QUALITY STANDARDS

Palliative Care

Technical Specifications

2024 UPDATE

Ontario
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How to Use the Technical Specifications

This document provides technical specifications to support the implementation of the *Palliative Care* quality standard. Palliative care for adults with a serious illness is a critical issue, and there are significant gaps and variations in the quality of palliative care that people receive in Ontario. Recognizing this, Ontario Health released the quality standard to identify opportunities that have a high potential for quality improvement.

This document is intended for use by those looking to implement the *Palliative Care* quality standard, including clinicians working in regional or local roles.

This document has dedicated sections to describe the following:

- Indicators that can be used to measure progress toward the overarching goals of the quality standard as a whole
- Statement-specific indicators that can be used to measure improvement for each quality statement within the quality standard

Indicators may be provincially or locally measurable:

- Provincially measurable indicators: how we can monitor the progress being made to improve care at the provincial level using provincial data sources
- Locally measurable indicators: what you can do to assess the quality of care that you provide locally

The following tools and resources are provided as suggestions to assist in the implementation of the *Palliative Care* quality standard:

- The *Getting Started Guide* outlines the process for using quality standards as a resource to deliver high-quality care; it contains evidence-based approaches, as well as useful tools and templates to implement change ideas at the practice level
- Our Spotlight Report highlights examples from the field to help you understand what successful quality standard implementation looks like

Measurement to Support Improvement

This document accompanies Ontario Health's *Palliative Care* quality standard. The Palliative Care Quality Standard Working Group identified 4 overarching indicators to monitor the progress being made to improve palliative care for adults with a serious illness in Ontario. All overarching indicators are provincially measurable (well-defined or validated data sources are available).

The *Palliative Care* quality standard also includes numerous statement-specific indicators that can be used to measure improvement for each quality statement within the quality standard.

Additional information on measuring indicators can be found in the *Quality Standards Measurement Guide*. The measurement guide also includes descriptions of data sources that can be used to support quality standard indicators that are measured consistently across providers, health care sectors, and the province.

Equity Considerations

Ontario Health is committed to promoting health equity and reducing disparities, and encourages collecting data and measuring indicators using equity stratifications that are relevant and appropriate for your population, such as patient socioeconomic and demographic characteristics. These may include age, income, region or geography, education, language, race and ethnicity, gender, and sex. Please refer to *Appendix 3, Values and Guiding Principles,* in the quality standard for additional equity considerations.

Quality Standard Scope

This quality standard addresses palliative care for adults with a serious illness, and for their family and care partners. It focuses on palliative care in all health settings, for all health disciplines, and in all health sectors. It includes information about general palliative care that applies to all health conditions. Palliative care can benefit individuals and their care partners as early as at the time of diagnosis of a serious illness through the end of life and bereavement.

This quality standard includes 13 quality statements. They address areas identified by the Palliative Care Quality Standard Working Group as having high potential for improving the quality of palliative care in Ontario for people with a serious illness.

Cohort Identification

For measurement at the provincial level, information about people who have died and about people who have received palliative care can be identified using administrative data. For local measurement, adults with a serious illness can be identified using local data sources (such as electronic medical records or clinical patient records).

Cohort Identification Using Administrative Data

The cohort for the *Palliative Care* quality standard is people with a serious illness, as well as their family and care partners. However, because of a lack of data sources and existing methodology to identify this population, the indicators selected to measure overall success are calculated based on people who have died in a selected reporting period (e.g., a fiscal year). Some indicators are measured using information from bereaved care partners (see individual indicators for details).

The indicators that accompany statements to guide the measurement of quality improvement are focused mostly on people with identified palliative care needs or on those who receive palliative care services. The cohort of people with identified palliative care needs is not currently measurable at the provincial level; local data collection may be required.

People Who Have Died

The total number of deaths in Ontario can be determined based on records in the following administrative data sets:

- Registered Persons Database: death date in reporting period
- Discharge Abstract Database: discharge_disposition = 07 (prior to 2018/19) or 72, 73, 74 (as of 2018/19)
- National Ambulatory Care Reporting System: visit_disposition = 10, 11 (prior to 2018/19) or 71, 72, 73, 74 (as of 2018/19)
- Ontario Mental Health Reporting System: discharge_reason (X90) = 2 or 3
- National Rehabilitation Reporting System: discharge_reason_code = 8
- Continuing Care Reporting System (complex continuing care and long-term care): discharge_to_facility_type= 11

Applied to specific data sets to exclude sudden deaths and suicides:

- Discharge Abstract Database
  - Sudden death: major clinical category = 19
  - Suicide: discharge_disposition = 67, 74
- National Ambulatory Care Reporting System
  - Sudden death: diagnostic code in S, T, V, W, X, Y
  - Suicide: discharge_disposition = 74
- Ontario Mental Health Reporting System: suicides: X90 = 2

Please refer to the measurement guide for more information on these databases.

People Who Have Died and Were Recipients of Palliative Care Services

The population in Ontario who have died and were recipients of palliative care services can be defined as follows: individuals who died in Ontario and who were designated a palliative care patient or who received any palliative care services in their last 12 months of life.

