Ontario Health

2023-24

Multi-Sector Service Accountability Agreement

Indicator Technical Specifications

December 20, 2022

Version 2

Contents

INTRODUCTION

This document specifies the 2023-24 MSAA indicators, indicator definitions, calculations, reporting periods, and other technical information for community-based health services organizations.

GLOSSARY OF TERMS

The following Glossary of Terms provides definitions for common terms used within this document.

Performance Indicator means a measure of HSP performance for which a Performance Target is set; technical specifications of specific Performance Indicators can be found in the MSAA Indicator Technical Specifications document.

Monitoring Indicator means a measure of HSP performance that may be monitored against provincial results or provincial targets, but for which no Performance Target is set.

Explanatory Indicator means a measure that is connected to and helps to explain performance in a Performance Indicator or a Monitoring Indicator. An Explanatory Indicator may or may not be a measure of the HSP's performance. No Performance Target is set for an Explanatory Indicator.

Performance Factor means any matter that could or will significantly affect a party's ability to fulfill its obligations under this Agreement.

Performance Target is the level of performance expected of the HSP in respect of a Performance Indicator or a Service Volume.

Performance Corridor is the acceptable range of results around a Performance Target.

Performance Standard is the acceptable range of performance for a Performance Indicator or a Service Volume that results when a Performance Corridor is applied to a Performance Target.

CORE INDICATORS

Intended Audience: OH, MSAA Health Service Providers

Performance

INDICATOR NAME	FUND TYPE 2 BALANCED BUDGET
INDICATOR DESCRIPTION	The amount by which total Fund Type 2 revenues exceeded or fell short of total Fund Type 2 expenses, and for all Ontario Health (OH) funded Transfer Payment Business Entities (TPBE).
INDICATOR CLASSIFICATION	Performance
PERFORMANCE STANDARD	**Performance Target**: $0. HSPs are required to submit a balanced budget for all OH funded Transfer Payment Business Entities (TPBE). **Performance Corridor:** >=0. No negative variance for this measure is indicated. Any time during the year that a provider is projecting not to balance at year end necessitates variance reporting to OH. Deficit: Where the Fund Type 2 Balanced Budget is less than 0 (deficit), it will be considered a performance factor and may trigger the performance factor escalation process with OH. Surplus: Where the Fund Type 2 Balanced Budget is greater than 0 (surplus), it may trigger monitoring from OH and/or a discussion with OH depending on the OH's threshold for materiality.
CAPS LOCATION	**TPBE Financial sheets: NET SURPLUS (DEFICIT) FROM OPERATIONS; Fin_Summary: NET SURPLUS (DEFICIT) FROM OPERATIONS**
NUMERATOR	
CALCULATION	1. Total Fund Type 2 Revenues – Total Fund Type 2 Expenses = 0 2. TPBE Fund Type 2 Revenues – TPBE Fund Type 2 Expenses = 0
DATA SOURCE	Community Accountability Planning Submission (CAPS) and quarterly Self-Reporting Initiative (SRI) reports for Quarters (Q) 2 to 4 1. Total Fund Type 2 data source is Fin_Summary sheet 2. TPBE Fund Type 2 data source is related TPBE Financial sheet
EXCLUSION/INCLUSION CRITERIA	**Includes:** Total Fund Type 2 **Excludes:**

	Fund Type 1 and Fund Type 3 other than the funds transferred into Fund Type 2 to offset a deficit.
DENOMINATOR	
CALCULATION	N/A
DATA SOURCE	N/A
EXCLUSION/INCLUSION CRITERIA	N/A
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Data are released quarterly beginning with Q2
LEVELS OF COMPARABILITY	The data are available at the Health Service Provider (HSP) level
TRENDING Years available for trending	Data available beginning Q2 of 2009/10
ADDITIONAL INFORMATION	
LIMITATIONS	Fund raising revenues may differ between organizations (e.g. if an organization is fundraising for a future project, the organization's Fund Type 2 Balanced Budget would be greater than zero while most organizations would have a zero or close zero budget).
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	All programs Fund Type 2 are planned with a zero balanced budget. The total revenue and total expenses for Fund Type 2 must balance exactly to zero. Performance corridor functions as described in Performance Standard.
REFERENCES Provide URLs of any key references	A copy of the Ontario Healthcare Reporting Standards (OHRS) can be obtained from the Ministry of Health Long-Term Care https://hsim.health.gov.on.ca/hdbportal/
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-10-19
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	PERCENTAGE TOTAL MARGIN
INDICATOR DESCRIPTION	The percentage total margin is used to measure whether an HSP, as a total entity, has met its Annual Balanced Budget requirement as per the Multi-Sector Service Accountability Agreement (MSAA). It is the percentage by which total revenues exceeded or fell short of total expenses.
INDICATOR CLASSIFICATION	Performance
PERFORMANCE STANDARD	**Performance Target** >=0. No negative variance for this measure is accepted. Deficit: Any time during the year that a provider is projecting a Percent Total Margin below zero (deficit), may trigger a discussion with OH. Where the Percent Total Margin is below zero (deficit) at fiscal year end, it will be considered a performance factor and may trigger the performance factor escalation process with OH.
CAPS LOCATION	**Fin_Summary: Total Revenue (All Funds); Fin_Summary: Total Expenses (All Funds)**
NUMERATOR	
CALCULATION	This indicator measures the percentage by which a provider's total revenues differs from its total expenses, from all sources (calculated before facility amortization). (Total Revenues (All Funds) - Total Expenses (All Funds)) X 100%
DATA SOURCE	Community Accountability Planning Submission (CAPS) and quarterly Self-Reporting Initiative (SRI) reports for Quarters (Q) 2 to 4. Fin_Summary page
EXCLUSION/INCLUSION CRITERIA	Includes All Fund Types (Type 1, 2, 3)
DENOMINATOR	
CALCULATION	Total Revenues (All Funds)
DATA SOURCE	Community Accountability Planning Submission (CAPS) and quarterly Self-Reporting Initiative (SRI) reports for Quarters (Q) 2 to 4. Fin_Summary page
EXCLUSION/INCLUSION CRITERIA	Includes All Fund Types (Type 1, 2, 3)
GEOGRAPHY & TIMING	

TIMING/FREQUENCY OF RELEASE How often and when are data being released	Budget Data are provided annually at the time of CAPS preparation by each HSP
LEVELS OF COMPARABILITY	N/A
TRENDING Years available for trending	Data available beginning in Q2 of 2009/10
ADDITIONAL INFORMATION	
LIMITATIONS	N/A
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Total Entity includes the complete span of the organization that reports to the corporate governance body, e.g., board of governors, municipal council, band council. If the total margin value is too high, it may suggest that there are relatively high levels of funding or under-provision of service. Conversely, if it is too low, there may be operational inefficiencies or relatively low levels of funding that may lead to financial difficulties.
REFERENCES Provide URLs of any key references	N/A
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-21
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	SERVICE ACTIVITY BY FUNCTIONAL CENTRE
INDICATOR DESCRIPTION	Actual number of units of service for each functional centre
INDICATOR CLASSIFICATION	Performance
PERFORMANCE STANDARD	**Performance Target:** OH-negotiated target based on CAPS **Performance Corridor:** The corridor applied to the service levels will be: • volumes < 500, +/- 20% • volumes 500 to 999, +/- 15% • volumes 1000 to 4999, +/- 10% • volumes 5000 to 24999, +/- 5% • volumes 25000 to 39999, +/- 4% • volumes >40000, +/- 3% Any performance target that falls outside of the performance corridor with a variance greater than the accepted percentage will be considered a performance factor and may trigger a discussion with OH, based upon the OH's threshold for materiality.
CAPS LOCATION	**Act_Summary**
NUMERATOR	
CALCULATION	Year End (YE) Actual for units of service by each functional centre must be within the performance corridor for the performance target.
DATA SOURCE	Community Accountability Planning Submission (CAPS) and quarterly Self-Reporting Initiative (SRI) reports for Quarter (Q) 4
EXCLUSION/INCLUSION CRITERIA	Includes all units of service in each functional centre.
DENOMINATOR	
CALCULATION	N/A
DATA SOURCE	N/A
EXCLUSION/INCLUSION CRITERIA	N/A
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	The data are available quarterly.

LEVELS OF COMPARABILITY	The data are available at the level of the health service provider.
TRENDING Years available for trending	Data available beginning Q2 of 2009/10
ADDITIONAL INFORMATION	
LIMITATIONS	The performance corridor for this indicator is applied to the performance target at year end. The calculation for this indicator does not include pro-rating the performance target quarterly or using Q4 variance forecasting to measure performance quarterly.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Baseline measure from budgeted values is also provided in CAPS submissions. HSPs receive funding for the provision of service volumes in addition to a specified number of individuals served. In planning submissions, HSPs identify the units of service that will be delivered in the planning year. CHCs may report Service Provider Interactions instead of Visits for units of service as it is not an OHRS requirement. See 2012 CHC memo in 'Reference' section.
REFERENCES Provide URLs of any key references	A copy of the Ontario Healthcare Reporting Standards (OHRS) can be obtained from the Ministry of Health Long-Term Care https://hsim.health.gov.on.ca/hdbportal/ MSAA Target Setting Guidelines Community Financial Policy, 2016 2012/13 Updates for Community Health Centres (CHC) Reporting (see document embedded below)  CHC Update for 2012_13 re OHRS
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-21
DATE LAST REVIEWED (YYYY-MM-DD)	2018-11

INDICATOR NAME	NUMBER OF INDIVIDUALS SERVED BY FUNCTIONAL CENTRE
INDICATOR DESCRIPTION	Actual number of clients served by Functional Centre
INDICATOR CLASSIFICATION	Performance
PERFORMANCE STANDARD	**Performance Target:** OH-negotiated targets based on CAPS **Performance Corridor:** The corridor applied to the service levels will be: • individuals served <499, +/- 20% • individuals served 500 to 999, +/- 15% • individuals served 1000 to 4999, +/- 10% • individuals served >5000, +/- 5% Any performance target that falls outside of the performance corridor with a variance greater than the accepted percentage will be considered a performance factor and may trigger a discussion with OH, based upon OH's threshold for materiality.
CAPS LOCATION	**Act_Summary**
NUMERATOR	
CALCULATION	Year End (YE) Actual for Individuals Served by each functional centre must be within the performance corridor for the performance target.
DATA SOURCE	Community Accountability Planning Submission (CAPS) and quarterly Self-Reporting Initiative (SRI) report for Quarter (Q) 4
EXCLUSION/INCLUSION CRITERIA	Includes individuals served by each functional centre
DENOMINATOR	
CALCULATION	N/A
DATA SOURCE	N/A
EXCLUSION/INCLUSION CRITERIA	N/A
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Data are available quarterly
LEVELS OF COMPARABILITY	Data are available at the level of the health service provider
TRENDING Years available for trending	Data available beginning Q2 in 2009/10
ADDITIONAL INFORMATION	

