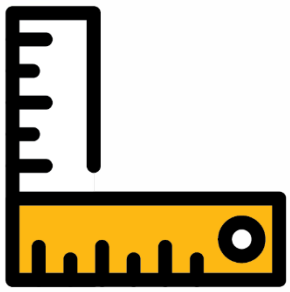

QUALITY IMPROVEMENT PLAN PROGRAM

Indicator Technical Specifications

2025/26

NOVEMBER 2024

Ontario Health

Table of Contents

Purpose of This Document

This document outlines Quality Improvement Plan (QIP) program priority issues and associated indicators, by providing definitions, calculation methods, reporting periods, and other technical information.

This document accompanies *Quality Improvement Plan Program Guidance Document 2025/26*, which describes the Ontario Health QIP program.

Introduction

Every health care organization must prioritize quality improvement to achieve local and system-wide change in Ontario health care. To evaluate quality and support quality improvement, organizations in every sector – **hospital**, **interprofessional primary care**, and **long-term care** – must incorporate indicators into their annual quality improvement plans (QIPs).

Priority Issues

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

Priority issues for 2025/26 are:

- **Access and flow:** A high-quality health system provides people with the care they need, when and where they need it.
- **Equity:** Advancing equity, inclusion and diversity and addressing racism to reduce disparities in outcomes for patients, families, and providers is the foundation of a high-quality health system.
- **Experience:** Better experiences result in better outcomes. Tracking and understanding experience is an important element of quality.
- **Safety:** A high-quality health system ensures people receive care in a way that is safe and effective.

Indicators

Priority and optional indicators are listed by priority issue in the matrix (Table 1) for each sector, and details for each indicator are specified in the subsequent tables. These indicators can be considered as a starting point and are defined in QIP Navigator for selection in the workplan; organizations may wish to consider including these indicators in their QIP but are not required to do so. Indicators that would be the most relevant to focus on can be determined by comparing the organization's current performance to that of the province (i.e., organizations are strongly encouraged to select indicators for which they are performing poorly in comparison with provincial averages).

General Notes for Indicators

Risk adjustment

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

Considerations for target-setting

- Considerations for target-setting are included for some indicators. Additional information on target-setting can be found in the QIP Target Setting Guide.

How to access data

- Where possible, organization-level data for optional indicators will be prepopulated in QIP Navigator.

Table 1. Indicator matrix.

Priority issue	Optional indicators (unless marked priority), by sector		
	Hospital	Interprofessional primary care	Long-term care
Access and flow	• 90th percentile ambulance offload time (Priority) • 90th percentile emergency department wait time to physician initial assessment (Priority) • Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. (Priority) • 90th percentile emergency department length of stay for admitted patients • 90th percentile emergency department length of stay for nonadmitted patients with low acuity • 90th percentile emergency department length of stay for nonadmitted patients with high acuity • 90th percentile emergency department wait time to inpatient bed • 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 • Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring • Percentage of screen-eligible people who are up to date with colorectal tests • Percentage of screen-eligible people who are up to date with cervical screening • Percentage of screen-eligible people who are up to date with breast screening	• 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 (CTAS 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 (CTAS 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 clients actively receiving mental health care from a traditional provider • Number of events and participants for traditional teaching, healing, or ceremony	• 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 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	• Number of faxes sent per 1,000 rostered patients • **Provincial digital solutions suite (6 indicators):** Percentage of clinicians in the primary care practice using… [eReferral, eConsult, OLIS, HRM, electronic prescribing, online appointment booking]	• 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

Abbreviations: CTAS, Canadian Triage and Acuity Scale; HRM, Health Report Manager; OLIS, Ontario Laboratory Information System.

Hospital

Access and Flow

90th percentile ambulance offload time

Abbreviated name	90th percentile AOT
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
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 *ambulance offload time* as the time elapsed between ambulance arrival (*Ambulance Arrival Date/Time*) and completion of the ambulance transfer of care process (*Ambulance Transfer of Care Process Date/Time*) 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 the 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 for the emergency department visit is by air, ground, or a combination (*Admit via Ambulance* = A, G, or C) **Exclusions:** Cases where • Date or time of registration and triage are both invalid or unknown (*Registration Date/Time* = 9999 or missing and *Triage Date/Time* = 9999 or missing) • The *Visit MIS Functional Centre Account Code* is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • Date or time of either ambulance arrival or transfer of care is invalid or unknown (*Ambulance Arrival Date/Time* or *Ambulance Transfer of Care Process Date/Time* = 9999 or missing) • *Ambulance offload time* is negative • *Ambulance offload time* is 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, 2023, to November 30, 2024, in alignment with the Pay for Results program For non-ERNI hospitals: April 1, 2024, to September 30, 2024 (Q1 and Q2)
Considerations for target-setting	Ontario Health, in consultation with Emergency Medical Services and Paramedic Services, has set a target of 30 minutes for this indicator. More information on target-setting can be found in the QIP Target Setting Guide.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

Abbreviations: ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; MIS, management information system; N/A, not applicable.

