Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

Indicator Technical Specifications

2020/21 Quality Improvement Plans

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Health Quality Ontario

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Revisions to indicator technical specifications

Date	Indicator	Revision
January 27, 2020	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day	New recommendations are available for hospitals describing how they can best address this issue.
January 27, 2020	Percentage of non-palliative care patients newly dispensed an opioid	Revisions were made to the wording of the technical specification to ensure clarity.
January 27, 2020	QIP Narrative prompts	Alternate level of care (ALC) has been removed as a prompt for hospitals as this issue is addressed in the ALC rate indicator for this sector.

Introduction

This document specifies indicator definitions, calculations, reporting periods, and other technical information for hospitals, interprofessional primary care organizations, and long-term care homes to use in their 2020/21 Quality Improvement Plans (QIPs). It also includes the narrative questions that organizations are to answer to address important quality issues.

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

Each sector has its own list of recommended priority indicators to measure performance on these key quality issues. The hospital sector must complete a mandatory indicator(s) as well. Types of indicators are outlined in Table 1. A summary of the quality issues and indicators for the 2020/21 QIPs is presented in Figure 1.

Table 1. Types of indicators

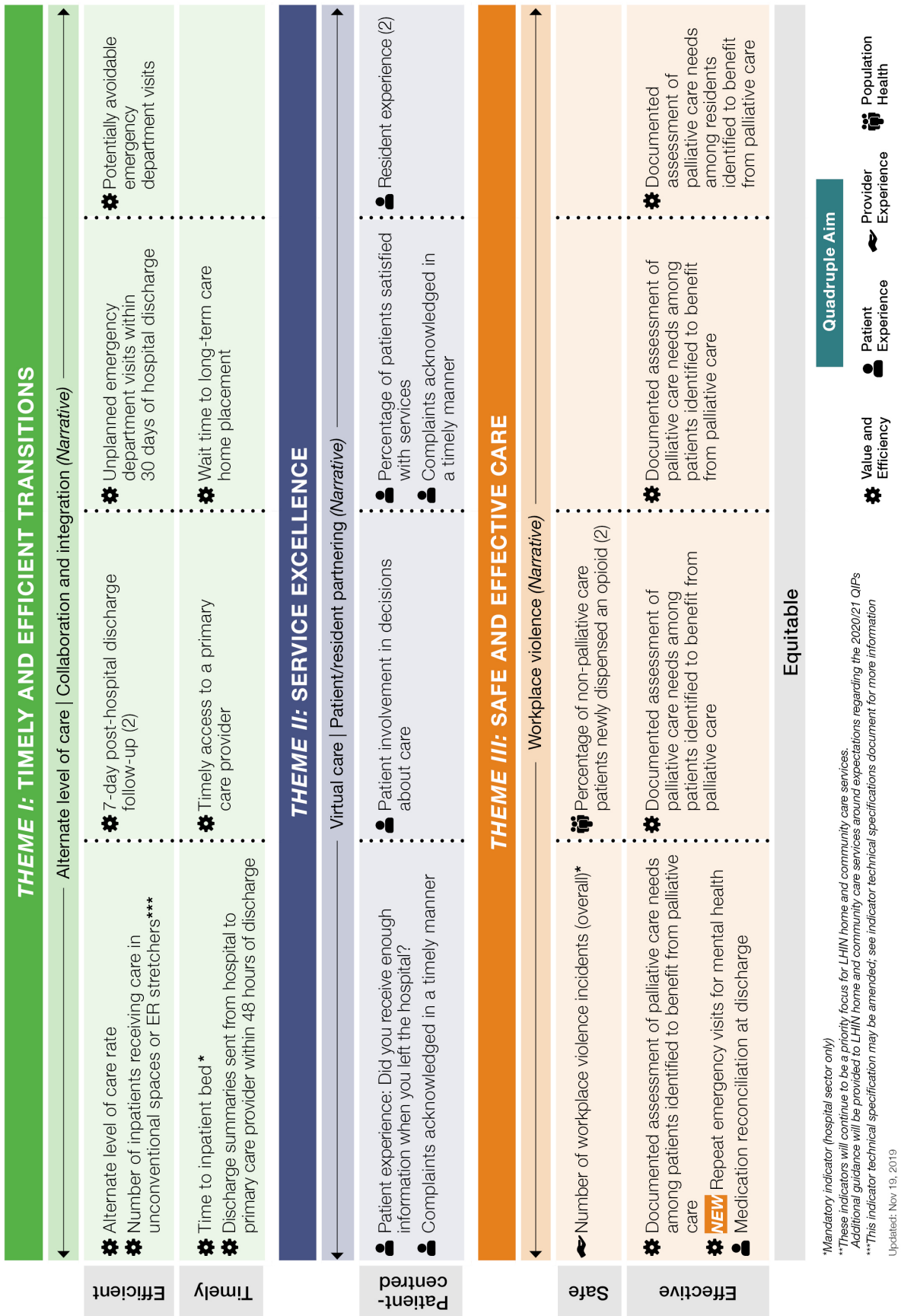
Indicator Type	Description
Mandatory (hospital sector only)	• Mandatory indicators only apply to the hospital sector. • You must include these mandatory indicators in your hospital's QIP. • These are tied to issues where province-wide improvement is urgently required. • Performance on these issues/indicators directly impacts patients, residents, and health care providers across the province. • Achieving improved performance requires every organization to prioritize, actively engage, and support improvement activities. • The mandatory issues and indicators will be clearly identified and communicated via a variety of mechanisms.
Priority	• Review the priority indicators for your sector and determine which are relevant for your organization. • Review your current performance against provincial data and benchmarks for all priority indicators. • Organizations scoring poorly in comparison with provincial averages/benchmarks are strongly encouraged to select these indicators in their QIP. • If your organization does not plan to include a priority indicator (for example, because performance already meets or exceeds the benchmark or is theoretical best), document the reason in the comments section of the Workplan.
Custom	• You may also choose to add custom indicators to reflect local initiatives or to modify the existing indicators to be more consistent with measurements used in your organization.