LIMITATIONS	The performance corridor for this indicator is applied to the performance target at year end. The calculation for this indicator does not include pro-rating the performance target quarterly or using Q4 variance forecasting to measure performance quarterly. Unique individuals served cannot be reported at the organization level.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Assesses the ability of an HSP to meet identified targets for individuals served by programs.
REFERENCES Provide URLs of any key references	A copy of the Ontario Healthcare Reporting Standards (OHRS) can be obtained from the Ministry of Health Long-Term Care https://hsim.health.gov.on.ca/hdbportal/ MSAA Target Setting Guidelines
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-21
DATE LAST REVIEWED (YYYY-MM-DD)	2018-11

Monitoring

INDICATOR NAME	VARIANCE FORECAST TO ACTUAL EXPENDITURES
INDICATOR DESCRIPTION	A measure of YTD actual expenditures at Q2 and Q3 and subtracted the respective quarterly pro-rated amount of year-end forecast expenditure
INDICATOR CLASSIFICATION	Monitoring
CAPS LOCATION	**TPBE Financial pages; Total Expenses Fund Type 2**
NUMERATOR	
CALCULATION	Q2 calculation: Year End (YE) actual total expenses minus Quarter (Q) 2 forecast total expenses Q3 calculation: YE actual total actual expenses minus Q3 forecast total expenses
DATA SOURCE	Quarterly Self-Reporting Initiative (SRI) reports for Q2 to Q4. Q2 and Q3 SRI reports provide Q4 forecasts for total Fund Type 2 expenses. Q4 SRI report provides YE actual expenses.
EXCLUSION/INCLUSION CRITERIA	**Includes:** Fund Type 2 for all OH funded Transfer Payment Business Entities (TPBE) **Excludes:** Fund Type 1 and 3 expenses
DENOMINATOR	
CALCULATION	YE actual total expenses
DATA SOURCE	Quarterly Self-Reporting Initiative (SRI) reports for Q4. Q4 SRI report provides YE actual Total Fund Type 2 expenses.
EXCLUSION/INCLUSION CRITERIA	**Includes:** Fund Type 2 for all OH funded Transfer Payment Business Entities (TPBE) **Excludes:** Fund Type 1 and 3 expenses
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Data are available annually
LEVELS OF COMPARABILITY	The data are available at the HSP level
TRENDING Years available for trending	Data available beginning in Q2 of 2009/10. Standardization of the Annual Reconciliation Reports begins in Q4 of 2009/10

ADDITIONAL INFORMATION	
LIMITATIONS	This is a lagging indicator that measures accuracy on Q2 and Q3 financial forecasting when compared to the actual YE position. The calculation does not take into consideration in-year adjustments to OH funding that would impact previous quarter Q4 expense forecasts.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	This indicator speaks to the accuracy of the forecast information the HSP submitted in Q2 and Q3. The measure is about assessment of HSP's forecasting ability at Q2 and Q3. Historically many HSPs have been challenged to provide accurate forecasting information when budgets have not been submitted or approved until part way into the new year.
REFERENCES Provide URLs of any key references	Community Financial Policy, 2016
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-10-19
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	**VARIANCE FORECAST TO ACTUAL UNITS OF SERVICE**
INDICATOR DESCRIPTION	Difference between forecasted units of service and actual units of service by functional centre.
INDICATOR CLASSIFICATION	Monitoring
CAPS LOCATION	**Act_Summary**
NUMERATOR	
CALCULATION	Q2 calculation: Year End (YE) actual units of service minus Quarter (Q) 2 forecast units of service Q3 calculation: YE actual units of service minus Q3 forecast units of service
DATA SOURCE	Quarterly Self-Reporting Initiative (SRI) reports for Q2 to Q4. Q2 and Q3 SRI reports provide Q4 forecasts for each unit of service. Q4 SRI report provides YE actuals for each unit of service.
EXCLUSION/INCLUSION CRITERIA	N/A
DENOMINATOR	
CALCULATION	YE Actual Units of Service
DATA SOURCE	Quarterly Self-Reporting Initiative (SRI) report for Q4. Q4 SRI report provides YE actual for each unit of service.
EXCLUSION/INCLUSION CRITERIA	N/A
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE	N/A

How often and when are data being released	
LEVELS OF COMPARABILITY	The data is available at the level of the health service provider
TRENDING Years available for trending	Data available beginning 2011/12
ADDITIONAL INFORMATION	
LIMITATIONS	This is a lagging indicator that measures accuracy on Q2 and Q3 service delivery forecasting when compared to the actual YE position.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	The objective of this indicator is to determine the quality of the forecast provided by the HSP in Q2 when compared with the actual results in Q3 and Q4. The calculation does not take into consideration in-year adjustments to service unit targets as a result of performance deliverables included in OH funding letters or OH-approved service delivery changes that would impact previous quarter service activity forecasts.
REFERENCES Provide URLs of any key references	Community Financial Policy, 2016
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-21
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	**ALTERNATE LEVEL OF CARE (ALC) RATE**
INDICATOR DESCRIPTION	This indicator is defined as the proportion of inpatient days in acute and post-acute care settings that are spent as ALC in a specific time period.
INDICATOR CLASSIFICATION	Monitoring
INDICATOR INFORMATION	
CALCULATION	Total number of ALC days in a given time period (WTIS) x 100 Total number of patient days in the same time period (Bed Census Summary (BCS)) Methodological Notes - Numerator ▪ 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).

NUMERATOR DATA SOURCE	Ontario Health, Wait Time Information System (WTIS) – Alternate Level of Care WTIS-ALC data is near-real time and is continuously monitored for data quality issues. Weekly Data Quality Reports are available to hospitals. Data Quality and Compliance indicators are monitored monthly and validated with hospitals against historical thresholds. The Access to Care Data Quality and Compliance teams work directly with facilities to validate information.
DENOMINATOR DATA SOURCE	Ministry of Health (MOH) – Health Data Branch, Bed Census Summary (BCS).
EXCLUSION/INCLUSION CRITERIA	Inclusion Criteria: Facilities (Acute & Post-Acute) submitting both ALC data (to the WTIS) and BCS data [through the Health Data Branch Web Portal (HDB)] are included in ALC Rate calculation. Exclusion Criteria: <u>Numerator Exclusion Criteria</u> 1. ALC cases discontinued due to 'Data Entry Error'. 2. ALC Days is excluded for the portion of the time when Inpatient Service = Discharge Destination for Post-Acute Care (*Exception: Bloorview Rehab, CCC to CCC) 3. ALC cases identified by the facility for exclusion. <u>Denominator Exclusion Criteria</u> 1. Patient days contributed by inpatients in the emergency department (Bed Type = Emergency (Emerg + PARR, Emergency + PARR)). <u>Overall Exclusion Criteria</u> 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.
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	WTIS-ALC data has been capturing data since July 2011; trending information is feasible.
ADDITIONAL INFORMATION	

LIMITATIONS	▪ Not all Ontario acute and post-acute care hospitals submit information to WTIS. Currently, 97% of inpatient beds in the province report ALC Information to the WTIS. ▪ The WTIS-ALC was deployed in May 2011. However, there was a period of data stabilization from May 2011 to June 2011. Therefore, WTIS-ALC data is only reported from July 2011 forward. ▪ BCS is an external source maintained by the Health Data Branch and has up to a 2-month time lag in reporting. BCS data are collected at the master number level, whereas WTIS-ALC data are collected at the site/inpatient service level. A linking table is maintained to assist with linking the two data sources together. Although WTIS-ALC data are near-real time, the BCS data have a 1-2 month lag time.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	
REFERENCES Provide URLs of any key references	
RESPONSIBILITY FOR REPORTING	Ontario Health
DATE CREATED (YYYY-MM-DD)	
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

Explanatory

INDICATOR NAME	COST PER UNIT OF SERVICE BY FUNCTIONAL CENTRE
INDICATOR DESCRIPTION	The total functional centre cost divided by the number of units of service of that functional centre
INDICATOR CLASSIFICATION	Explanatory
NUMERATOR	
CALCULATION	For the specified functional centre, total cost for Functional Centre.
DATA SOURCE	Community Accountability Planning Submission (CAPS) and quarterly Self-Reporting Initiative (SRI) reports for Quarters (Q) 2 to 4
EXCLUSION/INCLUSION CRITERIA	The total costs for functional centre does not include overhead admin expense.
DENOMINATOR	
CALCULATION	For the specified functional centre, total number of units delivered quarterly as per the OHRS/MIS definition
DATA SOURCE	Provider quarterly reports to OH, Ministry of Health.
EXCLUSION/INCLUSION CRITERIA	As per OHRS/MIS definition
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported Quarterly
LEVELS OF COMPARABILITY	Data are available at the level of the health service provider.
TRENDING Years available for trending	Data is available since 2014
ADDITIONAL INFORMATION	
LIMITATIONS	N/A
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	N/A
REFERENCES Provide URLs of any key references	N/A
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-21
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	COST PER INDIVIDUAL SERVED (BY PROGRAM/SERVICE/FUNCTIONAL CENTRE)
INDICATOR DESCRIPTION	This equals the total functional centre cost divided by the number of individuals served.
INDICATOR CLASSIFICATION	Explanatory
NUMERATOR	
CALCULATION	For the specified functional centre, total cost for Functional Centre.
DATA SOURCE	Provider quarterly reports to OH, Ministry of Health.
EXCLUSION/INCLUSION CRITERIA	The total costs for functional centre does not include overhead admin expense.
DENOMINATOR	
CALCULATION	For the specified functional centre, total number of individuals served quarterly as per the OHRS/MIS definition
DATA SOURCE	Community Accountability Planning Submission (CAPS) and quarterly Self-Reporting Initiative (SRI) reports for Quarters (Q) 2 to 4
EXCLUSION/INCLUSION CRITERIA	As per OHRS/MIS definition
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported Quarterly
LEVELS OF COMPARABILITY	Data are available at the level of the health service provider
TRENDING Years available for trending	Data is available since 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	N/A
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	N/A
REFERENCES Provide URLs of any key references	N/A
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-21
DATE LAST REVIEWED (YYYY-MM-DD)	2018-11