90th percentile emergency department wait time to physician initial assessment

Abbreviated name	90th percentile ED wait time to PIA
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	*Emergency department wait time to physician initial assessment* is the duration (time elapsed) between a patient being triaged or registered (whichever comes first) and physician initial assessment. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	To obtain the *90th percentile emergency department wait time to physician initial assessment*: **1)** Calculate the emergency department *wait time to physician initial assessment* as the time elapsed between triage or registration (*Triage Date/Time* or *Registration Date/Time,* whichever occurs first) and the *Date/Time of Physician Initial Assessment,*[a] applying inclusion and exclusion criteria. **2)** Sort the cases by *wait time to physician initial assessment* (from shortest to longest). **3)** Identify the time by which 90% had a physician initial assessment (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 physician initial assessment* of the *n*th case in the sorted list.) **Exclusions:** Cases where • Date or time of registration and triage are both invalid or unknown (*Registration Date/Time*= 9999 or missing and *Triage Date/Time* = 9999 or missing) • The *Visit MIS Functional Centre Account Code* is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • Time of assessment is invalid or unknown (*Date/Time of Physician Initial Assessment* = 9999 or missing) or the patient left without being seen (*Visit Disposition* = 61 or 63) • *Date/Time of Physician Initial Assessment* is after either *Disposition Date/Time* or *Date/Time Patient Left ED* • *Wait time to physician initial assessment* is greater than or equal to 1,666 hours (100,000 minutes)
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	For ERNI hospitals: December 1, 2023, to November 30, 2024, in alignment with the Pay for Results program For non-ERNI hospitals: April 1, 2024, to September 30, 2024 (Q1 and Q2)
Considerations for target-setting	The Ontario Health target for this indicator is 4 hours. More information on target-setting can be found in the QIP Target Setting Guide.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

Abbreviations: ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; MIS, management information system; N/A, not applicable.

[a] If physician initial assessment appears to happen within 24 hours before triage or registration, the time to physician initial assessment is set to 0. When physician initial assessment appears to happen more than 24 hours prior, it will be set to null/blank.

Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	The number of patients in the emergency department waiting for an inpatient bed at 8 a.m. (also known as *no bed admits*) is the number of people who had been admitted but who, by 8 a.m., had been waiting at least 2 hours since disposition, were still in the emergency department (i.e., not yet in an inpatient bed), and then left the emergency department. Evaluation metric: average
Unit of measure	Number of patients per day

Calculation methods	**Inclusions:**
	Cases where
	• Admitted patients waited in conventional and unconventional emergency department spaces for a bed in the hospital (include all service or bed types)
	• The emergency department visit resulted in admission (*Visit Disposition* = 06 or 07)
	  ○ *06*: Admitted into reporting facility as an inpatient to critical care unit or operating room directly from an ambulatory care visit functional centre
	  ○ *07*: Admitted into reporting facility as an inpatient to another unit of the reporting facility directly from the ambulatory care visit functional centre
	• The patient waited more than 2 hours (time since disposition decision was made)
	
	Exclusions:
	Cases where
	• The emergency department visit was scheduled (*ED Visit Indicator*= 0)
	• Date or time of disposition is invalid or unknown (*Disposition Date/Time* = 9999 or missing)
	• Date or time of the patient left is invalid or unknown (*Date/Time Patient Left ED* = 9999 or missing)
	• The time elapsed from *Disposition Date/Time* to *Date/Time Patient Left ED* was greater than 1,666 hours (100,000 minutes)

Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2024 (Q1 and Q2)
Considerations for target-setting	The Ontario Health target for this indicator is a 20% reduction from baseline. More information on target-setting can be found in the QIP Target Setting Guide.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

Abbreviations: ED, emergency department; MIS, management information system; N/A, not applicable.

90th percentile emergency department length of stay for admitted patients

Abbreviated name	90th percentile ED LOS for admitted patients
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	*Emergency department length of stay for admitted patients* is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the emergency department to go to an inpatient bed or operating room. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	To obtain the *90th percentile emergency department length of stay for admitted patients*: **1)** Calculate the *emergency department length of stay* as the time elapsed between triage or registration (*Triage Date/Time* or *Registration Date/Time*, whichever occurs first[a]) and departure from the emergency department for admission to an inpatient bed (*Date/Time Patient Left ED*), 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:** Cases where • The emergency department visit resulted in patient admission (*Visit Disposition* = 06 or 07) **Exclusions:** Cases where • Date or time of registration and triage are both invalid or unknown (*Registration Date/Time*= 9999 or missing and *Triage Date/Time* = 9999 or missing) • The *Visit MIS Functional Centre Account Code* is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • Date or time the patient left the emergency department is invalid or unknown (*Date/Time Patient Left ED* = 9999 or missing) • The patient left without being seen (*Visit Disposition* = 61 or 63) • *Emergency department length of stay* is greater than or equal to 1,666 hours (100,000 minutes) **Note***: Emergency department length of stay* excludes any time spent in a clinical decision unit.
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	For ERNI hospitals: December 1, 2023, to November 30, 2024, in alignment with the Pay for Results program For non-ERNI hospitals: April 1, 2024, to September 30, 2024 (Q1 and Q2)
Considerations for target-setting	The Ontario Health target for this indicator from the Pay for Results program is 25 hours. More information on target-setting can be found in the QIP Target Setting Guide.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

Abbreviations: ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; MIS, management information system; N/A, not applicable.

[a] 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.

