Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

Indicator Technical Specifications

2018/19 Quality Improvement Plans

Revised January 2018

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Revision History

Revision Date	Revisions
January 8, 2018	Primary Care • *Percentage of clients who have had a 7-day post hospital discharge follow-up (Community Health Centre, Aboriginal Health Access Centres, Nurse Practitioner-Led Clinic Profiles - AOHC sponsored reports)* – indicator has been modified to include AHACs and NPLCs along with CHCs • *Timely follow-up with hospital discharged patients* – the previous version '*Timely follow up with hospital discharged patients, by phone or in-person with any clinician, within 7 days of discharge (for patients for whom discharge notification was received)'* indicator has been updated based on AFHTO's D2D 5.1 • *Patient experience: Patient involvement in decisions about care* – the numerator and denominator fields were revised • *Timely access to primary care provider (patient perception)* – the numerator and denominator fields were revised • *Percentage of eligible patients overdue for colorectal cancer screening* – the clarification on reference to SAR reports has been added • *Percentage of Ontario screen-eligible women, 21–69 years old, who completed at least one Pap test in 42-month period* – the clarification on reference to SAR reports has been added
January 10, 2018	Home Care • *Falls for long-stay clients* – changes to methodology have been made based on HSSOntario's recommendation
January 15, 2018	Long Term Care • *Pressure ulcers* – small clarification was added to the description of this indicator

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Introduction: Quality Issues

This document specifies indicator definitions, calculations, reporting periods, and other technical information for hospitals, primary care organizations, LHIN home and community care services, and long-term care (LTC) homes to use in their 2018/19 Quality Improvement Plans (QIPs). It also includes the narrative questions organizations are to answer to provide a address important quality issues.

The indicators described within this document were carefully chosen as representative of corresponding quality issues by Health Quality Ontario and a number of collaborators.* These key quality issues reflect organizational and sector-specific priorities, as well as system-wide, transformational priorities where improved performance is co-dependent on collaboration with other sectors. Achieving system-wide change on these issues requires every sector and every organization to prioritize quality improvement.

Each sector has its own list of recommended priority and additional indicators to measure performance on these key quality issues. The hospital sector has a mandatory indicator as well. A summary of the quality issues and indicators for the 2018/19 QIPs is presented in Figure 1.

- **Mandatory indicators** are tied to issues where province-wide improvement is urgently required. Performance on these issues/indicators directly impacts patients, residents, and health care providers across the province. Achieving improved performance in these areas requires every organization within a sector to prioritize the required quality issue and indicator and actively engage in QI activities to support improvement. These mandatory indicators are required in your organization's QIP. These 'mandatory' issues and indicators will be clearly identified and communicated to you via a variety of mechanisms include the QIP Matrix, QIP Navigator, QIP Annual Memo and What's New documents. **Mandatory indicators only apply to the hospital sector.**

- Review the **priority indicators** recommended for your sector and determine which are relevant for your organization. To support this process, your organization should review its current performance against provincial data and benchmarks for all priority indicators; organizations scoring poorly in comparison with provincial averages/benchmarks are strongly encouraged to select these indicators in their QIP. If your organization elects not to include a priority indicator in the QIP (for example, because performance already meets or exceeds the benchmark or is theoretical best), the reason should be documented in the comments section of the QIP Workplan.

- **Additional indicators** also measure important areas for quality improvement and can be included in your QIP to reflect your organization's specific quality improvement goals and opportunities.

- You may also choose to add **custom indicators** to reflect local initiatives or to modify the existing indicators to be more consistent with measurements used in your organization.

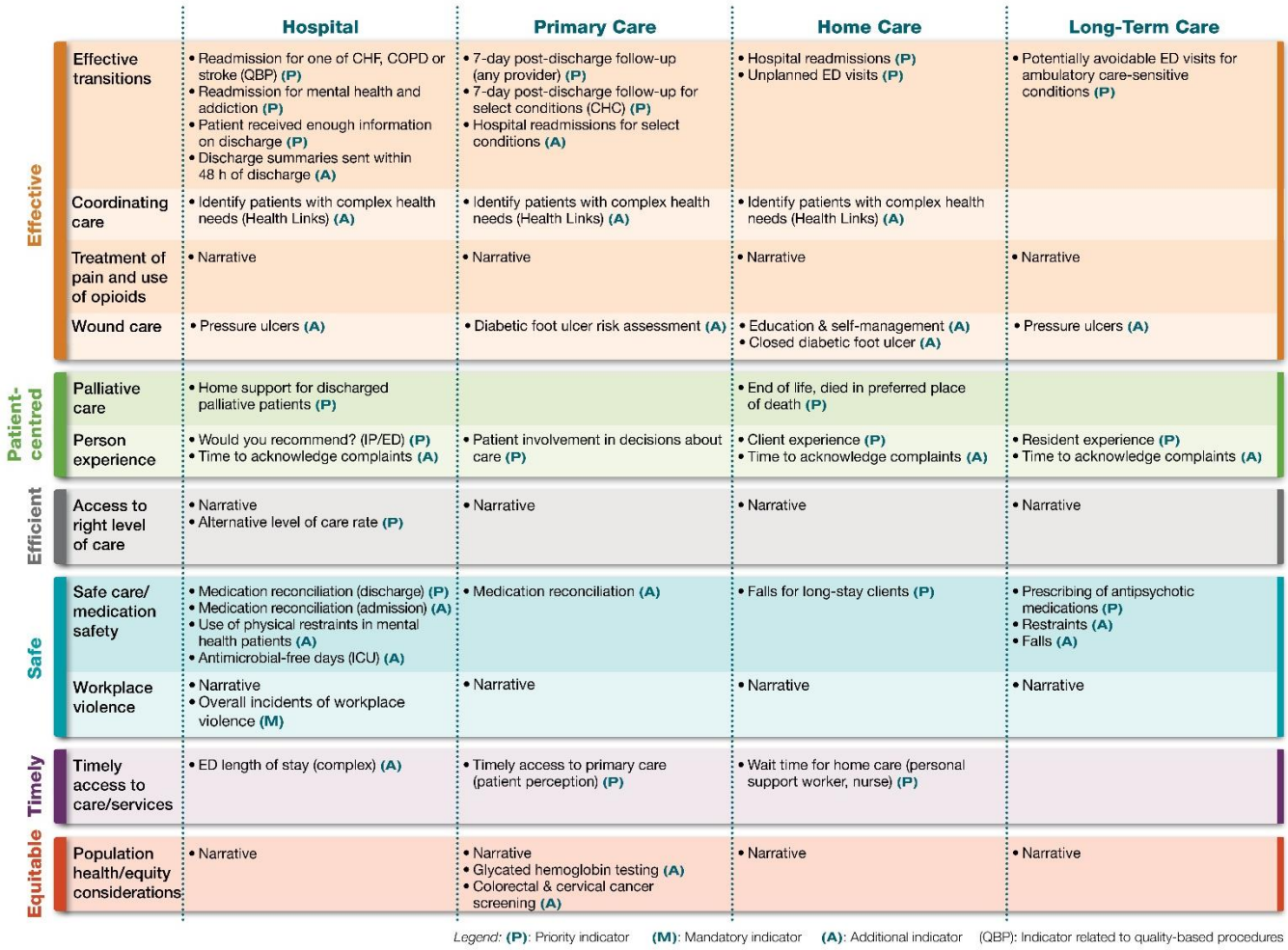
We encourage you to review the issues and indicators for other sectors as well as your own. While each sector has their own set of issues and indicators, many of these cannot be addressed without collaboration with other organizations. To support this, organizations should familiarize themselves with the work of peer organizations across the province or organizations in their region to identify opportunities for alignment or collaboration. To download individual QIPs or to search the QIP database, please visit the QIP Navigator website (https://qipnavigator.hqontario.ca/).

Health Quality Ontario also reports on other indicators that are not included as priority or additional indicators in the QIP program – for example, the indicators measured in our yearly report, Measuring Up. Definitions and technical specifications for all indicators reported on by Health Quality Ontario are included in our indicator library.

Please note that indicator results that are based on small numbers (numerators < 5; denominators < 30) should be interpreted with caution because of potentially unstable rates or potential risk to patient privacy. Because of these risks, results could be suppressed when the data are provided by external organizations (e.g., Ministry of Health and Long-Term Care, QIP Navigator). For more information on data suppression, please contact Health Quality Ontario at QIP@hqontario.ca.

**Health Quality Ontario thanks the following groups for contributing to the identification and definition of the issues and indicators for the 2018/19 QIPs: Health Quality Ontario's Patient, Family and Public Advisory Council; the Quality Improvement Plan Advisory Committee; the Association of Family Health Teams of Ontario; the Association of Ontario Health Centres; the Ontario Long-Term Care Association; the Ontario Association of Non-Profit Homes & Services for Seniors; the Ontario Association of Community Care Access Centres; the Registered Nurses' Association of Ontario; the Ontario Palliative Care Network; Cancer Care Ontario; the Institute for Clinical Evaluative Sciences; the Canadian Institute for Health Information; the Ministry of Health and Long-Term Care; and Ontario's Local Health Integration Networks.*

Figure 1. Quality issues and indicators for the 2018/19 QIPs



		Hospital	Primary Care	Home Care	Long-Term Care
Effective	Effective transitions	• Readmission for one of CHF, COPD or stroke (QBP) **(P)** • Readmission for mental health and addiction **(P)** • Patient received enough information on discharge **(P)** • Discharge summaries sent within 48 h of discharge **(A)**	• 7-day post-discharge follow-up (any provider) **(P)** • 7-day post-discharge follow-up for select conditions (CHC) **(P)** • Hospital readmissions for select conditions **(A)**	• Hospital readmissions **(P)** • Unplanned ED visits **(P)**	• Potentially avoidable ED visits for ambulatory care-sensitive conditions **(P)**
	Coordinating care	• Identify patients with complex health needs (Health Links) **(A)**	• Identify patients with complex health needs (Health Links) **(A)**	• Identify patients with complex health needs (Health Links) **(A)**	
	Treatment of pain and use of opioids	• Narrative	• Narrative	• Narrative	• Narrative
	Wound care	• Pressure ulcers **(A)**	• Diabetic foot ulcer risk assessment **(A)**	• Education & self-management **(A)** • Closed diabetic foot ulcer **(A)**	• Pressure ulcers **(A)**
Patient-centred	Palliative care	• Home support for discharged palliative patients **(P)**		• End of life, died in preferred place of death **(P)**	
	Person experience	• Would you recommend? (IP/ED) **(P)** • Time to acknowledge complaints **(A)**	• Patient involvement in decisions about care **(P)**	• Client experience **(P)** • Time to acknowledge complaints **(A)**	• Resident experience **(P)** • Time to acknowledge complaints **(A)**
Efficient	Access to right level of care	• Narrative • Alternative level of care rate **(P)**	• Narrative	• Narrative	• Narrative
Safe	Safe care/ medication safety	• Medication reconciliation (discharge) **(P)** • Medication reconciliation (admission) **(A)** • Use of physical restraints in mental health patients **(A)** • Antimicrobial-free days (ICU) **(A)**	• Medication reconciliation **(A)**	• Falls for long-stay clients **(P)**	• Prescribing of antipsychotic medications **(P)** • Restraints **(A)** • Falls **(A)**
	Workplace violence	• Narrative • Overall incidents of workplace violence **(M)**	• Narrative	• Narrative	• Narrative
Timely	Timely access to care/services	• ED length of stay (complex) **(A)**	• Timely access to primary care (patient perception) **(P)**	• Wait time for home care (personal support worker, nurse) **(P)**	
Equitable	Population health/equity considerations	• Narrative	• Narrative • Glycated hemoglobin testing **(A)** • Colorectal & cervical cancer screening **(A)**	• Narrative	• Narrative

Legend: **(P)**: Priority indicator **(M)**: Mandatory indicator **(A)**: Additional indicator (QBP): Indicator related to quality-based procedures

I. Hospital Indicators

New indicators are identified via a **"NEW"** icon.

Hospital Priority Indicators

Indicator Name **NEW**	**Number of workplace violence incidents (overall)**
Mandatory, priority or additional indicator?	**Mandatory**
Dimension	Safety
Direction of Improvement	If your organization is focused on building your reporting culture, your QIP target for this indicator may be to increase the number of reported incidents. If your organization's reporting culture is already well-developed, your QIP target may be to decrease.
Type	Outcome
Description	This indicator measures the number of reported workplace violence incidents by hospital workers (as defined by OHSA) within a 12-month period
Unit of Measurement	Number of workplace violence incidents reported by hospital workers
Calculation Methods	Number of workplace violence incidents reported by hospital workers within a 12-month period Inclusions: The terms "worker" and "workplace violence" as defined by under the Occupational Health and Safety Act (OHSA, 2016)
Numerator	N/A
Denominator	N/A
Risk adjustment	N/A
Current performance: reporting period	January – December 2017
Data source	Local data collection The number of reported workplace violence incidents is available via your organization's internal reporting mechanisms.
How to access data	Hospitals are encouraged to use their in-house hospital incident and patient safety reporting systems for determining the number of reported workplace violent incidents
Comments	For quality improvement purposes, hospitals are asked to collect data on the number of violent incidents reported by workers, including physicians and those who are contracted by other employers (e.g., food services, security, etc.) as defined by the Occupational Health and Safety Act. Worker means any of the following: • A person who performs work or supplies services for monetary compensation. • A secondary school student who performs work or supplies services for no monetary compensation under a work

	experience program authorized by the school board that operates the school in which the student is enrolled. • A person who performs work or supplies services for no monetary compensation under a program approved by a college of applied arts and technology, university or other post-secondary institution. • A person who receives training from an employer, but who, under the Employment Standards Act, 2000, is not an employee for the purposes of that Act because the conditions set out in subsection 1 (2) of that Act have been met. • Such other persons as may be prescribed who perform work or supply services to an employer for no monetary compensation. Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. It also includes an: • attempt to exercise physical force against a worker in a workplace, that could cause physical injury to the worker; and a • statement or behaviour that a worker could reasonably interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker For more information, please see the following resources to identify recommended practices and change ideas, key terms, references, etc.: Preventing Workplace Violence in the Health Care Sector Report Ministry of Labour Workplace Violence and Harassment Key Terms and Concepts **While there is no denominator for this indicator, organizations are asked to include the total number of hospital employee full-time equivalents (FTE) in the measures section of the QIP Workplan.** This information will be useful to support QIP analysis and interpretation (e.g., organizational size). Full time equivalence data is accessed via hospitals human resource information systems and, by definition, may not necessarily include all 'workers' as defined above but is used to provide context.- If the count of incidents is =/< 5, the value will be suppressed.

