Problematic Alcohol Use and Alcohol Use Disorder

Care for People 15 Years of Age and Older

Measurement Guide

August 2020

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Quality

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1 How to Use the Measurement Guide

This document is meant to serve as a measurement guide to support the adoption of the Problematic Alcohol Use and Alcohol Use Disorder quality standard. Care for people with problematic alcohol use and alcohol use disorder is a critical issue, and there are significant gaps and variations in the quality of care that people with problematic alcohol use and alcohol use disorder receive in Ontario. Recognizing this, the Quality business unit at Ontario Health released this quality standard to identify opportunities that have a high potential for quality improvement.

This guide is intended for use by those looking to adopt the Problematic Alcohol Use and Alcohol Use Disorder quality standard, including health care professionals working in regional or local roles.

This guide has dedicated sections for each of the two types of measurement within the quality standard:

- **Local measurement:** what you can do to assess the quality of care that you provide locally
- **Provincial measurement:** how we can measure the success of the quality standard on a provincial level using existing provincial data sources

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Important Resources for Quality Standard Adoption

Ontario Health (Quality) has created resources to assist with the adoption of quality standards:

- A *Getting Started Guide* that outlines a process for using quality standards as a resource to deliver high-quality care. It includes links to templates, tools, and stories and advice from health care professionals, patients, and caregivers. You can use this guide to learn about evidence-based approaches to implementing changes to practice
- A *Quality Improvement Guide* to give health care teams and organizations in Ontario easy access to well-established quality improvement tools. The guide provides examples of how to adapt and apply these tools to our Ontario health care environments
- An online community called Quorum that is dedicated to working together to improve the quality of health care across Ontario. Quorum can support your quality improvement efforts

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2 Quality Indicators in Quality Standards

Quality standards inform providers and patients about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are intended to guide quality improvement, monitoring, and evaluation.

Measurability is a key principle in developing and describing the quality statements; each statement is accompanied by one or more indicators. This section describes the measurement principles behind the quality indicators, the process for developing these indicators, and the technical definitions of the indicators.

An effective quality statement must be measurable. Measurement is necessary to demonstrate if a quality statement has been properly implemented, and if it is improving care for patients. This is a key part of the Plan-Do-Study-Act improvement cycle. If measurement shows there has been no improvement, you need to consider a change or try something different.

2.1   Measurement Principles

Ontario Health (Quality) uses the process, structure, and outcome indicator framework developed by Donabedian in 1966 to develop indicators for quality standards. The three indicator types play essential and interrelated roles in measuring the quality of health care and the impact of introducing and using quality standards.

The indicators provided are merely suggestions. It is not expected that every provider, team, or organization will be able to measure all of them (or even want to measure all of them), but they can identify which indicators best capture areas of improvement for their care and what can be measured given existing local data sources.

2.2   Process Indicators

Process indicators assess the activities involved in providing care. They measure the percentage of individuals, episodes, or encounters for which an activity (process) is performed. In most cases, the numerator should specify a timeframe in which the action is to be performed, established through evidence or expert consensus. When a quality statement applies to a subset of individuals rather than the total population, the denominator should reflect the population of the appropriate subgroup, rather than the entire Ontario population. If exclusions are required or stratifications are suggested, they are reflected in the indicator specifications.

Process indicators are central to assessing whether or not the quality statement has been achieved; nearly all quality statements are associated with one or more process indicators. In most cases, the numerator and denominator for process indicators can be derived from the language of the quality statement itself; additional parameters (such as a timeframe) can also appear in the definitions section. In some cases, a proxy indicator is provided that indirectly measures the process. Proxy indicators are used only when the actual indicator cannot be measured with currently available data.

While most quality statements focus on a single concept and are linked with a single process indicator, some statements include two or more closely related concepts. In these cases, multiple process

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indicators can be considered to capture all aspects of the quality statement. For example, a quality statement might suggest the need for a comprehensive assessment with several components, and each of those components might have a process indicator.

Examples of process indicators include the percentage of patients with hip fracture who receive surgery within 48 hours, or the percentage of patients with schizophrenia who are offered clozapine. Please refer to the published quality standards for more examples.

2.3   Structural Indicators

Structural indicators assess the structures and resources that influence and enable delivery of care. These can include equipment; systems of care; availability of resources; and teams, programs, policies, protocols, licences, or certifications. Structural indicators assess whether factors that are in place are known to help in achieving the quality statement.

Some quality statements have structural indicators associated with them. Structural indicators are binary or categorical and do not require the definition of a numerator and denominator. However, in some cases it could be useful to specify a denominator defining an organizational unit, such as a hospital, a primary care practice, or a local region. In many cases data to measure structural indicators are not readily available using existing administrative data, so local data collection might be required. This local data collection might require regional or provincial level data collection systems to be developed.

Structural indicators should be defined for a quality statement or for the quality standard as a whole when there is strong evidence that a particular resource, capacity, or characteristic is important for enabling the effective delivery of a process of care. It should be theoretically feasible for these structural elements to be implemented across Ontario, even if adoption is aspirational in some cases. In rare instances, a quality statement might have two or more associated structural indicators, if the quality standard advisory committee decides that multiple factors are crucial to the delivery of the quality statement.

Examples of structural indicators include the availability of a stroke unit, the existence of discharge planning protocols, or access to a specialized behavioural support team. Please refer to the published quality standards for more examples.

2.4   Outcome Indicators

Outcome indicators assess the end results of the care provided. They are crucial and are arguably the most meaningful measures to collect, but many health outcomes—such as mortality or unplanned hospital readmissions—are often the product of a variety of related factors and cannot be reliably attributed to a single process of care. For this reason, although relatively few quality statements are directly linked to an outcome indicator, a set of overall measures—including key outcome indicators—is defined for the quality standard as a whole, reflecting the combined effect of all of the quality statements in the standard. Similar to process indicators, outcome indicators should be specified using a defined denominator and a numerator that, in most cases, should include a clear timeframe.