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

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

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

Figure 1. Quality Priorities for the 2020/21 QIPs



I. Hospital Indicators

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

Hospital Mandatory Indicators

Indicator Name	**Emergency department wait time for inpatient bed**
Mandatory for 2020/21 QIP	
Dimension	Timely
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.
Unit of Measurement	Hours
Calculation Methods	The indicator is measured in hours using the 90th percentile, which represents the maximum length of time that 90% of patients admitted from the ED wait for an inpatient bed or an operating room. **ED Wait time = Date/Time Patient Left ED - Date/Time Disposition Decision** Unit of analysis: Single ED visit All emergency visits *Inclusions*: • Admitted unscheduled emergency visits • ED visits with a valid and known Disposition Date/Time and a valid and known date/time the patient left the ED *Exclusions*: • Scheduled emergency visits i.e. ED visit indicator is = "0" • Non-admitted unscheduled emergency visits • Visits with unknown/invalid Disposition Date/Time (9999) • Visits with Registration Date/Time AND Triage Date/Time BOTH blank/unknown (9999) • Visits with unknown/invalid Date/Time Patient Left ED (9999) • Duplicate cases within the same functional centre where all ED data elements have the same values except for Abstract ID number • Cases where MIS functional centre not under General Emergency Department ('713102000' '723102000' '733102000') or Urgent Care

	Centre ('713102500' '723102500' '733102500') • Cases where Time to IPB is greater than or equal to 100,000 minutes (1,666 hours) • Cases where time to IPB is less than 0 (i.e., negative value)
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance: reporting period	Q3 FY 2019/20 (i.e. October 2019 – December 2019)
Data source	National Ambulatory Care Reporting System (NACRS). Data provided to Health Quality Ontario by Cancer Care Ontario.
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2020. Alternatively, these data can be accessed by registered users via Cancer Care Ontario's iPort™ Access.
Comments	Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. Many factors can influence the indicator results, including the availability of inpatient beds, the percentage of alternate level of care (ALC) patients, the overall patient population and hospital resources. The 90th percentile of this indicator represents the maximum length of time that 90% of patients admitted from the ED wait for an inpatient bed or an operating room in the ED.

Indicator Name	**Number of workplace violence incidents (overall)**
Mandatory for 2020/21	
Dimension	Safety
Direction of Improvement	If your organization is focused on building your reporting culture, your QIP target for this indicator may be to increase the number of reported incidents. If your organization's reporting culture is already well-developed, your QIP target may be to decrease.
Type	Outcome
Description	This indicator measures the number of reported workplace violence incidents by hospital workers within a 12-month period. For quality improvement purposes, hospitals are asked to collect data on the number of violent incidents reported by workers, including physicians and those who are contracted by other employers (e.g., food services, security, etc.) as defined by the Occupational Health and Safety Act.
Unit of Measurement	Number of workplace violence incidents reported by hospital workers

Calculation Methods	Number of workplace violence incidents reported by hospital workers within a 12-month period *Inclusions*: The terms "worker" and "workplace violence" as defined by under the Occupational Health and Safety Act (OHSA, 2016)
Numerator	N/A
Denominator	N/A
Risk adjustment	N/A
Current performance: reporting period	January 2019–December 2019
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

Hospital Priority Indicators

Indicator Name	**Alternate level of care rate**
Priority for 2020/21 QIP	
Dimension	Efficient
Direction of Improvement	Reduce (lower)
Type	Process
Description	This indicator measures the total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data.
Unit of Measurement	Rate per 100 inpatient days
Calculation Methods	Numerator / denominator x 100% Please note that only those facilities (Acute & Post-Acute) submitting both ALC data (to the Wait Time Information System (WTIS)) and Daily Bed Census Summary (BCS) data (through the Health Database Web Portal) are included in ALC Rate calculation. Any master number that does not have inpatient days reported to the BCS for a given month/quarter will be excluded from reporting for that month/quarter.
Numerator	Total number of inpatient days designated as ALC in a given time period (i.e. monthly, quarterly, and yearly). Calculation: • Acute ALC days = the total number of ALC days contributed by ALC patients waiting in non-surgical (NS), surgical (SU), and intensive/critical care (IC) beds.

	• Post-Acute ALC days = ALC days for Inpatient Services CC + RB + MH • CCC ALC days = ALC days for Inpatient Service CC • Rehab ALC days = ALC days for Inpatient Service RB • Mental Health ALC days = ALC days for Inpatient Service MH *Exclusions*: • ALC cases discontinued due to 'Data Entry Error'. • ALC cases having Inpatient Service = Discharge Destination for Post-Acute Care (*Exception: Bloorview Rehab, CCC to CCC). • ALC cases identified by the facility for exclusion. Notes: • The day of ALC designation is counted as an ALC day but the date of discharge or discontinuation is not counted as an ALC day. • For cases with an ALC designation date on the last day of a reporting period and no discharge/discontinuation date, then ALC days = 1. • The ALC Rate indicator methodology makes the assumption that the Inpatient Service data element (as defined in the WTIS) is comparable to the Bed Type data element (as defined in the BCS)
Denominator	Total number of inpatient days in a given time period (i.e., monthly, quarterly, and yearly). Calculation: • Acute Patient days = the total number of patient days occupying Acute with Mental Health Children/Adolescent (AT) beds • Post-Acute Patient days = the total number of patient days occupying Complex Continuing Care (CR) + General Rehabilitation (GR) + Special Rehabilitation (SR) + Mental Health - Adult (MH) Beds o CCC Patient days = the total number of patient days occupying Complex Continuing Care (CR) Beds o Rehab Patient days = the total number of patient days occupying in General Rehabilitation (GR) + Special Rehabilitation (SR) Beds o Mental Health Patient days = the total number of patient days occupying Mental Health - Adult (MH) Beds Note: Bed Census Summary (BCS) data has been updated according to the new Daily Census Summary (DCS) format as of June 2017. The methodology for the calculation of the denominator has been updated beginning with June 2017 data.
Risk adjustment	None
Current performance: reporting period	July 2019 – September 2019

