except Malignancy 288 Disorder of Biliary Tract <i>Exclusions:</i> • DAD records with missing valid data on admission/discharge date, health number, age and gender; deaths; transfers, patient sign-outs against medical advice and discharge destinations of acute,
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	ambulatory, day surgery, ER and palliative care settings. Negated OHIP claims, duplicate claims and lab claims are also excluded. Steps: Identify index cases for enrolled patients: 1. Select all inpatient episodes for selected HIGs with discharge dates in the reporting period and the restrictions described by the inclusion/exclusion criteria above. 2. Link episodes to CAPE database by health number and keep only the records where the patient was found to be enrolled to at the time of discharge. Keep the physician billing number and group billing number from the CAPE record.
Risk adjustment	None
Current performance: reporting period	April 2015 – March 2016
Data source	Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI), Ontario Health Insurance Plan (OHIP) - Claims History Database (CHDB) Client Agency Program Enrolment (CAPE), Corporate Provider Database (CPDB)
How to access data	Primary care organizations with rostered patients will be able to access data on the Ministry's Health Data Branch Web Portal . Click on 'Primary Care' then 'Quality Improvement Plan'. Contact DDMSupport@ontario.ca to obtain a username and password if you do not already have one. Any CHCs, AHACs and nurse practitioner-led clinics that have signed up for AOHC ICES practice profiles should contact Jennifer Rayner at jrayner@lihc.on.ca .
Comments	The methods used to calculate the measure differ for patient enrollment models and for CHCs, AHACs and nurse practitioner-led clinics. This results in slight differences in the definition of the population included in the numerator and denominator. This indicator is included in the Primary Care Performance Measurement Framework.

Indicator Name	Patient experience: Patient involvement in decisions about care
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Patient- centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Organizations are expected to measure progress on this indicator using the <i>exact</i> wording of the following survey question: Involvement in care decisions: When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment?
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%

	To calculate the indicator result, add the number of respondents who responded “always” and “often”, divide by the number of respondents who registered an answer for this question (do not include non-respondents or respondents who answered “not applicable/don’t know/refused”).
Numerator	The number of respondents who responded "always" and "often" using the exact wording of the survey question. Involvement in care decisions: When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment? using the scale : • always • often • sometimes • rarely • never • not applicable (don't know/refused)
Denominator	The number of respondents who registered an answer using the exact wording of the survey question (as above). Do not include non-respondents or respondents who answered "not applicable/don't know/refused".
Risk adjustment	None
Current performance: reporting period	April 2016 – March 2017 (or most recent 12-month period available)
Data source	In house surveys.
How to access data	These data should be accessed from within your own organization.
Comments	Use of the Primary Care Patient Experience Survey (PCPES) is encouraged, as it includes all priority indicator survey questions and more. Developed by Health Quality Ontario in collaboration with AFHTO, AOHC, the Ontario College of Family Physicians, and the Ontario Medical Association, the survey is designed to be administered by practices and can be rolled up to the organizational level to support their quality improvement efforts. The PCPES captures patients’ experiences in two ways: very specific aspects of their most recent primary care visit and their ongoing experience with the care they receive. To access the PCPES as well as a comprehensive Survey Support Guide on how to implement it, click here. To access an alternate version of the survey for CHCs and AHACs, click here. These indicators also align with the Health Quality Ontario's Primary Care Performance Measurement Framework for Ontario, the Ministry's Health Care Experience Survey and the Commonwealth Fund Surveys that are reported in Health Quality Ontario's Measuring Up.

Indicator Name	Timely access to a primary care provider (patient perception)
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Organizations are expected to measure progress on this indicator using the exact wording of the following patient and client survey question: The number of respondents who responded "same day" and "next day" using the exact wording of the following patient and client survey question: The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office? • Same day • Next day • 2 - 19 days (enter number of days: _____) • 20 or more days • Not applicable (don't know/refused).
Denominator	The number of respondents who registered an answer using the exact wording of the following patient and client survey question: The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office? • Same day • Next day • 2 - 19 days (enter number of days: _____) • 20 or more days • Not applicable (don't know/refused). <i>Exclusions:</i> • Non-respondents; • Respondents who answered "Not applicable (don't know/refused)".
Risk adjustment	None
Current performance: reporting period	April 2016 – March 2017 (or most recent 12-month period available)
Data source	In house surveys
How to access data	These data should be accessed from within your own organization.
Comments	Use of the Primary Care Patient Experience Survey (PCPES) is encouraged, as it includes all priority indicator survey questions and more. Developed by Health Quality Ontario in collaboration with the Association of Family Health Teams of Ontario (AFHTO), the Association of Ontario Health Centres (AOHC), the Ontario College of Family Physicians, and

	the Ontario Medical Association, the survey is designed to be administered by practices and can be rolled up to the organizational level to support their quality improvement efforts. The PCPES captures patients' experiences in two ways: very specific aspects of their most recent primary care visit and their ongoing experience with the care received. To access the PCPES as well as a comprehensive Survey Support Guide on how to implement it, click here. To access an alternate version of the survey for community health centres (CHCs) and Aboriginal Health Access Centres (AHACs), click here. Consider using “third next available visit”, measures from scheduling software or asking additional questions, such as “Did you get an appointment on the date you wanted?” as process indicators to the indicator above. Organizations can choose to add these questions as other indicators. While the “third next available visit” is tracked at the provider level, this QIP indicator should be tracked at the organization level.
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Primary Care Additional Indicators

Indicator Name	Hospital readmission rate for primary care patient population within 30 days
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Percentage of patients who were discharged in a given period for a condition within selected HBAM Inpatient Grouper HIGs and had a non-elective hospital readmission within 30 days of discharge, by primary care practice model. Readmission for patients with an acute inpatient hospital stay for: • Acute Myocardial Infarction • Cardiac conditions (excluding heart attack) • Congestive heart failure • Chronic obstructive pulmonary disease • Pneumonia • Diabetes • Stroke • Gastrointestinal disease who after discharge have a subsequent non-elective readmission within 30 days
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100% Indicator Calculation Total number of rostered patients with a hospital readmission within 30 days following a discharge for a HIG in a given period x 100/Total number of rostered patients who were discharged for a selected condition (based on HIG) in a given period
Numerator	Total number of rostered patients with a hospital readmission in a given period within 30 days after a discharge for selected HIGs. <i>Inclusions:</i> • Selected conditions (select HIGs) are: stroke, COPD, pneumonia, congestive heart failure, diabetes, cardiac conditions and gastrointestinal disorders. • The hospitalization readmission is counted if: a. the re-admission date is within 30 days of the index case discharge; b. the DAD field “admission category” is urgent; c. the admission is not coded as an acute transfer by receiving hospital (unless the readmission was coded as a transfer from the same hospital). <i>Exclusions:</i> • Records with missing or invalid discharge/admission date, health number, age and gender.

