Eating Disorders

Care for People of All Ages

Measurement Guide

March 2023

Quality Standards

Ontario Health

Contents

1. How to Use the Measurement Guide

This document is meant to serve as a measurement guide to support implementation of the Eating Disorders quality standard. Care for people with an eating disorder is a critical issue, and there are significant gaps and variations in the quality of care that people with an eating disorder receive in Ontario. Recognizing this, 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 implement the Eating 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 monitor the progress being made to improve care on a provincial level using existing provincial data sources

1.1 Important Resources for Quality Implementation

Ontario Health has created resources to assist with implementation of quality standards:

- Our placemat, which summarizes the quality standard and includes links to helpful resources and tools
- Our Getting Started Guide, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of care across Ontario. This is a place where health care providers can share information and support each other, and it includes tools and resources to help you implement the quality statements within each standard
- The Health Equity Impact Assessment tool, which can help your organization consider how programs and policies impact population groups differently. This tool can help maximize positive impacts and reduce negative impacts, with an aim of reducing health inequities between population groups

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

The process, structure, and outcome indicator framework was developed by Donabedian in 1966. 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 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 time frame 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 time frame) 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 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 local availability of cognitive behavioural therapy (CBT) programs, 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 intended 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 time frame.

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 Eating 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:

- Review the list of identified indicators for each quality statement (see Appendix 2 in the quality standard), and determine which ones you will use as part of your implementation 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. This may be through clinical chart extraction or administration of local surveys for example
- 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 [ICES] 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 improvement of data quality.

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).

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, Ontario Health 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. Time frame 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, Ontario Health 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 to monitor the progress being made to improve care. 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 health care 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 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.

5. Measurement to Support Improvement

This measurement guide accompanies Ontario Health's Eating Disorders quality standard. Early in the development of each quality standard, several performance indicators are chosen to monitor the progress being made to improve care for people with an eating disorder. 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:

- Rate of emergency department visits for an eating disorder in the past year
- Rate of hospital admissions for an eating disorder in the past year
- Percentage of people with an emergency department visit for an eating disorder in the past year for whom the emergency department was the first point of contact for mental health or addictions care
- Percentage of people with an eating disorder who report an improvement in their quality of life

This guide includes data sources for indicators that can be consistently measured across providers, across the sectors of health care, and across the province.

Indicators are categorized as:

- Provincially measurable (there are well defined or validated data sources available) *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 (Appendix 2).

5.1 Quality Standard Scope

This quality standard addresses care for people with anorexia nervosa, bulimia nervosa, or binge-eating disorder. It applies to all care settings.

Although many statements may apply to avoidant/restrictive food intake disorder (ARFID), as well as specified and unspecified eating disorders, this quality standard does not directly address the management of these conditions. This quality standard also does not address pica or rumination disorder.

Ontario Health's *Transitions from Youth to Adult Health Care Services* and *Transitions Between Hospital and Home* quality standards provide further guidance in care and may be applicable to people with an eating disorder.

This quality standard includes nine quality statements. They address areas identified by Ontario Health's Eating Disorders Quality Standard Advisory Committee as having high potential for improving the quality of care in Ontario for people with an eating disorder.

In this quality standard, the term *patient* includes community care clients and residents of long-term care homes.

5.2 Cohort Identification

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

5.2.1 Equity Considerations

Consider collecting data and measuring indicators by various equity stratifications that are relevant and appropriate for your population, such as patient socioeconomic and demographic characteristics. These may include age, education, gender, income, language, race/ethnicity, and sex. Please refer to Appendix 4, Values and Guiding Principles, in the quality standard for additional equity considerations.

5.2.2 Cohort Identification Using Surveys

The Canadian Community Health Survey asks respondents if they have an eating disorder (such as anorexia nerovsa or bulimia nervosa). For local data collection purposes, the question from this survey can be included in provincial measures to identify respondents with an eating disorder.

5.2.3 Cohort Identification Using Administrative Data

To identify people who have visited the emergency department or who had a hospital admission for an eating disorder (for the provincially measurable indicators in this quality standard), the National Ambulatory Care Reporting System (NACRS) or the Discharge Abstract Database (DAD) data can be used.