90th percentile emergency department length of stay for nonadmitted patients with low acuity

Abbreviated name	90th percentile ED LOS for nonadmitted patients, low acuity
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	*Emergency department length of stay for nonadmitted patients with low acuity* is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the emergency department. It is limited to patients who are triaged as less severe and who leave the emergency department without being admitted. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	To obtain the *90th percentile emergency department length of stay for nonadmitted patients with low acuity*: **1)** Calculate the *emergency department length of stay* as the time elapsed between triage or registration (*Triage Date/Time* or *Registration Date/Time,* whichever occurs first[a]) and departure from the emergency department (*Date/Time Patient Left ED*) 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:** Cases where • The emergency department visit did not result in the patient being admitted (*Visit Disposition* not equal to 06 or 07), and the patient was triaged as low acuity (*Triage Level (CTAS)* = 4 or 5) **Exclusions:** Cases where • Date or time of registration and triage are both invalid or unknown (*Registration Date/Time*= 9999 or missing and *Triage Date/Time* = 9999 or missing) • The *Visit MIS Functional Centre Account Code* is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • Date or time the patient left the emergency department is invalid or unknown (*Date/Time Patient Left ED* = 9999 or missing) • The patient left without being seen (*Visit Disposition* = 61 or 63) • *Emergency department length of stay* is greater than or equal to 1,666 hours (100,000 minutes) **Note***: Emergency department length of stay* excludes any time spent in a clinical decision unit.
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	For ERNI hospitals: December 1, 2023, to November 30, 2024, in alignment with the Pay for Results program For non-ERNI hospitals: April 1, 2024, to September 30, 2024 (Q1 and Q2)
Considerations for target-setting	The Ontario Health target for this indicator from the Pay for Results program is 4 hours. More information on target-setting can be found in the QIP Target Setting Guide.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

Abbreviations: CTAS, Canadian Triage and Acuity Scale; ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; MIS, management information system; N/A, not applicable.

[a] 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.

90th percentile emergency department length of stay for nonadmitted patients with high acuity

Abbreviated name	90th percentile ED LOS for nonadmitted, high acuity
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	*Emergency department length of stay for nonadmitted patients with high acuity* is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the emergency department. It is limited to patients who are triaged as more severe and who leave the emergency department without being admitted. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	To obtain the *90th percentile emergency department length of stay for nonadmitted patients with high acuity*: **1)** Calculate the *emergency department length of stay* as the time elapsed between triage or registration (*Triage Date/Time* or *Registration Date/Time,* whichever occurs first[a]) and departure from the emergency department (*Date/Time Patient Left ED*) 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:** Cases where • The emergency department visit did not result in the patient being admitted (*Visit Disposition* not equal to 06 or 07), and the patient was triaged as high acuity (*Triage Level (CTAS)* = 1, 2, or 3) **Exclusions:** Cases where • Date or time of registration and triage are both invalid or unknown (*Registration Date/Time*= 9999 or missing and *Triage Date/Time* = 9999 or missing) • The *Visit MIS Functional Centre Account Code* is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • Date or time the patient left the emergency department is invalid or unknown (*Date/Time Patient Left ED* = 9999 or missing) • The patient left without being seen (*Visit Disposition* = 61 or 63) • *Emergency department length of stay* is greater than or equal to 1,666 hours (100,000 minutes) **Note***: Emergency department length of stay* excludes any time spent in a clinical decision unit.
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	For ERNI hospitals: December 1, 2023, to November 30, 2024, in alignment with the Pay for Results program For non-ERNI hospitals: April 1, 2024, to September 30, 2024 (Q1 and Q2)
Considerations for target-setting	The Ontario Health target for this indicator from the Pay for Results program is 7 hours. More information on target-setting can be found in the QIP Target Setting Guide.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

Abbreviations: CTAS, Canadian Triage and Acuity Scale; ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; MIS, management information system; N/A, not applicable.

[a] 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.

90th percentile emergency department wait time to inpatient bed

Abbreviated name	90th percentile ED wait time to inpatient bed
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
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	To obtain the *90th percentile emergency department wait time to inpatient bed*: **1)** Calculate the *wait time to inpatient bed* as the time elapsed between *Disposition Date/Time* and *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 (or operating room). (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 (*Visit Disposition* = 06 or 07) **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 • Date or time of visit disposition is invalid or unknown (*Disposition Date/Time* = 9999 or missing) • Date or time the patient left the emergency department is invalid or unknown (*Date/Time Patient Left ED* = 9999 or missing) • The *Visit MIS Functional Centre Account Code* is not under General Emergency Department or Urgent Care Centre • *Emergency department wait time to inpatient bed* is greater than or equal to 1,666 hours (100,000 minutes) • *Emergency department wait time to inpatient bed* is negative
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	For ERNI hospitals: December 1, 2023, to November 30, 2024, in alignment with the Pay for Results program For non-ERNI hospitals: April 1, 2024, to September 30, 2024 (Q1 and Q2)
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

Abbreviations: ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; MIS, management information system; N/A, not applicable.

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

Abbreviated name	% patients who visited ED and LWBS by a physician
Priority issue	Access and flow
Indicator type	Optional
Dimension	Timely
Direction of improvement	Decrease (lower is better)
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 *Visit MIS Functional Centre Account Code* 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 (*Visit Disposition* = 61 or 63) ◦ *61*: Left after registration – patient left at their own risk following registration; triage, further assessment by a service provider and treatment did not occur[1] ◦ *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[1] **Exclusions:** Cases where • The patient left against medical advice (*Visit Disposition* = 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, 2024 (Q1 and Q2)
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

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).

Equity

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100%
Numerator	Number of staff[a] who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period **Exclusions:** • Partial completions, if equity, diversity, inclusion, and antiracism education was required of staff
Denominator	Total number of staff targeted[a] for equity, diversity, inclusion, and antiracism training **Inclusions:** • Staff (workers) 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	More information on target-setting can be found in the QIP Target Setting Guide.
Data source	Learning software completion metrics
How to access data	Local data collection

[a] 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).