Indicator Name	**Risk-adjusted 30-day all-cause readmission rate for patients with congestive heart failure (quality-based procedures cohort)**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Definition	The measuring unit of this indicator is an admission for congestive heart failure, as defined for quality-based procedures (QBP). Results are expressed as the risk-adjusted all-cause 30 day non-elective readmission rate among patients admitted to Ontario acute care facilities.
Unit of Measurement	Rate
Calculation Methods	Numerator / denominator
Numerator	Number of admitted patients with congestive heart failure discharged with a readmission within 30 days.
Denominator	Total number of congestive heart failure index discharges from hospital *Inclusions*: • Ontario residents with a valid health card number • Age >= 20 years • Most responsible diagnosis of congestive heart failure *Exclusions*: • Surgical cases • Records with missing admission or discharge dates • Records where patient had an acute transfer out, or where discharge disposition is sign out or death
Risk adjustment	Age, gender, Charlson co-morbidity index, case mix, previous inpatient admissions within 30, 60 or 90 days as a general proxy for patient complexity, calendar year
Current performance: reporting period	January 2016 – December 2016
Data source	Discharge Abstract Database (DAD). Data provided to HQO by Ministry of Health and Long-term Care (MOHLTC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.
Comments	This indicator provides an opportunity to incorporate QBP indicators into the QIP for specific QBP Cohorts. The expectation is that hospitals will consider including within their QIP one of the QBP readmission indicators, but hospitals are not expected to include all three. Organizations are encouraged to consider QBP process measures and change ideas to reduce readmissions for one of these select groups. QBP Baseline Reports are accessible through the password-protected Health Data Branch web portal: https://hsim.health.gov.on.ca/hdbportal/

Indicator Name	**Risk-adjusted 30-day all-cause readmission rate for patients with chronic obstructive pulmonary disease (quality-based procedures cohort)**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	The measuring unit of this indicator is an admission for chronic obstructive pulmonary disease (COPD), as defined for the QBP. Results are expressed as risk-adjusted all-cause 30-day non-elective readmission rate among patients admitted to Ontario acute care facilities.
Unit of Measurement	Rate
Calculation Methods	Numerator / denominator
Numerator	Number of admitted patients with chronic obstructive pulmonary disease discharged with a readmission within 30 days.
Denominator	Total number of chronic obstructive pulmonary disease index discharges from hospital. *Inclusions*: • Ontario residents with a valid health card number • Age >= 35 • Most responsible diagnosis of chronic obstructive pulmonary disease *Exclusions*: • Major clinical category partition of Intervention • Most responsible diagnosis of Panlobular emphysema, Centrilobular emphysema, or Macleod's syndrome • Missing admission date, discharge date, or age • Records where patient had an acute transfer out, or where discharge disposition is sign out or death
Risk adjustment	Age, gender, Charlson co-morbidity index, case mix, previous inpatient admissions within 30, 60 or 90 days as a general proxy for patient complexity, Health-Based Allocation Model (HBAM) Inpatient Grouper (HIG) case mix, calendar year
Current performance: reporting period	January 2016 – December 2016
Data source	Discharge Abstract Database (DAD). Data provided to HQO by Ministry of Health and Long-term Care (MOHLTC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.
Comments	This indicator provides an opportunity to incorporate QBP indicators into the QIP for specific QBP Cohorts. The expectation is that hospitals will consider including within their QIP one of the QBP readmission indicators, but hospitals are not expected to include all three. Organizations are encouraged to consider QBP process measures and change ideas to reduce readmissions for one of these select groups. QBP Baseline Reports are accessible through the password-protected Health Data Branch web portal: https://hsim.health.gov.on.ca/hdbportal/

Indicator Name	**Risk-adjusted 30-day all-cause readmission rate for patients with stroke (quality-based procedures cohort)**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	The measuring unit of this indicator is an admission for stroke, as defined for the QBP. The result is risk-adjusted all-cause readmission rate among patients admitted to Ontario acute care facilities.
Unit of Measurement	Rate
Calculation Methods	Numerator / denominator
Numerator	Number of admitted patients with stroke discharged with a readmission within 30 days.
Denominator	Total number of stroke index discharges from hospital. *Inclusions*: • Ontario residents with a valid health card number • Age >= 18 years • Most responsible diagnosis of stroke or transient ischemic attack *Exclusions*: • Most responsible diagnosis of transient global amnesia or cerebral infarction due to cerebral venous thrombosis • Records with stroke as a post-admit complication • Missing admission date, discharge date or age • Records where patient had an acute transfer out, or where discharge disposition is sign out or death
Risk adjustment	Age, gender, Charlson co-morbidity index, case mix, previous inpatient admissions within 30, 60 or 90 days as a general proxy for patient complexity, Health-Based Allocation Model (HBAM) Inpatient Grouper (HIG) case mix, calendar year
Current performance: reporting period	January 2016 – December 2016
Data source	Discharge Abstract Database (DAD). Data provided to HQO by Ministry of Health and Long-term Care (MOHLTC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.
Comments	This indicator provides an opportunity to incorporate QBP indicators into the QIP for specific QBP Cohorts. The expectation is that hospitals will consider including within their QIP one of the QBP readmission indicators, but hospitals are not expected to include all three. Organizations are encouraged to consider QBP process measures and change ideas to reduce readmissions for one of these select groups. QBP Baseline Reports are accessible through the password-protected Health Data Branch web portal: https://hsim.health.gov.on.ca/hdbportal/

Indicator Name	**Hospital readmission rates for a mental illness or an addiction**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission.
Unit of Measurement	Rate per 100 discharges
Calculation Methods	Readmission rate equals the number of patients readmitted within 30 days of discharge divided by the number of patients discharged during the study period. OMHRS and CIHI/DAD databases are used to identify index as well as subsequent hospitalizations for mental health and addictions.
Numerator	Number of individuals with any MH&A hospital readmissions* within (≤) 30 days following the incident hospital discharge in the reporting period. For any MHA hospital discharge (denominator), calculate the following readmissions (numerator): 1. Any MHA Admission during follow-up period: • DAD ICD-10-CA Dx10Code1: F04 to F99, • or OMHRS DSM-IV: Any hospital admission (including missing diagnosis except for DSM-IV 290.x. 294.x in AXIS1_DSM4CODE_DISCH1) *Exclusions*: • Patients without a valid health insurance number • Patients without an Ontario residence • Gender not recorded as male or female • Age < 15 or Age > 105 • Invalid date of birth, admission date/time, discharge date/time • Individuals who die within 30 days of discharge (based on RPDB) before a follow-up or outcome occurs (i.e. a person dies before they have been readmitted or is readmitted but dies before they are discharged) • Any non-MH&A hospital readmissions* Notes: • Separately report the number of individuals who died and re-admitted during the follow-up period overall in all years. • Calculate within (≤) 30 days acute care re-admission proportion following the index MH&A hospital discharge date (i.e. Count only one visit per IKN per 30 day follow-up period). • *Reason for re-admission can be for a different MH&A reason than the initial MH&A diagnosis. • Incident discharges are restricted to calendar years but 30 day follow-up for readmission can cross over into the next calendar year.

Denominator	Total number of incident MH&A hospital discharges in the reporting period. Incident = 1st event in a calendar period without any look-back for past events (If multiple hospital visits in CY, use first). Keep only one discharge person per year. MH&A Hospital Discharges: From DAD var DX10CODE1 with any of the following ICD-10-CA codes: F04 to F99 From OMHRS: • If var AXIS1_DSM4CODE_DISCH1 complete* use AXIS1_DSM4CODE_DISCH1 • No, use PROVDX1 *Complete = listed diagnosis from below present Exclude OMHRS admissions if AXIS1_DSM4CODE_DISCH1 in: (290.x OR 294.x) Include visits with suspect diagnoses (suspect = T). With any of the following DSM-IV codes/provisional diagnoses: • Overall MHA ▪ ICD-10-CA: F04 to F99 ▪ DSM-IV: Any (including missing diagnoses, excluding 290.x. 294.x in AXIS1_DSM4CODE_DISCH1 which are dementia codes) ** MH&A diagnostic categories represent reason for the incident hospital discharge. Disposition of hospital discharge: • From DAD where var DISCHDISP = 2,3,4,5,6,12 • From OMHRS where var DISCHREASON = 1,5,6,7,8 • Exclude discharges with a DAD/OMHRS record within 1 day (i.e. are not a true discharge and are a transfer). Note: re-hospitalizations (numerator) do not have to result in discharge home Hospitalizations should be constructed as episodes using the following steps: 1) i) Pull all DAD and OMHRS records between the specified calendar years (CY) being examined for this indicator with an ICD-10-CA primary discharge diagnosis of F04 to F99 or DSM-IV codes, excluding 290.x and 294.x ○ Identify the IKNs found for these records 2) For **only the IKNs identified in the previous step**, pull all DAD records from 1988 onwards and all OMHRS records for all diagnoses, i.e. not only mental health diagnoses, and create

	episodes by adjoining OMHRS/DAD records that overlap within (+/-) 1 day. These will be considered part of a single episode. 3) Use discharge diagnoses and other variables from the final discharge of the episode ○ Note, if 2 or more records have the same discharge date as the discharge date of the episode, use an OMHRS discharge diagnoses, if applicable (i.e. if one record is DAD and one is OMHRS, take the OMHRS diagnoses) *Inclusions*: • 15 - 105 years i.e. Age >=15 and Age <=105 (other stratifications) *Exclusions:* • Patients without a valid health insurance number • Patients without an Ontario residence • Gender not recorded as male or female • Age < 15 or Age > 105 • Invalid date of birth, admission date/time, discharge date/time • Individuals who die within 30 days of discharge (based on RPDB) before a follow-up or outcome occurs (i.e., a person dies before they have been readmitted or is readmitted but dies before they are discharged) Note: If OMHRS records occurs within 24 hours of discharge/admission from institution then this should be considered as part of the same episode of care.
Risk adjustment	None
Current performance: reporting period	January 2016 – December 2016
Data source	Discharge Abstract Database (DAD), Ontario Mental Health Reporting System (OMHRS), Registered Persons Database (RPDB) Data to be provided to HQO by Ministry of Health and Long Term Care (MOHLTC)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.
Comments	See HQO's Indicator Library for limitations and caveats: http://www.hqontario.ca/System-Performance/Measuring-System-Performance/Indicator-Library

Indicator Name	**Patient experience: Did you receive enough information when you left the hospital?**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of respondents 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?
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 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. “Top box” refers to the respondents who choose the only the most positive response. Top-box Instructions: 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 (do not include non-respondents).
Risk adjustment	None
Current performance: reporting period	Average of all survey responses collected during Q1 FY 2017/18 i.e. April 2017 - June 2017
Data source	Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey – Inpatient Care (CPES)
How to access data	These data should be accessed from within your own organization.

Indicator Name	**Home support for discharged palliative patients**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percent of palliative care patients discharged home from hospital with the discharge status “Home with Support”
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Out of denominator (see below), number of inpatient acute care discharges who are discharged “home with support” (DAD Discharge disposition = 04)
Denominator	The number of home discharges in the reporting period with a hospital admission that indicates that the patient is receiving palliative care. *Inclusions*: 1) Any diagnosis code with a palliative care indication: ICD 10 Code Z51.5 or ICD 9 Code V66.7 **or** 2) Main patient service of palliative care (PATSERV = 058) **And** Discharge destination is home (Discharge disposition = 4 (home with support) or 5 (home without support) *Exclusions**:*** Same-day surgery
Risk adjustment	None
Current performance: reporting period	April 2016 – March 2017
Data source	Discharge Abstract Database (DAD). Data provided to HQO by Cancer Care Ontario (CCO)
How to access data	To access your organization’s data for the reporting period, refer to Health Quality Ontario’s QIP Navigator. Data will be available in February 2017.
Comments	For this indicator, “palliative care patient” is defined as an individual who was admitted as an inpatient with a palliative care indication. The indicator is reported at the level of admissions rather than unique patients, thus could capture multiple admissions per patient. For this indicator, ‘Discharged home with support’ and ‘Discharged home without support’ are derived from the following definitions from the CIHI DAD database: Home with Support (Discharge Disposition = 04): Discharged to home or a home setting with support services (senior’s lodge, attendant care, home care, meals on wheels, homemaking, supportive housing, et cetera) a. Example of discharged to a home setting with support: A facility where supervisory care is not required on a continuing basis. A patient is discharged and is able to function independently within a group setting. Community services would be brought in to provide support, when

	necessary. b. Example of discharged home with support services: A patient is discharged home with the support of home care workers who are providing daily dressing changes and wound care. Home without Support (Discharge Disposition = 05): Discharged home (patient functions independently with no support service from an external agency required) Nursing homes are not considered private residences (home) since there are support services at some level required.

Indicator Name	**Patient experience: Would you recommend inpatient care?**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of respondents who responded positively to the following question from the Canadian Patient Experiences Survey - Inpatient Care (CPES-IC): "Would you recommend this hospital to your friends and family?"
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Adult Inpatient (medical/surgical): From the Canadian Patient Experience Survey – Inpatient Care (CPES-IC): “Would you recommend this hospital to your friends and family?” ☐ Definitely no ☐ Probably no ☐ Probably yes ☐ Definitely yes Top-box Instructions: Add the number of respondents who responded “Definitely yes” and divide by number of respondents who registered any response to this question (do not include non-respondents).
Numerator	Number of survey respondents who answered "Definitely yes" to the following survey question: Would you recommend this hospital to family and friends? - Definitely no - Probably no - Probably yes - Definitely yes
Denominator	Number of survey respondents (exclude non-respondents)
Risk adjustment	None
Current performance: reporting period	Average of all survey responses collected during Q1 FY 2017/18 i.e. April 2017 - June 2017.
Data source	Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey – Inpatient Care (CPES)
How to access data	These data should be accessed from within your own organization.

Indicator Name	**Patient experience: Would you recommend emergency department?**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of respondents who responded positively to the following question from the Ontario Emergency Department Patient Experiences of Care Survey (EDPEC): "Would you recommend this emergency department to your friends and family?"
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Emergency Department: Ontario Emergency Department Patient Experience of Care Survey (EDPEC):"Would you recommend this emergency department to your friends and family?" ☐ Definitely no ☐ Probably no ☐ Probably yes ☐ Definitely yes Top-box Instructions: Add the number of respondents who responded "Definitely yes" and divide by number of respondents who registered any response to this question (do not include non-respondents).
Numerator	Number of survey respondents who answered "Definitely yes" to the following survey question: Would you recommend this emergency department to family and friends? - Definitely no - Probably no - Probably yes - Definitely yes
Denominator	Number of survey respondents (exclude non-respondents)
Risk adjustment	None
Current performance: reporting period	Average of all survey responses collected during Q1 FY 2017/18 i.e. April 2017 - June 2017.
Data source	Emergency Department Patient Experiences of Care (EDPEC)
How to access data	These data should be accessed from within your own organization.