	The numerator is the sum of all readmissions for all index cases in the reporting period. Steps: To obtain observed readmissions: • Index cases (denominator) must be identified first. • For each index case, identify whether there is a non-elective readmission to any facility within 30 days of discharge. The hospitalization readmission is counted if: • The readmission date is within 30 days of the index case discharge; • DAD field “admission category” is urgent (non-elective readmission). The hospitalization readmission is excluded if: • The readmission case is coded as an acute transfer by the receiving hospital (unless the readmission was coded as a transfer from the same hospital). • There is missing or invalid data for discharge date, admission date, health number, age and gender.												
Denominator	Total number of rostered patients who were discharged for a selected condition (based on HIG) in a given period <i>Inclusions:</i> 1. Patient with: • Acute Myocardial Infarction (age 45+) • Cardiac conditions other than heart attack (age 40+) • Congestive heart failure (age 45+) • Chronic obstructive pulmonary disease (age 45+) • Pneumonia • Diabetes • Stroke (age 45+) • Gastrointestinal disease 2. Cases where the Inpatient HIG atypical code is either ‘00’ (typical cases), ‘01’ (transfer in cases), ‘09’ (short stay outlier cases), ‘10’ (long stay outlier cases), or ‘11’ (transfer in long stay cases). <table> <thead> <tr> <th><u>HIG</u></th><th><u>HIG description</u></th></tr> </thead> <tbody> <tr> <td colspan="2">Acute Myocardial Infarction (Age ≥ 45)</td></tr> <tr> <td>193a</td><td>Myocardial Infarction/Shock/Arrest with Coronary Angiogram</td></tr> <tr> <td>193b</td><td>Myocardial Infarction/Shock/Arrest with Coronary Angiogram with Comorbid Cardiac Conditions</td></tr> <tr> <td>194a</td><td>Myocardial Infarction/Shock/Arrest without Coronary Angiogram</td></tr> <tr> <td>194b</td><td>Myocardial Infarction/Shock/Arrest without Coronary Angiogram with Comorbid Cardiac Conditions</td></tr> </tbody> </table>	<u>HIG</u>	<u>HIG description</u>	Acute Myocardial Infarction (Age ≥ 45)		193a	Myocardial Infarction/Shock/Arrest with Coronary Angiogram	193b	Myocardial Infarction/Shock/Arrest with Coronary Angiogram with Comorbid Cardiac Conditions	194a	Myocardial Infarction/Shock/Arrest without Coronary Angiogram	194b	Myocardial Infarction/Shock/Arrest without Coronary Angiogram with Comorbid Cardiac Conditions
<u>HIG</u>	<u>HIG description</u>												
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193b	Myocardial Infarction/Shock/Arrest with Coronary Angiogram with Comorbid Cardiac Conditions												
194a	Myocardial Infarction/Shock/Arrest without Coronary Angiogram												
194b	Myocardial Infarction/Shock/Arrest without Coronary Angiogram with Comorbid Cardiac Conditions												

Stroke	Stroke (Age ≥ 45)
	25 Hemorrhagic Event of Central Nervous System
	26 Ischemic Event of Central Nervous System
	28 Unspecified Stroke
COPD (Age ≥ 45)	
139c	Chronic Obstructive Pulmonary Disease with Lower Respiratory Infection
139d	Chronic Obstructive Pulmonary Disease without Lower Respiratory Infection
Pneumonia (All ages)	
136	Bacterial Pneumonia
138	Viral/Unspecified Pneumonia
143	Disease of Pleura
Congestive Heart Failure (Age ≥ 45)	
196	Heart Failure without Coronary Angiogram
Diabetes (All ages)	
437a	Diabetes, Other
437b	Diabetes with renal complications
437c	Diabetes with ophthalmic, neurological, or circulatory complications
437d	Diabetes with multiple complications
Cardiac (Age ≥ 40)	
202	Arrhythmia without Coronary Angiogram
204a	Unstable Angina/Atherosclerotic Heart Disease without Coronary Angiogram
204b	Unstable Angina/Atherosclerotic Heart Disease without Coronary Angiogram with Comorbid Cardiac Conditions
208a	Angina (except Unstable)/Chest Pain without Coronary Angiogram
208b	Angina (except Unstable)/Chest Pain without Coronary Angiogram with Comorbid Cardiac Conditions
Gastrointestinal HIGs (All ages)	
231	Minor Upper Gastrointestinal Intervention
248	Severe Enteritis
251	Complicated Ulcer
253	Inflammatory Bowel Disease
254	Gastrointestinal Hemorrhage
255	Gastrointestinal Obstruction
256	Esophagitis/Gastritis/Miscellaneous Digestive Disease
257	Symptom/Sign of Digestive System
258	Other Gastrointestinal Disorder
285	Cirrhosis/Alcoholic Hepatitis
286	Liver Disease except Cirrhosis/Malignancy
287	Disorder of Pancreas except Malignancy
288	Disorder of Biliary Tract
<i>Exclusions:</i>	
Records with missing valid data on discharge/admission date, health number, age and gender;	

	- Index cases coded as transfers to another acute inpatient hospital, deaths, and sign-outs; 3. Exclude cases with Discharge disposition = '07' (death) The denominator is the sum of all index cases (discharges in the reporting period for selected HIGs). Steps: Identify index cases: - The index hospitalization is counted if: a. The discharge date falls in the reporting period; b. The HIG Group and patient age restrictions match those listed in the appendix; c. The Inpatient HIG atypical code is '00' (typical cases), '01' (transfer in cases), '09' (short stay outlier cases), '10' (long stay outlier cases), or '11' (transfer in long stay cases). - The index hospitalization is excluded if: a. The case is coded as a transfer to another acute inpatient hospital. - The denominator is the sum of all index cases in the reporting period
Risk adjustment	None
Current performance: reporting period	April 2015 – March 2016
Data source	Discharge Abstract Database (DAD), Client Agency Program Enrolment (CAPE) Corporate Provider Database (CPDB).
How to access data	Organizations with rostered patients will be able to access data on the Ministry's Health Data Branch Web Portal . Click on 'Primary Care' then 'Quality Improvement Plan'. Contact DDMSupport@ontario.ca to obtain a username and password if you do not already have one. For CHCs, AHACs and nurse practitioner-led clinics that have signed up for AOHC ICES practice profiles, please contact Jennifer Rayner at jrayner@lihc.on.ca .
Comments	Methodological Notes: Data are not real-time, and are provided for FY 2015/16. Information based on administrative data lag in time owing to the data submission process. Although there are time lags with the reporting of these data, the information remains valuable for informing quality improvement initiatives. Data and metrics have been suppressed where numerator (events) are fewer than five and denominator (population admitted with selected conditions) is less than 30. This is standard practice regarding confidentiality of data and residual disclosure of individual information. Data should be interpreted with caution if numerator contains 6 – 19 events OR denominator contains 30 – 99 persons.

Indicator Name NEW	Timely follow up with hospital discharged patients, by phone or in-person with any clinician, within 7 days of discharge (for patients for whom discharge notification was received)
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of patients for whom discharge notification was received who were followed up within 7 days of discharge, by phone or in-person visit, with any clinician.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of patients for whom discharge notification was received and who had an encounter (by phone or in-person visit) within 7 days of discharge from hospital
Denominator	Number of discharged patients for whom discharge notification was received
Risk adjustment	None
Current performance: reporting period	Last consecutive 12 month period.
Data source	EMR
How to access data	In house data collection.
Comments	Refer to the “Follow up after hospitalization” queries developed by Association of Family Health Teams of Ontario, Decisions to Data 4.0 for more information about accessing data via the EMR.

Indicator Name NEW	Medication reconciliation in primary care
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of patients with medication reconciliation in the past year
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Number of patients with medication reconciliation in the past year
Denominator	Number of patients who have had a visit in the past year
Risk adjustment	None
Current performance: reporting period	Most recent 12 month period.
Data source	EMR
How to access data	In house data collection. Medication reconciliation is an important component of medication safety. While medication reconciliation processes should be implemented within each health care sector, linkages across sectors are required to be most

effective for patients. As primary care is the setting in which patients receive the majority of their health care and is often the point of care coordination for the rest of a patient's care, this sector plays a key role in creating these linkages. For their QIPs, primary care organizations are encouraged to develop medication reconciliation processes that leverage available resources.

The Institute for Safe Medication Practices (ISMP) has developed a [resource to support medication reconciliation in the primary care setting](#). As a starting point, completing medication reconciliation in primary care involves four main activities:

1. Collect and document an accurate and up-to-date medication list, called the Best Possible Medication History (BPMH). This can be done, for example, during an office visit for any patient who takes numerous medications, has been recently discharged from hospital, or has been referred to numerous specialists.
2. Compare the BPMH with information in the patient's chart and identify discrepancies (i.e., differences between various sources of medication information)
3. Correct the discrepancies as appropriate through discussion with the primary care provider and the patient and then update the BPMH with the resolved discrepancies, thereby creating a reconciled list. Note: pharmacists, community-based or otherwise, are a great resource to help create a reconciled list.
4. Communicate the resulting medication changes to the patient and verify the patient's understanding of their medication regimen.

Indicator Name	Glycated hemoglobin (HbA1c) testing
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1c) tests within the past 12 months
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Number of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin tests (HbA1c) within the past 12 months. OHIP defined by the OHIP fee code L093
Denominator	Total number of patients with diabetes aged 40 or over.

