Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

Indicator Technical Specifications

2019/20 Quality Improvement Plans

December 2018
Revised January 29, 2019

ISBN 978-1-4868-3084-8 (PDF)
ISSN 2371-6002 (PDF)

Revisions to indicator technical specifications

Date	Indicator title	Revision
January 24, 2019	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day *(revised title)*	Inpatients receiving care on ER stretchers have been added to the inclusion criteria for this indicator. The indicator title has been changed to reflect this.
January 29, 2019	Percentage of non-palliative care patients newly dispensed an opioid	The indicator definition has been modified to: • Emphasize that this is a system-level indicator (measuring prescriptions by any health care provider) • Clarify that this indicator is only available for family health teams and community health centres that receive MyPractice Reports
January 29, 2019	Emergency department wait time for inpatient bed	Additional detail has been added to the calculation methods for this indicator.
January 29, 2019	Early identification: Documented assessment of palliative care needs for an early, at-risk cohort *(revised title) (all sectors)*	The title, numerator and denominator of these indicators have changed. Additional resource links have been added.
January 29, 2019	Median number of days to long-term care home placement (acute care)	The inclusion criteria for this indicator have been edited for clarity.

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Introduction

This document specifies indicator definitions, calculations, reporting periods, and other technical information for hospitals, interprofessional primary care organizations, LHIN home and community care services, and long-term care homes to use in their 2019/20 Quality Improvement Plans (QIPs). It also includes the narrative questions that organizations are to answer to 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 indicators to measure performance on these key quality issues. The hospital sector must complete a mandatory indicator(s) as well. Types of indicators are outlined in Table 1. A summary of the quality issues and indicators for the 2019/20 QIPs is presented in Figure 1.

Table 1. Types of indicators

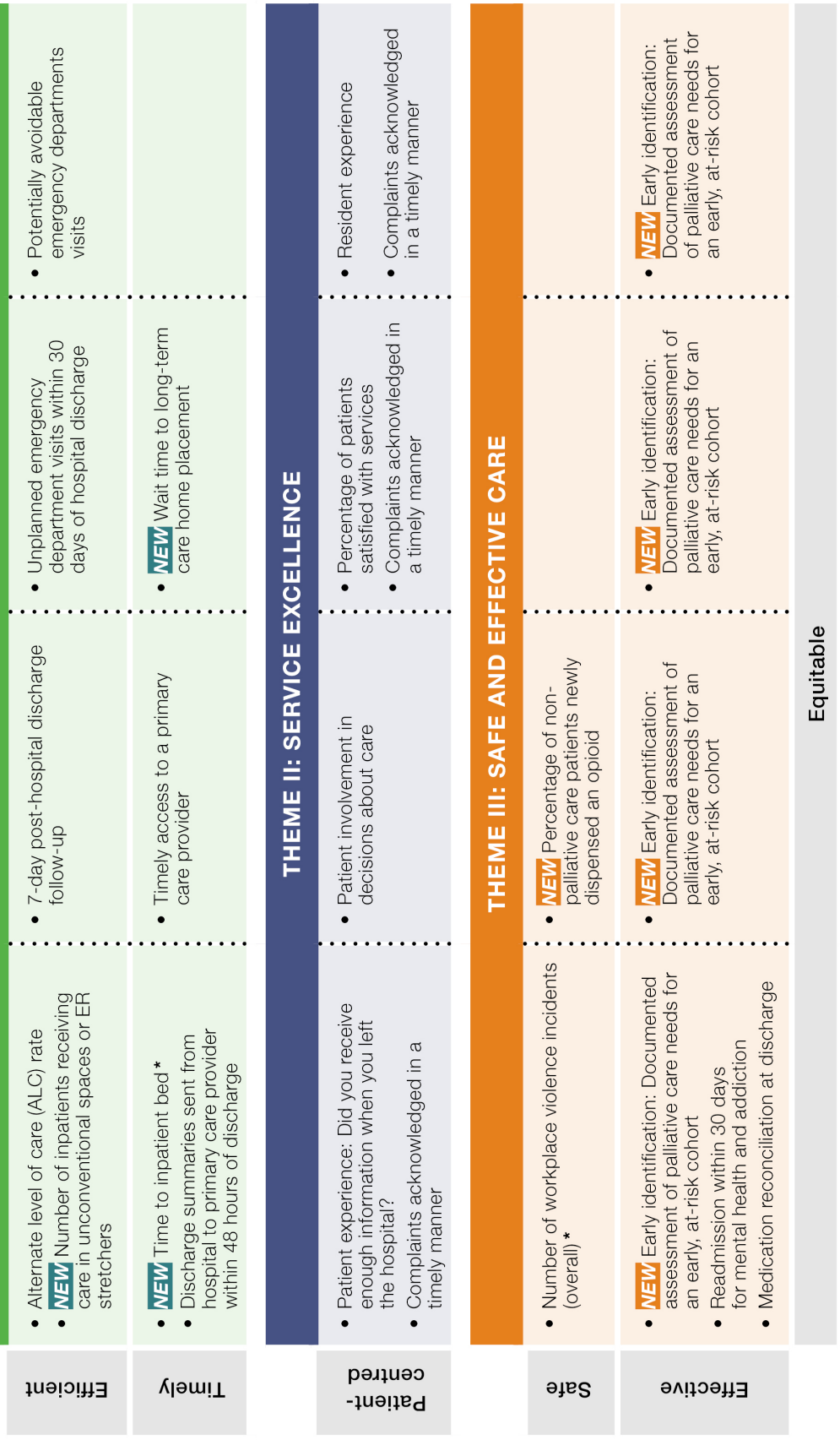
Indicator Type	Description
Mandatory (hospital sector only)	• Mandatory indicators only apply to the hospital sector. • You must include these mandatory indicators in your hospital's QIP. • These are tied to issues where province-wide improvement is urgently required. • Performance on these issues/indicators directly impacts patients, residents, and health care providers across the province. • Achieving improved performance requires every organization to prioritize, actively engage, and support improvement activities. • The mandatory issues and indicators will be clearly identified and communicated via a variety of mechanisms.
Priority	• Review the priority indicators for your sector and determine which are relevant for your organization. • Review your 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 does not plan to include a priority indicator (for example, because performance already meets or exceeds the benchmark or is theoretical best), document the reason in the comments section of the Workplan.
Custom	• 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, visit the QIP Navigator website (https://qipnavigator.hqontario.ca/).