Data source	BCS, Wait Time Information System (WTIS). Data provided to Health Quality Ontario by Cancer Care Ontario.
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2020. Alternatively, hospitals can access ALC reports via the Access to Care Site at https://share.cancercare.on.ca. Those not registered can contact Access To Care at ATC@cancercare.on.ca.
Comments	Consistent with the Hospital Service Accountability Agreement performance measure. There are three indicators related to patient flow for hospitals in this year's QIP. Both the time to inpatient bed and the number of unconventional bed indicators are lead indicators, capturing patient flow problems within the hospital, but related to flow problems in the system. The third indicator is the ALC rate indicator, a lag indicator that reflects system functionality.

Indicator Name	**Average number of inpatients receiving care in unconventional spaces or ER stretchers per day**
The indicator measuring care in unconventional spaces remains under revision while the Ministry of Health works to develop a measure that better reflects this issue. While we are working to finalize this technical specification as soon as possible, we know that organizations have already begun to develop their QIPs in anticipation of the April 1 deadline. For those organizations that are interested in incorporating this topic in their QIP, we recommend that you consider selecting the care in unconventional spaces indicator in your QIP, and select 'collecting baseline' instead of entering data. This will enable you to document your change ideas for this topic.	

Indicator Name	**Discharge summary sent from hospital to primary care provider within 48 hours of discharge**
Priority for 2020/21 QIP	
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Process
Description	This indicator measures the percentage of patients discharged from hospital for which discharge summaries are delivered to 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.

Indicator Name	**Patient experience: Did you receive enough information when you left the hospital?**
Priority for 2020/21 QIP	
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	Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey – Inpatient Care (CPES)
How to access data	These data should be accessed from within your own organization.
Comments	Current performance reporting period is adjusted to be a 12-month period from the previous one quarter period.

Indicator Name	**Percentage of complaints acknowledged to the individual who made a complaint within five business days**
Priority for 2020/21 QIP	
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Percent acknowledged within five business days = Number of complaints acknowledged within five business days divided by the total number of complaints received in the reporting period. To ensure a standardized approach to measurement, hospitals will now be asked to provide their numerator and denominator in the QIP workplan; QIP Navigator will calculate the percentage.
Numerator	Number of complaints that received a formal acknowledgement within five business days
Denominator	All complaints received by the hospital within the reporting period *Inclusion Criteria:* • Complaints received within the reporting period, but acknowledged and closed in the first 60 days of the following reporting period • The day and time of complaint should be recorded • Complaints received on and between the first and last day of the reporting period, including non-business days and after hours • Repeated complaints on the same issue from the same individual or by a different individual on behalf of the same patient/resident are counted as a single complaint • One complaint may include numerous issues, but should be counted as a single complaint • Complaints included must be documented through the established complaints process • Oral complaints made in person or by phone call • Written complaints made by letter, email, fax, text, etc. *Exclusion Criteria:* • The complaint is not documented through the established complaints process. For example: • Complaints that were acknowledged and resolved immediately after the complaint was received (e.g. changing the temperature in a patient or resident's room) • The complaint needed no additional intervention

Risk adjustment	None
Current performance: reporting period	Most recent 12-month period
Data source	Local data collection
How to access data	Local data collection
Comments	By regulation, hospitals must acknowledge complaints within five business days. Complaints received by the facility need to be formally acknowledged to the individual who made the complaint. To review the *Patient Relations Guidance Tools for Quality Improvement*, click here. Other indicators to consider can be found on Health Quality Ontario's Indicator Library.

Indicator Name	**Documented assessment of palliative care needs among patients with progressive, life-limiting illness who were identified to benefit from palliative care**
Priority for 2020/21 QIP	
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the proportion of hospitalizations where patients with a progressive, life-limiting illness are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment. Why is this important? Earlier identification can improve quality of life by ensuring adequate pain and symptom management, as well as relief of burdens by employing active person-centered decision-making (Ontario Palliative Care Network, 2019).
Unit of Measurement	Percentage expressed as a proportion
Calculation Methods	Numerator / Denominator
Numerator	Number of hospitalizations specified in the denominator that have a comprehensive and holistic assessment of palliative care needs documented in the patients' hospitalization records. Quality Standards: Definitions Used Within This Quality Statement states that the usual categories of palliative care needs included in a holistic palliative assessment could be from any part of a person's full range of needs (physical, psychological, social, linguistic, cultural, legal, ethical, or spiritual) at any stage of illness.

	See Step 2: Assess in the Ontario Palliative Care Network's Palliative Care Toolkit for guidance.
Denominator	Number of hospitalizations of patients with a progressive, life-limiting illness who are identified and found to benefit from palliative care. See **Step 1: Identify** in the Ontario Palliative Care Network's Palliative Care Toolkit for guidance. Preferred tools are cited in the Tools to Support Earlier Identification for Palliative Care, published by the Ontario Palliative Care Network. **Tools example**: the Supportive and Palliative Care Indicators Tool (SPICT) and the Hospital-Patient One-Year Mortality Risk (HOMR). **Note:** Some patients may have more than one hospitalization. References to tools for identifying individuals in need of palliative care and for assessing needs are presented in the comments section.
Risk adjustment	None
Current performance: reporting period	Most recent 6-month period
Data source	EMR
How to access data	Local data collection

Comments	The intent of the indicator is to influence a system change to 1) identify people who would benefit from palliative care as early as possible using a screening tool, and 2) to conduct a holistic assessment of their needs earlier in the disease trajectory.
	