INDICATOR NAME	CLIENT EXPERIENCE
INDICATOR DESCRIPTION	This indicator calculates the total number of clients that were satisfied with their experience with the HSP program/service as a percentage of all clients that responded to the HSP client experience survey for the HSP program/service
INDICATOR CLASSIFICATION	Explanatory
NUMERATOR	
CALCULATION	The number of client experience surveys that were returned to the HSP within the reporting period that indicate the client was "satisfied" or "very satisfied" with their experience with the HSP program/service
DATA SOURCE	HSP client experience survey
EXCLUSION/INCLUSION CRITERIA	N/A
DENOMINATOR	
CALCULATION	The total number of client experience surveys that were completed and returned to the HSP within the reporting period, regardless of the rating of client experience with the HSP program/service
DATA SOURCE	HSP client experience survey
EXCLUSION/INCLUSION CRITERIA	N/A
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	**Annually** The HSP will create and conduct a client experience survey for: a) the major programs/services offered by the HSP; or b) the HSP as a whole program where the program/services are substantially homogenous (i.e. all Addictions Programs).
LEVELS OF COMPARABILITY	The data is required at the HSP level
TRENDING Years available for trending	Data is available since 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	a) OH will not provide the HSPs a template survey to use. HSPs will be required to develop personalized client experience surveys if they don't already utilize one HSPs that currently conduct client experience surveys may be required to amend their surveys to comply with the 3 questions required for the client experience survey as outlined in "Comments" below
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	The client experience survey will include 3 questions measuring the clients' care experience. The questions will be substantially similar to: a) Overall care received (note 1); b) Enough say about care treatment (note 2); and

	c) Treated you with dignity and respect (note 3). The individual survey results will be collated based on an equal value attributed to each of the 3 questions, each worth approximately 33% of the total value. (e.g. if question a) = satisfied, question b) = unsatisfied and question c) = satisfied, then 2/3 satisfied = "satisfied" for this specific client survey) It is recommended that the client experience survey use a rating scale of: a) Completely dissatisfied b) Dissatisfied c) Neither satisfied or dissatisfied d) Satisfied e) Very satisfied The HSP will conduct the client experience survey in the following manner: i) For long-term clients (> 6 months on program), the HSP will provide a client experience survey to all clients every 6 months while on the program/service; and j) For both short-term and long-term clients, the HSP will provide a client experience survey to all clients upon discharge from the program/service It is recommended that the HSP administer the surveys on an ad hoc timing basis (i.e. daily, weekly as needed in i) and j) above, rather than a mass mail out once a year), but collate the results of the surveys on an annual basis as required for reporting. Note 1 – CHCs may use "Overall, how would you rate the care and services you received at [name of CHC]?" Note 2 – CHCs may use (originated from the QIP) "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?" Note 3 – CHCs may use "I always feel comfortable and welcome at *[name of CHC]*?"
REFERENCES Provide URLs of any key references	Not applicable
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2012-10-22
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	PERCENTAGE OF ACUTE ALTERNATE LEVEL OF CARE (ALC) DAYS
INDICATOR DESCRIPTION	The number of ALC days as a proportion of the total length of stay in acute care. 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.
INDICATOR CLASSIFICATION	Explanatory
INDICATOR INFORMATION	
CALCULATION	Total number of ALC days for patients discharged in a given Time period X 100 Total number of days for patients discharged in a given time period **Methodological Notes:** All numbers used for calculations are as reported by the each acute site of each hospital.
NUMERATOR DATA SOURCE	Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI) MLAA
DENOMINATOR DATA SOURCE	Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI)
EXCLUSION/INCLUSION CRITERIA	**Inclusion Criteria:** Data are retrieved from acute care hospitals. **Exclusion Criteria:** Newborns, stillborns, and records with missing or invalid discharge date are not included in this indicator.
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Final data by fiscal year are available annually (usually by September); interim data are updated quarterly
LEVELS OF COMPARABILITY	Data are available at OH level
TRENDING Years available for trending	Data are collected continually so quarterly/annual tracking is possible. Starting in April 2006, adult inpatient cases in designated mental health beds of acute care hospitals are no longer reported to the CIHI DAD. The Ontario Mental Health Reporting System (OMHRS) database captures information on all adult inpatient mental health beds in Ontario.
ADDITIONAL INFORMATION	
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.

COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	In 2006/07, reporting of activity from adult designated mental health units moved from the DAD to the Ontario Mental Health Reporting System (OMHRS). This means that moving a patient from an acute bed to a bed in a designated mental health bed is now coded as a transfer. This would account for the substantial increase in ALC separations and days transferred to acute or psychiatric facilities over the period.
REFERENCES Provide URLs of any key references	N/A
RESPONSIBILITY FOR REPORTING	Health Analytics Branch
DATE CREATED (YYYY-MM-DD)	2010-01-11
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

SECTOR SPECIFIC INDICATORS: CSS

Explanatory

INDICATOR NAME	NUMBER OF PERSONS WAITING FOR SERVICE (BY FUNCTIONAL CENTRE)
INDICATOR DESCRIPTION	Total number of persons waiting for service at the end of the reporting period (point in time) who cannot receive service due to lack of operational or organizational capacity.
INDICATOR CLASSIFICATION	Explanatory
NUMERATOR	
CALCULATION	Use Statistic S406**20 Individuals Currently Waiting for Service Initiation.
DATA SOURCE	OHRS
EXCLUSION/INCLUSION CRITERIA	Applies only to persons waiting for more than 1 day (24 hours). The S406**20 does not include individuals who are waiting for the following reasons: • when a threshold number is required for the scheduling/provision of service; • when the service is available to the Service Recipient but the Service Recipient requests to delay initiation of service Applies to all OH, Ministry funded Community Support programs and service which require the signing of a MSAA (accountability agreement).
DENOMINATOR	
CALCULATION	N/A
DATA SOURCE	N/A
EXCLUSION/INCLUSION CRITERIA	N/A
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Data are to be reported quarterly for each functional centre (program/service) and released at the end of Q2, Q3 and Q4.
LEVELS OF COMPARABILITY	Data are available at the HSP, OH and provincial level.
TRENDING Years available for trending	Data will be available in OHRS Trial Balance.
ADDITIONAL INFORMATION	

LIMITATIONS	Currently, information is reported by HSPs but may not be consistent across the sector due to the various intake or assessment processes used by HSPs. OHRS technical specifications do not include exclusions.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Currently, targets do not exist. Data must be collected and reported at a program or service (functional) level. Data is explanatory only.
REFERENCES Provide URLs of any key references	N/A
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2011-11-07
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

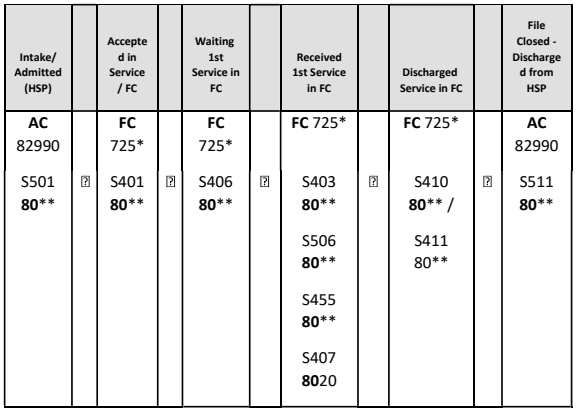
Developmental

INDICATOR NAME	AVERAGE NUMBER OF DAYS WAITED FOR FIRST SERVICE (BY FUNCTIONAL CENTRE)
INDICATOR DESCRIPTION	Average number of days individuals waited for first service in a particular functional centre. In the CSS sector, the focus of this indicator is to track the service recipients who are waiting to receive their first service due to lack of operational or organizational capacity. Indicator is S407* (days waited for service initiation) divided by S506* (number of individuals who received first service).
INDICATOR CLASSIFICATION	Developmental
PERFORMANCE STANDARD	**Performance Target:** Not applicable **Performance Corridor:** Not applicable
NUMERATOR	
CALCULATION	Use statistic S407* Days Waited for Service Initiation in a functional centre – the total number of days (24 hour period) waited by individuals who have received their first service in the functional centre during the current fiscal year as per the OHRS definition.
DATA SOURCE	OHRS
EXCLUSION/INCLUSION CRITERIA	A day of waiting is defined as the first day (24 hour period) that service could be offered after registered service recipients have had their intake and have been accepted in the service/functional centre (i.e., are reported in the S489*/S401* statistics) to receive service for the first time per existing instructions for reporting service recipient flow. Refer to the chart below from Chapter 10 of the OHRS manual for Functional Centres other than the residential type services:

Intake/ Admitted by HSP	Accepted in Service / FC	Waiting 1st Service in FC	Received 1st Service in FC	Discharged Service in FC	File Closed - Discharged from HSP
AC 82990	**FC** 725*	**FC** 725*	**FC** 725*	**FC** 725*	**AC** 82990
S501 **80****	S489 **80****	S406 **80** 20	S24880* or 4**80** S506 **80** S455 **80**	S513 **80****	S511 **80****

And the chart for residential type services FCs (725 82 40, 725 82 45 and 725 83 45):

Need to add chart



The counting/tracking of waiting days starts when S489* or S401* is reported. The reporting of days waited S407* occurs only after the individual has received his/her first service (i.e., only after the individual's waiting ended and is included in the S506* statistic).

Reference to relevant information under the indicator for number of persons waiting for service applies to all OH, Ministry funded Community Support programs and services which require the signing of an MSAA (accountability agreement). Days that individuals waited for first service for reasons other than a lack of organizational capacity (for example client choice, thresholds for the provision of service) would not be counted.

