

# Measuring Up 2019

## Technical Appendix

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# 1. Introduction

Each year, Measuring Up reports on the health of Ontarians and on how Ontario's health system is performing. The technical appendix provides detailed specifications for each of the indicators presented in the report and in the technical supplement. It also includes general information on the indicator selection process, analytical methods, data sources and external review process. This technical appendix accompanies the Measuring Up 2019 report and the technical supplement.

## Indicator selection

This year's Measuring Up report on the performance of the province's health system focuses on a set of 10 key indicators and is based on the Quadruple Aim of health care improvement: better health outcomes, better patient experience, better provider experience, and better value and efficiency. In addition, the report includes supplemental indicators to support and add context to key findings. This technical supplement provides additional data (trend over time, interprovincial and international) for the indicators included in Measuring Up 2019, as well as the results for additional indicators to support the overall understanding of each area of the health system.

## Analysis

### Data over time

For each indicator, we report the data for the most recent year (fiscal year or calendar year) in which the data are complete and scientifically sound (reliable and valid). Where data are available and comparable, we present results over time based on annual, monthly or quarterly data. We report the longest duration available up to a maximum of 15 years. For some indicators, we also note the provincial targets, along with the most recent performance of the corresponding indicator.

### How Ontario performs compared to others

To assess how Ontario's health system performs, we also provide comparisons with other provinces in Canada, where possible. We do not include data for Canadian territories as their population sizes are different from Ontario, and they may not be appropriate comparators.

Where data are available to allow for international comparisons, we typically compare Ontario's performance to other countries using the results of statistical analysis where available. One of the sources for international comparison is the Commonwealth Fund International Health Policy Survey. In addition to Canada, the countries included in the survey are: Australia, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States. These countries have many economic and demographic similarities to Canada and therefore are generally considered to be appropriate comparators. The other source for international comparisons is the Organisation for Economic Co-operation and Development (OECD) data.

## Adjustments (for age, sex and risk)

Where appropriate, indicators are age-adjusted or age- and sex-adjusted to a common population, for example the 2011 Canadian Census population, which is a commonly used standard population. In some cases, indicators are risk-adjusted for other factors (such as comorbidity) that are thought to affect the indicator result. Adjustments are done primarily for the purposes of comparison across geographic regions and over time. For details on which indicators were adjusted and the methodology used, please see the individual indicator technical specifications.

## Data Providers and Data Sources

The indicator results presented in Measuring Up were provided by a variety of data providers, including:

- Canadian Institute for Health Information (CIHI)
- Cancer Care Ontario (CCO)
- Health Shared Services Ontario (HSSO) (formerly known as the Ontario Association of Community Care Access Centres)
- Institute for Clinical Evaluative Sciences (ICES)
- Ministry of Health and Long-Term Care (MOHLTC)
- Ontario Hospital Association (OHA)
- Organisation for Economic Co-operation and Development (OECD)
- Public Health Ontario (PHO)
- Statistics Canada
- The Commonwealth Fund

The data source(s) for each indicator are listed within the individual indicator specifications. More details on the specific data sources used to produce the indicators are noted below. These data sources may be available through more than one data provider.

### Canadian Community Health Survey (CCHS)

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

The CCHS covers the population 12 years of age and older. Residents living on reserves and other Aboriginal settlements in the provinces, full-time members of the Canadian Forces, the institutionalized population, children aged 12-17 that are living in foster care, and persons living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James are excluded from the survey. The CCHS is offered in English and French. To remove language as a barrier in conducting interviews, each of the Statistics Canada Regional Offices recruit interviewers with a wide range of language competencies.

In 2012, CCHS began work on a major redesign project that was completed and implemented for the 2015 cycle. The objectives of the redesign were to review the sampling methodology, adopt a new sample frame, modernize the content and review the target population.

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

### **Canadian Patient Experiences Reporting System (CPERS)**

The Canadian Patient Experiences Reporting System (CPERS) collects standardized patient experience information from participating hospitals across Canada, starting with acute inpatient care. Information from CPERS provides insight into patients' perspectives on the health services they received. This information is used to inform and improve patient-centred care and patient outcomes. CPERS receives data about patient experiences from hospitals or jurisdictions that administer the Canadian Patient Experiences Survey on Inpatient Care (CPES-IC).

### **Client and Caregiver Experience Evaluation (CCEE) Survey**

The CCEE survey interviews publicly funded home care patients (active in-home, discharged in-home, and placement home care patients) about their home care experiences. The purpose is to provide the home care sector with statistically meaningful information and comparable data about patients' experiences when receiving services, and to support the home care sector in identifying gaps, levers and opportunities for quality improvement. National Research Corporation Health (NRC Health) developed the CCEE survey tool in collaboration with Health Shared Services Ontario (HSSO), researchers, Community Care Access Centres (CCACs) and service provider organization members. In Ontario, the survey is conducted in four waves per year in all 14 health regions using Computer Assisted Telephone methodology.

### **Client Profile Database (CPRO)**

The CPRO database contains patient-level application information for individuals placed or waiting to be placed in a long-term care home. The database includes three broad types of information: patient characteristics and location at application, long-term care home choices, and milestone (date) events throughout the long-term care home placement process. The CPRO is the authoritative data source for long-term care home bed demand, patient placement and wait list data. Health Shared Services Ontario submits patient-level data on behalf of each region on a monthly basis to support bed utilization monitoring, performance management and long-term care accountability planning. In the fall of 2016, a modernized CPRO was launched to improve data quality and timeliness. The modernized CPRO includes datasets from April 2012 onward. Data from the CPRO are housed by the Ministry of Health and Long-Term Care.

### **Death Database – Vital Statistics**

The Vital Statistics – Death Database is an administrative survey that collects demographic and medical (cause of death) information annually from all provincial and territorial vital statistics registries on all deaths in Canada. Prior to 2010, some data were also collected on Canadian residents who die in some American states. Starting with the reference year 2010, Canadian residents who die in American states are no longer collected.

The data are used to calculate basic indicators (such as counts and rates) on deaths of residents of Canada. Information from this database is also used in the calculation of statistics, such as cause-specific death rates and life expectancy.

## **Discharge Abstract Database (DAD)**

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

## **Health Care Experience Survey (HCES)**

The HCES is a voluntary telephone survey aimed at Ontarians aged 16 and older and is conducted on a quarterly basis. The HCES asks randomly selected Ontarians: for their views about their health care system, how healthy they are, if they have chronic conditions, if they have a primary care provider (family doctor, nurse practitioner or other health care provider), how long it takes to see their provider, about their experience using the health care system, if they have been to an emergency room or a walk-in clinic, and about their household and demographic characteristics.

People living in institutions or in households without telephones and those with invalid/missing household addresses in the Registered Persons Database (RPDB) are excluded. The Ministry of Health and Long-Term Care uses the information from the survey to understand the experiences of Ontarians with respect to primary care.

## **Home Care Database (HCD)**

The HCD is a clinical, patient-centred database that captures all home care services provided or coordinated by Ontario's health regions, including government-funded home and community services. The HCD is managed by Health Shared Services Ontario (HSSO). It includes patient, intake, assessment, and admission/discharge information as well as information on home care wait times. This information is used to determine the eligibility of patients and the intensity of care coordination, care planning, and services that align with their care needs. Clinical data are collected using standardized interRAI tools, including the Resident Assessment Instrument for Home Care (interRAI-HC).

## **Home Care Reporting System (HCRS)**

The HCRS was created by the Canadian Institute for Health Information (CIHI) to capture data from organizations responsible for providing publicly funded home care services in Canada. The HCRS contains demographic, clinical, functional and resource utilization information on all long-stay (received home care for more than 60 days) individuals who have been accepted into home care programs collected at multiple points throughout their home care services, as well as on individuals who receive an assessment for determining eligibility for placement into long-term care. The information within the HCRS is collected using the InterRAI Resident Assessment Instrument for Home Care (interRAI-HC), which is a standardized, validated and multi-dimensional assessment tool for determining patient needs, measuring changes in clinical status and patient outcomes, and describing relative costs of services and supports that the patient will likely use. The HCRS also contains information on home care organization characteristics to support comparative reporting. Ontario data have been submitted quarterly to CIHI since 2008.

## **Commonwealth Fund (CMWF) International Health Policy (IHP) Survey**

As part of its mandate, the Commonwealth Fund (CMWF) has been conducting the International Health Policy Survey in 11 countries (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States) for more than a decade. In a triennial cycle, the IHP survey targets different populations, including primary care physicians, older adults, and the general adult population. Data for this report are taken from the 2016 and 2019 years of the survey.

The 2016 CMWF study was conducted via landline and mobile telephone in each country with a nationally representative sample of respondents aged 18 and older. Survey data for Canada were weighted by age-by-gender, educational attainment, and phone-status (cell phone only or not) within each of the 10 provinces (Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia). Data were weighted for knowledge of official language within Quebec and Canada as a whole. Additionally, data were then weighted to reflect Canada's overall geographic distribution, by provinces and territories.

- Population parameters were derived from the Canada 2011 Census.
- Phone status was derived from the 2013 Residential Telephone Service Survey (RTSS), for Canada as a whole and for all ten provinces in particular

The 2019 IHP survey was conducted among primary care physicians (PCPs) in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. In the 2019 International Health Policy Survey of Primary Care Physicians, data from each country were weighted to ensure the final outcome was representative of the primary care physician population, based on the population parameters and selected specialty types. The PCP data in Canada were weighted to account for: (1) the over-representation of PCPs in some provinces; (2) the availability of an email address or not (since respondents with email addresses could be contacted both by mail and email); and (3) differential nonresponse along known geographic and demographic parameters. The weighting adjustment was conducted in 2 stages: design weight and stratification weight. Data were weighted by age and gender within Ontario, Quebec and the rest of Canada. Additionally, data were subsequently weighted to reflect Canada's distribution of primary care doctors by province. In this report, we compare Ontario data to the international survey results where possible.

## **National Ambulatory Care Reporting System (NACRS)**

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

## **National Health Expenditure Database (NHEX)**

The NHEX collects, processes, and analyzes summary data on all health spending in Canada from 1975 onwards with health expenditures for the most recent two years being forecasted. Data are extracted manually from various publicly available documents, such as Statistics Canada documents, national and provincial public accounts, and private insurance companies. The NHEX has data on health spending in Canada by spending category (i.e. public and private sectors) and source of funding (e.g. out of pocket, private health insurance, provincial government sector, etc.). National health expenditures in Canada are based on a system of classification consistent with international standards developed by the Organisation for Economic Co-operation and Development (OECD).

