Quality Standards

Anxiety Disorders

Care in All Settings

Measurement Guide

November 2019

Health Quality Ontario

Let's make our health system healthier

Ontario

Contents

1 How to Use the Measurement Guide

This document is meant to serve as a measurement guide to support the adoption of the Anxiety Disorders quality standard. Care for people with an anxiety disorder is a critical issue, and there are significant gaps and variations in the quality of care that people receive in Ontario. Recognizing this, Health Quality Ontario 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 Anxiety Disorders 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

Important Resources for Quality Standard Adoption

Health Quality Ontario 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

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 element 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

Health Quality Ontario 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 background and definitions sections. 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 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 chronic obstructive pulmonary disease who are offered clozapine after first- and second-line antipsychotics have been ineffective. 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. Structural indicators should align with the Recommendations for Adoption, which outline gaps in resources in the province.

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.

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 and generally not included in the standard, the intention of these types of measures is to monitor the unintended consequences.

3 Local Measurement

As part of the Anxiety Disorders 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:

1. Review the list of identified indicators (See Appendix 2 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
2. Determine the availability of data related to the indicators you have chosen
3. Identify a way to collect local data related to your chosen indicators. This may be through clinical chart extraction or administration of local surveys for example.
4. 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.

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).

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

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

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.

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, Health Quality Ontario 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

4 Provincial Measurement

In its quality standards, Health Quality Ontario 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 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 and Long-Term Care

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 and Long-Term Care 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.

5 How Success Can Be Measured for This Quality Standard

This measurement guide accompanies Health Quality Ontario's Anxiety Disorders quality standard. During the development of each quality standard, a few performance indicators are chosen by the Quality Standards 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:

- Percentage of people with an unscheduled emergency department (ED) visit for an anxiety disorder for whom the ED was the first point of contact for mental health and addictions care
- Percentage of repeat unscheduled ED visits related to mental health and addictions within 30 days following an unscheduled ED visit for an anxiety disorder
- Percentage of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, who receive a comprehensive assessment that determines whether they have a specific anxiety disorder, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment
- Percentage of people with an anxiety disorder for whom cognitive behavioural therapy (CBT) was determined to be appropriate and who receive disorder-specific CBT delivered by a health care professional with expertise in anxiety disorders
- Percentage of people with an anxiety disorder who report an improvement in their quality of life
- Percentage of people with an anxiety disorder who "strongly agree" with the following question: "The services I have received have helped me deal more effectively with my life's challenges"
- Percentage of people with an anxiety disorder who complete CBT and have reliable recovery
- Percentage of people with an anxiety disorder who complete CBT and have reliable improvement

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 care for people living with an anxiety disorder. It applies to care for people in all settings but focuses on primary and community care. This quality standard addressed the following anxiety disorder types:

- Specific phobia
- Social anxiety disorder
- Generalized anxiety disorder
- Panic disorder
- Agoraphobia

It focuses on care for adults (age 18 and older), but it includes content that is relevant for children and adolescents (under age 18 years). Guidance is provided where relevant clinical practice guideline recommendations and content for children and adolescents were available.

Although this quality standard includes information that could apply to other anxiety disorders, the scope of this quality standard does not address selective mutism, separation anxiety disorder, substance- or medication-induced anxiety disorder, anxiety disorder owing to another medical condition, or unspecified anxiety disorder. This quality standard also does not address trauma or stressor-related disorders (including post-traumatic stress disorder).

For information about obsessive–compulsive disorder, please see *Obsessive–Compulsive Disorder: Care in All Settings*, which was developed concurrently with this quality standard.

5.2 Cohort Identification

For the purpose of measurement at the provincial level, people with anxiety disorders can be identified in a variety of ways, including surveys or administrative data. For the purpose of local measurement, people with anxiety disorders may be identified using local data sources (such as electronic medical records or clinical patient records).

5.2.1 Cohort Identification Using Surveys

The following survey used in Canada asks respondents if they have an anxiety disorder (such as a phobia, obsessive-compulsive disorder or a panic disorder):

1. Canadian Community Health Survey (CCHS)

For local data collection purposes, the question from this survey can be included in local surveys or could be used in provincial measures to identify respondents with an anxiety disorder.