DENOMINATOR	
CALCULATION	Use statistic S506* Individuals Received First Service – the number of registered service recipients who have had their assessment/intake and received their first service in the functional centre during the current fiscal year.
DATA SOURCE	OHRS
EXCLUSION/INCLUSION CRITERIA	The count of individuals who received first service includes the service recipients who received their first service with or without waiting. This is a cumulative number, year to date count. The CSS OHRS Advisory Committee has recommended that clients who receive temporary service while another client's service is briefly interrupted (e.g., due to hospitalization, vacation, etc.) should be reported under S506* along with the other client flow statistics, including S407* (days waited) . The recommended reporting follows the existing client flow as in OHRS Chapter 10.
GEOGRAPHY & TIMING	

TIMING/FREQUENCY OF RELEASE How often and when are data being released	Data are reported quarterly for each functional centre (program/service) and released at the end of Q2, Q3 and Q4.
LEVELS OF COMPARABILITY	Data are available at the HSP, OH and provincial level.
TRENDING Years available for trending	Most data elements will be available in 2011/12. Trending may not be available until 2012/13 as S506* is a new statistic and was not a mandatory reporting requirement for the sector prior to Q2 2012/13.
ADDITIONAL INFORMATION	
LIMITATIONS	The indicator applies to services provided to registered service recipients only; i.e. individuals who have completed the intake or admission process and the organization maintains records of these individuals.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	OHRS technical specifications do not include exclusions.
REFERENCES Provide URLs of any key references	Data must be collected and reported at a program or service (functional centre) level. The indicator should be interpreted with caution because individuals who receive first service after a lengthy wait will significantly contribute to the numerator, thereby increasing the average days waited. The indicator may appear artefactually high for organizations that are clearing a backlog of people who have been waiting a long time for service. The inclusion of service recipients in the S489* and S401* statistics is determined per the existing instructions for reporting CSS client flow in the OHRS. It is not tied to any specific assessment protocol (e.g., RAI CHA).
RESPONSIBILITY FOR REPORTING	N/A
DATE CREATED (YYYY-MM-DD)	Health Service Providers
DATE LAST REVIEWED (YYYY-MM-DD)	2011-11-07

[1] Client Waiting Scenario :

- Client A has had intake and has been accepted for service. He/she is put on the wait list.
- An existing client (Client B) who is receiving service requires their service to be interrupted for a brief period of time.
- The organization “removes” Client A from the wait list and provides service briefly for the duration of the interruption experienced by Client B.
- Service for Client B is eventually resumed. The service that had been offered to Client A in the meantime is discontinued and he/she goes back on the wait list exactly where they were.

In a scenario where a client who is on a waitlist, receives temporary service while an existing client’s service is interrupted for a period of time (hospital, vacation, etc.), the following is the recommended reporting:

- Client A will be reported under S506* along with the other client flow statistics (S407* days waited, S513* discharged and S489* new referral will be reported if client B resumes services and client A resumes waiting on the waitlist)
- Client B will be “on hold” and services will be resumed based on client needs

- If both client A and B received services in the reporting period, the service activity (e.g. hours of service, etc.) and the Individual Served (S455* and S855*) will be reported. Note that S455* and S855* is counted only once per individual in a fiscal year in a functional centre and at the organizational level respectively.

Rationale

- The recommendations were made based on HSP's system challenges and reality in the field.
- Most HSPs have software application to manage waitlist, changes to the flow will be time and resource intensive
- The recommended reporting follows the existing client flow as in OHRS Chapter 10
- The number of clients receiving temporary services is expected to be immaterial. Therefore, the impact to the average days waited, etc. will be insignificant at the sector level.

SECTOR SPECIFIC INDICATORS: CHC

Performance

INDICATOR NAME	PROPORTION OF ELIGIBLE PEOPLE WHO WERE OFFERED AND/OR RECEIVED CERVICAL SCREENING
INDICATOR DESCRIPTION	Percentage of eligible female clients who received or were offered a Pap test in the previous three years either at the CHC or outside the CHC.
INDICATOR CLASSIFICATION	Performance
PERFORMANCE STANDARD	**Performance Target:** OH-negotiated target **Performance Corridor:** The corridor applied to locally negotiated performance targets for this indicator is +/-20% of the target. For a CHC that has submitted a plan to increase this rate, and has established a performance target through negotiations with their RCP of 30% for this indicator, reporting would be triggered by a variance below 24%.
NUMERATOR	
CALCULATION	Number of rostered females, aged 21-69 who have received or were offered a Pap test in last 3 years (at the CHC or recorded as done outside the CHC).
DATA SOURCE	BIRT Data Repository
EXCLUSION/INCLUSION CRITERIA	**Includes:** • Rostered female clients aged 21-69 who had an encounter with a GP/NP in the last three years. **Excludes:** • Inactive clients.
DENOMINATOR	
CALCULATION	Total number of rostered female clients, aged 21-69
DATA SOURCE	BIRT Data Repository
EXCLUSION/INCLUSION CRITERIA	**Includes:** • All rostered female clients, aged 21-69 who had an encounter with a GP/NP in the last three years. **Excludes:** • Inactive clients.
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly Timeliness – Currently: Updated weekly
LEVELS OF COMPARABILITY	Currently, no information has been provided.
TRENDING Years available for trending	Data are available as of 2008 Note: In October 2010, registered nurses (RNs) were added to the query as eligible providers.

	Note: In October 2012, the technical definition was changed to reflect the new practice guidelines as published by Ontario Health suggesting that the lower age limit for cervical cancer screening was 21.
ADDITIONAL INFORMATION	
LIMITATIONS	Data source does not allow clients who are ineligible (clients who have had a hysterectomy or prior cervical cancer) or who refused screening to be excluded. Therefore, numerator includes all clients who were offered a Pap test.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Ensuring that a Pap test is offered and performed can involve several members of the clinical team. While NPs may refer more Pap tests, RNs, registered practical nurses (RPNs) and general practitioners (GPs) often contribute by determining whether a Pap test is recommended and connecting with other members of the clinical team, such as the nurse practitioner (NP), to ensure that it is performed during the same visit.
REFERENCES Provide URLs of any key references	Ontario Health Cervical Screening Guidelines https://www.cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/resources-healthcare-providers/cervical-screening-guidelines-summary
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-14
DATE LAST REVIEWED (YYYY-MM-DD)	2022-11-25

INDICATOR NAME	**PROPORTION OF ELIGIBLE PEOPLE WHO WERE OFFERED AND/OR COMPLETED A FECAL-BASED TEST FOR COLORECTAL SCREENING**
INDICATOR DESCRIPTION	Percentage of rostered clients aged 50 - 74 who received or were offered a fecal-based screening test (fecal immunochemical test or guaiac fecal occult blood test) in the last 2 years.
INDICATOR CLASSIFICATION	Performance
PERFORMANCE STANDARD	**Performance Target:** OH-negotiated target **Performance Corridor:** The corridor applied to locally negotiated performance targets for this indicator is +/- 20% of the target. For a CHC that has submitted a plan to increase this rate, and has established a performance target through negotiations with their RCP of 60% for this indicator, reporting would be triggered by a variance below 48% and above 72%.
NUMERATOR	
CALCULATION	Number of rostered clients aged 50 - 74 who were offered or screened with a fecal-based screening test (fecal immunochemical test or guaiac fecal occult blood test) in the previous 2 years, excluding those who had a flexible sigmoidoscopy within the last 10 years, or a colonoscopy in the last 10 years.
DATA SOURCE	BIRT Data Repository

EXCLUSION/INCLUSION CRITERIA	**Includes:** • Rostered clients aged 50-74 who have had an encounter with a GP/NP in the previous 3 years **Excludes:** • Inactive clients
DENOMINATOR	
CALCULATION	Total number of rostered clients aged 50 - 74 who have seen a NP or physician in the previous 3 years
DATA SOURCE	BIRT Data Repository
EXCLUSION/INCLUSION CRITERIA	**Includes:** • All rostered clients aged 50-74 who have had an encounter with GP/NP in the previous 3 years **Excludes:** • Inactive clients • Clients who had a prior flexible sigmoidoscopy or colonoscopy in the last 10 years.
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly Timeliness – Currently: Updated weekly
LEVELS OF COMPARABILITY	Currently, no information has been provided.
TRENDING Years available for trending	Data are available from 2008 Note: In October 2010, registered nurses (RNs) were added to the query as eligible providers. Note: In October 2012, the technical definition was changed to reflect the new practice guidelines as published by Ontario Health suggesting that the upper age for colorectal screening was 74. Note: In April 2016, the use of a double contrast barium enema was removed as a recommended procedure for colorectal screening.
ADDITIONAL INFORMATION	
LIMITATIONS	Data source cannot exclude clients who are ineligible or who refused screening. Therefore, tests that were offered but declined, refused, ineligible or done elsewhere are included if recorded.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Ontario transitioned gFOBT to FIT as the recommended colorectal cancer screening test for people at average risk of colorectal cancer in June 2019 with an overlap period from June to December 2019.
REFERENCES Provide URLs of any key references	Ontario Health Colorectal Screening Guidelines https://www.cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/resources-healthcare-providers/colorectal-cancer-screening-summary
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-14
DATE LAST REVIEWED (YYYY-MM-DD)	2022-11-25

INDICATOR NAME	INTER-PROFESSIONAL DIABETES CARE RATE
INDICATOR DESCRIPTION	Percentage of rostered clients with diabetes who received services from two or more non-GP/NP providers/agencies in the previous two years
INDICATOR CLASSIFICATION	Performance
PERFORMANCE STANDARD	**Performance Target:** OH-negotiated target **Performance Corridor:** The corridor applied to locally negotiated performance targets for this indicator is +/-20% of target. For a CHC that has submitted a plan to increase this rate, and has established a performance target through negotiations with their OH Region of 60% for this indicator, reporting would be triggered by a variance below 48% and above 72%.
NUMERATOR	
CALCULATION	Number of rostered clients with diagnosis of Type 1 or Type 2 diabetes who, in the previous two years, received an internal referral, received individual service event, received an external diabetes-related referrals, or attended a group event intended for populations with diabetes to ≥2 provider types (other than physician or the NP)
DATA SOURCE	BIRT Data Repository
EXCLUSION/INCLUSION CRITERIA	Includes: • Eligible rostered clients who have had an encounter with a GP/NP in the last three years. Excludes: • Inactive clients. • Referrals to or individual service events performed by GP/NP
DENOMINATOR	
CALCULATION	Total number of CHC rostered clients with Type 1 or Type 2 diabetes
DATA SOURCE	BIRT Data Repository
EXCLUSION/INCLUSION CRITERIA	**ncludes:** • All rostered diabetic clients who have had an encounter with a GP/NP in the previous 3 years **Excludes:** Inactive clients
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly Timeliness – Currently: Updated weekly
LEVELS OF COMPARABILITY	Currently, no information has been provided.
TRENDING Years available for trending	Data are available from 2008