## **Narcotics Monitoring System (NMS)**

The Narcotics Monitoring System collects dispensing data on opioids, controlled substances, and other monitored drugs from pharmacies and other dispensaries across Ontario. The information collected in the NMS includes prescriber identification, patient identification, pharmacy and pharmacist identification, date the drug was dispensed, drug identification number and the amount of drug dispensed. The NMS does not include information about monitored drugs dispensed to an inpatient of a public hospital or to prisoners or inmates (i.e., prescriptions written for people confined to correctional institutions, penitentiaries, prisons or youth custody

facilities). The Ministry of Health and Long-Term Care maintains the NMS, which began collecting data in April 2012.

## **OECD Health Statistics**

The OECD is a unique forum where governments work together to address the economic, social and environmental challenges of globalisation. The OECD is also at the forefront of efforts to understand and to help governments respond to new developments and concerns, such as corporate governance, the information economy and the challenges of an ageing population. The Organisation provides a setting where governments can compare policy experiences, seek answers to common problems, identify good practice and work to co-ordinate domestic and international policies. OECD Publishing disseminates widely the results of the Organisation's statistics-gathering and research on economic, social and environmental issues, as well as the conventions, guidelines and standards agreed upon by its members.

## **Ontario Health Insurance Plan (OHIP) Claims Database**

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

## **Ontario Mental Health Reporting System (OMHRS)**

The OMHRS, housed at CIHI, collects information about individuals admitted to designated adult mental health beds in Ontario. The OMHRS includes information on admissions and discharges as well as clinical information. Clinical data are collected using the Resident Assessment Instrument for Mental Health (RAI-MH), a standardized assessment instrument for inpatient mental health care. It includes information about mental and physical health, social support and service use. Data are collected on clients from participating hospitals in Ontario at admission, discharge and every three months for patients with extended stays. Data are available from October 1, 2005 onward. The number of active OMHRS sites has varied between 65 and 74 since the start of the OMHRS in 2005–2006. In the early years of the 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, 2018, the OMHRS database contained 1,299,853 records, representing 702,817 episodes of care from 87 facilities.

## **Ontario Opioid-Related Death Database (OORDD)**

The Ontario Opioid-Related Death Database is a database maintained by the Ontario Drug Policy Research Network that contains detailed information from the Office of the Chief Coroner for Ontario (OCCO) on all opioid-related deaths occurring in Ontario. In Ontario, all deaths that are sudden and unexpected, or unnatural are investigated by the OCCO to ascertain cause and manner of death. Opioid-related deaths were defined by the coroner as those deaths in which post-mortem toxicological analyses revealed opioid concentrations sufficiently high to cause death, or if a combination of drugs (including at least one opioid at clinically significant levels) contributed to death. This database has been abstracted from the OCCO at several points in time with funding from the Canadian Institutes for Health Research (CIHR). In May of 2017 this database was replaced with an in-house electronic data collection system implemented by the OCCO.

## **Registered Persons Database (RPDB)**

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

## **Wait Time Information System (WTIS)**

The Ontario WTIS is maintained by Cancer Care Ontario (CCO) on behalf of the Ministry of Health (MOH). The web-based system collects or maintains data on wait times (including surgical, diagnostic imaging and emergency department wait times) and alternate level of care (ALC) days. The ALC days includes both acute-care and post-acute-care patients.

## **External review**

External peer reviews were obtained for Measuring Up. Subject matter experts, stakeholders and data providers were sent preliminary drafts, which included the full set of indicators and findings. Reviewers were asked to comment on the accuracy of the data and interpretations of the results. The report was revised accordingly.

## 2. Value and Efficiency

### Alternate level of care (ALC) rate

#### Description

This indicator measures the total number of alternate level of care (ALC) days contributed by patients within the specific reporting month/quarter using near-real-time acute and post-acute ALC information and monthly bed census data. A lower rate is better.

#### Reporting tool/product

Public reporting, Quality Improvement Plans (QIPs)

#### **DEFINITION AND SOURCE INFORMATION**

#### Unit of Measurement

Rate per 100 inpatient bed-days

#### Calculation Methods

This indicator is calculated as the numerator divided by the denominator times 100.

Note that only those acute & post-acute facilities submitting both alternate level of care (ALC) data to the Wait Time Information System (WTIS) and Bed Census Summary (BCS) data through the Health Database Web Portal are included in the ALC rate calculation. Any master number that does not have inpatient days reported to the BCS for a given month/quarter will be excluded from reporting for that month/quarter.

#### Numerator

The total number of inpatient days designated as alternate level of care (ALC) in a given time period (i.e., monthly, quarterly, yearly). Inpatient service type is identified in the Wait Time Information System (WTIS).

#### Calculation:

Acute ALC days equals the total number of ALC days contributed by patients waiting in non-surgical, surgical and intensive/critical care beds.

Post-acute ALC days equals ALC days for Inpatient Services in complex continuing care, rehabilitation and mental health beds.

#### Exclusions:

ALC cases discontinued due to 'Data Entry Error'.

ALC cases having Inpatient Service = Discharge Destination for Post-Acute Care (\*exception: Bloorview Rehab, complex continuing care to complex continuing care).

ALC cases identified by the facility for exclusion.

#### Notes:

The day of ALC designation is counted as an ALC day but the date of discharge or discontinuation is not counted as an ALC day.

For cases with an ALC designation date on the last day of a reporting period and no discharge/discontinuation date, ALC days for that period are equal to 1.

The ALC Rate indicator methodology makes the assumption that the Inpatient Service data element (as defined in the WTIS) is comparable to the Bed Type data element (as defined in the Bed Census Summary (BCS)).

### **Denominator**

The total number of inpatient days in a given time period (i.e., monthly, quarterly, yearly).

#### Calculation:

Acute patient days equals the total number of patient days contributed by patients in the following units: medical (MED), surgical (SURG), combined medical and surgical (CMS), intensive care and coronary care (ICU), obstetrics (OBS), paediatric (PAE), child/adolescent mental health (Children MH), acute addiction (Addiction), pediatrics in nursery (Paed Days in Nursery) and newborns.

Post-acute patient days equals the total number of patient days contributed by inpatients in the following units: chronic (Chronic), general rehabilitation (Gen. Rehab), special rehabilitation (Spec. Rehab), acute psych (Acute Psy), addiction (Addiction), forensic (Forensic), psychiatric crisis unit (Crisis Unit) and longer term psychiatric (Long Term).

CCC patient days = the total number of patient days contributed by inpatients in complex continuing care (Chronic) beds.

Rehabilitation patient days = the total number of patient days contributed by inpatients in general rehabilitation (Gen. Rehab) and special rehabilitation (Spec. Rehab).

Mental health patient days = the total number of patient days contributed by inpatients in the following units: acute psych (Acute Psy), addiction (Addiction), forensic (Forensic), psychiatric crisis unit (Crisis Unit) and longer term psychiatric (Long Term).

#### Exclusions:

Patient days contributed by patients in the emergency department.

### **Adjustment (risk, age/sex standardization)**

None

### **Data Source**

Wait Time Information System (WTIS), Bed Census Summary (BCS)

### **Data provided by**

Cancer Care Ontario (CCO)

### **Reported levels of comparability**

Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

The alternate level of care (ALC) rate indicator excludes facilities that are currently not reporting ALC data to the Wait Time Information System (WTIS). WTIS-ALC data are only available beginning in July 2011. The Bed Census Summary (BCS) has a three-month reporting lag. Validation is required to ensure that specific bed types (in the BCS) correspond to those in the WTIS. The information for both the numerator (WTIS) and denominator (BCS) are based on data that are available at a specific point in time. Therefore, rates calculated using these data are subject to change depending on when the calculations are made.

**Comments Summary**

This indicator looks at "bed-days" – a count of the days individual hospital beds were occupied by patients – to measure the percentage of days hospital beds were occupied by patients identified as requiring an alternate level of care (ALC), meaning they did not require the type of care for which the bed was designated. Patients designated ALC are usually waiting for a place elsewhere in the health system that provides the type of care they need, such as a long-term care home or home care. This is a Quality Improvement Plan (QIP) priority indicator for 2019/20. To access your organization's data for the reporting period, refer to the QIP Navigator. Alternatively, hospitals can access ALC reports via the Access to Care website at <https://share.cancercare.on.ca>.

The data do not include the patient population designated Alternate Level of Care at Reactivation Care Centre sites.

## Median number of days waited to move into a long-term care home

### Description

This indicator measures the median number of days residents waited to be placed in a long-term care home from the date of long-term care home application or consent to the date of placement, whichever is longer. A lower number of days is better.

### Reporting tool/product

Public reporting

## **DEFINITION AND SOURCE INFORMATION**

### Unit of Measurement

Days

### Calculation Methods

The median time, in days, for each included placement from the earlier of long-term care home application date or consent date to date of placement. The median is the number of days within which 50% of individuals waited from the date of application or consent to the date of placement.

The median time can be stratified by location of the individual prior to placement (e.g., placed from hospital or placed from community).

The median is calculated for each of the following placements:

#### 1) All placements

##### *Inclusions:*

- Includes residents (includes all priority categories) placed from hospitals (acute, rehab, CCC, etc.), assisted living residences, cluster care residences, group homes, private dwellings, retirement homes, supportive housing and other.

##### *Exclusions:*

- Residents placed from another long-term care home (i.e. residents who were transferred from another long-term care home)
- Residents for whom "Admitted from" and/or "Prior Location Code" is unknown

#### 2) Placed from acute care

##### *Inclusions:*

- All residents (includes all priority categories) placed from acute care hospitals. Does not include residents placed from rehab, CCC, etc.

#### 3) Placed from community

##### *Inclusions:*

- All residents (includes all priority categories) placed from assisted living residences, cluster care residences, group homes, private dwellings, retirement homes and supportive housing.

