Ontario Health

Indicator Technical Specifications

2022/23 Quality Improvement Plans

February 2022

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Introduction

This document specifies indicator definitions, calculations, reporting periods, and other technical information hospitals, interprofessional primary care organizations, home and community care services, and long-term care homes will use to complete their 2022/23 Quality Improvement Plans (QIPs). It also includes the questions organizations will answer in the Narrative section of their QIPs.

The indicators described within this document were chosen to reflect quality issues identified by Ontario Health after a consultative process. They will address organizational and sector-specific priorities, with a focus on health system recovery. (Additional indicators have been developed to address system-wide, transformational priorities where improved performance is dependent on collaboration with other sector partners; these will be addressed in collaborative QIPs, which will be developed and submitted by Ontario Health Teams.)

Every sector and organization must prioritize quality improvement to achieve system-wide change. Each sector has its own list of recommended priority indicators. This year the hospital sector does not have any mandatory indicators. Table 1 outlines indicator types and how to incorporate them into your Workplan. A summary of the quality issues and indicators for the 2022/23 QIPs is presented in Figure 1.

Supports to help organizations consider their approach to quality have been updated and are available on Quorum. The guidance document will give you overall direction. The Ontario Health team managing the QIP inbox (QIP@ontariohealth.ca) can help you with any queries. Definitions and descriptions of performance or quality indicators already in use by Ontario Health can be found in the Indicator Library.

Because this year's submission is voluntary, you are not required to *submit* your 2022/23 QIP to Ontario Health (although we hope you do). However, organizations do have existing legislative and/or contractual obligations to *complete* a QIP. To meet these obligations, we remind you to post your completed 2022/23 QIP on your website and share it with your administrative staff, clinicians, and patients/residents and their family members. Please e-mail QIP@OntarioHealth.ca if you have any questions.

If you do choose to submit your QIP to Ontario Health, the status quo will apply, including all the standard work functions and parameters in QIP Navigator. This will allow us to provide continuity by pulling your workplan into a progress report for the 2023/24 reporting year.

Table 1. Indicator types for the 2022/23 QIPs

Indicator type	Description
Priority	These indicators address identified local and systemic issues. Review the priority indicators for your sector and determine which are relevant to your organization. Review your current performance against provincial data 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 (e.g., because performance already meets or exceeds the benchmark or is theoretical best), document the reason in the comments section of the Workplan.
Additional	Additional indicators refer to those that are mandatory for the collaborative Quality Improvement Plan (cQIP), which will be developed by Ontario Health Teams. They are optional to include at the organizational level. If your organization does not plan to include these indicators, you do not need to document the reason in the comments section of the Workplan.
Custom*	Existing indicators in use by Ontario Health programs may be used by organizations and will be available to add to your QIPs. You may choose to add custom indicators to reflect local initiatives or to modify existing indicators to be more consistent with measurements used in your organization.

*At the time of printing, data providers have not confirmed that indicators described in this document can be calculated for the QIP. If the hospital-specific indicators are not available by early March 2022, we will encourage hospitals to choose these as custom indicators.