	Identification does not mean a referral to a palliative care specialist. Instead, identification should prompt a comprehensive and holistic assessment to determine the patient's full range of needs.
	
	Who are these patients?
	• The patient population will likely include identifying patients with palliative care needs earlier than has been done in the past.
	• Newly diagnosed, serious and life-limiting conditions
	  • Newly diagnosed cancer with significant risk of progression
	  • End-stage organ failure(s)
	  • Frailty
	  • Dementia
	  • Multiple medical conditions
	• Existing condition with a new development
	
	Step 1: Early Identification (the denominator): Ask yourself, what screening process is currently in place in our organization to identify patients earlier who may have progressive, life-limiting illnesses, and would benefit from palliative care?
	
	Early identification screening would happen after the patient has been admitted to hospital, during inpatient admission assessment on the unit. Some tools used in Ontario include the Supportive and Palliative

	Care Indicators Tool (SPICT) and the Hospital-Patient One-Year Mortality Risk (HOMR). The Ontario Palliative Care Network's Tools to Support Earlier Identification for Palliative Care is a great resource to help when determining this denominator. **Step 2: Assessment of palliative care needs (the numerator):** Once screening has identified patients who would benefit from palliative care, ask yourself, what process is currently in place in our organization to do a comprehensive and holistic assessment of their needs? **Needs assessment:** The patient's current and future needs and preferences should be assessed across all domains of care. The Ontario Palliative Care Network's Palliative Care Toolkit outlines the process, and suggested tools for Step 2. Health Quality Ontario's Palliative Care Standard includes 13 Quality Statements. This indicator closely aligns with Quality Statement #1. Limitations to this measure include that the needs change over time; patients may have more than one hospitalization; and needs may have been assessed in other settings as well. The quality of the assessments will not be captured, only completions.

Indicator Name	**Medication reconciliation at discharge**
Priority for 2020/21 QIP	
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged.
Unit of Measurement	Rate per total number of discharged patients
Calculation Methods	Numerator / denominator To ensure a standardized approach to measurement, hospitals will now be asked to provide their numerator and denominator in the QIP workplan; QIP Navigator will calculate the rate.
Numerator	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created. Excludes hospital discharge that is death, newborn or stillborn. Any additional exclusions should be documented in the comments section of the QIP.
Denominator	Number of patients discharged from the hospital in the same time period. Excludes hospital discharge that is death, newborn or stillborn. Any additional exclusions should be documented in the comments section of the QIP.

	Note: Hospitals will be asked to provide the total number of hospital discharges within the reporting period.
Risk adjustment	None
Current performance: reporting period	October 2019– December 2019 (Q3 2019/20)
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.

Indicator Name **NEW**	**Repeat emergency visits for mental health**
Priority for 2020/21 QIP	
Dimension	Effective
Direction of Improvement	Reduce (lower)
Type	Process
Description	Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.
Unit of Measurement	Percent
Calculation Methods	This indicator is presented as a proportion of all mental health emergency visits. A visit is counted as a repeat visit if it is for either a mental health or substance abuse condition and occurs within 30 days of an 'index' visit (first visit) for a mental health condition. The 'index' visit must be for a mental health condition; however, the repeat visit can be for any diagnosis within ICD-10-CA Chapter 5 (i.e., either a mental health OR substance abuse condition). To avoid under-counting of qualified repeat visit pairs, the calculation includes the reporting fiscal period plus an additional 30 days. In order to provide more timely results, the time period for the calculation has shifted. The indicator considers index visits occurring within the last 30 days of the previous quarter and the first 60 days of the reporting quarter. Repeat visits can occur within the reporting quarter or within the last 30 days of the previous quarter.
Numerator	Numerator = Number of unscheduled emergency visits for mental health conditions in the last 30 days of the previous quarter and the first two

	months of the reporting quarter followed by another visit within 30 days for either a mental health or substance abuse condition. For the QIP reporting period (i.e., fiscal Q1), the numerator will include emergency visits occurring between March 1 and May 31 with a possible repeat visit up until June 30. Calculation steps: Number of unscheduled visits for mental health conditions followed within 30 days by a repeat visit, in the reporting quarter. 1. Identify all mental health and substance abuse emergency visits: select unscheduled emergency visits with a MPDx in ICD-10-CA Chapter 5 in the reporting fiscal quarter plus the last 30 days of the previous fiscal quarter. 2. Determine 'index' visits: Sort emergency visits for each encrypted health card number by registration date/time; calculate the time interval between the discharge date/time of the previous visit and the registration date/time of the following visit; the visits that are followed within 30 days by another visit are identified as 'index' visits. 3. Categorize 'index' visit to Mental Health or Substance Abuse category based on its MPDx: substance abuse has MPDx F10-F19, all others are mental health (F00-F09 and F20-F99). *Inclusions:* • Information on unscheduled emergency visits to Ontario hospitals for mental health or substance abuse conditions, defined by the main problem diagnosis (MPDX) in ICD-10-CA Chapter 5. • The diagnostic categories refer to the main problem diagnosis for the 'index' visit. • All ICD-10-CA codes beginning with 'F'. *Exclusions:* • Visits for those without a valid health card number. • Visits for those without a valid registration date.
Denominator	Denominator = Total number of unscheduled emergency visits for mental health conditions in last 30 days of the previous quarter and the first two months of the reporting quarter. For the QIP reporting period (i.e., fiscal Q1), the denominator will include emergency visits occurring between March 1 and May 31. Calculation steps: 1. Identify all mental health and substance abuse emergency visits: select unscheduled emergency visits with MPDx in ICD-10-CA Chapter 5 in last 30 days of the previous fiscal quarter plus the first 60 days of the reporting fiscal quarter. 2. Select Mental Health visits based on the MPDx: substance abuse has MPDx F10-F19, all others (F00-F09 and F20-F99) are mental health. *Inclusions:*