Indicator Name	**Alternate level of care rate**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Efficient
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data
Unit of Measurement	Rate per 100 inpatient days
Calculation Methods	Numerator / denominator x 100% Please note that only those facilities (Acute & Post-Acute) submitting both ALC data (to the Wait Time Information System (WTIS))and Bed Census Summary (BCS) data (through the Health Database Web Portal) are included in 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	Total number of inpatient days designated as ALC in a given time period (i.e. monthly, quarterly, and yearly). Calculation: • Acute ALC days = the total number of ALC days contributed by ALC patients waiting in non-surgical (NS), surgical (SU), and intensive/critical care (IC) beds. • Post-Acute ALC days = ALC days for Inpatient Services CC + RB + MH • CCC ALC days = ALC days for Inpatient Service CC • Rehab ALC days = ALC days for Inpatient Service RB • Mental Health ALC days = ALC days for Inpatient Service MH *Exclusions*: • ALC cases discontinued due to 'Data Entry Error'. • ALC cases having Inpatient Service = Discharge Destination for Post-Acute Care (*Exception: Bloorview Rehab, CCC to CCC). • 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, then ALC days = 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 BCS)
Denominator	Total number of inpatient days in a given time period (i.e., monthly, quarterly, and yearly). Calculation:

	• Acute Patient days = the total number of patient days contributed by inpatients in Medical (MED) + Surgical (SURG) + Combined Medical & 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) + Newborns (Level 1 - General + Level 2 - Intermediate + Level 3 - ICU Neonatal + Not in Regular) • Post-Acute Patient days = the total number of patient days contributed by inpatients in Chronic (Chronic) + General Rehabilitation (Gen. Rehab) + Special Rehabilitation (Spec. Rehab) + Acute Psych (Acute Psy) + Addiction (Addiction) + Forensic (Forensic) + Psychiatric Crisis Unit (Crisis Unit) + Longer Term Psychiatric (Long Term) • CCC Patient days = the total number of patient days contributed by inpatients in complex continuing care (Chronic) beds • Rehab Patient days = the total number of patient days contributed by inpatients in General Rehabilitation (Gen. Rehab) + Special Rehabilitation (Spec. Rehab) • Mental Health Patient days = the total number of patient days contributed by inpatients in Acute Psych (Acute Psy) + Addiction (Addiction) + Forensic (Forensic) + Psychiatric Crisis Unit (Crisis Unit) + Longer Term Psychiatric (Long Term) *Exclusions*: • Patient days contributed by inpatients in the emergency department (Bed Type = Emergency (Emerg + PARR, Emergency + PARR)).
Risk adjustment	None
Current performance: reporting period	July 2017 – September 2017
Data source	Bed Census Summary (BCS), Wait Time Information System (WTIS). Data provided to HQO by Cancer Care Ontario (CCO)
wHow to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018. Alternatively, hospitals can access ALC reports via the Access to Care Site at https://share.cancercare.on.ca. Those not registered can contact Access To Care at ATC@cancercare.on.ca.
Comments	Consistent with the Hospital Service Accountability Agreement performance measure

Indicator Name	**Medication reconciliation at discharge**
Mandatory, priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Safe
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged.
Unit of Measurement	Rate per total number of discharged patients
Calculation Methods	Numerator / denominator To ensure a standardized approach to measurement, hospitals will now be asked to provide their numerator and denominator in the QIP workplan; QIP Navigator will calculate the rate.
Numerator	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created. Excludes hospital discharge that is death, newborn or stillborn. Any additional exclusions should be documented in the comments section of the QIP.
Denominator	Number of patients discharged from the hospital. Excludes hospital discharge that is death, newborn or stillborn. Any additional exclusions should be documented in the comments section of the QIP. Note: Hospitals will be asked to provide the total number of hospital discharges within the reporting period.
Risk adjustment	None
Current performance: reporting period	October – December (Q3) 2017
Data source	Local data collection
How to access data	These data should be accessed from within your own organization.
Comments	Organizations should report current performance and set targets for medication reconciliation at discharge at the organization level (i.e., for the entire hospital). Hospitals will be asked to provide the total number of hospital discharges within the reporting period. Hospitals are also asked to identify any programs or patients that are not included in their medication reconciliation calculation. For assistance with monitoring your ongoing medication reconciliation processes, visit the Measures page on the Safer Healthcare Now! website or contact metrics@saferhealthcarenow.ca.

Hospital Additional Indicators

Indicator Name	**Percent discharge summaries sent from hospital to community care provider within 48 hours of discharge**
Mandatory, priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Calculate number of discharge summaries transcribed, signed and sent within 48 hours of patient's discharge from hospital for the time period.
Numerator	Number of patients discharged from hospitals for whom a discharge summary is sent to primary care provider within 48 hours of discharge (electronically or by fax) for the time period. *Inclusions*: • Acute and post-acute hospital inpatient discharge summaries sent electronically to primary care provider with access to Hospital Report Manager, Clinical Connect or similar, or by fax to those without electronic access. *Exclusions*: • Discharges of inpatients who do not have a documented primary care provider. • Discharges from outside the LHIN. • Emergency Department patients. • Newborns, deaths, and delivery summaries.
Denominator	Number of inpatients discharged for the time period. *Inclusions*: • Acute and post-acute hospital inpatient discharge. *Exclusions*: • Discharges of inpatients whose primary care provider is not identified. • Emergency Department patients. • Newborns, deaths, and delivery summaries
Risk adjustment	None
Current performance: reporting period	Most recent 3-month period.
Data source	Local data collection
How to access data	Local data collection

Comments	Recommend organizations consider pilot testing this indicator in one program or unit for 2018/19 QIP. Timely distribution of discharge summaries is predicated on the following core elements: • Physicians (or delegate) dictate discharge summary as close to patient's discharge time (preferably before) as possible • Transcription to occur within 24 hours of dictation • Activate 'auto-authentication' to ensure one-step distribution of the discharge summary upon signature (note: will be e-HR specific and may require Medical Advisory (or similar) approval) • Improvement efforts may focus on (1) getting discharge summaries prepared and signed in a timely manner, and (2) signed discharge summaries distributed in a timely manner.

Indicator Name	**Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach**
Mandatory, priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Identify patients with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach The complex patient target population should: • Overlap substantially with high cost users, recognizing that not all high cost users are high needs patients (and vice versa); • Include patients with high needs and/or complex conditions; and, • Include patients with four or more chronic/high cost conditions, including a focus on individuals living with mental health and addictions, palliative patients, and the frail elderly. However, recognizing nuances exist across communities, LHINs and Health Links are encouraged to adapt the patient identification criteria to their local context and population needs.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Total number of patients who were offered access to the Health Link approach
Denominator	Total number of patients identified through clinical level assessments and/or data-driven case-finding methods sourced as meeting Health Links criteria *Exclusions*:

	• Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond the Health Link catchment area, or have died.
Risk adjustment	None
Current performance: reporting period	Most recent 3-month period.
Data source	Local, manual data collection (health record, EMR, other)
How to access data	Local data collection
Comments	In late 2015, Health Quality Ontario completed a review of the best available information about Health Links and analysis of innovations related to coordinated care management. The innovations framework includes detailed information to help organizations identify patients with multiple conditions and complex needs through clinical level assessments and data driven case finding methods at any point in the patient's health care journey. **Patients identification approaches:** Use ***clinical level patient identification mechanisms*** to support identification of patients during a service encounter. For example, as each patient presents to a health or wellness organization or program to receive care, the provider may identify that the patient may benefit from a Health Links/Coordinated Care Management approach. To further support clinical decision making, the provider may then administer a standardized risk assessment tool, if indicated. Use ***data driven case finding mechanisms*** to support prospective identification of patients with multiple conditions and complex needs using utilization data to identify complex patients. For example, triggers such as the number of visits to the emergency department, number/length of admissions to hospital within a specified time frame, or patients with specific diagnoses or conditions can be built into the electronic medical record or can be managed by targeted data extraction and analysis methods, to support the identification of potential patients with multiple conditions and complex needs. Note: A single, cross-sectorial clinical level risk assessment tool/method with adequate sensitivity and specificity to capture every patient who would benefit from a Health Links/Coordinated Care Management approach was not identified. However, the following risk assessment tools were highlighted by Health Links during the environmental scan, and are presented here for consideration based on the practice setting. The decision to implement/administer one of these tools must be considered alongside other contextually relevant information. • LACE (Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits) • PRA (Predictive Repetitive Admission) • DIVERT Scale (Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale) For more technical details, please refer to Identify Patients: Use a Combination of Clinical and Data Driven Strategies

	Note: Once a patient who has multiple conditions or complex needs has been identified, the organization should connect to the processes established by the local Health Link.

Indicator Name	**Pressure ulcers for complex continuing care patients**
Mandatory, priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Percentage of patients (residents) receiving complex continuing care with a newly occurring Stage 2 or higher pressure ulcer in the last three months
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of complex continuing care (CCC) patients (residents) that developed a new stage 2 or higher pressure ulcer in the 3-month period
Denominator	Total number of patients (residents) receiving complex continuing in the 3-month period
Risk adjustment	None
Current performance: reporting period	July 2017 – September 2017
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018. Alternatively, refer to CIHI's CCRS eReports for your organization's rates.
Comments	This indicator represents a rolling four-quarter average.

Indicator Name **NEW**	**Percentage of complaints acknowledged to the individual who made a complaint within three to five business days**
Mandatory, priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint. This indicator is calculated on the number of complaints received in the reporting period.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Percent acknowledged within three to five business days = Number of complaints acknowledged between three and five business days divided by the total number of complaints received in the reporting period.

	To ensure a standardized approach to measurement, hospitals will now be asked to provide their numerator and denominator in the QIP workplan; QIP Navigator will calculate the rate.
Numerator	Number of complaints that received a formal acknowledgement within three to five business days
Denominator	All complaints received by the hospital within the reporting period *Inclusion Criteria:* • Complaints received within the reporting period, but acknowledged and closed in the first 60 days of the following reporting period • The day and time of complaint should be recorded • Complaints received on and between the first and last day of the reporting period, including non-business days and after hours • Repeated complaints on the same issue from the same individual or by a different individual on behalf of the same patient/resident are counted as a single complaint • One complaint may include numerous issues, but should be counted as a single complaint • Complaints included must be documented through the established complaints process • Oral complaints made in person or by phone call • Written complaints made by letter, email, fax, text, etc. *Exclusion Criteria:* • The complaint is not documented through the established complaints process. For example: • Complaints that were acknowledged and resolved immediately after the complaint was received (e.g. changing the temperature in a patient or resident's room) • The complaint needed no additional intervention
Risk adjustment	None
Current performance: reporting period	Most recent 12-month period
Data source	Local data collection
How to access data	Local data collection
Comments	By regulation, hospitals must acknowledge complaints within five business days. Complaints received by the facility need to be formally acknowledged to the individual who made the complaint. Any hospital that currently acknowledges all of their complaints within 3 to 5 business days may wish to consider other custom indicators as set out below: Percent acknowledged within two business days = Number of complaints acknowledged within two business days divided by the total number of complaints received in the reporting period.

	Other indicators to consider can be found on Health Quality Ontario's Indicator Library: http://www.hqontario.ca/System-Performance/Measuring-System-Performance/Indicator-Library

Indicator Name	**90th percentile emergency department length of stay for complex patients**
Mandatory, priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Timely
Direction of Improvement	Reduce (lower)
Type	Process
Description	The total ED length of stay* where 9 out of 10 complex patients completed their visits. *ED Length of Stay defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED.
Unit of Measurement	Hours
Calculation Methods	Step 1: Calculate ED length of stay in hours for each patient. Step 2: Apply inclusion and exclusion criteria. Step 3: Sort the cases by ED length of stay from shortest to longest. Step 4: The 90th percentile is the case where 9 out of 10 complex patients have completed their visits. *Inclusions*: • Admitted patients – Disposition Codes 06 and 07 • Non-Admitted Patients – (Disposition Codes 01, 04 – 05 and 08 – 15) with assigned CTAS I, II, or III *Exclusions*: • ED visits where Registration Date/Time and Triage Date/Time are both blank/unknown (9999) • ED visits where the MIS functional centre is under Emergency Trauma, Observation or Emergency Mental Health Services (as of January 2015 data) • Duplicate cases within the same functional center where all ER data elements have the same values except for Abstract ID number • ED visits where the ED visit Indicator is = '0' • ED visits where patient has left without being seen by a physician during his/her visit (Disposition Code 02 and 03) • ED Length of Stay is greater than or equal to 100000 minutes (1666 hours) • Non-Admitted Patients (Disposition Codes 01 – 05 and 08 – 15) with assigned CTAS IV or V • Non-Admitted Patients (Disposition Codes 01 – 05 and 08 – 15) with missing CTAS
Numerator	n/a
Denominator	n/a

Risk adjustment	None
Current performance: reporting period	January 2017 – December 2017
Data source	NACRS, Canadian Institute for Health Information (CIHI) via Ontario's ER NACRS Initiative (ERNI-Level 1). Data provided to HQO by Cancer Care Ontario (CCO)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018. Alternatively, these data can be gathered by going to iPort Access.
Comments	Calculated indicator value is based on ED visits submitted by 126 sites participating in the ER National Ambulatory Care Reporting System (NACRS) Initiative (ERNI) reporting to the NACRS database. Approximately 90% of ED Visits in Ontario are captured by hospital sites participating in ERNI (based on NACRS 13/14 data released July 2014). As of April 2009, patient's stay in a designated Clinical Decision Unit (CDU) will be excluded in the total time spent in ED.

Indicator Name	**Medication reconciliation at admission**
Mandatory, priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Safe
Direction of Improvement	Increase (higher)
Type	Process
Description	Total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.
Unit of Measurement	Rate per total number of admitted patients
Calculation Methods	Numerator / denominator To ensure a standardized approach to measurement, hospitals will now be asked to provide their numerator and denominator in the QIP workplan; QIP Navigator will calculate the rate.
Numerator	Number of admitted patients with medications reconciled
Denominator	Number of patients admitted to the hospital Note: Hospitals will be asked to provide the total number of hospital admissions within the reporting period.
Risk adjustment	None
Current performance: reporting period	October – December (Q3) 2017
Data source	Local data collection
How to access data	These data should be accessed from within your own organization.
Comments	Note: Medication reconciliation at care transitions has been recognized as best practice and is increasingly becoming a system-wide standard. Organizations should report current performance and set targets for medication reconciliation at admission at the organization level (i.e., for the entire hospital). Hospitals will be asked to provide the total number of hospital admissions within the reporting period. Hospitals are also asked

	to identify any programs or patients that are not included in their medication reconciliation calculation. For more information on implementing and measuring medication reconciliation at admission, refer to the Safer Healthcare Now! Medication Reconciliation in Acute Care Getting Started Kit, which is available online, and visit the medication reconciliation page on the Institute for Safe Medication Practices Canada website. For assistance with monitoring your ongoing medication reconciliation processes, visit the Measures page on the Safer Healthcare Now! website or contact metrics@saferhealthcarenow.ca.

