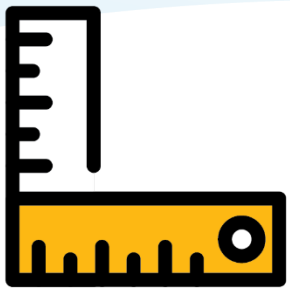

QUALITY IMPROVEMENT PLAN PROGRAM

Indicator Technical Specifications

2024/25

NOVEMBER 2023

Ontario Health

Table of Contents

Introduction

Quality Improvement

Every health care organization must prioritize quality improvement to achieve local and system-wide change in Ontario health care. To evaluate quality and quality improvement, organizations in every sector – **hospital**, **interprofessional primary care**, and **long-term care** – must incorporate indicators into their annual quality improvement plans (QIPs). The Ontario Health Quality Improvement Plan program is described in *Quality Improvement Plan Program Guidance 2024/25*.

Priority Issues

Province-wide priority issues (and associated indicators) for the Ontario health care system were identified by Ontario Health, after consultation with external organizations, the Ministry of Health, and the Ministry of Long-Term Care. Priority issues for 2024/25 are:

- Access and flow
- Equity
- Experience
- Safety

Indicators

Overview

An important change to the QIP program for 2024/25 is a shift to a suite of optional indicators. These indicators provide information relevant to local and systemic issues. For each sector, optional indicators are listed within each priority issue in the matrix (Figure 1). These indicators can be considered as a starting point; organizations may wish to consider including these indicators in their QIP but are not required to do so. This document outlines indicator definitions, calculation methods, reporting periods, and other technical information.

Information on how to incorporate these indicators into your organization's workplan in *QIP Navigator* can found in *Quality Improvement Plan Program Guidance 2024/25* and in the QIP Navigator User Guide.

Figure 1. Indicator matrix (accessible version)

Priority issue	Hospital optional indicators	Interprofessional primary care optional indicators	Long-term care optional indicators
Access and flow	• 90th percentile ambulance offload time • 90th percentile emergency department length of stay • 90th percentile emergency department wait time to inpatient bed • Alternate level of care throughput ratio • Percentage of patients who visited the emergency department and left without being seen by a physician	• Patient/client perception of timely access to care • Number of new patients/clients/enrolments	• Rate of potentially avoidable emergency department visits for long-term care residents
Equity	• Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education • Average emergency department wait time to physician initial assessment for individuals with sickle cell disease (Canadian Triage and Acuity Scale level 1 or 2) • Rate of emergency department 30-day repeat visits for individuals with sickle cell disease • Percentage of emergency department visits for individuals with sickle cell disease triaged with high severity (Canadian Triage and Acuity Scale level 1 or 2)	• Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education • Completion of sociodemographic data collection	• Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education
Experience	• Did patients feel they received adequate information about their health and their care at discharge?	• Do patients/clients feel comfortable and welcome at their primary care office? • Do patients/clients feel involved in decisions about their care?	• Do residents feel they can speak up without fear of consequences? • Do residents feel they have a voice and are listened to by staff?
Safety	• Rate of delirium onset during hospitalization • Rate of medication reconciliation at discharge • Rate of workplace violence incidents resulting in lost time injury	None	• Percentage of long-term care residents not living with psychosis who were given antipsychotic medication • Percentage of long-term care residents who fell in the last 30 days

Indicator Selection

Note for hospitals: Regions may prioritize an indicator(s) within one of the priority issues to encourage hospitals to consider in their QIP. In this case, the indicator will appear as a priority indicator within the workplan. If your organization elects not to include the priority indicator in the QIP, you must describe your reasons for this decision in the Comments section of your workplan.

We strongly encourage the selection of indicators for which your organization is performing poorly in comparison with provincial averages. Review the optional indicators listed for your organization's sector under each priority issue and determine which indicators would be most relevant for your organization to focus on, by comparing your organization's current performance data against provincial data.

Note: Where possible, provincial data for optional indicators will be prepopulated in *QIP Navigator*.

Organizations may also consider adding custom indicators to reflect local quality improvement initiatives, collaborative improvement with other health service providers outside their organization or with their Ontario Health Teams. Existing indicators in use by Ontario Health programs (e.g., Quality Standards) may also be used by organizations as custom indicators.

Indicator Specifications

The following tables outline the dimension and type of measure; technical details such as definition, and calculation method; and other relevant characteristics.

Note: QIP indicators are not risk-adjusted to optimally reflect performance over time within an organization.

Hospital Indicators

Access and Flow

90th percentile ambulance offload time (AOT)

Priority issue: Access and flow
Indicator type: Optional

Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Type	Process measure
Description	Ambulance offload time is the duration (time elapsed) between the time of ambulance arrival at the emergency department and the time the ambulance transfer of care process is complete. Evaluation metric: 90th percentile
Unit of measure	Minutes
Calculation methods	To obtain the 90th percentile ambulance offload time: 1) Calculate the time elapsed between ambulance arrival and completion of the ambulance transfer of care process for applicable cases (i.e., applying data inclusion and exclusion criteria) 2) Sort the cases by ambulance offload time (from shortest to longest). 3) Identify the time by which 90% had completed their ambulance transfer of care process. (If *N* is the total number of cases in the list, and $n = 0.9 \times N$, then the 90th percentile value is the ambulance offload time of the *n*th case in the sorted list.) **Inclusions:** Cases where • *Ambulance Arrival Indicator* = *A* (air), *G* (ground), or *C* (combination), for ED visits **Exclusions:** Cases where • *Registration Date/Time* and *Triage Date and Time* are both missing • The MIS functional centre is not under *General Emergency Department* or *Urgent Care Centre* • The emergency department visit was scheduled (*ED Visit Indicator* = *0*) • *Ambulance Arrival Date/Time* or *Ambulance Transfer of Care Process Date/Time* is missing • Ambulance offload time is negative • Ambulance offload time greater than or equal to 1,440 minutes
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	• For ERNI hospitals: December 1, 2022, to November 30, 2023, in alignment with the P4R program • For non-ERNI hospitals: April 1, 2023, to September 30, 2023 (Q1 and Q2)
Considerations for target-setting	N/A
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator.

Abbreviations: ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; MIS, Management Information System; P4R, Pay for Results.