Examples of outcome indicators include mortality rates, improvement (or decline) in function, and patients' experience of care. Please refer to the published quality standards for more examples.

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2.5 Balancing Measures

Balancing measures indicate if there are important unintended adverse consequences in other parts of the system. Examples include staff satisfaction and workload. Although they are not the focus of the standard, the intention of these measures is to monitor the unintended consequences.

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3 Local Measurement

As part of the Problematic Alcohol Use and Alcohol Use Disorder quality standard, *specific* indicators were identified for each of the statements to support measurement for quality improvement.

As an early step in your project, we suggest that your team complete an *initial assessment* of the relevant indicators in the standard and come up with a draft measurement plan.

Here are some concrete next steps:

- Review the list of identified indicators (in the quality standard), and determine which ones you will use as part of your adoption planning, given your knowledge of current gaps in care
- Determine the availability of data related to the indicators you have chosen
- Identify a way to collect local data related to your chosen indicators
- Develop a draft measurement plan

The earlier you complete the above steps, the more successful your quality improvement project is likely to be.

3.1 Local Data Collection

Local data collection refers to data collection at the health provider or team level for indicators that cannot be assessed using provincial administrative or survey databases (such as databases held by the Institute for Clinical Evaluative Sciences or the Canadian Institute for Health Information). Examples of local data include data from electronic medical records, clinical patient records, regional data collection systems, and locally administered patient surveys. Indicators that require local data collection can signal an opportunity for local measurement, data advocacy, or data quality improvement.

Local data collection has many strengths: it is timely, can be tailored to quality improvement initiatives, and is modifiable on the basis of currently available data. However, caution is required when comparing indicators using local data collection between providers and over time to ensure consistency in definitions, consistency in calculation, and validity across patient groups.

3.2 Measurement Principles for Local Data Collection

Three types of data can be used to construct measures in quality improvement: continuous, classification, and count data. For all three types of data, it is important to consider clinical relevance when analyzing results (i.e. not every change is a clinically relevant change).

3.2.1 Continuous Data

Continuous data can take any numerical value in a range of possible values. These values can refer to a dimension, a physical attribute, or a calculated number. Examples include patient weight, number of calendar days, and temperature.

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3.2.2   Classification Data

Classification (or categorical) data are recorded in two or more categories or classes. Examples include sex, race or ethnicity, and number of patients with depression versus number of patients without depression. In some cases, you might choose to convert continuous data into categories. For example, you could classify patient weight as underweight, normal weight, overweight, or obese.

Classification data are often presented as percentages. To calculate a percentage from classification data, you need a numerator and a denominator (a percentage is calculated by dividing the numerator by the denominator and multiplying by 100). The numerator includes the number of observations meeting the criteria (e.g., number of patients with depression), and the denominator includes the total number of observations measured (e.g., total number of patients in clinic). Note that the observations in the numerator must also be included in the denominator (source population).

Examples of measures that use classification data include percentage of patients with a family physician and percentage of patients who receive therapy.

3.2.3   Count Data

Count data often focus on attributes that are unusual or undesirable. Examples include number of falls in a long-term care home and number of medication errors.

Count data are often presented as a rate, such as the number of events per 100 patient-days or per 1,000 doses. The numerator of a rate counts the number of events/nonconformities, and the denominator counts the number of opportunities for an event. It is possible for the event to occur more than once per opportunity (e.g., a long-term care resident could fall more than once).

$$Rate\ of\ 30\text{-}day\ hospital\ readmission =$$

$$\frac{Number\ of\ hospital\ readmissions\ within\ 30\ days\ of\ discharge\ [\textbf{numerator}]}{Number\ of\ discharges\ from\ hospital\ [\textbf{denominator}]}$$

3.2.4   Benefits of Continuous Data

It is common practice in health care to measure toward a target instead of reporting continuous measures in their original form. An example would be measuring the number of patients who saw their primary care physician within 7 days of hospital discharge instead of measuring the number of days between hospital discharge and an appointment with a primary care physician. Targets should be evidence-based or based on a high degree of consensus across clinicians.

When a choice exists, continuous data sometimes are more useful than count or classification data for learning about the impact of changes tested. Measures based on continuous data are more responsive and can capture smaller changes than measures based on count data; therefore, it is easier and faster to see improvement with measures based on continuous data. This is especially true when the average value for the continuous measure is far from the target. Continuous data are also more sensitive to change. For example, while you might not increase the number of people who are seen within 7 days, you might reduce how long people wait.

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3.3   Benchmarks and Targets

Benchmarks are markers of excellence to which organizations can aspire. Benchmarks should be evidence-based or based on a high degree of consensus across clinicians. At this time, Ontario Health (Quality) does not develop benchmarks for the indicators. Users of these standards have variable practices, resources, and patient populations, so one benchmark might not be practical for the entire province.

Targets are goals for care that are often developed in the context of the local care environment. Providers, teams, and organizations are encouraged to develop their own targets appropriate to their patient populations, their current performance and their quality improvement work. Organizations that include a quality standard indicator in their quality improvement plans are asked to use a target that reflects improvement. Timeframe targets, like the number of people seen within 7 days, are typically provided with process indicators intended to guide quality improvement.

In many cases, achieving 100% on an indicator is not possible. For example, someone might not receive care in a wait time benchmark due to patient unavailability. This is why it is important to track these indicators over time, to compare results against those of colleagues, to track progress, and to aim for the successful implementation of the standard.

For guidance on setting benchmarks and targets at a local level, refer to:

- Approaches to Setting Targets for Quality Improvement Plans
- Long-Term Care Benchmarking Resource Guide

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4 Provincial Measurement

In its quality standards, Ontario Health (Quality) strives to incorporate measurement that is standardized, reliable, and comparable across providers to assess the impact of the standards provincially. Where possible, indicators should be measurable using province-wide data sources. However, in many instances provincial data are unavailable for indicator measurement. In these cases, the source is described as local data collection.