Note that an individual should be counted only once as a recipient of palliative care if they have multiple records with palliative care designations or palliative care services.

The following steps can be taken to identify the palliative care population or cohort from different data sources:

- Home Care Database (CCM, client care model; SRC, service recipient code)
  - If ADMISSION_DATE is in the last 12 months of life and at least 1 of the following conditions holds: SRC_AT_ADMISSION = 95 or SRC_AT_DISCHARGE = 95 (i.e., a service recipient code of end of life on admission) or RESIDENCE_CODE = 2000 (i.e., staying in a hospice or palliative care unit while receiving service)
  - If DATE_OF_CARE_DELIVERY is in the last 12 months of life and SRC_ASSOCIATED = 95 (i.e., a service care goal of end of life)
  - In the last 12 months of life, a CCM subpopulation of “palliative” or “end of life” at the time of admission, discharge, or service delivery: CCM population = 1 “Adult – Complex” and CCM subpopulation = 3 “Palliative”; or CCM population = 6 “Child – Complex” and CCM subpopulation = 14 “End of Life”
- Resident Assessment Instrument–Home Care: if A1 (i.e., the assessment date) is in the last 12 months of life and at least 1 of the following conditions holds: P2S = 0 or 1 (i.e., hospice care was provided with complete or partial adherence) or CC3F = 1 (i.e., the goal of care is palliative care)
- Resident Assessment Instrument–Contact Assessment: if ASSESS_DATE is in the last 12 months of life and at least 1 of the following conditions holds: B2C = 1 (i.e., a referral to initiate or continue palliative care) or B4 = 12 (i.e., the expected place of stay during service is a hospice facility or palliative care unit)
- Resident Assessment Instrument–Palliative Care: if A13 is in the last 12 months of life
- Continuing Care Reporting System
  - Complex continuing care: if A3_ASSESSMENT_DATE is in the last 12 months of life and P1AO_HOSPICE_CARE = 1 (i.e., the patient received hospice care in last 14 days of assessment)
  - Long-term care: if A3_ASSESSMENT_DATE is in the last 12 months of life and P1AO_HOSPICE_CARE = 1
- Discharge Abstract Database: if ADM_DATE_DATE is in the last 12 months of life and at least 1 of the following conditions holds: DIAG_CODE_[1-25] = Z515 (i.e., any diagnosis of palliative as the main or contributing reason for admission), MAIN_PATIENT_SERVICE = 58 (i.e., the main patient service of palliative care was responsible for care), INT_PROVIDER_SERVICE_[1-20] = 00121 (i.e., an intervention service code of palliative medicine was provided), or PROVIDER_SERVICE_[1–8] = 00121 (i.e., palliative medicine provided the service)
- National Ambulatory Care Reporting System: if REGISTRATION_DATE_DATE is in the last 12 months of life and at least 1 of the following conditions holds: MAIN_PROBLEM = Z515 (i.e.,

a palliative care diagnosis was the main problem for the patient’s visit), OTHER_PROBLEM_[1-9] = Z515 (i.e., a palliative care diagnosis was the contributing problem for the patient’s visit), PROVIDER_SERVICE_[1-8] = 00121 (i.e., a provider service code of palliative medicine), or CONSULT_REQ_SERV_[1-3] = 00121 (i.e., a consult service of palliative medicine was called)

- OHIP: if SERVICE_DATE is in the last 12 months of life and FEE_CODE is:
  - A945 (i.e., special palliative care consultation in clinic, office, or home)
  - B966 (i.e., travel premium for palliative care, billed with B998/B996)
  - B997 (i.e., home visit for palliative care between 24:00 and 07:00), B998 (i.e., home visit for palliative care between 07:00 and 24:00), or C882 (i.e., family medicine palliative care, nonemergency [routine] hospital inpatient service)
  - C945 (i.e., special palliative care consult [minimum 50 minutes]) or C982 (i.e., specialist palliative care, nonemergency [routine] hospital inpatient service)
  - G511 (i.e., telephone services to patient receiving palliative care at home; maximum 2 per week) or G512 (i.e., weekly care case management from palliative primary care management [Monday to Sunday])
  - K023 (i.e., palliative care support in half-hour increments)
  - K700 (i.e., palliative care outpatient case conference)
  - W872 (i.e., family physician palliative care subsequent visit)
  - W882 (i.e., family physician palliative care subsequent visit)
  - W972 (i.e., specialist physician palliative care subsequent visit)
  - W982 (i.e., specialist physician palliative care subsequent visit)

Overarching Indicators That Can Be Measured Using Provincial Data

Indicator 1: Percentage of people who receive care in their last 12 months, 3 months, and 1 month of life

Description

Indicator name: Percentage of people who lived in the community during their last 12 months, 3 months, and 1 month of life and who received at least 1 of the following:

- Home care services (any home care and palliative-specific home care)
- Health care provider home visits (currently only physician home visits are measurable)
- Hospice care (currently not measurable provincially; locally measurable)

Directionality: Higher is better

Measurability: Measurable at the provincial level

Dimension of quality: Patient-centred

Quality statement alignment:

- Quality Statement 2: Timely Access to Palliative Care Support
- Quality Statement 11: Setting of Care and Place of Death

Calculation

Note: The calculation descriptions below include 30 days (1 month) as an example but could be replicated for the last 3 months or 12 months of life.

