Quality Standards

Schizophrenia in the Community

Measurement Guide

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Health Quality Ontario

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Contents

1 How to Use the Measurement Guide

This document is meant to serve as a measurement guide to support the adoption of the Schizophrenia in the Community quality standard. Care for people with schizophrenia is a critical issue, and there are significant gaps and variations in the quality of care that people with schizophrenia receive in Ontario. Recognizing this, Health Quality Ontario released this quality standard to identify opportunities that have a high potential for quality improvement.

This guide is intended for use by those looking to adopt the Schizophrenia in the Community quality standard, including health care professionals working in regional or local roles. For a quality standard that addresses care for adults with schizophrenia who present at the emergency department or are admitted to hospital, please refer to the quality standard *Schizophrenia: Care for Adults in Hospitals*.

This guide has dedicated sections for each of the two types of measurement within the quality standard:

- **Local measurement:** what you can do to assess the quality of care that you provide locally
- **Provincial measurement:** how we can measure the success of the quality standard on a provincial level

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Important Resources for Quality Standard Adoption

Health Quality Ontario has created resources to assist with the adoption of quality standards:

- A *Getting Started Guide* that outlines a process for using quality standards as a resource to deliver high-quality care. It includes links to templates, tools, and stories and advice from health care professionals, patients, and caregivers. You can use this guide to learn about evidence-based approaches to implementing changes to practice
- A *Quality Improvement Guide* to give health care teams and organizations in Ontario easy access to well-established quality improvement tools. The guide provides examples of how to adapt and apply these tools to our Ontario health care environments
- An online community called Quorum that is dedicated to working together to improve the quality of health care across Ontario. Quorum can support your quality improvement efforts

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2 Quality Indicators in Quality Standards

Quality standards inform providers and patients about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are intended to guide quality improvement, monitoring, and evaluation.

Measurability is a key principle in developing the quality statements; each statement is accompanied by one or more indicators. This section describes the measurement principles behind the quality indicators, the process for developing these indicators, and the technical definitions of the indicators.

An effective quality statement must be measurable. Measurement is necessary to demonstrate if a quality statement has been properly implemented, and if it is improving care for patients. This is a key part of the Plan-Do-Study-Act improvement cycle. If measurement shows there has been no improvement, you need to consider a change or try something different.

2.1   Measurement Principles

Health Quality Ontario uses the process, structure, and outcome indicator framework developed by Donabedian in 1966 to develop indicators for quality standards. The three indicator types play essential and interrelated roles in measuring the quality of health care and the impact of introducing and using quality standards.

The indicators provided are suggestions intended to support quality improvement and implementation of the standard. It is not expected that every provider, team, or organization will be able measure all of them (or even want to measure all of them), but they can identify which indicators best capture areas of improvement for their care and what can be measured given existing local data sources.

2.2   Process Indicators

Process indicators assess the activities involved in providing care. They measure the percentage of individuals, episodes, or encounters for which an activity (process) is performed. In most cases, the numerator should specify a timeframe in which the action is to be performed, established through evidence or expert consensus. When a quality statement applies to a subset of individuals rather than the total population, the denominator should reflect the population of the appropriate subgroup, rather than the entire Ontario population. If exclusions are required or stratifications are suggested, they are reflected in the indicator specifications.

Process indicators are central to assessing whether or not the quality statement has been achieved; nearly all quality statements are associated with one or more process indicators. In most cases, the numerator and denominator for process indicators can be derived from the language of the quality statement itself; additional parameters (such as a timeframe) can also appear in the definitions section. In some cases, a proxy indicator is provided that indirectly measures the process. Proxy indicators are used only when the actual indicator cannot be measured with currently available data.

While most quality statements focus on a single concept and are linked with a single process indicator, some statements include two or more closely related concepts. In these cases, multiple process indicators can be considered to capture all aspects of the quality statement.

For example, a quality statement might suggest the need for a comprehensive assessment with several components, and each of those components might have a process indicator.

Examples of process indicators include the percentage of patients with hip fracture who receive surgery within 48 hours, or the percentage of patients with schizophrenia who are offered clozapine after first- and second-line antipsychotics have been ineffective. Please refer to the published quality standards for more examples.