For more information on the data sources referenced in this standard, please see the **appendix.**

4.1   Accessing Provincially Measurable Data

Provincial platforms are available to users to create custom analyses to help you calculate results for identified measures of success. Examples of these platforms include IntelliHealth and eReports. Please refer to the links below to determine if you have access to the platforms listed.

4.1.1   *IntelliHealth—Ministry of Health*

IntelliHealth is a knowledge repository that contains clinical and administrative data collected from various sectors of the Ontario healthcare system. IntelliHealth enables users to create queries and run reports through easy web-based access to high quality, well organized, integrated data.

4.1.2   *eReports—Canadian Institute for Health Information*

Quick Reports offer at-a-glance comparisons for the organizations you choose. The tool also provides some ways to manipulate the pre-formatted look and feel of the reports. Flexible or Organization Reports offer you many choices to compare your organization's data with those of other organizations. With these customizable reports, you can view data by different attributes and for multiple organizations.

4.1.3   *Applied Health Research Questions (AHRQ) — Institute for Clinical Evaluative Sciences*

ICES receives funds from the Ministry of Health to provide research evidence to organizations from across the Ontario health care system (Knowledge Users). This knowledge is used to inform planning, policy and program development. Knowledge Users can submit an Applied Health Research Question (AHRQ) to ICES. As a health services research institute that holds Ontario's administrative data, ICES is well positioned to respond to AHRQs that directly involve the use of ICES data holdings.

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5 How Success Can Be Measured for This Quality Standard

This measurement guide accompanies Ontario Health (Quality)'s Problematic Alcohol Use and Alcohol Use Disorder quality standard. Early in the development of each quality standard, a few performance indicators are chosen by the Quality Standard Advisory Committee to measure the success of the entire standard. These indicators guide the development of the quality standard so that every statement within the standard aids in achieving the standard's overall goals.

This measurement guide includes information on the definitions and technical details of the indicators listed below which were selected as the overall measures of success for this standard:

- Rate of emergency department visits entirely caused by alcohol within the last 12 months per 100,000 population
- Rate of hospitalizations entirely caused by alcohol within the last 12 months per 100,000 population
- Percentage of people who were heavy drinkers in the past year
- Percentage of people with alcohol use disorder who receive care in primary care settings
- Percentage of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings who are screened for problematic alcohol use and alcohol use disorder using a validated tool
- Percentage of people with alcohol use disorder who report a positive experience of care
- Percentage of people with alcohol use disorder who have a follow-up appointment with a health care professional after leaving the hospital
- Percentage of people with alcohol use disorder and their caregivers who receive information, education, and support appropriate for their needs and preferences
- Percentage of health care professionals and service providers who receive education about alcohol use disorder

Indicators are categorized as:

- Provincially measurable (the indicator is well defined and validated) *or*
- Locally measurable (the indicator is not well defined, and data sources do not currently exist to measure it consistently across providers and at the system level)

For more information on statement-specific indicators, please refer to the quality standard.

5.1 Quality Standard Scope

This quality standard addresses clinical care for people 15 years of age and older with problematic alcohol use or alcohol use disorder across all care settings and along the mental health and addictions care continuum. The scope of the standard covers screening for problematic alcohol use; a brief intervention; and the assessment, diagnosis, management, and treatment of alcohol use disorder. It addresses how to identify new or worsening symptoms of alcohol use disorder (withdrawal, tolerance, and cravings), and the support, treatment, and management of individuals with concurrent mental health disorders, other substance use disorders, or comorbid physical health conditions. This quality

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standard does not address the primary prevention of alcohol use, including public health interventions and regulatory policy.

Although this quality standard applies to adolescents and young adults, the statements are mostly based on guideline evidence that focuses primarily on adults (aged 18 years and older) and nonpregnant people. The Ontario Health (Quality) Alcohol Use Disorder Quality Standard Advisory Committee agrees that the guidance in this quality standard is also relevant and applicable to people with alcohol use disorder who are 15 years of age and older and people who are pregnant. Health care professionals and service providers should consider that specialized skills and expertise may be required when providing treatment for specific populations, including children, youth, and pregnant people with alcohol use disorder. If treatment of these or other specific populations is beyond a service provider's expertise, they should consult or work with another health care professional who has appropriate expertise.

5.2   Cohort Identification

There is currently no validated methodology to identify people with alcohol use disorder using health administrative data sources. Local data collection may also be used to identify the population.

5.3   How Success Can Be Measured Provincially

The following indicators are currently provincially measurable in Ontario's health care system:

Outcome indicator:

- Percentage of people who were heavy drinkers in the past year

Process indicators:

- Rate of emergency department visits entirely caused by alcohol within the last 12 months per 100,000 population
- Rate of hospitalizations entirely caused by alcohol within the last 12 months per 100,000 population

Methodological details for the provincially and locally measurable indicators are described in the tables below.

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Table 1: Rate of emergency department visits entirely caused by alcohol within the last 12 months per 100,000 population

GENERAL DESCRIPTION	Indicator description	This indicator measures the rate of emergency department visits entirely caused by alcohol within the last 12 months per 100,000 population Directionality: A lower rate is better.
	Measurability	**Measurable at the provincial level**
	Dimension of quality	Effective
	Quality statement alignment	**Quality Statement 1: Screening** People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are screened for problematic alcohol use and alcohol use disorder using a validated tool. **Quality Statement 5: Treatment of Alcohol Withdrawal Symptoms** People with alcohol use disorder who have withdrawal symptoms are offered assessment, treatment, and support tailored to the severity of their symptoms. **Quality Statement 8: Medications to Reduce Alcohol Cravings or Consumption** People with alcohol use disorder have timely access to medications that reduce alcohol cravings or consumption based on their needs and preferences.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people aged 10 and older *Inclusions* - Age between 10 to 105 years old *Exclusions* - Patients without an Ontario residence - Patients with unknown LHINs designation - Gender not recorded as male or female - Age less than 10 years old or over 105 years old Data source: Population estimates for LHINs are produced by the Ontario Ministry of Finance (MOF). All population data are extracted from Intellihealth. **Numerator** Total number of emergency department visits with wholly alcohol-attributable conditions among people aged 10 and older within the last 12 months The following codes (International Classification of Diseases, 10th Revision; ICD-10) were used to identify conditions wholly attributable to alcohol for any

