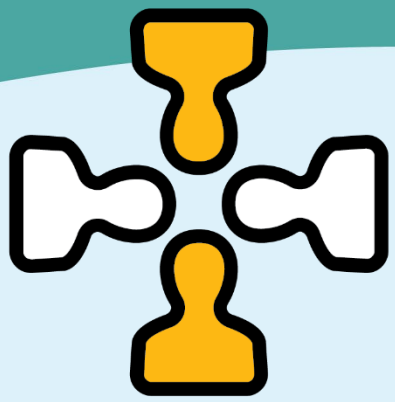

COLLABORATIVE QUALITY IMPROVEMENT PLAN PROGRAM

Indicator Technical Specifications

2025/26

JANUARY 2025

Ontario Health

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Introduction

This document includes definitions, calculations, reporting periods, and other technical information for the indicators chosen for the 2025/26 Collaborative Quality Improvement Plan (cQIP) program for Ontario Health Teams (OHTs).

There are new priority indicators for 2025/26, along with a continuation of the 2024/25 cQIP program indicators as optional indicators. These measures capture system-level work done by partners within each OHT. A cQIP reflects progress to date and captures the intent of an OHT as its partners work together to address common issues.

Considerations

Data time periods are set according to the limits of available data providers. Ontario Health is working with data providers to ensure that source data are as recent as possible. The most recent data for priority indicators will be available on the OHT Data Dashboard.

Additional information about the OHT Data Dashboard:

OHT Data Dashboard Launch Webinar
OHT Data Dashboard Technical Demonstration

OHTs are encouraged to review their data and use this to help identify areas for improvement.

Priority Indicators

Chronic Disease Prevention and Management

1. Admissions per 100 heart failure patients

Status	Priority for 2025/26
Dimension of quality	Efficient
Direction of improvement	Reduce (lower)
Type	Process
Description	The rate (per 100 cohort members) of inpatient admissions for people identified as being in the *HF cohort* (i.e., *HF patients*). Data for this indicator are stratified by Ontario Health Team in QIP Navigator. Data can also be stratified by admission (i.e., *CHF-specific*, *Cardiac*-related, and *Other*); the diagnosis codes used to categorize the 3 groups are available upon request.
Unit of measure	Admissions per 100 HF patients
Calculation method	(Numerator ÷ Denominator) × 100
Numerator	Number of admissions **Inclusions:** • All-cause admissions generated by the HF cohort **Exclusions:** • Elective admissions (*admcat* in "L", with a *Length of Stay* of 0 days [*ddate* – *admdate* = 0] in the Discharge Abstract Database) • *Length of Stay* = 0 and transfer-through to another facility on the same day as discharge date
Denominator	Prevalent HF patients in the HF cohort (see Appendix A for information on generating the cohort)
Risk adjustment	The indicator is age and sex standardized. Age and sex standardization ensures that differences in age and sex are accounted for when comparing across OHTs and years. 1. Calculate *overall* (for Ontario) *admissions per 100 HF patients* for each age and sex group combination (with age being split into 20–59, 60–79, and ≥ 80 years). 2. For each OHT, multiply HF patients within each age and sex group by *overall* (for Ontario) *admissions per 100 HF patients* to obtain *expected admissions per 100 HF patients*. Sum across all age and sex groups to obtain a single measure for *expected admissions per 100 HF patients* for each OHT. 3. Calculate the *actual-to-expected* ratio as *actual admissions per 100 HF patients ÷ expected admissions per 100 HF patients* for each OHT. 4. Multiply the *overall* (for Ontario) *admission per 100 HF patients* by the *actual-to-expected ratio* to obtain age- and sex-standardized admissions per 100 HF patients for each OHT.
Current reporting period	October 2023 to September 2024
Data source	Discharge Abstract Database: *Inpatient Admission* National Ambulatory Care Reporting System: *Ambulatory Visit* OHIP databases: *Ambulatory Visit* Registered Persons Database: *Death Year*

How to access data	Data have been released in 2024/25 through Ontario Health's eReports portal in both the *Integrated Clinical Pathways* and *OHT Reports* modules. Data (12 months, rolling) will also be prepopulated in QIP Navigator by January 2025.