	• Information on unscheduled emergency visits to Ontario hospitals for mental health conditions defined by the MPDX in ICD-10-CA Chapter 5. • The diagnostic categories refer to the visits' main problem. • All ICD-10-CA codes beginning with 'F', excluding Substance Abuse (F10-F19). *Exclusions:* • Visits for those without a valid health card number. • Visits for those without a valid registration date.
Risk adjustment	None
Current performance: reporting period	Q1 FY 2019/20 (i.e., April 2019 – June 2019)
Data source	National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health Information (CIHI), Data provided to Health Quality Ontario by Health Analytics Branch, Ontario Ministry of Health and Long-Term Care
How to access data	To access your organization's data for the reporting period, refer to Health Quality Ontario's QIP Navigator. Data will be available in February 2020.
Comments	We have seen an increasing trend toward patients visiting the emergency department for mental health and addiction issues. This indicator was added to better understand this issue and how the system can best support these patients. This indicator replaces the indicator on readmissions within 30 days for mental health and addiction included in the 2019/20 QIPs. This indicator is included in hospital service accountability agreements; therefore, hospitals will be familiar with it. This indicator is also closely aligned with broader pan-Canadian work happening on frequent emergency department visits, specifically the indicator that appears as part of the work of the federal, provincial, and territorial health ministries on shared health priorities. Organizations should consider the local population and acuity of patients when setting their targets; there will be an appropriate use of ED in severe episodes, Mental Health Act police apprehensions and among patients who require hospital-level monitoring and/or stabilization for their condition. As such, a target of zero is not appropriate.

Primary Care Priority Indicators

Indicator Name	7-day post-hospital discharge follow-up for selected conditions – CHCs	7-day post-hospital discharge follow-up (any condition, any provider)
Priority for 2020/21 QIP		
Directions	The 7-day post-hospital discharge follow-up indicator is measured differently for community health centres (CHCs). CHCs should complete the 7-day post-hospital discharge follow-up for selected conditions – CHCs indicator. All other organization models should complete the 7-day post-hospital discharge follow-up (any condition, any provider) indicator. Do **NOT** choose both indicators.	
Dimension	Efficient	
Direction of Improvement	Increase (higher)	
Type	Process	
Description	Percentage of patients who have had a 7-day post-hospital discharge follow-up by a primary care provider (physician or nurse practitioner) for the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, and cardiac conditions.	Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.
Unit of Measurement	Percentage	
Calculation Methods	Numerator / denominator x 100	
Numerator	Number of hospital discharges where the patient was seen by a primary care provider (physician or nurse practitioner) within 7 days of discharge for the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, and cardiac conditions.	Number of hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.
Denominator	Number of acute care discharges for an episode of care in which one of the mentioned conditions is recorded in the first hospitalization of the episode within each fiscal year (minus 30 days for follow-up).	Number of hospital discharges for which timely (within 48 hours) notification was received.
Risk adjustment	None	

Indicator Name	**7-day post-hospital discharge follow-up for selected conditions – CHCs**	**7-day post-hospital discharge follow-up (any condition, any provider)**
Current performance: reporting period	April 1, 2018 to December 31, 2018	Last consecutive 12-month period.
Data source	Discharge Abstract Database (DAD), ICES Physician Database (IPDB), Ontario Health Insurance Plan (OHIP), Registered Persons Database (RPDB), CHC encounter data.	EMR
How to access data	For the 2020/21 QIPs, data will be provided by the Community Health Centre Practice Profiles through the Alliance for Healthier Communities (AHC) (72/73 CHCs).	Local data collection
Comments	Please note the different source period for CHCs this year. Given this change, CHCs should be careful about comparing data over time. Data on this indicator will be distributed through MyPractice Reports for CHCs once EMR data migration issues are resolved. This will occur after the April 1st, 2020 QIP submission.	This indicator was developed by the Association of Family Health Teams of Ontario (AFHTO) and can be used by any model.

Indicator Name	**Timely access to a primary care provider**
Priority for 2020/21 QIP	
Dimension	Timely
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Organizations are expected to measure progress on this indicator using the *exact* wording of the following patient and client survey question as in the Primary Care Patient Experience Survey (PCPES). "Q6b. The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your

	doctor or nurse practitioner to when you actually SAW him/her or someone else in their office? • Same day • Next day • 2 – 19 days (enter number of days: _____) • 20 or more days • Not applicable (don't know/refused)." To calculate the indicator result, add the number of respondents who responded "Same day" or "Next day", divide by the number of respondents who registered an answer for this question (do not include non-respondents or respondents who answered "Not applicable (don't know/refused)".
Numerator	Number of respondents who responded "Same day" or "Next day" to this survey question.
Denominator	Number of respondents who registered a response to this question. *Exclusions*: • Non-respondents; • Respondents who answered "Not applicable (don't know/refused)".
Risk adjustment	None
Current performance: reporting period	April 2019 – March 2020 (or most recent 12-month period available)
Data source	In-house surveys
How to access data	Local data collection
Comments	Use of the Primary Care Patient Experience Survey (PCPES) is encouraged, as it includes all priority indicator survey questions and more. Developed by Health Quality Ontario in collaboration with the Association of Family Health Teams of Ontario (AFHTO), the Alliance for Healthier Communities (Alliance for Healthy Communities (previously AOHC), the Ontario College of Family Physicians, and the Ontario Medical Association, the survey is designed to be administered by practices and can be rolled up to the organizational level to support their quality improvement efforts. 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). Consider using "third next available visit", measures from scheduling software or asking additional questions, such as "Did you get an appointment on the date you wanted?" as process indicators to the indicator above. This indicator aligns with the Ministry's Health Care Experience Survey and the Commonwealth Fund Surveys that are reported in Health Quality Ontario's Measuring Up. See Health Quality Ontario's primary care performance data for results.