Figure 1. Summary of key issues and indicators

	Hospitals	Interprofessional Primary Care	Long-Term Care	Home and Community Care
COVID-19 HEALTH SYSTEM RECOVERY				
Theme 1: Timely and Efficient Transitions A high-quality health system manages transitions well, providing people with the care they need, when and where they need it.				
Efficient	♠ Number of people whose first point of contact for a mental health and addictions condition is the emergency department ♠ Percentage of inpatient days with an alternate level of care designation	♠ Percentage of screening eligible patients up to date with Papanicolaou (Pap) tests ♠ Percentage of screen-eligible patients up to date with a mammogram ♠ Percentage of screen-eligible patients up-to-date with colorectal screening	**Percentage of potentially avoidable emergency department visits for long-term care residents.**	
Timely	**Percentage of discharge summaries sent from hospital to community care providers within 48 hours of discharge.**			
Theme 2: Patient/Client/Resident Experience Better experiences result in better outcomes. Tracking and understanding experience is an important element of quality.				
Patient-Centred	**Did patients feel they received adequate information about their health and their care at discharge?**	**Do patients feel involved in decisions about their care?**	**Do residents feel they have a voice and are listened to by staff?** **Do residents feel they can speak up without fear of consequences?**	**Are clients satisfied with the care and services they are receiving?**
Theme 3: Safe and Effective Care A high-quality health system works together to ensure that people have access to the best care for their condition and that their care is delivered in a way that is safe and effective.				
Safe	**Number of workplace violence incidents overall**	**Percentage of non-palliative care patients newly dispensed an opioid (excluding opioid agonist therapy) within a 6-month reporting period**	**Percentage of long-term care home residents not living with psychosis who were given antipsychotic medications**	**Percentage of patients with diabetic foot ulcers that closed within a 12-week period**
Effective	**Proportion of patients discharged from hospital for whom medication reconciliation is provided**			**Percentage of patients with a new diabetic foot ulcer in a 6-month period (incidence)**
EQUITABLE				
♠ Additional indicators are also included on the collaborative QIP. Organizations partnering in an OHT may opt to choose these indicators at an organizational level.				

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

Hospital indicators

Discharge summary sent from hospital to primary care provider within 48 hours of discharge	
Priority for 2022/23	
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 their 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	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.

Alternate level of care (ALC) days expressed as a percentage of all inpatient days in the same period	
Additional for 2022/23	
Dimension	Efficient
Direction of Improvement	Reduce (lower)
Type	Process
Description	Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment. This indicator can be stratified by characteristics such as age or discharge destination (see Comments section for details).
Unit of Measurement	Percentage
Calculation Methods	ALC days are those days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed does not require the intensity of resources/services provided in acute care. It includes discharges from acute care hospitals and excludes newborns and still births. (Total number of inpatient days designated as ALC in a given period of time ÷ Total number of inpatient days in a given time period) multiply by 100.
Numerator	Total number of inpatient days designated as ALC in the reporting period. Calculation Steps: Select the DAD data field name: ALC length of stay. Calculate (sum) the total number of inpatient days designated as ALC in a given time period. Inclusions: Data from acute care hospitals, including those with psychiatric beds (AP hospitals) and without psychiatric beds (AT hospitals). Individuals designated as ALC.

	Exclusions: Newborns and stillborns; Records with missing or invalid “Discharge Date”. Note: Other inclusion/exclusion criteria may exist depending on any variables used for stratification.
Denominator	Total number of inpatient days in the reporting period. Calculation Steps: Select the DAD field name: Total length of stay. Calculate (sum) the total number of inpatient days in a given time period. Inclusions: Data from acute care hospitals, including those with psychiatric beds (AP hospitals) and without psychiatric beds (AT hospitals). Exclusions: Newborns and stillborns; Records with missing or invalid “Discharge Date”. Note: Other inclusion/exclusion criteria may exist depending on any variables used for stratification.
Risk adjustment	N/A
Current performance: reporting period	April 2020 – March 2021 (FY 2020)
Data source	DAD (Discharge Abstract Database)
How to access data	To access your organization’s data for this indicator, refer to your organization’s Your Health System (YHS): In Depth indicators report at CIHI for the indicator *Patient Days in Alternate Level of Care (Percentage)* for 2020–2021.
Comments	Specific limitations The ALC days included are based on hospital discharge information, and as such the measure does not include patients occupying ALC beds who have not been discharged. Additional information regarding the calculation, interpretation, data source, etc. The ALC indicator is often stratified by variables such as age or discharge destination. Discharge destinations are based on the ‘transfer to’ institution type. Approximately 12-14% of ALC separations have missing ‘transfer to’ codes, which indicates that either these patients were not transferred for further care or the transfer information was not available. In 2006/07, reporting of activity at adult designated mental health units moved from the DAD to the Ontario Mental Health Reporting System (OMHRS).