Comments

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

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Decrease (lower is better)
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 Problem* or *Other Problem*) for sickle cell disease: D570, D571, D572, D578 • Where the patient's condition was triaged as *resuscitation* or *emergent* (*Triage Level (CTAS)* = 1 or 2) **Exclusions:** Cases where • *Registration Date/Time* = 9999 or missing and *Triage Date/Time* = 9999 or missing • The *Visit MIS Functional Centre Account Code* is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (*ED Visit Indicator* = 0) • Date or time of initial assessment by physician is unknown (*Date/Time of Physician Initial Assessment* = 9999 or missing) or patient left without being seen (*Visit Disposition* = 61 or 63) • Time to physician initial assessment is greater than or equal to 100,000 minutes (1,666 hours)
Numerator	Sum of the number of minutes waited for a physician initial assessment for emergency department visits made by patients with sickle cell disease triaged CTAS level 1 or 2
Denominator	Total number of emergency department visits made by patients with sickle cell disease triaged CTAS level 1 or 2
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2024 (Q1 and Q2)
Considerations for target-setting	Target times to physician initial assessment by CTAS level have been defined by the Canadian Association of Emergency Physicians[2]: • 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 More information on target-setting can be found in the QIP Target Setting Guide.
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 stemming from the Sickle Cell Disease Quality Standard are also available through the eReport dashboard, accessible to hospitals via OneID.

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Decrease (lower is better)
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, out of all sickle cell disease emergency department visits.
Unit of measure	Percentage
Calculation methods	To obtain the *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 Problem* or *Other Problem*) 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:** • Cases where 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, 2024 (Q1 and Q2)
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
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: ED, emergency department; ICD-10-CA, International Statistical Classification of Diseases and Related Health Problems Tenth Revision Canada.

Comments

Similar indicators stemming from the Sickle Cell Disease Quality Standard are also available through the eReport dashboard, accessible to hospitals via OneID.

Note that repeat visits to a different emergency department than the index visit are attributed to the emergency department of the index visit.

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

Abbreviated name	N/A
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.
Description	Percentage of unscheduled emergency department visits triaged as high severity (CTAS 1 or 2) out of all unscheduled emergency department visits for patients with sickle cell disease.
Unit of measure	Percentage
Calculation methods	To obtain the *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:** • Cases with ICD-10-CA codes (in *Main Problem* or *Other Problem*) for sickle cell disease: D570, D571, D572, D578 **Exclusions:** • Cases where 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, 2024 (Q1 and Q2)
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
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 stemming from the Sickle Cell Disease Quality Standard are also available through the eReport dashboard, accessible to hospitals via OneID.

Experience

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

Abbreviated name	N/A
Priority issue	Experience
Indicator type	Optional
Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
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[3] the Ontario Hospital Association’s Adult Inpatient Short-form survey: 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
Numerator	Number of respondents who responded “Completely” **Inclusions:** • For patient experience questions, use the top-box method (i.e., count only respondents who choose the most positive response).
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	More information on target-setting can be found in the QIP Target Setting Guide.
Data source	Patient experiences survey data
How to access data	Local data collection. These data should be accessed from within your own organization.

Comments

Hospitals can leverage Canadian Patient Experiences Survey — Inpatient Care questions, also found within the Ontario Hospital Association’s Adult Inpatient Short-form survey, question 7, to self-report this indicator in their 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

Abbreviated name	N/A
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 focussing on increasing the identification and reporting of delirium, improvement may be defined as an increase in the reported rate of delirium onset during hospitalization.
Description	Rate of hospital-acquired delirium among inpatient hospitalizations in acute care (as proportion of all hospitalizations).
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100%
Numerator	Number of hospitalizations included 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 instances will be counted in the numerator. **Inclusions:** Hospitalizations • For delirium not induced by alcohol and other psychoactive substances (ICD-10-CA codes F05.*x*; i.e., F05.0, F05.1, F05.8, F05.9) • With *Diagnosis Type* = 2 (postadmit comorbidity)
Denominator	Total number of unique acute care hospitalizations. (Note that if a patient has multiple hospitalizations, all will be counted in the denominator.) **Exclusions:** Hospitalizations • For newborns (*Admit Category* = N), stillbirths (*Admit Category* = S), and cadaveric donors (*Admit Category* = R) • In reactivation care centres or alternative health facilities
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2024 (Q1 and Q2), based on the discharge date
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
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 in patients is critical to being able to initiate optimal health care. Evidence suggests that delirium is often unrecognized and misdiagnosed as another disorder or misattributed to dementia.[4] Although International Statistical Classification of Diseases and Related Health Problems Tenth Revision Canada (ICD-10-CA) F05.*x* codes have a high positive predictive value for the identification of 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.

Rate of medication reconciliation at discharge

Abbreviated name	N/A
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safety
Direction of improvement	Increase (higher is better)
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 enter the numerator and denominator in their organization's QIP workplan, and QIP Navigator will calculate the indicator value
Numerator	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created **Exclusions[a]:** • Hospital discharge that is death, newborn, or stillborn
Denominator	Number of patients discharged from hospital **Exclusions[a]:** • Hospital discharge that is death, newborn, or stillborn
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
Data source	Hospital information systems
How to access data	Local data collection. These data should be accessed from within your own organization.

[a] Any additional exclusions should be documented in the comments section in QIP Navigator.

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 are also asked to identify any programs or patients that are not included in their medication reconciliation calculation.

