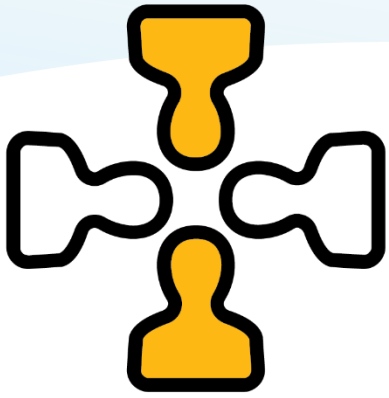

**COLLABORATIVE QUALITY IMPROVEMENT PLAN PROGRAM**

# Indicator Technical Specifications

2024/25

JANUARY 2024

Ontario Health

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# Introduction

This document includes definitions, calculations, reporting periods, and other technical information for the indicators chosen for the 2024/25 collaborative Quality Improvement Plan (cQIP) program for Ontario Health Teams (OHTs).

The indicators are a continuation of the 2023/24 cQIP program indicators, which captured system-level work done by partners within each OHT. A cQIP reflects progress to date and captures the intent of an OHT as its partners work together to address common issues.

**Considerations**

Data time periods are set according to the limits of available data providers. Ontario Health is working with data providers to ensure that source data are as recent as possible. The most recent data for priority indicators will be available on the OHT Data Dashboard.

Additional information about the OHT Data Dashboard:

OHT Data Dashboard Launch Webinar
OHT Data Dashboard Technical Demonstration

# Priority Indicators

## Access to Care in the Most Appropriate Setting

### 1. Alternate level of care days expressed as a percentage of all inpatient days in the same period

| | |
|---|---|
| Status | Priority for 2024/25 |
| Dimension of quality | Efficient |
| Direction of improvement | Reduce (lower) |
| Type | Process |
| Description | This indicator measures the percentage of time (i.e., inpatient days) for which acute care hospital beds were occupied by patients who had finished the acute care phase of treatment (i.e., designated *ALC by* a physician or other). Data for this indicator can be stratified by characteristics such as fiscal year, month, Ontario Health Team, discharge destination, diagnosis group, and hospital of discharge. |
| Unit of measure | Percentage |
| Calculation method | (Numerator ÷ Denominator) × 100 |
| Numerator | Total number of inpatient days designated as *ALC,* from discharge data, in the reporting period.<br>**Calculation steps:**<br>• Select the DAD data element *ALC Length of Stay*<br>• Calculate (sum) the total number of inpatient days designated as *ALC* in the reporting period<br>**Inclusions:**<br>• Data from acute care hospitals, including those with psychiatric beds and without psychiatric beds<br>• Data for individuals designated as *ALC*<br>**Exclusions:**<br>• Records for newborns (or stillbirths)<br>• Records with missing or invalid *Discharge Date* |
| Denominator | Total number of inpatient days, from discharge data, in the reporting period.<br>**Calculation steps:**<br>1. Select the DAD data element *Total Length of Stay*<br>2. Calculate (sum) the total number of inpatient days in the reporting period<br>**Inclusions:**<br>• Data from acute care hospitals, including those with psychiatric beds and without psychiatric beds<br>**Exclusions:**<br>• Records for newborns (or stillbirths)<br>• Records with missing or invalid *Discharge Date* |
| Risk adjustment | None |
| Current reporting period | October 2022 to September 2023 |
| Data source | Discharge Abstract Database, Registered Persons Database |
| How to access data | Data can be accessed from the OHT Data Dashboard.<br>Data (12 months, rolling) will also be prepopulated in QIP Navigator by January 2024. |

Abbreviations: ALC, alternate level of care; DAD, Discharge Abstract Database; OHT, Ontario Health Teams.