5.2.2 Cohort Identification Using Administrative Data

To identify people who have visited the emergency department for an anxiety disorder (for the provincially measurable indicators in this quality standard), the following administrative data can be used:

The National Ambulatory Care Reporting System (NACRS) captures data for all hospital-based and community-based ambulatory care (day surgery, outpatient and community-based clinics, emergency departments) in Ontario and other jurisdictions in Canada. Data is submitted to the Canadian Institute for Health Information from participating facilities in the province. For more information on this data set, please refer to https://www.cihi.ca/en/national-ambulatory-care-reporting-system-metadata.

To identify people who had an emergency department visit for an anxiety disorder, the following parameters can be used:

Inclusions (ICD-10-CA):

- Phobic anxiety disorders: F40
- Panic disorder: F41.0
- Generalized anxiety disorder: F41.1
- Mixed anxiety and depressive disorder: F41.2
- Anxiety Disorder, unspecified: F41.9

For youth, use the following in addition to the above:

- Phobic anxiety disorder of childhood: F93.1
- Social anxiety disorder of childhood: F93.2

5.3 How Success Can Be Measured Provincially

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

- Percentage of people with an unscheduled ED visit for an anxiety disorder for whom the ED was the first point of contact for mental health and addictions care
- Percentage of repeat unscheduled ED visits related to mental health and addictions within 30 days following an unscheduled ED visit for an anxiety disorder

Methodologic details for the provincially measurable indicators are described in the tables below.

Table 1: Percentage of people with an unscheduled emergency department (ED) visit for an anxiety disorder for whom the ED was the first point of contact for mental health and addictions care; 2016, 2017, 2018: Children and Youth (0-24); Adults (16-104)

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people with an unscheduled ED visit for an anxiety disorder for whom the ED was the first point of contact for mental health and addictions care, by: ○ Children and Youth (0-24) ○ Adults (16-104) Directionality: A lower percentage is better.
	Measurability	**Measurable at the provincial level**
	Dimension of quality	Patient-centered, Timely
	Quality statement alignment	**Quality Statement 1: Identification** People suspected to have an anxiety disorder are identified early using (1) a validated screening tool or recognized screening questions and (2) validated severity-rating scales. **Quality Statement 2: Comprehensive Assessment** People suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, receive a timely comprehensive assessment to determine whether they have a specific anxiety disorder, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with an unscheduled ED visit for an anxiety disorder; in each calendar year, 2016, 2017, 2018; stratified by: - Children and Youth - Adults ***Inclusions***: - Anxiety Disorders (ICD-10-CA) in NACRS: ○ Phobic anxiety disorders: F40 ○ Panic Disorder: F41.0 ○ Generalized anxiety disorder: F41.1 ○ Mixed anxiety and depressive disorder: F41.2 ○ Anxiety Disorder, unspecified: F41.9 For youth, the following codes are included in addition to the above: ○ Phobic anxiety disorder of childhood: F93.1 ○ Social anxiety disorder of childhood: F93.2 Incident = 1st event in a calendar period without any look-back for past events.

		Exclusions: - Invalid health card number - Non-Ontario resident - Age >= 105 or missing - Missing sex - Scheduled ED visits **Numerator** Number of people in the denominator who did not have a health care visit for mental health and addictions care in the previous 2 years ***Inclusions***: - Only includes people who did not have a mental health and addictions related: o Claims to a psychiatrist, general practitioner/family physician or pediatrician, or o Emergency department visits (scheduled or unscheduled), or o Hospital admission in the 2 years preceding the index ED visit. Refer to the Mental Health and Addictions System Performance scorecard for the full list of specifications used to determine previous mental health and addictions related contact. **Data sources**: National Ambulatory Care Reporting System (NACRS), Discharge Abstract Database (DAD), Ontario Health Insurance Plan (OHIP) Claims Database, Ontario Mental Health Reporting System (OMHRS), Registered Persons Database (RPDB) **Method** Numerator divided by the denominator times 100 *Note: Rates are reported as age- and sex-standardized.*
ADDITIONAL INFORMATION	Limitations	This indicator should be taken in conjunction with the other measures of success to provide a full view of care provided to the patient. Prior mental health and addictions related visits (numerator) only capture care provided by a physician. Care provided in the community for mental health and addictions by other health care providers (non-physicians) - e.g., psychologist or social worker - are not captured in the administrative data. As well, people unable to access mental health and addictions services delivered by physicians would be missed. The data may capture both anxiety symptoms and anxiety disorders, and could be skewed (i.e., the outcomes may not be specifically linked to diagnosed anxiety disorders). As well, emergency department visits for anxiety disorders may primarily capture certain types of anxiety disorders, such as panic disorder. Some types of anxiety disorders included in the Quality Standard may be more likely to be captured in other areas, such as the workplace or school absenteeism.