Rate of workplace violence incidents resulting in lost-time injury

Abbreviated name	N/A
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safety
Direction of improvement	Decrease (lower is better); however, if your organization is focussed on building your reporting culture, improvement may be defined as an increase. If your organization's reporting culture is already well-developed, improvement may be defined as a decrease.
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*.[5]
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100% Number of workplace violence incidents that result in 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*.[5]
Numerator	Number of workplace violence incidents[a] that result in a lost-time injury reported by hospital workers. **Exclusions:** • Fatalities
Denominator	Total number of hospital full-time equivalent workers
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
Data source	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	Local data collection. 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

[a] If the count of incidents is greater than 0 but less than or equal to 5, the value requires suppression.

Comments

Worker and *Workplace violence* are defined by the *Occupational Health and Safety Act*.

Lost time from an injury caused by a workplace violence incident includes situations where the worker is off work past the day of the incident, has loss of wages or earnings after the incident, or has a permanent disability or impairment because of the incident.

Interprofessional Primary Care

For all interprofessional primary care indicators, indicator language describing the patient (or client), the provider (or clinician), or any 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 similar concepts are slightly different.

Access and Flow

Patient/client perception of timely access to care

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Description	Percentage of patients (or 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 survey question wording (from the Primary Care Patient Experience Survey[5]): 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 (or 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 (or 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%.[6] More information on target-setting can be found in the QIP Target Setting Guide.
Data source	Patient or client experience survey, such as the Primary Care Patient Experiences Survey
How to access data	Local data collection

Comments

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

Use of the Primary Care Patient Experience Survey is encouraged. The survey was developed by Ontario Health (formerly 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 monitored at 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.

An indicator with a similar question but that specifies “same or next-day” access to a primary care provider is based on a question in the Ontario Ministry of Health’s Health Care Experience Survey.

Number of new patients/clients/enrolments

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Efficient
Direction of improvement	Increase (higher is better)
Description	Net number of new patients (or 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 (or clients, enrolments, etc.) 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	To obtain the *net number of new patients* (or clients, enrolments, etc.): **1)** Count the number of patients (or clients) newly attached or enrolled within the reporting period. **2)** Subtract the patients (or 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	More information on target-setting can be found in the QIP Target Setting Guide.
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

Abbreviations: N/A, not applicable.

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.

Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring

Abbreviated name	% clients with type 2 diabetes mellitus who are up to date with HbA1c blood glucose monitoring
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Efficient
Direction of improvement	Increase (higher is better)
Description	Percentage of clients with type 2 diabetes mellitus for whom HbA1c blood glucose level monitoring has been completed at least 2 times during the past 12 months
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100%
Numerator	Number of clients with type 2 diabetes mellitus for whom HbA1c blood glucose level monitoring has been completed at least 2 times during the reporting period
Denominator	Number of active clients with type 2 diabetes mellitus
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
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. Family health teams: Data can be accessed via *MyPractice*: Primary Care Reports. Community health centres and nurse practitioner–led clinics: Data can be accessed by electronic medical record query within organization.

Abbreviations: HbA1c, hemoglobin A1c (or glycated hemoglobin).

Comments

This indicator has been adapted from indicators in *Indigenous Primary Health Care Council (IPHCC) Funding Agreement Quarterly Indicators* and Ontario Health's *MyPractice* Primary Care Report.

Percentage of screen-eligible people who are up to date with colorectal tests

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Description	Percentage of screen-eligible people who are up to date with colorectal tests
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100%

Numerator	Total number of people in the denominator who have been screened for colorectal cancer within the designated appropriate time frames below.
	Inclusions:
	• People aged 50 to 74 years who had 1 of the following colorectal tests and whose results have been received by your practice:
	  ○ Fecal immunochemical test with a valid result in the past 2 years
	  ○ Colonoscopy in the previous 10 years
	  ○ Flexible sigmoidoscopy in the previous 10 years

Denominator	Total number of people (active clients within your organization) aged 50 to 74 years. **Exclusions:** • (If feasible) people who have had a colectomy or who have a history of colorectal cancer.
Risk adjustment	None
Current performance reporting period	Most recent information available
Considerations for target-setting	The target of 65% has been set in Ontario Health's Regional Performance Management Framework for 2024-25. More information on target-setting can be found in the QIP Target Setting Guide.
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. These data should be accessed from within your own organization. Family health teams: Data can be accessed via *MyPractice*: Primary Care Reports[a] Community health centres and Aboriginal Health Access Centres: Practice profiles are available through the Alliance for Healthier Communities. Primary care physicians may also be able to access data via the Screening Activity Report[a] tool. Nurse practitioner–led clinics: Data can be accessed by electronic medical record query within organization.

[a] Ontario Health's *MyPractice* Primary Care Report and Screening Activity Report are planned to be harmonized into a Primary Care Integrated Report in 2024/25.

Comments

This indicator has been adapted from the *Indigenous Primary Health Care Council (IPHCC) Funding Agreement Quarterly Indicators* and information on Ontario Health's Screening Programs.

For Indigenous interprofessional primary care organizations looking to report on colorectal screening as part of their QIPs, use of this optional indicator is encouraged (rather than using a custom indicator), and it can be selected despite any minor differences in calculation method or nuance from that of the IPHCC indicator. Additional information is available from Ontario Health on First Nations, Inuit, Métis and Urban Indigenous Cancer Screening Resources.