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 are submitted to the Canadian Institute for Health Information (CIHI) 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.

DAD captures administrative, clinical and demographic information on hospital discharges in Ontario and Canada (excluding Quebec). Data are submitted to CIHI from acute care facilities in the province. For more information on this data set, please refer to https://www.cihi.ca/en/discharge-abstract-database-metadata.

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

Inclusions (ICD-10-CA):

- F50.0: Anorexia nervosa
- F50.1: Atypical anorexia nervosa
- F50.2: Bulimia nervosa
- F50.3: Atypical bulimia nervosa
- F50.8: Other eating disorders
- F50.9: Eating disorder, unspecified

The Ontario Mental Health Reporting System (OMHRS) analyzes and reports on information about individuals receiving adult mental health services in Ontario and some individuals receiving services in youth inpatient beds. Data is submitted to CIHI from participating hospitals in Ontario and several other facilities in other provinces in Canada. For more information about this dataset, please refer to https://www.cihi.ca/en/ontario-mental-health-reportingsystem-metadata.

To identify people who had an OMHRS hospital discharge for an eating disorder, the following parameters can be used:

Inclusions (DSM-V):

- 307.1: Anorexia nervosa
- 307.51: Bulimia nervosa

5.3 Indicators That Can Be Measured Using Provincial Data

The Eating Disorders Quality Standard Advisory Committee identified a number of overarching goals **for this quality standard.** These have been mapped to indicators that may be used to assess quality of care provincially. The following indicators are currently potentially measurable in Ontario's health care system:

- Rate of emergency department visits for an eating disorder in the past year
- Rate of hospital admissions for an eating disorder in the past year
- Percentage of people with an emergency department visit for an eating disorder in the past year for whom the emergency department was the first point of contact for mental health or addictions care

Methodologic details are described in the tables below.

Table 1: Rate of emergency department visits for an eating disorder in the past year

General Description	
Indicator description	Name: Rate of emergency department visits for an eating disorder in the past year Directionality: A lower rate is better
Measurability	Measurable at the provincial level
Dimension of quality	Patient-Centred, Efficient, Timely
Quality statement alignment	All statements in the quality standard align
Definition and Source Information	
Calculation: General	**Denominator** Total population **Numerator** Number of people in the denominator who visited the emergency department for an eating disorder in the past year *Inclusions* From NACRS (ICD-10-CA): F50.0: Anorexia nervosa F50.1: Atypical anorexia nervosa F50.2: Bulimia nervosa F50.3: Atypical bulimia nervosa F50.8: Other eating disorders F50.9: Eating disorder, unspecified *Exclusions* Invalid health card number Non-Ontario resident Age >=105 or missing Missing sex Scheduled emergency department visits Emergency department visits transferred to another emergency department Patients that left without being seen **Method** Numerator ÷ Denominator × 100,000

(continued on following page)

	Data sources NACRS, appropriate Ontario population estimate (e.g., RPDB, Statistics Canada population tables)
Additional Information	
Limitations	Data from emergency department visits capture only those who visit the emergency department and may not reflect the total burden in the population. This indicator does not include individuals that had a scheduled visit with an emergency department. Anorexia nervosa and bulimia nervosa can be distinguished using ICD-10-CA codes, whereas binge eating is not captured precisely in diagnosis data.
Comments	Some rural regions use emergency departments for primary care. Some individuals do not seek treatment. Some individuals face access barriers to treatment.

Abbreviations: ICD-10-CA, International Classification of Diseases, 10th revision, Canadian version; NACRS, National Ambulatory Care Reporting System; RPDB, Registered Persons Database

Table 2: Rate of hospital admissions visits for an eating disorder in the past year