2.3   Structural Indicators

Structural indicators assess the structures and resources that influence and enable delivery of care. These can include equipment; systems of care; availability of resources; and teams, programs, policies, protocols, licences, or certifications. Structural indicators assess whether factors that are known to help in achieving the quality statement are in place.

Some quality statements have structural indicators associated with them. Structural indicators are binary or categorical and do not require the definition of a numerator and denominator. However, in some cases it could be useful to specify a denominator defining an organizational unit, such as a hospital, a primary care practice, or a local region. In many cases data to measure structural indicators are not readily available using existing administrative data, so local data collection might be required. This local data collection might require regional or provincial level data collection systems to be developed.

Structural indicators should be defined for a quality statement or for the quality standard as a whole when there is strong evidence that a particular resource, capacity, or characteristic is important for enabling the effective delivery of a process of care. It should be theoretically feasible for these structural elements to be implemented across Ontario, even if adoption is aspirational in some cases. In rare instances, a quality statement might have two or more associated structural indicators, if the quality standard advisory committee decides that multiple factors are crucial to the delivery of the quality statement.

Examples of structural indicators include the availability of a stroke unit, the existence of discharge planning protocols, or access to a specialized behavioural support team. Please refer to the published quality standards for more examples.

2.4   Outcome Indicators

Outcome indicators assess the end results of the care provided. They are crucial and are arguably the most meaningful measures to collect, but many health outcomes—such as mortality or unplanned hospital readmissions—are often the product of a variety of related factors and cannot be reliably attributed to a single process of care. For this reason, although relatively few quality statements are directly linked to an outcome indicator, a set of overall measures—including key outcome indicators—is defined for the quality standard as a whole, reflecting the combined effect of all of the quality statements in the standard. Similar to process indicators, outcome indicators should be specified using a defined denominator and a numerator that, in most cases, should include a clear timeframe.

Examples of outcome indicators include mortality rates, improvement (or decline) in function, and patients' experience of care. Please refer to the published quality standards for more examples.

2.5 Balancing Measures

Balancing measures indicate if there are important unintended adverse consequences in other parts of the system. Examples include staff satisfaction and workload. Although they are not the focus of the standard, the intention of these measures is to monitor the unintended consequences.

3 Local Measurement

As part of the Schizophrenia in the Community quality standard, *specific* measures were identified for each of the statements to support measurement for quality improvement.

As an early step in your project, we suggest that your team complete an *initial assessment* of the relevant measures in the standard and come up with a draft measurement plan.

Here are some concrete next steps:

1. Review the list of identified measures (in the quality standard), and determine which measures you will use as part of your adoption planning, given your knowledge of current gaps in care
2. Determine the availability of data related to the measures you have chosen
3. Identify a way to collect local data related to your chosen measures
4. Develop a draft measurement plan

The earlier you complete the above steps, the more successful your quality improvement project is likely to be.

3.1 Local Data Collection

Local data collection refers to data collection at the health provider or team level for indicators that cannot be assessed using provincial administrative or survey databases (such as databases held by the Institute for Clinical Evaluative Sciences or the Canadian Institute for Health Information). Examples of local data include data from electronic medical records, clinical patient records, regional data collection systems, and locally administered patient surveys. Indicators that require local data collection can signal an opportunity for local measurement, data advocacy, or data quality improvement.

Local data collection has many strengths: it is timely, can be tailored to quality improvement initiatives, and is modifiable on the basis of currently available data. However, caution is required when comparing indicators using local data collection between providers to ensure consistency in definitions, consistency in calculation, and validity across patient groups.

3.2 Measurement Principles for Local Data Collection

Three types of data can be used to construct measures in quality improvement: continuous, classification, and count data.

3.2.1 Continuous Data

Continuous data can take any numerical value in a range of possible values. These values can refer to a dimension, a physical attribute, or a calculated number. Examples include patient weight, number of calendar days, and temperature.

3.2.2 Classification Data

Classification (or categorical) data are recorded in two or more categories or classes. Examples include sex, race or ethnicity, and number of patients with depression versus number of patients without depression. In some cases, you might choose to convert continuous data into

categories. For example, you could classify patient weight as underweight, normal weight, overweight, or obese.

