Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

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Indicator Technical Specifications

Quality Improvement Plan 2016/17

Ontario
Health Quality Ontario

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 2016/17 quality improvement plans (QIPs).

Recommended priority QIP indicators 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 in these areas requires every sector and every organization to prioritize quality improvement.

Each sector has its own list of recommended priority and additional indicators. The QIP Indicator Technical Specifications Document includes all of the technical details for these indicators.

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 current performance 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.

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Note: 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 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.

Contents

I. Hospital QIP Indicators

Many of the indicators for hospitals are unchanged from last year. Where appropriate, the title of the indicator and definition have been amended to more accurately describe the actual calculation of the indicator.

New indicators are identified via a **"NEW"** icon.

Priority Hospital Indicators

Indicator	***Clostridium Difficile* Infection** This is a priority indicator for 2016/17 *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	Rate of *Clostridium difficile* infection per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired *Clostridium difficile* infection during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. Patient days are the number of days spent in a hospital for all patients. Consistent with Health Quality Ontario's Patient Safety public reporting website and Hospital Service Accountability Agreement Performance Measure.
Additional specifications	For more information about this indicator, visit the Ministry of Health and Long-Term Care Resource for Indicator Standards website.
Current performance: reporting period	January 2015 – December 2015
Data source	Ministry of Health and Long-Term Care
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.

Indicator	**Medication Reconciliation at Admission** This is a priority indicator for 2016/17 *Quality Dimension: Safe* *Direction of improvement: Increase*
Definition	Total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital. 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.
Additional specifications	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.

Indicator **NEW**	**Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure (Quality Based Procedures cohort)** This is a priority indicator for 2016/17 *Quality Dimension: Effective* *Direction of improvement: Reduce*
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 readmission rate among patients admitted to Ontario acute care facilities.
Additional specifications	Numerator Inclusion criteria • Non-elective readmission to any Ontario acute care facility within 30 days of acute hospital discharge Denominator Inclusion criteria • Ontario residents with valid health card number • Age ≥ 20 years • Most responsible diagnosis of congestive heart failure Exclusion criteria • 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-adjusted factors • Age group • Gender • Charlson Comorbidity 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 2014 – December 2014
Data source	Discharge Abstract Database (DAD), Canadian Institute of 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 2016.
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 **NEW**	**Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (Quality Based Procedure cohort)** This is a priority indicator for 2016/17 *Quality Dimension: Effective* *Direction of improvement: Reduce*
Definition	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.
Additional specifications	Numerator Inclusion criteria: • Non-elective readmission to any Ontario acute care facility within 30 days of the initial acute admission. Denominator Inclusion criteria: • Valid health card number • Age ≥ 35 • Most responsible diagnosis of chronic obstructive pulmonary disease Exclusion criteria: • 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-adjusted factors: • Age group • Gender • Charlson Comorbidity Index • Health-Based Allocation Model (HBAM) Inpatient Grouper (HIG) 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 2014 – December 2014
Data source	Discharge Abstract Database (DAD), Canadian Institute of 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 2016.
Comments	This indicator provides an opportunity to incorporate QBP Indicators into the QIPs for specific QBP Cohorts. The expectation is that hospitals will consider including within their QIP one of the QBP readmission indicators. 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 **NEW**	**Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke (Quality Based Procedure cohort)** This is a priority indicator for 2016/17 *Quality Dimension: Effective* *Direction of improvement: Reduce*
Definition	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.
Additional specifications	Numerator Inclusion criteria: • Non-elective readmission to any Ontario acute care facility within 30 days of the initial acute discharge Denominator Inclusion criteria: • Ontario residents with valid health card numbers • Age ≥ 18 years • Most responsible diagnosis of stroke or transient ischemic attack Exclusion criteria: • 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-adjusted factors: • Pre-admit comorbidities, secondary co-morbidities and any service transfer diagnoses • Age group • Gender • Charlson Comorbidity Index • Previous inpatient admissions within 30, 60 or 90 days as a general proxy for patient complexity • Case mix • Calendar year
Current Performance: Reporting period	January 2014 – December 2014
Data source	Discharge Abstract Database (DAD), Canadian Institute of 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 2016.
Comments	This indicator provides an opportunity to incorporate QBP Indicators into 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	**90th Percentile Emergency Department Length of Stay for Admitted Patients** This is a priority indicator for 2016/17 *Quality Dimension: Timely* *Direction of improvement: Reduce*
Definition	ED length of stay is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED to a hospital bed. Measured in hours. The 90th percentile is the maximum length of time in which 9 of 10 patients have completed their ED visit. Exclusion: non-admitted patients Note: This indicator definition is consistent with the Hospital Service Accountability Agreement Performance Measure.
Additional specifications	For more information about this indicator, visit the Ministry's Resource for Indicator Standards website or the Ministry's wait times website.
Current performance: Reporting period	January 2015 – December 2015
Data source	Cancer Care Ontario's Access to Care, using Level 1 data from CIHI's National Ambulatory Care Reporting System (NACRS).
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.