### Numerator

NA

**Denominator**

NA

**Adjustment (risk, age/sex standardization)**

None

**Data Source**

Modernized Client Profile Database (CPRO Modernized)

**Data provided by**

Ministry of Health and Long-Term Care (MOHLTC)

**Reported levels of comparability**

Time

**OTHER RELEVANT INFORMATION**

**Caveats and Limitations**

The wait time for long-term care placement is measured among individuals who have been placed into long-term care, so does not capture individuals who are waiting for long-term care but die or find alternative arrangements before receiving long-term care home accommodation. This indicator does not include the wait time for individuals transferring from another long-term care home.

**Comments Summary**

This is a system indicator and not an indicator of individual long-term care home performance.

## Average wait time in the emergency department for an inpatient bed

### Description

This indicator measures the average time (hours) between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.

### Reporting tool/product

Public reporting

### DEFINITION AND SOURCE INFORMATION

#### Unit of Measurement

Hours

#### Calculation Methods

The average wait time for an inpatient bed is calculated by dividing total time all admitted patients together waited for inpatient bed by total number of admitted patients. Wait time for an inpatient bed is the time interval between the disposition time and the time the patient is admitted to an inpatient bed or operating room.

#### Inclusion Criteria:

- ED visits with a valid and known registration date/time or triage date/time and a valid and known date/time the patient left the ED or disposition date/time
- Admitted Patients: unscheduled emergency visits with Disposition Codes 06 - 07

#### Exclusion Criteria:

- Scheduled visits to the emergency department, i.e. ED visit indicator is = "0"
- Non-admitted unscheduled emergency visits
- Visits with unknown/invalid Disposition Date/Time (9999)
- Visits with Registration Date/Time and Triage Data/Time both blank/unknown (9999)
- Visits with unknown/invalid Date/Time Patient Left ED (9999)
- Duplicate cases within the same functional centre where all ED data elements have the same values except for Abstract ID number
- Cases where MIS functional centre not under General Emergency Department ('713102000' '723102000' '733102000') or Urgent Care Centre ('713102500' '723102500' '733102500')
- Cases where Time to IPB is greater than or equal to 100,000 minutes (1,666 hours)

#### Numerator

NA

#### Denominator

NA

#### Adjustment (risk, age/sex standardization)

None

**Data Source**

National Ambulatory Care Reporting System (NACRS)

**Data provided by**

Cancer Care Ontario (CCO)

**Reported levels of comparability**

Province, Time

**OTHER RELEVANT INFORMATION****Caveats and Limitations**

1. Only Emergency Room National Ambulatory Initiative (ERNI) participating hospitals are included. 2. Scheduled visits to the ED are excluded from this analysis. 3. This indicator can also be calculated with percentiles, such as the 50th or 90th percentile. 4. Many factors can influence the indicator results, including triage level, patient population and hospital resources.

**Comments Summary**

None

# Frequent users of the emergency department for mental health & addiction

## Description

This indicator measures the percentage of individuals who had four or more emergency room or urgent care centre visits for help with mental health and/or addictions in a 365-day period among those who had at least one ER or UCC visit for mental health and/or addiction in a given year.

## Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

Numerator divided by the denominator times 100

### Numerator

Total number of individuals in the denominator who had at least 4 ED or UCC visits for MHA 365 days prior to their index visit.

**Note:** Each individual has a 365-day look-back period prior to his or her most recent visit in a given year. Therefore, data for two fiscal years is necessary to obtain the data for the numerator.

### Denominator

Total number of individuals who had at least one ED or UCC visit for mental health and/or addictions (MHA) in a fiscal year

**Index visit:** The most recent visit in a fiscal year is the index visit

Inclusions:

1. Emergency Department\* records (Amcare\_Group\_Code = ED)
2. Sex coded as male or female (Sex = M, F)
3. Records with valid age on the index visit
4. Records with either/or

a) MHA as defined by ICD-10-CA codes in the main problem or other problem fields:

- i. Substance-related and addictive disorders: ICD-10-CA: F10–F19, F55, F63.0
- ii. Schizophrenia and other psychotic disorders: ICD-10-CA: F20, F21, F22, F23, F24, F25, F28, F29
- iii. Mood disorders: ICD-10-CA: F30, F31, F32, F33, F34, F38, F39, F53.0, F53.1
- iv. Anxiety disorders: ICD-10-CA: F40, F41, F93.0, F93.1, F93.2, F94.0
- v. Selected disorders of personality and behaviour: ICD-10-CA: F60, F61, F62, F68 (excluding F68.1), F69
- vi. Other disorders: ICD-10-CA: F42, F43, F44, F45, F48.0, F48.1, F48.8, F48.9, F50, F51, F52, F53.8, F53.9, F54, F59, F63 (excluding F63.0), F64, F65, F66, F68.1, F70–F73, F78, F79, F80–F84, F88, F89, F90, F91, F92, F93.3, F93.8, F93.9, F94.1, F94.2, F94.8, F94.9, F95, F98.0, F98.1, F98.2, F98.3, F98.4, F98.5, F98.8, F98.9, F99, O99.3

b) An ED Discharge Diagnosis code as defined by the Canadian Emergency Department Diagnosis Shortlist (CED-DxS) version 2015, mental and behaviour disorders:

- i. Substance-related and addictive disorders: ICD-10-CA: F10.0, F10.3, F11.9, F13.9, F14.9, F15.9, F16.9, F18.9, F19.9
- ii. Schizophrenia and other psychotic disorders: ICD-10-CA: F20.9, F23.9
- iii. Mood disorders: ICD-10-CA: F31.9, F32.9
- iv. Anxiety disorders: ICD-10-CA: F41.9
- v. Selected disorders of personality and behaviour: ICD-10-CA: F60.9
- vi. Other disorders: ICD-10-CA: F48.9, F50.9, F99

\* Includes emergency department, UCC and emergency department mental health service visits.

#### Exclusions:

1. Records with invalid health card number
2. Records with an invalid code for province issuing health card number
3. Records that are dead on arrival (Visit Disposition = 11)
4. Scheduled ED visits (ED\_visit\_indicator = 0)
5. Transfer to and from ED (Transfer from OR Transfer to Type = E)

#### **Adjustment (risk, age/sex standardization)**

Results are adjusted for age/sex using logistic regression

#### **Data Source**

National Ambulatory Care Reporting System (NACRS)

#### **Data provided by**

Ministry of Health and Long-Term Care

#### **Reported levels of comparability**

Time

### **OTHER RELEVANT INFORMATION**

#### **Caveats and Limitations**

This indicator is a starting point to measure appropriate access to community-based mental health and addictions care.

Complete diagnoses in ERs are not always possible and tend to reflect symptoms or problems instead. That means mental health and addiction diagnoses may be under-reported or misreported. In addition, capture of diagnoses depends on the level of detail submitted to the National Ambulatory Care Reporting System.

Addiction- and substance-related visits may be underestimated, as poisonings are not included in the indicator.

This indicator does not include dementia or problems related to brain injuries, such as concussion or stroke.

Individuals of all ages with an ER or UCC visit for mental health and/or addictions are included in this indicator.

#### **Comments Summary**

This indicator belongs to CIHI's Shared Health Priorities portfolio measuring access to mental health and addictions services and to home and community care. More information on this indicator will be available in the Shared Health Priorities Companion Report by CIHI.

## **Total health spending per person**

### **Description**

This indicator measures total spending on health care in dollars per person in a given period of time.

### **Reporting tool/product**

Public reporting

## **DEFINITION AND SOURCE INFORMATION**

### **Unit of Measurement**

Dollars per person

### **Calculation Methods**

Numerator divided by denominator.

### **Numerator**

Total spending on health care, both public and private sources, on medical services and goods, public health and prevention programs and administration in dollars in a given period of time.

Total health spending can also be stratified by its two sectors: public spending and private spending. Public spending on health care is government spending on health care. Private spending on health care is private health insurance and out-of-pocket expenses. Together, public and private spending on health care make up total spending on health care.

### **Denominator**

The most recent revised population estimates from the Demography Division of Statistics Canada

### **Adjustment (risk, age/sex standardization)**

To compare spending over time in Ontario, constant (1997) dollars are used to adjust for both population growth and inflation, which varied over time. To compare spending levels between countries, Purchasing Power Parities (PPPs), which are the rates of currency conversion that equalize the purchasing power of different currencies, is used to eliminate differences in price levels between countries. Health spending per person is converted to a common currency (US dollar) and adjusted to take account of differences in the purchasing power of the national currencies.

### **Data Source**

OECD Health Statistics, National Health Expenditure Database (NHEX)

### **Data provided by**

Canadian Institute for Health Information (CIHI), Organisation for Economic Co-operation and Development (OECD)

### **Reported levels of comparability**

International comparison, Province, Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

OECD member countries are asked to report health spending according to concepts presented in the OECD manual A System of Health Accounts (SHA). Countries are at varying stages of reporting total health spending

according to the boundary of health care proposed in the SHA manual. That means data presented in OECD Health Statistics 2018 are at the varying levels of comparability. This indicator most closely follows the health care boundaries proposed in the SHA and is believed to be fairly comparable, although some deviations from SHA definitions may still exist among sub-categories.

**Comments Summary**

The data are obtained from National Health Expenditure Database (NHEX) or OECD database i.e. they are not calculated by Ontario Health.

# Percentage of emergency department visits as first point of contact for mental health and addictions care for children and youth

## Description

This indicator measures the percentage of children and youths who did not receive mental health care from a family doctor, pediatrician or psychiatrist over the preceding two years, among children and youths aged 0 to 24 years who visited the emergency department for a mental illness or addiction.

## Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

Numerator divided by the denominator times 100

### Numerator

Number of children and youths (0 to 24 years) without any mental health and addictions (MHA)- related service contact in a 2-year look-back period; includes only those who did not have an MHA-related outpatient visit to a psychiatrist, pediatrician or general practitioner/family physician, or an MHA-related emergency department (ED) visit (scheduled or unscheduled), or an MHA-related hospitalization, in the 2 years preceding the index ED visit

Exclusions: (apply to both numerator and denominator):

1. Invalid IKN
2. Missing sex
3. Non-Ontario resident
4. Planned or scheduled ED visits

### Denominator

Number of children and youths with an incident (first in a calendar year) unscheduled emergency department visit for MHA

### Adjustment (risk, age/sex standardization)

Age- and sex-standardized to the 2006 Ontario census population

### Data Source

National Ambulatory Care Reporting System (NACRS), Ontario Health Insurance Plan (OHIP) Claims History Database, Ontario Mental Health Reporting System (OMHRS), Registered Persons Database (RPDB), Discharge Abstract Database (DAD)

### Data provided by

Institute for Clinical Evaluative Sciences (ICES)

### Reported levels of comparability

Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

Limitations include potential coding errors and a lack of clinical detail. The data do not capture MHA-related care provided in the community by non-physicians (e.g., nurse practitioners, psychologists, and social workers).