	Comments	This indicator is similar to the *First Contact in the Emergency Department for MHA* indicator in the Mental Health and Addictions System Performance scorecard, with a few key differences: - It is specific to first contact for anxiety disorders - The diagnosis codes included in the Quality Standard for an anxiety disorder vary in comparison to the above report due to the types of anxiety disorders in scope for the Quality Standard.

Table 2: Percentage of repeat unscheduled ED visits related to mental health and addictions within 30 days following an unscheduled ED visit for an anxiety disorder; 2016, 2017, 2018

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of repeat unscheduled ED visits related to mental health and addictions within 30 days following an unscheduled ED visit for an anxiety disorder. Directionality: A lower percentage is better.
	Measurability	**Measurable at the provincial level**
	Dimension of quality	Patient-centered, Timely
	Quality statement alignment	All statements in the Quality Standard align.

DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator**
		Total number of unscheduled ED visits for an anxiety disorder; in each calendar year, 2016, 2017, 2018
		
		If an individual has multiple anxiety disorder-related ED visits in a calendar year, each ED visit would be counted in the denominator (based on an episode of care). It is possible for a single ED visit for an anxiety disorder to be included as both a visit in the denominator and a repeat visit in the numerator.
		
		Inclusions:
		- Anxiety Disorders (ICD-10-CA) in NACRS:
		  o Phobic anxiety disorders: F40
		  o Panic Disorder: F41.0
		  o Generalized anxiety disorder: F41.1
		  o Mixed anxiety and depressive disorder: F41.2
		  o Anxiety Disorder, unspecified: F41.9
		  o Phobic anxiety disorder of childhood: F93.1
		  o Social anxiety disorder of childhood: F93.2
		
		Exclusions:
		- Invalid health card number
		- Non-Ontario resident
		- Age >= 105 or missing
		- Missing sex
		- Scheduled ED visits
		- ED visit transferred to another ED
		- ED visit that did not result in discharge to the community
		- Patients that left without being seen
		
		Disposition of discharge to the community in NACRS:
		For records in FY2015/16 - FY2017/18:
		- 01 – Discharged to Place of Residence (private dwelling, no support)

		- 15 – Discharge to Place of Residence (institution or home with support) For records in FY2018/19: - 16 – Discharge to private home, condo, apt with support service/referral - 17 – Discharge to private home, condo, apt without support service/referral - 30 – Transfer to Residential care - 40 – Transfer to Group/Supportive living - 90 – Transfer to correctional facility **Numerator** Number of ED visits in the denominator followed within 30 days after leaving the hospital by a repeat unscheduled ED visit related to mental health and addictions ***Inclusions***: - Mental Health and Addictions visit (ICD-10-CA) in NACRS: o F04 to F99 in DX10CODE1, or o (X60-X84, Y10-Y19, Y28) in Dx10Code2 to Dx10Code10 and no specified Mental Health code in Dx10Code1 (F04 to F99) - 30 day follow-up for numerator can cross over into the next calendar year - 30 days calculated from discharge date of initial visit to ED registration date of next visit - Visits transferred from another ED - Visits transferred to inpatient ***Exclusions***: - Scheduled ED visits - Patients that left without being seen **Data sources**: National Ambulatory Care Reporting System (NACRS), Registered Persons Database (RPDB) **Method** Numerator divided by the denominator times 100 *Note: Rates are reported as age- and sex-standardized.*
ADDITIONAL INFORMATION	Limitations	This indicator should be taken in conjunction with the other measures of success to provide a full view of care provided to the patient. The data may capture both anxiety symptoms and anxiety disorders, and could be skewed (i.e., the outcomes may not be specifically linked to diagnosed anxiety disorders). As well, emergency department visits for anxiety disorders may primarily capture certain types of anxiety disorders, such as panic disorder. Some types of anxiety disorders included the Quality Standard may be more likely to be captured in other areas, such as the workplace or school absenteeism.

	Comments	This indicator is similar to the *Repeat Unscheduled Emergency Department Visit within 30 Days* indicator in the Mental Health and Addictions System Performance scorecard, with several key differences: - The initial visit is for an anxiety disorder - The diagnosis codes included in the Quality Standard for an anxiety disorder vary in comparison to the above report due to the types of anxiety disorders in scope for the Quality Standard. - Each visit is counted in the denominator, rather than one visit per person in a calendar year.