Indicator	**Positive Patient Experience** This is a priority indicator for 2016/17. *Quality Dimension: Patient-centred* *Direction of improvement: Increase*
Definition	Percentage of respondents who responded positively to one of the following general questions (choose the question(s) that is relevant to your hospital): • Would you recommend this hospital to your friends and family? • Would you recommend this emergency department to your friends and family? • Overall, how would you rate the care and services you received at this hospital? • Overall, how would you rate the care and services you received at this emergency department?
Additional specifications	Many hospitals in Ontario are transitioning from the NRC Canada Survey to the Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey—Inpatient Care (CPES) or Ontario Emergency Department Patient Experience of Care Survey (EDPEC). In discussions with the OHA, we have been advised that the NRC Canada Survey may no longer be available to hospitals as of April 2016.

To this end, hospitals have the following options:

Option 1: Use the Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey—Inpatient Care (CPES) or Ontario Emergency Department Patient Experience of Care Survey (EDPEC).

If your hospital is transitioning to the CPES (CIHI) and EDPEC survey, consider incorporating these indicators into your QIP as a custom indicator. If you do so, please indicate that you will be collecting baseline data for the 2016/2017 year (and note in the priority indicator "comments" section that you are moving to use another survey tool).

Would you recommend:

Adult Inpatient (medical/surgical): From the Canadian Patient Experience Survey—Inpatient Care (CPES-IC):

I. "Would you recommend this hospital to your friends and family?"
II. "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?"

Emergency Department: Ontario Emergency Department Patient Experience of Care Survey (EDPEC):

I. "Would you recommend this emergency department to your friends and family?"
II. "Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this emergency department visit?"

For patient experience questions, a "Top-box" method is recommended. "Top box" refers to the respondents who choose the only the most positive response.

Top-box Instructions: 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).

Overall Care:

For the questions "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" (IP) and "Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this emergency department visit?" (ED), reporting using a "Top-Box" method is recommended:

Top-box Instructions: HCAHPS guidelines recommend "top-box" scores as suitable to use for hospital rating questions. If using, "top box", add the number of respondents who responded "10" or "9" and divide by number of respondents

	who registered any response to this question (do not include non-respondents). Background: The “top-/ bottom-box” method has been adopted by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in the U.S. for their public reporting of the inpatient experience survey. HCAHPS results are publicly reported on Hospital Compare as “top-box,” “bottom-box” and “middle-box” scores. The “top-box” is the most positive response to HCAHPS Survey items. The “top-box” response is “‘9’ or ‘10’ (high)” for the Overall Hospital Rating item. Source: http://www.hcahpsonline.org/SummaryAnalyses.aspx **Option 2:** In house survey Hospitals that use an in-house survey should select the question that is most similar to the CPES-IC or EDPEC questions above. The question should reflect the overall level of care and services received at the hospital. Add the number of respondents who responded positively, and divide by the number of respondents who registered any response to the question. Where possible, the top box method is recommended. Incorporate these indicators into your QIP as custom indicators.
Current Performance: Reporting period	**Option 1:** Not applicable (collecting baseline) **Option 2:** Average of all survey responses collected over the most recent consecutive 12-month period.
Data source	Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey—Inpatient Care (CPES) or Ontario Emergency Department Patient Experience of Care Survey (EDPEC). or in-house survey
How to access data	These data should be accessed from within your own organization.
Comments	Given the late change to this indicator, the QIP Navigator will include the NRC Canada patient experience survey questions as a priority indicator. If your hospital is transitioning to the CPES-IC (CIHI) and EDPEC surveys, consider incorporating these indicators into your QIP as a custom indicator. If you do so, please indicate that your organization will be collecting baseline data for the 2016/2017 year (and note in the priority indicator “comments” section that you are moving to use another survey tool). If your hospital is using in house surveys, incorporate into your QIP as custom indicators.

Indicator **NEW**	**Alternate Level of Care Rate – Acute** This is a priority indicator for 2016/17. *Quality Dimension: Efficient* *Direction of improvement: Reduce*
Definition	Total number of alternate level of care (ALC) inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period. Overall Exclusion Please note that only those facilities (Acute & Post-Acute) submitting both ALC data (to the WTIS) and BCS data (through the HDB 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 = the total number of ALC days contributed by ALC patients waiting in complex continuing care (CC), rehabilitation (RB), and mental health (MH) beds CCC ALC days = the total number of ALC days contributed by ALC patients waiting in complex continuing care (CC) beds Rehab ALC days = the total number of ALC days contributed by ALC patients waiting in rehabilitation (RB) beds Mental Health ALC days = the total number of ALC days contributed by ALC patients waiting in mental health (MH) beds Exclusions: 1. ALC cases discontinued due to 'Data Entry Error'. 2. ALC cases having Inpatient Service = Discharge Destination for Post-Acute Care (*Exception: Bloorview Rehab, CCC to CCC). 3. ALC cases identified by the facility for exclusion. **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) Exclusion 1. Patient days contributed by inpatients in the emergency department (Bed Type = Emergency (Emerg + PARR, Emergency + PARR)). Consistent with the Hospital Service Accountability Agreement performance measure.
Additional specifications	For more information about this indicator, visit the Ministry's Resource for Indicator Standards website.
Current performance: Reporting period	July – September 2015 (Q2 FY 2015/16 report)
Data source	Wait Time Information System, Cancer Care Ontario
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, 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.