### **Comments Summary**

None

# Percentage of emergency department visits as first point of contact for mental health and addictions care for adults

## Description

This indicator measures the percentage of people who did not receive mental health care from a family doctor or psychiatrist over the preceding two years, among people aged 16 and older who visited the emergency department for a mental illness or addiction.

## Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

Numerator divided by the denominator times 100

### Numerator

Number of adults without any mental health and addictions (MHA)- related service contact in a 2-year look-back period; includes only those who did not have an MHA-related outpatient visit to a psychiatrist or a general practitioner/family physician, or an MHA-related emergency department (ED) visit (scheduled or unscheduled), or an MHA-related hospitalization in the 2 years preceding the index ED visit

Exclusions: (apply to both numerator and denominator):

1. Invalid IKN
2. Missing sex
3. Age: <16,>105
4. Non-Ontario resident
5. Planned or scheduled ED visits

### Denominator

Number of adults with an incident (first in a calendar year) unscheduled ED visit for MHA

### Adjustment (risk, age/sex standardization)

Age- and sex-standardized to the 2006 Ontario census population

### Data Source

National Ambulatory Care Reporting System (NACRS), Ontario Health Insurance Plan (OHIP) Claims History Database, Ontario Mental Health Reporting System (OMHRS), Registered Persons Database (RPDB), Discharge Abstract Database (DAD)

### Data provided by

Institute for Clinical Evaluative Sciences (ICES)

### Reported levels of comparability

Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

Limitations include potential coding errors and a lack of clinical detail. The data do not capture MHA-related care provided in the community by non-physicians (e.g., nurse practitioners, psychologists, and social workers).

### **Comments Summary**

None

# Emergency department visits for conditions people thought could have been treated by their primary care provider

## Description

This indicator measures the percentage of people with a regular primary care provider who reported in a survey that the last time they went to the emergency department, it was for a condition that they thought could have been treated by their primary care provider if that provider had been available. It includes only patients aged 16 and older who visited the emergency department in the previous 12 months. A lower percentage is better.

## Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

The indicator is calculated as numerator divided by denominator times 100

### Numerator

The weighted number of survey respondents who reported that the last time they went to the emergency department, it was for a condition that they thought could have been treated by their primary care provider if that provider had been available.

The last time you went to the emergency department, was it for a condition that you think could have been treated by your provider if he or she had been available?

- yes
- no
- don't know
- refused

### Denominator

Weighted number of survey respondents who reported having a primary care provider and visiting the emergency department because they were sick or had a health-related problem in the last 12 months.

Survey Question: Have you been to an emergency department because you were sick or for a health related problem in the last 12 months?

- yes
- no
- don't know
- refused

Exclusions:

- Respondents without a regular doctor/place of care and those who had not used the emergency department in the last 12 months.
- Respondents who answered "don't know" or "refused" to the above survey question

### Adjustment (risk, age/sex standardization)

None

### Data Source

Health Care Experience Survey (HCES)

**Data provided by**

Ministry of Health and Long-Term Care (MOHLTC)

**Reported levels of comparability**

International comparison, Province, Time

**OTHER RELEVANT INFORMATION****Caveats and Limitations**

Only people aged 16 years and older can complete the survey. People living in institutions or in households without telephones, and those with invalid/missing household addresses in the Registered Persons Database (RPDB) are excluded. Respondents who were unable to speak English or French or were not healthy enough (physically or mentally) to complete the interview were not surveyed. Data are based on self-reported information, whereby responses cannot be validated with respect to context and severity of or reason for visiting the emergency department instead of one's primary care provider nor actual availability of the regular primary care provider.

**Comments Summary**

The results are weighted to account for the design characteristics of the survey and post-stratified by age and sex to reflect the Ontario population. In addition, the regional and community weighting is applied. In the Measuring Up report the international and provincial comparisons are reported as well. The education stratification analysis is done among those aged 25 and older. Urban/rural status is defined using Statistics Canada's Statistical Area Classification. Household income analysis does not consider the household composition.

# Average length of stay for patients in the emergency department

## Description

This indicator measures the average time (hours) that patients can expect to spend in the emergency department (ED) waiting for and receiving treatment. The ED length of stay (LOS) is calculated as the average time interval between the earlier of triage date/time and registration date/time, and the date/time when a patient is admitted to the hospital or discharged from the ED (non-admitted patients). A lower number is better. Provincial targets have been set for the maximum amount of time patients should spend in the ED, waiting and being treated, before being discharged or admitted to the hospital, based on clinical evidence.

## Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Hours

### Calculation Methods

The average time spent in ED is calculated by dividing the total time patients spent in the ED by the total number of ED visits.

### Inclusion Criteria:

- ED visits with a valid and known registration date/time or triage date/time and a valid and known date/time patient left the ED or disposition date/time
- Admitted Patients: unscheduled emergency visits with Disposition Codes 06 - 07
- Non-admitted Patients with CTAS level 1-5: unscheduled emergency visits with Disposition Codes 01, 03-05, 08-15

### Exclusion Criteria:

- Scheduled visits to the emergency department
- ED visits with Visit Disposition 02 (Left without being seen or triaged)
- Visits with both unknown/invalid registration and triage date/time OR with unknown/invalid patient left ED date/time
- Negative ER LOS (i.e. the registration or triage date/time is after the date/time that the patient left ER)
- Duplicate records within the same functional centre
- Detailed exclusion based on the year of data:

### From July 2015 onwards:

- Cases where Registration date/time and Triage date/time are both blank/unknown (9999)
- Cases where the MIS functional centre not under General Emergency Department ('713102000' '723102000' '733102000') or Urgent Care Centre ('713102500' '723102500' '733102500') - as of January 2015 data
- Duplicate cases within the same functional centre where all ED data elements have the same values except for Abstract ID number
- Cases where ED visit indicator is = "0" (i.e. scheduled ED visit)
- Cases where Patient Left ED date/time are blank/unknown (9999)
- Cases where patient has left without being seen by a physician during his/her visit (Disposition Code 02 or 03)

- Cases where EDLOS is greater than or equal to 100,000 minutes (1,666 hours) April 2013 to June 2015:
- Cases where Registration date/time and Triage date/time are both blank/unknown (9999)
- Cases where the MIS functional centre not under General Emergency Department ('713102000' '723102000' '733102000') or Urgent Care Centre ('713102500' '723102500' '733102500') - as of January 2015 data
- Duplicate cases within the same functional centre where all ED data elements have the same values except for Abstract ID number
- Cases where ED visit indicator is = "0" (i.e. scheduled ED visit)
- Cases where Patient Left ED date/time are blank/unknown (9999)
- Cases where patient has left without being seen by a physician during his/her visit (Disposition Code 02 or 03)
- Cases where EDLOS is greater than or equal to 100,000 minutes (1,666 hours) From FY 11/12 to FY 12/13:
- Cases where Patient Left ED Date/Time and Disposition Date/Time are both blank/unknown (9999)
- Cases where Registration Date/Time and Triage Date/Time are both blank/unknown (9999)
- Cases where patients over the age of 125 on the earlier of triage or registration date
- Duplicate cases within the same functional center where all ER data elements have the same values except for Abstract ID number
- Cases where Scheduled Visit Indicator flag is = "Y" (i.e. scheduled ED visit)
- Cases where Patient left ED date/time is unknown or blank and the Disposition Code is 06-09, 12, 14 (admitted and transferred patients)
- Cases where patient has left without being seen by a physician during his/her visit (Disposition Code 02 or 03)
- Cases where EDLOS is greater than or equal to 100,000 minutes (1,666 hours)

**Numerator**

NA

**Denominator**

NA

**Adjustment (risk, age/sex standardization)**

None

**Data Source**

National Ambulatory Care Reporting System (NACRS)

**Data provided by**

Cancer Care Ontario (CCO)

**Reported levels of comparability**

Time, Acuity Level

**OTHER RELEVANT INFORMATION**

**Caveats and Limitations**

1. Only Emergency Room National Ambulatory Initiative (ERNI) participating hospitals are included. 2. Scheduled visits to the ED are excluded from this analysis. 3. Patients who registered in ED but left without being seen or triaged are not included in the analysis. 4. For non-admitted patients, patients who left without being seen or treatment and who left after triage and initiation of treatment are included in the analysis. 5. This

indicator can also be calculated with percentiles, such as the 50th or 90th percentile. 6. Many factors can influence the indicator results, including triage level, patient population and hospital resources. 7. Depending on the acuity of the case or hospital procedures, triage may occur before registration or vice versa. Therefore, the earlier of these 2 events is used as the starting point for calculation of this indicator.

**Comments Summary**

None

## 3. Patient Experience

### Satisfaction with time to primary care appointment

#### Description

This indicator measures the percentages of people aged 16 and older who said that the length of time they waited to an appointment with their health care provider when sick was either “about right,” “somewhat long,” or “much too long.”

#### Reporting tool/product

Public reporting

### DEFINITION AND SOURCE INFORMATION

#### Unit of Measurement

Percentage

#### Calculation Methods

Numerator divided by denominator times 100

#### Numerator

Weighted number of survey respondents who reported that the length of time they waited to an appointment with their health care provider when they were sick was either “about right,” “somewhat long,” or “much too long.”

Survey question:

Would you say the length of time it took between making the appointment and the actual visit was about right, somewhat too long, or much too long?

- about right
- somewhat too long
- much too long
- other (e.g., if they felt it was too short)
- don't know
- refused

#### Denominator

Weighted number of survey respondents who stated that they saw their primary care provider or someone else in the office when they were sick or were concerned that they had a health problem.

Did you actually see your provider or someone else in their office?