Indicator Name	**Patient involvement in decisions about care**
Priority for 2020/21 QIP	
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	Percentage of patients and clients who were always or often involved in the care decisions when they saw their doctor or nurse practitioner.
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Organizations are expected to measure progress on this indicator using the *exact* wording of the following survey question as in the Primary Care Patient Experience Survey (PCPES): "Q7. When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment? Using the scale: • Always • Often • Sometimes • Rarely • Never • Not applicable (don't know/refused)" To calculate the indicator result, add the number of respondents who responded "Always" and "Often", divide by the number of respondents who registered an answer for this question (do not include non-respondents or respondents who answered "Not applicable (don't know/refused)".
Numerator	Number of respondents who responded "Always" and "Often" to this survey question.
Denominator	Number of respondents who registered a response to this question. *Exclusions*: • Non-respondents; • Respondents who answered "Not applicable (don't know/refused)".
Risk adjustment	None
Current performance: reporting period	April 2019 – March 2020 (or most recent 12-month period available)
Data source	In-house surveys.
How to access data	Local data collection
Comments	Use of the Primary Care Patient Experience Survey (PCPES) is encouraged, as it includes all priority indicator survey questions and more. Developed by Health Quality Ontario in collaboration with AFHTO, Alliance for Healthy Communities (previously AOHC), the Ontario College of Family Physicians, and the Ontario Medical Association, the survey is designed to

	be administered by practices and can be rolled up to the organizational level to support their quality improvement efforts. 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 primary care performance reporting and align with the Ministry's Health Care Experience Survey and the Commonwealth Fund Surveys.

Indicator Name	**Percentage of non-palliative care patients newly dispensed an opioid**	
Priority for 2020/21 QIP		
Dimension	Safety	
Directions	For Family Health Teams (FHTs) in patient enrollment models and Community Health Centres (CHCs) associated with the Alliance for Healthier Communities	For Nurse Practitioner-Led Clinics (NPLCs), Aboriginal Health Access Centres (AHACs), FHTs in non-patient enrollment models, and CHCs that are not associated with the Alliance for Healthier Communities (one CHC in 2020/21).
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**.	This indicator measures the percentage of non-palliative patients newly prescribed an opioid within a 6-month reporting period by **a provider in your organization**.
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	Patients newly prescribed an opioid within a 6-month reporting period prescribed **by a provider in your organization.** New opioid prescriptions are defined using a 6-month washout period i.e., no opioid prescription dispensed within 6 months of the first opioid prescription dispensed

	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.	in the reporting period. Notes: • OAT, cough and antidiarrheal opioid medications were not included in the opioid definition. For reference when building your EMR query, 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. *Exclusions:* • 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.	Patients/clients receiving care from your organization *Exclusions*: • Patients younger than one year of age • Palliative care patients/clients For reference when building your EMR query, see Appendix C in the *MyPractice Primary Care* Report Technical Appendix for classification and codes to improve alignment between the indicators measured by different model types.
Risk adjustment	None	
Current performance: reporting period	Data point: March 31, 2019	Your most recent data point or end of calendar year.
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) Data was calculated and provided to Health Quality Ontario by Institute	Local data collection - EMR

	for Clinical Evaluative Sciences (ICES)	
How to access data	Sign up for Health Quality Ontario's MyPractice: Primary Care Reports available for FHTs and CHCs. Community Health Centre Practice Profiles are available through the Alliance for Healthier Communities (CHC only)	Standardized EMR queries can help you build an opioid use registry in your practice. Available for Telus PS Suite, Accuro and OSCAR. For more information, contact improve@afhto.ca.
Comments	Dispensed prescriptions don't always reflect actual use.	

Indicator Name	**Documented assessment of palliative care needs among patients with progressive, life-limiting illness who were identified to benefit from palliative care**
Priority for 2020/21 QIP	
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the proportion of patients with a progressive, life-limiting illness who were identified to benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment. Why is this important? Earlier identification can improve quality of life by ensuring adequate pain and symptom management, as well as relief of burdens by employing active person-centered decision-making (Ontario Palliative Care Network, 2019).
Unit of Measurement	Percentage expressed as a proportion
Calculation Methods	Numerator / Denominator
Numerator	Number of patients specified in the denominator who have a comprehensive and holistic assessment of their palliative care needs documented in their EMR. Quality Standards: Definitions Used Within This Quality Statement states that the usual categories of **palliative care needs** included in a holistic palliative assessment could be from any part of a person's full range of needs (physical, psychological, social, linguistic, cultural, legal, ethical, or spiritual) at any stage of illness. See **Step 2: Assess** in the Ontario Palliative Care Network's Palliative Care Toolkit for guidance.

Denominator	Number of patients with a progressive, life-limiting illness, who are identified and found to benefit from palliative care. See **Step 1: Identify** in the Ontario Palliative Care Network's Palliative Care Toolkit for guidance. Preferred tools are cited in the Tools to Support Earlier Identification for Palliative Care (April 2019), published by the Ontario Palliative Care Network. **Tool example**: Adaptation of the UK Gold Standards Framework Prognostic Indicator Guidance for Ontario. References to tools for identifying individuals in need of palliative care and for assessing needs are presented in the comments section.
Risk adjustment	None
Current performance: reporting period	Most recent 6-month period
Data source	EMR
How to access data	Local data collection

Comments	The intent of the indicator is to influence a system change to 1) identify patients who would benefit from palliative care as early as possible, using a screening tool, and 2) to conduct a holistic assessment of their needs earlier.
	
	Identification does not mean a referral to a palliative care specialist. Instead, identification should prompt a comprehensive and holistic assessment to determine the patient's full range of needs.
	
	Who are these patients?
	• The patient population will likely include identifying patients with palliative care needs earlier than has been done in the past.
	• Newly diagnosed, serious and life-limiting conditions
	  • Newly diagnosed cancer with significant risk of progression
	  • End-stage organ failure (s)
	  • Frailty
	  • Dementia
	  • Multiple medical conditions
	• Existing condition with a new development
	
	Step 1: Early Identification (the denominator): Ask yourself, what screening process is currently in place in our organization to identify patients earlier who may have progressive, life-limiting illnesses, and would benefit from palliative care?
	