# Access to Community Mental Health and Addictions Services

## 2. Emergency department visit as first point of contact for mental health and addictions–related care

| | |
|---|---|
| Status | Priority for 2024/25 |
| Dimension of quality | Timely |
| Direction of improvement | Reduce (lower) |
| Type | Process |
| Description | This indicator measures the percentage of individuals for whom the ED was the first point of contact for mental health and addictions–related care. Data for this indicator can be stratified by characteristics such as fiscal year, month, Ontario Health Team, age, sex, diagnosis, after-hours contact, weekend contact, and hospital of discharge. |
| Unit of measure | Percentage |
| Calculation method | (Numerator ÷ Denominator) × 100 |
| Numerator | Number of people in the Denominator without mental health and addictions–related service contact in the 2 years preceding the reporting period.<br>**Inclusions:**<br>• Individuals who did not have any of the following in the 2 years preceding the reporting period:<br>  ○ Mental health and addictions–related outpatient visits to a psychiatrist, primary care provider, or pediatrician<br>  ○ Mental health and addictions–related ED visits (scheduled or unscheduled)<br>  ○ Mental health and addictions–related hospitalizations |
| Denominator | **Denominator for fiscal year data:**<br>Number of unique Ontario residents aged 0 to 105 years with an incident (first in a fiscal year) unscheduled mental health and addictions–related ED visit in the reporting period.<br>**Denominator for rolling (12 months, i.e., October 2022 to September 2023) and monthly data in the OHT Data Dashboard:**<br>Number of unique Ontario residents aged 0 to 105 years with an incident (first in the reporting period) unscheduled mental health and addictions–related ED visit in the reporting period.<br>**Inclusions:**<br>ICD-10 codes in the<br>• *Primary Diagnosis* field = *F06–F99*<br>• *Secondary Diagnosis* fields = *X60–X84*, *Y10–Y19*, *Y28* when *Primary Diagnosis* is not *F06–F09*, *F20–F99* |
| Risk adjustment | None |
| Current reporting period | October 2022 to September 2023 |
| Data source | Discharge Abstract Database, National Ambulatory Care Reporting System, Registered Persons Database, OHIP databases, Ontario Mental Health Reporting System |
| How to access data | Data can be accessed from the OHT Data Dashboard.<br>Data (12 months, rolling) will also be prepopulated in QIP Navigator by January 2024. |

Abbreviations: ED, emergency department; ICD-10, International Statistical Classification of Diseases and Related Health Problems Tenth Revision; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Teams.

# Access to Preventive Care

## 3. Percentage of screen-eligible people who are up to date with Pap tests

| | |
|---|---|
| Status | Priority for 2024/25 |
| Dimension of quality | Effective |
| Direction of improvement | Increase (higher) |
| Type | Process |
| Description | This indicator measures the percentage of screen-eligible people aged 21 to 69 years who had a cytology test (i.e., Pap test) within the previous 3 years. Data for this indicator can be stratified by characteristics such as fiscal year, quarter, Ontario Health Team, forward sortation area, Ontario Health region, LHIN, PHU, marginalization index, age, and sex.<br>This indicator is calculated using Ontario Health Screening Activity Report methodology, which is slightly different from the previously used ICES methodology for the same indicator. |
| Unit of measure | Percentage |
| Calculation method | (Numerator ÷ Denominator) × 100 |
| Numerator | Number of screen-eligible people aged 21 to 69 years who have completed at least 1 cytology test (i.e., Pap test) within the 3 years leading up to the last day of the reporting period.<br>**Inclusions:**<br>• Cytology tests identified through CytoBase (or OHIP databases, using fee codes listed in Appendix A), with<br>  ○ All cytology tests in CytoBase counted, including those with inadequate specimens, and<br>  ○ Each person counted once, regardless of number of cytology tests performed within the 3 years leading up to the last day of the reporting period |
| Denominator | Total number of screen-eligible people aged 21 to 69 years in Ontario in the reporting period.<br>**Inclusions:**<br>• Screen-eligible people in Ontario aged 21 to 69 years at the index date; the *index date* is defined as the midpoint of the reporting period<br>**Exclusions:**<br>• People with a missing or invalid health insurance number, date of birth, region, or postal code<br>• People diagnosed with an invasive cervical cancer prior to the quarter or with a prior diagnosis of cervical cancer (ICD-O-3 code: *C53*) and a morphology indicative of cervical cancer, microscopically confirmed with a pathology report<br>• People who had a colposcopy or treatment within 2 years prior to the reporting period<br>• People with colposcopy or treatment identified using OHIP fee codes in Appendix B<br>• People with a hysterectomy prior to the reporting period<br>• People with a hysterectomy identified using OHIP fee codes in Appendix C |
| Risk adjustment | None |
| Current reporting period | Q2 (covering 3 years of participation up to September 2023) |
| Data source | CytoBase, Ontario Cancer Registry, OHIP databases, Registered Persons Database |
| How to access data | Data can be accessed from the OHT Data Dashboard.<br>Data will also be prepopulated in QIP Navigator by January 2024. |

Abbreviations: ICD-O-3, International Classification of Diseases for Oncology Third Edition; LHIN, local health integration network; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Teams; PHU, public health unit.