	Open ALC Days are calculated by Cancer Care Ontario. For more information on open ALC days, please contact RIS@ontario.ca. Please note that these indicators are also included in the cQIP at an OHT level. Partners who also participate in the cQIP may find the organization level data helpful for their OHT cQIP work.

NEW: Rates of emergency department visits as first point of contact for mental health and addictions–related care	
Additional for 2022/23	
Dimension	Efficient
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures number of individuals for whom the emergency department was the first point of contact for mental health and addictions care per 100 population aged 0 to 105 years with an incident MHA-related ED visit.
Unit of Measurement	Rate per 100 Population
Calculation Methods	Index ED visit includes individuals who left without being seen and those admitted to hospital. Visits on the same day as the index are not considered prior contact. Look-back can include scheduled ED visits. Person-level indicator: one index visit per person. Diagnostic categories represent the reason for the incident ED visit (i.e., the denominator). Diagnoses-specific denominators do not add up to the overall denominator Deliberate self-harm may be present as a secondary diagnosis in any of the other diagnostic types. Deliberate self-harm refers to residual deliberate self-harm, i.e., the presence of a self-harm diagnosis where the main reason for the ED visit is non-MHA-related.
Numerator	Number of individuals in Ontario without an MHA-related service contact in a 2-year look-back period; includes only those who did not have an MHA-related outpatient visit to a psychiatrist, primary care provider or pediatrician or an MHA-related ED visit (scheduled or unscheduled) or an MHA-related hospitalization in the 2 years preceding the index ED visit. The numerator is a subset of denominator. Index: Date of ED visit *Exclusions*: Age older than 105 years Non-residents of Ontario Individuals with an invalid health card number

	Missing sex information
Denominator	Number of unique Ontario residents aged 0–105 years with an incident (first in a calendar year) unscheduled mental health and addictions (MHA)–related emergency department (ED) visit in the reporting period *Exclusions*: Age older than 105 years Non-residents of Ontario Individuals with an invalid health card number Missing sex information Scheduled ED visits (from denominator only).
Risk adjustment	None
Current performance: reporting period	April 2020 – March 2021
Data source	DAD (Discharge Abstract Database), OMHRS (Ontario Mental Health Reporting System), NACRS (National Ambulatory Care Reporting System), OHIP (Ontario Health Insurance Plan), CHC (Community Health Centre), RPDB (Registered Persons Database), PCCF (Statistics Canada's Postal Code Conversion File)
How to access data	Data will be prepopulated into QIP Navigator by March 2022. Data is provided by Institute for Clinical Evaluative Sciences (ICES).
Comments	When access to timely community-based mental health assessment and treatment is insufficient, individuals who require services may use the emergency department (ED) as their first point of contact. Therefore, a high rate of use of the ED as a first point of contact for mental health and addictions (MHA) care may be a useful indicator of inadequate access to outpatient physician and community-based care. Limitations / Caveats: CHC data were not available for 2010/11 and after March 31, 2017, and only for reporting at organizational level. Data did not capture most non-physician mental health and addictions services (i.e., psychologists, counsellors, and social workers). General limitations of health administrative data include potential coding errors and lack of clinical detail. Please note that these indicators are also included in the cQIP at an OHT level. Partners who also participate in the cQIP may find the organization level data helpful for their OHT cQIP work.

Patient experience: Did you receive enough information when you left the hospital?	
Priority for 2022/23	
Dimension	Patient-centred
Direction of Improvement	Increase (higher)

Type	Outcome
Description	Percentage of respondents who responded “completely” 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 used. “Top box” refers to the respondents who choose the only the most positive response.
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	Local data collection
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. This indicator was analyzed previously by data collected from the *Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey – Inpatient Care (CPES)* currently not in use by hospitals. The original survey questions are kept as the indicator calculation/methodology remains the same. Hospitals can leverage the *CPES* survey questions to self report this indicator in their 2022/23 QIPs.