Risk adjustment	None
Current performance: reporting period	Annually
Data source	Ontario Diabetes Database (ODD), Ontario Health Insurance Plan (OHIP) - Claims History Database (CHDB), Registered Persons Database (RPDB)
How to access data	In house data collection. Primary Care Group Practice reports are available to family health teams (FHT) that register. For more information visit www.hqontario.ca/pcreport . Primary care organizations not registered to receive group practice reports will be required to extract data from EMRs.
Comments	Equivalent measures are available for CHCs, nurse practitioner-led clinics and AHACs, extracted from electronic medical records (EMRs).

Indicator Name	Percentage of screening eligible patients up-to-date with colorectal cancer screening
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years, other investigations (i.e., flexible sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Numerator: Number of screen-eligible individuals who had a fecal occult blood test within past two years, other investigations (i.e. flexible sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years - Fecal occult blood testing (L181 or G004, L179, Q152, Q043, Q133) in the past two years - Colonoscopy in the previous 10 years (Z555 plus one of E740 or E741 or E747 or E705 on the same day) - Flexible sigmoidoscopy in the previous 10 years (Z555 [without E740 or E741 or E747 or E705 on the same day] or Z580)
Denominator	Number of screen-eligible patients aged 50 to 74 years <i>Exclusions:</i> - Patients with a missing or invalid Health Card Number, date of birth or postal code - Patients who have had colon cancer or inflammatory bowel disease in the past five years
Risk adjustment	None
Current performance: reporting period	Annually

Data source	Colonoscopy Interim Reporting Tool (CIRT), Lab Reporting Tool (LRT), Ontario Health Insurance Plan (OHIP) - Claims History Database (CHDB), Cancer Care Ontario - Ontario Cancer Registry (CCO-OCR), Pathology Information Management System (PIMS), Registered Persons Database (RPDB), PCCF version 5k
How to access data	Primary Care Group Practice reports are available to family health teams and CHCs that register. For more information visit www.hqontario.ca/pcreport. Primary care organizations not registered to receive group practice reports will be required to extract data from EMRs. Alternate source is Cancer Care Ontario's Screening Activity Report (family health teams) and EMRs (all models).
Comments	For 2017/18, two colorectal cancer screening indicators are included as additional indicators. This indicator is a revised version of 2016/17 colorectal cancer screening indicator and relies on in house data collection or data available through the Primary Care Group Practice reports (PCPR) starting from 2017 November (scheduled). Primary care organizations that do not have access to Cancer Care Ontario's Screening Activity Reports (SAR) are encouraged to use this indicator. Health Quality Ontario recommends that primary care organizations select ONE of the colorectal cancer screening indicators for their QIP (e.g., either the PCPR or CCO indicator).

Indicator Name	Percentage of screening eligible patients up-to-date with cervical cancer screening
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of women aged 21-69 who had a Papanicolaou (Pap) smear within the past three years
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Number of screen-eligible women aged 21 – 69 years who had a Pap smear within the past three years. <i>Inclusions:</i> - Index date was defined as the first screen date per person by date of specimen collection in CytoBase or by service date in OHIP in a three-year period - Pap tests in CytoBase – note all Pap tests in CytoBase were counted, including those with inadequate specimens

	Identifying Pap tests using fee codes in OHIP (E430: G365: G394: L713; L733; L812, Q678A)
Denominator	Total number of Ontario screen-eligible women aged 21 – 69 years, in a given three-year period. <i>Exclusions:</i> - Women with a missing or invalid health card number, date of birth, LHIN or postal code - Women with invasive cervical cancer before the index date - Women with a hysterectomy before the index date Target populations comply with the existing cancer screening guidelines in Ontario.
Risk adjustment	None
Current performance: reporting period	Annually
Data source	Ontario Health Insurance Plan (OHIP), CytoBase, Cancer Care Ontario - Ontario Cancer Registry(CCO-OCR), Pathology Information Management System (PIMS), Client Agency Program Enrolment (CAPE), Corporate Provider Database (CPDB), Registered Persons Database (RPDB)
How to access data	Primary Care Group Practice reports are available to family health teams and CHCs that register. For more information visit www.hqontario.ca/pcreport. Primary care organizations not registered to receive group practice reports will be required to extract data from EMRs. Alternate source is Cancer Care Ontario's Screening Activity Report (family health teams) and EMRs (all models).
Comment	For 2017/18, two cervical cancer screening indicators are included as additional indicators. Health Quality Ontario recommends that primary care organizations select ONE of the cervical cancer screening indicators for their QIP (e.g., either the “up to date” or “completed a Pap in the last 42 months” (CCO) indicator.).

Indicator Name NEW	Percentage of eligible patients overdue for colorectal cancer screening
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Decrease (Lower)
Type	Outcome
Description	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening in each calendar year
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%

Numerator	Total number of Ontario screen-eligible individuals, 50–74 years old, who were overdue for colorectal screening by the end of the calendar year Individuals were considered overdue for colorectal screening if they: • Did not have an FOBT within the last two years (Jan 1 of the previous year to Dec 31st of the calendar year of interest), AND • Did not have a colonoscopy in the last 10 years (Jan 1 nine years prior to the calendar year of interest to Dec 31st of the calendar year of interest) AND • Did not have a flexible sigmoidoscopy in the last ten years (Jan 1 nine years prior to the calendar year of interest to Dec 31st of the calendar year of interest) For example: at the end of 2013, an individual would be considered overdue for colorectal screening if he or she did not have an FOBT test in 2012-2013, or flexible sigmoidoscopy in 2004-2013, or a colonoscopy in 2004-2013 • Identifying FOBTs: <u>Program CCC FOBT</u> was identified in LRT or OHIP: - L179 ColonCancerCheck Fecal Occult Blood Testing <u>Non-program FOBT</u> was identified using fee codes in OHIP: - L181 Lab Med - Biochem - Occult Blood • Colonoscopies were identified using fee code Z555, Z491A-Z499A in OHIP • Flexible sigmoidoscopies were identified using fee code Z580 in OHIP • Multiple claims with the same Health Insurance Number (HIN) and service date were assumed to be a single claim • Each individual was counted once regardless of the number of tests performed
Denominator	Total number of Ontario screen-eligible individuals, 50–74 years old in each calendar year. <i>Inclusions:</i> • Ontario residents aged 50–74 at the index date • Index date was defined as Jan 1 of a given year • The 2011 Canadian population was used as the standard population for calculating age-standardized rates • LHIN assignment was determined using PCCF+, version 6A; residential postal code was used to identify LHIN and individuals with unknown/missing LHINs were excluded from the analysis • Neighbourhood income quintile was determined using PCCF+, version 6A; this indicator was based on income quintiles developed by Statistics Canada; income quintiles range from 1 to 5 (low to high) • Rural or urban residence was determined using PCCF+, version 6A. This indicator was based on whether individuals lived within a census metropolitan area (CMA), census agglomeration (CA) or Influenced

	Zones (MIZ) which takes into account population size, distance and commuting flow between rural and small towns and larger centres. - o Urban: CMAs or CAs with a core population of 10,000 or more and 50+% of the population commute to a CMA/CA. - o Rural: Areas with a core population of <10,000 and 30-49% of the population commute to an urban area (referred to as strong MIZ in Statistics Canada's classification) - o Rural-Remote: Areas with a core population of <10,000 and 5-29% of the population commute to an urban area (referred to as Moderate MIZ in Statistics Canada's classification) - o Rural-Very Remote: Areas with a core population of <10,000 and 0-4% of the population commute to an urban area, also includes non-urban parts of Territories (referred to as Weak MIZ, No MIZ, Territories outside CAs in Statistics Canada's classification) • Neighborhood percent immigrant was determined using PCCF+, version 6A; this indicator divides DAs into three categories according to the percentage of immigrants: low immigrant ($\leq 27\%$ immigrant population), moderate immigrant (27.1-51.8% immigrant population), and high immigrant ($\geq 51.9\%$ immigrant population) • Public health unit data was determined using PCCF+, version 6A <i>Exclusions:</i> • Individuals with a missing or invalid HIN, date of birth, sex or postal code • Individuals with an invasive colorectal cancer prior to Jan 1 of the calendar year of interest; prior diagnosis of colorectal cancer was defined as: ICD-O-3 codes C18.0, C18.2-C18.9, C19.9, C20.9, a morphology indicative of colorectal cancer, microscopically confirmed with a path report • Individuals with a total colectomy prior to Jan 1 of the calendar year of interest; total colectomy was defined in OHIP by fee codes S169, S170, S172
Risk adjustment	None
Current performance: reporting period	Annually
Data source	• OHIP's CHDB (Claims History Database) – Colectomy claims, non-CCC FOBT, colonoscopy, flexible sigmoidoscopy • CIRT (Colonoscopy Interim Reporting Tool) – CCC program colonoscopy records • LRT (Laboratory Reporting Tool) – CCC FOBTs • CCO's OCR (Ontario Cancer Registry) - Resolved invasive colorectal cancers • RPDB (Registered Persons Database) – Demographics • PCCF+, version 6A - Residence and socio-demographic info
How to access data	Primary data source is EMR (all models). An alternate source is Cancer Care Ontario's Screening Activity Report (CCO-SAR) – for family health teams. Cancer Care Ontario Screening Activity Report. To enrol to receive SAR, click here. Alternatively, data can be manually extracted from EMR.