General Description	
Indicator description	Name: Rate of hospital admissions for an eating disorder in the past year Directionality: A lower rate is better
Measurability	Measurable at the provincial level
Dimension of quality	Patient-Centred, Efficient, Timely
Quality statement alignment	All statements in the quality standard align
Definition and Source Information	
Calculation: General	**Denominator** Total population **Numerator** Number of people in the denominator who were admitted to hospital for an eating disorder in the past year *Inclusions* From DAD (ICD-10-CA): F50.0: Anorexia nervosa F50.1: Atypical anorexia nervosa F50.2: Bulimia nervosa F50.3: Atypical bulimia nervosa F50.8: Other eating disorders F50.9: Eating disorder, unspecified From OMHRS (DSM-V): 307.1: Anorexia nervosa 307.51: Bulimia nervosa *Exclusions* Invalid health card number Non-Ontario resident Age >=105 or missing Missing sex **Method** Numerator ÷ Denominator × 100,000 **Data sources** DAD, OMHRS, appropriate Ontario population estimate (e.g., RPDB, Statistics Canada population tables)

(continued on following page)

Additional Information	
Limitations	Anorexia nervosa and bulimia nervosa can be distinguished using ICD-10-CA codes, whereas binge eating is not captured precisely in diagnosis data.
Comments	Some individuals do not seek treatment. Some individuals face access barriers to treatment.

Abbreviations: DAD, Discharge Abstract Database; ICD-10-CA, International Classification of Diseases, 10th revision, Canadian version; OMHRS, Ontario Mental Health Reporting System; RPDB, Registered Persons Database

Table 3: Percentage of people with an emergency department visit for an eating disorder in the past year for whom the emergency department was the first point of contact for mental health or addictions care

General Description	
Indicator description	Name: Percentage of people with an emergency department visit for an eating disorder in the past year for whom the emergency department was the first point of contact for mental health or addictions care Directionality: A lower percentage is better
Measurability	Measurable at the provincial level
Dimension of quality	Patient-Centred, Efficient, Timely
Quality statement alignment	Quality Statement 1: Comprehensive Assessment Quality Statement 4: Psychotherapy Quality Statement 7: Physical, Mental Health, and Addiction Comorbidities Quality Statement 8: Promoting Equity
Definition and Source Information	
Calculation: General *(continued on following page)*	**Denominator** Number of people with an emergency department visit for an eating disorder in the past year *Inclusions* From NACRS (ICD-10-CA): F50.0: Anorexia nervosa F50.1: Atypical anorexia nervosa F50.2: Bulimia nervosa F50.3: Atypical bulimia nervosa F50.8: Other eating disorders F50.9: Eating disorder, unspecified *Exclusions* Invalid health card number Non-Ontario resident Age >=105 or missing Missing sex Scheduled emergency department visits Emergency department visits transferred to another emergency department Patients that left without being seen

	Numerator Number of people in the denominator for whom the emergency department was the first point of contact for mental health or addictions care
	Inclusions Only includes people who did not have a mental health and addictions related: • Claims to a psychiatrist, general practitioner/family physician or pediatrician, or; • Emergency department visit (scheduled or unscheduled), or; • Hospital admission in the two years preceding the index emergency department 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 contacts.
	Method Numerator ÷ Denominator
	Data sources: DAD, NACRS, OHIP, OMHRS, appropriate Ontario population estimate (e.g., RPDB, Statistics Canada population tables)
Additional Information Limitations	Data from emergency department visits capture only those who visit the emergency department and may not reflect the total burden in the population. This indicator does not include individuals that had a scheduled visit with an emergency department. Anorexia nervosa and bulimia nervosa can be distinguished using ICD-10-CA codes, whereas binge eating is not captured precisely in diagnosis data. Prior mental health and addictions related visits 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., psychologists or social workers) are not captured in the administrative data. As well, People unable to access mental health and addictions services delivered by physicians would be missed.
Comments	Some rural regions use emergency departments for primary care. Some individuals do not seek treatment. Some individuals face access barriers to treatment.

(continued on following page)

	This indicator should be taken in conjunction with the other measures of success to provide a full view of care provided to the patient.

Abbreviations: DAD, Discharge Abstract Database; ICD-10-CA, International Classification of Diseases, 10th revision, Canadian version; NACRS, National Ambulatory Care Reporting System; OHIP, Ontario Health Insurance Plan Claims Database; OMHRS, Ontario Mental Health Reporting System; RPDB, Registered Persons Database

5.4 Indicator That Can Be Measured Using Only Local Data

You might want to assess the quality of care you provide to your patients with an eating 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. We recommend the following potential indicator, which cannot be measured provincially using currently available data:

- Percentage of people with an eating disorder who report an improvement in their quality of life

Methodologic details are described in the table below.