Medication reconciliation at discharge	
Priority for 2022/23	
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 2021– December 2021 (Q3 2021/22)
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: Medication Reconciliation page on the Canadian Patient Safety Institute website.

Number of workplace violence incidents (overall)	
Priority for 2022/23	
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 *Inclusion Criteria*: 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 2021–December 2021
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. 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

Interprofessional primary care indicators

NEW: Percentage of screen-eligible patients up to date with a mammogram	
Additional for 2022/23	
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of screen eligible female patients aged 52 to 69 years who had a mammogram within the past two years.
Unit of Measurement	Percentage
Calculation Methods	(Total number of screen-eligible women aged 52 to 69 years, who have completed at least one mammogram in the past two years) / (Total number of screen-eligible women aged 52 to 69 years at index date) X100%

Numerator	Total number of screen-eligible women aged 52 to 69 years, who have completed at least one mammogram in the past two years *Inclusions*: Ontario women (average risk and high risk) aged 52 to 69 years at the index date Index date was defined as the first screen date per person by screen date in Integrated Client Management System (ICMS) or by service date in OHIP in a two-year period OBSP mammograms for screening purposes were identified in the ICMS; all mammograms in ICMS were counted including those with partial views Non-OBSP mammograms were identified using OHIP fee code (X172 Unilateral screening mammography; X 178 bilateral screening mammography; X185 diagnostic bilateral mammography) Each woman was counted once regardless of the number of mammograms performed in a two-year period; if a woman had both a program and non-program mammogram within a two-year period, the program status was selected Mammograms conducted in outpatient clinics located within hospitals are captured
Denominator	Total number of screen-eligible women, aged 52 to 69 years at index date *Exclusions*: Women with a missing or invalid HCN, date of birth or postal code Women with a history of breast cancer using the diagnostic code (dxcode-174) Women with a mastectomy before Jan 1st of the two-year period Palliative care patients identified from hospital and physician billing claims data. Please see Appendix for classification and billing codes
Risk adjustment	N/A
Current performance: reporting period	April 2020 – March 2021
Data source	OHIP (Ontario Health Insurance Program), RPDB (Registered Persons Database), CCO-OCR (Cancer Care Ontario - Ontario Cancer Registry), CIHI (Canadian Institute of Health Information), SDS (Same-day Surgery Database)
How to access data	These data should be accessed from within your own organization. **FHTs**: Data can be accessed via Health Quality Ontario's (now part of Ontario Health) *MyPractice: Primary Care Reports*;

	CHC and **AHACs**: *Community Health Centre Practice Profiles* are available through the Alliance for Healthier Communities. **NPLC:** EMR query within organization
Comments	***Limitations / Caveats*** This indicator is based on OBSP and OHIP data, which have different data update cycles. As a result, mammography rates were underestimated during data periods when OBSP data was not yet available. In addition, in 2010 two additional OHIP fee codes were included to capture mammography rates. Note: Indicator definition and technical details may be updated to reflect the current evidence over the next 18 months. Please note that these indicators are also included in the cQIP at an OHT level. Partners who also participate in the cQIP may find the organization level data helpful for their OHT cQIP work.

Percentage of screen-eligible patients up to date with colorectal screening	
Additional for 2022/23	
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Process
Description	Percentage of screen eligible patients aged 52 to 74 years who had a FOBT/FIT within the past two years, other investigations (i.e., flexible sigmoidoscopy) or colonoscopy within the past 10 years.
Unit of Measurement	Percentage
Calculation Methods	(Number of screen eligible patients aged 52 to 74 years who had a FOBT/FIT within past two years, other investigations (e.g. flexible sigmoidoscopy) or a colonoscopy within the past 10 years) / (Number of screen-eligible patients aged 52 to 74 years at index date) X100%
Numerator	Number of screen eligible patients aged 52 to 74 years who had a FOBT/FIT within the past two years, other investigations (i.e., flexible sigmoidoscopy) or colonoscopy within the past 10 years *Inclusions*: Patients who received one of the following: A fecal occult blood testing (FOBT) or FIT (L181 or G004, L179, Q152, Q043, Q133) in the past 2 years A colonoscopy in the previous 10 years, codes Z491 through Z499, or Z555 A flexible sigmoidoscopy in the previous 10 years, code Z580
Denominator	Number of screen-eligible patients aged 52 to 74 years at index date