	Cancer Care Ontario offers Healthcare Provider Resources- Colorectal Screening. The Screening Activity Report (SAR) provides patient enrolment model (PEM) primary care doctors with a supplementary tool for improving their cancer screening rates and appropriate follow-up for breast, cervical and colorectal cancer screening. The information in the SAR are updated on the 10th calendar day every month to provide timely breast, cervical and colorectal cancer screening data.
Comments	- Historical RPDB address information is incomplete; therefore, the most recent primary address was selected for reporting, even for historical study periods - FOBTs in hospital labs could not be captured - Only FOBT as a primary screening test could be assessed; FOBT is recommended for those at average risk of colorectal cancer, while those at increased risk (1st degree relative with colorectal cancer) were not assessed as they could not be accurately identified - A small proportion of FOBTs performed as diagnostic tests could not be excluded from the analysis <u>Note:</u> For 2017/18, two colorectal cancer screening indicators are included as additional indicators. This indicator is consistent with Cancer Care Ontario's colorectal cancer screening indicator. Primary care organizations that have access to Cancer Care Ontario's Screening Activity Reports (SAR) are encouraged to use this indicator. Health Quality Ontario recommends that primary care organizations select ONE of the colorectal cancer screening indicators for their QIP (e.g., either the "up to date" or "overdue" (CCO) indicator.).

Indicator Name NEW	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Total number of Ontario screen-eligible women, 21-69 years old, who have completed at least one Pap test in a 42 month time frame - Identifying Pap tests: <u>Pap tests</u> were identified in CytoBase <u>Pap tests</u> were also identified using fee codes in OHIP: - E430A: add-on to a003, a004, a005, a006 when pap

	performed outside hospital ○ G365A: Periodic-pap smear ○ E431A: When Papanicolaou smear is performed outside of hospital, to G394. ○ G394A: Additional for follow-up of abnormal or inadequate smears ○ L713A: Lab.med.-anat path,hist,cyt-cytol-gynaecological specimen ○ L733A: Cervicovaginal specimen (monolayer cell methodology) ○ L812A: Cervical vaginal specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation ○ Q678A: Gynaecology – pap smear – periodic – nurse practitioners ○ L643A: Lab Med - Microbiol - Microscopy - Smear Only, Gram/Pap Stain • All Pap tests in CytoBase were counted, including those with inadequate specimens Each woman was counted once regardless of the number of Pap tests performed in a 42 month time frame (e.g. Jan 2013 to June 2016)
Denominator	Total number of Ontario screen-eligible women, 21-69 years old, in the reporting period • Ontario screen-eligible women aged 21-69 at the index date • Index date was defined as the midpoint in a reporting period, e.g. July 1st 2014 for 2013-2015 • The 2011 Canadian population was used as the standard population for calculating age-standardized rates • The RPDB address closest to the index date was used to assign postal code • LHIN assignment was determined using PCCF+, version 6A; residential postal code was used to identify LHIN and individuals with unknown/missing LHINs were excluded from the analysis • Neighborhood income quintile was determined using PCCF+, version 6A; this indicator was based on income quintiles developed by Statistics Canada; income quintiles range from 1 to 5 (low to high) • Rural or urban residence was determined using PCCF+, version 6A. This indicator was based on whether individuals lived within a census metropolitan area (CMA), census agglomeration (CA) or Influenced Zones (MIZ) which takes into account population size, distance and commuting flow between rural and small towns and larger centres. ○ Urban: CMAs or CAs with a core population of 10,000 or more and 50+% of the population commute to a CMA/CA. ○ Rural: Areas with a core population of <10,000 and 30-49% of the population commute to an urban area (referred to as strong MIZ in Statistics Canada's classification) ○ Rural-Remote: Areas with a core population of <10,000 and 5-29% of the population commute to an urban area (referred to as Moderate MIZ in Statistics Canada's classification) ○ Rural-Very Remote: Areas with a core population of <10,000 and 0-4% of the population commute to an urban area, also includes non-urban parts of Territories (referred to as Weak

	MIZ, No MIZ, Territories outside CAs in Statistics Canada's classification) • Neighborhood percent immigrant was determined using PCCF+, version 6A; this indicator divides DAs into three categories according to the percentage of immigrants: low immigrant ($\leq 27\%$ immigrant population), moderate immigrant (27.1-51.8% immigrant population), and high immigrant ($\geq 51.9\%$ immigrant population). • Public health unit data was determined using PCCF+, version 6A <i>Exclusions:</i> • Women with a missing or invalid HIN, date of birth, LHIN or postal code • Women diagnosed with an invasive cervical cancer prior to January 1st of the reporting period, e.g. January 1st 2013 for 2013-2015; prior diagnosis of cervical cancer was defined as: ICD-O-3 codes C53, a morphology indicative of cervical cancer, microscopically confirmed with a path report • Women with a hysterectomy prior to January 1st of the reporting period, e.g. January 1st 2013 for 2013-2015 • Women with a hysterectomy were identified through CHDB, using the following fee codes: ○ E862A – When hysterectomy is performed laparoscopically, or with laparoscopic assistance ○ P042A – Obstetrics – labour – delivery – caesarean section including hysterectomy ○ Q140A – Exclusion code for enrolled female patients aged 35-70 with hysterectomy ○ S710A – Hysterectomy - with or without adnexa (unless otherwise specified) – with omentectomy for malignancy ○ S727A – Ovarian debulking for stage 2C, 3B or 4 ovarian cancer and may include hysterectomy ○ S757A – Hysterectomy – with or without adnexa (unless otherwise specified) – abdominal – total or subtotal ○ S758A – Hysterectomy - with or without adnexa (unless otherwise specified) – with anterior and posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered ○ S759A - Hysterectomy - with or without adnexa (unless otherwise specified) – with anterior or posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered ○ S762A - Hysterectomy - with or without adnexa (unless otherwise specified) – radical trachelectomy - excluding node dissection ○ S763A - Hysterectomy - with or without adnexa (unless otherwise specified) – radical (Wertheim or Schauta) - includes node dissection ○ S765A – Amputation of cervix ○ S766A- Cervix uteri - Exc - cervical stump – abdominal ○ S767A- Cervix uteri - exc - Cervical stump – vaginal ○ S816A - Hysterectomy - with or without adnexa (unless otherwise specified) - vaginal
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Risk adjustment	None
Current performance: reporting period	Annually
Data source	Ontario Health Insurance Plan (OHIP) Claims History Database (CHDB), CytoBase, Cancer Care Ontario - Ontario Cancer Registry(CCO-OCR), Registered Persons Database (RPDB), PCCF+ version 6A
How to access data	Primary data source is EMR. An alternate source is Cancer Care Ontario Screening Activity Report – family health teams. To enrol to receive SAR, click here. Alternatively, data can be manually extracted from EMR. Cancer Care Ontario offers Healthcare Provider Resources - Cervical Screening. The Screening Activity Report (SAR) provides patient enrolment model (PEM) primary care doctors with a supplementary tool for improving their cancer screening rates and appropriate follow-up for breast, cervical and colorectal cancer screening. The information in the SAR are updated on the 10th calendar day every month to provide timely breast, cervical and colorectal cancer screening data.
Comment	For 2017/18, two cervical cancer screening indicators are included as additional indicators. This indicator is consistent with Cancer Care Ontario's cervical cancer screening indicator. Primary care organizations that have access to Cancer Care Ontario's Screening Activity Reports (SAR) are encouraged to use this indicator. Health Quality Ontario recommends that primary care organizations select ONE of the cervical cancer screening indicators for their QIP (e.g., either the “up to date” or “completed a Pap in the last 42 months” (CCO) indicator.).