# 4. Percentage of screen-eligible people who are up to date with mammograms

| | |
|---|---|
| Status | Priority for 2024/25 |
| Dimension of quality | Effective |
| Direction of improvement | Increase (higher) |
| Type | Process |
| Description | This indicator measures the percentage of screen-eligible people aged 50 to 74 years who completed at least 1 screening mammogram within the previous 2 years. Data for this indicator can be stratified by characteristics such as fiscal year, quarter, Ontario Health Team, forward sortation area, Ontario Health region, LHIN, PHU, marginalization index, age, and sex.<br>This indicator is calculated using Ontario Health Screening Activity Report methodology, which is slightly different from the previously used ICES methodology for the same indicator. |
| Unit of measure | Percentage |
| Calculation method | (Numerator ÷ Denominator) × 100 |
| Numerator | Number of screen-eligible people aged 50 to 74 years who completed at least 1 screening mammogram within the within the 2 years leading up to the last day of the reporting period.<br>• Screening mammograms identified as follows:<br>  ○ Ontario Breast Screening Program mammograms identified in ICMS<br>  ○ Non–Ontario Breast Screening Program mammograms identified in OHIP databases using fee codes *X178* (screening bilateral mammogram) and *X185* (diagnostic bilateral mammogram)<br>• With all mammograms in ICMS counted, including those with partial views, and<br>• Each person counted once regardless of the number of mammograms performed within the 2 years leading up to the last day of the reporting period years |
| Denominator | Total number of screen-eligible people aged 50 to 74 years in the reporting period in Ontario.<br>**Inclusions:**<br>• Screen-eligible people aged 50 to 74 years at the index date in Ontario; the *index date* is defined as the midpoint of the reporting period<br>**Exclusions:**<br>• People with a missing or invalid health insurance number, date of birth, region, or postal code<br>• People with a prior diagnosis of breast invasive cancer or ductal carcinoma in situ before the reporting period (prior diagnosis of breast cancer [ICD-O-3 code: *C50*] and a morphology indicative of ductal carcinoma in-situ or invasive breast cancer, microscopically confirmed with a pathology report)<br>• People with a mastectomy before the reporting period; mastectomy is defined using OHIP fee codes *E505*, *E506*, *E546*, *R108*, *R109*, and *R117* |
| Risk adjustment | None |
| Current reporting period | Q2 (covering 2 years of participation up to September 2023) |
| Data source | ICMS–Ontario Breast Screening Program, Ontario Cancer Registry, Registered Persons Database, OHIP databases |
| How to access data | Data can be accessed from the OHT Data Dashboard.<br>Data will also be prepopulated in QIP Navigator by January 2024. |

Abbreviations: ICD-O-3, International Classification of Diseases for Oncology Third Edition; ICMS, Integrated Client Management System; LHIN, local health integration network; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Teams; PHU, public health unit.