Comments

Variability in the data may reflect that some hospitals and EMS services have initiated the Fit2Sit program, in which paramedics will transfer the care of individuals who are able to wait in the waiting room to hospital staff, decreasing ambulance offload times.

90th percentile emergency department length of stay (LOS)

Priority issue: Access and flow
Indicator type: Optional

Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Type	Process measure
Description	Emergency department length of stay is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the emergency department. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	For the 90th percentile emergency department length of stay, 1) Calculate the time elapsed between triage or registration (whichever comes first) and departure from the emergency department for each patient visit, applying inclusion and exclusion criteria. 2) Sort the cases by emergency department length of stay (from shortest to longest). 3) Identify the time by which 90% had completed their stay in the emergency department. (If *N* is the total number of cases in the list, and $n = 0.9 \times N$, then the 90th percentile value is the emergency department length of stay of the *n*th case in the sorted list.) **Inclusions:** • Visits to the emergency department for all patients, irrespective of admission status or triage level (CTAS score) **Exclusions:** Cases where • *Registration Date/Time* and *Triage Date/Time* are both missing • The MIS functional centre is not under *General Emergency Department* or *Urgent Care Centre* • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • *Patient Left ED Date/Time* is missing • The patient left without being seen • Emergency department length of stay is greater than or equal to 100,000 minutes (1,666 hours)
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	• For ERNI hospitals: December 1, 2022, to November 30, 2023, in alignment with the P4R program • For non-ERNI hospitals: April 1, 2023, to September 30, 2023 (Q1 and Q2)
Considerations for target-setting	The provincial target for this indicator is a 10% reduction from current performance.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator.

Abbreviations: CTAS, Canadian Triage and Acuity Scale; ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; MIS, Management Information System; P4R, Pay for Results.

Comments

Depending on the acuity of the case or hospital procedures, triage may occur before registration or vice versa. Therefore, the earlier of these 2 events is used as the starting point for calculation of this indicator.

Note: Emergency department length of stay excludes any time spent in a Clinical Decision Unit (CDU).

90th percentile emergency department wait time to inpatient bed

Priority issue: Access and flow
Indicator type: Optional

Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Type	Process measure
Description	Emergency department wait time to inpatient bed is the duration (time elapsed) between the time of visit disposition, as determined by the main service provider, and the time that the patient left the emergency department to be admitted to an inpatient bed or operating room. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	For the 90th percentile emergency department wait time to inpatient bed: 1) Calculate the time elapsed between the *Disposition Date/Time* and the *Date/Time Patient Left ED* for admission to an inpatient bed (or operating room) for each case, applying inclusion and exclusion criteria. 2) Sort the cases by wait time to inpatient bed (from shortest to longest). 3) Identify the time by which 90% had left the emergency department to be admitted to an inpatient bed. (If N is the total number of cases in the list, and $n = 0.9 \times N$, then the 90th percentile value is the wait time to inpatient bed of the nth case in the sorted list.) **Inclusions:** Cases where • The emergency department visit was unscheduled and resulted in an admission • *Disposition Date/Time* and *Date/Time Patient Left ED* are valid **Exclusions:** Cases where • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • The emergency department visit was unscheduled but did not result in an admission • The time of visit disposition is unknown or invalid (*Disposition Date/Time* = 9999) • The time the patient left the emergency department is unknown or invalid (*Date/Time Patient Left ED* = 9999) • *Registration Date/Time* and *Triage Date/Time* are both missing • The MIS functional centre is not under *General Emergency Department* or *Urgent Care Centre* • Emergency department wait time to inpatient bed is greater than or equal to 100,000 minutes (1,666 hours) • Emergency department wait time to inpatient bed is less than 0 (negative)
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	• For ERNI hospitals: December 1, 2022, to November 30, 2023, in alignment with the P4R program • For non-ERNI hospitals: April 1 to September 30, 2023 (Q1 and Q2)
Considerations for target-setting	The 2010 Auditor General Report noted that the Canadian Association of Emergency Physicians and the National Emergency Nurses Affiliation have indicated that patients requiring admission to hospital should not have to wait in the emergency department for more than 6 hours.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator.

Abbreviations: ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; MIS, Management Information System; P4R, Pay for Results.

Comments

This indicator reflects potential bottlenecks in inpatient bed availability and turnover rate. Other contributing factors may include the percentage of alternate level of care patients, the overall patient population, and hospital resources.

There are a number of different locations within the emergency department where patients may be waiting prior to leaving the emergency department for admission into an inpatient bed or operating room. These locations include but are not limited to examination rooms, treatment rooms, observation rooms, waiting rooms, and hallways.

Alternate level of care (ALC) throughput ratio

Priority issue: Access and flow
Indicator type: Optional

Dimension of quality	Efficient
Direction of improvement	Increase (higher is better)
Type	Process measure
Description	The ALC throughput ratio is the number of discharged ALC cases divided by the number of new ALC cases. The ALC throughput ratio reflects the rate at which patients are being discharged versus designated ALC in a given time period. A ratio equal to 1 means the number of ALC cases going out is the same as the number coming in. A ratio greater than 1 is desired (more ALC cases going out than coming in). A ratio less than 1 is the undesired direction (more ALC cases coming in than going out).
Unit of measure	Ratio
Calculation methods	ALC Throughput Ratio = Numerator: Volume of Discharged ALC Cases ÷ Denominator: Volume of Newly Added ALC Cases **Inclusions:** • ALC cases **Exclusions:** ALC cases where • "Data Entry Error" is the reason of discontinuation • The calculated ALC length of stay is 0 days • In postacute care, the inpatient service was the same as the discharge destination
Numerator	Number of ALC hospitalizations that are discharged within the reporting period.
Denominator	Number of new ALC designations, including ALC re-designations, within the reporting period.
Risk adjustment	None
Current performance reporting period	July 1 to September 30, 2023 (Q2)
Considerations for target-setting	Refer to provincial HSAA target for 2024/25.
Data source	Wait Times Information System
How to access data	Indicator data will be prepopulated in QIP Navigator. Hospitals that do not submit data to the Wait Times Information System may be able to identify ALC cases and discharges via their hospital information system.

Abbreviations: ALC, alternate level of care; HSAA, Hospital Service Accountability Agreements.