5.4 How Success Can Be Measured Locally

You might want to assess the quality of care you provide to your patients with an anxiety 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 suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, who receive a comprehensive assessment that determines whether they have a specific anxiety disorder, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment
- Percentage of people with an anxiety disorder for whom cognitive behavioural therapy (CBT) was determined to be appropriate and who receive disorder-specific CBT delivered by a health care professional with expertise in anxiety disorders
- Percentage of people with an anxiety disorder who report an improvement in their quality of life
- Percentage of people with an anxiety disorder who “strongly agree” with the following question: “The services I have received have helped me deal more effectively with my life’s challenges”
- Percentage of people with an anxiety disorder who complete CBT and have reliable recovery
- Percentage of people with an anxiety disorder who complete CBT and have reliable improvement

Methodologic details are described in the table below.

Table 3: Percentage of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, who receive a comprehensive assessment

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, who receive a comprehensive assessment that determines whether they have a specific anxiety disorder, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment. Directionality: A higher percentage is better.
	Measurability	**Not measurable**
	Dimension of quality	Patient-Centred, Efficient, Timely
	Quality statement alignment	**Quality Statement 2: Comprehensive Assessment** People suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, receive a timely comprehensive assessment to determine whether they have a specific anxiety disorder, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder Refer to Quality Statement 2 for definitions. **Numerator** Number of people in the denominator who receive a comprehensive assessment that determines whether they have a specific anxiety disorder, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment Refer to Quality Statement 2 for definitions. **Data sources**: local data collection **Method** Numerator divided by the denominator times 100
ADDITIONAL INFORMATION	Limitations	

Table 4: Percentage of people with an anxiety disorder for whom cognitive behavioural therapy (CBT) was determined to be appropriate and who receive disorder-specific CBT delivered by a health care professional with expertise in anxiety disorders

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people with an anxiety disorder for whom CBT was determined to be appropriate and who receive disorder-specific CBT delivered by a health care professional with expertise in anxiety disorders. Directionality: A higher percentage is better.
	Measurability	**Not measurable**
	Dimension of quality	Patient-Centred, Effective
	Quality statement alignment	**Quality Statement 6: Cognitive Behavioural Therapy** People with an anxiety disorder have timely access to cognitive behavioural therapy, considering their individual needs and preferences and in alignment with a stepped-care approach. The cognitive behavioural therapy is delivered by a health care professional with expertise in anxiety disorders.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with an anxiety disorder for whom CBT was determined to be appropriate Refer to Quality Statement 6 for definitions. Appropriateness of CBT is based on a stepped-care approach (refer to Quality Statement 4 for information about the stepped-care approach). **Numerator** Number of people in the denominator who receive disorder-specific CBT delivered by a health care professional with expertise in anxiety disorders Refer to Quality Statement 6 for definitions. **Data sources**: local data collection **Method** Numerator divided by the denominator times 100
ADDITIONAL INFORMATION	Limitations	

Table 5: Percentage of people with an anxiety disorder who report an improvement in their quality of life

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people with an anxiety disorder who report an improvement in their quality of life. Directionality: A higher percentage is better.
	Measurability	**Not measurable**
	Dimension of quality	Patient-Centred, Effective
	Quality statement alignment	All statements in the Quality Standard align.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with an anxiety disorder **Numerator** Number of people in the denominator who report an improvement in their quality of life Consider using a validated tool to assess quality of life. As well, consider a timeframe to conduct the baseline and follow-up assessments. **Data sources**: local data collection **Method** Numerator divided by the denominator times 100
ADDITIONAL INFORMATION	Limitations	

Table 6: Percentage of people with an anxiety disorder who "strongly agree" with the following question: "The services I have received have helped me deal more effectively with my life's challenges"

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people with an anxiety disorder who "strongly agree" with the following question: "The services I have received have helped me deal more effectively with my life's challenges" Directionality: A higher percentage is better.
	Measurability	**Developmental**
	Dimension of quality	Patient-Centred
	Quality statement alignment	All statements in the Quality Standard align.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with an anxiety disorder who answer the following question, "The services I have received have helped me deal more effectively with my life's challenges" **Numerator** Number of people in the denominator who "strongly agree" **Data sources**: local data collection **Method** Numerator divided by the denominator times 100
ADDITIONAL INFORMATION	Limitations	
	Comments	The question used in this indicator is from the Ontario Perception of Care Tool (OPOC) for Mental Health and Addictions (question 30) developed at the Centre for Addiction and Mental Health (CAMH). This question closely aligns with the overall quality standard and can be useful in determining patient experience. This question is part of a larger survey made available through CAMH and can be accessed upon completion of a Memorandum of Understanding and License Agreement with CAMH. Please see the OPOC Community of Practice for more information: https://www.eenetconnect.ca/g/provincial-opoc-cop/ Questions related to this instrument can be directed to OPOC.MHA@camh.ca. This indicator is also an area of focus for the Excellence through Quality Improvement Project (EQIP), which is a project led by Addictions and Mental Health Ontario (AMHO) and the Canadian Mental Health Association, Ontario (CMHA) and delivered in close partnership with