Health Quality Ontario also reports on other indicators that are not included as priority 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, contact Health Quality Ontario at QIP@hqontario.ca.

Figure 1. Quality Priorities for the 2019/20 QIPs



** Mandatory indicator (hospital sector only)*

Updated: January 29, 2019

I. Hospital Indicators

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

Hospital Mandatory Indicators

Indicator Name **NEW**	**Emergency department wait time for inpatient bed**
Mandatory for 2019/20 QIP	
Dimension	Timely
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.
Unit of Measurement	Hours
Calculation Methods	The indicator is measured in hours using the 90th percentile, which represents the maximum length of time that 90% of patients admitted from the ED wait for an inpatient bed or an operating room. **ED Wait time = Date/Time Patient Left ED - Date/Time Disposition Decision** Unit of analysis: Single ED visit All emergency visits *Inclusions*: • Admitted unscheduled emergency visits • ED visits with a valid and known Disposition Date/Time and a valid and known date/time the patient left the ED *Exclusions*: • Scheduled emergency visits i.e. ED visit indicator is = ""0"" • Non-admitted unscheduled emergency visits • Visits with unknown/invalid Disposition Date/Time (9999) • Visits with Registration Date/Time AND Triage Date/Time BOTH blank/unknown (9999) • Visits with unknown/invalid Date/Time Patient Left ED (9999) • Duplicate cases within the same functional centre where all ED data elements have the same values except for Abstract ID number • Cases where MIS functional centre not under General Emergency Department ('713102000' '723102000' '733102000') or Urgent Care

	Centre ('713102500' '723102500' '733102500') • Cases where Time to IPB is greater than or equal to 100,000 minutes (1,666 hours)
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance: reporting period	Q3 FY 2018/19 (i.e. October 2018 – December 2018)
Data source	National Ambulatory Care Reporting System (NACRS). Data provided to Health Quality Ontario by Cancer Care Ontario.
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 2019. Alternatively, these data can be accessed by registered users via Cancer Care Ontario's iPort™ Access.
Comments	Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. Many factors can influence the indicator results, including the availability of inpatient beds, the percentage of alternate level of care (ALC) patients, the overall patient population and hospital resources. The 90th percentile of this indicator represents the maximum length of time that 90% of patients admitted from the ED wait for an inpatient bed or an operating room in the ED.

Indicator Name	**Number of workplace violence incidents (overall)**
Mandatory for 2019/20	
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 within a 12-month period. 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.
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 2018– December 2018
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	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 **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 and > 0, the value will be suppressed. Information relating to these consequence indicators can be found on the Workplace Violence Guidance Document 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 Multiple resources from the Public Service Health and Safety organization

Hospital Priority Indicators

Indicator Name	**Alternate level of care rate**
Priority for 2019/20 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 Daily 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 2018 – September 2018

Data source	BCS, Wait Time Information System (WTIS). Data provided to Health Quality Ontario by Cancer Care Ontario.
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 2019. 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. There are three indicators related to patient flow for hospitals in this year's QIP. Both the time to inpatient bed and the number of unconventional bed indicators are lead indicators, capturing patient flow problems within the hospital, but related to flow problems in the system. The third indicator is the ALC rate indicator, a lag indicator that reflects system functionality.

Indicator Name **NEW**	**Average number of inpatients receiving care in unconventional spaces or ER stretchers per day**
Priority for 2019/20 QIP	
Dimension	Efficient
Direction of Improvement	Decrease (lower)
Type	Process
Description	This indicator measures the average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.
Unit of Measurement	Average or Mean
Calculation Methods	Total number of inpatients receiving care in unconventional spaces or ER stretchers in each day (at 12am), summed for all days in the given reporting period, divided by total submission days within the given time period. **Unconventional Spaces (UNCONVENTIONALBEDSUSED):** An **unconventional space** is an area in a hospital, which has been enabled to place beds to provide care to inpatients. Unconventional spaces refer specifically to the placement of a bed in any place spacious enough, i.e. an office, hallways, including hallways in the emergency department or inpatient unit, or auditorium that does not meet the required fire and safety standards. Beds in unconventional space can be beds or stretchers (not gurney type) that have been placed to provide care. These beds have been brought in to provide care for inpatients in the event of shortages or surges, as such these beds do not have assigned staff but staff has been called in to care for these patients. Patients placed in beds in unconventional spaces do not have access to nurse call-bell, washrooms, suction, oxygen, etc. **ER Stretchers (ERSTRETCHERSUSED):** Includes any emergency beds/emergency stretchers (not gurney type) or any other area in acute care, recovery or after care (e.g. PACU/PARR)