	Note: In October 2010, the numerator was broadened to include internal referrals to any provider type other than the physician or NP, external referrals to specific agencies and provider type and attendance to groups were diabetes is an issue addressed. Note: In April 2012, Diabetes Type I was added.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	N/A
REFERENCES Provide URLs of any key references	Meneghini. L et al. Appropriate advancement of type 2 diabetes therapy. Current Clinical Practice 1 (1), 2007. Canadian Diabetes Association Clinical Practice Guidelines http://guidelines.diabetes.ca/
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-14
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	**PANEL SIZE**
INDICATOR DESCRIPTION	The indicator calculates the current number of clients provided clinical services as a percentage of the total number of clients the member organization is expected to serve. Where the "expected" client count or full potential of the member organization assumes a fully staffed clinical team and the client complexity is factored into the count.
INDICATOR CLASSIFICATION	Perfomance
PERFORMANCE STANDARD	**Performance Target:** OH-negotiated target **Performance Corridor:** **Rapid Growth: +/- 10% of Target Value** **Continue High Level of service: +/- 5% of Target** **Rapid growth** is defined when a target is agreed to and this target is greater than 10% of their current value. (Example current level = 45% where agreed to target is 60%. (60-45)/45 = 33% growth
NUMERATOR	
CALCULATION	Number of clients that have had an encounter with a Physician, Nurse Practitioner, Registered Nurse, Registered Practical Nurse, or Physician Assistant within the last 3 years AND have had an encounter with a Physician or Nurse Practitioner anytime.

DATA SOURCE	BIRT data repository
EXCLUSION/INCLUSION CRITERIA	**Includes:** 1. Primary care clients seen by Physicians, Nurse Practitioners, Physician Assistants, Registered Practical Nurses or Registered Nurses in a three year period AND seen by a Physician or Nurse Practitioner at any time. All active or inactive clients seen in the past 3 years
DENOMINATOR	
CALCULATION	Target Adjusted Panel Size for the member organization = 1137.5/ member organization specific Standardized ACG Morbidity Index (SAMI) x FTE primary care providers (Physicians + Nurse Practitioners)
DATA SOURCE	ICES practice profile (SAMI) + member organization budget (FTE Count)
EXCLUSION/INCLUSION CRITERIA	**Includes:** 1. Funded FTE count of Primary Care Providers (Physician+ Nurse Practitioner) **Excludes:** 1. Any practitioner that is not funded to provide clinical services as part of an approved budget for a member organization
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Denominator: Recalculation will be done annually. Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Trending of panel size began in April 2014, however the numerator was changed in April 2016 to include primary care that was provided by a Registered Nurse, Registered Practical Nurse or Physician Assistant over three years.
ADDITIONAL INFORMATION	
LIMITATIONS	Denominator refresh is done annually. As there is no way of distinguishing a Physician, Nurse Practitioner, Registered Nurse, Registered Practical Nurse, or Physician Assistant who delivers primary care services from those who do not, this indicator may inadvertently capture community individuals who are not primary care clients. It is anticipated that since the client was seen at one time by a Physician or Nurse Practitioner that they continue to be primary care clients, however, this may not always be the case. It is projected that the impact of this limitation will be low.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	This indicator does not describe the full picture of the clients receiving primary care such as: equity, sustainability and quality. Therefore, this indicator has been implemented with additional explanatory indicators. These indicators provide contextual information for the member organizations to describe their services and/or priority populations. The adjusted target panel size will vary depending on the complexity of clients (SAMI). New member organizations or member organizations that are in a period of growth may have changing SAMIs. If a member organization's current panel is greater than the adjusted target panel size it is recommended that at least their current panel be

	used for calculating the denominator for the MSAA indicator (MSAA target should not exceed 100%). Select three explanatory measures for this indicator.
REFERENCES Provide URLs of any key references	Glazier RH, Zagorski BM, Rayner J. Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences; 2012. Muldoon L, Dahrouge S, Russell G, Hogg W, Ward N. How many patients should a family doctor have? Factors to consider in answering a deceptively simple question. Healthcare Policy 2012 7(4) Family Health Teams Guide to Physician Compensation https://www.rtso.ca/wp-content/uploads/2015/06/MOHLTC-fht_inter_provider-Oct-2013.pdf
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2012-06-09
DATE LAST REVIEWED (YYYY-MM-DD)	2022-11-25

Explanatory to the Access to Primary Care Indicator

INDICATOR NAME	**CLIENT SATISFACTION – ACCESS**

INDICATOR DESCRIPTION	The percentage of clients that report that they have timely access to their Physician, Nurse Practitioner, Physician Assistant, Registered Nurse or Registered Practical Nurse.
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	Number of respondents who stated 'same day' or 'next day' access to a primary care provider at their organization
DATA SOURCE	Client Experience Survey
EXCLUSION/INCLUSION CRITERIA	**Includes:** All clinical survey respondents **Excludes:** Clients who selected 'not applicable'
DENOMINATOR	
CALCULATION	Total number of respondents
DATA SOURCE	Client Experience Survey
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Clients who selected 'not applicable'
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Yearly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	The following question must be included in the client experience survey. The last time you were sick, 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? a) same day b) next day c) 2-19 days (enter number of days:___) d) 20 or more days e) Not applicable
REFERENCES Provide URLs of any key references	http://indicatorlibrary.hqontario.ca/Indicator/Summary/Timely-access-primary-care-provider-patient/EN
KEYWORDS	Community Health Centre, Access, Client Experience, Quality

DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	**CLINIC SUPPORT STAFF PER PRIMARY CARE PROVIDER**
INDICATOR DESCRIPTION	The percentage of clinical support staff per Physician and Nurse Practitioner.
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	The total number of clinical support staff
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	Includes: Physician Assistants, Registered Nurses, Registered Practical Nurses, Medical Secretaries, Pharmacists, Medical Assistants, Health Technicians, and Lab Technicians.
DENOMINATOR	
CALCULATION	Total number of funded primary care providers (Physicians and Nurse Practitioners)
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Dietitians, social workers, and other staff are valuable members of the primary care team, but for the purposes of this measure only support staff who work directly in the clinic should be included. This measure reflects the number of staff available to assist and manage primary care clients alleviating some of the work that Physicians or Nurse Practitioners would manage otherwise.
REFERENCES Provide URLs of any key references	
KEYWORDS	Community Health Centre, Clinic Support, Sustainability
DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	INTERPRETATION
INDICATOR DESCRIPTION	The percentage of encounters by a primary care provider (Physician, Nurse Practitioner, Physician Assistant, Registered Nurse or Registered Practical Nurse) that include interpretation services.
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	The total number of encounters by a primary care provider (Physician, Nurse Practitioner, Physician Assistant, Registered Nurse or Registered Practical Nurse) that require interpretation services.
DATA SOURCE	BIRT
EXCLUSION/INCLUSION CRITERIA	None
DENOMINATOR	
CALCULATION	The total number of encounters by a primary care provide (Physician, Nurse Practitioner, Physician Assistant, Registered Nurse or Registered Practical Nurse).
DATA SOURCE	BIRT
EXCLUSION/INCLUSION CRITERIA	**Includes:** • Primary care clients seen by a Physician, Nurse Practitioner, Physician Assistant, Registered Practical Nurse or Registered Nurse in a three year period AND seen by a Physician or Nurse Practitioner at any time. • All active or inactive clients seen in the past 3 years
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	
REFERENCES Provide URLs of any key references	
KEYWORDS	Community Health Centre, Specialty Clinics, High-Risk Populations, Complex Populations, Equity
DATE CREATED (YYYY-MM-DD)	2013-02-24

DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	**EXAM ROOMS PER PRIMARY CARE PROVIDER**
INDICATOR DESCRIPTION	The number of exam rooms per primary care provider (Physician, Nurse Practitioner, Physician Assistant, Registered Nurse and Registered Practical Nurse)
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	The total number of exam and consult rooms used for provision of client care.
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	**Includes:** All rooms that are equipped to interview, assess and treat clients
DENOMINATOR	
CALCULATION	Total number of primary care providers (Physician, Nurse Practitioner, Physician Assistant, Registered Nurse and Registered Practical Nurse)
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Exam rooms are defined as full-equipped rooms in which providers and other staff can interview and assess clients. Consult/interview rooms should be counted when they are used by clinical staff for the provision of care. The total number of exam rooms in the clinic is counted.
REFERENCES Provide URLs of any key references	
KEYWORDS	Community Health Centre, Exam Rooms, Sustainability
DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07
INDICATOR NAME	**NEW GRADS/NEW STAFF**