Percentage of screen-eligible people who are up to date with cervical screening

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Description	Percentage of eligible clients who have been screened for cervical cancer in the past 3 years.
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100%
Numerator	Total number of people in the denominator who have had a cytology (Pap) test within the past 3 years **Inclusions:** • People with a cervix aged 21 to 69 years who had a cytology (Pap) test in the past 3 years and whose results have been received by your practice
Denominator	Total number of people (active clients within your organization) with a cervix aged 21 to 69 years **Exclusions:** • People who have had a hysterectomy or who have a history of cervical cancer
Risk adjustment	None
Current performance reporting period	Most recent information available
Considerations for target-setting	The target of 60% has been set in Ontario Health's Regional Performance Management Framework for 2024-25. More information on target-setting can be found in the QIP Target Setting Guide.
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. These data should be accessed from within your own organization. Family health teams: Data can be accessed via *MyPractice*: Primary Care Reports[a] Community health centres and Aboriginal Health Access Centres: Practice profiles are available through the Alliance for Healthier Communities. Primary care physicians may also be able to access data via the Screening Activity Report[a] tool. Nurse practitioner–led clinics: Data can be accessed by electronic medical record query within organization.

[a] Ontario Health's *MyPractice* Primary Care Report and Screening Activity Report are planned to be harmonized into a Primary Care Integrated Report in 2024/25.

Comments

This indicator has been adapted from *Indigenous Primary Health Care Council (IPHCC) Funding Agreement Quarterly Indicators* and information on Ontario Health's Screening Programs.

For Indigenous interprofessional primary care organizations looking to report on cervical screening as part of their QIPs, use of this optional indicator is encouraged (rather than using a custom indicator), and it can be selected despite any minor differences in calculation method or nuance from that of the IPHCC indicator. Additional information is available from Ontario Health on First Nations, Inuit, Métis and Urban Indigenous Cancer Screening Resources.

It is anticipated that the cervical cancer screening approach in Ontario will shift from Pap tests to human papillomavirus (HPV) primary screening starting in 2025. HPV primary screening will begin at age 25 years,

rather than age 21 years for Pap tests. During this transitional phase, it is likely that cervical screening indicators will be adapted to include a blend of these modalities.

Percentage of screen-eligible people who are up to date with breast screening

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Description	Percentage of screen-eligible people who have been screened for breast cancer with a mammogram in the past 2 years.
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100%
Numerator	Total number of people in the denominator who have had a mammogram within the past 2 years **Inclusions:** • People aged 50 to 74 years who had a screening mammogram in the past 2 years and whose results have been received by your practice
Denominator	Total number of people (active clients within your organization) aged 50 to 74 years who qualify for a screening mammogram **Inclusions:** • People assigned female at birth and gender-diverse people who are receiving estrogens **Exclusions:** • People who have had a mastectomy or who have a history of breast cancer
Risk adjustment	None
Current performance reporting period	Most recent information available
Considerations for target-setting	The target of 65% has been set in Ontario Health's Regional Performance Management Framework for 2024-25. More information on target-setting can be found in the QIP Target Setting Guide.
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. These data should be accessed from within your own organization. Family health teams: Data can be accessed via *MyPractice*: Primary Care Reports[a] Community health centres and Aboriginal Health Access Centres: Practice profiles are available through the Alliance for Healthier Communities. Primary care physicians may also be able to access data via the Screening Activity Report[a] tool. Nurse practitioner–led clinics: Data can be accessed by electronic medical record query within organization.

[a] Ontario Health's MyPractice Primary Care Report and Screening Activity Report are planned to be harmonized into a Primary Care Integrated Report in 2024/25.

Comments

This indicator has been adapted from the *Indigenous Primary Health Care Council (IPHCC) Funding Agreement Quarterly Indicators* and information on Ontario Health's Screening Programs.

For Indigenous interprofessional primary care organizations looking to report on breast screening as part of their QIPs, use of this optional indicator is encouraged (rather than using a custom indicator), and it can be selected despite any minor differences in calculation method or nuance from that of the IPHCC indicator.

Additional information is available from Ontario Health on First Nations, Inuit, Métis and Urban Indigenous Cancer Screening Resources.

Eligibility for mammography is being opened up to people aged 40 to 49 years in fall 2024; it is expected that a separate indicator will be used at the system level (outside of the QIP) to understand screening in this younger age group.

Equity

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100%
Numerator	Number of staff[a] who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period **Exclusions:** • Staff with partially completed training
Denominator	Total number of staff targeted for equity, diversity, inclusion, and antiracism training **Inclusions:** • Staff (workers) 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	More information on target-setting can be found in the QIP Target Setting Guide.
Data source	Learning software completion metrics
How to access data	Local data collection

[a] 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).

Comments

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

Completion of sociodemographic data collection

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	Percentage of patients (or 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 (or clients) aged 13 years and older who had an individual encounter with the primary care organization within the reporting period and who responded to at least 1 of the 4 sociodemographic data questions (i.e., racial/ethnic group, disability, gender identity, or sexual orientation) **Inclusions:** Patients (or 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 (or clients) aged 13 years and older who had an individual encounter with the primary care organization within the reporting period **Exclusions:** • Group patients (or clients) (e.g., not an individual patient [or client] visit) • Patients (or clients) younger than 13 years • Patients (or clients) who had unregistered encounters (e.g., nonrostered clients) • Anonymous patients (or clients) • Patients (or clients) who did not have an encounter with the primary care organization in the reporting period
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%. More information on target-setting can be found in the QIP Target Setting Guide.
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 is based on a question from the Updated Health Equity (Sociodemographic) Questionnaire by the Alliance for Healthier Communities.