Abbreviations: CHF, congestive heart failure; HF, heart failure; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Team.

2. Admissions per 100 COPD patients

Status	Priority for 2025/26
Dimension of quality	Efficient
Direction of improvement	Reduce (lower)
Type	Process
Description	The rate (per 100 cohort members) of inpatient admissions for people identified as being in the *COPD cohort* (i.e., *COPD patients*). Data for this indicator are stratified by Ontario Health Team in QIP Navigator. Data can also be stratified by admission (i.e., *COPD-specific* and *Other*); the diagnosis codes used to categorize the 2 groups are available upon request.
Unit of measure	Admissions per 100 COPD patients
Calculation method	(Numerator ÷ Denominator) × 100
Numerator	Number of admissions **Inclusions:** • All-cause admissions generated by the COPD cohort **Exclusions:** • AdmitCategory that are elective, cadaver, newborn, or stillborn (“L”, “R”, “N”, or “S”) • Elective admissions (*admcat* in “L”, with a *Length of Stay* of 0 days [*ddate* – *admdate* = 0] in the Discharge Abstract Database) • *Length of Stay* = 0 and transfer-through to another facility on the same day as discharge date • *Discharge disposition: cadaver (08), stillborn (09)* • Records with invalid age, sex, or HCN, or HCN not from Ontario
Denominator	Prevalent COPD patients in the COPD cohort (see Appendix B for information on generating the cohort)
Risk adjustment	The indicator is age and sex standardized. Age and sex standardization ensures that differences in age and sex are accounted for when comparing across OHTs and years. 1. Calculate *overall* (for Ontario) *admissions per 100 COPD patients* for each age and sex group combination (with age being split into 35–44, 45–54, 55–64, 65–74, 75–84, and ≥ 85 years). 2. For each OHT, multiply COPD patients within each age and sex group by *overall* (for Ontario) *admissions per 100 HF patients* to obtain *expected admissions per 100 COPD patients*. Sum across all age and sex groups to obtain a single measure for *expected admissions per 100 HF patients* for each OHT. 3. Calculate the a*ctual-to-expected* ratio as *actual admissions per 100* COPD *patients* ÷ *expected admissions per 100* COPD *patients* for each OHT. 4. Multiply the *overall* (for Ontario) *admission per 100* COPD *patients* by the *actual-to-expected ratio* to obtain age- and sex-standardized admissions per 100 COPD patients for each OHT.
Current reporting period	October 2023 to September 2024
Data source	Discharge Abstract Database: *Inpatient Admission* National Ambulatory Care Reporting System: *Ambulatory Visit* OHIP databases: *Ambulatory Visit* Registered Persons Database: *Death Year*
How to access data	Data have been released in 2024/25 through Ontario Health’s eReports portal in both the *Integrated Clinical Pathways* and *OHT Reports* modules. Data (12 months, rolling) will also be prepopulated in QIP Navigator by January 2025.

Abbreviations: COPD, chronic obstructive pulmonary disease; HCN, health card number; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Team.