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		problem related to the visit (i.e., main reason for the visit or having contributed to the visit):
		- Alcohol-induced pseudo-Cushing's syndrome E24.4 - Mental and behavioural disorders due to use of alcohol F10.– - Degeneration of nervous system due to alcohol G31.2 - Alcoholic polyneuropathy G62.1 - Alcoholic myopathy G72.1 - Alcoholic cardiomyopathy I42.6 - Alcoholic gastritis K29.2 - Alcoholic liver disease K70.– - Alcohol-induced acute pancreatitis K85.2 - Alcohol-induced chronic pancreatitis K86.0 - Maternal care for (suspected) damage to fetus from alcohol O35.4– - Fetal alcohol syndrome (dysmorphic) Q86.0 - Finding of alcohol in blood R78.0 - Toxic effects of alcohol T51.– - Accidental poisoning by and exposure to alcohol X45 - Intentional self-poisoning by and exposure to alcohol X65 - Poisoning by and exposure to alcohol, undetermined intent Y15 *Exclusions* - Patients without a valid health insurance number - Patients without an Ontario residence - Patients with unknown LHINs designation - Gender not recorded as male or female - Age less than 10 years old or over 105 years old Data source: National Ambulatory Care Reporting System **Method** Numerator divided by the denominator times 100,000
ADDITIONAL INFORMATION	Limitations	The indicator measures emergency department visits due to conditions wholly attributable to alcohol, based on the diagnostic codes from the Canadian Institute for Health Information's indicator called "hospitalizations entirely caused by alcohol". According to the Canadian Institute for Health Information (CIHI), conditions partially attributable to alcohol, such as cancers, strokes, respiratory diseases, are not directly captured. As a result, this should be taken into consideration while interpreting the indicator results. Since this indicator depends on the documentation of alcohol as the cause of a disease condition (100% attributable) for which care is delivered, conditions that are potentially related to alcohol but not diagnosed and documented might not be captured (e.g., liver disease not linked to alcohol). The stigma associated with alcohol may influence the documentation of conditions associated with alcohol use.

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		Since focus of the indicator is on the mental and medical conditions attributable to alcohol, accidents and injuries to self or others due to harmful use of alcohol might not be captured.
		The rates of emergency department visits due to conditions wholly attributable to alcohol in Ontario was also studied by Dr. Myran and colleagues to analyze the data by sex, age and neighborhood income over time (Myran et al., 2019).
		Regional differences in performance may be due to differences in the prevalence of alcohol use disorder and not to differences in the delivery of care.

Reference: Myran, D.T., Hsu, A.T., Smith, G., & Tanuseputro, P. (2019). Rates of emergency department visits attributable to alcohol use in Ontario from 2003 to 2016: A retrospective population-level study. CMAJ, 191(29), E804–E810.

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Table 2: Rate of hospitalizations entirely caused by alcohol within the last 12 months per 100,000 population

GENERAL DESCRIPTION	Indicator description	This indicator measures the rate of hospitalizations entirely caused by alcohol within the last 12 months per 100,000 population Directionality: A lower rate is better.
	Measurability	**Measurable at the provincial level**
	Dimension of quality	Effective
	Quality statement alignment	**Quality Statement 1: Screening** People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are screened for problematic alcohol use and alcohol use disorder using a validated tool. **Quality Statement 5: Treatment of Alcohol Withdrawal Symptoms** People with alcohol use disorder who have withdrawal symptoms are offered assessment, treatment, and support tailored to the severity of their symptoms. **Quality Statement 8: Medications to Reduce Alcohol Cravings or Consumption** People with alcohol use disorder have timely access to medications that reduce alcohol cravings or consumption based on their needs and preferences.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total mid-year population age 10 and older Data source: Statistics Canada **Numerator** Total number of hospitalizations with wholly alcohol-attributable conditions among people aged 10 and older within the last 12 months *Inclusions* - Sex recorded as male or female - Discharge from a general or psychiatric hospital, or a day surgery clinic. *Exclusions* - Records with admission category of cadaveric donor or stillbirth (Admission Category Code = R or S).

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The following codes were used to identify conditions wholly attributable to alcohol (outside of Quebec):

a) **Inpatient and day surgery records:**

- ICD-10-CA codes for conditions 100% attributable to alcohol (or 100% alcohol-attributable fraction [AAF] codes) (see Appendix 1, ICD-10-CA codes) coded as diagnosis type (M), (1), (2), (W), (X), (Y) or (9) in the Discharge Abstract Database (DAD), or as Main Problem (MP) or Other Problem (OP) in the National Ambulatory Care Reporting System (NACRS); or

b) **Records from the Ontario Mental Health Reporting System (OMHRS):**

- DSM-IV-TR and DSM-5 (ICD-9-CM version) 100% AAF codes (see Appendix 1, DSM-IV and DSM-5 codes) coded as a principal diagnosis or secondary diagnosis for inpatient records; or
- A category diagnosis of substance-related and addictive disorder coded as a principal diagnosis or secondary diagnosis and emergency department visit with 100% AAF codes in NACRS within 7 days prior to admission to an OMHRS bed (for patients without a DSM-IV-TR or DSM-5 (ICD-9-CM version) 100% AAF code and without another substance coded on the abstract)

Data source: Discharge Abstract Database, Hospital Morbidity Database, National Ambulatory Care Reporting System, Ontario Mental Health Reporting System