- yes saw own doctor
- yes saw someone else in office
- saw both provider and someone else (and others)
- no
- don't know
- refused

Exclusion:

Respondents who answered "don't know" or "refused" to the above survey question

#### Adjustment (risk, age/sex standardization)

None

**Data Source**

Health Care Experience Survey (HCES)

**Data provided by**

Ministry of Health and Long-Term Care (MOHLTC)

**Reported levels of comparability**

Time

**OTHER RELEVANT INFORMATION**

**Caveats and Limitations**

Only people aged 16 years and older can complete the survey. People living in institutions, in households without telephones, and those with invalid/missing household addresses in the Registered Persons Database (RPDB) are excluded. Respondents who were unable to speak English or French or were not healthy enough (physically or mentally) to complete the interview were not surveyed. Respondents that were away; had non-residential numbers; out-of-service numbers were not included as well.

**Comments Summary**

The results are weighted to account for the design characteristics of the survey and post-stratified by age and sex to reflect the Ontario population. In addition, the regional and community weighting is applied. In the Measuring Up report the international and provincial comparisons are reported as well. The education stratification analysis is done among those aged 25 and older. Urban/rural status is defined using Statistics Canada's Statistical Area Classification. Household income analysis does not consider the household composition.

## **Emailing provider with a medical question**

### **Description**

Percentage of people in Ontario aged 16 and older who have a primary care provider and who reported that in the last 12 months they had emailed their provider with a medical question

### **Reporting tool/product**

Public reporting

## **DEFINITION AND SOURCE INFORMATION**

### **Unit of Measurement**

Percentage

### **Calculation Methods**

Numerator divided by the denominator times 100

### **Numerator**

Weighted number of survey respondents who responded "Yes" to following question: In the last 12 months, have you emailed your provider with a medical question?

### **Denominator**

Weighted number of respondents who reported having a primary care provider

### **Adjustment (risk, age/sex standardization)**

None

### **Data Source**

Health Care Experience Survey (HCES)

### **Data provided by**

Ministry of Health and Long-Term Care (MOHLTC)

### **Reported levels of comparability**

Province, International comparison, Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

Only people aged 16 years and older can complete the survey. People living in institutions, in households without telephones, and those with invalid/missing household addresses in the Registered Persons Database (RPDB) are excluded. Respondents who were unable to speak English or French or were not healthy enough (physically or mentally) to complete the interview were not surveyed. Respondents that were away; had non-residential numbers; out-of-service numbers were not included as well.

### **Comments Summary**

The results are weighted to account for the design characteristics of the survey and post-stratified by age and sex to reflect the Ontario population. In the Measuring Up report the international and provincial comparisons are reported as well. The education stratification analysis is done among those aged 25 and older. Urban/rural status is defined using Statistics Canada's Statistical Area Classification. Household income analysis does not consider the household composition.

International comparisons are reported in the Measuring Up report using the 2016 Commonwealth Fund International Health Policy Survey of Adults question: “In the last two years, have you emailed your regular practice/GP practice/GP surgery with a medical question?” The CMWF question denominator is adults aged 18 and older and who reported having a regular place or doctor where they usually go to for their medical care.

## Home care clients involved in developing their care plan

### Description

This measures the percentages of publicly funded home care clients, of all ages, who strongly agreed, somewhat agreed, neither agreed nor disagreed, somewhat disagreed, or strongly disagreed that they felt involved in developing their home care plan.

### Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

Numerator divided by the denominator times 100

### Numerator

The number of respondents who responded, given a five-point Likert scale, to the survey question: "Thinking about the planning of your care, please tell me whether you agree or disagree with the following statements: I felt involved in developing my plan".

### Denominator

The total number of responses to the statement minus the total number of responses not applicable to these questions.

### Inclusions:

#### General Survey Inclusion Criteria:

All unique active or discharged clients receiving in-home services and discharged clients to placement in one of the following categories during the specified time period:

- admission final
- withdrawn, interim became final
- withdrawn, placement by other Local Health Integration Network (LHIN)
- refused bed.

### Exclusions:

#### Excludes clients who received:

- In-school service only
- Nursing clinic services
- Respite services
- Medical supplies and equipment
- End-of-life clients (SRC 95)
- Clients not yet categorized (SRC 99)
- In-home clients classified as out of region
- Convalescent care clients

Other exclusions: Home care clients with hospital or death discharges; clients on hold in hospital; clients with a claim against the LHIN or before the Ontario Health Services Appeal and Review Board.

Question-specific exclusion criteria: Respondents are excluded if they did not know the case manager or have not seen or spoken to the case manager, do not recall the in-home service, or were surveyed about placement services.

**Adjustment (risk, age/sex standardization)**

None

**Data Source**

Client and Caregiver Experience Evaluation (CCEE) Survey

**Data provided by**

Health Shared Services Ontario (HSSO)

**Reported levels of comparability**

Time

**OTHER RELEVANT INFORMATION**

**Caveats and Limitations**

Several types of home care clients and services are excluded (e.g. end-of-life clients, respite services, nursing clinic services), suggesting these results cannot be widely applied to all home care clients and all home care services. Caregivers were surveyed in place of clients in the event any of the following criteria were met:

- 1) Client is <19 years of age at time of sample selection
- 2) Client is identified as cognitively incapable
- 3) Client is discharged from placement with one of the four discharge dispositions listed under the General Survey Inclusion Criteria.

Surveying may be done while a person is still a home care client. They may feel like they cannot respond honestly because of risk to their services. This is mitigated by the survey not being conducted by the provider.

**Comments Detailed**

The survey is intended to be an ongoing evaluation tool, with four sample waves conducted annually in each region. The survey population comprises individuals who have received publicly funded home care services. Both active and discharged clients are included in the survey population. A minimum of 1,000 respondents are to be surveyed in each health region over the period of a year. Some health regions have chosen to conduct over 1,500 surveys per year. For each health region, samples are based on a random selection of clients from either proportionate or disproportionate strata, depending on plans developed with the health region. Strata may include: service level, geographic region, service type and/or provider (e.g., nursing, homemaking care, physiotherapy, etc.).

**Footnotes**

The term "client" is used in public reporting to denote an individual who received home care services. Other organizations may use the term "patient". Both terms refer to the same home care recipients.

## **Distress among informal caregivers of home care clients**

### **Description**

This indicator measures the percentage of long-stay home care clients, of all ages, whose primary informal caregiver experienced distress, anger or depression in relation to their caregiving role. It includes only clients who had at least one unpaid informal caregiver. A lower percentage is better.

### **Reporting tool/product**

Public reporting

### **DEFINITION AND SOURCE INFORMATION**

#### **Unit of Measurement**

Percentage

#### **Calculation Methods**

Numerator divided by the denominator times 100

#### **Numerator**

The number of clients with informal caregivers who reported distress, anger or depression in relation to their caregiving role or were unable to continue in caring activities.

The following data elements are used:

- G2a A caregiver is unable to continue in caring activities
- G2c Primary caregiver expresses feelings of distress, anger or depression.

#### **Denominator**

The number of home care clients with at least one informal caregiver.

The following data elements are used:

- G1ea (primary informal caregiver) lives with client. An informal caregiver ("caregiver") may be a family member, friend or neighbour (but not a paid provider) who helps the home care client with activities of daily living, such as meal preparation, housework, transportation, bathing and dressing, or who provides advice or emotional support to the client.

#### **General Exclusion Criteria:**

To prevent capturing outcomes that result from the care received outside of the home care setting, assessments are excluded according to the following criteria:

- if case open date is missing and Reason for Assessment is "Initial Assessment"
- if the assessment took place within 60 days of when the referral was first received/case open date
- if the assessment was completed in a hospital setting

#### **Adjustment (risk, age/sex standardization)**

None

#### **Data Source**

Home Care Reporting System (HCRS)

#### **Data provided by**

Canadian Institute for Health Information (CIHI)

#### **Reported levels of comparability**

Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

The results are derived from interRAI-HC assessment information in the HCRS database. Therefore, the results are representative of long-stay home care clients receiving publicly funded home care (i.e., home care clients who require care for more than 60 days represent approximately half of publicly funded home care clients. The remaining population are short-stay home care clients who require short-term care while they recover from injury or surgery.)

Distress, anger, or depression and ability to continue providing care are subjective measures. Results may underestimate true rates of distress if some informal caregivers do not want to admit that they feel burdened by having to care for a friend or family member or if they do not exhibit obvious signs of distress. Similarly, cultural differences exist that can affect one's perception of distress caused by caring for a friend or family member since it is simply accepted as something that should be done, regardless of the stress it may cause. Includes clients of varying levels of complexity, including palliative patients.

### **Comments Summary**

Data are based on information from mandatory Resident Assessment Instrument - Home Care (interRAI-HC) assessments.

## **Access to viewing online or downloading health information**

### **Description**

Percentage of adults, with a regular place or doctor for their medical care, who are 18 and older who have viewed online or downloaded their health information in the last two years

### **Reporting tool/product**

Public reporting

## **DEFINITION AND SOURCE INFORMATION**

### **Unit of Measurement**

Percentage

### **Calculation Methods**

Numerator divided by the denominator times 100

### **Numerator**

Weighted number of survey respondents who answered “Yes” to the question: “In the last two years, have you viewed online or downloaded your health information, such as your tests or laboratory results?”

### **Denominator**

Total weighted number of respondents who reported having a regular place or doctor where they usually go to for their medical care

### **Adjustment (risk, age/sex standardization)**

None

### **Data Source**

Commonwealth Fund International Health Policy Survey, 2016

### **Data provided by**

Social Science Research Solutions (SSRS)

### **Reported levels of comparability**

International comparison, Province

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

The data are self-reported. The type of health information (e.g. lab test results, or electronic medical records, immunization records, medication and prescription history, referrals to specialist care, etc. cannot be determined in the indicator results. The device type (e.g. mobile, tablet, PC, or laptop) used to access digital health information is unavailable. The question also does not determine the source provider (e.g. regular place of care, province, health region, lab testing company, etc.) of the electronic health information.

### **Comments Summary**

Survey data for Canada were weighted by age-by-gender, educational attainment, and phone-status (cellphone only or not) within each of the ten largest provinces. Data were weighted for knowledge of official language within Quebec and Canada as a whole. Additionally, data were then weighted to reflect Canada’s overall geographic distribution, by provinces and territories.

# People who received enough information about what to do when leaving hospital

## Description

This indicator measures the percentage of discharged patients who responded positively to the following question: “Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?”