Indicator	**Readmission Within 30 days for Selected HBAM Inpatient Grouper** This is a priority indicator for 2016/17. *Quality Dimension: Effective* *Direction of improvement: Reduce*
Definition **NEW**	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.
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 2014 – June 2015
Data source	DAD, 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 2016. Alternatively, refer to the Ministry's Health Data Branch Web Portal for your organization's rates (click on 'Hospitals', then 'Quality Improvement Plans').

Additional Hospital Indicators

Indicator	**Percent Alternate Level of Care Days** *Quality Dimension: Efficient* *Direction of improvement: Reduce*
Definition	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. Includes: Data from acute care hospitals (with and without psychiatric beds), and individuals designated as ALC. Excludes: Newborns, stillborns and records with missing or invalid "Discharge Date"
Additional specifications	This was the former priority indicator in 2015/16. For more information about this indicator, visit the Ministry's Resource for Indicator Standards website.
Current performance: Reporting period	October 2014 – September 2015
Data source	DAD, 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 2016. Alternatively, refer to the Ministry's Health Data Branch Web Portal for your organization's rates (click on 'Hospitals', then 'Quality Improvement Plans').

Indicator	**Medication Reconciliation at Discharge** *Quality Dimension: Safe* *Direction of improvement: Increase*
Definition	Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion of the total number of patients discharged.
Additional specifications	Indicator excludes hospital discharge that is death, newborn or stillborn. Any additional exclusions should be documented in the comments section of the QIP. A Best Possible Medication Discharge Plan is the result of the medication reconciliation at discharge and consists of clear and comprehensive information for the patient and family and other care providers regarding the medication(s) the patient should be taking after discharge, including medications that have been initiated, discontinued or modified. Note: 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. Medication reconciliation can occur at varying levels of intensity, starting with medication reconciliation at admission and the creation of a Best Possible Medication Discharge Plan and building from there. For the purposes of the QIP, organizations should strive to at least meet the following basic components of medication reconciliation at discharge: • Discharge reconciliation conducted by prescriber (informed by Best Possible Medication History and current medication profile) and • Creation of Best Possible Medication Discharge Plan for the patient, family and other care providers (can be electronically generated, or not) Organizations may wish to work toward more comprehensive and extensive medication reconciliation processes. For more information on implementing and measuring medication reconciliation at discharge, including tools and resources for completing a Best Possible Medication Discharge Plan, 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.
Current Performance: Reporting period	Most recent quarter available
Data source	In-house data collection
How to access	These data should be accessed from within your own organization.

data	

Indicator	**Hand Hygiene Compliance Before Patient Contact** *Quality Dimension: Safe* *Direction of improvement: Increase*
Definition	Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100. As an example, hand hygiene was performed 60 times before patient contact by all health care providers. There were 100 observed hand hygiene opportunities before patient contact for all health care providers. Therefore, the percent hand hygiene compliance for before patient environment contact = (60/100) x 100 = 60% compliance rate. Consistent with Health Quality Ontario's Patient Safety public reporting website.
Additional specifications	None
Current Performance: Reporting period	January 2015 – December 2015
Data source	Ministry of Health and Long-Term Care
How to access data	These data can be accessed from within your own organization.

Indicator **NEW**	**Home Support for Discharged Palliative Patients** *Quality Dimension: Effective* *Direction of improvement: Increase*
Definition	Number of palliative patients (inpatient acute care) discharged home from hospital with support, divided by the number of home discharges in the reporting period with a hospital admission that indicates that the patient is receiving palliative care. Includes: Any diagnosis code with a palliative care indication, or main patient service of palliative care, and the discharge destination is home (with/without support). Excludes: Same day surgery. Long-term care homes are not considered discharges home.
Additional specifications	None
Current Performance: Reporting period	April 2014 – March 2015
Data source	CIHI, DAD
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.

Indicator	**Ventilator-Associated Pneumonia** *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	Ventilator-associated pneumonia (VAP) rate per 1,000 ventilator days: Total number of newly diagnosed VAP cases in intensive care units (ICU) after at least 48 hours of mechanical ventilation during the reporting period, divided by the number of ventilator days in that reporting period, multiplied by 1,000. Ventilator days are the number of days spent on a ventilator for all patients in ICUs who are 18 years and older. Consistent with publicly reportable patient safety data available on Health Quality Ontario's Patient Safety public reporting website.
Additional specifications	None
Current Performance: Reporting period	January 2015 – December 2015
Data source	Ministry of Health and Long-Term Care
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.

Indicator	**Central Line–Associated Blood Stream Infection** *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	Central line–associated blood stream infection (CLI) per 1,000 central line days: Total number of newly diagnosed CLI cases in the ICU after at least 48 hours with a central line during the reporting period, divided by the number of central line days in that reporting period, multiplied by 1,000. Central line days are the number of days spent with a central line for all patients in ICU 18 years and older. Consistent with Health Quality Ontario's Patient Safety public reporting website.
Additional specifications	None
Current Performance: Reporting period	January 2015 – December 2015
Data source	Ministry of Health and Long-Term Care
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.