Method

(Total number of hospitalizations with wholly alcohol-attributable conditions among patients age 10 and older ÷ Total mid-year population age 10 and older) × 100,000 (age-adjusted)

Data for this indicator are available through CIHI:
https://yourhealthsystem.cihi.ca/hsp/inbrief#!/indicators/061/hospitalizations-entirely-caused-by-alcohol/;mapC1;mapLevel2;overview;/

ADDITIONAL INFORMATION	Limitations & Comments	The indicator measures hospitalizations due to conditions wholly attributable to alcohol. According to the Canadian Institute for Health Information (CIHI), conditions partially attributable to alcohol, such as cancers, strokes, respiratory diseases, are not directly captured. As a result, this should be taken into consideration while interpreting the indicator results.
		CIHI estimates that out of all hospitalizations attributable to alcohol, 30% are due to wholly attributable conditions and 70% are due to partially attributable conditions (CIHI, 2019).
		Since this indicator depends on the documentation of alcohol as the cause of a disease condition (100% attributable) for which care is delivered, conditions that are potentially related to alcohol but not diagnosed and documented might not be captured (e.g., liver disease not linked to alcohol).

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		The stigma associated with alcohol may influence the documentation of conditions associated with alcohol use.
		Since focus of the indicator is on the mental and medical conditions attributable to alcohol, accidents and injuries to self or others due to harmful use of alcohol might not be captured.
		Regional differences in performance may be due to differences in the prevalence of alcohol use disorder and not to differences in the delivery of care.

Reference: CIHI (2019). CIHI's Indicator Library on Hospitalizations Entirely Caused by Alcohol indicator.
http://indicatorlibrary.cihi.ca/pages/viewpage.action?pageId=10453006

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Table 3: Percentage of people who were heavy drinkers in the past year

<table>
<tr>
<td rowspan="4">GENERAL DESCRIPTION</td>
<td>Indicator description</td>
<td>This indicator measures the percentage of people who were heavy drinkers in the past year

Directionality: A lower percentage is generally better.</td>
</tr>
<tr>
<td>Measurability</td>
<td>Measurable at the provincial level</td>
</tr>
<tr>
<td>Dimension of quality</td>
<td>Effective</td>
</tr>
<tr>
<td>Quality statement alignment</td>
<td>Quality Statement 1: Screening
People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are screened for problematic alcohol use and alcohol use disorder using a validated tool.

Quality Statement 2: Brief Intervention
People who screen positive for problematic alcohol use are offered a brief intervention.</td>
</tr>
<tr>
<td rowspan="1">DEFINITION & SOURCE INFORMATION</td>
<td>Calculation: General</td>
<td>Denominator
The weighted number of respondents aged 12 or older that responded to the two survey questions.

If respondents answered ALC_010 as not having had an alcoholic drink in the last year, then they were not asked ALC_020, and were marked as a "valid skip" for ALC_020. The denominator includes the 'valid skip' for ALC_20.

Inclusions
If variable ALC_010 equals 1 and 2.
Question Text: During the past 12 months, that is, from [CURRENTDATE-1] to yesterday, have you had a drink of beer, wine, liquor or any other alcoholic beverage?

Codes for ALC_010 variable:
1 = Yes
2 = No
8 = Refusal
9 = Don't know

Exclusions
Don't know, not stated and refusal are not included in the analysis.

Data source: Canadian Community Health Survey</td>
</tr>
</table>

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		Numerator
		The weighted number of respondents who were heavy drinkers.
		- For males, heavy drinking refers to having consumed five or more drinks, per occasion, at least once a month during the past year. - For females, heavy drinking refers to having consumed four or more drinks, per occasion, at least once a month during the past year.
		If variable ALC_020 equals 3, 4, 5 and 6.
		Question Text: How often in the past 12 months have you had [5/4] or more drinks on one occasion?
		Codes for ALC_020 variable:
		1 = Never 2 = Less than once a month 3 = Once a month 4 = 2 to 3 times a month 5 = Once a week 6 = More than once a week 8 = Refusal 9 = Don't know
		Data source: Canadian Community Health Survey
		Method
		Numerator divided by the denominator times 100
ADDITIONAL INFORMATION	Limitations	Since the alcohol consumption was self-reported, some participants may have underestimated their consumption (Wilsnack and Wilsnack, 2002).
		Because of the significant changes to the survey methodology, Statistics Canada does not recommend making comparisons of the redesigned 2015 cycle of the CCHS with past cycles. As this indicator relies on self-reported data, the true rate might in fact be higher or lower. In addition, the survey coverage excludes: persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; the institutionalized population, children aged 12-17 that are living in foster care, and persons living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James. Altogether, these exclusions represent less than 3% of the Canadian population aged 12 and over.
		This indicator can also be calculated with the Canadian Tobacco, Alcohol and Drugs Survey (CTADS). CTADS is a biennial general population survey of tobacco, alcohol and drug use among Canadians aged 15 years and older. CTADS is conducted by Statistics Canada on behalf of Health Canada.

Reference: Wilsnack SC, Wilsnack RW. International gender and alcohol research: recent findings and future directions. Alcohol Res Health 2002;26:245–250.

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5.4   How Success Can Be Measured Locally

You might want to assess the quality of care you provide to your patients with problematic alcohol use and alcohol use disorder. You might also want to monitor your own quality improvement efforts. It can be possible to do this using your own clinical records, or you might need to collect additional data. In addition to the provincially measurable indicators, we recommend the following list of indicators, which cannot be measured provincially using currently available data:

- Percentage of people with alcohol use disorder who receive care in primary care settings
- Percentage of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings who are screened for problematic alcohol use and alcohol use disorder using a validated tool
- Percentage of people with alcohol use disorder who report a positive experience of care
- Percentage of people with alcohol use disorder who have a follow-up appointment with a health care professional after leaving the hospital
- Percentage of people with alcohol use disorder and their caregivers who receive information, education, and support appropriate for their needs and preferences
- Percentage of health care professionals and service providers who receive education about alcohol use disorder

Methodological details are described in the tables below.