## 5. Percentage of screen-eligible people who are up to date with colorectal tests

| | |
|---|---|
| Status | Priority for 2024/25 |
| Dimension of quality | Effective |
| Direction of improvement | Increase (higher) |
| Type | Process |
| Description | This indicator measures the percentage of Ontario screen-eligible people aged 50 to 74 years who had a fecal immunochemical test within the previous 2 years, a colonoscopy within the previous 10 years, or a flexible sigmoidoscopy within the previous 10 years. Data for this indicator can be stratified by characteristics such fiscal year, quarter, Ontario Health Team, forward sortation area, Ontario Health region, LHIN, PHU, marginalization index, age, and sex.<br>This indicator is calculated using the Ontario Health Screening Activity Report methodology, which is slightly different from the previously used ICES methodology for the same indicator. |
| Unit of measure | Percentage |
| Calculation method | (Numerator ÷ Denominator) × 100 |
| Numerator | Number of screen-eligible people aged 50 to 74 years in Ontario who had a FIT within 2 years, colonoscopy within 10 years, or flexible sigmoidoscopy within 10 years of the last day of the reporting period.<br>**Inclusions:**<br>• Individuals are considered up to date with colorectal cancer screening if they:<br>  ○ Had a FIT within the 2 years leading up to the last day of the reporting period or<br>  ○ Had a colonoscopy within the 10 years leading up to the last day of the reporting period or<br>  ○ Had a flexible sigmoidoscopy within the 10 years leading up to the last day of the reporting period<br>• FITs identified in Fecal Immunochemical Test Data Submission Portal<br>• Only valid FITs included; FITs with either normal or abnormal results are considered valid<br>• Colonoscopies identified using OHIP fee codes *Z555A*, *Z491A–Z499A*, or in the Colonoscopy Interim Reporting Tool or Gastrointestinal Endoscopy Data Submission Portal<br>• Flexible sigmoidoscopies identified using OHIP fee code *Z580A*<br>• Multiple claims with the same health insurance number and service date assumed to be for a single procedure<br>• Each individual counted once regardless of number of tests performed |
| Denominator | Total number screen-eligible people aged 50 to 74 years in the reporting period in Ontario.<br>**Inclusions:**<br>• Ontario residents aged 50 to 74 years at the index date; the *index date* is defined as the midpoint of the reporting period<br>**Exclusions:**<br>• Individuals with a missing or invalid health insurance number, date of birth, or postal code<br>• Individuals diagnosed with an invasive colorectal cancer prior to the reporting period (prior diagnosis of colorectal cancer [ICD-O-3 codes: *C18.0*, *C18.2–C18.9*, *C19.9*, *C20.9*] and a morphology indicative of colorectal cancer, microscopically confirmed with a pathology report)<br>• Individuals with a total colectomy prior to the reporting period (total colectomy is defined in OHIP databases by fee codes *S169A*, *S170A*, *S172A*) |
| Risk adjustment | None |
| Current reporting period | Q2 (covering 2 years of participation for FIT and 10 years of participation for flexible sigmoidoscopy or colonoscopy up to September 2023) |
| Data source | Fecal Immunochemical Test Data Submission Portal, Gastrointestinal Endoscopy Data Submission Portal, Ontario Cancer Registry, Registered Persons Database, OHIP databases |
| How to access data | Data can be accessed from the OHT Data Dashboard.<br>Data will also be prepopulated in QIP Navigator by January 2024. |

Abbreviations: FIT, fecal immunochemical test; ICD-O-3, International Classification of Diseases for Oncology Third Edition; LHIN, local health integration network; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Teams; PHU, public health unit.

# Supplementary Indicators

## 6. Alternate level of care rate

| | |
|---|---|
| Status | Supplementary for 2024/25 |
| Dimension of quality | Efficient |
| Direction of improvement | Reduce (lower) |
| Type | Process |
| Description | This indicator measures the proportion of time (in days per fiscal quarter) in which acute and postacute care inpatient beds were occupied by patients designated as *ALC*. This indicator includes patients designated *ALC* both still waiting (open) and discharged/discontinued (closed) and is different from priority indicator 1 (*Alternate level of care days expressed as a percentage of all inpatient days in the same period*), which uses data from the Discharge Abstract Database.<br>Data for this indicator can be stratified by characteristics such as hospitals, discharge destination, and type of inpatient care. |
| Unit of measure | Percentage |
| Calculation method | (Numerator ÷ Denominator) × 100 |
| Numerator | Total number of days patients spent designated *ALC* within the specified time period.<br>For Ontario Health Teams, the Numerator associated with this indicator is presented as *ALC days per 10,000 population*. |
| Denominator | Total number of inpatient bed days contributed by patients within the specific time period.<br>To calculate the total number of inpatient days, an extract of the Daily Bed Census Summary is taken on the 6th business day of each reporting month to coincide with the Wait Time Information System data cut-off date.<br>The following guiding principles are then used to calculate inpatient bed days by designated bed type:<br>• Acute<br>  ○ Total number of days patients occupy beds for acute care, inclusive of beds occupied by children or adolescents for mental health care<br>• Postacute<br>  ○ Total number of days patients occupy beds for complex continuing care + general rehabilitation + special rehabilitation + adult mental health care<br>• Complex continuing care<br>  ○ Total number of days patients occupy complex continuing care beds<br>• Rehabilitation<br>  ○ Total number of days patients occupy general rehabilitation + special rehabilitation beds<br>• Mental health<br>  ○ Total number of days patients occupy beds for adult mental health care |
| Risk adjustment | None |
| Reporting frequency | Quarterly |
| Data source | Daily Bed Census, Wait Time Information System–ALC |
| How to access data | Data can be accessed from the OHT Data Dashboard. |