3. Hospitalizations for ambulatory care sensitive conditions

Status	Priority for 2025/26
Dimension of quality	Efficient
Direction of improvement	Reduce (lower)
Type	Process
Description	The number of hospitalizations related to ACSCs, which are the health conditions that may be prevented or managed by appropriate primary health care. The 7 conditions are epilepsy, COPD, asthma, diabetes, heart failure and pulmonary edema, hypertension, and angina (diagnosis codes are listed blow). Data for this indicator are stratified by Ontario Health Team and conditions in the *OHT Reports* module.
Unit of measure	Numeric (rate per 10,000) (e.g., 453 hospitalizations per 10,000 population)
ACSC definition	Hospitalization for an ACSC is identified as any MRDx code of the following: 1. Grand mal status and other epileptic convulsions ○ ICD-9/9-CM: 345 ○ ICD-10-CA: G40, G41 2. Chronic lower respiratory diseases (except asthma) ○ Any MRDx code of – ICD-9/9-CM: 491, 492, 494, 496 – ICD-10-CA: J41, J42, J43, J44, J47 ○ MRDx of acute lower respiratory infection, only when a secondary diagnosis* of J44 in – ICD-10-CA or 496 in ICD-9/9-CM is also present – ICD-9/9-CM: 466, 480–486, 487.0 – ICD-10-CA: J10.0, J11.0, J12–J16, J18, J20, J21, J22 3. Asthma ○ ICD-9/9-CM: 493 ○ ICD-10-CA: J45 4. Diabetes ○ ICD-9: 250.0, 250.1, 250.2, 250.7 ○ ICD-9-CM: 250.0, 250.1, 250.2, 250.8 ○ ICD-10-CA: E10.0, E10.1, E10.63, E10.64, E10.9, E11.0, E11.1, E11.63, E11.64, E11.9, E13.0, E13.1, E13.63, E13.64, E13.9, E14.0, E14.1, E14.63, E14.64, E14.9 5. Heart failure and pulmonary edema† ○ ICD-9/9-CM: 428, 518.4 ○ ICD-10-CA: J81 (MRDx), I50 (MRDx), I50 as diagnosis type (1) when I11 is MRDx 6. Hypertension† ○ ICD-9/9-CM: 401.0, 401.9, 402.0, 402.1, 402.9 ○ ICD-10-CA: I10 (MRDx), I11 as MRDx when I50 as diagnosis type (1) is not present 7. Angina† ○ ICD-9: 411, 413 ○ ICD-9-CM: 411.1, 411.8, 413 ○ ICD-10-CA: I20, I23.82, I24.0, I24.8, I24.9 *Secondary diagnosis refers to a diagnosis other than the MRDx. †Excluding cases with cardiac procedures. • List of cardiac procedure codes for exclusion: ○ CCP: 47^^, 480^–483^, 489.1, 489.9, 492^–495^, 497^, 498^ ○ ICD-9-CM: 336, 35^^, 36^^, 373^, 375^, 377^, 378^, 379.4–379.8

	○ CCI: 1.HA.58.^^, 1.HA.80.^^, 1.HA.87.^^, 1.HB.53.^^, 1.HB.54.^^, 1.HB.55.^^, 1.HB.87.^^, 1.HD.53.^^, 1.HD.54.^^, 1.HD.55.^^, 1.HH.59.^^, 1.HH.71.^^, 1.HJ.76.^^, 1.HJ.82.^^, 1.HM.57.^^, 1.HM.78.^^, 1.HM.80.^^, 1.HN.71.^^, 1.HN.80.^^, 1.HN.87.^^, 1.HP.76.^^, 1.HP.78.^^, 1.HP.80.^^, 1.HP.82.^^, 1.HP.83.^^, 1.HP.87.^^, 1.HR.71.^^, 1.HR.80.^^, 1.HR.84.^^, 1.HR.87.^^, 1.HS.80.^^, 1.HS.90.^^, 1.HT.80.^^, 1.HT.89.^^, 1.HT.90.^^, 1.HU.80.^^, 1.HU.90.^^, 1.HV.80.^^, 1.HV.90.^^, 1.HW.78.^^, 1.HW.79.^^, 1.HX.71.^^, 1.HX.78.^^, 1.HX.79.^^, 1.HX.80.^^, 1.HX.83.^^, 1.HX.86.^^, 1.HX.87.^^, 1.HY.85.^^, 1.HZ.53 rubric (except 1.HZ.53.LA-KP), 1.HZ.54.^^, 1.HZ.55 rubric (except 1.HZ.55.LA-KP), 1.HZ.56.^^, 1.HZ.57.^^, 1.HZ.59.^^, 1.HZ.80.^^, 1.HZ.85.^^, 1.HZ.87.^^, 1.IF.83.^^, 1.IJ.50.^^, 1.IJ.54.GQ-AZ, 1.IJ.55.^^, 1.IJ.57.^^, 1.IJ.76.^^, 1.IJ.80.^^, 1.IJ.86.^^, 1.IK.50.^^, 1.IK.57.^^, 1.IK.80.^^, 1.IK.87.^^, 1.IN.84.^^, 1.LA.84.^^, 1.LC.84.^^, 1.LD.84.^^, 1.YY.54.LA-NJ, 1.YY.54.LA-FS, 1.YY.54.LA-NM, 1.YY.54.LA-FR, 1.YY.54.LA-FU **Note:** Code may be coded in any position. Procedures coded as abandoned after onset (Intervention Status Attribute = A) are excluded. • Admission to an acute care institution (Facility Type Code = 1) • Sex recorded as male or female
Exclusions	• Records with discharge as death (Discharge Disposition Code = 07, 72, 73, or 74) • Newborn, stillbirth, or cadaveric donor records (Admission Category Code = N, R, or S)
Risk adjustment	None
Current reporting period	October 2023 to September 2024
Data source	Discharge Abstract Database: *Inpatient Admission* OHIP databases: *Ambulatory Visit* Registered Persons Database: *Death Year*
How to access data	Data have been released in 2024/25 through Ontario Health's eReports portal in the *OHT Reports* module. Data (12 months, rolling) will also be prepopulated in QIP Navigator by January 2025.