Denominator

Number of people who died and were in the community in their last 30 days of life

Exclusions

Exclude people who were in an institution for their last 30 days of life. If the sum of the lengths of stay (considering episodes of care in acute inpatient stays) across all institutions during their last 30 days of life equals or exceeds 30 days, the person should be considered to be in an institution for the duration of interest and therefore excluded (*institution* is defined as an acute inpatient hospital, complex continuing care, a long-term care home, inpatient mental health, or inpatient rehabilitation)

Numerator

Number of people in the denominator who in their last 30 days of life received:

- Any home care (Home Care Database, SERVICE variable [i.e., type of home care service provided] = 1–9, 11–13, 15–18):
  - 1 = Nursing – visit
  - 2 = Nursing – shift (hour)
  - 3 = Respiratory services
  - 4 = Nutrition/dietetic
  - 5 = Physiotherapy
  - 6 = Occupational therapy
  - 7 = Speech language therapy
  - 8 = Social work
  - 9 = Psychology
  - 10 = Case management
  - 11 = Personal services (hour)
  - 12 = Homemaking services (hour)
  - 13 = Combined personal services and homemaking services (hour)
  - 14 = Placement services
  - 15 = Respite
  - 16 = Mental health and addiction nursing visit
  - 17 = Nurse practitioner palliative visit
  - 18 = Rapid response nursing visit
  - 99 = Other

- Palliative home care (Home Care Database, any of the codes below)
  - Service_RPC = 95 (service recipient code, service care goal of end of life); patient provided service under end-of-life designation
  - For any service record within the 30 days, consider it palliative if:
    - SRC_admission = 95 (service recipient code [i.e., classification] of end of life on admission)
    - SRC_discharge = 95 (service recipient code of end of life on discharge)
  - A CCM subpopulation of “palliative” or “end of life” at the time of:
    - Admission (using a combination of ADMIT_CCM_POP_CD and ADMIT_CCM_SUBPOP_CD)
    - Discharge (using a combination of DISCH_CCM_POP_CD and DISCH_CCM_SUBPOP_CD)
    - Service delivery (using a combination of CARE_CCM_POP_CD and CARE_CCM_SUBPOP_CD)
    - Note: A CCM subpopulation of “palliative” or “end of life” is defined as the following: CCM population = 1 “Adult- Complex” and CCM subpopulation = 3 “Palliative”; or CCM population = 6 “Child – Complex” and CCM subpopulation = 14 “End of Life”

  - Decedents received 1 or more home services of any type except for 10 and 14 (Home Care Database, SERVICE variable [i.e., type of home care service provided])
    - 1 = Nursing – visit
    - 2 = Nursing – shift (hour)
    - 3 = Respiratory services
    - 4 = Nutrition/dietetic
    - 5 = Physiotherapy
    - 6 = Occupational therapy
    - 7 = Speech language therapy
    - 8 = Social work
    - 9 = Psychology
    - 10 = Case management
    - 11 = Personal services (hour)
    - 12 = Homemaking services (hour)
    - 13 = Combined personal services and homemaking services (hour)
    - 14 = Placement services
    - 15 = Respite
    - 16 = Mental health and addiction nursing visit
    - 17 = Nurse practitioner palliative visit
    - 18 = Rapid response nursing visit
    - 19 = Primary care clinics
    - 20 = Pharmacy
    - 21 = Health promotion education and symptom management
    - 22 = Other combined clinics
    - 23 = Telehomecare
    - 24 = Primary care
    - 99 = Other

- A physician home visit (identified using the following OHIP fee codes):
  - G511: Telephone services to patient receiving palliative care at home
  - B966: Travel premium for palliative care (billed with B998/B996)
  - B998: Home visit for palliative care between 07:00 and 24:00 (Saturday, Sunday, and holidays)
  - B997: Home visit for palliative care between 24:00 and 07:00
  - A901: House call assessment (general practitioner/family physician)
  - B990: Special visit to patient’s home (weekday/daytime or elective home visit)
  - B992: Special visit to patient’s home (weekday/daytime) with sacrifice to office hours, nonelective
  - B993: Special visit to patient’s home (Saturday, Sunday, and holidays) between 07:00 and 24:00, nonelective