Indicator Name	**Physical restraints in mental health**
Mandatory, priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Process
Description	The number of hospital patients who were physically restrained at least once in the 3 days prior to a full admission assessment, divided by all patients with a full admission assessment in the reporting period.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of patients who were physically restrained in the 3 days prior to a full admission assessment in the reporting period. *Inclusions:* The number of full admission assessments with physical restraint use (any of M1a ≥ 1 or M1b ≥ 1 or M1c ≥ 1) coded on the RAI-MH • M1a: The number of full admission assessments for the 12-month period (inclusive) with M1a "Mechanical Restraint" use coded within the last 3 days • M1b: The number of full admission assessments for the 12-month period with M1b "Chair Prevents Rising" use coded within the last 3 days • M1c: The number of full admission assessments for the twelve months period with M1c "Physical/Manual Restraint by Staff" coded within the last 3 days
Denominator	The number of patients with a full admission assessment in the reporting period (i.e. Total number of full admission assessments)
Risk adjustment	None
Current performance: reporting period	October 2016 – September 2017
Data source	Ontario Mental Health Reporting System (OMHRS). Data provided to HQO by Canadian Institute for Health Information (CIHI)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.

	Alternatively, access your data from the CIHI OMHRS Quarterly Comparative reports.

Indicator Name **NEW**	**ICU antimicrobial utilization – Antimicrobial-free days (AFD)**
Mandatory, priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Safe
Direction of Improvement	Increase (Higher) Since it is generally accepted that 30-50% of antimicrobials used in acute care are unnecessary or inappropriate, the desired directionality is an upward trend in the number of antimicrobial-free days. However, for mature ASPs where ICU stewardship efforts have been optimized, this metric would be expected to plateau and the target should be to maintain.
ssType	Process
Description	This indicator measures the number of antimicrobial-free days (both antibacterial and antifungal) in ICU for the reporting period. **Antimicrobial-free days**: Number of patient-days when both antifungal and antibacterial therapies were not administered (for the selected reporting period and entity)
Unit of Measurement	Rate per 1000 patient days
Calculation Methods	Numerator / denominator x 1000
Numerator	Total number of antimicrobial-free days (sum of all ICU patient days where number of antibacterial and antifungal therapy days = 0)
Denominator	Total patient days in ICU for the reporting period
Risk adjustment	None
Current performance: reporting period	Most recent quarter available, with monthly trends.
Data source	CCIS
How to access data	Critical Care Information System (CCIS) ICU Reports, 10.2b Antimicrobial Free Days (Trend)
Comments	This metric only applies to hospitals with level 2 and 3 Critical Care Units. An antimicrobial stewardship program can help to optimize antimicrobial free days by ensuring appropriateness of antimicrobial therapy, including minimizing unnecessary therapy and reducing prolonged duration of treatment. The 32 antimicrobial stewardship strategies which have been compiled by Public Health Ontario to help organizations build, grow and enhance their antimicrobial stewardship programs may be useful to hospitals when considering interventions that can be used to optimize antimicrobial use in the ICU. The Ontario Antimicrobial Stewardship Program (ASP) Comparison Tool is an online interactive report of antimicrobial stewardship programs in

	Ontario hospitals/corporations that enables users to compare program structural elements as well as specific program strategies that have been implemented in participating hospitals. Contact information is included and reaching out to colleagues to learn and share is encouraged. Further details about antimicrobial utilization metrics can be found at: http://www.publichealthontario.ca/en/eRepository/ASP_Metrics_Examples.pdf. A tool to assist programs in ensuring accurate antimicrobial data is included in CCIS is provided on page 11 of this metrics document. This includes key tips on collecting this data and a list of systemic antibacterial and antifungal agents to be entered into CCIS.

Information for hospitals with complex continuing care and rehabilitation services

Hospitals that have beds devoted to complex continuing care (CCC) and rehabilitation services should consider including quality improvement measures specific to the adult CCC and rehabilitation patient populations.

The Rehabilitative Care Alliance is a province-wide collaborative that was established in April 2013 by Ontario's Local Health Integration Networks (LHINs) to build on the work of the Rehabilitation and Complex Continuing Care Expert Panel. They have developed a Rehabilitative Care System Evaluation Framework, including a list of indicators that may be appropriate for inclusion in the QIP. For more information, visit their website at http://www.rehabcarealliance.ca.

II. Primary Care Indicators

Primary Care Priority Indicators

Indicator Name **NEW**	**Percentage of clients who have had a 7-day post hospital discharge follow-up (**Community Health Centre, Aboriginal Health Access Centres, Nurse Practitioner-Led Clinic Profiles -AOHC sponsored reports)
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of patients who have had a 7-day post hospital discharge follow-up, by a primary care provider (physician or nurse practitioner) for the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, and cardiac conditions.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100
Numerator	Number of discharges where the patient was seen by a primary care provider (physician or nurse practitioner) within 7 days of discharge from hospital for the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, and cardiac conditions.
Denominator	Number of acute care discharges for an episode of care in which one of the mentioned conditions is recorded in the first hospitalization of the episode within each fiscal year (minus 30 days for follow-up).
Risk adjustment	None
Current performance: reporting period	Last consecutive 12-month period.
Data source	Discharge Abstract Database (DAD), ICES Physician Database (IPDB), Ontario Health Insurance Plan (OHIP), Registered persons Database (RPDB), CHC encounter data.
How to access data	Community Health Centre, Aboriginal Health Access Centres, Nurse Practitioner-Led Clinic Profiles sponsored by Association of Ontario Health Centres.
Comments	This indicator is consistent with the technical specifications provided in the Community Health Centre, Aboriginal Health Access Centres, Nurse Practitioner-Led Clinic Profiles sponsored by Association of Ontario Health Centres.

Indicator Name	**Timely follow-up with hospital discharged patients**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective

Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.
Denominator	Number of hospital discharges for which timely (within 48 hours) notification was received.
Risk adjustment	None
Current performance: reporting period	Last consecutive 12-month period.
Data source	EMR
How to access data	Local data collection
Comments	Refer to the "Follow up after hospitalization" indicator developed by Association of Family Health Teams of Ontario (AFHTO), Data to Decisions 5.1 for more information about accessing data via the EMR.

Indicator Name	**Patient experience: Patient involvement in decisions about care**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of patients and clients who were always or often involved in the care decisions when they saw their doctor or nurse practitioner.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Organizations are expected to measure progress on this indicator using the *exact* wording of the following survey question as in Primary Care Patient Experience Survey (PCPES): "Q7. When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment? Using the scale: • Always • Often • Sometimes • Rarely • Never • Not applicable (don't know/refused)" To calculate the indicator result, add the number of respondents who responded "Always" and "Often", divide by the number of respondents

	who registered an answer for this question (do not include non-respondents or respondents who answered “Not applicable(don’t know/refused)”.
Numerator	Number of respondents who responded "Always" and "Often" to this survey question.
Denominator	Number of respondents who registered a response to this question. Exclusions: • Non-respondents; • Respondents who answered “Not applicable(don’t know/refused)”.
Risk adjustment	None
Current performance: reporting period	April 2017 – March 2018 (or most recent 12-month period available)
Data source	In-house surveys.
How to access data	These data should be accessed from within your own organization.
Comments	Use of the Primary Care Patient Experience Survey (PCPES) is encouraged, as it includes all priority indicator survey questions and more. Developed by Health Quality Ontario in collaboration with AFHTO, AOHC, the Ontario College of Family Physicians, and the Ontario Medical Association, the survey is designed to be administered by practices and can be rolled up to the organizational level to support their quality improvement efforts. The PCPES captures patients’ experiences in two ways: very specific aspects of their most recent primary care visit and their ongoing experience with the care they receive. To access the PCPES as well as a comprehensive Survey Support Guide on how to implement it, click here. To access an alternate version of the survey for CHCs and AHACs, click here. These indicators also align with the Health Quality Ontario’s Primary Care Performance Measurement Framework for Ontario, the Ministry’s Health Care Experience Survey and the Commonwealth Fund Surveys that are reported in Health Quality Ontario’s Measuring Up.

Indicator Name	**Timely access to a primary care provider (patient perception)**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Organizations are expected to measure progress on this indicator using the *exact* wording of the following patient and client survey question as in Primary Care Patient Experience Survey (PCPES).

	"Q6b. 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? • Same day • Next day • 2 – 19 days (enter number of days: _____) • 20 or more days • Not applicable (don't know/refused)." To calculate the indicator result, add the number of respondents who responded "Same day" or "Next day", divide by the number of respondents who registered an answer for this question (do not include non-respondents or respondents who answered "Not applicable(don't know/refused)".
Numerator	Number of respondents who responded "Same day" or "Next day" to this survey question
Denominator	Number of respondents who registered a response to this question. Exclusions: • Non-respondents; • Respondents who answered "Not applicable(don't know/refused)".
Risk adjustment	None
Current performance: reporting period	April 2017 – March 2018 (or most recent 12-month period available)
Data source	In-house surveys
How to access data	These data should be accessed from within your own organization.
Comments	Use of the Primary Care Patient Experience Survey (PCPES) is encouraged, as it includes all priority indicator survey questions and more. Developed by Health Quality Ontario in collaboration with the Association of Family Health Teams of Ontario (AFHTO), the Association of Ontario Health Centres (AOHC), the Ontario College of Family Physicians, and the Ontario Medical Association, the survey is designed to be administered by practices and can be rolled up to the organizational level to support their quality improvement efforts. The PCPES captures patients' experiences in two ways: very specific aspects of their most recent primary care visit and their ongoing experience with the care received. To access the PCPES as well as a comprehensive Survey Support Guide on how to implement it, click here. To access an alternate version of the survey for community health centres (CHCs) and Aboriginal Health Access Centres (AHACs), click here. Consider using "third next available visit", measures from scheduling software or asking additional questions, such as "Did you get an appointment on the date you wanted?" as process indicators to the indicator above. Organizations can choose to add these questions as other indicators. While the "third next available visit" is tracked at the provider level, this QIP indicator should be tracked at the organization level.

Primary Care Additional Indicators

Indicator Name	**Hospital readmission rate for primary care patient population within 30 days**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Percentage of patients who were discharged in a given period for a condition within selected HBAM Inpatient Grouper HIGs and had a non-elective hospital readmission within 30 days of discharge, by primary care practice model. Readmission enrolled for patients with an acute inpatient hospital stay for: • Acute Myocardial Infarction AMI (age 45+) • Cardiac conditions (excluding AMI and CHF) (age 40+) • Congestive heart failure CHF (age 45+) • Chronic obstructive pulmonary disease COPD (age 45+) • Pneumonia • Diabetes • Stroke (age 45+) • Gastrointestinal disease who after discharge have a subsequent non-elective readmission within 30 days
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Indicator Calculation Total number of enrolled patients with a hospital readmission within 30 days following a discharge for a HIG in a given period x 100/Total number of enrolled patients who were discharged for a selected condition (based on HIG) in a given period
Numerator	Total number of enrolled patients with a hospital readmission in a given period within 30 days after a discharge for selected HIGs. *Inclusions*: • Selected conditions (select HIGS) are: stroke, COPD, pneumonia, congestive heart failure, diabetes, cardiac conditions and gastrointestinal disorders. • The hospitalization readmission is counted if: a. the re-admission date is within 30 days of the index case discharge; b. the DAD field “admission category” is urgent; c. the admission is not coded as an acute transfer by receiving hospital (unless the readmission was coded as a transfer from the same hospital).

	Exclusions: • Records with missing or invalid discharge/admission date, health number, age or gender. The numerator is the sum of all readmissions for all index cases in the reporting period. Steps: To obtain observed readmissions: • Index cases (denominator) must be identified first. • For each index case, identify whether there is a non-elective readmission to any facility within 30 days of discharge. The hospitalization readmission is counted if: • The readmission date is within 30 days of the index case discharge; • DAD field "admission category" is urgent (non-elective readmission). The hospitalization readmission is excluded if: • The readmission case is coded as an acute transfer by the receiving hospital (unless the readmission was coded as a transfer from the same hospital). • There is missing or invalid data for discharge date, admission date, health number, age or gender.
Denominator	Total number of enrolled patients who were discharged for a selected condition (based on HIG) in a given period *Inclusions*: 1. Patient with: • Acute Myocardial Infarction AMI (age 45+) • Cardiac conditions (excluding AMI and CHF) (age 40+) • Congestive heart failure CHF (age 45+) • Chronic obstructive pulmonary disease COPD (age 45+) • Pneumonia • Diabetes • Stroke (age 45+) • Gastrointestinal disease 2. Cases where the Inpatient HIG atypical code is either '00' (typical cases), '01' (transfer in cases), '09' (short stay outlier cases), '10' (long stay outlier cases), or '11' (transfer in long stay cases). **HIG** **HIG description** Acute Myocardial Infarction (Age ≥ 45) 193a Myocardial Infarction/Shock/Arrest with Coronary Angiogram 193b Myocardial Infarction/Shock/Arrest with Coronary Angiogram with Comorbid Cardiac Conditions 194a Myocardial Infarction/Shock/Arrest without Coronary Angiogram

	194b Myocardial Infarction/Shock/Arrest without Coronary Angiogram with Comorbid Cardiac Conditions Stroke Stroke (Age ≥ 45) 25 Hemorrhagic Event of Central Nervous System 26 Ischemic Event of Central Nervous System 28 Unspecified Stroke COPD (Age ≥ 45) 139c Chronic Obstructive Pulmonary Disease with Lower Respiratory Infection 139d Chronic Obstructive Pulmonary Disease without Lower Respiratory Infection Pneumonia (All ages) 136 Bacterial Pneumonia 138 Viral/Unspecified Pneumonia 143 Disease of Pleura Congestive Heart Failure (Age ≥ 45) 196 Heart Failure without Coronary Angiogram Diabetes (All ages) 437a Diabetes, Other 437b Diabetes with renal complications 437c Diabetes with ophthalmic, neurological, or circulatory complications 437d Diabetes with multiple complications Cardiac (Age ≥ 40) 202 Arrhythmia without Coronary Angiogram 204a Unstable Angina/Atherosclerotic Heart Disease without Coronary Angiogram 204b Unstable Angina/Atherosclerotic Heart Disease without Coronary Angiogram with Comorbid Cardiac Conditions 208a Angina (except Unstable)/Chest Pain without Coronary Angiogram 208b Angina (except Unstable)/Chest Pain without Coronary Angiogram with Comorbid Cardiac Conditions Gastrointestinal HIGs (All ages) 231 Minor Upper Gastrointestinal Intervention 248 Severe Enteritis 251 Complicated Ulcer 253 Inflammatory Bowel Disease 254 Gastrointestinal Hemorrhage 255 Gastrointestinal Obstruction 256 Esophagitis/Gastritis/Miscellaneous Digestive Disease 257 Symptom/Sign of Digestive System 258 Other Gastrointestinal Disorder 285 Cirrhosis/Alcoholic Hepatitis 286 Liver Disease except Cirrhosis/Malignancy 287 Disorder of Pancreas except Malignancy 288 Disorder of Biliary Tract

	Exclusions: • Records with missing valid data on discharge/admission date, health number, age or gender; • Index cases coded as transfers to another acute inpatient hospital, deaths, and sign-outs; 3. Exclude cases with Discharge disposition = '07' (death) The denominator is the sum of all index cases (discharges in the reporting period for selected HIGs). Steps: Identify index cases: 1. The index hospitalization is counted if: a. The discharge date falls in the reporting period; b. The HIG Group and patient age restrictions match those listed in the appendix; 2. The Inpatient HIG atypical code is '00' (typical cases), '01' (transfer in cases), '09' (short stay outlier cases), '10' (long stay outlier cases), or '11' (transfer in long stay cases). The index hospitalization is excluded if the case is coded as a transfer to another acute inpatient hospital (unless the readmission was coded as a transfer from the same hospital). 3. The denominator is the sum of all index cases in the reporting period
Risk adjustment	None
Current performance: reporting period	April 2016 – March 2017
Data source	Discharge Abstract Database (DAD), Client Agency Program Enrolment (CAPE) Corporate Provider Database (CPDB).
How to access data	Organizations with enrolled patients will be able to access data on the Ministry's Health Data Branch Web Portal. Click on 'Primary Care' then 'Quality Improvement Plan'. Contact DDMSupport@ontario.ca to obtain a username and password if you do not already have one. For CHCs, AHACs and nurse practitioner-led clinics that have signed up for AOHC ICES practice profiles, please contact Jennifer Rayner at jrayner@lihc.on.ca.
Comments	Methodological Notes: Data are not real-time, and are provided for FY 2016/17. Information based on administrative data lag in time owing to the data submission process. Although there are time lags with the reporting of these data, the information remains valuable for informing quality improvement initiatives. Data and metrics have been suppressed where numerator (events) are fewer than five and denominator (population admitted with selected conditions) is less than 30. This is standard practice regarding confidentiality of data and residual disclosure of individual information. Data should be interpreted with caution if numerator contains 6 – 19 events OR denominator contains 30 – 99 persons.