	with staff assigned and located in an area or space meeting the fire protection and safety standards (excludes emergency stretchers in hallways) that were used to provide services to inpatients. **Note**: If a patient is discharged the same day he/she is admitted, the daily BCS count will only include the admission and the discharge. The bed is no longer relevant, as there is no patient occupying a bed at midnight. For detailed information on unconventional spaces, please refer to the **Daily BCS FAQ** document provided to registered users within the Health Data Branch Web Portal, Ministry of Health and Long-Term Care.
Numerator	Number of inpatients receiving care in unconventional spaces or ER stretchers in each day (at 12am), summed for all days in the given reporting period. **Inclusions:** All patients admitted to a bed/stretcher etc. that is placed at an unconventional space or ER stretcher to receive care at 12am. **Exclusions:** Patients admitted and discharged the same day (i.e. not occupying a bed at 12am)
Denominator	Total number of submission days within the reporting period
Risk adjustment	N/A
Current performance: reporting period	Q3 FY 2018/19 i.e. October 2018 – December 2018
Data source	Daily Bed Census Summary (Daily BCS) Note: data was self-reported daily by hospitals and available the following day. For general information on BCS, please visit https://www.ontario.ca/data/bed-census-summary-bcs.
How to access data	Local data collection
Comments	This indicator provides contextual information on the average number of patients who were admitted into hospitals receiving care in unconventional spaces or ER stretchers during the third quarter, 2018/19. This may reflect seasonal surges. The indicator profiles the average number of beds over capacity in Ontario hospitals during this time. In conjunction with other indicators such as time to inpatient bed and the ALC rate, this indicator can be used to monitor a hospital's space capacity and contribute to a better understanding of the issue.

Indicator Name	**Discharge summary sent from hospital to community care provider within 48 hours of discharge**
Priority for 2019/20 QIP	
Dimension	Timely
Direction of Improvement	Increase (higher)

Type	Process
Description	This indicator measures the 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%
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 2019/20 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	**Patient experience: Did you receive enough information when you left the hospital?**
Priority for 2019/20 QIP	
Dimension	Patient-centred
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	Most recent consecutive 12-month period
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.
Comments	Current performance reporting period is adjusted to be a 12-month period from the previous one quarter period.

Indicator Name	**Percentage of complaints acknowledged to the individual who made a complaint within five business days**
Priority for 2019/20 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.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Percent acknowledged within five business days = Number of complaints acknowledged within 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 percentage.
Numerator	Number of complaints that received a formal acknowledgement within 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. To review the *Patient Relations Guidance Tools for Quality Improvement*, please click here. Other indicators to consider can be found on Health Quality Ontario's Indicator Library

Indicator Name **NEW**	**Early identification: Documented assessment of palliative care needs for an early, at-risk cohort**
Priority for 2019/20 QIP	
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.
Unit of Measurement	Percentage expressed as a proportion
Calculation Methods	Numerator / Denominator
Numerator	Number of hospitalizations specified in the denominator that have a documented assessment of palliative care needs in the patients' hospitalization records. Quality Standards: Definitions Used Within This Quality Statement states that the usual categories of **palliative care needs** included in a holistic palliative assessment could be from any part of a person's full range of needs (physical, psychological, social, linguistic, cultural, legal, ethical, or spiritual) at any stage of illness.
Denominator	Number of hospitalizations where patients were identified with palliative care needs. See **Step 1: Identify** in the Ontario Palliative Care Network's Palliative Care Toolkit for guidance. Note: some patients may have more than one hospitalization.

	References to tools for identifying individuals in need of palliative care and assessment needs are presented in the comments section.
Risk adjustment	None
Current performance: reporting period	Most recent 6-month period
Data source	EMR
How to access data	Local data collection

Comments	Most palliative and end of life care is not done by palliative care specialists. It would not be sufficient to use referrals to palliative care as a proxy for this indicator.
	
	Who are these at-risk patients?
	• The patient populations may include patients nearing the end of life
	• Newly diagnosed, serious and life-limiting conditions
	  • Newly diagnosed cancer
	  • End-stage organ failure (s)
	  • Frailty
	  • Dementia
	  • Multiple medical conditions
	• Existing condition with a new development
	
	Step 1: Early Identification: Ask yourself, what screening process is currently in place in our organization to identify patients with progressive, life-threatening illnesses that may have palliative care needs?
	
	Early Identification: the Ontario Palliative Care Network's Palliative Care Toolkit lists tools for reference for Step 1: Identify. *Coming soon*: the Ontario Palliative Care Network Early Identification Guide (reference will be updated when it becomes available).
	
	Early identification screening would happen after the patient has been admitted to hospital, during inpatient admission assessment on the unit. Some tools used in Ontario include the Gold Standards Framework (GSF), and Hospital-Patient One-Year Mortality Risk (HOMR). Some tools rely on the "surprise" question as an initial screen. A more comprehensive guide will be available soon from the Ontario Palliative Care Network about these tools.
	
	Step 2: Assessment of palliative care needs: Ask yourself, what process is currently in place in our organization to do a comprehensive assessment of palliative care needs?
	
	Palliative care needs assessment:
	The Ontario Palliative Care Network's Palliative Care Toolkit lists these tools for reference for Step 2: Assess: Edmonton Symptom Assessment System, Palliative Performance Scale, Ken Rockwood 9 Point Frailty Tool, and Patient Reported Functional Status.

	Health Quality Ontario's Palliative Care Standard includes 13 Quality Statements. This indicator closely aligns with Quality Statement #1. Finally, there are several good strategies for improvement included within the Innovative Practices Guides for Complex Patients, published by Health Quality Ontario. **Codes:** Existing codes are used to capture received palliative care services and not identification and assessment; therefore, we would not recommend using the existing codes as proxies. Limitations to this measure include that the needs change over time; patients may have more than one hospitalization; and needs may have been assessed in other settings as well. The quality of the assessments will not be captured, only completions.