  - B994: Special visit to patient’s home, nonelective (weekdays/evenings)
  - B996: Special visit to patient’s home, night-time, first patient of the night
  - A900: Complex house call assessment (general practitioner/family physician)
  - B960: Travel premium – special visit to patient’s home (weekday/daytime or elective home visit)
  - B961: Travel premium – special visit to patient’s home (weekday/daytime), with sacrifice to office hours, nonelective
  - B962: Travel premium – special visit to patient’s home, nonelective, (weekday/evenings)
  - B963: Travel premium – special visit to patient’s home (Saturday, Sunday, and holidays) between 07:00 and 24:00, nonelective
  - B964: Travel premium – special visit to patient’s home, night-time, first patient of the night
  - B986: Travel premium – geriatric home visit, weekdays with or without sacrifice to office hours, or Saturday, Sunday, holidays (07:00 to 24:00) and nights (00:00 to 07:00)
  - B987: Geriatric home visit, nights (00:00 to 07:00)
  - B988: Geriatric home visit, weekdays with or without sacrifice to office hours, or Saturday, Sunday, holidays (07:00 to 24:00)

Method

Numerator ÷ Denominator × 100

Data sources

Continuing Care Reporting System (Long Term Care, Complex Continuing Care), Discharge Abstract Database, Home Care Database, National Ambulatory Care Reporting System, National Rehabilitation Reporting System, Ontario Health Insurance Plan Claims History Database, Registered Persons Database, Ontario Mental Health Reporting System

Limitations

- The data do not show the details or quality of the home care, people’s health care needs or preferences, or the appropriateness of care
- The data show the number of people who have received at least 1 home care service, which may not be sufficient
- There is no evidence for the appropriate amount or mix of home care services to which the data could be compared
- The data do not show whether people had any other home support or a care partner
- People receiving hospice care cannot be identified
- Home visits by non-physician providers are not captured

Comments

This indicator has been reported for 30 days (1 month) and can also be reported for different time frames (e.g., a person’s last 12 months, 3 months)

Indicator 2: Percentage of people who had 1 or more unplanned emergency department visits in their last 12 months, 3 months, and 1 month of life

Description

Indicator name: Percentage of people who had 1 or more unplanned emergency department visits in their last 12 months, 3 months, and 1 month of life

Directionality: Lower is better

Measurability: Measurable at the provincial level

Dimension of quality: Efficient

Quality statement alignment:

- Quality Statement 2: Timely Access to Palliative Care Support
- Quality Statement 11: Setting of Care and Place of Death

Calculation

Note: The calculation descriptions below include 30 days (1 month) as an example but could be replicated for the last 3 months or 12 months of life.

Denominator

Number of people in Ontario who died in the year of interest

Exclusions

- Exclude people who spent their last month in hospital, complex continuing care, or an inpatient rehabilitation facility
- Exclude people who were hospitalized in an acute care facility for the last 30 days of life. If the sum of all episodes of care in acute care facilities during the last 30 days of life equals or exceeds 30 days, the person is considered to have been hospitalized for the duration of interest and is excluded)

Numerator

Number of people in the denominator who had at least 1 unplanned emergency department visit in their last 30 days of life

Inclusions

People who had an unplanned emergency department visit:

- In the National Ambulatory Care Reporting System, unscheduled or unplanned emergency department visits are identified by the variables VISITTYPE = [1,2,4] or SCHEDEDVISIT = N
- Emergency department visits are defined in the National Ambulatory Care Reporting System as visit functional centre = 71310

Exclusions
Planned emergency department visits

Method

Numerator ÷ Denominator × 100

Data sources

Continuing Care Reporting System (Long Term Care, Complex Continuing Care), Discharge Abstract Database, National Ambulatory Care Reporting System, National Rehabilitation Reporting System Ontario Health Insurance Plan Claims History Database, Ontario Mental Health Reporting System, Registered Persons Database

Limitations

- This indicator does not provide information about clinical details, people’s health care needs or preferences, or the appropriateness of the unplanned emergency visits
- This information is difficult to interpret because there are no benchmarks or targets for an acceptable rate of emergency department visits in this population

Comments

- This indicator aligns with provincial measurement initiatives
- This indicator has been reported for 30 days (1 month) and can also be reported for different time frames (e.g., a person’s last 12 months, 3 months)

Indicator 3: Percentage of deaths that occurred in hospitals, long-term care homes, and the community

Description

Indicator name: Percentage of deaths that occurred in:

- Hospitals (acute inpatient care, emergency department, complex continuing care, inpatient rehabilitation; deaths in palliative care beds are currently not provincially measurable)
- Long-term care homes
- The community (may include home, hospice residence, retirement home, or assisted-living home)

Directionality: Not applicable

Measurability: Measurable at the provincial level

Dimension of quality: Patient-centred

Quality statement alignment: Quality Statement 11: Setting of Care and Place of Death

Calculation

Denominator

Number of people in Ontario who died in the year of interest

Numerator

Number of people in the denominator who died in each of the following settings:

- Hospitals (acute inpatient care, emergency department, complex continuing care, inpatient rehabilitation)
- Long-term care homes
- The community (home, hospice residence, retirement home, or assisted-living home)