Indicator Name	**Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Identify patients with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach The complex patient target population should: • Overlap substantially with high cost users, recognizing that not all high cost users are high needs patients (and vice versa); • Include patients with high needs and/or complex conditions; and, • Include patients with four or more chronic/high cost conditions, including a focus on individuals living with mental health and addictions, palliative patients, and the frail elderly. However, recognizing nuances exist across communities, LHINs and Health Links are encouraged to adapt the patient identification criteria to their local context and population needs.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Total number of patients who were offered access to the Health Link approach
Denominator	Total number of patients identified through clinical level assessments and/or data-driven case-finding methods sourced as meeting HLs criteria *Exclusions*: • Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Risk adjustment	None
Current performance: reporting period	Most recent 3-month period.
Data source	Local, manual data collection (health record, EMR, other)
How to access data	Local data collection
Comments	In late 2015, Health Quality Ontario completed a review of the best available information about Health Links and analysis of innovations related to coordinated care management. The innovations framework includes detailed information to help organizations identify patients with multiple conditions and complex needs through clinical level assessments and data driven case finding methods at any point in the patient's health care journey. **Patients identification approaches:** Use ***clinical level patient identification mechanisms*** to support identification of patients during a service encounter. For example, as each patient presents to a health or wellness organization or program to

	receive care, the provider may identify that the patient may benefit from a Health Links/Coordinated Care Management approach. To further support clinical decision making, the provider may then administer a standardized risk assessment tool, if indicated. Use ***data driven case finding mechanisms*** to support prospective identification of patients with multiple conditions and complex needs using utilization data to identify complex patients. For example, triggers such as the number of visits to the emergency department, number/length of admissions to hospital within a specified time frame, or patients with specific diagnoses or conditions can be built into the electronic medical record or can be managed by targeted data extraction and analysis methods, to support the identification of potential Patients with multiple conditions and complex needs. Note: A single, cross-sectorial clinical level risk assessment tool/method with adequate sensitivity and specificity to capture every patient who would benefit from a Health Links/Coordinated Care Management approach was not identified. However, the following risk assessment tools were highlighted by Health Links during the environmental scan, and are presented here for consideration based on the practice setting. The decision to implement/administer one of these tools must be considered alongside other contextually relevant information. • LACE (Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits) • PRA (Predictive Repetitive Admission) • DIVERT Scale (Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale) For more technical details, please refer to Identify Patients: Use a Combination of Clinical and Data Driven Strategies Note: Once a patient who has multiple conditions or complex needs has been identified, the organization should connect to the processes established by the local Health Link.

Indicator Name	**Glycated hemoglobin (HbA1c) testing**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Equitable
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1c) tests within the past 12 months
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin tests (HbA1c) within the past 12 months. OHIP defined by the OHIP fee code L093

Denominator	Total number of patients with diabetes aged 40 or over.
Risk adjustment	None
Current performance: reporting period	Annually
Data source	Ontario Diabetes Database (ODD), Ontario Health Insurance Plan (OHIP) - Claims History Database (CHDB), Registered Persons Database (RPDB)
How to access data	Local data collection. Primary Care Group Practice reports are available to family health teams (FHT) that register. For more information, visit www.hqontario.ca/pcreport. Primary care organizations not registered to receive group practice reports will be required to extract data from EMRs.
Comments	Equivalent measures are available for CHCs, nurse practitioner-led clinics and AHACs, extracted from electronic medical records (EMRs).

Indicator Name	**Percentage of eligible patients overdue for colorectal cancer screening**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Equitable
Direction of Improvement	Decrease (Lower)
Type	Outcome
Description	Percentage of Ontario screen-eligible individuals, 50–74 years old, who were overdue for colorectal screening in each calendar year
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Total number of Ontario screen-eligible individuals, 50–74 years old, who were overdue for colorectal screening by the end of the calendar year • Individuals were considered overdue for colorectal screening if they: 1. Did not have an FOBT within the last two years (Jan 1 of the previous year to Dec 31st of the calendar year of interest), AND 2. Did not have a colonoscopy in the last 10 years (Jan 1 nine years prior to the calendar year of interest to Dec 31st of the calendar year of interest) AND 3. Did not have a flexible sigmoidoscopy in the last ten years (Jan 1 nine years prior to the calendar year of interest to Dec 31st of the calendar year of interest) For example: at the end of 2013, an individual would be considered overdue for colorectal screening if he or she did not have an FOBT test in 2012-2013, or flexible sigmoidoscopy in 2004-2013, or a colonoscopy in 2004-2013 • Identifying FOBTs: Program CCC FOBT was identified in LRT or OHIP: - L179A ColonCancerCheck Fecal Occult Blood Testing

	Non-program FOBT was identified using fee codes in OHIP: - L181A Lab Med - Biochem - Occult Blood • Colonoscopies were identified using fee code Z555A, Z491A- Z499A in OHIP • Flexible sigmoidoscopies were identified using fee code Z580A in OHIP • Multiple claims with the same Health Insurance Number (HIN) and service date were assumed to be a single claim • Each individual was counted once regardless of the number of tests performed
Denominator	Total number of Ontario screen-eligible individuals, 50–74 years old in each calendar year. *Inclusions*: • Ontario residents aged 50–74 at the index date • Index date was defined as Jan 1 of a given year • LHIN assignment was determined using PCCF+, version 6C; residential postal code was used to identify LHIN and individuals with unknown/missing LHINs were excluded from the analysis • Public health unit data was determined using PCCF+, version 6C *Exclusions*: • Individuals with a missing or invalid HIN, date of birth, sex or postal code • Individuals with an invasive colorectal cancer prior to Jan 1 of the calendar year of interest; prior diagnosis of colorectal cancer was defined as: ICD-O-3 codes C18.0, C18.2-C18.9, C19.9, C20.9, a morphology indicative of colorectal cancer, microscopically confirmed with a path report • Individuals with a total colectomy prior to Jan 1 of the calendar year of interest • Total colectomy was defined in OHIP by fee codes S169A, S170A, S172A
Risk adjustment	None
Current performance: reporting period	Annually
Data source	• OHIP's CHDB (Claims History Database) – Colectomy claims, non-CCC FOBT, colonoscopy, flexible sigmoidoscopy • CIRT (Colonoscopy Interim Reporting Tool) – CCC program colonoscopy records • LRT (Laboratory Reporting Tool) – CCC FOBTs • CCO's OCR (Ontario Cancer Registry) - Resolved invasive colorectal cancers • RPDB (Registered Persons Database) – Demographics • PCCF+, version 6C - Residence and socio-demographic info
How to access data	Primary data source is EMR (all models). Organizations may also find it helpful to consult their physicians' CCO SAR reports to validate the data from their EMR. To enrol to receive SARs, click here.

	Cancer Care Ontario offers Healthcare Provider Resources for Colorectal Screening. The SAR provides patient enrolment model (PEM) **primary care doctors** with a supplementary tool for improving their cancer screening rates and appropriate follow-up for breast, cervical and colorectal cancer screening. The information in the SAR are updated on the 10th calendar day every month to provide timely breast, cervical and colorectal cancer screening data.
Comments	• Historical RPDB address information is incomplete; therefore, the most recent primary address was selected for reporting, even for historical study periods • FOBTs in hospital labs could not be captured • A small proportion of FOBTs performed as diagnostic tests could not be excluded from the analysis This indicator is consistent with Cancer Care Ontario's colorectal cancer screening indicator included on Cancer System Quality Index (CSQI) website http://www.csqi.on.ca/. For the detailed methodology, please refer to Colorectal Screening Participation.

Indicator Name	**Percentage of Ontario screen-eligible women, 21–69 years old, who completed at least one Pap test in 42-month period**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Equitable
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of Ontario screen-eligible women, 21–69 years old, who completed at least one Pap test in 42-month period
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Total number of Ontario screen-eligible women, 21–69 years old, who have completed at least one Pap test in a 42 month time frame • Identifying Pap tests: Pap tests were identified through CytoBase Pap tests were also identified using fee codes in OHIP: ○ E430A: add-on to a003, a004, a005, a006 when pap 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 ○ L643A: Lab Med - Microbiol - Microscopy - Smear Only, Gram/Pap Stain • All Pap tests in CytoBase were counted, including those with inadequate specimens ○ Each woman was counted once regardless of the number of Pap tests performed in a 42-month time frame
Denominator	Total number of Ontario screen-eligible women, 21–69 years old, in the reporting period • Ontario screen-eligible women aged 21–69 at the index date • Index date was defined as the midpoint in a reporting period, e.g., July 1st 2014 for 2013-2015 • The 2011 Canadian population was used as the standard population for calculating age-standardized rates • The RPDB address closest to the index date was used to assign postal code • LHIN assignment was determined using PCCF+, version 6C; residential postal code was used to identify LHIN and individuals with unknown/missing LHINs were excluded from the analysis • Public health unit data was determined using PCCF+, version 6C *Exclusions*: • Women with a missing or invalid HIN, date of birth, LHIN or postal code • Women diagnosed with an invasive cervical cancer prior to January 1st of the reporting period, e.g., January 1st 2013 for 2013-2015; prior diagnosis of cervical cancer was defined as: ICD-O-3 codes C53, a morphology indicative of cervical cancer, microscopically confirmed with a path report • Women who had a colposcopy and/or treatment within 2 years prior to January 1st of the reporting period Colposcopy and/or treatment were identified through OHIP, using the following fee codes: ○ **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

	▪ Z720 - Cervix Biopsy - with or without fulguration ▪ Z729 - Cryoconization, electroconization or CO2 laser therapy with or without curettage for premalignant lesion (dysplasia or carcinoma in-situ), out-patient procedure • Women with a hysterectomy prior to January 1st of the reporting period, e.g. January 1st 2013 for 2013-2015 • Women with a hysterectomy were identified through CHDB, using the following fee codes: ○ 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
Risk adjustment	None
Current performance: reporting period	Annually
Data source	Ontario Health Insurance Plan (OHIP) Claims History Database (CHDB), CytoBase, Cancer Care Ontario - Ontario Cancer Registry(CCO-OCR), Registered Persons Database (RPDB), PCCF+ version 6C
How to access data	Primary data source is EMR. Organizations may also find it helpful to consult their physicians' CCO SAR reports' to validate the data from their EMR. To enrol to receive SAR, click here. Cancer Care Ontario offers Healthcare Provider Resources - Cervical Screening The Screening Activity Report (SAR) provides patient

	enrolment model (PEM) **primary care doctors** with a supplementary tool for improving their cancer screening rates and appropriate follow-up for breast, cervical and colorectal cancer screening. The information in the SAR are updated on the 10th calendar day every month to provide timely breast, cervical and colorectal cancer screening data.
Comment	This indicator is consistent with Cancer Care Ontario's cervical cancer screening indicator included on Cancer System Quality Index (CSQI) website http://www.csqi.on.ca/. For the detailed methodology, please refer to Cervical Screening Participation. Please note that QIP rate is not risk adjusted.

Indicator Name **NEW**	**Diabetic Foot Ulcer Risk Assessment**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of patients with diabetes, age 18 or over, who have had a diabetic foot ulcer risk assessment using a standard, validated tool within the past 12 months
Unit of Measurement	Percentage
Calculation Methods	Numerator / Denominator x 100
Numerator	Number of patients in the denominator who have had a diabetic foot ulcer risk assessment using a standard, validated tool within the past 12 months
Denominator	Number of patients with diabetes, age 18 or over
Risk adjustment	None
Current performance: reporting period	Last consecutive 12-month period.
Data source	EMR
How to access data	Local data collection
Comments	This indicator is recommended for quality statement #1 in the Quality Standard for Diabetic Foot Ulcers. Please see the standard for more detailed information about risk assessment for diabetic foot ulcers. The Quality Standard includes standardized tools to guide clinical practice. **Standard validated tools** These should address the following components, at a minimum: Examination of both legs and feet (including the spaces between the toes) for evidence of: • Neuropathy (e.g., using a 10 g monofilament) • Ulceration • Callus

	• Skin temperature (a difference of 2°C or 3–4°F between the two feet could indicate infection, issues with vascular supply, or deep trauma) • Structural abnormalities and deformities • Charcot arthropathy • Swelling of the calf, thigh, or ankles • Skin colour changes • Skin and nail changes • Range of motion, gait, and footwear • Palpation of foot pulses (top of foot and inner ankle) Asking about previous foot ulcers and amputations Ankle-brachial pressure index or toe-brachial pressure index at regular intervals to screen for peripheral arterial disease (calcified arteries may falsely elevate results in people with diabetes, so results should be interpreted carefully) One example of a standard validated tool is Inlow's 60-second Diabetic Foot Screen Tool.