Indicator Name NEW	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Identify patients with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach The complex patient target population should: • Overlap substantially with high cost users, recognizing that not all high cost users are high needs patients (and vice versa); • Include patients with high needs and/or complex conditions; and, • Include patients with four or more chronic/high cost conditions, including a focus on individuals living with mental health and addictions, palliative patients, and the frail elderly.

	However, recognizing nuances exist across communities, LHINs and Health Links are encouraged to adapt the patient identification criteria to their local context and population needs.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Total number of patients who were offered access to the Health Link approach
Denominator	Total number of patients identified through clinical level assessments and/or data-driven case-finding methods sourced as meeting HLs criteria <i>Exclusions:</i> Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Risk adjustment	None
Current performance: reporting period	Most recent 3 month period.
Data source	In house, manual data collection (health record, EMR, other)
How to access data	In house data collection.
Comments	In late 2015, Health Quality Ontario completed a review of the best available information about Health Links and analysis of innovations related to Coordinated Care Management. The innovations framework includes detailed information to help organizations identify patients with multiple conditions and complex needs through clinical level assessments and data driven case finding methods at any point in the patient's healthcare journey. Patients identification approaches: Use clinical level patient identification mechanisms to support identification of patients during a service encounter. For example, as each patient presents to a health or wellness organization or program to receive care, the provider may identify that the patient may benefit from a Health Links/Coordinated Care Management approach. To further support clinical decision making, the provider may then administer a standardized risk assessment tool, if indicated. Use data driven case finding mechanisms to support prospective identification of patients with multiple conditions and complex needs using utilization data to identify complex patients. For example, triggers such as the number of visits to the emergency department, number/length of admissions to hospital within a specified time frame, or patients with specific diagnoses or conditions can be built into the electronic medical record or can be managed by targeted data extraction and analysis methods, to support the identification of potential Patients with multiple conditions and complex needs. <u>Note:</u> A single, cross-sectorial clinical level risk assessment tool/method with adequate sensitivity and specificity to capture every patient who

	would benefit from a Health Links/Coordinated Care Management approach was not identified. However, the following risk assessment tools were highlighted by Health Links during the environmental scan, and are presented here for consideration based on the practice setting. The decision to implement/administer one of these tools must be considered alongside other contextually relevant information. • LACE (Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits) • PRA (Predictive Repetitive Admission) • DIVERT Scale (Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale) For more technical details, please refer to Identify Patients: Use a Combination of Clinical and Data Driven Strategies <u>Note:</u> Once a patient who has multiple conditions or complex needs has been identified, the organization should connect to the processes established by the local Health Link.
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Primary Care Practice report: Additional supports for Quality Improvement

Primary Care Practice Reports give family physicians, Community Health Centres and Family Health Teams access to customized information about their practice and compares this information to regional and provincial data. Primary Care Practice Reports were created by Health Quality Ontario and the Institute for Clinical Evaluative Sciences, in partnership with the Association of Family Health Teams of Ontario, Association for Ontario Health Centres and the Ontario College of Family Physicians. The Primary Care Practice Report provides cross-sectional and longitudinal data on practice demographics and case mix, patterns of service use (e.g., emergency department visits, hospital admissions, and specialist referrals), chronic disease prevention and management, and the health status of the practice population.

Physicians or Executive Directors who would like to receive a practice report or learn more about it can find more information on the [Primary Care Practice Report page on Health Quality Ontario's website.](#)

III. Home Care Indicators

Home Care Priority Indicators

Indicator Name	Hospital readmissions
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Percentage of home care clients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Number of adult home care clients with an unplanned readmission to hospital within 30 days of hospital discharge.
Denominator	All adult CCAC home care clients discharged from a hospital. <i>Exclusions:</i> • Service is case management; • Hospital discharge that is newborn, stillborn, or cadaver donor; • Planned readmissions.
Risk adjustment	None
Current performance: reporting period	July 2015 – June 2016
Data source	Discharge Abstract Database (DAD), Home Care Database (HCD), National Ambulatory Care Reporting System (NACRS). Data provided to HQO by Ontario Association of Community Care Access Centres (OACCAC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2016. Alternatively, you can access your organization's data for this indicator by visiting the CCAC Reporting Portal.

Indicator Name	Unplanned emergency department visits
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Process
Description	Percentage of home care clients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Number of adult home care clients who had an ED visit assessed at Canadian Triage and Acuity Scale levels 4 or 5 (but who were not admitted to hospital) in the first 30 days after hospital discharge.
Denominator	All adult CCAC home care clients discharged from a hospital. <i>Exclusions:</i> • Service if case management; • Hospital discharge that is newborn, stillborn, or cadaver donor; • Planned ED visits
Risk adjustment	None
Current performance: reporting period	July 2015 – June 2016
Data source	Discharge Abstract Database (DAD), Home Care Database (HCD), National Ambulatory Care Reporting System (NACRS). Data provided to HQO by Ontario Association of Community Care Access Centres (OACCAC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017. Alternatively, you can access your organization's data for this indicator by visiting the CCAC Reporting Portal.

Indicator Name	Clients' experience
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Patient- centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator provides information on the overall experience of home care patients. It reports the percentage of home care patients who are satisfied with services provided by Community Care Access Centres (CCACs), with the handling of their care by CCAC care coordinators and with the services provided by service provider organizations.
Unit of Measurement	Percentage
Calculation Methods	Percentage of "Good", "Very Good" and "Excellent" responses on a 5 point scale (poor to excellent) to three Client Experience KPI 1 Survey questions: • Overall rating of CCAC services • Overall rating of management or handling of care by Care Coordinator • Overall rating of service provided by service provider General survey Inclusion criteria: 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. General Survey Exclusion criteria: • 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 Other exclusions: • Home care patients with hospital or death discharges; • Patients on hold in hospital; • Patients with a claim against the CCAC or before the Ontario Health Services Appeal and Review Board. Question specific exclusion criteria: • Respondents are also excluded if they did not know the case manager or have not seen or spoken to the case manager, do not recall the in-home service, or were surveyed about placement services.

Numerator	The sum of the number of positive responses ("good", "very good", or "excellent") registered for each of the three questions that form the KPI 1 Score for the overall experience rating. (n positive Q4) + (n positive Q24) + (n positive Q39) Question 4: Overall how would you rate the services that you received from your CCAC and any of the individuals who provided care to you? Question 24: Overall, how would you rate the management and handling of your care by your case manager? Question 39: Overall how would you rate the x service provided by y (where x is any of: nursing, personal support, physiotherapy, occupational therapy, nutrition/dietetics, speech and language, or social work and y is the name of the service provider)? *Sum of the weighted responses are used. Post-sample weighting is applied to adjust for disproportionate sampling and to ensure that the reported survey results are representative of the actual population served by the CCAC
Denominator	The total number of valid responses registered for all of the questions listed above.
Risk adjustment	Results are weighted to reflect the population of home care patients eligible to be surveyed within each CCAC (i.e., sampled home care patients are standardized to CCAC-specific population).
Current performance: reporting period	April 2015 – March 2016
Data source	Client and Caregiver Experience Evaluation (CCEE) Survey. Data provided to HQO by Ontario Association of Community Care Access Centres (OACCAC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2016. Alternatively, to access your organization's data for this indicator, refer to the NRC Canada eReports website .