Indicator Name	**Readmission within 30 days for mental health and addiction**
Priority for 2019/20 QIP	
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Outcome
Description	This indicator measures the rate of mental health or addiction episodes of care 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 mental health or addiction episodes of care (EOCs) that are followed by a mental health or addiction readmission within 30 days of discharge divided by the number of mental health or addiction EOCs during the study period. Ontario Mental Health Reporting System (OMHRS) and Discharge Abstract Database (DAD) databases are used to identify index as well as subsequent hospitalizations for mental health and addictions.
Numerator	Number of mental health or addiction EOC that are followed by a mental health or addiction readmission within (≤) 30 days of discharge. For each unique mental health or addiction EOC in the study period (denominator), calculate the number that are followed (within 30 days) by a mental health or addiction admission (numerator), defined as: Mental Health or Addiction: 1. DAD ICD-10-CA Dx10Code1: F04 to F99, 2. OMHRS DSM-IV or DSM-V codes: Any hospital admission (including missing diagnosis except for DSM-IV 290.x. 294.x) Deliberate Self-Harm:

	3. ICD-10-CA Dx10Code1 is not equal to F04 to F99 and DXcodes2-25=X60-X84 or Y10-Y19 (Dxtype=9). *Exclusions:* • Patients without a valid health insurance number • Patients without an Ontario residence • Gender not recorded as male or female • Age > 105 years • 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 • Hospital admission for conditions other than mental health, addiction, or deliberate self-harm Notes: • Admissions for acute care for the treatment of deliberate self-harm are considered mental health admissions. • Episodes of care (EOC) included in the denominator are restricted to calendar years but 30-day follow-up for readmission can cross over into the next calendar year. • The reason for the readmission can be for a different MHA condition than the index discharge.
Denominator	Total number of mental health or addiction EOCs in the reporting period. Mental health or addiction EOCs are contiguous inpatient hospital stays for eligible conditions (described below). Two or more hospital records may be used to define a single EOC. This situation arises when the patient is transferred. Transfers are defined as those instances where: (1) An admission occurs within one day of a discharge, and (2) The institution numbers are different across the contiguous records (this includes transfers between acute medical and designated mental health units at the same hospital site). To create the EOCs, all DAD and OMHRS records with an eligible condition are pulled and organized in chronological order for each unique person (using encrypted health card numbers). Readmission is assessed from the final date of discharge in an EOC. Eligible conditions are determined using: • The primary ICD-10-CA code in DAD (F04 to F99 are eligible) • Primary ICD-10-CA is not equal to F04 to F99 and Dxcodes 2-25 include X60-X84 or Y10-19 (DXtype=9) • The primary DSM codes in OMHRS (all DSM codes excluding 290.x to 294.x are eligible) • If a DSM code is not present on the OMHRS record in question, the provisional DSM category ranked first in OMHRS (all provisional categories are eligible) *Inclusions:* • 0 - 105 years, inclusive

	Exclusions: • Patients without a valid health insurance number • Patients without an Ontario residence • Gender not recorded as male or female • Age > 105 years • 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)
Risk adjustment	None
Current performance: reporting period	January 2017 – December 2017
Data source	Discharge Abstract Database (DAD), Ontario Mental Health Reporting System (OMHRS), Registered Persons Database (RPDB) Data provided to Health Quality Ontario by Health Analytics Branch, Ontario Ministry of Health and Long-Term Care
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 2019.
Comments	See Health Quality Ontario's Indicator Library for limitations and caveats: http://www.hqontario.ca/System-Performance/Measuring-System-Performance/Indicator-Library

Indicator Name	**Medication reconciliation at discharge**
Priority for 2019/20 QIP	
Dimension	Effective
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 in the same time period. 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 2018 (Q3 2018/19)
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.

II. Primary Care Priority Indicators

Indicator Name	**7-day post-hospital discharge follow-up for selected conditions – CHCs, AHACs, NPLCs**	**7-day post-hospital discharge follow-up (any condition, any provider)**
Priority for 2019/20 QIP		
Directions	Please complete ONE of the following indicators below. Do **NOT** choose both.	
Dimension	Efficient	Efficient
Direction of Improvement	Increase (higher)	Increase (higher)
Type	Process	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.	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	Percentage
Calculation Methods	Numerator / denominator x 100	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.	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 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).	Number of hospital discharges for which timely (within 48 hours) notification was received.
Risk adjustment	None	None
Current performance: reporting period	Last consecutive 12-month 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.	EMR

How to access data	Community Health Centre, Aboriginal Health Access Centres, Nurse Practitioner-Led Clinic Profiles sponsored by Alliance for Healthier Communities	Local data collection
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 Alliance for Healthier Communities	This indicator is consistent with the technical specifications of the "Follow up after hospitalization" indicator developed by Association of Family Health Teams of Ontario (AFHTO), Data to Decisions 6.0

Indicator Name	**Timely access to a primary care provider**
Priority for 2019/20 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 the 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 2018 – March 2019 (or most recent 12-month period available)
Data source	In-house surveys
How to access data	Local data collection
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 Alliance for Healthier Communities (Alliance for Healthy Communities (previously 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. 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. This indicator is also reported on Health Quality Ontario’s primary care performance web pages.

Indicator Name	**Patient involvement in decisions about care**
Priority for 2019/20 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 the 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 2018 – March 2019 (or most recent 12-month period available)
Data source	In-house surveys.
How to access data	Local data collection
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, Alliance for Healthy Communities (previously 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. Organizations will be asked to provide the total number of respondents who registered an answer to each survey response scale to QIP Navigator if this indicator is selected. These indicators are reported in Health Quality Ontario's primary care performance reporting and 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.