Inclusions

- Hospital deaths are identified by the following codes:
  - Emergency department: National Ambulatory Care Reporting System, visit_disposition = 10, 11 (prior to 2018/19) or 71, 72, 73, 74 (as of 2018/19)
  - Inpatient: Discharge Abstract Database, discharge_disposition = 07 (prior to 2018/19); or 72, 73, 74 (as of 2018/19)
  - Complex continuing care: Continuing Care Reporting System, discharge_to_facility_type = 11
  - Inpatient Rehabilitation facility: National Rehabilitation Reporting System, discharge_reason_code = 8
  - Inpatient: Ontario Mental Health Reporting System, discharge_reason (X90) = 2 or 3

- Long-term care home deaths are identified by the following code: Continuing Care Reporting System–Long-Term Care, discharge_to_facility_type = 11
- Community deaths are all other deaths (e.g., deaths in home or residential hospice) from the Registered Persons Database in the year of interest that are not included in the above categories

Method

Numerator ÷ Denominator × 100

Data sources

Continuing Care Reporting System (Long Term Care, Complex Continuing Care), Discharge Abstract Database, National Ambulatory Care Reporting System, National Rehabilitation Reporting System, Ontario Health Insurance Plan Claims History Database, Ontario Mental Health Reporting System Registered Persons Database

Limitations

- The data show the location of the death, but not where care was received before death (e.g., death may have occurred in the emergency department, but overall care may have been provided in a long-term care home)
- No information on the preferred place of death is provided
- Deaths in palliative care beds are included in overall hospital deaths, but cannot be identified

Comments

- If there were multiple death records with different death dates in each of the above administrative databases, the last (i.e., the most recent) death record for each unique health card number was selected
- When a patient appears in multiple sources, a hierarchical approach is used to determine the date of death and setting of death. The following order is applied: Discharge Abstract Database, Ontario Mental Health Reporting System, National Ambulatory Care Reporting System, Continuing Care Reporting System Complex Continuing Care, National Rehabilitation Reporting System, Continuing Care Reporting System Long-Term Care, Registered Persons Database
- Setting of death is then assigned based on which data source is selected:
    - Death in hospital (inpatient): Discharge Abstract Database, Ontario Mental Health Reporting System, National Rehabilitation Reporting System, Continuing Care Reporting System Complex Continuing Care
    - Death in the emergency department: National Ambulatory Care Reporting System
    - Death in long-term care: Continuing Care Reporting System Long-Term Care
    - Death in home or residential hospice: Registered Persons Database

Indicator 4: Percentage of care partners who rated the overall care the patient received in their last 3 months of life as excellent

Description

Indicator name: Percentage of care partners who rated the overall care the patient received in their last 3 months of life as excellent

Note: This is the provincially measurable component of the indicator "Percentage of people who receive palliative care (or their care partners) who rated the overall care received in their last 12 months, 3 months, and 1 month of life as excellent."

Directionality: Higher is better

Measurability: Measurable at the provincial level

Dimension of quality: Patient-centred

Quality statement alignment: All quality statements align

Calculation

Note: The calculation descriptions below reflect the last 30 days of life, based on what is provincially measurable. The indicator could be replicated based on local data collection for the last 12 months or 1 month of life.

Denominator

All CaregiverVoice Survey[1] respondents who responded to the survey question below.

Exclusions
Exclude those who answered "Don't know"

Numerator

Survey respondents who answered "Excellent" to the following question: Overall, and taking all services in all settings into account, how would you rate his/her care in the last 3 months of life?

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know

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[1] The Palliative Care Quality Standard Working Group recommended that this indicator measure perception among those receiving palliative care and their care partners, but the CaregiverVoice Survey reflects only the perceptions of care partners and is specific to the last 3 months of life.

Method

Numerator ÷ Denominator × 100

Data source

CaregiverVoice Survey

Limitations

- The CaregiverVoice Survey reflects the perceptions of care partners of people who received home and community care. Survey coverage has varied over time
- This indicator relies on data from bereaved care partners; no data are available from the people who received palliative care

Comments

Data for the CaregiverVoice survey are available up to fiscal year 2020/21; the date of its next release is still to be determined. The survey is currently on pause, awaiting the selection of a new survey vendor.

Past releases reported data only for overall care received in the last 3 months of life. This indicator is provincially measurable for care partners who rated the overall care received in the person's last 3 months of life. Results for this indicator from the perspective of people who received palliative care, or from alternative time frames (12 months and 1 month) may be locally measurable.

Statement-Specific Indicators

The *Palliative Care* quality standard includes statement-specific indicators that are provided as examples; you may wish to create your own quality improvement indicators based on the needs of your population. We recommend that you identify areas to focus on in the quality standard and then use 1 or more of the associated indicators to guide and evaluate your quality improvement efforts.