Indicator Name	5-day wait time for home care: Personal support for complex patients
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Process
Description	This indicator measures the percentage of complex home care patients authorized for personal support services who received their first personal support service visit within five days. The wait time is described as the number of days between service authorization date and the date of Community Care Access Centre (CCAC) in-home personal support.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	The number of complex home care patients who received their first personal support service visit within five days of the date they were authorized for personal support services by the CCAC. The wait time equals the number of days between the first service date and the care authorization date.
Denominator	The number of adult complex home care patients who received in-home personal support services. Three patient populations are included: • New patients • Existing patients who now require a new service • Existing patients who are receiving services after a break in service <i>Inclusions:</i> • Home care patients with complex needs (Authorization Client Care Model Population = 1) • Home care patients who requested in-home program at the time of referral (Request program=1) • First personal support service must take place in the period selected • Home care patients who received in-home service (SRC = 91 to 95) • Home care patients who received personal support services (Service Type = 11, 12, 13, 15) • Home care patients whose age at service authorization date is greater than 18 <i>Exclusions:</i> • Children receiving personal support service (Age ≤ 18) • Service delivered in school setting (Care site = 12, 24, 25) • Overlapping personal support authorizations (i.e. if the personal support service is not discharged and a new personal support service is added, only the first personal support service would be counted) • Episodes of care where service on hold date falls between the service authorization date and first service date

Risk adjustment	None
Current performance: reporting period	October 2015 – September 2016
Data source	CCAC's Client Health & Related Information System (CHRIS), Home Care Database (HCD). Data provided to HQO by Ontario Association of Community Care Access Centres (OACCAC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017. Alternatively, you can access your organization's data for this indicator by visiting the CCAC Reporting Portal.

Indicator Name	5-day wait time for home care: Nursing Visits
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Process
Description	This indicator measures the percentage of home care patients authorized for nursing services who received their first nursing visit within five days. The wait time is described as the number of days between service authorization date and the date of Community Care Access Centre (CCAC) in-home nursing.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	The number of home care patients who received their first nursing service visit within five days of the date they were authorized for nursing services by the CCAC. The wait time equals the number of days between the first service date and the care authorization date.
Denominator	The number of adult home care patients who received in-home nursing services. Three patient populations are included: • New patients • Existing patients who now require a new service • Existing patients who are receiving services after a break in service <i>Inclusions:</i> • Home care patients who requested in-home program at the time of referral (Request program = 1) • First nursing visit must take place in the period selected • Home care patients who received in-home service (SRC = 91 to 95) • Home care patients who received nursing services (Service type = 1, 17, 18) • Home care patients whose age at service authorization date is greater than 18 <i>Exclusions:</i> • Shift nursing (Service type = 2)

	• Mental health and addiction nursing service, which is a service delivered in school setting for children (Service type = 16) • Children receiving nursing service (Age < 19) • Service delivered in school setting (Care site = 12, 24, 25) • Overlapping nursing authorizations (i.e. if the nursing service is not discharged and a new nursing service is added, only the first nursing service would be counted) • Episodes of care where service on hold date falls between the service authorization date and first service date
Risk adjustment	None
Current performance: reporting period	October 2015 – September 2016
Data source	CCAC's Client Health & Related Information System (CHRIS), Home Care Database (HCD). Data provided to HQO by Ontario Association of Community Care Access Centres (OACCAC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017. Alternatively, you can access your organization's data for this indicator by visiting the CCAC Reporting Portal.

Indicator Name	Falls for long stay clients
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Percentage of adult long-stay home care clients who have a fall on their follow-up of the international research network's Resident Assessment Instrument (interRAI) for home care.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Number of long-stay home care clients who record a fall in the last 90 days
Denominator	Number of all long-stay home care clients Exclusion Criteria: - Patients totally dependent in bed mobility To prevent capturing outcomes that result from the care received outside of the home care settings, assessments are excluded according to the following criteria: • if case open date is missing and Reason for Assessment is Initial Assessment • if the assessment took place within 60 days of when the referral was first received/case open date • if assessment was completed in hospital settings
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	October 2015 – September 2016

Data source	Home Care Database (HCD). Data provided to HQO by Ontario Association of Community Care Access Centres (OACCAC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator . Data will be available in February 2017. Alternatively, you can access your organization's data for this indicator by visiting the Community Care Access Centre (CCAC) Reporting Portal.

Home Care Additional Indicators

Indicator Name NEW	End of life, preferred place of death
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Patient- centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percent palliative/ end of life patients who died in their preferred place of death
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of palliative / end of life patients who died in their preferred place of death. Patient must be discharged with a disposition of death in the period selected <i>Inclusions:</i> • In home referrals only • > 18 years of age at the time • CCM population of "complex palliative" or "chronic palliative" or end of life (SRC95) at time of discharge • Discharge dispositions: • Died at home (preferred place of death) • Died in hospital (preferred place of death) • Died in residential hospice (preferred place of death) • Died in Long-Term Care home (preferred place of death) • Died in Retirement Home (preferred place of death) • Died in other location (preferred place of death) <i>Exclusions:</i> • Other CCM or SRC codes • Children ≤18 years old at the time of discharge • Referrals other than in home (school, placement) • Other death discharge dispositions (not preferred place of death) • Patients with blank or invalid health card numbers
Denominator	Number of palliative/ end of life patients whose discharge disposition is death in the reporting period. <i>Inclusions:</i> • In home referrals only • > 18 years of age at the time

	• CCM population of “complex palliative” or “chronic palliative” or end of life (SRC95) at time of discharge • Any discharge where Discharge disposition flag “has died” = 1 • Died (while under CCAC care) • Died in Hospital (< 14 days) • Died in Hospital • Died at Home • Died at Home (preferred place of death) • Died in Hospital (preferred place of death) • Died in Residential Hospice (preferred place of death) • Died in LTCH (preferred place of death) • Died in Retirement Home • Died in Retirement Home (preferred place of death) • Died in Other Location • Died in Other Location (preferred place of death) • Died in Residential Hospice • Unplanned Death <i>Exclusions:</i> • Other CCM or SRC codes • Children ≤18 years old at the time of discharge • Referrals other than in home (school, placement) • Discharges other than death • Patients with blank or invalid health card numbers
Risk adjustment	None
Current performance: reporting period	July 2015 – June 2016
Data source	CCAC’s Client Health & Related Information System (CHRIS). Data provided to HQO by Ontario Association of Community Care Access Centres.
How to access data	To access your organization’s data for the reporting period, refer to Health Quality Ontario’s QIP Navigator . Data will be available in February 2017. Alternatively, you can access your organization’s data for this indicator by visiting the CCAC Reporting Portal.

Indicator Name NEW	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Identify patients with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach The complex patient target population should: • Overlap substantially with high cost users, recognizing that not all high cost users are high needs patients (and vice versa); • Include patients with high needs and/or complex conditions; and, • Include patients with four or more chronic/high cost conditions, including a focus on individuals living with mental health and addictions, palliative patients, and the frail elderly. However, recognizing nuances exist across communities, LHINs and Health Links are encouraged to adapt the patient identification criteria to their local context and population needs.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Total number of patients who were offered access to the Health Link approach
Denominator	Total number of patients identified through clinical level assessments and/or data-driven case-finding methods sourced as meeting HLs criteria <i>Exclusions:</i> • Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Risk adjustment	None
Current performance: reporting period	Most recent 3 month period.
Data source	In house, manual data collection (health record, EMR, other)
How to access data	In house data collection.
Comments	In late 2015, Health Quality Ontario completed a review of the best available information about Health Links and analysis of innovations related to Coordinated Care Management. The innovations framework includes detailed information to help organizations identify patients with multiple conditions and complex needs through clinical level assessments and data driven case finding methods at any point in the patient's healthcare journey. Patients identification approaches: Use <i>clinical level patient identification mechanisms</i> to support identification of patients during a service encounter. For example, as each patient presents to a health or wellness organization or program to

	receive care, the provider may identify that the patient may benefit from a Health Links/Coordinated Care Management approach. To further support clinical decision making, the provider may then administer a standardized risk assessment tool, if indicated. Use data driven case finding mechanisms to support prospective identification of patients with multiple conditions and complex needs using utilization data to identify complex patients. For example, triggers such as the number of visits to the emergency department, number/length of admissions to hospital within a specified time frame, or patients with specific diagnoses or conditions can be built into the electronic medical record or can be managed by targeted data extraction and analysis methods, to support the identification of potential Patients with multiple conditions and complex needs. <u>Note:</u> A single, cross-sectorial clinical level risk assessment tool/method with adequate sensitivity and specificity to capture every patient who would benefit from a Health Links/Coordinated Care Management approach was not identified. However, the following risk assessment tools were highlighted by Health Links during the environmental scan, and are presented here for consideration based on the practice setting. The decision to implement/administer one of these tools must be considered alongside other contextually relevant information. • LACE (Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits) • PRA (Predictive Repetitive Admission) • DIVERT Scale (Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale) For more technical details, please refer to Identify Patients: Use a Combination of Clinical and Data Driven Strategies <u>Note:</u> Once a patient who has multiple conditions or complex needs has been identified, the organization should connect to the processes established by the local Health Link.
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IV. Long-Term Care