Indicator	**Pressure Ulcers for Complex Continuing Care Patients** *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	Percent of residents receiving complex continuing care with a newly occurring Stage 2 or higher pressure ulcer in the last three months
Additional specifications	This indicator is not risk-adjusted and represents a rolling four-quarter average.
Current performance: Reporting period	July – September 2015 (Q2 FY 2015/16 report)
Data source	CIHI Continuing Care Reporting System (CCRS)
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, refer to CIHI's CCRS eReports for your organization's rates.

Indicator	**Falls for Complex Continuing Care Patients** *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	Percent of residents receiving complex continuing care who fell in the last 30 days
Additional specifications	This indicator is not risk-adjusted and represents a rolling four quarter average.
Current performance: Reporting period	July – September 2015 (Q2 FY 2015/16 report)
Data source	CIHI CCRS
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, refer to CIHI CCRS eReports for your organization's rates.

Indicator	**Physical Restraints in Mental Health** *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	Number of admission assessments where restraint use occurred in last three days divided by the number of full admission assessments in period
Additional specifications	None
Current performance: Reporting period	October 2014 ─ September 2015
Data source	Ontario Mental Health Reporting System, 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 2016. Alternatively, access your data from the CIHI OMHRS Quarterly Comparative

	reports.

Indicator	**Use of Surgical Safety Checklist** *Quality Dimension: Safe* *Direction of improvement: Increase*
Definition	Number of times all three phases of the surgical safety checklist were performed ('briefing', 'timeout' and 'debriefing') during the reporting period, divided by the total number of surgeries performed in the reporting period, multiplied by 100. Exclusions are minor surgical procedures that are done under local anaesthetic. Inclusions are surgical procedures such as: major surgery, day surgery, endoscopy, cystoscopy, bronchoscopy, colonoscopy, colposcopy, cataracts, dental procedures, caesarean sections and emergency surgeries. Consistent with publicly reportable patient safety data available on Health Quality Ontario's System Performance public reporting website.
Additional specifications	None
Current performance: reporting period	January 2015 – December 2015
Data source	Ministry of Health and Long-Term Care
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.

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 QIP Indicators

Priority Primary Care Indicators

Indicator	**Timely Access to a Primary Care Provider** This is a priority indicator for 2016/17. *Quality Dimension: Timely* *Direction of improvement: Increase*
Definition	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed
Additional specifications	Organizations are expected to measure progress on this indicator 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) To calculate the indicator result, add the number of respondents who responded "same day" and "next day", 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"). 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.
Current performance: reporting period	April 2015 – March 2016 (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.

Indicator	**Patients' Experience: Patient Involvement in Decisions About Care** This is a priority indicator for 2016/17. *Quality Dimension: Patient-centred* *Direction of improvement: Increase*
Definition	Organizations are expected to measure progress on this indicator using the *exact* wording of the following patient/client survey questions: 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?
Additional specifications	Percentage of respondents who responded positively, using the scale "always, often, sometimes, rarely, never, not applicable (Don't know/refused)": 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"). Use of the 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.
Current performance: reporting period	April 2015 – March 2016 (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.

Indicator	**Patients' Experiences: Primary Care Providers Spending Enough Time With Patients** This is a priority indicator for 2016/17. *Quality Dimension: Patient-centred* *Direction of improvement: Increase*
Definition	Organizations are expected to measure progress on this indicator using the *exact* wording of the following patient or client survey questions: Enough time: When you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you?
Additional specifications	Percentage of respondents who responded positively, using the scale "always, often, sometimes, rarely, never, not applicable (don't know/refused)": 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"). Use of the 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 tool 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*.
Current performance: reporting period	April 2015 – March 2016 (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.

Indicator	**Patients' Experiences: Opportunity To Ask Questions** This is a priority indicator for 2016/17. *Quality Dimension: Patient-centred* *Direction of improvement: Increase*
Definition	Organizations are expected to measure progress on this indicator using the *exact* wording of the following patient/client survey question: Ask questions: When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment?
Additional specifications	Percentage of respondents who responded positively, using the scale "always, often, sometimes, rarely, never, not applicable (don't know/refused)": 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"). Use of the 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*.
Current performance: reporting period	April 2015 – March 2016 (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.

Indicator	**7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions** This is a priority indicator for 2016/17. *Quality Dimension: Timely* *Direction of improvement: Increase*
Definition	Percentage of patients or clients who see their primary care provider within 7 days after discharge from hospital for selected conditions
Additional specifications	*This is a developmental indicator, and future results could incorporate refinements to the methodology that are not presented here.* Inclusion criteria: 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 the ED, or visits to other non-physician providers. For a list of selected conditions and further inclusion and exclusion criteria, refer to the Ministry's Resource for Indicator Standards website. Exclusion criteria: Records with missing valid data on admission or discharge date, health card number, age and gender; deaths; transfers, patient sign-outs against medical advice and discharge destinations of acute, ambulatory, day surgery, ED and palliative care settings. Negated Ontario Health Insurance Plan (OHIP) claims, duplicate claims and lab claims are also excluded. Methodological notes: Data are provided at the organization level, are not real-time, and are provided for fiscal year 2014/15. 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 fewer 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. Please use the value "x" to depict any data that is suppressed. 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.
Current performance: reporting period	April 2014 – March 2015

Data source	DAD, CIHI; Claims History Database, data (M7), Client Agency Program Enrolment (Ontario Population Health Index of Databases), Corporate Provider Database
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.