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Table 4: Percentage of people with alcohol use disorder who receive care in primary care settings

GENERAL DESCRIPTION		
	Indicator description	This indicator measures the percentage of people with alcohol use disorder who receive care in primary care settings Directionality: A higher percentage is better.
	Indicator status	**Developmental**
	Dimension of quality	Effective
	Quality statement alignment	**Quality Statement 1: Screening** People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are screened for problematic alcohol use and alcohol use disorder using a validated tool. **Quality Statement 2: Brief Intervention** People who screen positive for problematic alcohol use are offered a brief intervention. **Quality Statement 3: Comprehensive Assessment** People who may have alcohol use disorder are offered a comprehensive assessment that informs their care plan. **Quality Statement 4: Care Plan** People with alcohol use disorder have an individualized care plan developed in collaboration with their health care professional that includes appropriate services and treatment goals. Care is seamlessly integrated, interprofessional, and provided in primary care or in collaboration with primary care. **Quality Statement 7: Psychological and Social Interventions** People with alcohol use disorder are offered information on psychological and social interventions that address their needs and preferences. **Quality Statement 8: Medications to Reduce Alcohol Cravings or Consumption** People with alcohol use disorder have timely access to medications that reduce alcohol cravings or consumption based on their needs and preferences. **Quality Statement 9: Concurrent Mental Health and Substance Use Disorders and Comorbid Physical Health Disorders** People with alcohol use disorder who also have a mental health disorder, physical health disorder, or another substance use disorder are offered treatment for their concurrent and comorbid disorders. **Quality Statement 10: Monitoring, Support, and Follow-up** People with alcohol use disorder are offered ongoing follow-up with their health care professional on a regular basis to monitor treatment and response.

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DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with alcohol use disorder **Numerator** Number of people in the denominator who receive care in primary care settings **Method** Numerator divided by the denominator times 100
	Data source	Local data collection
ADDITIONAL INFORMATION	Comments	There is no standardized data source or cohort to identify people with alcohol use disorder in Ontario.

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Table 5: Percentage of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings who are screened for problematic alcohol use and alcohol use disorder using a validated tool

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings who are screened for problematic alcohol use and alcohol use disorder using a validated tool Directionality: A higher percentage is better.
	Indicator status	**Developmental**
	Dimension of quality	Safe, Effective, Timely
	Quality statement alignment	**Quality Statement 1: Screening** People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are screened for problematic alcohol use and alcohol use disorder using a validated tool.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings **Numerator** Number of people in the denominator who are screened for problematic alcohol use and alcohol use disorder using a validated tool **Method** Numerator divided by the denominator times 100
	Data source	Local data collection
ADDITIONAL INFORMATION	Comments	A screening instrument that uses questions to identify if a person is at risk for or has problematic alcohol use. The screening instrument must be tested for validity, reliability, and sensitivity to be considered validated. There are different validated tools that can be used to screen different populations of people for problematic alcohol use or alcohol use disorder. These tools may include the AUDIT-C[1], Fast Alcohol Screening Test (FAST), the Single Item Alcohol Screening Questionnaire (SASQ)[2], and the Global Appraisal of Individual Needs—Short Screener (GAIN-SS)[3]. When providers have the option of selecting from several validated tools, they should choose the right tool for the person being screened. These tools will facilitate a conversation with the person and

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		will determine the level of support the person with problematic alcohol use or alcohol use disorder may require.

References:

1: National Institute for Health and Clinical Excellence. Alcohol-use disorders: diagnosis and management [Internet]. London (UK): National Institute for Health and Care Excellence; 2011 [cited 2018 Sep]. Available from: https://www.nice.org.uk/guidance/qs11/resources/alcoholuse-disorders-diagnosis-and-management-pdf-2098480272325

2: The Management of Substance Use Disorders Work Group. Va/DoD clinical practice guideline for the management of substance use disorders. Washington, DC: Department of Veterans Affairs, Department of Defense; 2015.

3: Dennis ML, Feeney T, Stevens LH, Bedoya L. Global appraisal of individual needs - short screener (GAIN-SS): administration and scoring manual for the GAIN-SS version 2.0.1. Bloomington (IL): Chestnut Health Systems; 2006.

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Table 6: Percentage of people with alcohol use disorder who report a positive experience of care

<table>
<tr><td rowspan="11">GENERAL DESCRIPTION</td><td>Indicator description</td><td>This indicator measures the percentage of people with alcohol use disorder who report a positive experience of care

Directionality: A higher percentage is better.</td></tr>
<tr><td>Indicator status</td><td>Developmental</td></tr>
<tr><td>Dimension of quality</td><td>Patient-Centred</td></tr>
<tr><td>Quality statement alignment</td><td>

Quality Statement 1: Screening
People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are screened for problematic alcohol use and alcohol use disorder using a validated tool.

Quality Statement 2: Brief Intervention
People who screen positive for problematic alcohol use are offered a brief intervention.

Quality Statement 3: Comprehensive Assessment
People who may have alcohol use disorder are offered a comprehensive assessment that informs their care plan.

Quality Statement 4: Care Plan
People with alcohol use disorder have an individualized care plan developed in collaboration with their health care professional that includes appropriate services and treatment goals. Care is seamlessly integrated, interprofessional, and provided in primary care or in collaboration with primary care.

Quality Statement 5: Treatment of Alcohol Withdrawal Symptoms
People with alcohol use disorder who have withdrawal symptoms are offered assessment, treatment, and support tailored to the severity of their symptoms.

Quality Statement 6: Information and Education
People with alcohol use disorder and their caregivers are offered information, education, and support appropriate for their needs and preferences.

Quality Statement 7: Psychological and Social Interventions
People with alcohol use disorder are offered information on psychological and social interventions that address their needs and preferences.