Quality Statement 1: Identification and Assessment of Needs

Percentage of people with identified palliative care needs who have a documented assessment of their palliative care needs, including physical, psychological, social, linguistic, cultural, legal, ethical, spiritual, and other needs

- Denominator: total number of people with identified palliative care needs
- Numerator: number of people in the denominator who have a documented assessment of their palliative care needs, including physical, psychological, social, linguistic, cultural, legal, ethical, spiritual, and other needs
- Data source: local data collection
- Note: Consider measuring separately by each palliative care need and/or grouping them together as an overall measure

Number of days between receiving first palliative care service and death

- Calculation: can be measured as mean, median, or distribution
- Data sources: Continuing Care Reporting System, Discharge Abstract Database, Home Care Database, National Ambulatory Care Reporting System, Ontario Health Insurance Plan Claims History Database, Registered Persons Database

Evidence of locally adopted tools to:

  - **Identify people in need of palliative care**
  - **Assess their needs**
- Data source: local data collection

Quality Statement 2: Timely Access to Palliative Care Support

Local availability of palliative care support (as defined above) that is accessible 24 hours a day, 7 days a week

- Data source: local data collection

Percentage of people with identified palliative care needs (or their care partners) who state that they are able to receive community palliative care support, including after-hours care, when needed

- Denominator: total number of people with identified palliative care needs (or their care partners)
- Numerator: number of people in the denominator who state that they are able to receive community palliative care support, including after-hours care, when needed
- Data source: local data collection

Quality Statement 3: Advance Care Planning – Substitute Decision-Maker

Percentage of people with identified palliative care needs who know who their future substitute decision-maker is

- Denominator: total number of people with identified palliative care needs
- Numerator: number of people in the denominator who know who their future substitute decision-maker is
- Data source: local data collection
- Similar question available in the CaregiverVoice Survey: "Did your family member/friend know which person would be their substitute decision-maker in case he/she was not able to make decisions about future care?" (Response options: Yes, he/she knew who their substitute decision-maker would be; No, he/she did not know who their substitute decision-maker would be; Don't know)[45,46]

Percentage of people with identified palliative care needs who state that they have shared their wishes, values, and beliefs with their substitute decision-maker regarding the kind of health and personal care they would want to receive in the future

- Denominator: total number of people with identified palliative care needs who know who their substitute decision-maker is
- Numerator: number of people in the denominator who state that they have shared their wishes, values, and beliefs with their substitute decision-maker regarding the kind of health and personal care they would want to receive in the future
- Data source: local data collection
- Similar question available in the CaregiverVoice Survey: "Did he/she have conversations with his/her substitute decision-maker to share their wishes, values, and beliefs about the kind of health and personal care they would want to receive in the future?" (Response options: Yes, he/she had these conversations with their substitute decision-maker; No, he/she did not have these conversations with their substitute decision-maker; Don't know)[45,46]

Quality Statement 4: Goals-of-Care Discussions and Consent

Percentage of people with identified palliative care needs who have documented discussions with a health care professional about their goals of care in their medical record

- Denominator: total number of people with identified palliative care needs
- Numerator: number of people in the denominator who have documented discussions with a health care professional about their goals of care in their medical record
- Data source: local data collection

Percentage of people with identified palliative care needs (or their care partners) who state that discussions with a health care professional about their goals of care helped them to make treatment decisions

- Denominator: total number of people with identified palliative care needs (or their care partners) who had discussions with a health care professional about their goals of care
- Numerator: number of people in the denominator who state that those discussions helped them to make treatment decisions
- Data source: local data collection

Percentage of people with identified palliative care needs (or their care partners) who state that discussions about goals of care with a health care professional happened at the right time

- Denominator: total number of people with identified palliative care needs (or their care partners) who indicate that they had discussions about goals of care with a health care professional
- Numerator: number of people in the denominator who state that those discussions happened at the right time
- Data source: local data collection
- Similar questions available in the CaregiverVoice Survey:
  - “Who introduced the conversation about his/her values and wishes for the kind of health and personal care they would want to receive in the future?” (Response options: Family or friend; His/her family doctor; Palliative care doctor; Nurse practitioner; Oncologist; Other doctor/specialist; Homecare nurse; Hospital nurse; Hospice nurse; Other; Don’t know; This conversation didn’t happen)[45,46]
  - “Did this conversation happen:” (Response options: Too early; Too late; At the right time; Don’t know)[45,46]

Percentage of people receiving palliative care whose informed consent (obtained directly or from the substitute decision-maker) is documented prior to the initiation of a treatment

- Denominator: total number of people who receive palliative care

- Numerator: number of people in the denominator whose informed consent (obtained directly or from the substitute decision-maker) is documented prior to the initiation of a treatment
- Data source: local data collection

Quality Statement 5: Individualized, Person-Centred Care Plan

Percentage of people with identified palliative care needs (or their care partners) who state that they worked together with their health care provider to develop a care plan

- Denominator: total number of people with identified palliative care needs (or their care partners)
- Numerator: number of people in the denominator who state that they worked together with their health care provider to develop a care plan
- Data source: local data collection

Percentage of people with identified palliative care needs (or their care partners) who state that they have had the opportunity to review and update their care plan when they wanted to do so

- Denominator: total number of people with identified palliative care needs (or their care partners) who have a care plan
- Numerator: number of people in the denominator who state that they have had the opportunity to review and update their care plan when they wanted to do so
- Data source: local data collection

Percentage of people with identified palliative care needs who have a documented care plan in their medical record

- Denominator: total number of people with identified palliative care needs
- Numerator: number of people in the denominator who have a documented care plan in their medical record
- Data source: local data collection