Classification data are often presented as percentages. To calculate a percentage from classification data, you need a numerator and a denominator (a percentage is calculated by dividing the numerator by the denominator and multiplying by 100). The numerator includes the number of observations meeting the criteria (e.g., number of patients with depression), and the denominator includes the total number of observations measured (e.g., total number of patients in clinic). Note that the observations in the numerator must also be included in the denominator (source population).

Examples of measures that use classification data include percentage of patients with a family physician and percentage of patients who receive therapy.

3.2.3 Count Data

Count data often focus on attributes that are unusual or undesirable. Examples include number of falls in a long-term care home and number of medication errors.

Count data are often presented as a rate, such as the number of events per 100 patient-days or per 1,000 doses. The numerator of a rate counts the number of events/nonconformities, and the denominator counts the number of opportunities for an event. It is possible for the event to occur more than once per opportunity (e.g., a long-term care resident could fall more than once).

$$Rate\ of\ 30\text{-}day\ hospital\ readmission =$$

$$\frac{Number\ of\ hospital\ readmissions\ within\ 30\ days\ of\ discharge\ [\textbf{numerator}]}{Number\ of\ discharges\ from\ hospital\ [\textbf{denominator}]}$$

3.2.4 Benefits of Continuous Data

It is common practice in health care to measure toward a target instead of reporting continuous measures in their original form. An example would be measuring the number of patients who saw their primary care physician within 7 days of hospital discharge instead of measuring the number of days between hospital discharge and an appointment with a primary care physician. Targets should be evidence-based or based on a high degree of consensus across clinicians.

When a choice exists, continuous data sometimes are more useful than count or classification data for learning about the impact of changes tested. Measures based on continuous data are more responsive and can capture smaller changes than measures based on count data; therefore, it is easier and faster to see improvement with measures based on continuous data. This is especially true when the average value for the continuous measure is far from the target. Continuous data are also more sensitive to change. For example, while you might not increase the number of people who are seen within 7 days, you might reduce how long people wait.

3.3 Benchmarks and Targets

Benchmarks are markers of excellence to which organizations can aspire. Benchmarks should be evidence-based or based on a high degree of consensus across clinicians. At this time, Health Quality Ontario does not develop benchmarks for quality standards indicators. Users of these standards have variable practices, resources, and patient populations, so one benchmark might not be practical for the entire province.

Targets are goals for care that are often developed in the context of the local care environment. Providers, teams, and organizations are encouraged to develop their own targets appropriate to their patient populations and their quality improvement work. Organizations that include a quality standard indicator in their quality improvement plans are asked to use a target that reflects improvement. Timeframe targets, like the number of people seen within 7 days, are typically provided with process indicators intended to guide quality improvement.

In many cases, achieving 100% on an indicator is not possible. This is why it is important to track these indicators over time, to compare results against those of colleagues, to track progress, and to aim for the successful implementation of the standard.

For guidance on setting benchmarks and targets at a local level, refer to:

- Approaches to Setting Targets for Quality Improvement Plans
- Long-Term Care Benchmarking Resource Guide

4 Provincial Measurement

In its quality standards, Health Quality Ontario strives to incorporate measurement that is standardized, reliable, and comparable across providers to assess the impact of the standards provincially. Where possible, indicators should be measurable using province-wide data sources. However, in many instances data are unavailable for indicator measurement. In these cases, the source is described as local data collection.

For more information on the data sources referenced in this standard, please see the **appendix.**

4.1   Accessing Provincially Measurable Data

Provincial platforms are available to certain users to create custom analyses to help you calculate results for identified measures of success. Examples of these platforms include IntelliHealth and eReports. Please refer to the links below to determine if you have access to the platforms listed.

4.1.1   IntelliHealth—Ministry of Health and Long-Term Care

"IntelliHealth is a knowledge repository that contains clinical and administrative data collected from various sectors of the Ontario healthcare system. IntelliHealth enables users to create queries and run reports through easy web-based access to high quality, well organized, integrated data."

4.1.2   eReports—Canadian Institute for Health Information

Quick Reports offer at-a-glance comparisons for the organizations you choose. The tool also provides some ways to manipulate the pre-formatted look and feel of the reports. Flexible or Organization Reports offer you many choices to compare your organization's data with those of other organizations. With these customizable reports, you can view data by different attributes and for multiple organizations.