Long-Term Care Priority Indicators

Indicator Name	Potentially avoidable emergency department visits for long-term care residents
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Process
Description	Number of ED visits for a modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.
Unit of Measurement	Rate per 100 residents
Calculation Methods	Total ED visits, transfers between EDs, ED visits resulting in admission, and deaths in EDs for all active LTC home residents aged 65 and older in Ontario LTC homes in a given year. Numerator: Steps: 1. Count the number of unscheduled emergency department (ED) visits made by long-term care home residents for the selected conditions. Step 2. Multiply by 100. Denominator: Steps: 1. Extract the population of active long-term care home residents.
Numerator	ED visits, transfers between EDs, ED visits resulting in admission, and deaths in EDs for all active LTC home residents aged 65 and older in Ontario LTC homes in a given year. <i>Inclusions:</i> • All active LTC home residents aged 65 and older in Ontario LTC homes in a given year. • ED visits, transfers between EDs, ED visits resulting in admission, and deaths in ED. • Modified ambulatory care-sensitive conditions presenting to EDs that are potentially preventable are as follows: - Angina - Asthma - Cellulitis - Chronic obstructive pulmonary disease - Congestive heart failure - Septicemia - Dehydration - Dental conditions - Diabetes - Gastroenteritis - Grand mal and seizure disorders - Hypertension - Hypoglycemia - Injuries from falls - Mental health and behavioural disorders

	- Pneumonia - Severe ear, nose and throat disorders <i>Exclusions:</i> Planned or scheduled ED visits and urinary tract infections.
Denominator	<i>Inclusions:</i> • All active residents of long-term care homes aged 65 and older in a given year. <i>Exclusions:</i> • Individuals with invalid health card numbers.
Risk adjustment	None
Current performance: reporting period	October 2015 – September 2016
Data source	Continuing Care Reporting System (CCRS), National Ambulatory Care Reporting System (NACRS). Data provided to HQO by Health Analytics Branch with the MOHLTC.
How to access data	The Ministry will provide organizations with this data via LTCHomes.net
Comments	Quality improvement guidance related to this indicator is available on the Health Quality Ontario website and through the INTERACT (Interventions to Reduce Acute Care Transfers) program.

Indicator Name	Resident experience: Overall satisfaction
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Patient- centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	The percentage of residents who responded positively to the question/statement: <i>Would you recommend this nursing home to others? /I would recommend this site or organization to others.</i>
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Homes using the NHCAHPS Long-Stay Resident Survey should measure this domain by calculating the percentage of residents who responded positively. • Add the number of respondents who responded '4' to the question: <i>Would you recommend this nursing home to others?</i> • Responses are coded from 1 - 4, where 1 = Definitely no 2 = Probably no 3 = Probably yes 4 = Definitely yes Homes using the interRAI Quality of Life Survey should measure this domain by calculating the percentage of residents who responded positively to the statement. • Add the number of respondents who responded '3' and '4' to the statement: <i>I would recommend this site or organization to others.</i>

	Responses are coded from 0 - 8 (0, 1, 2, 3, 4, 6, 7, 8), where 0 = Never 1 = Rarely 2 = Sometimes 3 = Most of the time 4 = Always 6 = Don't know 7 = Refused 8 = No response or cannot be coded from response
Denominator	For homes using the NHCAHPS Long-Stay Resident Survey, add the total number who registered any response to the question. Do not include non-respondents. For homes using the interRAI Quality of Life Survey, add the total number who registered any response to the statement. Do not include non-respondents (6 = Don't know, 7 = Refused, 8 = No response).
Risk adjustment	None
Current performance: reporting period	April 2016 – March 2017 (or most recent 12-month period). If you have completed this year's survey, you do not have to resubmit the survey.
Data source	In-house data collection, InterRAI Quality of Life Survey, NHCAHPS Long-Stay Resident Survey
How to access data	These data should be accessed from within your own organization.
Comments	For more information about the NHCAHPS Long-Stay Resident Survey, refer to Agency for Healthcare Research and Quality's website: Get Nursing Home Surveys and Instructions. For more information about the interRAI Quality of Life Survey, refer to interRAI's website. Homes that use a validated survey tool other than NHCAHPS Long-Stay Resident Survey or InterRAI Quality of Life should select and use the questions from their survey that are most similar to the ones listed above. Homes that design and administer their own survey should consider adding questions that align with either the NHCAHPS Long-Stay Resident Survey or InterRAI Quality of Life questions listed above.

Indicator Name	Residents' experience: Having a voice
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Patient- centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Organizations should measure progress on the following indicator: Having a voice The percentage of residents who responded positively to the question: What number would you use to rate how well the staff listen to you?
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Homes using the NHCAHPS Long-Stay Resident Survey should measure this domain by calculating the percentage of residents who responded positively. • Add the number of respondents who responded '9' and '10' to the question: What number would you use to rate how well the staff listen to you? • Responses are coded from 0 - 10, where 0 = worst possible and 10 = best possible.
Denominator	For homes using the NHCAHPS Long-Stay Resident Survey , add the total number who registered any response to the question. Do not include non-respondents.
Risk adjustment	None
Current performance: reporting period	April 2016 – March 2017 (or most recent 12-month period). If you have completed this year's survey, you do not have to resubmit the survey.
Data source	In-house data collection, NHCAHPS Long-Stay Resident Survey
How to access data	These data should be accessed from within your own organization.
Comments	For more information about the NHCAHPS Long-Stay Resident Survey, refer to Agency for Healthcare Research and Quality's website: Get Nursing Home Surveys and Instructions .

Indicator Name	Residents' experience: Being able to speak up about the home
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Patient- centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Organizations should measure progress on the following indicator: Being able to speak up about the home The percentage of residents who responded positively to the following: I can express my opinion without fear of consequences
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100%
Numerator	Homes using the interRAI Quality of Life Survey should measure this domain by calculating the percentage of residents who responded positively. Add the number of respondents who responded '3' and '4' to the statement: I can express my opinion without fear of consequences. Responses are coded from 0 - 8 (0, 1, 2, 3, 4, 6, 7, 8), where 0 = Never 1 = Rarely 2 = Sometimes 3 = Most of the time 4 = Always 6 = Don't know 7 = Refused 8 = No response or cannot be coded from response
Denominator	For homes using the interRAI Quality of Life Survey , add the total number who registered any response to the statement. Do not include non-respondents (6 = Don't know, 7 = Refused, 8 = No response).
Risk adjustment	None
Current performance: reporting period	April 2016 – March 2017 (or most recent 12-month period). If you have completed this year's survey, you do not have to resubmit the survey.
Data source	In-house data collection, InterRAI Quality of Life Survey.
How to access data	These data should be accessed from within your own organization.
Comments	For more information about the interRAI Quality of Life Survey, refer to interRAI's website .

Indicator Name	Appropriate prescribing – potentially inappropriate antipsychotic use in long-term care
Priority or additional indicator?	Priority for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the percentage of long-term care (LTC) home residents without psychosis who were given antipsychotic medication in the seven days preceding their resident assessment.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100% The indicator is calculated using four rolling quarters of data by summing the number of residents that meet the inclusion criteria for the target quarter and each of the previous three fiscal quarters. This is done for both the numerator and denominator.
Numerator	LTC home residents who received antipsychotic medication on one or more days in the week before their Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS) target assessment <i>Inclusions:</i> • O4a = 1, 2, 3, 4, 5, 6 or 7 • Where, O4A = Number of days the resident received an antipsychotic medication during the last seven days [0-7]
Denominator	LTC home residents with a valid RAI-MDS assessment*, excluding those with schizophrenia, Huntington's chorea, hallucinations or delusions, as well as residents who are end-stage disease or receiving hospice care <i>Exclusions:</i> • Residents who are end-stage disease (J5c = 1) or receiving hospice care (P1ao = 1) • Residents who have a diagnosis of schizophrenia (I1ii = 1) or Huntington's chorea (I1x = 1), or those experiencing hallucinations (J1i = 1) or delusions (J1e = 1) *For an assessment to be valid and included in the quality indicator calculation, the selected assessment must: • Be the latest assessment in the quarter • Be carried out more than 92 days after the Admission Date • Not be an Admission Full Assessment
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	July 2016 – September 2016
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI).
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at www.cihi.ca .
Comments	The indicator is calculated as a rolling four quarter average.