Abbreviations: ALC, alternate level of care; OHT, Ontario Health Teams.

## 7. Cumulative alternate level of care days

| | |
|---|---|
| Status | Supplementary for 2024/25 |
| Dimension of quality | Efficient |
| Direction of improvement | Reduce (lower) |
| Type | Process |
| Description | This indicator measures the total number of days patients are actively waiting for an alternate level of care (a less intensive level of care than an acute care hospital bed).<br>Data for this indicator can be stratified by characteristics such as month, Ontario Health Team, type of inpatient care, discharge destination (e.g., by most appropriate discharge destination), and wait time (e.g., long wait: *ALC Length of Stay* ≥ 30 days). |
| Unit of measure | Number |
| Calculation method | Total number of days patients are actively waiting for an alternate level of care |
| Numerator | Not applicable |
| Denominator | Not applicable |
| Risk adjustment | None |
| Reporting frequency | Quarterly |
| Data source | Wait Time Information System |
| How to access data | Data can be accessed from the OHT Data Dashboard. |

Abbreviations: ALC, alternate level of care; OHT, Ontario Health Teams.; WTIS, Wait Time Information System.

## 8. Volume of open alternate level of care cases

| | |
|---|---|
| Status | Supplementary for 2024/25 |
| Dimension of quality | Efficient |
| Direction of improvement | Reduce (lower) |
| Type | Process |
| Description | This indicator measures the number of patients waiting for an alternate level of care at a specified point in time.<br>Data for this indicator can be stratified by characteristics such as month, Ontario Health Team, type of inpatient care, discharge destination (e.g., by most appropriate discharge destination), and wait time (e.g., long wait: *ALC Length of Stay* ≥ 30 days). |
| Unit of measure | Number |
| Calculation method | Number of patients waiting for an alternate level of care at a specified point in time |
| Numerator | Not applicable |
| Denominator | Not applicable |
| Risk adjustment | None |
| Reporting frequency | Quarterly |
| Data source | Wait Time Information System |
| How to access data | Data can be accessed from the OHT Data Dashboard. |

Abbreviations: ALC, alternate level of care OHT, Ontario Health Teams.