5 How Success Can Be Measured for This Quality Standard

This measurement guide accompanies Health Quality Ontario's Schizophrenia in the Community quality standard. Early in the development of each quality standard, a few performance indicators are chosen to measure the success of the entire standard. These indicators guide the development of the quality standard so that every statement within the standard aids in achieving the standard's overall goals.

This measurement guide includes information on the definitions and technical details of the indicators listed below:

- Percentage of adults hospitalized for schizophrenia who have had an unplanned hospital readmission for a mental health or addictions condition within 30 days of discharge
- Percentage of adults hospitalized for schizophrenia who had contact with a trained mental health physician:
    - within 7 days of hospital discharge
    - within 28 days of hospital discharge
- Percentage of adults with schizophrenia who report unmet care needs
- Percentage of adults with schizophrenia who report living in stable housing for the past year
- Percentage of adults hospitalized for schizophrenia who had contact with a trained mental health professional:
    - within 7 days of hospital discharge
    - within 28 days of hospital discharge

This guide includes data sources for indicators that can be consistently measured across providers, across the sectors of health care, and across the province.

Indicators are categorized as:

- Provincially measurable (the indicator is well defined and validated and can be measured using comprehensive provincial data) *or*
- Locally measurable (data sources do not currently exist to measure it consistently across providers and at the system level)

For more information on statement-specific indicators, please refer to the quality standard.

5.1 Quality Standard Scope

This quality standard addresses care for adults aged 18 years and older with a diagnosis of schizophrenia, including related disorders such as schizoaffective disorder. The quality standard focuses on care provided in the community, including primary care, hospital outpatient care, rehabilitation, correctional facilities, and community supports and services. It also provides guidance on early psychosis intervention for people who experience a first episode of schizophrenia.

For a quality standard that addresses care for adults with schizophrenia who present at the emergency department or are admitted to hospital, please refer to the quality standard *Schizophrenia: Care for Adults in Hospitals*.

The quality statements in this standard are based on clinical practice guidelines developed specifically for adults who have been diagnosed with schizophrenia; hence, this quality standard is intended to be used to inform care for only this population. However, the Schizophrenia Care in the Community Quality Standard Advisory Committee also took the view that some quality statements may be relevant to people experiencing a first episode of psychosis who have not been diagnosed with schizophrenia.

This quality standard includes 15 quality statements addressing areas identified by Health Quality Ontario's Schizophrenia Care in the Community Quality Standard Advisory Committee as having high potential to improve the quality of care for adults with schizophrenia.

5.2   Cohort Identification

For provincially measurable indicators, people with schizophrenia can be identified in administrative databases using the following ICD-10-CA codes: F20(Schizophrenia)and F25(Schizoaffective Disorder) or the following DSM-IV code: 295 (Schizophrenia and Schizoaffective Disorder). Only those who are 18 years of age or older should be included.

Local data (such as EMR or clinical chart review) may be used to identify the population within your clinical setting that have been diagnosed with schizophrenia or schizoaffective disorder.

5.3   How Success Can Be Measured Provincially

The Schizophrenia in the Community Quality Standard Advisory Committee identified a small number of overarching goals **for this quality standard.** These have been mapped to indicators that may be used to assess quality of care provincially. The following indicators are currently provincially measurable in Ontario's health care system:

- Percentage of adults hospitalized for schizophrenia who have had an unplanned hospital readmission for a mental health or addictions condition within 30 days of discharge
- Percentage of adults hospitalized for schizophrenia who had contact with a mental health physician:
  - within 7 days of hospital discharge
  - within 28 days of hospital discharge

Methodologic details are described in the tables below.

Table 1: Percentage of adults hospitalized for schizophrenia who have had an unplanned hospital readmission for a mental health or addictions condition within 30 days of discharge