Quality Statement 6: Management of Pain and Other Symptoms

Percentage of people who receive palliative care who have documented assessments of their pain and other symptoms in their medical record

- Denominator: total number of people who receive palliative care
- Numerator: number of people in the denominator who have documented assessments of their pain and other symptoms in their medical record
- Data source: local data collection

Locally adopted appropriate tools to assess pain and other symptoms for people with identified palliative care needs

- Data source: local data collection

Percentage of people who receive palliative care (or their care partners) who rate the level of support to relieve their pain and other symptoms as excellent

- Denominator: total number of people who receive palliative care (or their care partners)
- Numerator: number of people in the denominator who rate the level of support to relieve their pain and other symptoms as excellent
- Data sources: local data collection; alternative source is InterRAI [Resident Assessment Instrument] tools
- Similar question available in the CaregiverVoice Survey: "During the last 3 months of his/her life, while he/she was receiving homecare services, what is your assessment of the overall level of support given in the following areas: relief of physical pain, relief of other symptoms?" (Response options: Excellent, Very good, Good, Fair, Poor, Does not apply, Don't know)[45,46]

Quality Statement 7: Psychosocial Aspects of Care

Percentage of people who receive palliative care who have assessments of their psychosocial needs documented in their medical record

- Denominator: total number of people who receive palliative care
- Numerator: number of people in the denominator who have assessments of their psychosocial needs documented in their medical record
- Data source: local data collection

Percentage of people who receive palliative care (or their care partners) who state that they received timely psychosocial support to address their identified mental, emotional, social, cultural, and spiritual needs

- Denominator: total number of people who receive palliative care who had identified psychosocial needs (or their care partners)
- Numerator: number of people in the denominator who state that they received timely psychosocial support to address their mental, emotional, social, cultural, and spiritual needs
- Data source: local data collection
- Note: Consider measuring separately by each type of psychosocial need, or grouping together as an overall measure of psychosocial support

Percentage of people who receive palliative care (or their care partners) who rated the level of support in addressing their psychosocial needs (mental, emotional, social, cultural, and spiritual) as excellent

- Denominator: total number of people who receive palliative care and have psychosocial needs (or their care partners)
- Numerator: number of people in the denominator who rated the level of support in addressing their psychosocial needs (mental, emotional, social, cultural, and spiritual) as excellent

- Data source: local data collection
- Similar question available in the CaregiverVoice Survey: "During the last 3 months of his/her life, while he/she was receiving homecare services, what is your assessment of the overall level of support given in the following areas: spiritual support, emotional support, respect and dignity?" (Response options: Excellent, Very good, Good, Fair, Poor, Does not apply, Don't know)[45,46]
- Note: Consider measuring separately by each type of psychosocial need, or grouping together as an overall measure of psychosocial support

Quality Statement 8: Education for People with a Serious Illness, Substitute Decision-Makers, Families, and Care Partners

Percentage of people with identified palliative care needs (or their care partners) who state that health care professionals helped them understand palliative care and provided information about available resources and supports

- Denominator: total number of people with identified palliative care needs (or their care partners)
- Numerator: number of people in the denominator who state that health care professionals helped them understand palliative care and provided information about available resources and supports
- Data source: local data collection

Percentage of people with identified palliative care needs (or their care partners) who state that a health care professional helped them understand what to expect and how to prepare for each stage of the journey toward the end of life

- Denominator: total number of care partners of people with identified palliative care needs (or their care partners)
- Numerator: number of people in the denominator who state that a health care professional helped them understand what to expect and how to prepare for each stage of the journey toward the end of life
- Data source: local data collection
- Similar question available in the CaregiverVoice Survey: "Did your healthcare providers help you, the caregiver, understand what to expect/how to prepare for his/her death?" (Response options: Yes; No, I was not aware of these services but I would have liked to use them; No, I was not aware of these services but I was not interested anyway; No, I was aware of these services but I was not interested anyway; Not sure)[45,46]

Local availability of resources and tools for health care professionals to provide education about palliative care to patients, families, and care partners

- Data source: local data collection

Quality Statement 9: Care Partner Support

Percentage of people with identified palliative care needs who have a care partner needs assessment documented in their medical record

- Denominator: total number of people with identified palliative care needs who have a care partner
- Numerator: number of people in the denominator who have a care partner needs assessment documented in their medical record
- Data source: local data collection

Percentage of care partners of people who receive palliative care who state that they and their family members receive as much help and support as they need

- Denominator: total number of care partners of people who receive palliative care
- Numerator: number of people in the denominator who state that they and their family members receive as much help and support as they need
- Data source: local data collection
- Similar question available in the CaregiverVoice Survey: "Overall, do you feel that you and your family got as much help and support from homecare services as you needed?" (Response options: Yes, we got as much support as we needed; No, we did not get as much support as we needed though we tried to get more; No, we did not get as much support as we needed, but we did not ask for more)[45,46]

Percentage of care partners who state that, after the patient's death, they talked to someone from health and supportive services or bereavement services about their feelings regarding the illness and death