Indicator **NEW**	**HbA1C** This is a priority indicator for 2016/17. *Quality Dimension: Effective* *Direction of improvement: Increase*
Definition	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1c) tests within the past 12 months
Additional specifications	Numerator: Number of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin tests (HbA1c) within the past 12 months. Denominator: Total number of patients with diabetes aged 40 or over. Equivalent measures are available for CHCs, nurse practitioner-led clinics and AHACs, extracted from electronic medical records (EMRs).
Current performance: reporting period	Annually
Data source	Ontario Diabetes Database, OHIP defined by the OHIP fee code L093, and Registered Persons Database
How to access data	Beginning December 2015, Primary Care Group Practice reports will be available to family health teams (FHT) that register. For more information visit http://www.hqontario.ca/Quality-Improvement/Practice-Reports. Primary care organizations not registered to receive group practice reports will be required to extract data from EMRs.

Indicator **NEW**	**Colorectal Cancer Screening** This is a priority indicator for 2016/17. *Quality Dimension: Effective* *Direction of improvement: Increase*
Definition	Percentage of patients aged 50 – 74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years
Additional specifications	Numerator: Number of screen-eligible individuals who had a fecal occult blood test within past two years, other investigations (barium enema, sigmoidoscopy) within five 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) • Rigid sigmoidoscopy (Z535 or Z536) in the previous five years • Flexible sigmoidoscopy in the previous five years (Z555 [without E740 or E741 or E747 or E705 on the same day] or Z580) • Single-contrast barium enema in the previous five years (X112) • Double-contrast barium enema in the previous five years (X113) Denominator: Number of screen-eligible individuals aged 50 – 74 years. Excludes patients who have had colon cancer or inflammatory bowel disease in the past five years Limitations • Historical address information from the Registered Persons Database is incomplete; therefore, the most recent primary address was selected for reporting, even for historical study periods. • Fecal occult blood tests analyzed in hospital labs could not be captured. • Only fecal occult blood test as a primary screening test could be assessed; it is recommended for those at average risk of colorectal cancer, while those at increased risk (first-degree relative with colorectal cancer) were not assessed, as they could not be accurately identified. • A small proportion of fecal occult blood tests performed as diagnostic tests could not be excluded from the analysis. • OHIP data could include (CCC program) rejected kits.
Current performance: Reporting period	Annually
Data source	Colonoscopy Interim Reporting Tool, Lab Reporting Tool, OHIP, Claims History Database, Ontario Cancer Registry, Pathology Information Management System, Registered Persons Database (PCCF version 5k)
How to access data	Beginning December 2015, Primary Care Group Practice reports will be available to family health teams and CHCs that register. For more information visit http://www.hqontario.ca/quality-improvement/practice-reports/primary-care. 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).

Indicator **NEW**	**Cervical Cancer Screening** This is a priority indicator for 2016/17. *Quality Dimension: Effective* *Direction of improvement: Increase*
Definition	Percentage of women aged 21 – 69 who had a Papanicolaou (Pap) smear within the past three years
Additional specifications	Numerator: Number of screen-eligible women aged 21 – 69 years who had a Pap smear within the past three years. Includes: • 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. Excludes: • 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.
Current performance: Reporting period	Annually
Data source	OHIP, CytoBase, Ontario Cancer Registry, Pathology Information Management System, Client Agency Program Enrolment (Ontario Population Health Index of Databases), Corporate Provider Database, Registered Persons Database
How to access data	Beginning December 2015, Primary Care Group Practice reports will be available to family health teams and CHCs that register. For more information visit http://www.hqontario.ca/Quality-Improvement/Practice-Reports. 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).

Additional Primary Care Indicators

Organizations are expected to include the priority indicators above in their QIPs. Organizations can also include any additional indicators in their QIPs considered relevant to their quality improvement goals. The material below lists additional indicators that often are included in the QIP, but other indicators beyond this list can be included to address unique organizational priorities.

Indicator	**Emergency Department Visits for Conditions Best Managed Elsewhere** *Quality Dimension: Efficient* *Direction of improvement: Reduce*
Definition	Percentage of patients or clients who visited the emergency department (ED) for conditions "best managed elsewhere"
Additional specifications	Inclusion Criteria Numerator: Conditions designated as best managed elsewhere include conjunctivitis, cystitis, otitis media, and upper respiratory infections (e.g., common cold, acute or chronic sinusitis and tonsillitis, acute pharyngitis, laryngitis or tracheitis). Denominator: Total number of rostered patients between 1 and 74 years old in a given period Exclusion Criteria Patients less than 1 year of age and patients older than age 74; visits with an inpatient admission; visits with Canadian Triage and Acuity Scale levels 1, 2 or 3; and planned ED visits. Methodological Notes • Data are not real time, and are provided for FY 2014/15. 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) is 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.
Current performance: Reporting period	April 2014 – March 2015
Data source	DAD, Claims History Database, data (M7), Client Agency Program Enrolment (Ontario Population Health Index of Databases), Corporate Provider Database
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.