		Health Quality Ontario (HQO) and the Provincial Systems Support Program (PSSP) at CAMH. To find out more, visit http://ontario.cmha.ca/provincial-programs/e-qip-excellence-through-quality-improvement-project/ or https://amho.ca/our-work/e-qip/.

Table 7: Percentage of people with an anxiety disorder who complete cognitive behavioural therapy (CBT) and have reliable recovery

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people with an anxiety disorder who complete CBT and have reliable recovery. Directionality: A higher percentage is better.
	Measurability	**Developmental**
	Dimension of quality	Patient-Centred
	Quality statement alignment	**Quality Statement 6: Cognitive Behavioural Therapy** People with an anxiety disorder have timely access to cognitive behavioural therapy, considering their individual needs and preferences and in alignment with a stepped-care approach. The cognitive behavioural therapy is delivered by a health care professional with expertise in anxiety disorders.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with an anxiety disorder who complete CBT Refer to Quality Statement 6 for more information on CBT. This indicator is in development for the Ontario Structured Psychotherapy Program, in which *completion* is defined as a client who has: 1. Recorded a final treatment session OR has Exit disposition 2. At least 2 recorded sessions (mental health assessment and/or treatment session) **Numerator** Number of people in the denominator who have reliable recovery *Reliable Recovery:* Reliable recovery occurs when a client's score on an anxiety disorder-specific validated severity-rating scale meets the following: - Recovery threshold: Is above a clinical cut-off before treatment is initiated and is below the clinical cut-off after treatment is completed (reduction in symptoms); **and** - Statistically reliable change: Changes (improves) by a set number of points (that is statistically significant) between treatment initiation and treatment completion Refer to Quality Statement 1 for more information about validated severity-rating scales. The table below is based on guidance provided by the Ontario Structured Psychotherapy Program and can be used to measure this indicator. For scales not included in the table, consider using an alternate source to determine an evidence-based recovery threshold and statistically reliable change.

<table>
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<tr><th>Severity-rating scale</th><th>Recovery threshold</th><th>Statistically reliable change</th></tr>
<tr><td>Penn State Worry Questionnaire (PSWQ)</td><td>≥45</td><td>TBD</td></tr>
<tr><td>Social Phobia Inventory (SPIN)</td><td>≥21</td><td>TBD</td></tr>
<tr><td>Mobility Inventory for Agoraphobia (MIA)</td><td>≥1.61 on Avoidance Alone scale</td><td>TBD</td></tr>
<tr><td>Panic Disorder Severity Scale Self-report (PDSS-SR)</td><td>≥8</td><td>TBD</td></tr>
</table>

Data sources: local data collection

Method
Numerator divided by the denominator times 100
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<td>ADDITIONAL INFORMATION</td>
<td>Limitations</td>
<td></td>
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<tr>
<td></td>
<td>Comments</td>
<td>The Ontario Structured Psychotherapy Program was funded in 2017/18 as part of a 3-year pilot project to test the provision of evidence-based forms of CBT for anxiety and depression. The program is being initially rolled out with intake through four hospitals: the Centre for Addiction and Mental Health, the Royal Ottawa Healthcare Group, Ontario Shores Centre for Mental Health Sciences, and Waypoint Centre for Mental Health Care. Through these four “hubs,” group and individual psychotherapy is being delivered in multiple satellite sites, including primary care teams, community mental health and addictions agencies, social service agencies, and postsecondary campuses. To support high-quality service delivery, the program developed a consistent approach to training and supervision. Based on early positive results, consideration for further program expansion will be made.