	Early Identification: the *Ontario Palliative Care Network's Palliative Care Toolkit* lists tools for reference for Step 1. The Ontario Palliative Care Network's *Tools to Support Earlier Identification for Palliative Care* is a great resource to help when determining this denominator.
	
	Some tools used in Ontario include the adaptation of the UK Gold Standards Framework Prognostic Indicator Guidance for Ontario.

	Step 2: Assessment of palliative care needs (the numerator): Once screening has identified patients who would benefit from palliative care, ask yourself, what process is currently in place in our organization to do a comprehensive and holistic assessment of their needs? **Needs assessment:** The patient's current and future needs and preferences should be assessed across all domains of care. The Ontario Palliative Care Network's Palliative Care Toolkit outlines the process and suggested tools for Step 2. Health Quality Ontario's Palliative Care Quality Standard includes 13 Quality Statements. This indicator closely aligns with Quality Statement #1. Limitations of this measure include that the needs change over time, and needs may have been assessed in other settings. Assessment quality will not be captured, only completions.

II. Long-Term Care Priority Indicators

Indicator Name	**Potentially avoidable emergency department visits for long-term care residents**
Priority for the 2020/21 QIPs	
Dimension	Efficient
Direction of Improvement	Reduce (lower)
Type	Process
Description	Number of ED visits for a modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.
Unit of Measurement	Rate per 100 residents
Calculation Methods	Total ED visits including transfers between EDs and ED visits resulting in admission or death for all active LTC home residents in Ontario in a given year. Numerator: Steps: 1. Count the number of unscheduled ED visits made by long-term care home residents for the selected conditions. Step 2. Multiply by 100. Denominator: Steps: 1. Extract the population of active long-term care home residents.
Numerator	Total ED visits including transfers between EDs and ED visits resulting in admission or death for all active LTC home residents in Ontario in a given year. *Inclusions*: • All active LTC home residents in Ontario in a given year. • ED visits including transfers between EDs and ED visits resulting in admission or deaths. • Modified ambulatory care–sensitive conditions presenting to EDs that are potentially preventable are as follows: - Angina - Asthma - Cellulitis - Chronic obstructive pulmonary disease - Congestive heart failure - Septicemia - Dehydration - Dental conditions - Diabetes - Gastroenteritis - Grand mal and seizure disorders - Hypertension - Hypoglycemia - Injuries from falls - Mental health and behavioural disorders - Pneumonia

	- Severe ear, nose and throat disorders *Exclusions*: • Planned or scheduled ED visits. • LTC home residents who were first admitted to the home before the age of 65.
Denominator	*Inclusions*: • All active residents of long-term care homes. *Exclusions*: • Individuals with invalid health card numbers. • LTC home residents who were first admitted to the home before the age of 65.
Risk adjustment	None
Current performance: reporting period	October 2018 – September 2019
Data source	Continuing Care Reporting System (CCRS), National Ambulatory Care Reporting System (NACRS). Data provided to Health Quality Ontario by the Health Analytics Branch with the Ministry of Health and Long-Term Care.
How to access data	The Ministry will provide organizations with this data via LTCHomes.net
Comments	Quality improvement guidance related to this indicator is available on the Health Quality Ontario website and through the INTERACT (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers) program.

Indicator Name	**Resident experience: Having a voice**
Priority for the 2020/21 QIPs	
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	The percentage of residents who responded positively to the question: *What number would you use to rate how well the staff listen to you?*
Unit of Measurement	Percentage
Calculation Methods	Numerator / denominator x 100% Homes using the **NHCAHPS Long-Stay Resident Survey** should measure this domain by calculating the percentage of residents who responded positively to the question: *What number would you use to rate how well the staff listen to you?* Responses are coded from 0 - 10, where 0 = worst possible and 10 = best possible.
Numerator	For homes using the **NHCAHPS Long-Stay Resident Survey**, add the number of respondents who responded '9' or '10' to the question

Denominator	For homes using the **NHCAHPS Long-Stay Resident Survey**, add the total number who registered any response to the question. Do not include non-respondents.
Risk adjustment	None
Current performance: reporting period	April 2019 – March 2020 (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.

Indicator Name	**Resident experience: Being able to speak up about the home**
Priority for the 2020/21 QIPs	
Dimension	Patient-centred
Direction of Improvement	Increase (higher)
Type	Outcome
Description	The percentage of residents who responded positively to the following statement: *I can express my opinion without fear of consequences.*
Unit of Measurement	Percentage
Calculation Methods	Numerator / Denominator x 100% Homes using the **interRAI Quality of Life Survey** should measure this domain by calculating the percentage of residents who responded positively to statement: *F3. I can express my opinion without fear of consequences.* Responses are coded from 0 – 8 (0, 1, 2, 3, 4, 6, 7, 8), where • 0 = Never • 1 = Rarely • 2 = Sometimes • 3 = Most of the time • 4 = Always • 6 = Don't know • 7 = Refused • 8 = No response or cannot be coded from response
Numerator	Add the number of respondents who responded '3' or '4' to the statement
Denominator	Add the total number who registered any response to the statement and include non-respondents (6, 7, 8).
Risk adjustment	None
Current performance: reporting period	April 2019 – March 2020 (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.