Quality Statement 8: Medications to Reduce Alcohol Cravings or Consumption
People with alcohol use disorder have timely access to medications that reduce alcohol cravings or consumption based on their needs and preferences.

</td></tr>
</table>

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		Quality Statement 9: Concurrent Mental Health and Substance Use Disorders and Comorbid Physical Health Disorders People with alcohol use disorder who also have a mental health disorder, physical health disorder, or another substance use disorder are offered treatment for their concurrent and comorbid disorders. **Quality Statement 10: Monitoring, Support, and Follow-up** People with alcohol use disorder are offered ongoing follow-up with their health care professional on a regular basis to monitor treatment and response.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with alcohol use disorder **Numerator** Number of people in the denominator who report a positive experience of care (see some example questions in the "Comments" section) **Method** Numerator divided by the denominator times 100
	Data source	Local data collection
ADDITIONAL INFORMATION	Comments	There is no standardized data source or cohort to identify people with alcohol use disorder in Ontario. If your local data collection system includes diagnosis information, that may be a preferable approach to identify people with alcohol use disorder. There are a number of patient experience surveys and tools used across different care settings in Ontario. Here are some examples that can be adapted for your care setting for local data collection: • 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 visit?[1] • Would you recommend this [care setting] to your friends and family? (Definitely no, Probably no, Probably yes, Definitely yes)[1] • The services I have received have helped me deal more effectively with my life's challenges (Strongly disagree, Disagree, Agree, Strongly agree, Not applicable)[2] • I think the services provided here are of high quality (Strongly disagree, Disagree, Agree, Strongly agree, Not applicable)[2]

References:

1. Ontario Hospital Association. EDPEC Survey. https://www.oha.com/data-and-analytics-old/patient-reported-performance-measurement/recommended-patient-experience-surveys

2. The Centre for Addiction and Mental Health (CAMH). Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA). https://www.client-data-system.ca/OPOC_EE-war/faces/help/Client_OPOC.pdf

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Table 7: Percentage of people with alcohol use disorder who have a follow-up appointment with a health care professional after leaving the hospital

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people with alcohol use disorder who have a follow-up appointment with a health care professional after leaving the hospital Directionality: A higher percentage is better.
	Indicator status	**Developmental**
	Dimension of quality	Effective, Timely
	Quality statement alignment	**Quality Statement 5: Treatment of Alcohol Withdrawal Symptoms** People with alcohol use disorder who have withdrawal symptoms are offered assessment, treatment, and support tailored to the severity of their symptoms. **Quality Statement 10: Monitoring, Support, and Follow-up** People with alcohol use disorder are offered ongoing follow-up with their health care professional on a regular basis to monitor treatment and response.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people who spend time in hospital for their alcohol use disorder **Numerator** Number of people in the denominator who have a follow-up appointment with a health care professional after leaving the hospital Note: The follow-up appointment with a health care professional after leaving the hospital should be an appropriate provider and not just any professional. **Method** Numerator divided by the denominator times 100
	Data source	Local data collection
ADDITIONAL INFORMATION	Comments	There is no standardized data source or cohort to identify people with alcohol use disorder in Ontario. If your local data collection system includes diagnosis information, that may be a preferable approach to identify people with alcohol use disorder. Initial follow-up should occur 48 to 72 hours[1] after diagnosis of alcohol use disorder, and follow-up appointments should be pre-booked for subsequent weeks. The length of time between appointments will be determined collaboratively between the person with alcohol use disorder and the health care professional at a schedule that is convenient for both. People should

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| | | continue to engage with their health care professional for a minimum of 6 months following their diagnosis to assist with treatment continuity and increase the likelihood of improved outcomes. |

Reference:

1. Watts K, Kaham M, Ordean A, Lefebvre L, Silveira J, Spifhoff S. Managing alcohol withdrawal [Internet]. Toronto (ON): Centre for Addiction and Mental Health; n.d. [cited 2019 Oct 21]. Available from: https://www.porticonetwork.ca/web/alcohol-toolkit/treatment/alcohol-withdrawal

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Table 8: Percentage of people with alcohol use disorder and their caregivers who receive information, education and support that is appropriate to their needs and preferences

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people with alcohol use disorder and their caregivers who receive information, education and support that is appropriate to their needs and preferences Directionality: A higher percentage is better.
	Indicator status	**Developmental**
	Dimension of quality	Patient-Centred
	Quality statement alignment	**Quality Statement 6: Information and Education** People with alcohol use disorder and their caregivers are offered information, education, and support appropriate for their needs and preferences.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with alcohol use disorder and their caregivers **Numerator** Number of people in the denominator who receive information, education and support that is appropriate to their needs and preferences **Potential stratification:** • People with alcohol use disorder • Caregivers for people with alcohol use disorder **Method** Numerator divided by the denominator times 100
	Data source	Local data collection
ADDITIONAL INFORMATION	Comments	There is no standardized data source or cohort to identify people with alcohol use disorder in Ontario. If your local data collection system includes diagnosis information, that may be a preferable approach to identify people with alcohol use disorder. In addition, if your local data collection system includes information about caregivers, that may be a preferable approach to identify caregivers for people with alcohol use disorder.

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Table 9: Percentage of health care professionals and service providers who receive education about alcohol use disorder

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of health care professionals and service providers who receive education about alcohol use disorder Directionality: A higher percentage is better.
	Indicator status	**Developmental**
	Dimension of quality	Effective, Safe
	Quality statement alignment	**Quality Statement 1: Screening** People who present to primary care, the emergency department, mental health and addictions settings, or other appropriate settings are screened for problematic alcohol use and alcohol use disorder using a validated tool. **Quality Statement 5: Treatment of Alcohol Withdrawal Symptoms** People with alcohol use disorder who have withdrawal symptoms are offered assessment, treatment, and support tailored to the severity of their symptoms. **Quality Statement 7: Psychological and Social Interventions** People with alcohol use disorder are offered information on psychological and social interventions that address their needs and preferences. **Quality Statement 8: Medications to Reduce Alcohol Cravings or Consumption** People with alcohol use disorder have timely access to medications that reduce alcohol cravings or consumption based on their needs and preferences.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of health care professionals and service providers Note: Only relevant health care professionals and service providers should be included in the denominator **Numerator** Number of people in the denominator who receive education about alcohol use disorder **Method** Numerator divided by the denominator times 100
	Data source	Local data collection
ADDITIONAL INFORMATION	Comments	There is no standard definition for education. It can cover all types of education, including (but not limited to) informal, formal, modules, and full curricula/courses.