## Reporting tool/product

Public reporting, Quality Improvement Plans (QIPs)

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

The percentage is calculated as: numerator divided by denominator multiplied by 100.

Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey—Inpatient Care (CPES) Question 38: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?

- Completely
- Quite a bit
- Partly
- Not at all

For patient experience questions, a “Top-box” method is recommended: Add the number of respondents who responded “Completely” and divide by number of respondents who registered any response to this question (do not include non-respondents).

### Numerator

Number of respondents who responded "Completely"

### Denominator

Number of respondents who registered any response to this question.

Exclusions:

- Non-respondents

### Adjustment (risk, age/sex standardization)

None

### Data Source

Canadian Patient Experiences Survey-Inpatient Care (CPES-IC)

### Data provided by

Canadian Institute for Health Information (CIHI)

### Reported levels of comparability

Time

## **Median time waited by clients between application for home care services or hospital discharge and first service**

### **Description**

This is the median number of days that new clients of publicly funded home care, who are 19 years or older, waited for home care. It is measured from a request for services to their first home visit for those who applied in the community, or from hospital discharge to their first home visit for those who applied in the hospital. A lower number of days is better. The median is the midpoint of days waited; half the clients waited shorter times, half waited longer times. Services include nursing (administering medication and changing dressings), and personal support for complex needs (such as assistance with bathing and eating).

### **Reporting tool/product**

On-Line Public Reporting, Public Reports (annual report, bulletins and theme reports)

### **DEFINITION AND SOURCE INFORMATION**

#### **Unit of Measurement**

Days

#### **Calculation Methods**

The wait time is calculated as the number of days between two time points.

Calculation:

1. Select service date for the time period of interest
2. Identify client eligibility for home care
3. Determine if the application was from community or hospital using the Intake Referral Source
4. Calculate the number of days between application date and first non-case management service date
5. Calculate the median number of days between the application date and the first non-case management service date

#### **Numerator**

Wait time, in days, between application/discharge and first service

Inclusion Criteria:

1. In-Home Program includes requested programs being In-home (01); in Adult Day Care (05); or in Supportive Housing (06)
2. Eligible clients: Assessment Outcome EQUAL TO (12) Eligible client admitted to in-home services; (15) Eligible for long-term care (LTC); or (16) Eligible in-home plus other services
3. Community clients (based on Step 3 of the calculation above)

Exclusion Criteria:

1. Community referrals (School, LTC placement and other programs)
2. Home care episodes with calculated wait time less than 0 days or more than 365 days
3. Episodes with only a case management service.

#### **Denominator**

NA (No denominator because value will be given as a median)

#### **Adjustment (risk, age/sex standardization)**

NA

#### **Data Source**

Client Health and Related Information System (CHRIS), Home Care Database (HCD)

**Data provided by**

Health Shared Services Ontario (HSSO), Ministry of Health and Long-Term Care (MOHLTC)

**Reported levels of comparability**

Time, Discharge location, Service type

**OTHER RELEVANT INFORMATION****Caveats and Limitations**

Only applies to new home care clients. There could be wait lists in place in some health regions which would affect the performance in a specific period since the clients will not be counted until the service is delivered. Each case is reported under the fiscal year and quarter in which the client received their first home care service. Approximately 3% of records per fiscal year are dropped due to invalid (less than 0 days) or implausible (more than 365 days) wait times.

**Comments Summary**

The term "client" is used in public reporting to denote an individual who received home care services. Other organizations may use the term "patient". Both terms refer to the same home care recipients.

## **Patients whose surgery was completed within the target wait time**

### **Description**

This indicator measures the percentage of patients whose surgery was completed within the access target for the surgical service area/surgery being reported. This wait time represents the time, in days, from when the patient and surgeon decides to proceed with surgery to having the surgery completed. In this case, the higher the percentage completed the better. The surgical service area/surgery reported in Measuring Up includes general surgeries, cancer surgeries, and hip and knee replacement surgeries.

Patients are assigned a priority level for their surgery by the physician based on clinical evidence.

### **Reporting tool/product**

Public reporting

## **DEFINITION AND SOURCE INFORMATION**

### **Unit of Measurement**

Percentage

### **Calculation Methods**

Numerator divided by the denominator times 100

### **Numerator**

Number of patients in the denominator whose surgery or procedure was completed within the provincial target wait time.

### **Denominator**

All patients whose surgery or procedure was completed and met the criteria below to be included.

#### **Inclusions:**

- All closed wait list entries with procedure dates within the reporting period.
- For adult surgical procedures, patients that are 18 years and older on the day the procedure was completed.
- For cancer procedures, only treatment cancer procedures.
- Patients assigned as Priority Level 2 - 4 for surgery (Wait 2)

#### **Exclusions:**

- Diagnostic, Palliative and Reconstructive cancer procedures
- Procedures on Skin - Carcinoma, Skin-Melanoma, and Lymphomas
- Procedures no longer required cases
- Patients assigned as Priority Level 1 for surgery (Wait 2)
- Wait list entries identified by hospitals as data entry errors

**Adjustment (risk, age/sex standardization)**

None

**Data Source**

Wait Time Information System (WTIS)

**Data provided by**

Cancer Care Ontario (CCO)

**Reported levels of comparability**

Priority level, Time

**OTHER RELEVANT INFORMATION****Caveats and Limitations**

1. This indicator is collected for patients who have undergone their surgery. That is, patients who are still waiting are not included in the calculation. 2. This indicator is reported not at the surgeon level but rather at the level of the facility where the procedure took place. 3. Ninety among 114 surgical facilities in Ontario report surgical wait times to the WTIS; the remaining 24 facilities do not receive wait time funding for reporting and so do not report wait times. 4. Hospitals with small volumes will be more severely impacted by extreme waits. For example, an unusually long or short wait time for a single patient in a reporting period for hospitals that do not treat a lot of patients (e.g., a small hospital performing cataract surgery) will have a greater impact on the percentage of patients who underwent surgery within the target time. 5. Since Wait Time data are reported at the hospital corporation or facility level, facilities with multiple sites will be reported together even though data are collected at each site. Wait Times may also vary by surgeon which will not be apparent in this data as it is reported at the institution level rather than individual surgeon. 6. There are other factors that affect wait times for a surgical procedure or diagnostic exam that do not relate to a hospital's efficiency, to a particular doctor or the availability of resources. They include: a. Patient Choice – a patient with a non-life-threatening condition may choose a non-surgical treatment or may decide to delay treatment for personal or family reasons to a more convenient time. b. Patient Condition – a patient's condition may need to improve before the surgery or exam takes place. c. Follow-up Care – a patient who has an existing condition may be pre-booked for a follow-up treatment or exam a long time in advance. d. Treatment Complexity – a patient with special requirements may need specific equipment or a certain kind of facility and there is a delay until these can be scheduled.

**Comments Summary**

None

## Timely access to primary care when sick or have a health concern

### Description

The indicator measures the percentage of people in Ontario aged 16 and older who reported that in the last 12 months when they were sick or were concerned that they had a health problem they were able to see their primary care provider (i.e. a family doctor, a general practitioner or GP, or nurse practitioner) or someone else in their office the same day or the next day (in less than 2 days).

The results can be reported for 2-3 days; 4-7 days and 8 or more days.

### Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

Numerator divided by the denominator times 100

### Numerator

Weighted number of respondents who answered to the following question and provided the number of days that they waited to see their primary care provider :

How many days did it take from when you first tried to see your [fill fd\_type] to when you actually saw them or someone else in their office?

- Saw doctor same day
- Saw doctor next day
- 2 to 19 (enter number of days)
- Twenty or more days
- Don't know
- Refused

### Denominator

Weighted number of respondents who reported having a primary care provider and answered "yes" to the following questions:

Not counting yearly check-ups or monitoring of an ongoing health issue, in the last 12 months did you want to see your [name type of provider] because you were sick or were concerned that you had a health problem?

- Yes
- No
- Don't know
- Refused

AND

Respondents who answered "yes saw own doctor", "yes saw someone else in office", or "saw both [fill fd\_type] and someone else (and others)" to the following question:

Did you actually see your [fill fd\_type] or someone else in their office?

- Yes saw own doctor
- Yes saw someone else in office
- Saw both [fill fd\_type] and someone else (others)
- No

- Don't know

- Refused

Exclusion

Respondents who answered "don't know" or "refused" are excluded from analyses

### **Adjustment (risk, age/sex standardization)**

None

### **Data Source**

Health Care Experience Survey (HCES)

### **Data provided by**

Ministry of Health and Long-Term Care (MOHLTC)

### **Reported levels of comparability**

International comparison, Province, Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

Only people aged 16 years and older can complete the survey. People living in institutions, in households without telephones, and those with invalid/missing household addresses in the Registered Persons Database (RPDB) are excluded. Respondents who were unable to speak English or French or were not healthy enough (physically or mentally) to complete the interview were not surveyed.

### **Comments Summary**

The results are weighted to account for the design characteristics of the survey and post-stratified by age and sex to reflect the Ontario population. In addition, the LHIN and community weighting is applied. References 'fill fd\_type' in the question can mean a family doctor, GP, nurse practitioner, or anyone else the respondent said they get their primary care from. International and provincial comparisons are reported in the Measuring Up report. The data source for international and provincial comparisons is the Commonwealth Fund International Health Policy Survey of Adults, that has a similar question: The survey question in CMWF IHP is: "Last time you were sick or needed medical attention, how quickly could you get an appointment to see a doctor or a nurse?" The CMWF survey population is adults aged 18 and older. A similar indicator is included in the primary care QIP as well. The data source for it is local data collection. The question advised in the QIP guidance document is: The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office? The education stratification analysis is done among those aged 25 and older. Urban/rural status is defined using Statistics Canada's Statistical Area Classification. Household income analysis does not consider the household composition.

## **Time to a specialist appointment**

### **Description**

The indicator measures the percentages of people 16 and older who reported in a survey that they needed to see a specialist and that they saw a specialist in: less than 30 days, 30 to 89 days, or 90 or more days, after referral by a primary care provider.