Table 4: Percentage of people with an eating disorder who report an improvement in their quality of life

General Description	
Indicator description	Name: Percentage of people with an eating disorder who report an improvement in their quality of life Directionality: A higher percentage is better
Indicator status	Developmental
Dimensions of quality	Safe, Effective, Patient-Centred, Efficient
Quality statement alignment	All statements in the quality standard align
Definition and Source Information	
Calculation: General	**Denominator** Total number of people with an eating 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 and a timeframe to conduct the baseline and follow-up assessments. Also consider CIHI's patient-reported outcome measures (PROMs) program. **Method** Numerator ÷ Denominator × 100
Data source	Local data collection
Additional Information	
Limitations	Data captured may not reflect the total burden in the population.
Comments	CIHI's patient-reported outcome measures (PROMs) program supports development of PROMs data collection and reporting.

Abbreviation: CIHI, Canadian Institute for Health information

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

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 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 that can be 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 used to produce the indicators are noted below.

Canadian Community Health Survey—Statistics Canada
The Canadian Community Health Survey, conducted by Statistics Canada, is a nationally representative, cross-sectional survey of the Canadian community-dwelling population. It collects information related to health status, health care use, 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 were collected annually instead of every 2 years. Also, the sample size was changed to 65,000 respondents each year.

The Canadian Community Health Survey covers the population 12 years of age and older. Excluded from the survey are residents living on reserves and other Indigenous settlements in the provinces and territories; full-time members of the Canadian Forces; people living in institutions; children aged 12 to 17 living in foster care; and people living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James.

The Canadian Community Health Survey 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, the survey 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.

Discharge Abstract Database—Canadian Institute for Health Information
The Discharge Abstract Database by the Canadian Institute for Health Information contains information abstracted from hospital records that capture administrative, clinical, and patient demographic data on all hospital in-patient separations, including discharges, deaths, sign-outs, and transfers. The institute receives Ontario data directly from participating facilities, from their respective regional health authorities, or from the Ministry of Health. The database includes patient-level data for acute care facilities in Ontario. Data are collected, maintained, and validated by the institute.

The main data elements of this database are patient identifiers (e.g., name, health card number), patient demographics (e.g., age, sex, geographic location), clinical information (e.g., diagnoses, procedures), and administrative information.

National Ambulatory Care Reporting System—Canadian Institute for Health Information

The National Ambulatory Care Reporting System by the Canadian Institute for Health Information contains data for all hospital- and community-based emergency and ambulatory care, including day surgeries, outpatient clinics, and emergency departments. Data are collected, maintained, and validated by the institute. The institute receives Ontario data directly from participating facilities, from their respective regional health authorities, or from the Ministry of Health. Data are collected, maintained, and validated by the institute.

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, procedures), and administrative information.

Ontario Health Insurance Plan—Ministry of Health

The Ontario Health Insurance Plan (OHIP) claims database covers all reimbursement claims to the ministry 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, dates of service, associated diagnoses, and fees paid. Services missing from OHIP data include some laboratory services, services received in provincial psychiatric hospitals, services provided by health service organizations and other alternative providers, diagnostic procedures performed on an in-patient basis, and laboratory services performed at hospitals (both in-patient and same day). Also excluded is remuneration to physicians through alternative funding plans; this could distort analyses because of their concentration in certain specialties or geographic areas.

Ontario Mental Health Reporting System

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.

QUALITY STANDARDS

Looking for more information?

Visit HQOntario.ca or contact us at QualityStandards@OntarioHealth.ca if you have any questions or feedback about this guide.

Ontario Health
60 Bloor Street West, 5th Floor
Toronto, Ontario
M4W 3B8

Toll Free: 1-877-280-8538
TTY: 1-800-855-0511
Email: QualityStandards@OntarioHealth.ca
Website: HQOntario.ca

ISBN 978-1-4868-6777-6 (PDF)

Ontario Health