	Exclusions: Patients with a missing or invalid HCN, date of birth or postal code Patients who have ever had colon cancer, inflammatory bowel disease or colectomy Palliative care patients identified from hospital and physician billing claims data. Please see Appendix for classification and billing codes
Risk adjustment	N/A
Current performance: reporting period	April 2020 – March 2021
Data source	OHIP (Ontario Health Insurance Program), RPDB (Registered Persons Database), CCO-OCR (Cancer Care Ontario - Ontario Cancer Registry), CIHI (Canadian Institute of Health Information), SDS (Same-day Surgery Database)
How to access data	These data should be accessed from within your own organization. **FHTs**: Data can be accessed via Health Quality Ontario's (now part of Ontario Health) *MyPractice: Primary Care Reports*; **CHC** and **AHACs**: *Community Health Centre Practice Profiles* are available through the Alliance for Healthier Communities. **NPLC:** EMR query within the organization.
Comments	***Limitations / Caveats*** A small proportion of FOBTs performed as diagnostic tests could not be excluded from the analysis. FOBTs analyzed in hospital labs could not be captured. Note: Indicator definition and technical details may be updated to reflect the current evidence over the next 18 months. On June 24, 2019, Ontario transitioned from the guaiac fecal occult blood test (gFOBT) to the fecal immunochemical test (FIT) in the ColonCancerCheck Program as the recommended screening test for people at average risk of developing colorectal cancer. Beginning with the September 2019 data cycle, the CRC screening indicator has been updated, including the addition of FIT. Beginning with the March 2020 data cycle, OHIP fee codes L181 and G004 were excluded for OHIP services rendered beginning January 2020 as gFOBT is no longer considered up-to-date for colorectal cancer screening. Please note that these indicators are also included in the cQIP at an OHT level. Partners who also participate in the cQIP may find the organization level data helpful for their OHT cQIP work.

Percentage of screening eligible patients up to date with Papanicolaou (Pap) tests	
Additional for 2022/23	
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Process
Description	This indicator is measuring the percentage of female patients aged 23 to 69 years who had a Pap test within the previous three years.
Unit of Measurement	Percentage
Calculation Methods	(Number of screen eligible women aged 23 to 69 years who had a Pap smear within the past three years) / (Total number of screen-eligible women aged 23 to 69 years at index date) X 100%
Numerator	Number of screen eligible women aged 23 to 69 years who had a Pap smear within the past three years *Inclusions*: Ontario women aged 23-69 years at the index date Index date was defined by service date in OHIP in a three-year period Pap tests identified using fee codes in OHIP (E430, G365a, G394a, L712, or L812, Q678, L713 and L733) Each woman is counted once regardless of the number of Pap tests performed in a three-year period
Denominator	Total number of screen-eligible women aged 23 to 69 years at index date *Exclusions*: Women with a missing or invalid HCN, date of birth, LHIN or postal code Women with a history of cervical cancer and/or a hysterectomy Palliative care patients identified from hospital and physician billing claims data. Please see Appendix for classification and billing codes
Risk adjustment	N/A
Current performance: reporting period	April 2020 – March 2021
Data source	OHIP (Ontario Health Insurance Program), RPDB (Registered Persons Database), CCO-OCR (Cancer Care Ontario - Ontario Cancer Registry), CIHI (Canadian Institute of Health Information), SDS (Same-day Surgery Database)
How to access data	These data should be accessed from within your own organization. **FHTs**: Data can be accessed via Health Quality Ontario's (now part of Ontario Health) *MyPractice: Primary Care Reports*;