This indicator is aligned with a larger set that will be used by the Ontario Structured Psychotherapy Program.</td>
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Table 8: Percentage of people with an anxiety disorder who complete cognitive behavioural therapy (CBT) and have reliable improvement

GENERAL DESCRIPTION	Indicator description	This indicator measures the percentage of people with an anxiety disorder who complete CBT and have reliable improvement. Directionality: A higher percentage is better.
	Measurability	**Developmental**
	Dimension of quality	Patient-Centred
	Quality statement alignment	**Quality Statement 6: Cognitive Behavioural Therapy** People with an anxiety disorder have timely access to cognitive behavioural therapy, considering their individual needs and preferences and in alignment with a stepped-care approach. The cognitive behavioural therapy is delivered by a health care professional with expertise in anxiety disorders.
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with an anxiety disorder who complete CBT Refer to Quality Statement 6 for more information on CBT. This indicator is in development for the Ontario Structured Psychotherapy Program, in which *completion* is defined as a client who has: 1. Recorded a final treatment session OR has Exit disposition 2. At least 2 recorded sessions (mental health assessment and/or treatment session) **Numerator** Number of people in the denominator who have reliable improvement *Reliable Improvement:* Reliable improvement occurs when a client's score on an anxiety disorder-specific validated severity-rating scale meets the following: - Statistically reliable change: Changes (improves) by a set number of points (that is statistically significant) between treatment initiation and treatment completion Refer to Quality Statement 1 for more information about validated severity-rating scales. Guidance from the Ontario Structured Psychotherapy Program can be used to measure this indicator. For scales not included in the program, consider using an alternate source to determine an evidence-based statistically reliable change. **Data sources**: local data collection **Method** Numerator divided by the denominator times 100

ADDITIONAL INFORMATION	Limitations	
	Comments	The Ontario Structured Psychotherapy Program was funded in 2017/18 as part of a 3-year pilot project to test the provision of evidence-based forms of CBT for anxiety and depression. The program is being initially rolled out with intake through four hospitals: the Centre for Addiction and Mental Health, the Royal Ottawa Healthcare Group, Ontario Shores Centre for Mental Health Sciences, and Waypoint Centre for Mental Health Care. Through these four "hubs," group and individual psychotherapy is being delivered in multiple satellite sites, including primary care teams, community mental health and addictions agencies, social service agencies, and postsecondary campuses. To support high-quality service delivery, the program developed a consistent approach to training and supervision. Based on early positive results, consideration for further program expansion will be made. This indicator is aligned with a larger set that will be used by the Ontario Structured Psychotherapy Program.

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@hqontario.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.

Health Quality Ontario 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 Health Quality Ontario used to produce the indicators are noted below.

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

National Ambulatory Care Reporting System (NACRS)
The NACRS by the Canadian Institute for Health Information (CIHI) 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, from their respective regional health authorities, or from the Ministry of Health and Long-Term Care. Data are collected, maintained and validated by CIHI. Data elements of this reporting system include patient identifiers (e.g., name, health card number), patient demographics (e.g., age, sex, geographic location), clinical information (e.g., diagnoses and procedures), and administrative information.

Ontario Health Insurance Plan (OHIP) Claims Database
The OHIP claims database covers all reimbursement claims to the Ministry of Health and Long-Term Care made by fee-for-service physicians, community-based laboratories and radiology facilities. The OHIP database at the Institute for Clinical Evaluative Sciences contains encrypted patient and physician identifiers, codes for services provided, date of service, the associated diagnosis and fee paid. Services which are missing from the OHIP data include: some laboratory services; services received in provincial psychiatric hospitals; services provided by health service organizations and other alternate providers; diagnostic procedures performed on an inpatient basis and laboratory services performed at hospitals (both inpatient and same day). Also excluded is remuneration to physicians through alternate funding plans (AFPs), which could distort analyses because of their concentration in certain specialties or geographic areas.

Ontario Mental Health Reporting System (OMHRS)
The OMHRS, housed at the Canadian Institute for Health Information, 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. 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.

Registered Persons Data Base (RPDB)

The RPDB provides basic demographic information about anyone who has ever received an Ontario health card number. The RPDB is a historical listing of the unique health numbers issued to each person eligible for Ontario health services. This listing includes corresponding demographic information such as date of birth, sex, address, date of death (where applicable) and changes in eligibility status. At the Institute for Clinical Evaluative Sciences (ICES), data from the RPDB are enhanced with available information through other administrative data sources; however, even the enhanced dataset overestimates the number of people living in Ontario for several reasons, including the source of death information and record linkage issues. Although improvements have been made in recent years, the RPDB still contains a substantial number of individuals who are deceased or no longer living in Ontario. As such, the RPDB will underestimate mortality. To ensure that rates and estimates are correct, a methodology has been developed to adjust the RPDB so that regional population counts by age and sex match estimates from Statistics Canada.

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