Indicator	**Hospital Readmission Rate for Primary Care Patient Population** *Quality Dimension: Effective* *Direction of improvement: Reduce*
Definition	Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission, by primary care practice model. Indicator Calculation Total number of rostered patients with a hospital readmission in a given period x 100/Total number of rostered patients who were admitted for a selected condition (based on HIG) in a given period
Additional specifications	Inclusion Criteria Selected HIGs are stroke, chronic obstructive pulmonary disease, pneumonia, congestive heart failure, diabetes, cardiac conditions and gastrointestinal disorders. Exclusion Criteria DAD records with missing valid data on admission or discharge date, health card number, age and gender; deaths; transfers and patient sign-outs against medical advice. Methodological Notes • Data are not real-time, and are provided for FY 2014/15. 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.
Current performance: Reporting period	April 2014 – March 2015
Data source	DAD; Client Agency Program Enrolment (Ontario Population Health Index of Databases); Corporate Provider Database
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.

Indicator	**Immunization** *Quality Dimension: Effective*

	Direction of improvement: Increase
Definition	Percentage of people who report having a seasonal flu shot in the past year
Additional specifications	Organizations are encouraged to measure this indicator using EMRs or through patient and client surveys. Ideally, survey data are to be incorporated into EMRs. Numerator: Number of respondents who reported receiving a seasonal flu shot in the past year. Denominator: All respondents. Excludes: • Not sure • Decline to answer **Survey question (Canadian Community Health Survey):** Base: Have you ever had a seasonal flu shot? • Yes • No • Don't know • Refused When did you have your last seasonal flu shot? • Less than 1 year ago • 1 year to less than 2 years ago • 2 years ago or more • Don't know • Refused **Survey question (Commonwealth Fund):** In the past year, have you had a seasonal flu shot? • Yes • No • Not sure • Decline to answer The Canadian Community Health Survey population is 12 years and older; it is conducted annually and gives an opportunity for interprovincial comparison. The Commonwealth Fund survey of the general population is conducted every three years and gives an opportunity for international comparison.
Current performance: Reporting period	Annually
Data source	In-house surveys or EMRs.
How to access data	Data should be accessed from within your own organization.

Primary Care Practice report – additional supports for Quality Improvement

Health Quality Ontario and the Institute for Clinical Evaluative Sciences (ICES), in partnership with the Ontario College of Family Physicians (OCFP), the Association of Family Health Teams of Ontario (AFHTO) and other primary care stakeholders, have developed a confidential report for primary care physicians that provides each physician with easy-to-read data derived from administrative databases for select indicators. The reports include information on each practice's own patient population, case mix, health care use, cancer screening, and chronic disease management data. The reports will also include regional and provincial comparators (all at the aggregate level). The reports are customized to individual physicians, and access is limited to that physician alone.

Physicians who would like to receive their personalized report or learn more about it can find more information on the Primary Care Practice Report page on Health Quality Ontario's website.

Beginning December 2015, Primary Care Group Practice reports will be available to family health teams and CHCs that register. Executive Directors can register for these reports, which (unlike the physician report) do not contain physician-level data. For more information visit http://www.hqontario.ca/Quality-Improvement/Practice-Reports/Primary-Care.

III. Community Care Access Centre QIP Indicators

Priority Community Care Access Centre Indicators

Indicator	**Falls for Long-Stay Clients** This is a priority indicator for 2016/17. *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	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.
Additional specifications	This indicator is not risk adjusted.
Current performance: Reporting period	October 2014 – September 2015
Data source	Home Care Database, interRAI for home care via Long-Stay Assessment Software
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 Community Care Access Centre (CCAC) Reporting Portal.