INDICATOR DESCRIPTION	This indicator calculates the percentage of Physician and Nurse Practitioner staff who are defined as a new grad or newly hired positions.
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	Total number of new staff and/or new grads (Physician, Nurse Practitioner)
DATA SOURCE	Manual – Organizational Data
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services
DENOMINATOR	
CALCULATION	Total number Physicians and Nurse Practitioners
DATA SOURCE	Manual – Organizational Data
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Newly-hired providers who are building a panel of new patients may take 12-15 months to achieve a full panel equal to that of an established provider. It is also recognized that if a newly-hired provider is assuming the responsibility for an established panel, approximately 9 months may be required before they have the ability to care for the panel of a fully-established provider.
REFERENCES Provide URLs of any key references	
KEYWORDS	Community Health Centre, Sustainability, New Grads, New Hires
DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	NON-PRIMARY CARE ACTIVITIES
INDICATOR DESCRIPTION	The FTE percentage of Physician and Nurse Practitioner time spent on non-primary care activities. This includes time spent in clinical management, teaching/research, and or community development activities
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	Total FTE Physician, Nurse Practitioner time spent on non-primary care activities
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services
DENOMINATOR	
CALCULATION	Total FTE time for all Physicians and Nurse Practitioners
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	The FTE count for the Access to Primary Care includes all funded Physicians and Nurse Practitioners. Some of these providers spend their time in other activities such as broad community outreach activities, personal development activities, advocacy, management, research activities or other activities not specifically related to client care.
REFERENCES Provide URLs of any key references	
KEYWORDS	Community Health Centre, Non-primary care activities, Sustainability
DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	NUMBER OF NEW CLIENTS
INDICATOR DESCRIPTION	This indicator calculates the percentage of Primary Care Clients who had their first encounter with a Physician or Nurse Practitioner within the last 3 years.
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	The total number Primary Care Clients who had their first encounter with a Physician or Nurse Practitioner in the last 3 years
DATA SOURCE	BIRT
EXCLUSION/INCLUSION CRITERIA	**Includes:** All active or inactive clients seen in the past 3 years
DENOMINATOR	
CALCULATION	The total number of all Primary Care Clients seen in the last 3 years.
DATA SOURCE	BIRT
EXCLUSION/INCLUSION CRITERIA	**Includes:** • Primary care clients seen by Physicians, Nurse Practitioners, Physician Assistants, Registered Practical Nurses or Registered Nurses in a three year period AND seen by a Physician or Nurse Practitioner at any time. • All active or inactive clients seen in the past 3 years
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	
REFERENCES Provide URLs of any key references	
KEYWORDS	Community Health Centre, New Clients, Access, Sustainability
DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	NUMBER OF REGISTERED CLIENTS
INDICATOR DESCRIPTION	Total number of clients registered to a Physician or Nurse Practitioner.
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
CALCULATION	
CALCULATION	Total number of active clients who have received primary care services from a Physician or Nurse Practitioner at any time, including people who have not had an encounter in the last 3 years, however, the member organization is still responsible for providing primary care when required
DATA SOURCE	BIRT
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Inactive Clients
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	This measure reflects the total number of clients who, despite not having had an encounter in 3 years (therefore excluded from panel size) still consider the member organization as their primary care provider and will return if the need arises. This is an important measure for some member organizations who have a stable population.
REFERENCES Provide URLs of any key references	
KEYWORDS	Community Health Centre, Registered Clients
DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	SPECIALIZED CARE
INDICATOR DESCRIPTION	The percentage of FTE time spent on specialized care. This includes specialty clinics such as palliative care, obstetrics and may include priority populations (e.g. geriatric)
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	The total FTE time spent on provision of specialized care by Physician and Nurse Practitioner.
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services
DENOMINATOR	
CALCULATION	The total FTE time spent on clinical activities by Physicians and Nurse Practitioners.
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services.
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	This measure accounts for highly-specialized panels not various priority populations. This may include a priority population that requires home visits.
REFERENCES Provide URLs of any key references	
KEYWORDS	Community Health Centre, Specialty Clinics, High-Risk Populations, Complex Populations, Sustainability
DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	SUPERVISION OF STUDENTS
INDICATOR DESCRIPTION	The percentage of Physician and Nurse Practitioner time spent supervising students
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	Total FTE time spent supervising/teaching Physician and Nurse Practitioner students.
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services.
DENOMINATOR	
CALCULATION	The total FTE time spent on clinical activities by Physicians and Nurse Practitioners
DATA SOURCE	Manual
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Any practitioner that is not funded as part of an approved budget for a member organization to provide clinical services.
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	
REFERENCES Provide URLs of any key references	http://www.rrh.org.au/publishedarticles/article_print_403.pdf
KEYWORDS	Community Health Centre, Student Supervision, Sustainability
DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	THIRD NEXT AVAILABLE APPOINTMENT (3NAA)
INDICATOR DESCRIPTION	Average length of time in days between the day a client makes a request for an appointment with a Physician or Nurse Practitioner and the third next available appointment for a new client, routine exam, or a return visit.
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
CALCULATION	
CALCULATION	Count the number of days between a fictitious or real request for an appointment and the third next available appointment in your schedule.
DATA SOURCE	Manual/Scheduler
EXCLUSION/INCLUSION CRITERIA	**Include:** • Vacation days • Weekends **Exclude:** • Statutory holidays
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	Difficult to include providers that work less than a 0.5 FTE.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Continuity is an important element of quality care and access. Continuity measures may be important to measure with 3NAA to ensure that clients have the ability to see their own provider.
REFERENCES Provide URLs of any key references	http://www.ihi.org/knowledge/Pages/Measures/ThirdNextAvailableAppointment.aspx http://www.health.gov.on.ca/en/pro/programs/ris/docs/third_next_available_appointment_en.pdf
KEYWORDS	Community Health Centre, Access to Care, 3NAA, Third Next Available Appointment
DATE CREATED (YYYY-MM-DD)	2013-02-24
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	NON-INSURED CLIENTS
INDICATOR DESCRIPTION	This indictor calculates the percentage of clients who do not have Ontario Health Insurance Plan (OHIP).
INDICATOR CLASSIFICATION	Explanatory to the Access to Primary Care indicator
NUMERATOR	
CALCULATION	The number of primary care clients who do not have Ontario Health Insurance Plan (OHIP)
DATA SOURCE	Practice Profile (or BIRT)
EXCLUSION/INCLUSION CRITERIA	**Includes:** • Primary care clients seen by a Physician, Nurse Practitioner, Physician Assistant, Registered Practical Nurse or Registered Nurse in a three year period AND seen by a Physician or Nurse Practitioner at any time. • All active or inactive clients seen in the past 3 years
DENOMINATOR	
CALCULATION	Number of primary care clients seen by a Physician, Nurse Practitioner, Physician Assistant, Registered Practical Nurse or Registered Nurse in a three year period AND seen by a Physician or Nurse Practitioner at any time.
DATA SOURCE	BIRT
EXCLUSION/INCLUSION CRITERIA	**Includes:** • Primary care clients seen by a Physician, Nurse Practitioner, Physician Assistant, Registered Practical Nurse or Registered Nurse in a three year period AND seen by a Physician or Nurse Practitioner at any time. • All active or inactive clients seen in the past 3 years
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Individuals without Ontario health insurance (OHIP) are not included in the SAMI calculation.
REFERENCES Provide URLs of any key references	
KEYWORDS	Non-Insured
DATE CREATED (YYYY-MM-DD)	
DATE LAST REVIEWED (YYYY-MM-DD)	2018-07

INDICATOR NAME	TRAVEL TIME
INDICATOR DESCRIPTION	This indicator calculates the percentage of total time Physician, Nurse Practitioner, Physician Assistant, Registered Nurse and Registered Practical Nurse spend travelling for the purpose of direct service delivery to clients.
INDICATOR CLASSIFICATION	Explanatory
NUMERATOR	
CALCULATION	The sum of the number of hours spent travelling by Physician, Nurse Practitioner, Physician Assistant, Registered Nurse AND Registered Practical Nurse cumulative to the end of the reporting period.
DATA SOURCE	Individual Human Resources (HR) records
EXCLUSION/INCLUSION CRITERIA	Contract staff, secondments and transfers
DENOMINATOR	
CALCULATION	The sum of the total number of hours worked by Physicians and Nurse Practitioners cumulative to the end of the reporting period.
DATA SOURCE	Individual HR records
EXCLUSION/INCLUSION CRITERIA	**Excludes:** Contract staff, secondments and transfers
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	A common sector-wide data source does not exist. Data is self-reported by HR staff. Vacations and Statutory Holidays to be included in worked hours as per standard practice.
REFERENCES Provide URLs of any key references	
RESPONSIBILITY FOR REPORTING	
DATE CREATED (YYYY-MM-DD)	2018-07-05
DATE LAST REVIEWED (YYYY-MM-DD)	

INDICATOR NAME	HIGH RISK URBAN POPULATION
INDICATOR DESCRIPTION	This indicator identifies Community Health Centres who provide services to a high risk urban population.
INDICATOR CLASSIFICATION	Explanatory
NUMERATOR	
CALCULATION	A positive answer to the following question: Does your centre provide services to individuals (as a priority population) who: • are homeless or at risk of being homeless • live with mental health issues or mental illness • live with an addiction • are living in poverty or with low income • are street involved youth
DATA SOURCE	Individual HR records
EXCLUSION/INCLUSION CRITERIA	
DENOMINATOR	
CALCULATION	N/A
DATA SOURCE	N/A
EXCLUSION/INCLUSION CRITERIA	N/A
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data is available from April 2014.
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Member organizations that provide services the High Risk Urban clients tend to have a higher SAMI, and therefore have a higher than expected resource use thus resulting in a reduced ability to see the same number of clients as a centre with a lower SAMI. It is to note that social conditions confounded with mental health addictions add to complexity and are not properly adjusted with the SAMI. A common sector-wide data source does not exist. Data is self-reported by HR staff.
REFERENCES Provide URLs of any key references	Glazier RH, Zagorski BM, Rayner J. Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences; 2012.
DATE CREATED (YYYY-MM-DD)	2018-07-05
DATE LAST REVIEWED (YYYY-MM-DD)	

Monitoring

INDICATOR NAME	BREAST CANCER SCREENING RATE
INDICATOR DESCRIPTION	This indicator calculates the percentage of recommended clients who received or were offered a mammogram in the previous two years.
INDICATOR CLASSIFICATION	Monitoring
PERFORMANCE STANDARD	**Performance Target:** OH-negotiated target **Performance Corridor:** The corridor applied to locally negotiated performance targets for this indicator is +/- 20% of target. For a CHC that has submitted a plan to increase this rate, and has established a performance target through negotiations with OH of 60% for this indicator, reporting would be triggered by a variance below 48% and above 72%.
NUMERATOR	
CALCULATION	Rostered, female clients, aged 50-74 years who received or were offered a mammogram in the previous two years.
DATA SOURCE	BIRT Data Repository
EXCLUSION/INCLUSION CRITERIA	**Includes:** • Eligible rostered female clients, who had an encounter with a GP/NP in the last three years. • Clients who receive mammography outside of the CHC (i.e. Ontario Breast Screening Program) are included in the numerator if this data is entered **Excludes:** • Inactive clients.
DENOMINATOR	
CALCULATION	Rostered, female clients, aged 50-74 years
DATA SOURCE	BIRT Data Repository
EXCLUSION/INCLUSION CRITERIA	**Includes:** • All rostered female clients aged 50-74 who had an encounter with a GP/NP in the last three years. **Excludes:** • Inactive clients.
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly Timeliness – Currently: Updated weekly
LEVELS OF COMPARABILITY	Currently, no information has been provided.