- Denominator: total number of care partners of people who died of a serious illness
- Numerator: number of people in the denominator who state that, after the patient's death, they talked to someone from health and supportive services or bereavement services about their feelings regarding the illness and death
- Data source: local data collection
- Similar question available in the CaregiverVoice Survey: "Since he/she died, have you talked to anyone from health and supportive services, or from a bereavement service, about your feelings about his/her illness and death?" (Response options: Yes; No, I was not aware of these services but I would have liked to use them; No, I was not aware of these services but I was not interested anyway; No, I was aware of these services but I was not interested anyway; Not sure)[45,46]

Quality Statement 10: Transitions in Care

Percentage of people who receive palliative care whose medical record identifies the member of the care team responsible for care coordination

- Denominator: total number of people who receive palliative care
- Numerator: number of people in the denominator whose medical record identifies the member of the care team responsible for care coordination
- Data source: local data collection

Percentage of people who receive palliative care (or their care partners) who state that they experienced seamless transitions between care settings

- Denominator: total number of people who receive palliative care (or their care partners)
- Numerator: number of people in the denominator who state that they experienced seamless transitions between care settings
- Data source: local data collection
- Similar question available in the CaregiverVoice Survey: “To what extent did he/she experience smooth transitions between all settings of care during the last 3 months of life?” (Response options: Always, Most of the time, Sometimes, Rarely, Never, Don’t know)[45,46]

Quality Statement 11: Setting of Care and Place of Death

Percentage of people with identified palliative care needs who have documentation of their preferred setting of care and place of death in their medical record

- Denominator: total number of people with identified palliative care needs
- Numerator: number of people in the denominator who have documentation of their preferred setting of care and place of death in their medical record
- Data source: local data collection
- Similar questions available in the CaregiverVoice survey:
  - “What was his/her last known preferred place to die?” (Response options: At home; In a hospice; In a hospital; In a long-term care home; In a retirement home; He/she said that he/she did not mind where he/she died; Anywhere except at home; Anywhere except in hospital; Don’t know)[45,46]
  - “Did the health care providers have a record of this preference of where he/she wanted to die?” (Response options: Yes; No; Not sure)[45,46]
- Note: Consider measuring the preferred setting of care and preferred place of death separately

Availability of a survey to capture care partner experience in all care settings (e.g., CaregiverVoice Survey)

- Data source: local data collection

Percentage of people with identified palliative care needs whose medical records indicate that they died in their preferred place of death

- Denominator: total number of people with identified palliative care needs who had their preferred place of death recorded in their care plan
- Numerator: number of people in the denominator who died in their preferred place of death
- Data source: local data collection (similar indicator is currently measured in the Client Health and Related Information System for palliative home care clients)

Percentage of care partners of people who died of a serious illness who think that the person they cared for died in the right place

- Denominator: total number of care partners of people who died of a serious illness
- Numerator: number of people in the denominator who think that the person they cared for died in the right place
- Data source: local data collection
- Similar question available in the CaregiverVoice Survey: "Do you think that he/she died in the right place?" (Response options: Yes; No; Not sure)[45,46]

Quality Statement 12: Interprofessional Team-Based Care

Percentage of people who receive palliative care (or their care partners) who state that they have received care from 2 or more health care providers, such as a physician, nurse, social worker, psychologist, spiritual care provider, volunteer, and others

- Denominator: total number of people who receive palliative care (or their care partners)
- Numerator: number of people in the denominator who state that they have received care from 2 or more health care providers, such as a physician, nurse, social worker, psychologist, spiritual care provider, volunteer, and others
- Data source: local data collection
- Note: The survey respondent will be asked to select all that apply; consider reporting by number and type of health care provider

Percentage of people who receive palliative care (or their care partners) who state that their health care providers work well together

- Denominator: total number of people who receive palliative care (or their care partners) from more than 1 provider
- Numerator: number of people in the denominator who state that their health care providers work well together
- Data source: local data collection

- Similar question available in the CaregiverVoice Survey: “When he/she was at home in the last 3 months of life, did the homecare providers work well together?” (Response options: Yes, definitely; Yes, to some extent; No, they did not work well together; Don’t know)[45,46]

Quality Statement 13: Education for Health Care Providers and Volunteers

Percentage of health care providers and volunteers who provide palliative care who have evidence of receiving palliative care education appropriate to their role

- Denominator: total number of health care providers and volunteers who provide palliative care
- Numerator: number of providers in the denominator who have evidence of receiving palliative care education appropriate to their role
- Data source: local data collection
- Potential stratification: health care providers, volunteers

Percentage of health care providers and volunteers who provide palliative care who state that they have the knowledge and skills to provide palliative care

- Denominator: total number of health care providers and volunteers who provide palliative care
  Numerator: number of people in the denominator groups who state that they have the knowledge and skills to provide palliative care
- Data source: local data collection
- Potential stratification: health care providers, volunteers

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Ontario Health
500–525 University Avenue
Toronto, Ontario
M5G 2L3

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

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@OntarioHealth.ca
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