Indicator Name **NEW**	**Percentage of non-palliative care patients newly dispensed an opioid**
Priority for 2019/20 QIP	
Dimension	Safety
Directions	The data for this indicator comes from MyPractice Reports (family health team [FHT] or community health centre [CHC] versions). For organizations that do not have this data, please note in the comments section of the Workplan that you do not have access to this data and complete a custom indicator.
Direction of Improvement	Decrease The direction of improvement should be considered by the organization. Likely, most organizations will choose to decrease (to reduce new opioid prescriptions dispensed). There may be a situation where an organization expects that the number of opioid prescriptions dispensed will increase, perhaps due to an initial measurement plan being put in place. In this case (setting a direction of improvement to increase dispensing opioid prescriptions), note the rationale in the target justification section of the Workplan.
Type	Process
Description	This indicator measures the percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed **by any provider in the health care system** within a 6-month reporting period.
Unit of Measurement	Percentage
Calculation Methods	Numerator / Denominator x 100%
Numerator	Patients newly dispensed an opioid within a 6-month reporting period prescribed by any provider in the health care system. New opioid dispenses are defined using a 6-month washout period, i.e., no opioid prescription dispensed within 6 months of the first opioid prescription dispensed in the reporting period.

<table>
<tr><td></td><td colspan="2">Notes:
OAT, cough and antidiarrheal opioid medications were not included in the opioid definition.
For a complete list of medications, see Table A in the MyPractice: Primary Care Report Technical Appendix (CHCs) (PDF) or the MyPractice: Primary Care Report Technical Appendix (physicians and FHTs) (PDF).</td></tr>
<tr><td>Denominator</td><td>CHC
Clients in your CHC for the specific reporting period.

Exclusions:
Clients younger than one year of age.
Palliative care clients identified from hospital and physician billing claims.
See Appendix C in MyPractice Primary Care Report Technical Appendix (CHCs) (PDF) for classification and billing codes</td><td>FHT
Patients assigned (rostered & virtually rostered) to a physician for the specific reporting period.

Exclusions:
Patients younger than one year of age.
Palliative care patients identified from hospital and physician billing claims data.
See Appendix C in MyPractice Primary Care Report Technical Appendix (physicians and FHTs) (PDF) for classification and billing codes.</td></tr>
<tr><td>Risk adjustment</td><td colspan="2">None</td></tr>
<tr><td>Current performance: reporting period</td><td>June 2018 Release
Data point: March 31, 2017</td><td>November 2018 Release
Data point: March 31, 2018</td></tr>
<tr><td>Data source</td><td colspan="2">Client Agency Program Enrolment (CAPE), Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD), Ontario Health Insurance Plan (OHIP), Registered Persons Database (RPDB), Narcotics Monitoring System (NMS)

Data was calculated and provided to Health Quality Ontario by Institute for Clinical Evaluative Sciences (ICES)</td></tr>
<tr><td>How to access data</td><td colspan="2">Health Quality Ontario's MyPractice: Primary Care Reports are available for FHTs and CHCs. To register, contact practicereport@hqontario.ca or sign up at https://www.hqontario.ca/quality-improvement/guides-tools-and-practice-reports/primary-care/consent

For organizations not eligible to receive MyPractice: Primary Care FHT or CHC, contact qip@hqontario.ca.

For more information, visit http://www.hqontario.ca/Quality-Improvement/Guides-Tools-and-Practice-Reports/Primary-Care</td></tr>
<tr><td>Comments</td><td colspan="2">Dispensed prescriptions don't always reflect actual use.
Opioids obtained through other means, such as out- of-province or hospital dispensing, were not captured in the calculation of this indicator.</td></tr>
</table>

	Organizations who received *MyPractice: Primary Care* Reports can find change ideas and other resources within this resource.

Indicator Name **NEW**	**Early identification: Documented assessment of palliative care needs for an early, at-risk cohort**
Priority for 2019/20 QIP	
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the proportion of primary care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.
Unit of Measurement	Percentage expressed as a proportion
Calculation Methods	Numerator / Denominator
Numerator	Number of patients specified in the denominator that have a documented assessment of their palliative care needs in their EMR. Quality Standards: Definitions Used Within This Quality Statement states that the usual categories of **palliative care needs** included in a holistic palliative assessment could be from any part of a person's full range of needs (physical, psychological, social, linguistic, cultural, legal, ethical, or spiritual) at any stage of illness.
Denominator	Number of patients that were identified with palliative care needs. See Step 1: Identify in the Ontario Palliative Care Network's Palliative Care Toolkit References to tools for identifying individuals in need of palliative care and assessment needs are presented in the comments section.
Risk adjustment	None
Current performance: reporting period	Most recent 6-month period
Data source	EMR
How to access data	Local data collection

Comments	Most palliative and end of life care is not done by palliative care specialists. It would not be sufficient to use palliative care referrals as a proxy for this indicator.
	
	Who are these at-risk patients? The patient populations may include
	• Patients nearing the end of life
	• Newly diagnosed, serious and life-limiting conditions
	  • Newly diagnosed cancer
	  • End-stage organ failure(s)
	  • Frailty

	• Dementia • Multiple medical conditions • Existing condition with a new development **Step 1: Early Identification:** Ask yourself, what screening process is currently in place in our organization to identify patients with progressive, life threatening illnesses that may have palliative care needs? **Early Identification**: the Ontario Palliative Care Network Palliative Care Toolkit lists tools for reference for step one. *Coming soon*: the Ontario Palliative Care Network Early Identification Guide (reference will be updated when it becomes available). Some tools used in Ontario include the Gold Standards Framework (GSF) and Hospital-Patient One-Year Mortality Risk (HOMR). Some tools rely on the "surprise" question as an initial screen. A more comprehensive guide will be available soon from the Ontario Palliative Care Network about these tools. **Step 2: Assessment of palliative care needs:** Ask yourself, what process is currently in place in our organization to do a comprehensive assessment of palliative care needs? **Needs assessment tools** are found in the Ontario Palliative Care Network's Palliative Care Toolkit. Health Quality Ontario's Palliative Care Quality Standard includes 13 Quality Statements. This indicator closely aligns with Quality Statement #1. There are several strategies for improvement included within the Innovative Practices Guides for Complex Patients, published by Health Quality Ontario. The Health Links Coordinated Care Plan (CCP) includes needs assessments with a specific palliative section. **Codes:** Existing codes are used to capture received palliative care services and not identification and assessment, therefore we would not recommend using the existing codes as proxies. Limitations of this measure include that the needs change over time, and needs may have been assessed in other settings. Assessment quality will not be captured, only completions.