# For Use With Custom Indicators

## 9. Admissions per 100 HF patients

| | |
|---|---|
| Status | Optional for 2024/25 |
| Dimension of quality | Efficient |
| Direction of improvement | Reduce (lower) |
| Type | Process |
| Description | The rate (per 100 cohort members) of inpatient admissions for people identified as being in the *HF cohort* (i.e., *HF patients*).<br>Data for this indicator are stratified by Ontario Health Team in QIP Navigator. Data can also be stratified by admission (i.e., *CHF-specific*, *Cardiac*-related, and *Other*); the diagnosis codes used to categorize the 3 groups are available upon request. |
| Unit of measure | Admissions per 100 HF patients |
| Calculation method | (Numerator ÷ Denominator) × 100 |
| Numerator | Number of admissions<br>**Inclusions:**<br>• All-cause admissions generated by the HF cohort<br>**Exclusions:**<br>• Elective admissions (*admcat* in "L", with a *Length of Stay* of 0 days [*ddate* – *admdate* = 0] in the Discharge Abstract Database)<br>• *Length of Stay* = 0 and transfer-through to another facility on the same day as discharge date |
| Denominator | Prevalent HF patients in the HF cohort (see Appendix D for information on generating the cohort) |
| Risk adjustment | The indicator is age and sex standardized. Age and sex standardization ensures that differences in age and sex are accounted for when comparing across OHTs and years.<br>1. Calculate overall (for Ontario) *admissions per 100 HF patients* for each age and sex group combination (with age being split into 20–59, 60–79, and ≥ 80 years).<br>2. For each OHT, multiply HF patients within each age and sex group by overall (for Ontario) *admissions per 100 HF patients* to obtain *expected admissions per 100 HF patients*. Sum across all age and sex groups to obtain a single measure for *expected admissions per 100 HF patients* for each OHT.<br>3. Calculate the actual-to-expected ratio as *actual admissions per 100 HF patients ÷ expected admissions per 100 HF patients* for each OHT.<br>4. Multiply the overall (for Ontario) *admission per 100 HF patients* by the actual-to-expected ratio to obtain age- and sex-standardized *admissions per 100 HF patients* for each OHT. |
| Reporting frequency | Annual |
| Data source | Discharge Abstract Database: *Inpatient Admission*<br>National Ambulatory Care Reporting System: *Ambulatory Visit*<br>OHIP databases: *Ambulatory Visit*<br>Registered Persons Database: *Death Year* |
| How to access data | Data will be released in 2024/25 through Ontario Health's eReports portal in both the *Integrated Clinical Pathways* and *OHT Reports* modules. |

Abbreviations: HF, heart failure; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Teams.

# 10. Emergency department visits per 100 HF patients

| | |
|---|---|
| Status | Optional for 2024/25 |
| Dimension of quality | Efficient |
| Direction of improvement | Reduce (lower) |
| Type | Process |
| Description | The rate (per 100 cohort member)s of ED visits made by people identified as being in the *HF cohort* (i.e., *HF patients*).<br>Data for this indicator are stratified by Ontario Health Team in QIP Navigator. Data can also be stratified by admission (i.e., *CHF-specific*, *Cardiac*-related, and *Other*); the diagnosis codes used to categorize the 3 groups are available upon request. |
| Unit of measure | ED visits per 100 HF patients |
| Calculation method | (Numerator ÷ Denominator) × 100 |
| Numerator | Number of ED visits by HF patients<br>**Inclusions:**<br>• All-cause ED visits generated by the HF cohort |
| Denominator | Prevalent HF patients in the HF cohort (see Appendix D for information on generating the cohort) |
| Risk adjustment | The indicator is age and sex standardized. Age and sex standardization ensures that differences in age and sex are accounted for when comparing across OHTs and years.<br>1. Calculate overall (for Ontario) *ED visits per 100 HF patients* for each age and sex group combination (with age being split into 20–59, 60–79, and ≥ 80 years).<br>2. For each OHT, multiply HF patients within each age and sex group by the overall (for Ontario) *ED visits per 100 HF patients*, to obtain *expected ED visits per 100 HF patients*. Sum across all age and sex groups to obtain a single measure for expected *ED visits per 100 HF patients* for each OHT.<br>3. Calculate the actual-to-expected ratio as actual *ED visits per 100 HF patients* ÷ expected *ED visits per 100 HF patients* for each OHT.<br>4. Multiply the overall (for Ontario) *ED visits per 100 HF patients* by the actual-to-expected ratio to obtain age- and sex-standardized *ED visits per 100 HF patients* for each OHT |
| Reporting frequency | Annual |
| Data source | Discharge Abstract Database: *Inpatient Admission*<br>National Ambulatory Care Reporting System: *Ambulatory Visit*<br>OHIP databases: *Ambulatory Visit*<br>Registered Persons Database: *Death Year* |
| How to access data | Data will be released in 2024/25 through Ontario Health's eReports portal in both the *Integrated Clinical Pathways* and *OHT Reports* modules. |

Abbreviations: CHF, congestive heart failure; ED, emergency department; HF, heart failure; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Teams.