Percentage of patients who visited the emergency department and left without being seen (LWBS) by a physician

Priority issue: Access and flow
Indicator type: Optional

Dimension	Timely
Direction of improvement	Decrease (lower is better)
Type	Process measure
Description	The percentage of visits to the emergency department that resulted in the patient leaving before being assessed or treated by a physician.
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% **Inclusions:** All cases, irrespective of admission status or triage level (CTAS score). **Exclusions:** Cases where • The MIS functional centre is not under *General Emergency Department* or *Urgent Care Centre* • The emergency department visit was scheduled (*ED Visit Indicator* = 0)

Numerator	Number of emergency department visits where the patient left without being seen by a physician, during the reporting period.
	
	Inclusions:
	Cases where
	• The patient left the emergency department without being seen, with visit disposition codes *61* or *63*:
	  ○ *61*: Left post registration – patient left at their own risk following registration; triage, further assessment by a service provider and treatment did not occur
	  ○ *63*: Left after triage – patient left the emergency department at their own risk following registration and triage; further assessment by a service provider and treatment did not occur
	
	Exclusions:
	Cases where
	• The patient left against medical advice, with visit disposition codes *62* or *64*:
	  ○ *64*: Left after initial assessment
	  ○ *62*: Left after initial treatment

Denominator	Total number of unscheduled emergency department visits during the reporting period.
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2023 (Q1 and Q2)
Considerations for target-setting	N/A
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator.

Abbreviations: CTAS, Canadian Triage and Acuity Scale; ED, emergency department; MIS, Management Information System.

Comments

This indicator does not capture patients who visit the emergency department and leave without any interaction (no registration, triage, assessment, or treatment).

For hospitals that are part of the Emergency Room National Ambulatory Reporting System Initiative (ERNI), site-level data for number of patients who left without being seen are available on a monthly basis in Ontario Health's ED Fiscal Year Report.

Equity

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education

Priority issue: Equity
Indicator type: Optional

Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Type	Process measure
Description	Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education.
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% Number of staff who have completed relevant equity, diversity, inclusion, and/or anti-racism education, divided by the total number of staff members.
Numerator	Number of staff who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period. • If equity, diversity, inclusion, and antiracism education was required of staff and only partially completed, do not count partial completions
Denominator	Total number of staff targeted for equity, diversity, inclusion and antiracism training. • Include staff (workers) who are actively working at the organization at any point within the reporting period.
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	N/A
Data source	Learning software completion metrics
How to access data	Local data collection

Comments

This indicator can reflect a wide variety of equity, diversity, inclusion, and/or antiracism education, such as training courses, online modules, webinars and info sessions.

Organizations are encouraged to report on this indicator for all staff. If data are not available for all staff, the scope can be narrowed to management or executive level for both the numerator and denominator. The selection of the staff population should be reported in QIP Navigator (in the comments section).

Resources

- Change ideas related to Health Equity: available at Quorum
- Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework

Average emergency department wait time to physician initial assessment (PIA) for individuals with sickle cell disease (CTAS 1 or 2)

Priority issue: Equity
Indicator type: Optional

Dimension of quality	Equitable
Direction of improvement	Decrease (lower is better)
Type	Process measure
Description	Emergency department wait time to physician initial assessment is the duration (time elapsed) between triage and physician initial assessment for patients with sickle cell disease who have been triaged CTAS level 1 or 2. Evaluation metric: average
Unit of measure	Minutes
Calculation methods	Numerator / Denominator **Inclusions:** Cases • With ICD-10-CA codes (in *Main* or *Other problem* field) for sickle cell disease: D570, D571, D572, D578 • With the patient triaged CTAS level 1 (resuscitation) or 2 (emergent) **Exclusions:** Cases where • *Registration Date/Time* and *Triage Date/Time* are both missing • The MIS functional centre is not under *General Emergency Department* or *Urgent Care Centre* • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • Time of initial assessment by physician is unknown (*Physician Initial Assessment Date/Time* = 9999) or patient left without being seen • Time to physician initial assessment is greater than or equal to 100,000 minutes (1,666 hours)
Numerator	Sum of the number of minutes that patients with sickle cell disease triaged CTAS 1 or 2 have waited for a physician initial assessment.
Denominator	Total number of emergency department visits for patients with sickle cell disease triaged CTAS 1 or 2.
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2023 (Q1 and Q2)
Considerations for target-setting	The target time to physician initial assessment by CTAS level has been defined by the Canadian Association of Emergency Physicians, as follows: • For CTAS level 1 – immediate (e.g., within 5 minutes) • For CTAS level 2 – within 15 minutes • For CTAS level 3 – within 30 minutes • For CTAS level 4 – within 60 minutes • For CTAS level 5 – within 120 minutes
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator for hospitals with large enough volumes of emergency department visits for patients with sickle cell disease.

Abbreviations: CTAS, Canadian Triage and Acuity Scale; ED, emergency department; ICD-10-CA, International Statistical Classification of Diseases and Related Health Problems Tenth Revision Canada; MIS, Management Information System.

Comments

Similar indicators are also available through the eReport dashboard for the Sickle Cell Disease Quality Standard**.**

Resources

For additional information on sickle cell disease and equity considerations, see the Sickle Cell Disease Quality Standard and Ontario Health's Black Health Plan.

Rate of emergency department 30-day repeat visits for individuals with sickle cell disease

Priority issue: Equity
Indicator type: Optional

Dimension of quality	Equitable
Direction of improvement	Decrease (lower is better)
Type	Process measure
Description	Percentage of patients with sickle cell disease who make at least 1 unscheduled repeat visit to the emergency department within 30 days of a previous unscheduled visit to an emergency department. This indicator is presented as a proportion of all sickle cell disease emergency visits.
Unit of measure	Percentage
Calculation methods	For rate of emergency department 30-day repeat visits for individuals with sickle cell disease 1) Determine the denominator (i.e., total number of emergency department visits for sickle cell disease) 2) Determine the numerator, by identifying the repeat visits within 30 days 3) Calculate the percentage of these repeat visits out of the total emergency department visits: Numerator / Denominator × 100% **Inclusions:** • For index visit and repeat visit, ICD-10-CA codes (in main or other problem field) for sickle cell disease: D570, D571, D572, D578 • A visit is counted as a repeat visit if it is for sickle cell disease and occurs within 30 days of an index visit (i.e., first visit) for sickle cell disease. **Exclusions:** • The emergency department visit was scheduled (*ED Visit Indicator* = 0)
Numerator	Number of repeat visits (i.e., unscheduled emergency department visits for sickle cell disease within 30 days of a previous emergency department visit for sickle cell disease)
Denominator	Total number of unscheduled emergency department visits for sickle cell disease
Risk adjustment	None
Current performance reporting period	Index visits from April 1 to September 30, 2023 (Q1 and Q2).
Considerations for target-setting	N/A
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator for hospitals with large enough volumes of emergency department visits for patients with sickle cell disease.