	CHC and **AHACs**: *Community Health Centre Practice Profiles* are available through the Alliance for Healthier Communities. **NPLC** EMR query within organization
Comments	***Limitations / Caveats*** A small proportion of Pap tests performed as a diagnostic test could not be excluded from the analysis. The indicator does not capture test done in hospital laboratories or paid through alternate payment plans such as out-of-pocket. Note: Indicator definition and technical details may be updated to reflect the current evidence over the next 18 months. The indicator's definition is aligned with Health Quality Ontario's (now part of Ontario Health)MyPractice: Primary Care Reports (MPPR) for year 2022/23 QIPs. Given that OH CCO has updated its Cervical Screening Guidelines by increasing the eligible screening age range from 23-69 years old to 25-69 years old, organizations may be modifying the age range accordingly and using a custom indicator to adjust to the new higher age cut off. For OH CCO's *Cervical Screening Guidelines Summary*, please visit: https://www.cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/resources-healthcare-providers/cervical-screening-guidelines-summary Please note that these indicators are also included in the cQIP at an OHT level. Partners who also participate in the cQIP may find the organization level data helpful for their OHT cQIP work.

Patient involvement in decisions about care	
Priority for 2022/23	
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. *Exclusion Criteria*: Non-respondents; Respondents who answered "Not applicable (don't know/refused)".
Risk adjustment	None
Current performance: reporting period	April 2021 – March 2022 (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 (now part of Ontario Health) 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. To access the PCPES as well as a comprehensive Survey Support Guide on how to implement it, click here. This page includes an alternate version of the survey for community health centres (CHCs) and Aboriginal Health Access Centres (AHACs). 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 (now part of Ontario Health) primary care performance reporting and align with the

	Ministry's Health Care Experience Survey and the Commonwealth Fund Surveys.

Percentage of non-palliative care patients newly dispensed an opioid	
Priority for 2022/23	
Dimension	Safety
Direction of Improvement	Decrease. However, sometimes opioid prescriptions are appropriate. The data cannot weigh the benefits against the possible harms, but they can point to practice patterns worthy of reflection.
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**.
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. Notes: OAT, cough and antidiarrheal opioid medications were not included in the opioid definition. See Table A in the *MyPractice Primary Care* Report Technical Appendix for a complete list of opioid medications.
Denominator	Patients/clients assigned (rostered & virtually rostered) to the organization for the specific reporting period. *Exclusion Criteria:* Patients younger than one year of age. Palliative care patients identified from hospital and physician billing claims data. See Appendix C in the MyPractice *Primary Care* Report Technical Appendix for classification and billing codes.
Risk adjustment	None

Current performance: reporting period	Data point: March 31, 2021
Data source	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)
How to access data	These data should be accessed from within your own organization. **FHT**: Data can be accessed via Health Quality Ontario's (now part of Ontario Health) MyPractice: Primary Care Reports; **CHC** and **AHAC**: Community Health Centre Practice Profiles are available through the Alliance for Healthier Communities; **NPLC**: EMR query within organization.
Comments	Dispensed prescriptions don't always reflect actual use.

Long-term care indicators

Potentially avoidable emergency department visits for long-term care residents	
Priority for 2022/23	
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.

	Inclusion Criteria: 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 *Exclusion Criteria*: Planned or scheduled ED visits. LTC home residents who were first admitted to the home before the age of 65.
Denominator	*Inclusion Criteria*: All active residents of long-term care homes. *Exclusion Criteria*: 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 2020 – September 2021
Data source	Continuing Care Reporting System (CCRS), National Ambulatory Care Reporting System (NACRS). Data is provided by the Health Analytics & Insights Branch with the Ministry of Health and Ministry of Long-Term Care (MOH/MLTC).
How to access data	The Ministry will provide organizations with this data via LTCHomes.net. Data will also be prepopulated into QIP Navigator by March 2022.
Comments	Quality improvement guidance related to this indicator is available on the Health Quality Ontario's (now part of Ontario Health) website and through the INTERACT (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers) program.