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 collection 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 data collection. Sociodemographic questions should

be voluntary so that a patient (or client) can refuse to respond to some or all of the questions. Patients (or clients) should be asked these questions at the first encounter, and then every 3 years to determine if there have been any changes.

Percentage of clients actively receiving mental health care from a traditional provider

Abbreviated name	% clients actively receiving mental health care from a traditional provider
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	Percentage of clients actively receiving mental health care from a traditional provider, out of all clients receiving care from a traditional provider
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100%
Numerator	Number of clients who had an encounter with a traditional provider for mental health care
Denominator	Number of clients who had an encounter with a traditional provider. *Traditional provider* may include roles such as traditional healer, cultural coordinator, or similar
Risk adjustment	None
Current performance reporting period	Most recent quarter of data available
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
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 has been adapted from an indicator in *Indigenous Primary Health Care Council (IPHCC) Funding Agreement Quarterly Indicators*.

Number of events and participants for traditional teaching, healing, or ceremony

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	A 2-part indicator; item a is the number of events for traditional teaching, healing, or ceremony, and item b is the number of participants for traditional teaching, healing, or ceremony.
Unit of measure	Count
Calculation methods	Item a: Calculate the sum of the number of events for traditional teaching, healing, or ceremony[a] Item b: Calculate the sum of the number of clients who accessed traditional teaching, healing, or ceremony and the number of participants in events for traditional teaching, healing, or ceremony[b]
Numerator	For the population or cultural group of interest[c]: Item a: Total of events for traditional teaching, healing, or ceremony Item b: Total of the number of clients who accessed traditional teaching, healing, or ceremony plus the number of participants in events for traditional teaching, healing, or ceremony
Denominator	N/A
Risk adjustment	None
Current performance reporting period	Most recent quarter of data available
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
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

Abbreviations: N/A, not applicable.

[a]Item a will appear in the comments section for this indicator.

[b]The *current performance* and *target performance* fields apply to item b.

[c]The population or cultural group of interest should also be specified in the *Primary Care Population* field.

Comments

This indicator has been adapted from an indicator in *Indigenous Primary Health Care Council (IPHCC) Funding Agreement Quarterly Indicators*.

Item b, related to the number of clients and participants, is the most important component of this indicator and is tied to current performance and target performance. Inclusion of item b is a requirement for selecting this indicator, although organizations are encouraged to capture both item a and item b.

Experience

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

Abbreviated name	N/A
Priority issue	Experience
Indicator type	Optional
Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
Description	Percentage of patients (or 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 (or 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 (or 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%. More information on target-setting can be found in the QIP Target Setting Guide.
Data source	These data should be accessed from within your own organization, using a patient or 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.

Safety

Number of faxes sent per 1,000 rostered patients

Abbreviated name	N/A
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safe
Direction of improvement	Decrease (lower is better)
Description	Number of faxes in a quarter per 1,000 patients attached to the primary care organization.
Unit of measure	Number of faxes
Calculation methods	(Numerator ÷ Denominator) × 1,000 Total number of faxes sent by the primary health care organization in the last quarter (3 months) divided by total number of rostered patients, multiplied by 1,000
Numerator	Number of faxes sent from the primary care organization in the reporting period
Denominator	Total number of patients rostered to the primary care organization
Risk adjustment	None
Current performance reporting period	Most recent quarter of data available (consecutive 3-month period)
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
Data source	These data should be accessed from within your own organization, using patient information systems and fax machine data.
How to access data	Local data collection.

Comments

This indicator is related to the "Axe the fax" and "Patients Before Paperwork" campaigns. A reduction in overall faxes reduces the number of failed or incorrect faxes which pose patient safety risks. A focus away from faxes also lessens the administrative burden.

Provincial digital solutions suite (6 indicators): Percentage of clinicians in the primary care practice using… [eReferral, eConsult, OLIS, HRM, electronic prescribing, online appointment booking]

Abbreviated name	N/A
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safe
Direction of improvement	Increase (higher is better)
Description	A suite of 6 indicators, each representing the percentage of clinicians in the primary care organization who are using the specified provincial digital solution: • eReferral • eConsult • Ontario Laboratories Information System (OLIS) • Health Report Manager (HRM) • Electronic prescribing • Online appointment booking
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100 Number of clinicians using the digital solution divided by the total number of clinicians in the primary care practice. Organizations will be asked to enter the numerators and the denominator in QIP Navigator.
Numerator	a. Number of clinicians in the primary care organization who are using eReferral b. Number of clinicians in the primary care organization who are using eConsult c. Number of clinicians in the primary care organization who are using the Ontario Laboratories Information System d. Number of clinicians in the primary care organization who are using Health Report Manager e. Number of clinicians in the primary care organization who are using electronic prescribing f. Number of clinicians in the primary care organization who are using online appointment booking
Denominator	Total number of clinicians in the primary care organization
Risk adjustment	None
Current performance reporting period	Most recent information available
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide.
Data source	These data should be accessed from within your own organization via communication with clinicians.
How to access data	Local data collection

Comments

This indicator is related to the "Axe the fax" and "Patients Before Paperwork" campaigns. Uptake of digital solutions helps reduce overall administrative burden and fax rate. It can also reduce patient safety risks by mitigating errors in information entry and communication.