### **Reporting tool/product**

Public Reporting

## **DEFINITION AND SOURCE INFORMATION**

### **Unit of Measurement**

Percentage

### **Calculation Methods**

Numerator divided by the denominator times 100

### **Numerator**

Weighted number of survey respondents who reported that they saw a specialist in: less than 30 days, 30 to 89 days, or 90 or more days, after referral by a primary care provider.

Survey Question: "After you were advised to see a specialist, how many days, weeks or months did you have to wait for an appointment?"

### **Denominator**

Weighted total number of survey respondents who reported needing to see a specialist in the previous 2 years

Exclusion:

Those who selected " never got an appointment/still waiting/etc."; " don't know"; "refused" to the question.

### **Adjustment (risk, age/sex standardization)**

Weighted

### **Data Source**

Health Care Experience Survey (HCES)

### **Data provided by**

Ministry of Health and Long-Term Care (MOHLTC)

### **Reported levels of comparability**

Province, International comparison, Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

Only people aged 16 years and older can complete the survey. People living in institutions, in households without telephones, and those with invalid/missing household addresses in the Registered Persons Database (RPDB) are excluded. Respondents who were unable to speak English or French or were not healthy enough (physically or mentally) to complete the interview were not surveyed. Inability to distinguish if people consider Telehealth to be access to primary care after hours. In addition, people who had not yet seen a specialist (i.e., still waiting) or who never got an appointment are not included.

### **Comments Summary**

Weighted to account for the design characteristics of the survey and post-stratified by age and sex to reflect the Ontario population. In addition, the LHIN and community weighting is applied. The data source for international and provincial comparisons is the Commonwealth Fund International Health Policy Survey 2016 . The survey population is adults aged 18 and older. The education stratification analysis is done among those aged 25 and older. Urban/rural status is defined using Statistics Canada's Statistical Area Classification. Household income analysis does not consider the household composition.

## 4. Provider Experience

### Stressful job for primary care doctors

#### Description

The indicator measures the percentage of primary care doctors who report their job as a primary care doctor is extremely/very stressful

#### Reporting tool/product

Public reporting

### DEFINITION AND SOURCE INFORMATION

#### Unit of Measurement

Percentage

#### Calculation Methods

Numerator divided by the denominator times 100

#### Numerator

Weighted number of respondents who answered “Extremely/very stressful” to the following question:

How stressful is your job as a general practitioner/primary care physician?

#### Denominator

Weighted number of respondents to the survey question above who answered “extremely/very stressful”, “somewhat stressful,” or “not too/not at all stressful”

#### Exclusions:

Those who answered “multiple-response code” and “decline to answer”.

#### Adjustment (risk, age/sex standardization)

The primary care physician (PCP) data in Canada were weighted to account for: (1) the over-representation of PCPs in some provinces; (2) the availability of an email address or not (since respondents with email addresses could be contacted both by mail and email); and (3) differential nonresponse along known geographic and demographic parameters.

#### Data Source

2019 Commonwealth Fund International Health Policy Survey

#### Data provided by

Social Science Research Solutions (SSRS)

#### Reported levels of comparability

International comparison, Province

**OTHER RELEVANT INFORMATION**

**Caveats and Limitations**

Data are self-reported

**Comments Summary**

None

## **Satisfaction with daily workload for primary care doctors**

### **Description**

The indicator measures the percentage of primary care doctors who report that they are extremely or very satisfied with their daily workload

### **Reporting tool/product**

Public reporting

### **DEFINITION AND SOURCE INFORMATION**

#### **Unit of Measurement**

Percentage

#### **Calculation Methods**

Numerator divided by the denominator times 100

#### **Numerator**

Weighted number of respondents who answered “Slightly/not at all satisfied” to the following question: Please indicate how satisfied you are with the following aspect of your medical practice: your daily workload

#### **Denominator**

Weighted number of respondents to the survey question above who answered “extremely/very satisfied,” “moderately satisfied,” or “slightly/not at all satisfied”.

#### **Exclusions:**

Those who answered “multiple-response code” and “decline to answer”.

#### **Adjustment (risk, age/sex standardization)**

The primary care physician (PCP) data in Canada were weighted to account for: (1) the over-representation of PCPs in some provinces; (2) the availability of an email address or not (since respondents with email addresses could be contacted both by mail and email); and (3) differential nonresponse along known geographic and demographic parameters.

#### **Data Source**

2019 Commonwealth Fund International Health Policy Survey

#### **Data provided by**

Social Science Research Solutions (SSRS)

#### **Reported levels of comparability**

International comparison, Province

### **OTHER RELEVANT INFORMATION**

#### **Caveats and Limitations**

Data are self-reported

#### **Comments Summary**

None

# 5. Population Health

## Opioid-poisoning deaths

### Description

This indicator measures the rate of deaths due to opioid poisonings, per 100,000 people. It includes all deaths where opioid poisoning was considered as contributing to the cause of death. A lower rate is better.

### Reporting tool/product

Public reporting

### DEFINITION AND SOURCE INFORMATION

#### Unit of Measurement

Rate per 100,000 people

#### Calculation Methods

This indicator is calculated as the numerator divided by the denominator times 100,000

#### Numerator

Number of deaths from opioid poisonings

Inclusions:

- All deaths where opioid poisoning was considered as contributing to the cause of death

#### Denominator

Total population

#### Adjustment (risk, age/sex standardization)

None

#### Data Source

Office of the Chief Coroner for Ontario, Ontario Opioid-Related Death Database  
Population Estimates, 2003–2016, Ontario Ministry of Health and Long-Term Care, IntelliHealth ONTARIO  
Population Projections, 2017–2019 Ontario Ministry of Health and Long-Term Care, IntelliHealth ONTARIO  
Special Advisory Committee on the Opioid Overdoses. National Report; Apparent Opioid Deaths in Canada, provided by Public Health Agency of Canada

#### Data provided by

Public Health Ontario (PHO)

#### Reported levels of comparability

Province, Time

### OTHER RELEVANT INFORMATION

#### Caveats and Limitations

Data for Ontario residents who die outside of the province are not included

#### Comments Summary

Interprovincial data are from Special Advisory Committee on the Opioid Overdoses. National Report; Apparent Opioid Deaths in Canada, provided by Public Health Agency of Canada

## Life expectancy at birth

### Description

This indicator measures the number of years a person would be expected to live, starting from birth, if the age- and sex-specific mortality rates for a given observation period (such as a calendar year) were held constant over the estimated life span. A higher result is better

### Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Years

### Calculation Methods

This indicator is calculated as: the numerator divided by the denominator

Age- and sex-specific mortality rates corresponding to the reference period are applied to a hypothetical cohort, typically of 100,000. Starting at birth, the probability of dying at each age or age interval is applied to the number of people surviving to that age or the beginning of the age interval, respectively.

### Numerator

Cumulative number of person-years lived, for a cohort of 100,000 persons

### Denominator

Number of persons in an initial cohort of 100,000 live births

### Exclusions:

1. Births to mothers who are not residents of Canada
2. Births to mothers who are residents of Canada whose province or territory of residence was unknown
3. Deaths of non-residents of Canada
4. Deaths of residents of Canada whose province or territory of residence was unknown
5. Deaths for which age or sex of the decedent was unknown

### Adjustment (risk, age/sex standardization)

None

### Data Source

Vital Statistics, Death Database

### Data provided by

Statistics Canada

### Reported levels of comparability

International comparison, Province, Time

## OTHER RELEVANT INFORMATION

### Caveats and Limitations

This indicator does not provide information on the individual causes of deaths or on quality of life.

### Comments Summary

1. Life expectancy and other elements of the life table, Canada, all provinces except Prince Edward Island, three-year average, Statistics Canada Table 13-10-0114-01
2. Life expectancy and other elements of the life table, Prince Edward Island and the territories, three-year average, Statistics Canada Table 13-10-0140-01
3. For international comparisons, data are provided from the OECD (2019, <https://data.oecd.org/healthstat/life-expectancy-at-birth.htm>), Life expectancy at birth (indicator). doi: 10.1787/27e0fc9d-en (Accessed on 7 October 2019)

## Deaths by suicide (children and youth, adult)

### Description

Rate of deaths by suicide per 1,000 people (children & youth, adult)

### Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Rate per 1,000 population

### Calculation Methods

Numerator times the denominator multiplied by 1,000 – calculated separately for children and youths, and adults

### Numerator

Total number of annual deaths by suicide

C&Y age-group: 10-24

Adult age-group: 16-105

### Exclusions:

- Ages <10 or >105
- No valid IKN / Cannot be linked in RPDB
- Not Ontario resident (pull the PRCDDA and exclude if first two characters NE '35')

### Denominator

General Ontario population

C&Y age-group: 10-24

Adult age-group: 16-105

### Exclusions:

- Ages <10 or >105
- No valid IKN / Cannot be linked in RPDB
- Not Ontario resident (pull the PRCDDA and exclude if first two characters NE '35')
- Sex = N/A

### Adjustment (risk, age/sex standardization)

Age- and sex-standardized to the 2006 Ontario census population

### Data Source

Ontario Registrar General – Deaths (ORGD), Registered Persons Database (RPDB)

### Data provided by

Institute for Clinical & Evaluative Sciences

**Reported levels of comparability**

Time

**OTHER RELEVANT INFORMATION**

**Caveats and Limitations**

As it can be difficult to determine intent in some cases, the true incidence of suicide mortality can be difficult to estimate.

**Comments Summary**

None

## **Cigarette smoking**

### **Description**

This indicator measures the percentage of people aged 12 and older who report currently smoking cigarettes (daily or occasionally). A lower percentage is better.

### **Reporting tool/product**

Public reporting

## **DEFINITION AND SOURCE INFORMATION**

### **Unit of Measurement**

Percentage

### **Calculation Methods**

Numerator divided by denominator times 100

### **Numerator**

The weighted number of respondents who reported current daily or occasional smoking of cigarettes.

Inclusions: If variable SMK\_005 equals 1 and 2

Question Text: At the present time, do you smoke cigarettes every day, occasionally or not at all?

1 = Daily

2 = Occasionally

3 = Not at all

8 = Refusal

9 = Don't know

### **Denominator**

The weighted number of respondents aged 12 or older that responded to the survey question.