Indicator Name	**Medication reconciliation in primary care**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Safe
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of patients with medication reconciliation in the past year
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of patients with medication reconciliation in the past year
Denominator	Number of patients who have had a visit in the past year
Risk adjustment	None
Current performance: reporting period	Most recent 12-month period.
Data source	EMR
How to access data	Local data collection. Primary Care Organizations are encouraged to determine the most appropriate patient population who will benefit from medication reconciliation (e.g., recent discharge from hospital, referrals to specialists who may prescribe medications, > 2 medications prescribed, high risk medications prescribed). Medication reconciliation is an important component of medication safety. While medication reconciliation processes should be implemented within each health care sector, linkages across sectors are required to be most effective for patients. As primary care is the setting in which patients receive the majority of their health care and is often the point of care

	coordination for the rest of a patient's care, this sector plays a key role in creating these linkages. For their QIPs, primary care organizations are encouraged to develop medication reconciliation processes that leverage available resources. The Institute for Safe Medication Practices (ISMP) has developed a resource to support medication reconciliation in the primary care setting. As a starting point, completing medication reconciliation in primary care involves four main activities: 1. Collect and document an accurate and up-to-date medication list, called the Best Possible Medication History (BPMH). This can be done, for example, during an office visit for any patient who takes numerous medications, has been recently discharged from hospital, or has been referred to numerous specialists. 2. Compare the BPMH with information in the patient's chart and identify discrepancies (i.e., differences between various sources of medication information) 3. Correct the discrepancies as appropriate through discussion with the primary care provider and the patient and then update the BPMH with the resolved discrepancies, thereby creating a reconciled list. Note: pharmacists, community-based or otherwise, are a great resource to help create a reconciled list. 4. Communicate the resulting medication changes to the patient and verify the patient's understanding of their medication regimen.

MyPractice report: Additional supports for Quality Improvement

MyPractice reports (formerly the Primary Care Practice Reports) enable physicians to confidentially see their opioid prescribing patterns compared with others. In addition, physicians can see how their patients are doing with their cancer screening and diabetes management – and learn how they are using other health services, like emergency departments. Plus, physicians will get practice ideas specific to improvement topics which means less effort and time finding solutions that may already exist. To learn more, or to sign up, visit www.hqontario.ca/mypractice.

III. Home Care Indicators

Home Care Priority Indicators

Indicator Name	**Hospital readmissions**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Percentage of home care clients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of adult home care clients with an unplanned readmission to hospital within 30 days of hospital discharge. *Inclusions*: • Hospital Discharge Date is within 30 days of Hospital Index case • Urgent Readmission: Hospital Admission Category=U *Exclusions*: • Planned Readmission: Hospital Readmission Code=1
Denominator	All adult home care clients discharged from a hospital. *Inclusions*: • Client applied for in-home services: request program =01 • Client is Short or Long-Stay: Last SRC=91,92,93,94 • Client is active at time of Hospital Discharge: HC Admission Date <= Hospital Discharge Date + 7 days AND HC Discharge Date is NULL OR > Hospital Discharge Date • Client is discharged from an Acute Hospital: Analytical institution type =1 • Client received home care service within 30 days of hospital discharge: HC Service Date between Hospital Discharge Date AND Hospital Discharge Date + 30days *Exclusions*: • Invalid Health Card Numbers: HCN_index=D • Palliative Care Clients: Last SRC= 95 • Newborn or Stillborn Discharges: Hospital Entry code = N,S • Cadaver Donor Discharges: Hospital Admit Category=R • Case Management Services: Service Type Code=10 • Clients less than 19 at time of hospital discharge: Hospital Age <19 • Hospital transfer to acute care: Inst_to_type=1 AND Disposition code= 01 • Hospital sign-outs and deaths: Disposition code = 06 or 07

	Hospital is based on the location of the index visit; Client's SRC is based on the last SRC recorded; Age is calculated at time of discharge.
Risk adjustment	None
Current performance: reporting period	July 2016 – June 2017
Data source	Discharge Abstract Database (DAD), Home Care Database (HCD), National Ambulatory Care Reporting System (NACRS). Data provided to HQO by Health Shared Services Ontario (HSSO)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.

Indicator Name	**Unplanned emergency department visits**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Process
Description	Percentage of home care clients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of adult home care clients who had an ED visit assessed at Canadian Triage and Acuity Scale levels 4 or 5 (but who were not admitted to hospital) in the first 30 days after hospital discharge. *Inclusions*: • ED Visit: ED Indicator=1 • ED Registration Date is within 30 days of Hospital Index case • Low Acuity: CTAS Level = 4,5
Denominator	All adult home care clients discharged from a hospital. *Inclusions*: • Client applied for in-home services: request program =01 • Client is Short or Long-Stay: Last SRC=91,92,93,94 • Client is active at time of Hospital Discharge: HC Admission Date <= Hospital Discharge Date + 7 days AND HC Discharge Date is NULL OR > Hospital Discharge Date • Client is discharged from an Acute Hospital: Analytical institution type =1 • Client received home care service within 30 days of hospital discharge: HC Service Date between Hospital Discharge Date AND Hospital Discharge Date + 30 days *Exclusions*: • Invalid Health Card Numbers: HCN_index = D • Palliative Care Clients: Last SRC = 95 • Newborn or Stillborn Discharges: Hospital Entry code = N,S • Cadaver Donor Discharges: Hospital Admit Category = R • Case Management Services: Service Type Code = 10

	• Clients less than 19 at time of hospital discharge: Hospital Age <19 • Hospital transfer to acute care: Inst_to_type=1 AND Disposition code = 01 • Hospital sign-outs and deaths: Disposition code = 06 or 07 Hospital is based on the location of the index visit; Client's SRC is based on the last SRC recorded; Age is calculated at time of discharge.
Risk adjustment	None
Current performance: reporting period	July 2016 – June 2017
Data source	Discharge Abstract Database (DAD), Home Care Database (HCD), National Ambulatory Care Reporting System (NACRS). Data provided to HQO by Health Shared Services Ontario (HSSO)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.

Indicator Name	**End of life, preferred place of death**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percent palliative/ end of life patients who died in their preferred place of death
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of palliative / end of life patients who died in their preferred place of death. Patient must be discharged with a disposition of death in the period selected *Inclusions*: • In home referrals only • > 18 years of age at the time • CCM population of "complex palliative" or "chronic palliative" or end of life (SRC95) at time of discharge • Discharge dispositions: • Died in Palliative Care Unit (preferred place of death) • Died at home (preferred place of death) • Died in hospital (preferred place of death) • Died in residential hospice (preferred place of death) • Died in Long-Term Care home (preferred place of death) • Died in Retirement Home (preferred place of death) • Died in other location (preferred place of death) *Exclusions*: • Other CCM or SRC codes • Children ≤18 years old at the time of discharge • Referrals other than in home (school, placement) • Other death discharge dispositions (not preferred place of death)

	• Patients with blank or invalid health card numbers
Denominator	Number of palliative/ end of life patients whose discharge disposition is death in the reporting period. *Inclusions*: • In home referrals only • > 18 years of age at the time • CCM population of “complex palliative” or “chronic palliative” or end of life (SRC95) at time of discharge • Any discharge where Discharge disposition flag “has died” = 1 • Died (while under LHIN home and community care) • Died in Hospital (< 14 days) • Died in Hospital • Died at Home • Died in Palliative Care Unit (preferred place of death) • Died at Home (preferred place of death) • Died in Hospital (preferred place of death) • Died in Residential Hospice (preferred place of death) • Died in LTCH (preferred place of death) • Died in Retirement Home • Died in Retirement Home (preferred place of death) • Died in Other Location • Died in Other Location (preferred place of death) • Died in Residential Hospice • Unplanned Death *Exclusions*: • Other CCM or SRC codes • Children ≤18 years old at the time of discharge • Referrals other than in home (school, placement) • Discharges other than death • Patients with blank or invalid health card numbers
Risk adjustment	None
Current performance: reporting period	October 2016 – September 2017
Data source	Client Health & Related Information System (CHRIS). Data provided to HQO by Health Shared Services Ontario (HSSO)
How to access data	To access your organization’s data for the reporting period, refer to Health Quality Ontario’s QIP Navigator. Data will be available in February 2018.

Indicator Name	**Client experience**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator provides information on the overall experience of home care patients. It reports the percentage of home care patients who are satisfied with services provided by LHIN home and community care, with the handling of their care by care coordinators and with the services provided by service provider organizations.
Unit of Measurement	Percentage
Calculation Methods	Percentage of "Good", "Very Good" and "Excellent" responses on a 5 point scale (poor to excellent) to three Client Experience KPI 1 Survey questions: • Overall rating of LHIN home and community care services • Overall rating of management or handling of care by care coordinator • Overall rating of service provided by service provider **General survey inclusion criteria**: All unique active or discharged patients receiving in-home services and discharge patients to placement in one of the following categories during the specified time period: • Admission final • Withdrawn, interim became final • Withdrawn, placement by other LHIN home and community care • Refused bed. **General survey exclusion criteria:** • Excludes patients who received in-school service only • Nursing clinic services • Respite services • Medical supplies and equipment • End-of-life patients (SRC 95) • Clients not yet categorized (SRC 99) • In-home patients classified as out of region • Convalescent care patients **Other exclusions**: • Home care patients with hospital or death discharges; • Patients on hold in hospital; • Patients with a claim against the LHIN home and community care or before the Ontario Health Services Appeal and Review Board. **Question specific exclusion criteria**: • Respondents are also 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.

Numerator	The sum of the number of positive responses ("good", "very good", or "excellent") registered for each of the three questions that form the KPI 1 Score for the overall experience rating. (n positive Q4) + (n positive Q24) + (n positive Q39) **Question 4:** Overall how would you rate the services that you received from your LHIN home and community care and any of the individuals who provided care to you? **Question 24:** Overall, how would you rate the management and handling of your care by your case manager? **Question 39**: Overall how would you rate the x service provided by y (where x is any of: nursing, personal support, physiotherapy, occupational therapy, nutrition/dietetics, speech and language, or social work and y is the name of the service provider)? *Sum of the weighted responses are used. Post-sample weighting is applied to adjust for disproportionate sampling and to ensure that the reported survey results are representative of the actual population served by the LHIN home and community care.
Denominator	The total number of valid responses registered for all of the questions listed above.
Risk adjustment	Results are weighted to reflect the population of home care patients eligible to be surveyed within each LHIN home and community care (i.e., sampled home care patients are standardized to a specific population).
Current performance: reporting period	April 2016 – March 2017
Data source	Client and Caregiver Experience Evaluation (CCEE) Survey. Data provided to HQO by Health Shared Services Ontario (HSSO)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018. Alternatively, to access your organization's data for this indicator, refer to the NRC Canada eReports website.

Indicator Name	**5-day wait time for home care: Personal support for complex patients – by Patient Available Date**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Process
Description	This indicator measures the percentage of complex home care patients who received their first personal support service visit within five days of the patient available date (PAD).
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%

Numerator	The number of complex patients who received their first personal support service for a new service authorization within 5 days of the patient available date. First visit must take place in the period selected. *Inclusions:* • Patients who received the first personal support service within 5 days of the patient available date • First personal support service must take place in the period selected • In Home referrals only • Age >=19 at time of PAD • Personal support service type only • 'payable' visits only • SRC 91, 92, 93, 94, 95 at time of PAD • CCM population of 'complex' at time of PAD • Find the last PAD of each service before the first visit • In cases where there are overlapping service authorizations, take the earliest of the 'last PADs' before the first visit • In cases where the PAD selected above still produces a negative wait time, we will set the wait time to 0 days *Exclusions:* • CCM populations other than 'complex' • Children – age < 19 at time of PAD • Referrals other than in home (school, placement) • Overlapping personal support authorizations (i.e. if the personal support service is not discharged and a new personal support service is added, only the first personal support service would be counted) • Patients who were on hold between the PAD and the first visit (all on hold reasons)
Denominator	The number of complex patients who received their first personal support service for a new service authorization within the period selected. *Inclusions*: • First personal support service must take place in the period selected • In Home referrals only • Age >=19 at time of PAD • Personal Support service type • 'payable' visits only • SRC 91, 92, 93, 94, 95 at time of PAD • CCM population of 'complex' at time of PAD • For this report we find the last PAD of each service before the first visit • In cases where there are overlapping service authorizations, take the earliest of the 'last PADs' before the first visit • In cases where the PAD selected above still produces a negative wait time, we will set the wait time to 0 days *Exclusions*:

	• Children – age < 19 at time of PAD • Referrals other than in home (school, placement) • CCM populations other than 'complex' • Overlapping personal support authorizations (i.e. if the personal support service is not discharged and a new personal support service is added, only the first personal support service would be counted) • Patients who were on hold between the PAD date and the first visit (all on hold reasons)
Risk adjustment	None
Current performance: reporting period	October 2016 – September 2017
Data source	Client Health & Related Information System (CHRIS), Home Care Database (HCD). Data provided to HQO by Health Shared Services Ontario (HSSO)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.
Comments	When reporting by referral source of hospital and community, the referral source of hospital is only valid if the authorization occurs up to 14 days from the referral start. Any authorizations that occur after 14 days should be considered community referrals.

Indicator Name	**5-day wait time for home care: Nursing visits – by patient available date**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Process
Description	This indicator measures the percentage of home care patients who received their first nursing visit within 5 days of the patient available date (PAD).
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	The number of home care patients who received their first nursing service visit for a new service authorization within 5 days of the patient available date. First visit must take place in the period selected. *Inclusions:* • Patients who received the first nursing visit within 5 days of the PAD • First nursing visit must take place in the period selected • In Home referrals only • Age >=19 at time of PAD • SRC 91, 92, 93, 94, 95 at time of PAD • Nursing visits, RRN, nursing clinic, NP Palliative • 'payable' visits only • For this report we find the last PAD of each service before the first visit

	• In cases where there are overlapping service authorizations, take the earliest of the 'last PADs' before the first visit • In cases where the PAD selected above still produces a negative wait time, we will set the wait time to 0 days *Exclusions:* • Children – age < 19 at time of PAD • Referrals other than in home (school, placement) • Shift nursing • Overlapping nursing authorizations (i.e. if the nursing service is not discharged and a new nursing service is added, only the first nursing service would be counted) • Patients who were on hold between the PAD and the first visit (all on hold reasons)
Denominator	The number of home care patients who received their first nursing visit for a new service authorization within the period selected. *Inclusions:* • First nursing visit must take place in the period selected • In Home referrals only • Age >= 19 at time of PAD • SRC 91, 92, 93, 94, 95 • Nursing visits, RRN, nursing clinic, NP Palliative • 'payable' visits only • For this report we find the last PAD of each service before the first visit • In cases where there are overlapping service authorizations, take the earliest of the 'last PADs' before the first visit • In cases where the PAD selected above still produces a negative wait time, we will set the wait time to 0 days *Exclusions:* • Children – age < 19 at time of PAD • Referrals other than in home (school, placement) • Shift nursing • Overlapping nursing authorizations (i.e. if the nursing service is not discharged and a new nursing service is added, only the first nursing service would be counted) • Patients who were on hold between the PAD and the first visit (all on hold reasons)
Risk adjustment	None
Current performance: reporting period	October 2016 – September 2017
Data source	Client Health & Related Information System (CHRIS), Home Care Database (HCD). Data provided to HQO by Health Shared Services Ontario (HSSO)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.
Comments	When reporting by referral source of hospital and community, the referral source of hospital is only valid if the authorization occurs up to 14 days from the referral start. Any authorizations that occur after 14 days should be considered community referrals.