Resident experience: Having a voice	
Priority for 2022/23	
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 2021 – March 2022 (or most recent 12-month period).
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.

Resident experience: Being able to speak up about the home	
Priority for 2022/23	
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 2021 – March 2022 (or most recent 12-month period).
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.

Appropriate prescribing: Potentially inappropriate antipsychotic use in long-term care	
Priority for 2022/23	
Dimension	Safe
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the percentage of LTC home residents without psychosis who were given antipsychotic medication in the seven days preceding their resident assessment.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100%

	The indicator is calculated using four rolling quarters of data by summing the number of residents that meet the inclusion criteria for the target quarter and each of the previous three fiscal quarters. This is done for both the numerator and denominator.
Numerator	LTC home residents who received antipsychotic medication on one or more days in the week before their Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS) target assessment *Inclusion Criteria*: O4a = 1, 2, 3, 4, 5, 6 or 7 Where, O4A = Number of days the resident received an antipsychotic medication during the last seven days [0-7]
Denominator	LTC home residents with a valid RAI-MDS assessment*, excluding those with schizophrenia, Huntington's chorea, hallucinations or delusions, as well as residents who are end-stage disease or receiving hospice care *Exclusion Criteria:* Residents who are end-stage disease (J5c = 1) or receiving hospice care (P1ao = 1) Residents who have a diagnosis of schizophrenia (I1ii = 1) or Huntington's chorea (I1x = 1), or those experiencing hallucinations (J1i = 1) or delusions (J1e = 1) *For an assessment to be valid and included in the quality indicator calculation, the selected assessment must: Be the latest assessment in the quarter Be carried out more than 92 days after the admission date Not be an Admission Full Assessment
Risk adjustment	Unadjusted for QIP
Current performance: reporting period	July 2021 – September 2021 (i.e. Q2 2021-2022)
Data source	Continuing Care Reporting System (CCRS), Integrated interRAI Reporting System (IRRS). Data is provided by Canadian Institute for Health Information (CIHI) via CCRS eReports.
How to access data	To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at www.cihi.ca. Data will also be prepopulated into QIP Navigator by March 2022.
Comments	The indicator is calculated as a rolling four quarter average by CIHI. Q2 2021-2022 is calculated based on data from Quarter 3, 2020-2021 to Quarter 2, 2021-2022 and Q2 is the final quarter used in the calculation. Q2 data represents the data in Q2, as well as three previous quarters. This indicator is consistent with Health Quality Ontario's (now part of Ontario Health) LTC Public Reporting website; however, the LTC Public Reporting website publicly reports *adjusted rates.* For the purposes of quality improvement planning, *unadjusted rates* (i.e., not risk-adjusted) should be used.

	Health Quality Ontario (now part of Ontario Health) developed a confidential practice report for physicians who practice long-term care. These reports are intended to complement other sources of information physicians receive (e.g., pharmacy reports). The current report includes indicators related to the prescribing of antipsychotic medications and benzodiazepines, and contains change ideas related to the topics of behavioural and psychological symptoms of dementia (BPSD) and fall prevention. For more information, please visit www.hqontario.ca/LTCreport.

Home and community care services indicators

Percentage of patients satisfied with services	
Priority for 2022/23	
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 home and community care service 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 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 2020 – March 2021
Data source	Local data collection
How to access data	These data should be accessed from within your own organization.
Comments	This indicator was analyzed by data collected from the *Client and Caregiver Experience Evaluation (CCEE)* survey currently not in use by home and community care services. The original survey questions are kept as the

	indicator calculation/methodology remains the same. The home and community care services can leverage the CCEE survey questions to self report this indicator in their 2022/23 QIPs.