TRENDING Years available for trending	Data is available from 2008. Note: In April 2016, the technical definition was changed to reflect the new practice guidelines as published by Ontario Health suggesting that the upper age limit for breast cancer screening was 74.
ADDITIONAL INFORMATION	
LIMITATIONS	Data source does not allow clients who are ineligible (because they have had a mastectomy or are being treated for clinical breast disease) or who refused screening to be excluded. Therefore numerator includes all clients who were offered a mammogram.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	Ensuring that a mammography is offered and performed can involve several members of the clinical team. While NPs may refer more mammograms, RNs, RPNs and GPs often contribute by determining whether a mammogram is recommended and contacting with other members of the clinical team.
REFERENCES Provide URLs of any key references	Ontario Health Breast Screening Guidelines http://www.cancercare.on.ca/pcs/screening/breastscreening/mammograms/
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2010-12-14
DATE LAST REVIEWED (YYYY-MM-DD)	2022-11-25

INDICATOR NAME	**VACANCY RATE**
INDICATOR DESCRIPTION	This indicator calculates the percentage of Physician and Nurse Practitioner permanent full-time equivalent (FTE) positions that are occupied over the reporting period.
INDICATOR CLASSIFICATION	Monitoring
PERFORMANCE STANDARD	**Performance Target:** OH-negotiated target **Performance Corridor:** The corridor applied to locally negotiated performance targets for this indicator is 20% of target. For a CHC that has submitted a plan to increase this rate, and has established a performance target through negotiations with OH of 80% for this indicator, reporting would be triggered by a variance below 64%.
NUMERATOR	
CALCULATION	The sum of the number of hours worked by Physician and Nurse Practitioner cumulative to the end of the reporting period.

	Example: For Q2 reporting: Q2 corresponds from April 1st to September 30th inclusive. Numerator = sum the total number of hours worked by GPs and NPs from April 1st to September 30th inclusive. Note: Vacations and Statutory Holidays to be included in worked hours as per standard practice.
DATA SOURCE	Individual Community Health Centre (CHC) Human Resources (HR) records
EXCLUSION/INCLUSION CRITERIA	Currently, no information has been provided.
DENOMINATOR	
CALCULATION	The sum of the number of hours worked by Physician and Nurse Practitioner if the complement was fully occupied over the time period. As per OHRS definition, FTE position is a 1950 hour total for the fiscal year. So total hours per reporting period per FTE are listed below: Reporting Period Q2: 975 hours per FTE Reporting Period Q3: 1462.5 hours per FTE Reporting Period Q4: 1950 hours per FTE Example: Assuming 5 FTE and reporting period is Q2 Total Budgeted Hours for GP and NP = # FTE * 975 = 5 * 975 = 4,875 Note: The sample calculation is based on a 37.5 hour work week (different hours would be applied to a 35 hour work week).
DATA SOURCE	Individual CHC HR records
EXCLUSION/INCLUSION CRITERIA	**Excludes:** • Contract staff, secondments and transfers
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Reported: Quarterly Timeliness – Currently: Updated weekly
LEVELS OF COMPARABILITY	Currently, no information has been provided.
TRENDING Years available for trending	Data available from April 2015 (prior to 2015 collected as vacancy rate)
ADDITIONAL INFORMATION	
LIMITATIONS	Currently, no information has been provided.
COMMENTS	A common CHC sector-wide data source does not exist. Data is self-reported by CHC HR staff.

Additional information regarding the calculation, interpretation, data source, etc.	Vacations and Statutory Holidays to be included in worked hours as per standard practice. The 20% corridor takes into account the normal or expected variation in staff complement over a fiscal year (maternity leaves, short term vacancies and the time to hire professional staff). This measure is a complement to the access to primary care measure Note: The smaller the FTE complement the effect of vacancies will be larger. Therefore when comparing the performance of CHCs for this indicator one of the items to take into account is to ensure that the CHCs compared have the same number of FTE.
REFERENCES Provide URLs of any key references	
RESPONSIBILITY FOR REPORTING	Health Service Providers
DATE CREATED (YYYY-MM-DD)	2014-10-01
DATE LAST REVIEWED (YYYY-MM-DD)	2022-11-25

SECTOR SPECIFIC INDICATORS: MH&A

Explanatory

INDICATOR NAME	REPEAT UNSCHEDULED EMERGENCY VISITS WITHIN 30 DAYS FOR MENTAL HEALTH CONDITIONS
INDICATOR DESCRIPTION	Percent of repeat emergency visits following a visit for a mental health condition. 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. This indicator is presented as a proportion of all mental health emergency visits.
INDICATOR CLASSIFICATION	Explanatory
CALCULATION	
CALCULATION	A visit is counted as an index visit if it is followed by another visit that occurs in any Ontario hospital within 30 days, for any diagnosis within ICD-10-CA Chapter 5. The diagnostic category and groups refer to the diagnosis reported for the index visit. The repeat visit could be for either a mental health or substance abuse diagnosis. To avoid under-counting of qualified repeat visit pairs, the calculation includes the fiscal period plus an additional 30 days. In order to provide more timely results, the time period for the calculation has shifted. For each quarter, the data period includes the reporting quarter and the last 30 days of the previous quarter. Numerator = # 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 instance, if the reporting quarter is fiscal Q1, the numerator will include number of ER visits occurring between March 1 and May 31 with a possible repeat visit up until June 30). 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, at the OH region level by OH of patient residence (MOH-OHAA indicator) and at the hospital level by OH where the index visit occurred (HSAA indicator) (for instance, if the reporting quarter is fiscal Q1, the denominator will include number of ER visits occurring between March 1 and May 31).

	For each fiscal year and each quarter: Step 1: Identify all mental health and substance abuse emergency visits: select unscheduled emergency visits with a Main Problem Diagnosis (MPDx) in ICD-10-CA Chapter 5. Step 2: Determine index visits: line up emergency visits identified in Step 1 based on health card number and visit date/time, calculate the time difference between the disposition date of the visit and the registration date of the next visit, and then identify and mark the visits that are followed within 30 days by another visit as index visits. Step 3: Categorize index visit to Mental Health based on its MPDx: mental health has MPDx FF00-F09; F20-F99 Step 4: Calculate repeat visit rate for mental health conditions. For the mental health indicator, divide the number of mental health index visits by the total number of mental health visits.
DATA SOURCE	National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health Information (CIHI)
EXCLUSION/INCLUSION CRITERIA	▪ Includes information on unscheduled emergency department visits to Ontario hospitals for Mental Health and Substance Abuse conditions, defined by the main problem diagnosis in ICD-10-CA Chapter 5. ▪ The diagnostic categories refer to the main problem diagnosis (the problem deemed to be the most clinically significant reason for the visit) and are based on ICD-10-CA diagnoses. ▪ Mental Health: ICD-10-CA codes beginning with F00 – F09 or F20-F99. ▪ The analysis excludes visits for those without a valid health card number.
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Data are collected quarterly so quarterly/annual tracking is possible.
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	Data are collected quarterly so quarterly/annual tracking is possible.
ADDITIONAL INFORMATION	
LIMITATIONS	Some calculations may be based on interim data which are subject to change.
COMMENTS	

Additional information regarding the calculation, interpretation, data source, etc.	
REFERENCES Provide URLs of any key references	
RESPONSIBILITY FOR REPORTING	
DATE CREATED (YYYY-MM-DD)	
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	**REPEAT UNSCHEDULED EMERGENCY VISITS WITHIN 30 DAYS FOR SUBSTANCE ABUSE CONDITIONS**
INDICATOR DESCRIPTION	Percent of repeat emergency visits following a visit for a substance abuse condition. A visit is counted as a repeat visit if it is for either of a mental health or substance abuse condition, and occurs within 30 days of an index visit for a substance abuse condition. This indicator is presented as a proportion of all substance abuse emergency visits.
INDICATOR CLASSIFICATION	Explanatory
CALCULATION	
CALCULATION	A visit is counted as an index visit if it is followed by another visit that occurs in any Ontario hospital within 30 days, for any diagnosis within ICD-10-CA Chapter 5. The diagnostic category and groups refer to the diagnosis reported for the index visit. The repeat visit could be for either a mental health or substance abuse diagnosis. To avoid under-counting of qualified repeat visit pairs, the calculation includes the fiscal period plus an additional 30 days. In order to provide more timely results, the time period for the calculation has shifted. For each quarter, the data period includes the reporting quarter and the last 30 days of the previous quarter. Numerator = # of unscheduled emergency visits for substance abuse 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 instance, if the reporting quarter is fiscal Q1, the numerator will include number of ER visits occurring between March 1 and May 31 with a possible repeat visit up until June 30). Denominator = Total number of unscheduled emergency visits for substance abuse conditions in last 30 days of the previous quarter and the first two months of the reporting quarter, at the OH region level by OH of patient residence (MOH-OHAA indicator) and at the hospital level by the OH where the index visit occurred (HSAA indicator) (for instance, if the reporting quarter is fiscal Q1, the denominator will include number of ER visits occurring between March 1 and May 31).