Abbreviations: CTAS, Canadian Triage and Acuity Scale; ED, emergency department; ICD-10-CA, International Statistical Classification of Diseases and Related Health Problems Tenth Revision Canada.

Comments

Similar indicators are also available through the eReport dashboard for the Sickle Cell Disease Quality Standard.

For additional information on sickle cell disease and equity considerations, see the Sickle Cell Disease Quality Standard and Ontario Health's Black Health Plan.

Percentage of emergency department visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2)

Priority issue: Equity
Indicator type: Optional

Dimension of quality	Equitable
Direction of improvement	Nondirectional (i.e., improvement in this indicator can be an increase or decrease depending on organizational goals): • An increase could reflect emergency departments triaging sickle cell disease more appropriately over time to reflect the seriousness of the condition. • A decrease could be evidence of individuals with sickle cell disease receiving better overall treatment and a genuine reduction in the number of patients experiencing severe symptoms from sickle cell disease.
Type	Process measure
Description	Percentage of unscheduled emergency department visits for sickle cell disease that are triaged as high severity (CTAS 1 or 2) This indicator is presented as a proportion of all sickle cell disease emergency department visits.
Unit of measure	Percentage
Calculation methods	For percentage of emergency department visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2), 1) Determine the denominator (i.e., the total number of emergency department visits for sickle cell disease) 2) Determine the numerator, by identifying the visits with CTAS level 1 or 2 3) Calculate the percentage with CTAS level 1 or 2 visits out of the total emergency department visits for sickle cell disease: Numerator / Denominator × 100% **Inclusions:** • ICD-10-CA codes (in *Main* or *Other problem* field) for sickle cell disease: D570, D571, D572, D578 **Exclusions:** • The emergency department visit was scheduled (*ED Visit Indicator* = 0)
Numerator	Number of unscheduled emergency department visits for sickle cell disease that are triaged as high severity (CTAS 1 or 2) **Inclusions:** • Triaged as CTAS level 1 (resuscitation) or 2 (emergent)
Denominator	Total number of unscheduled emergency department visits for sickle cell disease
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2023 (Q1 and Q2)
Considerations for target-setting	N/A
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator for hospitals with large enough volumes of emergency department visits for patients with sickle cell disease.

Abbreviations: CTAS, Canadian Triage and Acuity Scale; ED, emergency department; ICD-10-CA, International Statistical Classification of Diseases and Related Health Problems Tenth Revision Canada.

Comments

Similar indicators are also available through the eReport dashboard for the Sickle Cell Disease Quality Standard.

Resources

For additional information on sickle cell disease and equity considerations, see the Sickle Cell Disease Quality Standard and Ontario Health's Black Health Plan.

Experience

Did patients feel they received adequate information about their health and their care at discharge?

Priority issue: Experience
Indicator type: Optional

Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
Type	Outcome measure
Description	Percentage of respondents who responded “Completely” to the following question: “Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?”
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% From the Canadian Institute of Health Information Canadian Patient Experiences Survey—Inpatient Care: Question 38: *Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?* – *Completely* – *Quite a bit* – *Partly* – *Not at all* For patient experience questions, a top-box method is used, counting only respondents who choose the only the most positive response.
Numerator	Number of respondents who responded “Completely”
Denominator	Number of respondents who registered any response to this question (do not include nonrespondents)
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	N/A
Data source	Local data collection
How to access data	These data should be accessed from within your own organization

Comments

Hospitals can leverage the Canadian Patient Experiences Survey—Inpatient Care (CPES—IC) survey questions to self-report this indicator in their 2024/25 QIPs.

This indicator has previously been referred to as "Did you receive enough information when you left the hospital?"

Safety

Rate of delirium onset during hospitalization

Priority issue: Safety
Indicator type: Optional

Dimension of quality	Safety
Direction of improvement	Nondirectional, at this time. While lower rates of delirium are better, if your organization is focusing on increasing the identification and reporting of delirium, your direction of improvement may be an increase in the rate of delirium onset during hospitalization.
Type	Outcome measure
Description	Rate of hospital-acquired delirium among inpatient hospitalizations in acute care. This indicator is presented as a proportion of all hospitalizations.
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100%
Numerator	Number of hospitalizations in the denominator with the onset of delirium during that hospitalization (i.e., hospital-acquired delirium). Note that if a patient has hospital-acquired delirium in multiple different hospitalizations, all of those instances will be counted in the numerator. **Inclusions:** • ICD-10-CA codes F05.x for delirium not induced by alcohol and other psychoactive substances: F05.0, F05.1, F05.2, F05.8, F05.9 • Type 2 diagnosis code: postadmit comorbidity
Denominator	Total number of unique hospitalizations in acute care. Note that if a patient has multiple hospitalizations, all of those will be counted in the denominator. **Exclusions:** • Hospitalizations for newborns (*admit category* = N), stillbirths (*admit category* = S), and cadaveric donors (*admit category* = R)
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2023 (Q1 and Q2)
Considerations for target-setting	N/A
Data source	Discharge Abstract Database
How to access data	Indicator data will be prepopulated in QIP Navigator.

Abbreviations: ICD-10-CA, International Statistical Classification of Diseases and Related Health Problems Tenth Revision Canada.

Comments

The ability to accurately identify delirium is critical to initiate optimal health care. Previous evidence suggests that delirium is often unrecognized and misdiagnosed as another disorder or misattributed to dementia.[1] Although the F05.*x* set of diagnostic codes have a high positive predictive value in identifying delirium, the sensitivity is low, resulting in underreporting of delirium.

Health care providers should aim for increased detection and reporting of delirium. An enabler of this is to identify risk factors for delirium such as age 65 years or older, cognitive impairment and/or dementia, current hip fracture, severe illness, and previous delirium.