Indicator Name	**Falls for long-stay clients**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	Percentage of adult long-stay home care clients who record a fall on their follow-up RAI-HC assessment
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	The number of long-stay home clients who record a fall on follow-up assessment (i.e. K5>0 on follow-up assessment) *Inclusions:* • Service Recipient Code (SRC) 93 or 94 • Clients who have >1 RAI-HC assessment • K5>0 on follow-up assessment • Chronic and Complex Clients only (RAI Score >=11) • Clients not completely dependent in bed mobility on previous assessment *Exclusions:* • Hospital assessments
Denominator	Total number of long-stay home care clients *Inclusions:* • SRC 93 or 94 • Clients who have > 1 RAI-HC assessment • Clients not completely dependent in bed mobility on previous assessment • Chronic and Complex Clients only (RAI Score >=11) *Exclusions:* • Hospital assessments
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	October 2016 – September 2017
Data source	Home Care Database (HCD), Health Shared Services Ontario (HSSOntario), Resident Assessment Instrument for Home Care (RAI-HC) via Long Stay Assessment Software (LSAS). Data provided to HQO by Health Shared Services Ontario (HSSO)
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2018.

Home Care Additional Indicators

Indicator Name	**Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Identify patients with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach The complex patient target population should: • Overlap substantially with high cost users, recognizing that not all high cost users are high needs patients (and vice versa); • Include patients with high needs and/or complex conditions; and, • Include patients with four or more chronic/high cost conditions, including a focus on individuals living with mental health and addictions, palliative patients, and the frail elderly. However, recognizing nuances exist across communities, LHINs and Health Links are encouraged to adapt the patient identification criteria to their local context and population needs.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Total number of patients who were offered access to the Health Link approach
Denominator	Total number of patients identified through clinical level assessments and/or data-driven case-finding methods sourced as meeting HLs criteria *Exclusions*: • Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, or have died.
Risk adjustment	None
Current performance: reporting period	Most recent 3-month period
Data source	Local, manual data collection (health record, EMR, other)
How to access data	Local data collection
Comments	In late 2015, Health Quality Ontario completed a review of the best available information about Health Links and analysis of innovations related to coordinated care management. The innovations framework includes detailed information to help organizations identify patients with multiple conditions and complex needs through clinical level assessments and data driven case finding methods at any point in the patient's health care journey.

	Patients identification approaches: Use ***clinical level patient identification mechanisms*** to support identification of patients during a service encounter. For example, as each patient presents to a health or wellness organization or program to receive care, the provider may identify that the patient may benefit from a Health Links/Coordinated Care Management approach. To further support clinical decision making, the provider may then administer a standardized risk assessment tool, if indicated. Use ***data driven case finding mechanisms*** to support prospective identification of patients with multiple conditions and complex needs using utilization data to identify complex patients. For example, triggers such as the number of visits to the emergency department, number/length of admissions to hospital within a specified time frame, or patients with specific diagnoses or conditions can be built into the electronic medical record or can be managed by targeted data extraction and analysis methods, to support the identification of potential Patients with multiple conditions and complex needs. Note: A single, cross-sectorial clinical level risk assessment tool/method with adequate sensitivity and specificity to capture every patient who would benefit from a Health Links/Coordinated Care Management approach was not identified. However, the following risk assessment tools were highlighted by Health Links during the environmental scan, and are presented here for consideration based on the practice setting. The decision to implement/administer one of these tools must be considered alongside other contextually relevant information. • LACE (Length of Stay, Acuity of Admission, Comorbidities, Emergency Room Visits) • PRA (Predictive Repetitive Admission) • DIVERT Scale (Detection of Indicators and Vulnerabilities for Emergency Room Trips Scale) For more technical details, please refer to Identify Patients: Use a Combination of Clinical and Data Driven Strategies Note: Once a patient who has multiple conditions or complex needs has been identified, the organization should connect to the processes established by the local Health Link.

Indicator Name **NEW**	**Percentage of complaints acknowledged to the individual who made a complaint within two business days**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Patient Centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the percentage of complaints received by LHIN home and community care services that were acknowledged to the

	individual who made a complaint. This indicator is calculated on the number of complaints received within the reporting period.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Percent acknowledged within two business days = number of complaints acknowledged within two business days divided by the total number of complaints received in the reporting period. To ensure a standardized approach to measurement, LHIN home and community care services will now be asked to provide their numerator and denominator in the QIP Workplan; QIP Navigator will calculate the rate.
Numerator	Number of complaints that received a formal acknowledgement within two business days
Denominator	All complaints received by the LHIN home and community care services within the reporting period Inclusion criteria: • Complaints received within the reporting period, but acknowledged and closed in the first 60 days of the following reporting period • The day and time of complaint should be recorded • Complaints received on and between the first and last day of the reporting period, including non-business days and after hours • Repeated complaints on the same issue from the same individual or by a different individual on behalf of the same patient/resident are counted as a single complaint • One complaint may include numerous issues, but should be counted as a single complaint • Complaints included must be documented through the established complaints process • Oral complaints made in person or by phone call • Written complaints made by letter, email, fax, text, etc. • For home care, complaints that come to or are recorded by service providers or LHIN home and community care staff should be included if the complaint is not immediately resolvable Exclusion criteria: • The complaint is not documented through the established complaints process. For example: • Complaints that were acknowledged and resolved immediately after the complaint was received (e.g. changing the temperature in a patient or resident's room) • The complaint needed no additional intervention
Risk adjustment	None
Current performance: reporting period	Most recent 12-month period
Data source	Local data collection
How to access data	Local data collection

Comments	By regulation LHIN home and community care require complaints to be acknowledged to the individual that made the complaint within two business days. Complaints received by the LHIN home and community care need to be formally acknowledged to the individual who made the complaint. The acknowledgement is to confirm to that the issue has been received by the complaints representative/ office and the investigative process has been initiated. This indicator measures patient-centredness and responsiveness in the complaints process. Other indicators to consider can be found here.

Indicator Name **NEW**	**Percentage of patients with a diabetic foot ulcer that closed within a 12 week period**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Increase (Higher)
Type	Outcome (developmental)
Description	This indicator measures the percentage of patients, diagnosed with a healable diabetic foot ulcer, whose ulcer closed within 12 weeks
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100
Numerator	Number of patients in the denominator whose diabetic foot ulcer closed within 12 weeks Exclusion: Patients with a non-healable diabetic foot ulcer
Denominator	Number of patients with a diagnosis of a diabetic foot ulcer
Risk adjustment	None for QIP
Current performance: reporting period	Most recent 12-month period
Data source	Local data collection
How to access data	Local data collection
Comments	This indicator aligns with the Quality Standard for Diabetic Foot Ulcers. To guide quality improvement efforts, the quality standard identifies quality statements and corresponding process measures Although the majority of closed diabetic foot ulcers eventually heal, this indicator would not capture diabetic foot ulcers that reopen beyond 12 weeks due to poor assessment or care. If a patient has more than one diabetic foot ulcer, the indicator should capture the most severe diabetic foot ulcer.

Indicator Name **NEW**	**Education and self-management for wounds**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of people with diabetes and their families or caregivers who are offered education about how to prevent foot complications, how to monitor for the signs and symptoms of foot complications, and who to contact in the event of a concerning change.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Number of people in the denominator who, along with their families or caregivers, are offered education (such as printed materials, video presentations, and in-person resources/instruction) about how to prevent foot complications, how to monitor for the signs and symptoms of foot complications, and who to contact in the event of a concerning change.
Denominator	Number of people with diabetes
Risk adjustment	None
Current performance: reporting period	Most recent 12-month period
Data source	Local data collection
How to access data	Local data collection
Comments	This indicator is recommended for quality statement #2 in the Quality Standard for Diabetic Foot Ulcers. Please see the standard for more detailed information about patient education and self management, risk assessment, etc.

IV. Long-Term Care

Long-Term Care Priority Indicators

Indicator Name	**Potentially avoidable emergency department visits for long-term care residents**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Process
Description	Number of ED visits for a modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.
Unit of Measurement	Rate per 100 residents
Calculation Methods	Total ED visits including transfers between EDs and ED visits resulting in admission or death for all active LTC home residents in Ontario in a given year. Numerator: Steps: 1. Count the number of unscheduled ED visits made by long-term care home residents for the selected conditions. Step 2. Multiply by 100. Denominator: Steps: 1. Extract the population of active long-term care home residents.
Numerator	Total ED visits including transfers between EDs and ED visits resulting in admission or death for all active LTC home residents in Ontario in a given year. *Inclusions*: • All active LTC home residents in Ontario in a given year. • ED visits including transfers between EDs and ED visits resulting in admission or deaths. • Modified ambulatory care–sensitive conditions presenting to EDs that are potentially preventable are as follows: - Angina - Asthma - Cellulitis - Chronic obstructive pulmonary disease - Congestive heart failure - Septicemia - Dehydration - Dental conditions - Diabetes - Gastroenteritis - Grand mal and seizure disorders - Hypertension - Hypoglycemia - Injuries from falls - Mental health and behavioural disorders - Pneumonia

	- Severe ear, nose and throat disorders *Exclusions*: • Planned or scheduled ED visits. • LTC home residents who were first admitted to the home before the age of 65.
Denominator	*Inclusions*: • All active residents of long-term care homes. *Exclusions*: • Individuals with invalid health card numbers. • LTC home residents who were first admitted to the home before the age of 65.
Risk adjustment	None
Current performance: reporting period	October 2016 – September 2017
Data source	Continuing Care Reporting System (CCRS), National Ambulatory Care Reporting System (NACRS). Data provided to HQO by Health Analytics Branch with the MOHLTC.
How to access data	The Ministry will provide organizations with this data via LTCHomes.net
Comments	Quality improvement guidance related to this indicator is available on the Health Quality Ontario website and through the INTERACT (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers) program.

Indicator Name	**Resident experience: Overall satisfaction**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	The percentage of residents who responded positively to the question/statement: Would you recommend this nursing home to others? /I would recommend this site or organization to others.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Homes using the **NHCAHPS Long-Stay Resident Survey** should measure this domain by calculating the percentage of residents who responded positively. • Add the number of respondents who responded '4' to the question: *Would you recommend this nursing home to others?* • Responses are coded from 1 - 4, where 1 = Definitely no 2 = Probably no 3 = Probably yes 4 = Definitely yes Homes using the **interRAI Quality of Life** Survey should measure this domain by calculating the percentage of residents who responded positively to the statement. • Add the number of respondents who responded '3' and '4' to the statement: *I would recommend this site or organization to others*.

	• Responses are coded from 0 - 8 (0, 1, 2, 3, 4, 6, 7, 8), where 0 = Never 1 = Rarely 2 = Sometimes 3 = Most of the time 4 = Always 6 = Don't know 7 = Refused 8 = No response or cannot be coded from response
Denominator	For homes using the **NHCAHPS Long-Stay Resident Survey**, add the total number who registered any response to the question. Do not include non-respondents. For homes using the **interRAI Quality of Life Survey**, add the total number who registered any response to the statement. Do not include non-respondents (6 = Don't know, 7 = Refused, 8 = No response).
Risk adjustment	None
Current performance: reporting period	April 2017 – March 2018 (or most recent 12-month period). If you have completed this year's survey, you do not have to resubmit the survey.
Data source	Local data collection, InterRAI Quality of Life Survey, NHCAHPS Long-Stay Resident Survey
How to access data	These data should be accessed from within your own organization.
Comments	For more information about the **NHCAHPS Long-Stay Resident Survey**, refer to Agency for Healthcare Research and Quality's website: *Get Nursing Home Surveys and Instructions*. For more information about the **interRAI Quality of Life Survey**, refer to interRAI's website. Homes that use a validated survey tool other than NHCAHPS Long-Stay Resident Survey or InterRAI Quality of Life should select and use the questions from their survey that are most similar to the ones listed above. Homes that design and administer their own survey should consider adding questions that align with either the NHCAHPS Long-Stay Resident Survey or InterRAI Quality of Life questions listed above.

Indicator Name	**Resident experience: Having a voice**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Organizations should measure progress on the following indicator: **Having a voice** The percentage of residents who responded positively to the question: What number would you use to rate how well the staff listen to you?
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Homes using the **NHCAHPS Long-Stay Resident Survey** should measure this domain by calculating the percentage of residents who responded positively. • Add the number of respondents who responded '9' and '10' to the question: What number would you use to rate how well the staff listen to you? • Responses are coded from 0 - 10, where 0 = worst possible and 10 = best possible.
Denominator	For homes using the **NHCAHPS Long-Stay Resident Survey**, add the total number who registered any response to the question. Do not include non-respondents.
Risk adjustment	None
Current performance: reporting period	April 2017 – March 2018 (or most recent 12-month period). If you have completed this year's survey, you do not have to resubmit the survey.
Data source	Local data collection, NHCAHPS Long-Stay Resident Survey
How to access data	These data should be accessed from within your own organization.
Comments	For more information about the NHCAHPS Long-Stay Resident Survey, refer to Agency for Healthcare Research and Quality's website: *Get Nursing Home Surveys and Instructions*.

Indicator Name	**Resident experience: Being able to speak up about the home**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Organizations should measure progress on the following indicator: **Being able to speak up about the home** The percentage of residents who responded positively to the following: I can express my opinion without fear of consequences
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%
Numerator	Homes using the **interRAI Quality of Life Survey** should measure this domain by calculating the percentage of residents who responded positively. • Add the number of respondents who responded '3' and '4' to the statement: I can express my opinion without fear of consequences. Responses are coded from 0 - 8 (0, 1, 2, 3, 4, 6, 7, 8), where 0 = Never 1 = Rarely 2 = Sometimes 3 = Most of the time 4 = Always 6 = Don't know 7 = Refused 8 = No response or cannot be coded from response
Denominator	For homes using the **interRAI Quality of Life Survey**, add the total number who registered any response to the statement. Do not include non-respondents (6 = Don't know, 7 = Refused, 8 = No response).
Risk adjustment	None
Current performance: reporting period	April 2017 – March 2018 (or most recent 12-month period). If you have completed this year's survey, you do not have to resubmit the survey.
Data source	Local data collection, InterRAI Quality of Life Survey.
How to access data	These data should be accessed from within your own organization.
Comments	For more information about the interRAI Quality of Life Survey, refer to interRAI's website.