Long-Term Care

Access and Flow

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

Abbreviated name	Rate of potentially avoidable ED visits for LTC residents
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Efficient
Direction of improvement	Decrease (lower is better)
Description	Number of emergency department visits for a modified list of ambulatory care–sensitive conditions[a] 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[a] **Inclusions:** • 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, 2023, to September 30, 2024 (Q3 to the end of the following Q2)
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide. Organizations should strive for improvement and should avoid including corporate targets that represent performance worse than current performance.
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 and the Ministry of Long-Term Care.
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

[a] 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.

Equity

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education.
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100%
Numerator	Number of staff[a] who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period **Exclusions:** • Partial completions, if equity, diversity, inclusion, and antiracism education was required of staff
Denominator	Total number of staff targeted for equity, diversity, inclusion, and antiracism training **Inclusions:** • Staff (workers) 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	More information on target-setting can be found in the QIP Target Setting Guide. Organizations should strive for improvement and should avoid including corporate targets that represent performance worse than current performance.
Data source	Learning software completion metrics
How to access data	Local data collection

[a] 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).

Comments

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

Experience

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

Abbreviated name	N/A
Priority issue	Experience
Indicator type	Optional
Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
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[7] 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	More information on target-setting can be found in the QIP Target Setting Guide. Organizations should strive for improvement and should avoid including corporate targets that represent performance worse than current performance.
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 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?

Abbreviated name	N/A
Priority issue	Experience
Indicator type	Optional
Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
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 Nursing Home CAHPS Long-Stay Resident Survey[8] should measure this domain by calculating the percentage of residents who responded with a 9 or 10 (responses are coded from 0 to 10, where 0 = worst possible and 10 = best possible) to the following question: What number would you use to rate how well the staff listen to you?
Numerator	For homes using the Nursing Home CAHPS Long-Stay Resident Survey, the number of respondents who responded with a 9 or 10 to the question.
Denominator	For homes using the Nursing Home CAHPS 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	More information on target-setting can be found in the QIP Target Setting Guide. Organizations should strive for improvement and should avoid including corporate targets that represent performance worse than current performance.
Data source	Survey tool such as the Nursing Home CAHPS Long-Stay Resident Survey.
How to access data	Local data collection. These data should be accessed from within your own organization.

Abbreviations: CAHPS, Consumer Assessment of Healthcare Providers and Systems.

Comments

For more information about the Nursing Home CAHPS 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

Abbreviated name	% LTC 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)
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 a rolling 4-quarter average (target quarter and the 3 preceding quarters).[a]
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[b] **Inclusions:** • Residents who received an antipsychotic medication during the 7 days preceding assessment (RAI-MDS *O4a* = 1, 2, 3, 4, 5, 6, or 7)
Denominator	Number of long-term care home residents with a valid RAI-MDS assessment[b] **Exclusions:** • Residents who have end-stage disease (RAI-MDS *J5c* = 1) or are receiving hospice care (*P1ao* = 1) • Residents who have a diagnosis of schizophrenia (*I1ii* = 1) or Huntington chorea (*I1x* = 1), or those experiencing hallucinations (*J1i* = 1) or delusions (*J1e* = 1)
Risk adjustment	None. Unadjusted for QIP
Current performance reporting period	July 1 to September 30, 2024 (Q2), as target quarter of rolling 4-quarter average[a]
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide. Organizations should strive for improvement and should avoid including corporate targets that represent performance worse than current performance.
Data source	Continuing Care Reporting System (data are provided by CIHI via CCRS eReports)
How to access data	Indicator data will be prepopulated in QIP Navigator. To access unadjusted rates for this indicator, refer to your organization's CCRS eReports at the CIHI website.

Abbreviations: CCRS, Continuing Care Reporting System; CIHI, Canadian Institute for Health Information; RAI-MDS, Resident Assessment Instrument—Minimum Data Set 2.0.

[a] The indicator is calculated by the Canadian Institute for Health Information as a rolling 4-quarter average. Q2 2024/25 is calculated based on data from Q3 2023/24, Q4 2023/24, Q1 2024/25, and Q2 2024/25.

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

Comments

This indicator is consistent with that reported by Ontario Health's Long-Term Care Home Performance website; however, the website includes 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 *MyPractice* Long-Term Care.

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

Abbreviated name	% LTC 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)
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 a rolling 4-quarter average (target quarter and the 3 preceding quarters).[a]
Numerator	Number of long-term care home residents who fell in the 30 days leading up to the date of their quarterly clinical assessment[b] **Inclusions:** • Residents who fell in past 30 days (RAI-MDS *J4a* = 1)
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 1 to September 30, 2024 (Q2), as target quarter of rolling 4-quarter average[a]
Considerations for target-setting	More information on target-setting can be found in the QIP Target Setting Guide. Organizations should strive for improvement and should avoid including corporate targets that represent performance worse than current performance.
Data source	Continuing Care Reporting System (data are provided by CIHI via CCRS eReports)
How to access data	Indicator data will be prepopulated in QIP Navigator. To access unadjusted rates for this indicator, refer to your organization's CCRS eReports at the CIHI website.

Abbreviations: CCRS, Continuing Care Reporting System; CIHI, Canadian Institute for Health Information; RAI-MDS, Resident Assessment Instrument — Minimum Data Set 2.0.

[a] The indicator is calculated by the Canadian Institute for Health Information as a rolling 4-quarter average. Q2 2024/25 is calculated based on data from Q3 2023/24, Q4 2023/24, Q1 2024/25, and Q2 2024/25.

[b] 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.

Comments

This indicator is consistent with that reported by Ontario Health's Long-Term Care Home Performance website; however, the website includes 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 *MyPractice* Long-Term Care.

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ISBN 978-1-4868-8538-1 (PDF)

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