To apply a more sensitive case definition, possible delirium cases can be captured using the F05.*x* codes along with proxy codes, such as R41.0 (Disorientation) and R41.8*x* (Other and unspecified symptoms and signs involving cognitive functions and awareness). These proxy codes may account for some patients who should have received a delirium diagnosis but do not have the term "delirium" documented in their chart or discharge summary; however, this method is less specific since some cases with R41.0 and R41.8x codes may not have been true delirium.

The etiology of delirium is multifactorial and frequently reflects the consequence of a combination of acute illness and medical complications. Using hospitalizations as the unit of analysis enables further investigation of patients with multiple instances of hospital-acquired delirium in different hospitalizations. If each unique patient was to be used for the unit of analysis, the same patient would only be captured once.

Reference

1. Pendlebury ST, Lovett NG, Thomson RJ, Smith SC. Impact of a system-wide multicomponent intervention on administrative diagnostic coding for delirium and other cognitive frailty syndromes: observational prospective study. *Clin Med (Lond)*. 2020;20(5):454-464.

Rate of medication reconciliation at discharge

Priority issue: Safety
Indicator type: Optional

Dimension of quality	Safety
Direction of improvement	Increase (higher is better)
Type	Outcome measure
Description	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created out of the total number of patients discharged.
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% To ensure a standardized approach to measurement, hospitals will be asked to provide the numerator and denominator in their QIP workplan; QIP Navigator will calculate the rate
Numerator	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created. **Exclusions:** • Hospital discharge that is death, newborn, or stillborn. Note: Any additional exclusions should be documented in the comments section in QIP Navigator.
Denominator	Number of patients discharged from hospital. **Exclusions:** • Hospital discharge that is death, newborn, or stillborn. Note: Any additional exclusions should be documented in the comments section in QIP Navigator. Note: Hospitals will be asked to input the total number of hospital discharges within the reporting period into QIP Navigator
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	N/A
Data source	Local data collection
How to access data	These data should be accessed from within your own organization.

Comments

Organizations should report current performance and set targets for medication reconciliation at discharge at the organization level (i.e., for the entire hospital). Hospitals will be required to input the total number of hospital discharges during the reporting period in the data section for indicator current performance in QIP Navigator. Hospitals are also asked to identify any programs or patients that are not included in their medication reconciliation calculation.

For resources to support monitoring your ongoing medication reconciliation processes, visit the Measures: Medication Reconciliation page on Healthcare Excellence Canada's website (formerly the Canadian Patient Safety Institute).

A checklist on the Steps for Creating the Best Possible Medication Discharge Plan is available from the Institute for Safe Medication Practices Canada.

Rate of workplace violence incidents resulting in lost time injury

Priority issue: Safety
Indicator type: Optional

Dimension of quality	Safety
Direction of improvement	Decrease (lower rates are better); however, if your organization is focused on building your reporting culture, your QIP target for this indicator may be to increase reporting. If your organization's reporting culture is already well-developed, your QIP target may be to decrease the number of incidents taking place.
Type	Outcome measure
Description	Rate of reported workplace violence incidents by hospital workers that resulted in a lost time injury within a 12-month period. For quality improvement purposes, hospitals are asked to collect data on the number of violent incidents reported by workers that result in a lost time injury, including physicians and those who are contracted by other employers (e.g., food services, security) as defined by the *Occupational Health and Safety Act.*
Unit of measure	Percentage
Calculation methods	Number of workplace violence incidents that result in a lost time reported by hospital workers per 100 full-time equivalent workers within a 12-month period, with "worker" and "workplace violence" as defined in the *Occupational Health and Safety Act.* Numerator / Denominator × 100%
Numerator	Number of workplace violence incidents that result in a lost time injury reported by hospital workers **Exclusions:** • Fatalities
Denominator	Total number of hospital employee full time equivalent workers (FTEs)
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	N/A
Data source	Local data collection; the number of reported workplace violence incidents resulting in a lost time injury is available via your organization's internal reporting mechanisms
How to access data	Hospitals are encouraged to use their in-house hospital incident and patient safety reporting systems for determining the number of reported workplace violence incidents resulting in a lost time injury

Comments

Worker means any of the following: a person who performs work or supplies services for monetary compensation; a secondary school student who performs work or supplies services for no monetary compensation under a work experience program authorized by the school board that operates the school in which the student is enrolled; a person who performs work or supplies services for no monetary compensation under a program approved by a college of applied arts and technology, university, or other postsecondary institution; a person who receives training from an employer, but who, under the Employment Standards Act, 2000, is not an employee for the purposes of that Act because the conditions set out in subsection 1 (2) of that Act have been met; such other persons as may be prescribed who perform work or supply services to an employer for no monetary compensation.

Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person (e.g. a patient, visitor or other staff member) against a worker, in a workplace, that causes or could cause physical injury to the worker. It also includes an attempt to exercise physical force against a worker in a

workplace that could cause physical injury to the worker or a statement or behaviour that a worker could reasonably interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

Workplace violence incidents resulting in a lost time injury include situations where the worker is off work past the day of the incident, or has loss of wages/earnings, or a permanent disability/impairment.

If the count of incidents is ≤ 5 and > 0, the value requires suppression.

Additional Resources

Preventing Workplace Violence in the Health Care Sector Report

Ministry of Labour Workplace Violence and Harassment Key Terms and Concepts

Public Service Health and Safety

Interprofessional Primary Care Indicators

For all interprofessional primary care indicators, indicator language describing the patient/client, the provider/clinician, or other aspects of the indicator has been chosen to be inclusive of different models of care. Organizations are encouraged to use the indicators listed below rather than adapting them into custom indicators, even if the terms used to describe those concepts are slightly different.

Access and Flow

Patient/client perception of timely access to care

Priority issue: Access and flow
Indicator type: Optional

Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Type	Outcome measure
Description	Percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted.
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% Organizations are expected to measure progress on this indicator using the following wording for the survey question as in the Primary Care Patient Experience Survey (PCPES) *Q6 "The last time you were sick or were concerned you had a health problem, did you get an appointment on the date you wanted?* – *a. Yes* – *b. No*
Numerator	Number of patients/clients who responded "Yes" to the survey question, indicating that the last time they were sick or were concerned they had a health problem, they got an appointment on the date they wanted.
Denominator	Total number of patients/clients who responded to the survey question. **Exclusions:** • Nonrespondents
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	The target corridor set by the Alliance for Healthier Communities is 85% to 100%.
Data source	Patient/client experience survey, such as the Primary Care Patient Experiences Survey (PCPES)
How to access data	Local data collection.