	This indicator is consistent with Health Quality Ontario's LTC Public Reporting website; however, Health Quality Ontario publicly reports <i>adjusted rates</i>. For the purposes of quality improvement planning, <i>unadjusted rates</i> (i.e., not risk-adjusted) should be used. Health Quality Ontario developed a confidential practice report for physicians who practise Long-Term Care. These reports are intended to complement other sources of information physicians receive (e.g., pharmacy reports). The current report focuses on indicators related to the prescribing of antipsychotic medications and contains change ideas related to the topic of antipsychotic prescribing. For more information please visit www.hqontario.ca/LTCreport.
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Long-Term Care Additional Indicators

Indicator Name	Falls
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	This indicator measures the percentage of long-term care (LTC) home residents who fell during the 30 days preceding their resident assessment.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100% The indicator is calculated using four rolling quarters of data by summing the number of residents that meet the inclusion criteria for the target quarter and each of the previous three fiscal quarters. This is done for both the numerator and denominator.
Numerator	LTC home residents who had a fall in the last 30 days recorded on their target Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS) assessment <i>Inclusions:</i> J4a = 1 Where, J4a = Fell in past 30 days [0,1] [0,1] 0 = No 1 = Yes
Denominator	LTC home residents with a valid RAI-MDS assessment* *For an assessment to be valid and included in the quality indicator calculation, the selected assessment must: Be the latest assessment in the quarter

	• Be carried out more than 92 days after the admission date • Not be an admission full assessment
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	July 2016 – September 2016
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI).
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at www.cihi.ca .
Comments	This indicator is consistent with Health Quality Ontario's LTC Public Reporting website; however, Health Quality Ontario publicly reports <i>adjusted rates</i>. For the purposes of quality improvement planning, <i>unadjusted rates</i> (i.e., not risk-adjusted) should be used. Health Quality Ontario developed a confidential practice report for physicians who practise Long-Term Care. These reports are intended to complement other sources of information physicians receive (e.g., pharmacy reports). The current report focuses on indicators related to the prescribing of antipsychotic medications and contains change ideas related to the topic of antipsychotic prescribing. For more information please visit www.hqontario.ca/LTCreport.

Indicator Name	Daily restraints use
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the percentage of long-term care (LTC) home residents who were physically restrained every day during the seven days preceding their resident assessment.
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100% The indicator is calculated using four rolling quarters of data by summing the number of residents that meet the inclusion criteria for the target quarter and each of the previous three fiscal quarters. This is done for both the numerator and denominator.
Numerator	LTC home residents who were recorded as having been physically restrained daily during the seven days preceding their target Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS) assessment <i>Inclusions:</i> • (P4c = 2) OR (P4d = 2) OR (P4e = 2) Where, P4c = Trunk restraint [0,1,2] P4d = Limb restraint [0,1,2]

	P4e = Chair prevents rising [0,1,2] [0,1,2] 0 = not used 1 = used less than daily 2 = used daily
Denominator	LTC home residents with valid RAI-MDS assessments* <i>Exclusions:</i> - Residents who were comatose (B1= 1) - Residents who were quadriplegic (I1bb = 1) *For an assessment to be valid and included in the quality indicator calculation, the selected assessment must: - Be the latest assessment in the quarter - Be carried out more than 92 days after the admission date - Not be an admission full assessment
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	July 2016 – September 2016
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI).
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at www.cihi.ca .
Comments	The indicator is calculated as a rolling four quarter average. This indicator is consistent with Health Quality Ontario's LTC Public Reporting website; however, Health Quality Ontario publicly reports <i>adjusted rates</i>. For the purposes of quality improvement planning, <i>unadjusted rates</i> (i.e., not risk-adjusted) should be used. Health Quality Ontario developed a confidential practice report for physicians who practise Long-Term Care. These reports are intended to complement other sources of information physicians receive (e.g., pharmacy reports). The current report focuses on indicators related to the prescribing of antipsychotic medications and contains change ideas related to the topic of antipsychotic prescribing. For more information please visit www.hqontario.ca/LTCreport.

Indicator Name	Pressure ulcers
Priority or additional indicator?	Additional for 2017/18 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	This indicator measures the percentage of long-term care (LTC) home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment.
Unit of Measurement	Percentage

Calculation Methods	Numerator/ denominator x 100% The indicator is calculated using four rolling quarters of data by summing the number of residents that meet the inclusion criteria for the target quarter and each of the previous three fiscal quarters. This is done for both the numerator and denominator.
Numerator	LTC home residents who had a pressure ulcer at stage 2 to 4 on their target Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS) assessment and either they did not have a pressure ulcer on their previous assessment or the stage of pressure ulcer is greater on their target compared with their previous assessment <i>Inclusions:</i> • M2a > 1 AND (M2a - Prev_M2a) > 0 AND Prev_M2a < 4 • Where, M2a = Stage of pressure ulcer at target assessment [0-4] • Prev_M2a = Stage of pressure ulcer at prior assessment [0-4]
Denominator	LTC residents with two valid RAI-MDS assessments*, excluding those who had a stage 4 pressure ulcer on their prior assessment (i.e., residents are only included if they did not have a pressure ulcer at the maximum stage on their previous assessment) <i>Exclusions:</i> • Prev_M2a = 4 *Two valid assessments within consecutive quarters are required for a given resident to calculate the quality indicator. The assessment selected as the "target" assessment in the current quarter must: • Be the latest assessment in the quarter • Be carried out more than 92 days after the Admission Date • Not be an Admission Full Assessment - Be from a resident that had an assessment in the previous quarter • Have 45 to 165 days between the target assessment and assessment in the previous quarter (Note: If there are multiple assessments from the previous quarter that meet the time period criteria, the latest assessment is selected as the "prior" assessment)
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	July 2016 – September 2016
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI).
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at www.cihi.ca .
Comments	The indicator is calculated as a rolling four quarter average. This indicator is consistent with Health Quality Ontario's LTC Public Reporting website; however, Health Quality Ontario publicly reports <i>adjusted rates</i>. For the purposes of quality improvement planning, <i>unadjusted rates</i> (i.e., not risk-adjusted) should be used. Health Quality Ontario developed a confidential practice report for physicians who practise Long-Term Care. These reports are intended to complement other sources of information physicians receive (e.g.,

	pharmacy reports). The current report focuses on indicators related to the prescribing of antipsychotic medications and contains change ideas related to the topic of antipsychotic prescribing. For more information please visit www.hqontario.ca/LTCreport .
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V. Abbreviations

AFHTO	Association of Family Health Teams of Ontario
AHAC	Aboriginal Health Access Centre
ALC	Alternate level of care
AOHC	Association of Ontario Health Centres
CCAC	Community Care Access Centre
CCC	Complex Continuing Care
CCRS	Continuing Care Reporting System
CHC	Community Health Centre
CIHI	Canadian Institute of Health Information
DAD	Discharge Abstract Database
EMR	Electronic Medical Record
FY	Fiscal year. The Ontario government's fiscal year runs from April 1 to March 31.
HBAM	Health-Based Allocation Model
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HIG	Health-Based Allocation Model Inpatient Grouper
ICU	Intensive Care Unit
InterRAI	International research network's Resident Assessment Instrument
NACRS	National Ambulatory Care Reporting System
NHCAHPS	Nursing Home Consumer Assessment of Healthcare Providers and Systems
NRC	National Research Council of Canada
PPCF	Postal Code Conversion File
PCPES	Primary Care Patient Experience Survey
QBP	Quality-Based Procedures
QIP	Quality Improvement Plan