# Appendices

## Appendix A: OHIP Fee Codes for Cytology Tests (Pap Tests)

The following are OHIP fee codes used to identify cytology tests (Pap tests) for priority indicator 3 (*Percentage of screen-eligible people who are up to date with Pap tests*):

- E430A: Add-on to A003, A004, A005, A006 when Pap test performed outside hospital
- G365A: Periodic – Pap smear
- E431A: When Papanicolaou smear is performed outside of hospital, to G394
- G394A: Additional for follow-up of abnormal or inadequate smears
- L713A: Lab/med/anat/path/hist/cyt/cytol/gynaecological specimen
- L733A: Cervicovaginal specimen (monolayer cell methodology)
- L812A: Cervical vaginal specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation
- Q678A: Gynaecology – pap smear – periodic – nurse practitioners

# Appendix B: OHIP Fee Codes for Colposcopy and Treatment

The following are OHIP fee codes used to identify people who have had colposcopy and treatment, which are exclusion criteria for priority indicator 3 (*Percentage of screen-eligible people who are up to date with Pap tests*).

### Colposcopy

- Z731: Initial investigation of abnormal cytology of vulva and/or vagina or cervix under colposcopic technique with or without biopsy(ies) and/or endocervical curetting
- Z787: Follow-up colposcopy with biopsy(ies) with or without endocervical curetting
- Z730: Follow-up colposcopy without biopsy with or without endocervical curetting

### Treatment

- Z732: Cryotherapy
- Z724: Electro
- Z766: Electrosurgical excision procedure (LEEP)
- S744: Cervix – cone biopsy – any technique, with or without D&C
- Z729: Cryoconization, electroconization or $CO_2$ laser therapy with or without curettage for premalignant lesion (dysplasia or carcinoma in-situ), outpatient procedure

# Appendix C: OHIP Fee Codes for Hysterectomy

The following are OHIP fee codes used to identify people who have had a hysterectomy, which is an exclusion criterion for priority indicator 3 (*Percentage of screen-eligible people who are up to date with Pap tests*):

- E862A: When hysterectomy is performed laparoscopically, or with laparoscopic assistance
- P042A: Obstetrics – labour – delivery – caesarean section including hysterectomy
- Q140A: Exclusion code for enrolled female patients aged 35–70 with hysterectomy
- S710A: Hysterectomy – with or without adnexa (unless otherwise specified) – with omentectomy for malignancy
- S727A: Ovarian debulking for stage 2C, 3B, or 4 ovarian cancer and may include hysterectomy
- S757A: Hysterectomy – with or without adnexa (unless otherwise specified) – abdominal – total or subtotal
- S758A: Hysterectomy – with or without adnexa (unless otherwise specified) – with anterior and posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered
- S759A: Hysterectomy – with or without adnexa (unless otherwise specified) – with anterior or posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered
- S762A: Hysterectomy – with or without adnexa (unless otherwise specified) – radical trachelectomy – excluding node dissection
- S763A: Hysterectomy – with or without adnexa (unless otherwise specified) – radical (Wertheim or Schauta) – includes node dissection
- S765A: Amputation of cervix
- S766A: Cervix uteri – exc – cervical stump – abdominal
- S767A: Cervix uteri – exc – Cervical stump – vaginal
- S816A: Hysterectomy – with or without adnexa (unless otherwise specified) – vaginal

# Appendix D: HF Cohort Criteria

To identify patients within the HF cohort, query data from fiscal year (FY) 2008/09 to the most recent FY. For a given FY, the HF cohort comprises patients alive at any point during that fiscal year and diagnosed with HF any year prior to or during the FY of interest, based on the following criteria:

- Patients aged > 20 years who had 1 inpatient admission for heart failure identified through the Discharge Abstract Database, or
- Patients aged > 40 years who had 1 visit, identified through OHIP databases, with fee code *Q050*, or
- Patients aged > 40 years who had 2 ambulatory records for heart failure (identified through the National Ambulatory Care Reporting System) within 1 year of each other. Qualifying ambulatory records include:
    - ED visits with 1 of the following diagnosis codes: *I50**, *I40**, *I41**, *I42**, *I43** or *I255**
    - Visits identified through OHIP databases with diagnosis code *428*

### Qualifying Criteria for Inpatient Admissions and ED Visits

- Any diagnosis of *I50** (heart failure) and age >40 years or *Primary Diagnosis* = *I40**, *I41**, *I42**, *I43** or *I255** and age > 20 years
- Valid health insurance number
- MCC partition = D (only for *Inpatient Admission*)

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