Comments

This indicator can be used in all interprofessional primary care settings and was based on Alliance for Healthier Communities Common Indicators.

Use of the Primary Care Patient Experience Survey is encouraged. The survey was developed by Ontario Health (Health Quality Ontario) in collaboration with Association of Family Health Teams of Ontario, Alliance for Healthy Communities, the Ontario College of Family Physicians, and the Ontario Medical Association. The

survey is designed to be administered by practices and can be rolled up to the organizational level to support their quality improvement efforts.

A comprehensive Survey Support Guide and an alternative version of the survey for community health centres and Aboriginal Health Access Centres are also available

A similar indicator, on same or next-day access to a primary care provider, is available in the Ministry of Health's Health Care Experience Survey.

Number of new patients/clients/enrolments

Priority issue: Access and flow
Indicator type: Optional

Dimension of quality	Efficient
Direction of improvement	Increase (higher is better)
Type	Process measure
Description	Number of net new patients/clients attached or enrolled to a primary care physician or nurse practitioner within the primary care organization or community health centre within the last 12 months. This indicator takes into account patients/clients/enrolments that have been newly added to the primary care organization or community health centre, as well as those who have left.
Unit of measure	Number of patients
Calculation methods	For net number of new patients/clients/enrolments, 4) Count the number of patients/clients newly attached or enrolled within the last 12 months 5) Subtract the patients/clients who have left the primary care organization or community health centre (e.g., passed away, unenrolled).
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	N/A
Data source	These data should be accessed from within your own organization, from the information management system or electronic medical record system
How to access data	Local data collection

Comments

Information on identifying the number of new clients for Alliance for Healthier Communities community health centres can be found on page 25 of the Alliance for Healthier Communities panel size handbook.

Equity

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education

Priority issue: Equity
Indicator type: Optional

Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Type	Process measure
Description	Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education.
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% Number of staff who have completed relevant equity, diversity, inclusion, and/or antiracism education, divided by the total number of staff members.
Numerator	Number of staff who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period. • If equity, diversity, inclusion, and antiracism education was required of staff and only partially completed, do not count partial completions
Denominator	Total number of staff targeted for equity, diversity, inclusion and antiracism training. • Include staff (workers) who are actively working at the organization at any point within the reporting period.
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	N/A
Data source	Learning software completion metrics
How to access data	Local data collection

Comments

This indicator can reflect a wide variety of equity, diversity, inclusion, and/or antiracism education, such as training courses, online modules, webinars and info sessions.

Organizations are encouraged to report on this indicator for all staff. If data are not available for all staff, the scope can be narrowed to management or executive level for both the numerator and denominator. The selection of the staff population should be reported in QIP Navigator (in the comments section).

Resources

- Change ideas related to Health Equity: available on Quorum
- Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework

Completion of sociodemographic data collection

Priority issue: Equity
Indicator type: Optional

Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Type	Process measure
Description	Percentage of patients/clients who responded to at least 1 of the 4 specified sociodemographic questions among clients who had an individual encounter with the primary care organization within the most recent consecutive 12-month period
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100%
Numerator	Number of patients/clients age 13 years and older who had an individual encounter with the primary care organization within the most recent 1-year period and who responded to at least 1 of the following 4 sociodemographic data questions: racial/ethnic group, disability, gender identity, or sexual orientation. **Inclusions:** Patients/clients who • Provided their sociodemographic information • Indicated they did not know or did not want to answer (i.e., responded "Do not know" or "Prefer not to answer")
Denominator	Total number of patients/clients age 13 years and older who had an individual encounter with the primary care organization within the most recent 1-year period. **Exclusions:** • Group patients/clients (e.g., not an individual patient/client visit) • Patients/clients younger than 13 years • Patients/clients who had unregistered encounters (e.g., nonrostered clients) • Anonymous patients/clients • Patients/clients who did not have an encounter with the primary care organization in the past year
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	The target corridor set by the Alliance for Healthier Communities is 65% to 100%.
Data source	These data should be accessed from within your own organization, from the information management system or electronic medical record system.
How to access data	Local data collection.

Comments

This indicator can be used for all interprofessional primary care settings and was based on the Alliance for Healthier Communities Common Indicators.

In partnership with The Association of Family Health Teams of Ontario, family health teams (FHTs) are encouraged to use the Health Equity Questionnaire, developed by East Wellington FHT, for this indicator but are not precluded from using an alternative survey option. While developed for FHTs, this survey can be applied to all primary care models.

Collecting sociodemographic data can allow primary care organizations to better understand the populations they serve and how health care access and utilization differ across various equity-deserving groups. This indicator is a measure of progress on the collection of equity data. Low participation rates may indicate challenges clients experience in responding to the questions or challenges primary care organizations experience in collecting the data. Strategies can be identified to improve participation. Sociodemographic questions should be voluntary so that a patient/client can refuse to respond to some or all of the questions. Patients/clients should be asked these questions at the first encounter, and then every 3 years to determine if there have been any changes.

Experience

Do patients/clients feel comfortable and welcome at their primary care office?

Priority issue: Experience
Indicator type: Optional

Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
Type	Outcome measure
Description	Percentage of patients/clients who report feeling comfortable and welcome at the primary care office
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100%
Numerator	Number of patients/clients who responded "Yes" to the suggested survey question below (indicating that they feel comfortable and welcome at the community health centre or primary care office): *I always feel comfortable and welcome at [centre/office name]?* – *a. Yes* – *b. No*
Denominator	Total number of patients/clients who responded to the survey question.
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	The target corridor set by the Alliance for Healthier Communities is 90% to 100%.
Data source	These data should be accessed from within your own organization, using a patient/client experience survey.
How to access data	Local data collection

Comments

This indicator can be used in all interprofessional primary care settings and was based on Alliance for Healthier Communities Common Indicators.

The data collected for this indicator can be compared with national data collected through the Canadian Community Health Survey and the Canadian Index of Wellbeing.

Do patients/clients feel involved in decisions about their care?