III. Home and Community Care Priority Indicators

Indicator Name	**Unplanned emergency department visits within 30 days of hospital discharge**
Priority for the 2019/20 QIPs	
Dimension	Efficient
Direction of Improvement	Reduce (lower)
Type	Process
Description	Percentage of home care patients 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 patients 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 patients discharged from a hospital. *Inclusions*: • Patient applied for in-home services: request program =01 • Patient is Short or Long-Stay: Last SRC=91,92,93,94 • Patient 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 • Patient is discharged from an Acute Hospital: Analytical institution type =1 • Patient 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 Patients: 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 • Patients 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; Patient's SRC is based on the last SRC recorded; Age is calculated at time of discharge.
Risk adjustment	None
Current performance: reporting period	July 2017 – June 2018
Data source	Discharge Abstract Database (DAD), Home Care Database (HCD), National Ambulatory Care Reporting System (NACRS). Data provided to Health Quality Ontario 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 2019.

Indicator Name **NEW**	**Median number of days to long-term care home placement (community)**
Priority for the 2019/20 QIPs	
Dimension	Timely
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the median number of days residents waited to be placed in a long-term care home from the date of long-term care home application or consent to the date of placement, whichever is longer.
Unit of Measurement	Days
Calculation Methods	The median time, in days, for each included placement from the earlier of long-term care home application date or consent date to date of placement. The median is the number of days within which 50% of individuals waited from the date of application or consent to the date of placement. The median time can be stratified by location of the individual prior to placement (e.g., placed from hospital or placed from community). The median is calculated for the following placements for this indicator: **Placed from community** *Inclusions*: • All residents placed from the home, retirement homes, and supportive housing only *Exclusions*: • Residents for whom "Admitted from" and/or "Prior Location Code" is unknown
Numerator	N/A
Denominator	N/A
Risk adjustment	None

Current performance: reporting period	FY 2017/18 (i.e. April 2017 – March 2018)
Data source	Modernized Client Profile Database (CPRO Modernized). Data provided to Health Quality Ontario by Ministry of Health and Long-Term Care.
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 2019. Alternatively, these data can be gathered from Health Quality Ontario's Wait Times for Long-Term Care Homes
Comments	**Caveats and Limitations** The wait time for long-term care placement is measured among individuals who have been placed into long-term care, so does not capture individuals who are waiting for long-term care but die or find alternative arrangements before receiving long-term care home accommodation. This indicator does not include the wait time for individuals transferring from another long-term care home. **Comments Detailed** The results by Local Health Integration Network (LHIN) region represent the median of the wait times for residents placed within a LHIN region – i.e., the result is the median of the wait experienced by residents by the LHIN region where the placement occurred (based on location of the long-term care home) regardless of their prior location. The median was chosen as a summary measure because the overall distribution of wait time is highly skewed by very long waits.

Indicator Name **NEW**	**Median number of days to long-term care home placement (acute care)**
Priority for the 2019/20 QIPs	
Dimension	Timely
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the median number of days residents waited to be placed in a long-term care home from the date of long-term care home application or consent to the date of placement, whichever is longer.
Unit of Measurement	Days

Calculation Methods	The median time, in days, for each included placement from the earlier of long-term care home application date or consent date to date of placement. The median is the number of days within which 50% of individuals waited from the date of application or consent to the date of placement. The median time can be stratified by location of the individual prior to placement (e.g., placed from hospital or placed from community). The median is calculated for the following placements for this indicator: **Placed from acute care** *Inclusions*: • All residents placed from acute care hospitals. *Exclusions*: • Residents placed from rehab, CCC, etc. • Residents for whom "Admitted from" and/or "Prior Location Code" is unknown
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance: reporting period	FY 2017/18 (i.e. April 2017 – March 2018)
Data source	Modernized Client Profile Database (CPRO Modernized). Data provided to Health Quality Ontario by Ministry of Health and Long-Term Care.
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 2019. Alternatively, these data can be gathered from Health Quality Ontario's Wait Times for Long-Term Care Homes
Comments	**Caveats and Limitations** The wait time for long-term care placement is measured among individuals who have been placed into long-term care, so does not capture individuals who are waiting for long-term care but die or find alternative arrangements before receiving long-term care home accommodation. This indicator does not include the wait time for individuals transferring from another long-term care home. **Comments Detailed** The results by Local Health Integration Network (LHIN) region represent the median of the wait times for residents placed within a LHIN region – i.e., the result is the median of the wait experienced by residents by the LHIN region where the placement occurred (based on location of the long-term care home) regardless of their prior location. The median was chosen as a summary measure because the overall distribution of wait time is highly skewed by very long waits.

Indicator Name	**Percentage of patients satisfied with services**
Priority for the 2019/20 QIPs	
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 organizations (HCC), with the handling of their care by CCAC 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 HCC 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 HCC organizations • 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 HCC 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 HCC 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 HCC
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 (i.e., sampled home care patients are standardized to LHIN-specific population).
Current performance: reporting period	April 2017 – March 2018
Data source	Client and Caregiver Experience Evaluation (CCEE) Survey. Data provided to Health Quality Ontario 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 2019. Alternatively, to access your organization's data for this indicator, refer to the NRC Canada eReports website.