	For each fiscal year and each quarter: Step 1: Identify all mental health and substance abuse emergency visits: select unscheduled emergency visits with a Main Problem Diagnosis (MPDx) in ICD-10-CA Chapter 5. Step 2: Determine index visits: line up emergency visits identified in Step 1 based on health card number and visit date/time, calculate the time difference between the disposition date of the visit and the registration date of the next visit, and then identify and mark the visits that are followed within 30 days by another visit as index visits. Step 3: Categorize index visit to Substance Abuse category based on its MPDx: substance abuse has MPDx F10-F19. Step 4: Calculate repeat visit rate for substance abuse conditions. For the substance abuse indicator, divide the number of substance abuse index visits by the total number of substance abuse visits.
DATA SOURCE	National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health Information (CIHI)
EXCLUSION/INCLUSION CRITERIA	• Includes information on unscheduled emergency department visits to Ontario hospitals for Mental Health and Substance Abuse conditions, defined by the main problem diagnosis in ICD-10-CA Chapter 5. • The diagnostic categories refer to the main problem diagnosis (the problem deemed to be the most clinically significant reason for the visit) and are based on ICD-10-CA diagnoses. • Substance Abuse: ICD-10-CA codes beginning with 'F10' – 'F19'. • The analysis excludes visits for those without a valid health card number.
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Data are collected quarterly so quarterly/annual tracking is possible.
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	
ADDITIONAL INFORMATION	
LIMITATIONS	Some calculations may be based on interim data which are subject to change.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	

REFERENCES Provide URLs of any key references	
RESPONSIBILITY FOR REPORTING	
DATE CREATED (YYYY-MM-DD)	
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	**AVERAGE NUMBER OF DAYS WAITED FROM REFERRAL/APPLICATION TO INITIAL ASSESSMENT COMPLETE**
INDICATOR DESCRIPTION	This indicator calculates the average number of days waited by clients from the client application/referral date to the date when the HSP completes the initial assessment to determine eligibility for service.
INDICATOR CLASSIFICATION	Explanatory
NUMERATOR	
CALCULATION	Total cumulative number of days waited for all clients in reporting period from the date when the HSP receives the client application or referral for the client and when the HSP completes the initial assessment to determine the client is eligible for service. Days can only be counted for clients who are deemed eligible within the reporting period (as outlined in the definition in "References" below)
DATA SOURCE	Based on 2011/12 OHRS Community Mental Health and Addiction Comparative Reports: Report 2 – "Client Activity Stats" Report 2b – "Client Activity Stats by OH by Organization Column 3 – "Days waited for Initial Assessment – s. 407**10"
EXCLUSION/INCLUSION CRITERIA	**Includes:** 1. Case Management /Supportive Counselling & Services Functional Centre 72509**, Clinic/Program Functional Centres 72510*, Day Night Care 72520* & Residential Services 72540 2. Count the day the assessment is completed in the calculation **Excludes:** 1. All other service Functional Centres2. Do not count the day the referral/application is received by the HSP (except where the assessment is complete on the same day as per the inclusion above)
DENOMINATOR	
CALCULATION	Total cumulative number of clients that had an initial assessment completed during reporting period
DATA SOURCE	Based on 2011/12 OHRS Community Mental Health and Addiction Comparative Reports Report 2 – "Client Activity Stats" Report 2b – "Client Activity Stats by OH by Organization Column "11" – " New Referral (referral to the functional centre) S489*
EXCLUSION/INCLUSION CRITERIA	**Includes:** 1. Case Management/Supportive Counselling & Services Functional Centre 72509** Clinic/Program Functional Centres 72510*, Day Night Care 72520* & Residential Services 72540 **Excludes:** 1. All other service Functional Centres

GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Quarterly Timing subject to the release of "CMH&A Data Quality & Comparative Reports" by Health Data Branch on the HDB portal: https://hsim.health.gov.on.ca/hdbportal/cmha
LEVELS OF COMPARABILITY	The information is available at the HSP level, OH level or for the province in total.
TRENDING Years available for trending	s. 489**** only becomes a mandatory statistic effective 2013/14 therefore there is no comparative/trending data available
ADDITIONAL INFORMATION	
LIMITATIONS	Since the 489**** stat only became mandatory effective 2013/14, the data quality could be poor in the first year until there is broad and thorough education done with the sector on this importance of data collection and report on the stats required for this indicator.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	
REFERENCES Provide URLs of any key references	OHRS definition: 407 ** 10 "Days Waited For Assessment The number of days a client waited from the date of application/referral to the assessment complete date by the organization. This statistic is a cumulative figure and can only be recorded after the initial assessment for the client has been completed. This statistic is used to produce the average wait time for client assessments. If the client is not accepted for service, no days waited would be included. OHRS definition: 489**** **New Referral** (Internal Referral to the Functional Centre) The number of service recipients accepted to receive service in a functional centre during the reporting period. Includes all SRs who are eligible to receive service regardless of whether they had to wait or not for service to commence. There may be multiple referrals to various service functional centres as one SR may be referred to a number of functional centres. If a client has received service and later discharged from a functional centre and then re-admitted again to the same FC within the same reporting period, both referrals for the same client can be reported.
RESPONSIBILITY FOR REPORTING	HSPs through the OHRS trial balance submission process
DATE CREATED (YYYY-MM-DD)	2012-10-22
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	AVERAGE NUMBER OF DAYS WAITED FROM INITIAL ASSESSMENT COMPLETE TO SERVICE INITIATION
INDICATOR DESCRIPTION	This indicator calculates the average number of days waited by clients from the date when the HSP completes the initial assessment determining eligibility of the client and when the client receives the first service.
INDICATOR CLASSIFICATION	Explanatory
NUMERATOR	
CALCULATION	Total cumulative number of days waited for all clients in reporting period from the date when the HSP completes the initial assessment to determine client eligibility and when the client receives the first service. Days can only be counted for clients who receive a first service within the reporting period (as outlined in the definition in "References" below)
DATA SOURCE	Based on OHRS Community Mental Health and Addiction Comparative Reports: Report 2 – "Client Activity Stats" Report 2b – "Client Activity Stats by OH by Organization Column 4 – "Days waited for Service initiation – s. 407**20"
EXCLUSION/INCLUSION CRITERIA	**Includes:** Count the day the HSP provides the first service in the calculation **Excludes:** Do not count the day the assessment is completed on the clientby the HSP (except where the assessment is complete on the same day as the first service visit date)
DENOMINATOR	
CALCULATION	Total cumulative number of clients that received their first service during reporting period for all Functional Centres
DATA SOURCE	Based on OHRS Community Mental Health and Addiction Comparative Reports Report 2 – "Client Activity Stats" Report 2b – "Client Activity Stats by OH by Organization Column "6" – "Individuals Who Received First Service – s 506****"
EXCLUSION/INCLUSION CRITERIA	**Includes:** 1. Case Management /Supportive Counselling & Services Functional Centre 72509** Clinic/Program Functional Centres 72510*, Day Night Care 72520* & Residential Services 72540 **Excludes:** 1. All other functional centres

GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Quarterly Timing subject to the release of "CMH&A Data Quality & Comparative Reports" by Health Data Branch on the HDB portal: https://hsim.health.gov.on.ca/hdbportal/cmha
LEVELS OF COMPARABILITY	The information is available at the HSP level, OH level or for the province in total
TRENDING Years available for trending	s. 506**** only becomes a mandatory statistic effective 2013/14 therefore there is no comparative/trending data available
ADDITIONAL INFORMATION	
LIMITATIONS	Since the 506**** stat only became mandatory effective 2013/14, the data quality could be poor in the first year until there is broad and thorough education done with the sector on this importance of data collection and report on the stats required for this indicator.
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	
REFERENCES Provide URLs of any key references	OHRS definition: 407 ** 20 "Days Waited For Service Initiation" The number of days waited from the accepted for service date to service initiation date (date of the actual first service received). These days can only be counted after the service has started and the client is no longer waiting for service. This statistic is recorded in the service delivery functional centre. This is to be recorded from the date that the client is deemed eligible for the service and not from the date the service is arranged. This is a cumulative number, year-to-date value. This statistic is used to calculate/ approximate the number of days waiting for service by the eligible clients. OHRS definition: 506 ** ** **Individuals Received First Service** The number of registered service recipients (SR) who have had their assessment/intake and received their first service in the functional centre (FC) during current fiscal year. This count includes the SRs who received their first service with or without waiting. If a client has received service and later discharged from the functional centre and then readmitted to the same FC within the same reporting period, another first service count is reported. This is a cumulative number, year-to-date count. **Individuals Received First Service** The number of registered service recipients (SR) who have had their assessment/intake and received their first service in the functional

	centre (FC) during current fiscal year. This count includes the SRs who received their first service with or without waiting. If a client has received service and later discharged from the functional centre and then readmitted to the same FC within the same reporting period, another first service count is reported. This is a cumulative number, year-to-date count.
RESPONSIBILITY FOR REPORTING	HSPs through the OHRS trial balance submission process
DATE CREATED (YYYY-MM-DD)	2012-10-22
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

Developmental

INDICATOR NAME	OCAN
INDICATOR DESCRIPTION	A standardized assessment tool used in the community mental health sector.
INDICATOR CLASSIFICATION	Developmental
NUMERATOR	
CALCULATION	TBD
DATA SOURCE	OCAN/GAIN
EXCLUSION/INCLUSION CRITERIA	**Includes:** 1. TBD **Excludes:** 1. TBD
DENOMINATOR	
CALCULATION	TBD
DATA SOURCE	TBD
EXCLUSION/INCLUSION CRITERIA	**Includes:** 1. TBD **Excludes:** 1. TBD
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	Data are available quarterly
LEVELS OF COMPARABILITY	Data are available at the OH and HSP levels
TRENDING Years available for trending	Data are available from fiscal year <<>>
ADDITIONAL INFORMATION	
LIMITATIONS	TBD
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	TBD
REFERENCES Provide URLs of any key references	N/A
RESPONSIBILITY FOR REPORTING	Health Analytics Branch
DATE CREATED (YYYY-MM-DD)	
DATE LAST REVIEWED (YYYY-MM-DD)	2018-10

INDICATOR NAME	ONTARIO PERCEPTION OF CARE (OPOC) TOOL FOR MH&A
INDICATOR DESCRIPTION	A standardized way for gathering client feedback on the quality of care received across both community and hospital settings.
INDICATOR CLASSIFICATION	
PERFORMANCE STANDARD	
NUMERATOR	
CALCULATION	
DATA SOURCE	
EXCLUSION/INCLUSION CRITERIA	
DENOMINATOR	
CALCULATION	
DATA SOURCE	
EXCLUSION/INCLUSION CRITERIA	
GEOGRAPHY & TIMING	
TIMING/FREQUENCY OF RELEASE How often and when are data being released	
LEVELS OF COMPARABILITY	
TRENDING Years available for trending	
ADDITIONAL INFORMATION	
LIMITATIONS	
COMMENTS Additional information regarding the calculation, interpretation, data source, etc.	
REFERENCES Provide URLs of any key references	
RESPONSIBILITY FOR REPORTING	
DATE CREATED (YYYY-MM-DD)	
DATE LAST REVIEWED (YYYY-MM-DD)	