Indicator	**Unplanned Emergency Department Visits** This is a priority indicator for 2016/17. *Quality Dimension: Effective* *Direction of improvement: Reduce*
Definition	Percentage of home care clients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital
Additional specifications	This indicator is not risk adjusted. 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. Exclusion criteria: Excludes service if case management; excludes hospital discharge that is newborn, stillborn, or cadaver donor; excludes planned ED visits.
Current performance: Reporting period	July 2014 – June 2015
Data source	Home Care Database, CIHI DAD, CIHI NACRS
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	**Hospital Readmissions** This is a priority indicator for 2016/17. *Quality Dimension: Effective* *Direction of improvement: Reduce*
Definition	Percentage of home care clients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital.
Additional specifications	This indicator is not risk adjusted. 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. Exclusion criteria: Excludes service if case management; excludes hospital discharge that is newborn, stillborn, or cadaver donor; excludes planned readmissions.
Current performance: Reporting period	July 2014 – June 2015
Data source	Home Care Database, CIHI DAD, CIHI NACRS
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	**Five-Day Wait Time for Home Care: Personal Support for Complex Patients** This is a priority indicator for 2016/17. *Quality Dimension: Timely* *Direction of improvement: Increase*
Definition	Organizations are expected to measure progress on five-day wait times for home care using the measure "Personal Support for Complex Patients": Percentage of complex patients who received their first personal support service within five days of the service authorization date
Additional specifications	None
Current performance: Reporting period	October 2014 – September 2015
Data source	CCAC's Client Health & Related Information System (CHRIS)
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	**Five-Day Wait Time for Home Care: Nursing Visits** This is a priority indicator for 2016/17. *Quality Dimension: Timely* *Direction of improvement: Increase*
Definition	Organizations are expected to measure progress on five-day wait times for home care using the measures “Nursing Visits”: Percentage of patients who received their first nursing visit within five days of the service authorization date
Additional specifications	None
Current performance: Reporting period	October 2014 – September 2015
Data source	CCAC’s Client Health & Related Information System (CHRIS)
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	**Clients' Experience** This is a priority indicator for 2016/17. *Quality Dimension: Patient-centred* *Direction of improvement: Increase*
Definition	Percentage of home care clients who responded "good", "very good", or "excellent" on a five-point scale to any of the following survey questions about clients' experiences: • Overall rating of CCAC services • Overall rating of management or handling of care by Care Coordinator • Overall rating of service provided by service provider
Additional specifications	This indicator is not risk adjusted and is consistent with Health Quality Ontario's Home Care Public Reporting website for FY 2012/13 and onward. Note: Because results are based on a sample of patients, indicator values are weighted to reflect the population of home care patients eligible to be surveyed within each CCAC. Numerator: The sum of the number of positive responses ("good", "very good", or "excellent") registered for each of the three questions about clients' experiences listed above. Denominator: The total number of valid responses registered for all of the questions listed above. Exclusion criteria: Excludes clients who received in-school service only, nursing clinic services, respite, or medical supplies and equipment; excludes end-of-life clients, clients not yet categorized, in-home clients classified as out of region, convalescent care clients; 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. 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.
Current performance: Reporting period	April 2014 – March 2015
Data source	Client and Caregiver Experience Evaluation Survey, 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 2016. Alternatively, to access your organization's data for this indicator, refer to the NRC Canada eReports website.

IV. Long-Term Care Home QIP Indicators

Priority Long-Term Care Home Indicators

Indicator	**Falls** This is a priority indicator for 2016/17. *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	Percentage of residents who had a recent fall (in the last 30 days)
Additional specifications	This indicator is not risk-adjusted and represents a rolling four-quarter average. This indicator is consistent with Health Quality Ontario's LTC Public Reporting website; however, Health Quality Ontario publicly reports *adjusted rates.* For the purposes of quality improvement planning, *unadjusted rates* (i.e., not risk-adjusted) should be used.
Current performance: Reporting period	July – September 2015 (Q2 FY 2015/16 report)
Data source	CIHI CCRS
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports.

Indicator	**Pressure ulcers** This is a priority indicator for 2016/17. *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	Percentage of residents who had a pressure ulcer that recently got worse
Additional specifications	This indicator is not risk-adjusted and represents a rolling four-quarter average. This indicator is consistent with Health Quality Ontario's LTC Public Reporting website; however, Health Quality Ontario publicly reports *adjusted rates.* For the purposes of quality improvement planning, *unadjusted rates* (i.e., not risk-adjusted) should be used.
Current performance: Reporting period	July – September 2015 (Q2 FY 2015/16 report)
Data source	CIHI CCRS
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports

Indicator	**Restraints** This is a priority indicator for 2016/17. *Quality Dimension: Safe* *Direction of improvement: Reduce*
Definition	Percentage of residents who were physically restrained (daily)
Additional specifications	This indicator is not risk-adjusted and represents a rolling four-quarter average. This indicator is consistent with Health Quality Ontario's LTC Public Reporting website; however, Health Quality Ontario publicly reports *adjusted rates.* For the purposes of quality improvement planning, *unadjusted rates* (i.e., not risk-adjusted) should be used.
Current performance: Reporting period	July – September 2015 (Q2 FY 2015/16 report)
Data source	CIHI CCRS
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports.

Indicator	**Appropriate Prescribing – Potentially Inappropriate Antipsychotic Use in Long-Term Care** This is a priority indicator for 2016/17. *Quality Dimension: Effective* *Direction of improvement: Reduce*
Definition	Percentage of residents receiving antipsychotics without a diagnosis of psychosis. Exclusion criteria are expanded to include those experiencing delusions
Additional specifications	This indicator is not risk-adjusted and represents a rolling four-quarter average. Note: This indicator is calculated on a quarterly basis by CIHI and made available to all LTC homes in Ontario via CIHI's CCRS eReports. Homes that are not currently tracking antipsychotic prescribing are encouraged to use this indicator because data are readily available. However, LTC homes that are already engaged in quality improvement efforts related to appropriate prescribing could choose to use a different indicator in alignment with their ongoing improvement activities.
Current performance: Reporting period	July – September 2015 (Q2 FY 2015/16 report)
Data source	CIHI CCRS
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports.
Additional resources	Health Quality Ontario's Quality Compass includes effective change ideas, tools and resources to support improvement on this indicator. Health Quality Ontario has recently 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 http://www.hqontario.ca/quality-improvement/practice-reports/long-term-care.