Indicator Name	**Percentage of complaints acknowledged to the individual who made a complaint within two business days**
Priority for the 2019/20 QIPs	
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 *Inclusions*: • 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 *Exclusions*: • 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 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. For more information about the Patient Relations Guidance Tools for Quality Improvement, please link here. Other indicators to consider can be found here.

Indicator Name **NEW**	**Early identification: Documented assessment of palliative care needs for an early, at-risk cohort**
Priority for the 2019/20 QIPs	
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the proportion of home care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.
Unit of Measurement	Percentage expressed as a proportion
Calculation Methods	Numerator / Denominator
Numerator	Number of home care patients specified in the denominator that have a documented assessment of their palliative care needs in their record. Quality Standards: Definitions Used Within This Quality Statement states that the usual categories of **palliative care needs** included in a holistic palliative assessment could be from any part of a person's full range of needs (physical, psychological, social, linguistic, cultural, legal, ethical, or spiritual) at any stage of illness. The InterRAI tools provide assessment of palliative care needs. The Health Links Coordinated Care Plan (CCP) provides a palliative section with assessment.
Denominator	Number of home care patients that were identified with palliative care needs References to tools for identifying individuals in need of palliative care and assessment needs are in the comments section. Note: the same client may have multiple home care episodes.

	See Step 1: Identify in the Ontario Palliative Care Network's Palliative Care Toolkit. The InterRAI tools may also provide guidance to identify patients with palliative care needs.
Risk adjustment	None
Current performance: reporting period	Most recent 6-month period
Data source	InterRAI tools, or other tools chosen by the organization
How to access data	Local data collection

Comments	Most palliative and end of life care is not done by palliative care specialists. It would not be sufficient to use palliative care referrals as a proxy for this indicator.
	
	Who are these at-risk patients? The patient populations may include
	• Patients nearing the end of life
	• Newly diagnosed, serious and life-limiting conditions
	  • Newly diagnosed cancer
	  • End-stage organ failure(s)
	  • Frailty
	  • Dementia
	  • Multiple medical conditions
	• Existing condition with a new development
	
	Step 1: Early Identification: Ask yourself, what screening process is currently in place in our organization to identify patients with progressive, life threatening illnesses that may have palliative care needs?
	
	Early Identification: the Ontario Palliative Care Network's Palliative Care Toolkit lists tools for reference for step one. *Coming soon*: the Ontario Palliative Care Network's Early Identification Guide (reference will be updated when it becomes available).
	
	Some tools used in Ontario include the Gold Standards Framework (GSF) and Hospital-Patient One-Year Mortality Risk (HOMR). Some tools rely on the "surprise" question as an initial screen. A more comprehensive guide will be available soon from the Ontario Palliative Care Network about these tools.
	
	Step 2: Assessment of palliative care needs: Ask yourself, what process is currently in place in our organization to do a comprehensive assessment of palliative care needs?
	
	The InterRAI palliative care tool is the current assessment for palliative care needs in home and community care. Some LHINs also use other tools.
	
	Needs assessment tools are found in the Ontario Palliative Care Network's Palliative Care Toolkit.

	Health Quality Ontario's Palliative Care Quality Standard includes 13 Quality Statements. This indicator closely aligns with Quality Statement #1. There are several strategies for improvement included within the Innovative Practices Guides for Complex Patients, published by Health Quality Ontario. **Codes:** Existing codes are used to capture received palliative care services and not identification and assessment; therefore, we would not recommend using the existing codes as proxies. Limitations to this measure include that the needs change over time; patients may have more than one home care episode; and needs may have been assessed in other settings. Assessment quality will not be captured, only completions.

IV. Long-Term Care Priority Indicators

Indicator Name	**Potentially avoidable emergency department visits for long-term care residents**
Priority for the 2019/20 QIPs	
Dimension	Efficient
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 2017 – September 2018
Data source	Continuing Care Reporting System (CCRS), National Ambulatory Care Reporting System (NACRS). Data provided to Health Quality Ontario by the Health Analytics Branch with the Ministry of Health and Long-Term Care.
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 for the 2019/20 QIPs		
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?(***NHCAHPS Long-Stay Resident Survey)** **OR** • *I would recommend this site or organization to others.(***InterRAI Quality of Life Survey**)	
Unit of Measurement	Percentage	
Calculation Methods (Choose Either NHCAHPS OR InterRAI. Same construct measured	Numerator / denominator x 100%	
	Homes using the **NHCAHPS Long-Stay Resident Survey** should measure this domain by calculating the percentage of residents who responded positively to question:	Homes using the **interRAI Quality of Life Survey** should measure this domain by calculating the percentage of residents who