Indicator Name	**Documented assessment of palliative care needs among residents with progressive, life-limiting illness who were identified to benefit from palliative care**
Priority for the 2020/21 QIPs	
Dimension	Effective
Direction of Improvement	Increase (higher)
Type	Outcome
Description	This indicator measures the proportion of residents with a progressive, life-limiting illness who were identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment. Why is this important? Earlier identification can improve quality of life by ensuring adequate pain and symptom management, as well as relief of burdens by employing active person-centered decision-making (Ontario Palliative Care Network, 2019).
Unit of Measurement	Percentage expressed as a proportion
Calculation Methods	Numerator / Denominator
Numerator	Number of long-term care home residents specified in the denominator who have a comprehensive and holistic assessment of their palliative care needs documented in their record. Quality Standards: Definitions Used Within This Quality Statement states that the usual categories of **palliative care needs** included in a holistic palliative assessment could be from any part of a person's full range of needs (physical, psychological, social, linguistic, cultural, legal, ethical, or spiritual) at any stage of illness. See **Step 2: Assess** in the Ontario Palliative Care Network's Palliative Care Toolkit for guidance.
Denominator	Number of residents with a progressive, life-limiting illness who are identified and found to benefit from palliative care. See **Step 1: Identify** in the Ontario Palliative Care Network's Palliative Care Toolkit for guidance. Preferred tools are cited in the Tools to Support Earlier Identification for Palliative Care (April 2019), published by the Ontario Palliative Care Network. References to tools for identifying individuals in need of palliative care and assessment needs are presented in the comments section.
Risk adjustment	None

Current performance: reporting period	Most recent 6-month period
Data source	RAI MDS tool, or other tools chosen by the organization
How to access data	Local data collection

Comments	The intent of the indicator is to influence a system change to 1) identify residents who would benefit from palliative care as early as possible using a screening tool, and 2) to conduct a holistic assessment of their needs earlier.
	
	Identification does not mean a referral to a palliative care specialist. Instead, identification should prompt a comprehensive and holistic assessment to determine the resident's full range of needs.
	
	In long-term care, it would be anticipated that a large percentage of the population may be identified to benefit from palliative care. Families and residents need more time for critical conversations, and these should be initiated earlier.
	
	Who are these residents?
	• The resident population will likely include identifying residents with palliative care needs earlier than has been done in the past.
	• Newly diagnosed, serious and life-limiting conditions
	  • Newly diagnosed cancer with significant risk of progression
	  • End-stage organ failure (s)
	  • Frailty
	  • Dementia
	  • Multiple medical conditions
	• Existing condition with a new development
	
	Step 1: Early Identification (the denominator): Ask yourself, what screening process is currently in place in our organization to identify residents earlier who may have progressive, life-limiting illnesses, and would benefit from palliative care?
	
	Early identification: The Ontario Palliative Care Network's Palliative Care Toolkit lists tools for reference for Step 1. The Ontario Palliative Care Network's Tools to Support Earlier Identification for Palliative Care is a great resource to help when determining this denominator.
	
	Step 2: Assessment of palliative care needs (the numerator): Once screening has identified residents who would benefit from palliative care, ask yourself, what process is currently in place in our organization to do a comprehensive and holistic assessment of the resident's needs? How often is it repeated?
	
	Needs assessment: The resident's current and future needs and preferences should be assessed across all domains of care. The Ontario Palliative Care Network's Palliative Care Toolkit outlines the process and suggested tools for Step 2.

	Health Quality Ontario's Palliative Care Quality Standard includes 13 Quality Statements. This indicator closely aligns with Quality Statement #1. A relevant Canadian resource for long-term care is the Quality in Long-Term Care Palliative Care toolkit. Limitations to this measure include that the needs change over time. Assessment quality will not be captured, only completions.

III. Narrative Questions

Overview

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

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

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

Recommended length: 250 words.

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

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

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

Suggestion: Upload graphs or photos of your results here.

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

- Access and transitions – for example, stories related to helping people receive the right care in the right place at the right time
- Mental health and addictions
- Management of pain and use of opioids
- Palliative care

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

Recommended length: 250 words.

Collaboration and integration

We know that in order to achieve large-scale improvement, many of the indicators in the QIPs require collaboration with other partners. In this section, please describe who your organization is working with to improve integration and continuity of care as your patients move across the health system.

If you are an organization that has been selected as an Ontario Health Team (OHT), describe the collaborative quality goals of your OHT in this section. What is the OHT's joint commitment to quality? For example: What is your population of focus? How will the OHT improve the care experience for patients? What quality measures will your OHT focus on?

Include the name of your OHT in your description. Also remember to describe your OHT work in your QIP Workplan by naming your collaborators on the relevant indicators and reflecting collaborative work in your change ideas.

Organizations in earlier stages of the OHT application process are also strongly encouraged to document your collaborative efforts in this section.

Recommended length: 250 words.

Patient/client/resident partnering and relations

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

Recommended length: 250 words.

Workplace violence prevention

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

If yes, describe how it is a priority – for example, is it included in your strategic plan, do you report on it to your board, or have you made significant investments to improve in this area? Given that this is the third year that this is appearing in the QIP, what have you done differently and what are you planning to do differently this year?

Recommended length: 250 words.

Alternate level of care (primary care and long-term care sectors only)

Alternate level of care (ALC) refers to patients who no longer need treatment in a hospital, but who continue to occupy hospital beds as they wait to be discharged or transferred to another care environment. While the QIP has traditionally included an indicator related to this issue for the hospital sector, ALC is truly a cross-sector challenge. There are many factors that contribute to ALC, including

capacity issues. In this section, please tell us about what your organization is doing to address ALC, including process improvements within your organization that can affect ALC as well as collaborations with your partners.

Recommended length: 250 words.

Virtual care

In order for care to be effective, it needs to be delivered at the right time and in the right setting. There may be opportunities to improve the design and delivery of services using virtual care. Describe how you are using or supporting virtual care to improve health care delivery to your patients/residents. Examples of virtual care include (but are not limited to) virtual visits, online scheduling, secure emails with providers, and e-consultations.

Recommended length: 250 words.

Compensation (hospitals only)

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

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

IV. 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. The Ontario government's fiscal year runs from April 1 to March 31.
HBAM	Health-Based Allocation Model
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HIG	Health-Based Allocation Model Inpatient Grouper
ICU	Intensive Care Unit
InterRAI	International 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