Indicator	**Residents' Experiences** This is a priority indicator for 2016/17. *Quality Dimension: Patient-centred* *Direction of improvement: Increase*
Definition	Organizations should measure progress on this indicator across two domains of residents' experiences: **Domain 1: Having a voice and being able to speak up about the home** • Homes using the NHCAHPS Long-Stay Resident Survey should measure this domain by calculating the percentage of residents who responded positively 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. Calculation instructions: Add the number of respondents who responded '9' and '10' and divide by the number who registered any response to the question. Do not include non-respondents. Express as a percent. • Homes using the interRAI Quality of Life Survey should measure this domain by calculating the percentage of residents who responded positively 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 Calculation instructions: Add the number of respondents who responded 3 = Most of the time and 4 = Always and divide by the number who registered any response to the question. Do not include non-respondents (6 = Don't know, 7 = Refused, 8 = No response). Express as a percent. **Domain 2: Overall satisfaction** (Organizations should measure progress on this indicator by selecting one of the following survey questions). • Homes using the NHCAHPS Long-Stay Resident Survey should measure this domain by calculating the percentage of residents who responded positively to the question: ***Would you recommend this nursing home to others?*** Responses are coded from 1 – 4, where • 1 = Definitely no • 2 = Probably no • 3 = Probably yes • 4 = Definitely yes Calculation instructions: Add the number of respondents who responded 4 = Definitely yes and divide by the number who registered any response to the question. Do not include non-respondents. Express as a percent. • Homes using the interRAI Quality of Life Survey should measure this domain by calculating the percentage of residents who responded positively to the statement: ***I would recommend this site or organization to others.*** 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 Calculation instructions: Add the number of respondents who responded 3 = Most of the time and 4 = Always and divide by the number who registered any response to the question. Do not include non-respondents (6 = Don't know, 7 = Refused, 8 = No response. Express as a percent. Note: Homes that use a validated survey tool other than HCAHPS or interRAI Quality of Life should select and use the questions from their survey that are most similar to the ones listed (one question per domain). Homes that design and administer their own survey should consider adding questions (one per domain) that align with either the NHCAHPS or interRAI Quality of Life questions listed above.
Additional specifications	The *Long-Term Care Homes Act, 2010* stipulates that every LTC home shall ensure that, at least once every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85 (1). The act also requires homes to seek the advice of the residents' councils in developing and carrying out the survey, and in acting on its results. C. 8, s. 85 (3). Where homes are integrating information about residents' experiences into the QIP from their existing resident satisfaction processes, they must ensure they are meeting all of the requirements under the Long-Term Care Homes Act and Ontario Regulation 79/10. See the exemptions for the alternative settings in section 318(1)(6) and (7) of the Regulation. For more information about the HCAHPS Long-Stay Resident Survey, refer to the Agency for Healthcare Research and Quality's *Get Nursing Home Surveys and Instructions* website. For more information about the interRAI Quality of Life Survey, refer to interRAI's website.
Current performance: Reporting period	April 2015 – March 2016 (or most recent 12-month period). If you have completed this year's survey, you do not have to resubmit the survey.
Data source	HCAHPS Long-Stay Resident Survey; interRAI's Quality of Life Survey; other validated survey about residents' experiences; or in-house survey.
How to access data	These data should be accessed from within your own organization.

Indicator	**Potentially Avoidable Emergency Department Visits for Long-Term Care Residents** This is a priority indicator for 2016/17. *Quality Dimension: Effective* *Direction of improvement: Reduce*
Definition	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.
Additional specifications	Inclusion criteria: Includes all active LTC home residents aged 65 and older in Ontario LTC homes in a given year. Includes ED visits, transfers between EDs, ED visits resulting in admission, and deaths in EDs. 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 Exclusion criteria: Excludes planned or scheduled ED visits and urinary tract infections. ED visits can be necessary and appropriate. Tracking ED visits for these conditions can help homes identify ED visits that could have been avoided if the underlying cause was effectively managed earlier. For many homes, the target this year will be to understand their baseline. Quality improvement guidance related to this indicator is available on the Health Quality Ontario website and through the INTERACT (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers) program.
Current performance: Reporting period	October 2014 – September 2015
Data source	CIHI NACRS, CIHI CCRS
How to access data	The Ministry will provide organizations with this data via https://www.ltchomes.net/LTCF2/Login.aspx.

Additional Long-Term Care Home Indicators

Indicator	**Incontinence** *Quality Dimension: Effective* *Direction of improvement: Reduce*
Definition	Percentage of residents with worsening bladder control during a 90-day period
Additional specifications	This indicator is not risk-adjusted and represents a rolling four-quarter average.
Current performance: Reporting period	July – September 2015 (Q2 FY 2015/16 report)
Data source	CIHI CCRS
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports.

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
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