but using different methods)	*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	responded positively to the statement: *D2. 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
Numerator	For Homes using the **NHCAHPS Long-Stay Resident Survey:** Add the number of respondents who responded '4' to the question	Homes using the **interRAI Quality of Life Survey:** Add the number of respondents who responded '3' or '4' to the statement
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. **Include non-respondents**
Risk adjustment	None	
Current performance: reporting period	April 2018 – March 2019 (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 for the 2019/20 QIPs	
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	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% Homes using the **NHCAHPS Long-Stay Resident Survey** should measure this domain by calculating the percentage of residents who responded positively 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.
Numerator	For homes using the **NHCAHPS Long-Stay Resident Survey**, add the number of respondents who responded '9' or '10' to the question
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 2018 – March 2019 (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 for the 2019/20 QIPs	
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	The percentage of residents who responded positively to the following statement: *I can express my opinion without fear of consequences.*
Unit of Measurement	Percentage
Calculation Methods	Numerator / Denominator x 100% Homes using the **interRAI Quality of Life Survey** should measure this domain by calculating the percentage of residents who responded positively to statement: *F3. 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
Numerator	Add the number of respondents who responded '3' or '4' to the statement
Denominator	Add the total number who registered any response to the statement and include non-respondents (6, 7, 8).
Risk adjustment	None
Current performance: reporting period	April 2018 – March 2019 (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	**Percentage of complaints acknowledged to the individual who made a complaint within 10 business days**
Priority for the 2019/20 QIPs	
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 10 business days= Number of complaints acknowledged within 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 10 business days
Denominator	All complaints received by the long-term care home within the reporting period *Inclusions*: • 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. *Exclusions*: • 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 that the issue has been received by the complaints representative / office and the investigative process has been initiated. This indicator measures resident-centredness and responsiveness in the complaints process. For more information about the Patient Relations Guidance Tools for Quality Improvement, please link here. Other indicators to consider can be found here.

Indicator Name **NEW**	**Early identification: Documented assessment of palliative care needs for an early, at-risk cohort**
Priority for the 2019/20 QIPs	
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the proportion of long-term care home residents with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.
Unit of Measurement	Percentage expressed as a proportion
Calculation Methods	Numerator / Denominator
Numerator	Number of long-term care home residents specified in the denominator that have a documented assessment of their palliative care needs in their record. Quality Standards: Definitions Used Within This Quality Statement states that the usual categories of **palliative care needs** included in a holistic palliative assessment could be from any part of a person's full range of needs (physical, psychological, social, linguistic, cultural, legal, ethical, or spiritual) at any stage of illness.

Denominator	Number of long-term care home residents identified with palliative care needs. See Step 1: Identify in the Ontario Palliative Care Network's Palliative Care Toolkit. References to tools for identifying individuals in need of palliative care and assessment needs are presented in the comments section.
Risk adjustment	None
Current performance: reporting period	Most recent 6-month period
Data source	RAI MDS tool, or other tools chosen by the organization
How to access data	Local data collection
Comments	Most palliative and end of life care is not done by palliative care specialists. It would not be sufficient to use palliative care referrals as a proxy for this indicator. **Who are these at-risk residents?** Most long-term care residents likely meet the at-risk criteria. The RAI MDS tool includes palliative screening questions to help with early identification of those with palliative care needs. **Step 1: Early Identification:** Ask yourself, what process is currently in place in our organization to screen residents who may have palliative care needs. The Ontario Palliative Care Network's Palliative Care Toolkit lists tools for early identification. A relevant tool for long-term care is the Risk Evaluation for Support: Predictions for Elder-life in the Community Tool (RESPECT). C*oming soon*: the OPCN Early Identification guide (reference will be updated when it becomes available). **Step 2: Assessment of palliative care needs:** Ask yourself, what process is currently in place in our organization to do a comprehensive assessment of palliative care needs? **Needs assessment tools** are found in the Ontario Palliative Care Network's Palliative Care Toolkit. Health Quality Ontario's Palliative Care Quality Standard includes 13 Quality Statements. This indicator closely aligns with Quality Statement #1. A relevant Canadian resource for long-term care is the Quality in Long Term Care Palliative Care toolkit. **Codes:** Existing codes are used to capture received palliative care services and not identification and assessment, therefore we would not recommend using the existing codes as proxies.

	Limitations of this measure include that the needs change over time. Assessment quality will not be captured, only completions.

V. Narrative Questions

Overview

Include a brief description of your organization and an introduction to your organization's Quality Improvement Plan (QIP).

Imagine you are telling a member of the public about your organization – some key facts, what you do, who your clients are, and your focus of care. Include a description of how you work to improve care for any specific under-served populations you might serve.

For the introduction to your QIP, include an overview of the key areas of focus for your QIP. Think of this as an executive summary that helps to contextualize and connect the different parts of the QIP.

Suggestion: Upload your organization's logo here.

Describe your organization's greatest quality improvement achievement from the past year

Provide a story about a specific quality improvement achievement that your organization is proud of. Try to think of this as a "bright spot" that can be shared with other organizations. The story should include results from the improvement initiative (for example, data demonstrating the impact of your project or program).

The purpose of this section is to demonstrate what is possible and inspire teams within your organization to continue to do more in the year ahead.

Suggestion: Upload graphs or photos of your results here.

This year, we are particularly interested in achievements that focus on any of the following priority areas:

- Access and transitions – for example, stories related to helping people receive the right care in the right place at the right time
- Mental health and addictions
- Opioids

Suggestion: For inspiration, visit Quorum to read about other organizations' greatest quality improvement achievements.

Patient/client/resident partnering and relations

Briefly outline how you partnered with patients/clients/residents in your quality improvement initiatives this year, including in the development of this QIP. Can you identify examples where their input has had an impact on your quality improvement initiatives? For example, have patients/clients/residents helped to choose areas of focus for your QIP, contributed change ideas, or co-designed/co-delivered quality improvement activities? Have you identified any broader impacts on staff, the patients/clients/residents who were engaged, or those being served by your organization?

Workplace violence prevention

Is workplace violence a strategic priority for your organization? (yes/no).

If yes, describe how it is a priority – for example, is it included in your strategic plan, do you report on it to your board, or have you made significant investments to improve in this area?

Compensation (hospitals only)

Please describe how you have connected executive compensation to the priorities in your QIP, with special consideration for the priority and mandatory QIP indicators. For guidance on how to complete performance-based compensation, please review **Performance-Based Compensation** and the Quality Improvement Plan:

http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/performancecomp/pbc_update_20111122.pdf

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