GENERAL DESCRIPTION	Indicator description	Name: This indicator measures the percentage of people with schizophrenia that had an unplanned readmission to hospital within 30 days with a schizophrenia-related hospital admission. Directionality: Lower is generally better
	Measurability	**Measurable at the provincial level**
	Dimension of quality	Effective
	Quality statement alignment	All statements align
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Acute care discharges from episodes of care in which schizophrenia was coded as most responsible diagnosis. The index cases are identified from both the DAD and OMHRS databases. *Inclusions* • Age≥ 18years • Diagnosis codes • (ICD-10-CA): F20(Schizophrenia)and F25(Schizoaffective Disorder) • (DSM-IV): 295 (Schizophrenia and Schizoaffective Disorder) Diagnosis type • DAD: Most Responsible Diagnosis (diagnosis type=M) • OMHRS: DSM-IVinQ2A/Q2D Discharge disposition • DAD:04 (discharged to home or home setting with support services) or 05 (discharged to home with no support service from an external agency required) • OMHRS: X90=1(a planned and regular discharge) *Exclusions* • Records without a valid health insurance number • Records without an Ontario residence • Gender not recorded as male or female • Invalid date of birth, admission date/time, discharge date/time • Individuals who left against medical advice (DAD Discharge Disposition = 06,12) Note: Admission to another institution within 24 hours of discharge from an institution should be considered part of the same episode of care

		Numerator
		Number of individuals with subsequent readmission to an acute care hospital within 30 days of index hospitalization discharge for a most responsible diagnosis (i.e., diagnosis type = M in DAD or DSM - IV in Q2A/Q2D, or provisional diagnosis Q1D/Q1E/Q1F/Q1G/ Q1O/Q1P = 1 in OMHRS) of a mental health condition. **Method** Numerator divided by the denominator times 100 **Data sources:** Ontario Mental Health Reporting System (OMHRS), Registered Persons Database (RPDB), Discharge Abstract Database (DAD)**.**
ADDITIONAL INFORMATION	Limitations	It is not possible to differentiate between elective and non - elective admissions in OMHRS database. It would be possible to do for the CIHI records that would approximately comprise around 23% of the cases, the remaining 77% are identified through OMHRS. As such, both planned/unplanned readmissions are counted. Index discharges were all derived using the OMHRS. This may underestimate the total number of psychiatric admissions in the province because a certain proportion of psychiatric admissions are captured using only the CIHI – DAD. These numbers cannot tell us what happens to individuals between discharge and readmission to hospital within 30 days.
	Comments	Not all hospital readmissions are indicative of poor quality care.

Abbreviations: DAD: Discharge Abstract Database; OMHRS: Ontario Mental Health Reporting System; ICD-10-CA, International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canada.; DSM: Diagnostic and Statistical Manual of Mental Disorders.

Table 2: Percentage of adults hospitalized for schizophrenia who had contact with a mental health physician:

o   within 7 days of hospital discharge

o   within 28 days of hospital discharge

<table>
<tr><td rowspan="4">GENERAL DESCRIPTION</td><td>Indicator description</td><td>Name: This indicator measures the percentage of people with schizophrenia that had a follow - up visit to either a primary care physician or psychiatrist, within 7 or 28 days of a hospital discharge.
Directionality: A higher percentage is better.</td></tr>
<tr><td>**Measurability**</td><td>**Measurable at the provincial level**</td></tr>
<tr><td>Dimension of quality</td><td>Effective</td></tr>
<tr><td>Quality statement alignment</td><td>Quality Statement 1: Care Plan and Comprehensive Assessment
Quality Statement 2: Physical Health Assessment
Quality Statement 3: Self-Management</td></tr>
<tr><td>DEFINITION & SOURCE INFORMATION</td><td>Calculation: General</td><td>**Denominator**
Acute care discharges from episodes of care in which schizophrenia was coded as most responsible diagnosis. The index cases are identified from both the DAD and OMHRS databases.

Inclusions
- Age≥ 18years
- Diagnosis codes
- (ICD-10-CA): F20(Schizophrenia)and F25(Schizoaffective Disorder)
- (DSM-IV): 295 (Schizophrenia and Schizoaffective Disorder)

Diagnosis type
  •   DAD: Most Responsible Diagnosis (diagnosis type=M)
  •   OMHRS: DSM-IVinQ2A/Q2D

Discharge disposition
  •   DAD:04 (discharged to home or home setting with support services) or 05 (discharged to home with no support service from an external agency required)
  •   OMHRS: X90=1(a planned and regular discharge)

Exclusions
  •   Records without a valid health insurance number
  •   Records without an Ontario residence
  •   Gender not recorded as male or female
  •   Invalid date of birth, admission date/time, discharge date/time</td></tr>
</table>