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

### **Adjustment (risk, age/sex standardization)**

Direct age-adjusted using 2011 Canada population

### **Data Source**

Canadian Community Health Survey (CCHS)

### **Data provided by**

Statistics Canada

### **Reported levels of comparability**

Province, Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

Because of the significant changes to the survey methodology, Statistics Canada does not recommend making comparisons of the redesigned 2015 cycle of the CCHS with past cycles. As this indicator relies on self-reported data, the true rate might in fact be higher or lower. In addition, the survey coverage excludes: persons

living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; the institutionalized population, children aged 12-17 that are living in foster care, and persons living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James. Altogether, these exclusions represent less than 3% of the Canadian population aged 12 and over.

### **Comments Summary**

A major redesign project was completed and implemented for the 2015 cycle. The objectives of the redesign were to review the sampling methodology, adopt a new sample frame, modernize the content and review the target population. As a result of the redesign, the 2015 CCHS has a new collection strategy, is drawing the sample from two different frames and has undergone major content revisions. With all these factors taken together, caution should be taken when comparing data from previous cycles to data released for the 2015 cycle onwards. Education stratification analysis is restricted to 25 and older. Proportions and ratios are obtained by summing the final weights of records having the characteristic of the numerator and the denominator, and then dividing the first estimate by the second.

## Adjusted obesity

### Description

This indicator measures the percentage of people who are classified as being obese based on adjusted self-reported weight and height. Obesity is measured using body mass index (BMI), based on adjusted self-reported height and weight. For adults 18 years and older, BMI > 30 is considered obese. A lower percentage is better.

### Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

Numerator divided by denominator times 100

### Numerator

Weighted number of respondents aged 18 and older with an adjusted BMI > 30.

Inclusions: If HWTDVCOR equals 4, 5, or 6

Codes for HWTDVCOR (BMI adjusted):

- 1 = Underweight: Adjusted BMI < 18.50 = underweight
- 2 = Normal weight: 18.50 <= Adjusted BMI < 25 = normal
- 3 = Overweight: 25<= Adjusted BMI < 30 = overweight
- 4 = Obese – class 1: 30 <= Adjusted BMI < 35 = obese (class I)
- 5 = Obese – class 2: 35 <= Adjusted BMI < 40 = obese (class II)
- 6 = Obese – class 3: 40 <= Adjusted BMI = obese (class III)

This variable assigns adult respondents aged 18 and over (except pregnant women) to one of the following categories, according to their adjusted Body Mass Index (BMI): underweight; acceptable weight; overweight; obese class I; obese class II; and, obese class III. Here, the BMI categories are adopted from a body weight classification system recommended by Health Canada and the World Health Organization (WHO) which has been widely used internationally.

### Denominator

Weighted number of respondents aged 18 or older that responded to the survey question.

Exclusions: Pregnant women; people don't know, not stated and refusal are not included in the analysis.

### Adjustment (risk, age/sex standardization)

Direct age-adjusted using 2011 Canada population

### Data Source

Canadian Community Health Survey (CCHS)

### Data provided by

Statistics Canada

## **Reported levels of comparability**

Province, Time

## **OTHER RELEVANT INFORMATION**

### **Caveats and Limitations**

Because of the significant changes to the survey methodology, Statistics Canada does not recommend making comparisons of the redesigned 2015 cycle of the CCHS with past cycles. In addition, the survey coverage excludes: persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; the institutionalized population, children aged 12-17 that are living in foster care, and persons living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James. Altogether, these exclusions represent less than 3% of the Canadian population aged 12 and over.

### **Comments Summary**

BMI is not calculated for pregnant women. Although calculation of BMI is not recommended for lactating women, the index provided here is calculated for women who report that they are breastfeeding. A systematic review of the literature concluded that the use of self-reported data among adults underestimates weight and overestimates height, resulting in lower estimates of obesity than those obtained from measured data. Using data from the 2005 Canadian Community Health Survey (CCHS) subsample, where both measured and self-reported values were collected, correction equations have been developed (Connor Gorber et al. 2008). These correction equations have been successfully applied to both 2005 and 2008 self-reported CCHS data to produce more accurate estimates of obesity (Connor Gorber et al. 2008; Shields et al. 2011). Differential musculature or bone mass among individuals, as well as across ethno-cultural groups and sexes does not factor into how the BMI is calculated. A major redesign project was completed and implemented for the 2015 cycle. The objectives of the redesign were to review the sampling methodology, adopt a new sample frame, modernize the content and review the target population. As a result of the redesign, the 2015 CCHS has a new collection strategy, is drawing the sample from two different frames and has undergone major content revisions. With all these factors taken together, caution should be taken when comparing data from previous cycles to data released for the 2015 cycle onwards. Education stratification analysis is restricted to 25 and older. Proportions and ratios are obtained by summing the final weights of records having the characteristic of the numerator and the denominator, and then dividing the first estimate by the second.

## Physical inactivity

### Description

This indicator measures the percentage of people aged 18 or older who reported being physically inactive, based on the number of minutes of physical activity reported in the last 7 days. This means that they didn't engage in any moderate or vigorous physical activity that lasted a minimum of 10 continuous minutes in a week. Moderate exercise is defined as an activity that causes a person to breathe harder and sweat at least a little. A lower percentage is better.

### Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

Numerator divided by denominator times 100

### Numerator

Total weighted number of respondents categorized as "inactive".

Inclusions: The variable used is PAADVAC2.

When PAADVAC2 is equal to 4 (Sedentary) considered the respondent inactive.

1. PAADVMVA => 150 Active
2.  $75 \leq \text{PAADVMVA} < 150$  Moderately active
3.  $0 < \text{PAADVMVA} < 75$  Somewhat active
4. PAADVMVA = 0 Sedentary

PAADVAC2: This derived variable represents an alternate classification of physical activity for adults, based on the number of minutes of moderate to vigorous activity done in a week. It breaks down those who were not above the threshold of 150 minutes per week into subcategories of their activity level. Derived based on another variable PAADVMVA:

- PAADVMVA is based on PAA\_005, PAA\_015, PAA\_020, PAA\_030, PAA\_035, PAA\_045, PAA\_050, PAA\_060, PAA\_065, PAA\_075, PAA\_080

This derived variable represents the total number of minutes a respondent engaged in active transportation and moderate to vigorous recreational and other physical activities. This derived variable indicates whether a respondent is physically active according to the Canadian Physical Activity Guidelines (CPAG).

Physically active is defined by the Canadian Physical Activity Guidelines as engaging in at least 150 minutes of moderate- to vigorous-intensity aerobic physical activity per week, in bouts of 10 minutes or more.

### Denominator

Total weighted number of respondents aged 18 and older that responded to the survey question.

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

### Adjustment (risk, age/sex standardization)

Direct age-adjusted using 2011 Canada population

**Data Source**

Canadian Community Health Survey (CCHS)

**Data provided by**

Statistics Canada

**Reported levels of comparability**

Province, Time

**OTHER RELEVANT INFORMATION****Caveats and Limitations**

Because of the significant changes to the survey methodology, Statistics Canada does not recommend making comparisons of the redesigned 2015 cycle of the CCHS with past cycles. As this indicator relies on self-reported data, the true rate might in fact be higher or lower. In addition, the survey coverage excludes: persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; the institutionalized population, children aged 12-17 that are living in foster care, and persons living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James. Altogether, these exclusions represent less than 3% of the Canadian population aged 12 and over.

**Comments Summary**

A major redesign project was completed and implemented for the 2015 cycle. The objectives of the redesign were to review the sampling methodology, adopt a new sample frame, modernize the content and review the target population. As a result of the redesign, the 2015 CCHS has a new collection strategy, is drawing the sample from two different frames and has undergone major content revisions. With all these factors taken together, caution should be taken when comparing data from previous cycles to data released for the 2015 cycle onwards. Education stratification analysis is restricted to 25 and older. Proportions and ratios are obtained by summing the final weights of records having the characteristic of the numerator and the denominator, and then dividing the first estimate by the second.

## Heavy drinking

### Description

This indicator measures the percentage of people aged 12 and older who were heavy drinkers. A lower percentage is better.

### Reporting tool/product

Public reporting

## DEFINITION AND SOURCE INFORMATION

### Unit of Measurement

Percentage

### Calculation Methods

Numerator divided by denominator times 100

### Numerator

The weighted number of respondents who were heavy drinkers. For males, heavy drinking refers to having consumed five or more drinks, per occasion, at least once a month during the past year. For females, heavy drinking refers to having consumed four or more drinks, per occasion, at least once a month during the past year.

Inclusions: If variable ALC\_020 equals 3, 4, 5 and 6.

Question Text: How often in the past 12 months have you had [5/4] or more drinks on one occasion?

Codes for ALC\_020 variable:

- 1 = Never
- 2 = Less than once a month
- 3 = Once a month
- 4 = 2 to 3 times a month
- 5 = Once a week
- 6 = More than once a week
- 8 = Refusal
- 9 = Don't know

Based on the Canadian Community Health Survey (CCHS) survey, a 'drink' refers to:

- a bottle or small can of beer, cider or cooler with 5% alcohol content, or a small draft;
- a glass of wine with 12% alcohol content;
- a glass or cocktail containing 1.5 oz. of a spirit with 40% alcohol content.

### Denominator

The weighted number of respondents aged 12 or older that responded to the two survey questions. If respondents answered ALC\_010 as not having had an alcoholic drink in the last year, then they were not asked ALC\_020, and were marked as a "valid skip" for ALC\_020. The denominator includes the 'valid skip' for ALC\_20.

Inclusions: If variable ALC\_010 equals 1 and 2.

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

Codes for ALC\_010 variable:

1 = Yes

2 = No

8 = Refusal

9 = Don't know

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

**Adjustment (risk, age/sex standardization)**

Direct age-adjusted using 2011 Canada population

**Data Source**

Canadian Community Health Survey (CCHS)

**Data provided by**

Statistics Canada

**Reported levels of comparability**

Province, Time

**OTHER RELEVANT INFORMATION**

**Caveats and Limitations**

Because of the significant changes to the survey methodology, Statistics Canada does not recommend making comparisons of the redesigned 2015 cycle of the CCHS with past cycles. As this indicator relies on self-reported data, the true rate might in fact be higher or lower. In addition, the survey coverage excludes: persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; the institutionalized population, children aged 12-17 that are living in foster care, and persons living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James. Altogether, these exclusions represent less than 3% of the Canadian population aged 12 and over.

**Comments Summary**

None