Abbreviations: ACSC, ambulatory care sensitive condition; COPD, chronic obstructive pulmonary disease; MRDx, most responsible diagnosis; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Team.

4. Alternate level of care days expressed as a percentage of all inpatient days in the same period (also known as % ALC days)

Status	Priority for 2025/26
Dimension of quality	Efficient
Direction of improvement	Reduce (lower)
Type	Process
Description	This indicator measures the percentage of time (i.e., inpatient days) for which acute care hospital beds were occupied by patients who had finished the acute care phase of treatment (i.e., designated *ALC* by a physician or other). Data for this indicator can be stratified by characteristics such as fiscal year, month, Ontario Health Team, discharge destination, diagnosis group, and hospital of discharge.
Unit of measure	Percentage
Calculation method	(Numerator ÷ Denominator) × 100
Numerator	Total number of inpatient days designated as *ALC,* from discharge data, in the reporting period. **Calculation steps:** • Select the DAD data element *ALC Length of Stay* • Calculate (sum) the total number of inpatient days designated as *ALC* in the reporting period **Inclusions:** • Data from acute care hospitals, including those with psychiatric beds and without psychiatric beds • Data for individuals designated as *ALC* **Exclusions:** • Records for newborns (or stillbirths) • Records with missing or invalid *Discharge Date*
Denominator	Total number of inpatient days, from discharge data, in the reporting period. **Calculation steps:** 1. Select the DAD data element *Total Length of Stay* 2. Calculate (sum) the total number of inpatient days in the reporting period **Inclusions:** • Data from acute care hospitals, including those with psychiatric beds and without psychiatric beds **Exclusions:** • Records for newborns (or stillbirths) • Records with missing or invalid *Discharge Date*
Risk adjustment	None
Current reporting period	October 2023 to September 2024
Data source	Discharge Abstract Database, Registered Persons Database
How to access data	Data can be accessed from the OHT Data Dashboard. Data (12 months, rolling) will also be prepopulated in QIP Navigator by January 2025.

Abbreviations: ALC, alternate level of care; DAD, Discharge Abstract Database; OHT, Ontario Health Team.

Optional Indicators

Chronic Disease Prevention and Management

1. Emergency department visit as first point of contact for mental health and addictions–related care

Status	Optional for 2025/26
Dimension of quality	Timely
Direction of improvement	Reduce (lower)
Type	Process
Description	This indicator measures the percentage of individuals for whom the ED was the first point of contact for mental health and addictions–related care. Data for this indicator can be stratified by characteristics such as fiscal year, month, Ontario Health Team, age, sex, diagnosis, after-hours contact, weekend contact, and hospital of discharge.
Unit of measure	Percentage
Calculation method	(Numerator ÷ Denominator) × 100

Numerator	Number of people in the Denominator without mental health and addictions–related service contact in the 2 years preceding the reporting period.
	Inclusions:
	• Individuals who did not have any of the following in the 2 years preceding the reporting period:
	  ○ Mental health and addictions–related outpatient visits to a psychiatrist, primary care provider, or pediatrician
	  ○ Mental health and addictions–related ED visits (scheduled or unscheduled)
	  ○ Mental health and addictions–related hospitalizations