Priority issue: Experience
Indicator type: Optional

Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
Type	Outcome measure
Description	Percentage of patients/clients who report they were always or often involved in their care decisions when they saw their primary care provider.
Unit of measure	Percentage
Calculation methods	Numerator / denominator × 100% Organizations are expected to measure progress on this indicator using the wording of the following survey question as in the Primary Care Patient Experience Survey: *Q7. When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment?* Using the scale always, often, sometimes, rarely, never, not applicable (don't know/refused) To calculate the indicator result, add the number of respondents who responded "Always" and "Often" and divide by the number of respondents who registered an answer for this question. Do not include non-respondents or respondents who answered "Not applicable (don't know/refused)"
Numerator	• Number of respondents who responded "Always" or "Often" to this question.
Denominator	Number of respondents who registered a response to this question. **Exclusions:** • Nonrespondents • Respondents who answered "Not applicable (don't know/refused)"
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	The target corridor set by the Alliance for Healthier Communities is 90% to 100%.
Data source	These data should be accessed from within your own organization, using a patient/client experience survey.
How to access data	Local data collection.

Comments

This indicator can be used in all interprofessional primary care settings and was based on Alliance for Healthier Communities Common Indicators.

Use of the Primary Care Patient Experience Survey is encouraged. The survey was developed by Ontario Health (Health Quality Ontario) in collaboration with Association of Family Health Teams of Ontario, Alliance for Healthy Communities, the Ontario College of Family Physicians, and the Ontario Medical Association. The survey is designed to be administered by practices and can be rolled up to the organizational level to support their quality improvement efforts.

A comprehensive Survey Support Guide and an alternative version of the survey for community health centres and Aboriginal Health Access Centres are also available.

Organizations will be asked to provide the total number of respondents who registered an answer to each survey response scale to QIP Navigator if this indicator is selected.

A similar indicator is available in the Ministry of Health's Health Care Experience Survey (HCES).

Long-Term Care Indicators

Access and Flow

Rate of potentially avoidable emergency department visits for long-term care residents

Priority issue: Access and flow
Indicator type: Optional

Dimension of quality	Efficient
Direction of improvement	Decrease (lower is better)
Type	Process measure
Description	Number of emergency department visits for a modified list of ambulatory care–sensitive conditions* per 100 long-term care residents
Unit of measure	Rate per 100 residents
Calculation methods	Numerator / Denominator × 100 The number of unscheduled emergency department visits made by long-term care home residents for the selected conditions divided by the population of active long-term care home residents.
Numerator	Total unscheduled emergency department visits for a modified list of ambulatory care–sensitive conditions*, which includes transfers between emergency departments and emergency department visits that resulted in admission or death for all active long-term care home residents in Ontario. **Exclusions:** • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • Visits for residents who were first admitted to the long-term care home before the age of 65 years
Denominator	Total number of active residents of long-term care homes. **Exclusions:** • Individuals with invalid health card numbers. • Residents who were first admitted to the long-term care home before the age of 65 years
Risk adjustment	None
Current performance reporting period	• October 1, 2022, to September 30, 2023 (Q3 to the end of the following Q2)
Considerations for target-setting	N/A
Data source	Continuing Care Reporting System and National Ambulatory Care Reporting System data provided by the Health Analytics and Insights Branch with the Ministry of Health (MOH) and the Ministry of Long-Term Care (MLTC).
How to access data	Indicator data will be prepopulated in QIP Navigator. Quarterly data for this indicator are available from the Ministry via LTCHomes.net

*Modified ambulatory care–sensitive conditions presenting to emergency departments that are potentially preventable are as follows: angina, asthma, cellulitis, chronic obstructive pulmonary disease, congestive heart failure, septicemia, dehydration, dental conditions, diabetes, gastroenteritis, grand mal and seizure disorders, hypertension, hypoglycemia, injuries from falls, mental health and behavioural disorders, pneumonia, severe ear, nose, and throat disorders.

Comments

Quality improvement guidance related to this indicator is available on Ontario Health's website.

Additional guidance is available here: INTERACT (Interventions to Reduce Acute Care Transfers) program.

Equity

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education

Priority issue: Equity
Indicator type: Optional

Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Type	Process measure
Description	Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education.
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% Number of staff who have completed relevant equity, diversity, inclusion, and/or antiracism education, divided by the total number of staff members.
Numerator	Number of staff who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period. • If equity, diversity, inclusion, and antiracism education was required of staff and only partially completed, do not count partial completions
Denominator	Total number of staff targeted for equity, diversity, inclusion and antiracism training. • Include staff (workers) who are actively working at the organization at any point within the reporting period.
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	N/A
Data source	Learning software completion metrics
How to access data	Local data collection

Comments

This indicator can reflect a wide variety of equity, diversity, inclusion, and/or antiracism education, such as training courses, online modules, webinars and info sessions.

Organizations are encouraged to report on this indicator for all staff. If data are not available for all staff, the scope can be narrowed to management or executive level for both the numerator and denominator. The selection of the staff population should be reported in QIP Navigator (in the comments section).

Resources

- Change ideas related to Health Equity: available at Quorum
- Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework

Experience

Do residents feel they can speak up without fear of consequences?

Priority issue: Experience
Indicator type: Optional

Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
Type	Outcome measure
Description	Percentage of residents who responded positively to the following statement: "I can express my opinion without fear of consequences."
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% Homes using the interRAI Quality of Life Survey should measure this domain by calculating the percentage of residents who responded positively to statement: *F3. I can express my opinion without fear of consequences.* – *0 = Never* – *1 = Rarely* – *2 = Sometimes* – *3 = Most of the time* – *4 = Always* – *6 = Don't know* – *7 = Refused* – *8 = No response or cannot be coded from response*
Numerator	Number of respondents who responded with *3* or *4* to the statement
Denominator	Total number who registered any response to the statement (responses from *0* to *8*), which includes nonrespondents (*6*, *7*, *8*)
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	N/A
Data source	These data should be accessed from within your own organization, using the interRAI Quality of Life Survey.
How to access data	Local data collection

Abbreviations: interRAI, International Resident Assessment Instrument.

Comments

For more information about the interRAI Quality of Life Survey, refer to the interRAI's website.

This indicator has also been referred to as "Being able to speak up about the home."

Do residents feel they have a voice and are listened to by staff?