Indicator Name	**Appropriate prescribing: Potentially inappropriate antipsychotic use in long-term care**
Priority or additional indicator?	**Priority** for 2018/19 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the percentage of LTC home residents without psychosis who were given antipsychotic medication in the seven days preceding their resident assessment.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%

	The indicator is calculated using four rolling quarters of data by summing the number of residents that meet the inclusion criteria for the target quarter and each of the previous three fiscal quarters. This is done for both the numerator and denominator.
Numerator	LTC home residents who received antipsychotic medication on one or more days in the week before their Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS) target assessment *Inclusions*: • O4a = 1, 2, 3, 4, 5, 6 or 7 • Where, O4A = Number of days the resident received an antipsychotic medication during the last seven days [0-7]
Denominator	LTC home residents with a valid RAI-MDS assessment*, excluding those with schizophrenia, Huntington's chorea, hallucinations or delusions, as well as residents who are end-stage disease or receiving hospice care *Exclusions*: • Residents who are end-stage disease (J5c = 1) or receiving hospice care (P1ao = 1) • Residents who have a diagnosis of schizophrenia (I1ii = 1) or Huntington's chorea (I1x = 1), or those experiencing hallucinations (J1i = 1) or delusions (J1e = 1) *For an assessment to be valid and included in the quality indicator calculation, the selected assessment must: • Be the latest assessment in the quarter • Be carried out more than 92 days after the admission date • Not be an Admission Full Assessment
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	July 2017 – September 2017 (i.e. Q2 2017-2018)
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI).
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at www.cihi.ca.
Comments	The indicator is calculated as a rolling four quarter average by CIHI. Q2 2017-2018 is calculated based on data from Quarter 3, 2016-2017 to Quarter 2, 2017-2018 and Q2 is the final quarter used in the calculation. Q2 data represents the data in Q2, as well as three previous quarters. This indicator is consistent with HQO's LTC Public Reporting website; however, HQO publicly reports *adjusted rates.* For the purposes of quality improvement planning, *unadjusted rates* (i.e., not risk-adjusted) should be used. HQO developed a confidential practice report for physicians who practise long-term care. These reports are intended to complement other sources of information physicians receive (e.g., pharmacy reports). The current report includes indicators related to the prescribing of antipsychotic medications and benzodiazepines, and contains change ideas related to the topics of behavioural and psychological symptoms of dementia

	(BPSD) and fall prevention. For more information, please visit www.hqontario.ca/LTCreport.

Long-Term Care Additional Indicators

Indicator Name	**Pressure ulcers**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	This indicator measures the percentage of long-term care (LTC) home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment. *This indicator is identical to CIHI's CCRS QI indicator *worsened Stage 2 to 4 Pressure Ulcer.*
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% The indicator is calculated using four rolling quarters of data by summing the number of residents that meet the inclusion criteria for the target quarter and each of the previous three fiscal quarters. This is done for both the numerator and denominator.
Numerator	LTC home residents who had a pressure ulcer at stage 2 to 4 on their target Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS) assessment and either they did not have a pressure ulcer on their previous assessment or the stage of pressure ulcer is greater on their target compared with their previous assessment *Inclusions*: • M2a > 1 AND (M2a - Prev_M2a) > 0 AND Prev_M2a < 4 • Where, M2a = Stage of pressure ulcer at target assessment [0-4] • Prev_M2a = Stage of pressure ulcer at prior assessment [0-4]
Denominator	LTC residents with two valid RAI-MDS assessments*, excluding those who had a stage 4 pressure ulcer on their prior assessment (i.e., residents are only included if they did not have a pressure ulcer at the maximum stage on their previous assessment) *Exclusions*: • Prev_M2a = 4 *Two valid assessments within consecutive quarters are required for a given resident to calculate the quality indicator. The assessment selected as the "target" assessment in the current quarter must: • Be the latest assessment in the quarter • Be carried out more than 92 days after the Admission Date • Not be an Admission Full Assessment - Be from a resident that had an assessment in the previous quarter • Have 45 to 165 days between the target assessment and assessment in the previous quarter (Note: If there are multiple assessments from the previous quarter that meet the time period

	criteria, the latest assessment is selected as the "prior" assessment)
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	July 2017 – September 2017 (i.e. Q2 2017-2018)
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI).
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at www.cihi.ca.
Comments	The indicator is calculated as a rolling four quarter average by CIHI. Q2 2017-2018 is calculated based on data from Quarter 3, 2016-2017 to Quarter 2, 2017-2018 and Q2 is the final quarter used in the calculation. Q2 data represents the data in Q2, as well as three previous quarters.

Indicator Name **NEW**	**Percentage of complaints acknowledged to the individual who made a complaint within six to 10 business days**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the percentage of complaints received by a long-term care home, that were acknowledged to the individual who made a complaint. This indicator is calculated based on the number of complaints received within the reporting period.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Percent Acknowledged within six to 10 business days= Number of complaints acknowledged between six and 10 business days divided by the total number of complaints received in the reporting period. To ensure a standardized approach to measurement, long-term care homes will now be asked to provide their numerator and denominator in the QIP workplan; QIP Navigator will calculate the rate.
Numerator	Number of complaints that received a formal acknowledgement within six to 10 business days
Denominator	All complaints received by the long-term care home within the reporting period Inclusion Criteria: • Complaints received within the reporting period, but acknowledged and closed in the first 60 days of the following reporting period ◦ The day and time of complaint should be recorded • Complaints received on and between the first and last day of the reporting period, including non-business days and after hours • Repeated complaints on the same issue from the same individual or by a different individual on behalf of the same patient/resident are counted as a single complaint

	• One complaint may include numerous issues, but should be counted as a single complaint • Complaints included must be documented through the established complaints process • Oral complaints made in person or by phone call • Written complaints made by letter, email, fax, text, etc. Exclusion Criteria: • The complaint is not documented through the established complaints process. For example: • Complaints that were acknowledged and resolved immediately after the complaint was received (e.g. changing the temperature in a resident's room) • The complaint needed no additional intervention
Risk adjustment	None
Current performance: reporting period	Most recent 12-month period
Data source	Local data collection
How to access data	Local data collection
Comments	By regulation, long-term care homes are required to have complaints acknowledged and actioned within 10 business days. Complaints received by the home need to be formally acknowledged to the individual who made the complaint. The acknowledgement is to confirm to that the issue has been received by the complaints representative / office and the investigative process has been initiated. As this indicator measures resident-centredness and responsiveness in the complaints process. Any long-term care home that currently acknowledges all of their complaints within six to 10 business days may wish to consider other custom indicators as set out below: Percent acknowledged within three to five business days = Number of complaints acknowledged within three to five business days divided by the total number of complaints received in the reporting period. Other indicators to consider can be found here.

Indicator Name	**Falls**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	This indicator measures the percentage of long-term care (LTC) home residents who fell during the 30 days preceding their resident assessment.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% The indicator is calculated using four rolling quarters of data by summing the number of residents that meet the inclusion criteria for the target quarter and each of the previous three fiscal quarters. This is done for both the numerator and denominator.
Numerator	LTC home residents who had a fall in the last 30 days recorded on their target Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS) assessment *Inclusions*: • J4a = 1 Where, J4a = Fell in past 30 days [0,1] [0,1] 0 = No 1 = Yes
Denominator	LTC home residents with a valid RAI-MDS assessment* *For an assessment to be valid and included in the quality indicator calculation, the selected assessment must: • Be the latest assessment in the quarter • Be carried out more than 92 days after the admission date • Not be an admission full assessment
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	July 2017 – September 2017 (i.e., Q2 2017-2018)
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI).
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at www.cihi.ca.
Comments	The indicator is calculated as a rolling four quarter average by CIHI. Q2 2017-2018 is calculated based on data from Quarter 3, 2016-2017 to Quarter 2, 2017-2018 and Q2 is the final quarter used in the calculation. Q2 data represents the data in Q2, as well as three previous quarters. This indicator is consistent with Health Quality Ontario's LTC Public Reporting website; however, Health Quality Ontario publicly reports *adjusted rates.* For the purposes of quality improvement planning, *unadjusted rates* (i.e., not risk-adjusted) should be used.

	HQO has developed a confidential practice report for physicians who practise Long-Term Care. These reports are intended to complement other sources of information physicians receive (e.g., pharmacy reports). The current report focuses on indicators related to the prescribing of antipsychotic medications and benzodiazepines, and contains change ideas related to the topics of behavioural and psychological symptoms of dementia (BPSD) and fall prevention. For more information, please visit www.hqontario.ca/LTCreport.

Indicator Name	**Daily restraints use**
Priority or additional indicator?	**Additional** for 2018/19 QIP
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the percentage of long-term care (LTC) home residents who were physically restrained every day during the seven days preceding their resident assessment.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% The indicator is calculated using four rolling quarters of data by summing the number of residents that meet the inclusion criteria for the target quarter and each of the previous three fiscal quarters. This is done for both the numerator and denominator.
Numerator	LTC home residents who were recorded as having been physically restrained daily during the seven days preceding their target Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS) assessment *Inclusions*: • (P4c = 2) OR (P4d = 2) OR (P4e = 2) Where, P4c = Trunk restraint [0,1,2] P4d = Limb restraint [0,1,2] P4e = Chair prevents rising [0,1,2] [0,1,2] 0 = not used 1 = used less than daily 2 = used daily
Denominator	LTC home residents with valid RAI-MDS assessments* *Exclusions*: • Residents who were comatose (B1= 1) • Residents who were quadriplegic (I1bb = 1)

	*For an assessment to be valid and included in the quality indicator calculation, the selected assessment must: • Be the latest assessment in the quarter • Be carried out more than 92 days after the admission date • Not be an admission full assessment
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	July 2017 – September 2017 (i.e. Q2 2017-2018)
Data source	Continuing Care Reporting System (CCRS). Data provided to HQO by Canadian Institute for Health Information (CIHI).
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at www.cihi.ca.
Comments	The indicator is calculated as a rolling four quarter average by CIHI. Q2 2017-2018 is calculated based on data from Quarter 3, 2016-2017 to Quarter 2, 2017-2018 and Q2 is the final quarter used in the calculation. Q2 data represents the data in Q2, as well as three previous quarters. This indicator is consistent with Health Quality Ontario's LTC Public Reporting website; however, Health Quality Ontario publicly reports *adjusted rates.* For the purposes of quality improvement planning, *unadjusted rates* (i.e., not risk-adjusted) should be used. Health Quality Ontario developed a confidential practice report for physicians who practise Long-Term Care. These reports are intended to complement other sources of information physicians receive (e.g., pharmacy reports). The current report focuses on indicators related to the prescribing of antipsychotic medications, benzodiazepines and specified CNS active medications, and contains change ideas related to the topic of BPSD and fall prevention. Daily restraints are included as a balancing measure. For more information, please visit www.hqontario.ca/LTCreport.

V. Narrative Questions

Overview

Please use the Overview to provide HQO and the public with contextual information about your QIP, including information about broader organizational strategy, key considerations, significant challenges that might influence your QIP. The Overview should also include information about how progress to date, strategic documents (e.g. strategic plan, SAAs), patient/client/resident feedback, and other important inputs have come together to inform this year's QIP priorities, targets, and activities. Put another way, the Overview should help your patients/clients/residents, staff members, and members of the public understand the goals and objectives of your QIP.

Describe your organization's greatest QI achievement from the past year.

Think of this as an opportunity to tell a story about a specific achievement that your organization is proud of - for example, last year we heard from a long-term care home who got their local community to assist with developing a music program for their residents. It should also not be merely a reiteration of the indicators you chose in your quality improvement plan - try to think of it as a "bright spot" that can be shared with other organizations. Consider including information about how patients/clients/residents were engaged or were impacted by this achievement. Have any of these focused on equity, mental health and addictions, palliative care, or mental health? Please provide as much detail as possible to help us understand the significance of this achievement to your organization and the patients/clients/residents you serve. For more ideas about stories, go to the Query QIPs to read examples from other organization's achievement section. Please also visit the QIP Navigator site to learn about other tools that may help.

Alternate Level of Care (ALC)

Alternate Level of Care (ALC) refers to patients who no longer need treatment in a hospital, but who continue to occupy hospital beds as they wait to be discharged or transferred to another care environment. While the QIP has traditionally included an indicator related to this issue for the hospital sector, ALC is truly a cross-sector challenge. To reflect this and to learn more about what organizations across the system are doing to address ALC, please describe the work that your organization is doing to support ALC initiatives in your region and to ensure that patients have access to the right level of care.

Engagement of Clinicians, Leadership and Staff

Please describe how your organization is engaging your leadership, clinicians, and staff in your QIP. How does staff/clinician experience impact your quality improvement initiatives?

Population Health and Equity Considerations

How has your organization addressed/recognized the needs of unique populations in its quality improvement efforts including, for example, indigenous and francophone communities? How has your organization worked to promote health equity through your quality improvement initiatives?

Patient / Resident Engagement and Relations

There is a spectrum of approaches for engaging patients / clients / residents, including sharing, consulting, deliberating, and collaborating with advisors.

Describe how your organization has engaged your patients / clients / residents in the development and implementation of your Quality Improvement Plan and quality improvement activities over the past year. What do you have planned for the year ahead?

Collaboration and Integration
Many of the indicators in the QIPs can only achieve large-scale improvement with collaboration with other partners. In this section, please describe who your organization is working with to improve integration and continuity of care as your patients move across the system. (For example, how you're working with other sectors to support transitions in care.) If you are part of a Health Link, consider describing how this fits into your quality improvement initiatives related to integration and continuity of care, specifically how you are supporting complex patients as they move across the system. Please provide information about specific partnerships and how they support your QIP and QI initiatives, as well as any successes that you attribute to these partnerships.

Opioids prescribing for the treatment of pain and opioid use disorder
Describe what steps your organization is taking to support the effective treatment of pain, including reviewing opioid prescribing practices and promoting alternatives to opioids. Think about access to addiction services, social services, (sub) populations, etc.

Workplace Violence Prevention
Please describe how workplace violence prevention is a strategic priority for your organization. For example, is it included in your strategic plan or do you report on it to your board?

VI. Abbreviations

AFHTO	Association of Family Health Teams of Ontario
AHAC	Aboriginal Health Access Centre
ALC	Alternate level of care
AOHC	Association of Ontario Health Centres
CCAC	Community Care Access Centre
CCC	Complex Continuing Care
CCRS	Continuing Care Reporting System
CHC	Community Health Centre
CIHI	Canadian Institute of Health Information
DAD	Discharge Abstract Database
EMR	Electronic Medical Record
FY	Fiscal year. The Ontario government's fiscal year runs from April 1 to March 31.
HBAM	Health-Based Allocation Model
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HIG	Health-Based Allocation Model Inpatient Grouper
ICU	Intensive Care Unit
InterRAI	International research network's Resident Assessment Instrument
NACRS	National Ambulatory Care Reporting System
NHCAHPS	Nursing Home Consumer Assessment of Healthcare Providers and Systems
NRC	National Research Council of Canada
PPCF	Postal Code Conversion File
PCPES	Primary Care Patient Experience Survey
QBP	Quality-Based Procedures
QIP	Quality Improvement Plan