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6 Resources and Questions

6.1 Resources

Several resources are available for more information:

- The **quality standard** provides information on the background, definitions of terminology, numerators and denominators for all statement-specific indicators
- The ***Getting Started Guide*** includes quality improvement tools and resources for health care professionals, including an action plan template
- The **case for improvement deck** provides data on why a particular quality standard has been created and the data behind it
- The **data tables** provide data that can be used to examine variations in indicator results across the province

6.2 Questions?

Please contact qualitystandards@ontariohealth.ca. We would be happy to provide advice on measuring quality standard indicators, or put you in touch with other providers who have implemented the standards and might have faced similar questions.

Ontario Health (Quality) offers an online community dedicated to improving the quality of health care across Ontario together called Quorum. Quorum can support your quality improvement work by allowing you to:

- Find and connect with others working to improve health care quality
- Identify opportunities to collaborate
- Stay informed with the latest quality improvement news
- Give and receive support from the community
- Share what works and what doesn't
- See details of completed quality improvement projects
- Learn about training opportunities
- Join a community of practice

7 Appendix: Data Sources Referenced in This Quality Standard

Within this quality standard, there are several data sources used for provincial measurement. The data source(s) for each indicator are listed within the individual indicator specifications. More details on the specific data sources that Ontario Health (Quality) used to produce the indicators are noted below.

Canadian Community Health Survey (CCHS)
The CCHS is a nationally representative, cross-sectional survey of the Canadian community-dwelling population conducted by Statistics Canada. It collects information related to health status, health care utilization and health determinants of the Canadian population. It relies upon a large sample of respondents and is designed to provide reliable estimates at the health region level every 2 years. Starting in 2007, data for the Canadian Community Health Survey (CCHS) were collected annually instead of every two years. The sample size was changed to 65,000 respondents each year starting in 2007.

The CCHS covers the population 12 years of age and older. Residents living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; the institutionalized population, children aged 12-17 that are living in foster care, and persons living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James are excluded from the survey. The CCHS is offered in English and French. To remove language as a barrier in conducting interviews, each of the Statistics Canada Regional Offices recruits interviewers with a wide range of language competencies. In 2012, CCHS began work on a major redesign project that was completed and implemented for the 2015 cycle. The objectives of the redesign were to review the sampling methodology, adopt a new sample frame, modernize the content and review the target population.

As a result of the redesign, the 2015 CCHS has a new collection strategy, is drawing the sample from two different frames and has undergone major content revisions. With all these factors taken together, the report does not compare the data from previous cycles to data collected in the 2015 cycle and onwards, as recommended by Statistics Canada.

Discharge Abstract Database (DAD)
The DAD is a database of information abstracted from hospital records that captures administrative, clinical and patient demographic information on all hospital inpatient separations, including discharges, deaths, signouts and transfers. CIHI receives Ontario data directly from participating facilities or from their respective regional health authorities or the MOHLTC. The DAD includes patient-level data for acute care facilities in Ontario. Data are collected, maintained and validated by CIHI. The main data elements of the DAD are patient identifiers (e.g. name, health care number), administrative information, clinical information (e.g. diagnoses and procedures) and patient demographics (e.g. age, sex, geographic location).

Hospital Morbidity Database (HMDB)
The Hospital Morbidity Database (HMDB) was launched in 1994–1995. The HMDB is a national data holding that captures administrative, clinical and demographic information on inpatient separations from acute care hospitals. The HMDB also contains pan-Canadian acute care data, Quebec day surgery data as of 2012–2013, and provides national discharge statistics from Canadian health care institutions

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by diagnoses and procedures. It is important to note that discharge data on psychiatric facilities, day procedures (such as day surgery in all provinces and territories except Quebec) and emergency department visits is not captured in this database.

National Ambulatory Care Reporting System (NACRS)
The NACRS contains data for all hospital-based and community-based emergency and ambulatory care, including day surgeries, outpatient clinics and emergency departments. Data are collected, maintained and validated by CIHI. CIHI receives Ontario data directly from participating facilities or from their respective regional health authorities or the MOHLTC. Data are collected, maintained and validated by CIHI. Data elements of the NACRS include patient identifiers (e.g. name, health care number), patient demographics (e.g. age, sex, geographic location), clinical information (e.g. diagnoses and procedures), and administrative information.

Ontario Mental Health Reporting System (OMHRS)
The OMHRS, housed at CIHI, collects information about individuals admitted to designated adult mental health beds in Ontario. OMHRS includes information on admissions and discharges as well as clinical information. Clinical data are collected using the Resident Assessment Instrument for Mental Health (RAI-MH), a standardized assessment instrument for inpatient mental health care. It includes information about mental and physical health, social support and service use. Data are collected on clients from participating hospitals in Ontario at admission, discharge and every three months for patients with extended stays. Data are available from October 1, 2005 onward. The number of active OMHRS sites has varied between 65 and 74 since the start of OMHRS in 2005–2006. In the early years of OMHRS, between 90% and 98% of active sites submitted at least some data every quarter. This rate has increased to 100% for all 4 quarters of 2014–2015. As of May 15, 2017, there were 84 participating facilities that have submitted data at least once to the OMHRS database since the implementation of OMHRS in October 2005.

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Looking for more information?

Visit **hqontario.ca** or contact us at **qualitystandards@ontariohealth.ca** if you have any questions or feedback about this guide.

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