		Note: Admission to another institution within 24 hours of discharge from an institution should be considered part of the same episode of care
		Numerator The number of patients who within 7 days or 28 days of discharge following a schizophrenia related- hospitalization had at least one psychiatrist or primary care physician visit. All - cause follow - up: Any visit to a primary care provider (IPDB main specialty = 'GP/FP' or 'F.P./Emergency medicine') or a psychiatrist (IPDB main specialty ='psychiatry') taking place in office, home, or long - term care (OHIP - location = 'O' or 'H' or 'L') **Method** Numerator divided by the denominator times 100 **Potential Stratification** Provider type (primary care provider; psychiatrist) **Data sources:** Ontario Health Insurance Plan (OHIP) Claims History Database, Ontario Mental Health Reporting System (OMHRS), Registered Persons Database (RPDB), Discharge Abstract Database (DAD)
ADDITIONAL INFORMATION	Limitations	The indicator does not capture medical services delivered in other forms of post - discharge care and by non - physician providers. (e.g., salaried physicians, community mental health programs, client-based initiatives). This indicator includes follow up by family physicians who may not have specific expertise in the delivery of mental health care, and thus is a proxy of mental health follow-up.

Abbreviations: DAD: Discharge Abstract Database; OMHRS: Ontario Mental Health Reporting System ICD-10-CA, International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canada. DSM: Diagnostic and Statistical Manual of Mental Disorders.

5.4   How Success Can Be Measured Locally

You might want to assess the quality of care you provide to your patients with Schizophrenia in the community. You might also want to monitor your own quality improvement efforts. It can be possible to do this using your own clinical records, or you might need to collect additional data. In addition to the provincially measurable indicators, we recommend the following list of indicators which cannot be measured provincially using currently available data:

- Percentage of adults with schizophrenia who report unmet care needs (suggested stratification: type of need)
- Percentage of adults with schizophrenia who report living in stable housing for the past year
- Percentage of adults hospitalized for schizophrenia who had contact with a trained mental health professional:
    - within 7 days of hospital discharge
    - within 28 days of hospital discharge

Methodologic details are described in the tables below.

Table 3: Percentage of adults with schizophrenia who report unmet care needs

GENERAL DESCRIPTION	Indicator description	Name: This indicator measures the percentage of adults with schizophrenia who report unmet care needs Directionality: A lower percentage is better
	Indicator status	**Developmental**
	Dimension of quality	Equitable; Effective; Patient Centred
	Quality statement alignment	All statements align
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of adults with Schizophrenia **Numerator** Number of people in the denominator who reported unmet care needs If using the OCAN[a] assessment, the response option "Unmet Need" can be used in questions 1-24. **Method** Numerator/denominator × 100
	Data source	Local data collection; Ontario Common Assessment of Need (where available)
ADDITIONAL INFORMATION	Limitations	The Ontario Common Assessment of Need (OCAN) is not available for all providers in the province, so other surveys may be required.
	Comments	It is suggested that results of this indicator be broken down by type of need. Example domains of need in the Ontario Common Assessment of Need include: Physical Health, Money, Food and Company.[a]

[a]*Source:* Ontario Common Assessment of Need (OCAN) Overview, Jennifer Zosky. http://eenet.ca/sites/default/files/Health-Equity-OCAN_Zosky.pdf
Abbreviations: OCAN: Ontario Common Assessment of Need

Table 4: Percentage of adults with schizophrenia who report living in stable housing for the past year

GENERAL DESCRIPTION	Indicator description	Name: This indicator measures the percentage of adults with schizophrenia who reported living in stable housing for the past year Directionality: A higher percentage is better
	Indicator status	**Developmental**
	Dimension of quality	Patient-Centered; Equitable
	Quality statement alignment	Quality Statement 6: Housing
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of adults with Schizophrenia **Numerator** Number of people in the denominator who reported living in stable housing for the past year. If using the OCAN[a] assessment, the following question can be used: Accommodation, Q1: "Does the person lack a current place to stay?", A: 2 = Unmet Need (Serious problem) **Method** Numerator/denominator × 100
	Data source	Local data collection; Ontario Common Assessment of Need (where available)
ADDITIONAL INFORMATION	Limitations	The Ontario Common Assessment of Need (OCAN) is not available for all providers in the province, so other surveys may be required.