Priority issue: Experience
Indicator type: Optional

Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
Type	Outcome measure
Description	The percentage of residents who responded positively (a response of 9 or 10) to the question: "What number would you use to rate how well the staff listen to you?"
Unit of measurement	Percentage
Calculation methods	Numerator / denominator × 100% Homes using the NHCAHPS Long-Stay Resident Survey should measure this domain by calculating the percentage of residents who responded positively to the question: *What number would you use to rate how well the staff listen to you?* Responses are coded from 0 to 10, where 0 = worst possible and 10 = best possible
Numerator	For homes using the NHCAHPS Long-Stay Resident Survey, the number of respondents who responded with a 9 or 10 to the question.
Denominator	For homes using the NHCAHPS Long-Stay Resident Survey, total number of residents who registered any response to the question. **Exclusions:** • Nonrespondents
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	N/A
Data source	Local data collection, with a tool such as the NHCAHPS Long-Stay Resident Survey.
How to access data	These data should be accessed from within your own organization.

Abbreviations: NHCAHPS, Nursing Home Consumer Assessment of Healthcare Providers and Systems.

Comments

For more information about the NHCAHPS Long-Stay Resident Survey, refer to the Agency for Healthcare Research and Quality's website.

This indicator has also been referred to as "Having a voice."

Safety

Percentage of long-term care residents not living with psychosis who were given antipsychotic medication

Priority issue: Safety
Indicator type: Optional

Dimension of quality	Safety
Direction of improvement	Decrease (lower is better)
Type	Process measure
Description	Percentage of long-term care home residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% Both the numerator and denominator are calculated using 4 rolling quarters of data for the target quarter and the 3 previous quarters.
Numerator	Number of long-term care home residents who received antipsychotic medication on 1 or more days in the week before their RAI-MDS target assessment. **Inclusions:** RAI-MDS *O4a* = 1, 2, 3, 4, 5, 6, or 7 *O4a* is the number of days the resident received an antipsychotic medication during the last 7 days (0–7)
Denominator	Number of long-term care home residents with a valid RAI-MDS assessment, excluding those with schizophrenia, Huntington chorea, hallucinations, or delusions, as well as residents who have end-stage disease or are receiving hospice care **Exclusions:** Residents who have end-stage disease (*J5c* = 1) or are receiving hospice care (*P1ao* = 1) Residents who have a diagnosis of schizophrenia (*I1ii* = 1) or Huntington's chorea (*I1x* = 1), or those experiencing hallucinations (*J1i* = 1) or delusions (*J1e* = 1)
Risk adjustment	None. Unadjusted for QIP
Current performance reporting period	July 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average
Considerations for target-setting	N/A
Data source	Continuing Care Reporting System (CCRS). Data are provided by the Canadian Institute for Health Information (CIHI) via CCRS eReports.
How to access data	Indicator data will be prepopulated in QIP Navigator. To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at the Canadian Institute for Health Information website (www.cihi.ca)

Abbreviations: CCRS, Continuing Care Reporting System; RAI-MDS, Resident Assessment Instrument—Minimum Data Set 2.0.

Comments

The indicator is calculated as a rolling 4-quarter average by CIHI. Q2 2023/24 is calculated based on data from quarter 3 in the 2022/23 fiscal year up to (and including) quarter 2 in the 2023/24 fiscal year. Thus, Q2 indicator data represents data from Q2, as well as those from the 3 preceding quarters.

For an assessment to be valid and included in the quality indicator calculation, the selected assessment must be the latest assessment in the quarter, be carried out more than 92 days after the admission date, not be an Admission Full Assessment.

This indicator is consistent with that reported by Ontario Health's LTC Public Reporting website; however, the LTC Public Reporting website publicly reports adjusted rates. For the purposes of quality improvement planning, unadjusted rates (i.e., not risk-adjusted) should be used.

Ontario Health develops confidential practice reports for physicians who practice in long-term care facilities and includes indicators related to the prescribing of antipsychotic medications. These reports are intended to complement other sources of information physicians receive (e.g., pharmacy reports). For more information, please visit MyPracticeLong-TermCare.

Percentage of long-term care residents who fell in the last 30 days

Priority issue: Safety
Indicator type: Optional

Dimension of quality	Safety
Direction of improvement	Decrease (lower is better)
Type	Outcome measure
Description	Percentage of long-term care home residents who fell in the 30 days leading up to their assessment.
Unit of measure	Percentage
Calculation methods	Numerator / Denominator × 100% Both the numerator and denominator are calculated using 4 rolling quarters of data for the target quarter and the 3 previous quarters.
Numerator	Number of long-term care home residents who fell in the 30 days leading up to the date of their quarterly clinical assessment. **Inclusions:** RAI-MDS *J4a* = 1 *J4a* indicates the resident fell in past 30 days.
Denominator	Number of long-term care home residents with a valid RAI-MDS assessment.
Risk adjustment	None. Unadjusted for QIP
Current performance: reporting period	July 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average
Considerations for target-setting	N/A
Data source	Continuing Care Reporting System (CCRS). Data are provided by the Canadian Institute for Health Information (CIHI) via CCRS eReports
How to access data	Indicator data will be prepopulated in QIP Navigator. To access your organization's unadjusted rates for this indicator, refer to your organization's CCRS eReports at the Canadian Institute for Health Information website (www.cihi.ca)

Abbreviations: CCRS, Continuing Care Reporting System; RAI-MDS, Resident Assessment Instrument—Minimum Data Set 2.0.

Comments

The indicator is calculated as a rolling 4-quarter average by CIHI. Q2 2023/24 is calculated based on data from quarter 3 in the 2022/23 fiscal year up to (and including) quarter 2 in the 2023/24 fiscal year. Thus, Q2 indicator data represents data from Q2, as well as those from the 3 preceding quarters.

For an assessment to be valid and included in the quality indicator calculation, the selected assessment must be the latest assessment in the quarter, be carried out more than 92 days after the admission date, not be an Admission Full Assessment.

This indicator is consistent with that reported by Ontario Health's LTC Public Reporting website; however, the LTC Public Reporting website publicly reports adjusted rates. For the purposes of quality improvement planning, unadjusted rates (i.e., not risk-adjusted) should be used.

Ontario Health develops confidential practice reports for physicians who practice in long-term care facilities and includes indicators related to falls. These reports are intended to complement other sources of information physicians receive. For more information, please visit MyPracticeLong-TermCare

Additional Resources

Support and resource materials are available to help organizations consider their approach to quality and can be found on the Resource page of Navigator and on Quorum. The QIP team at Ontario Health can help you with any queries and can be reached at QIP@ontariohealth.ca.

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