Percentage of patients with a diabetic foot ulcer that closed within a 12-week period

Priority for 2022/23	
Dimension	Effectiveness
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the percentage of patients, diagnosed with a healable diabetic foot ulcer, whose ulcer closed within 12 weeks Calculation Methods Numerator / denominator x 100
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100
Numerator	Number of patients in the denominator whose diabetic foot ulcer closed within 12 weeks
Denominator	Number of patients with a diagnosis of a diabetic foot ulcer
Risk adjustment	N/A
Current performance: reporting period	April 2020 – March 2021
Data source	Local data collection
How to access data	These data should be accessed from within your own organization.
Comments	Comments This indicator aligns with the Quality Standard for Diabetic Foot Ulcers. To guide quality improvement efforts, the quality standard identifies quality statements and corresponding process measures Although the majority of closed diabetic foot ulcers eventually heal, this indicator would not capture diabetic foot ulcers that reopen beyond 12 weeks due to poor assessment or care. If a patient has more than one diabetic foot ulcer, the indicator should capture the most severe diabetic foot ulcer.

New: Percentage of patients with a new diabetic foot ulcer in a 6-month period (incidence)

Priority for 2022/23	
Dimension	Effectiveness

Direction of Improvement	Decrease (lower)
Type	Outcome
Description	This indicator measures the percentage of patients receiving home care and with a current diagnosis of diabetes, who develop a new diabetic foot ulcer (incidence)
Unit of Measurement	Percentage
Calculation Methods	Numerator/ denominator x 100
Numerator	Number of patients in the denominator with diagnostic code for diabetic foot ulcer **Exclusions** Patients with a diabetic foot ulcer on their previous assessment Patients whose diabetic foot ulcer formed while in another care setting, e.g., in acute care **Potential adjustments:** Home care: activities of daily living (ADL) impairment (ADL hierarchy score = 4 ,5, 6 vs. 0, 1, 2, 3)
Denominator	Total number of patients with diagnosed diabetes who have received home care services for at least 6 months
Risk adjustment	N/A
Current performance: reporting period	April 2020 – March 2021
Data source	Local data collection
How to access data	These data should be accessed from within your own organization.
Comments	The indicator only captures new diabetic foot ulcers. If a patient develops a secondary diabetic foot ulcer while the first injury has not healed or within 6 months of a previous ulcer, this will not be counted in the indicator. This indicator measures incidence, so it is a measure of prevention, not treatment. Patients with undiagnosed diabetes are not captured in the denominator

Narrative questions

Overview

Introduce your QIP with a brief overview of key facts or highlights that you think a member of the public would like to know. This opening paragraph will set the context within which you are doing your

improvement work. Tell us about your corporate strategy and how the QIP reporting reflects your strategic plan.

Reflections since your last QIP submission

Describe your organization's experiences since your last QIP. Given the focus on COVID-19 response over the past 18 months, we are aware that organizations are resetting their quality efforts. How has quality improvement work changed for you and how will you fit quality improvement work into the changes you have made to your organization during the pandemic?

Patient/client/resident partnering and relations

How has your partnering with patients work changed in the past year? What are the challenges? Have you been able to utilize innovations to sustain or advance this work?

Provider experience

Our consultations revealed a significant concern with what health care providers are experiencing in the current environment. In this section, please outline your experience with these challenges. How have you supported staff?

Resident experience

Note: For long-term care only.

Our consultations revealed concerns that the existing resident experience indicators were not as relevant to residents' experiences in today's climate. Looking forward to next year's QIP, we are asking for your input regarding indicators that would reflect residents' social connectedness. We are interested in knowing more about what your organization is doing or plans on doing to restore and enhance social connectedness. You may wish to direct us to a survey question or a measure for which you are currently collecting data.

Executive compensation

Note: Required for hospitals only.

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

Contact information

You can opt to include your contact information so that other organizations can connect with you after your QIP is posted publicly.

Other

Is there anything else you would like to share with us about quality improvement in your organization that has not been mentioned above?

Abbreviations

AFHTO	Association of Family Health Teams of Ontario
AHAC	Aboriginal Health Access Centre
ALC	Alternate level of care
AHC	Alliance for Healthier Communities
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 (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 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