[a]*Source: Ontario Common Assessment of Need (OCAN), https://www.ccim.on.ca/wp-content/uploads/2017/07/OCAN_2.0_FULL_v2.0.5i.pdf*

Table 5: Percentage of adults hospitalized for schizophrenia who had contact with a trained mental health professional:

• within 7 days of hospital discharge

• within 28 days of hospital discharge

GENERAL DESCRIPTION	Indicator description	Name: This indicator measures the percentage of schizophrenia discharges that had a follow - up visit with a trained mental health professional within 7 and 28 days of discharge.
		Directionality: A higher percentage is better
	Indicator status	**Developmental**
	Dimension of quality	Effective; Timely; Equitable
	Quality statement alignment	Quality Statement 1: Care Plan and Comprehensive Assessment
		Quality Statement 2: Physical Health Assessment
		Quality Statement 3: Self-Management
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator**
		Acute care discharges from episodes of care in which schizophrenia was coded as most responsible diagnosis
		Numerator
		The number of patients who within 7 and 28 days of discharge following schizophrenia related hospitalization had a follow-up visit with a trained mental health professional)
		Method
		Numerator/denominator × 100
	Data source	Ontario Mental Health Reporting System (OMHRS), Registered Persons Database (RPDB), Discharge Abstract Database (DAD) for the denominator
		Ontario Health Insurance Plan (OHIP) Claims History Database (for physician follow-up) local data collection (for non-physician provider follow-up care) for the numerator

aSource: Ontario Common Assessment of Need (OCAN), https://www.ccim.on.ca/wp-content/uploads/2017/07/OCAN_2.0_FULL_v2.0.5i.pdf

6 Resources and Questions

6.1   Resources

Several resources are available for more information:

- The **quality standard** provides information on the background, definitions of terminology, numerators and denominators for all statement-specific indicators
- The ***Getting Started Guide*** includes quality improvement tools and resources for health care professionals, including an action plan template
- The **infobrief** provides data on why a particular quality standard has been created and the data behind it

6.2   Questions?

Please contact qualitystandards@hqontario.ca. We would be happy to provide advice on measuring quality standard indicators, or put you in touch with other providers who have implemented the standards and might have faced similar questions.

Health Quality Ontario offers an online community dedicated to improving the quality of health care across Ontario together called Quorum. Quorum can support your quality improvement work by allowing you to:

- Find and connect with others working to improve health care quality
- Identify opportunities to collaborate
- Stay informed with the latest quality improvement news
- Give and receive support from the community
- Share what works and what doesn't
- See details of completed quality improvement projects
- Learn about training opportunities
- Join a community of practice

7 Appendix: Data Sources Referenced in This Quality Standard

Within this quality standard, there are several data sources used for provincial measurement. The data source(s) for each indicator are listed within the individual indicator specifications. More details on the specific data sources that Health Quality Ontario used to produce the indicators are noted below.

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

Ontario Common Assessment of Need (OCAN) – Community Care Information Management (CCIM)
The OCAN database contains responses from the OCAN tool. The OCAN tool is used to support conversations between the worker and the client, meeting the client where they are at. It focuses on what is most important to the client, such as a goal or an area of unmet need that concerns them the most. The summary of actions is also client driven. While working through the OCAN, workers provide positive feedback to clients on their resourcefulness and strengths. Workers also encourage clients to complete the self-assessment and provide support as needed.

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

Ontario Mental Health Reporting System (OMHRS) – Canadian Institute for Health Information (CIHI) The OMHRS, housed at CIHI, collects information about individuals admitted to designated adult mental health beds in Ontario. OMHRS includes information on admissions and discharges as well as clinical information. Clinical data are collected using the Resident Assessment Instrument for Mental Health (RAI - MH), a standardized assessment instrument for inpatient mental health care. It includes information about mental and physical health, social support and service use. Data are collected on clients from participating hospitals in Ontario at admission, discharge and every three months for patients with extended stays.

Data are available from October 1, 2005 onward. The number of active OMHRS sites has varied between 65 and 74 since the start of OMHRS in 2005 – 2006. In the early years of OMHRS, between 90% and 98% of active sites submitted at least some data every quarter. This rate has increased to 100% for all 4 quarters of 2014 – 2015. As of May 15, 2017, there were 84 participating facilities that have submitted data at least once to the OMHRS database since the implementation of OMHRS in October 2005

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