Denominator	**Denominator for fiscal year data:** Number of unique Ontario residents aged 0 to 105 years with an incident (first in a fiscal year) unscheduled mental health and addictions–related ED visit in the reporting period. **Denominator for rolling (12 months, i.e., October 2023 to September 2024) and monthly data in the OHT Data Dashboard:** Number of unique Ontario residents aged 0 to 105 years with an incident (first in the reporting period) unscheduled mental health and addictions–related ED visit in the reporting period. **Inclusions:** ICD-10 codes in the • *Primary Diagnosis* field = *F06–F99* • *Secondary Diagnosis* fields = *X60–X84*, *Y10–Y19*, *Y28* when *Primary Diagnosis* is not *F06–F09*, *F20–F99*
Risk adjustment	None
Current reporting period	October 2023 to September 2024
Data source	Discharge Abstract Database, National Ambulatory Care Reporting System, Registered Persons Database, OHIP databases, Ontario Mental Health Reporting System
How to access data	Data can be accessed from the OHT Data Dashboard. Data (12 months, rolling) will also be prepopulated in QIP Navigator by January 2025.

Abbreviations: ED, emergency department; ICD-10, International Statistical Classification of Diseases and Related Health Problems Tenth Revision; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Team.

2. Percentage of screen-eligible people who are up to date with Pap tests

Status	Optional for 2025/26
Dimension of quality	Effective
Direction of improvement	Increase (higher)
Type	Process
Description	This indicator measures the percentage of screen-eligible people aged 21 to 69 years who had a cytology test (i.e., Pap test) within the previous 3 years. Data for this indicator can be stratified by characteristics such as fiscal year, quarter, Ontario Health Team, forward sortation area, Ontario Health region, LHIN, PHU, marginalization index, age, and sex. This indicator is calculated using Ontario Health Screening Activity Report methodology, which is slightly different from the previously used ICES methodology for the same indicator.
Unit of measure	Percentage
Calculation method	(Numerator ÷ Denominator) × 100

Numerator	Number of screen-eligible people aged 21 to 69 years who have completed at least 1 cytology test (i.e., Pap test) within the 3 years leading up to the last day of the reporting period.
	Inclusions:
	• Cytology tests identified through CytoBase (or OHIP databases, using fee codes listed in Appendix C), with
	  ○ All cytology tests in CytoBase counted, including those with inadequate specimens, and
	  ○ Each person counted once, regardless of number of cytology tests performed within the 3 years leading up to the last day of the reporting period

Denominator	Total number of screen-eligible people aged 21 to 69 years in Ontario in the reporting period. **Inclusions:** • Screen-eligible people in Ontario aged 21 to 69 years at the index date; the *index date* is defined as the midpoint of the reporting period **Exclusions:** • People with a missing or invalid health insurance number, date of birth, region, or postal code • People diagnosed with an invasive cervical cancer prior to the quarter or with a prior diagnosis of cervical cancer (ICD-O-3 code: *C53*) and a morphology indicative of cervical cancer, microscopically confirmed with a pathology report • People who had a colposcopy or treatment within 2 years prior to the reporting period • People with colposcopy or treatment identified using OHIP fee codes in Appendix D • People with a hysterectomy prior to the reporting period • People with a hysterectomy identified using OHIP fee codes in Appendix E
Risk adjustment	None
Current reporting period	Q2 (covering 3 years of participation up to September 2024)
Data source	CytoBase, Ontario Cancer Registry, OHIP databases, Registered Persons Database
How to access data	Data can be accessed from the OHT Data Dashboard. Data will also be prepopulated in QIP Navigator by January 2025.

Abbreviations: ICD-O-3, International Classification of Diseases for Oncology Third Edition; LHIN, local health integration network; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Team; PHU, public health unit.

3. Percentage of screen-eligible people who are up to date with mammograms

Status	Optional for 2025/26
Dimension of quality	Effective
Direction of improvement	Increase (higher)
Type	Process
Description	This indicator measures the percentage of screen-eligible people aged 50 to 74 years who completed at least 1 screening mammogram within the previous 2 years. Data for this indicator can be stratified by characteristics such as fiscal year, quarter, Ontario Health Team, forward sortation area, Ontario Health region, LHIN, PHU, marginalization index, age, and sex. This indicator is calculated using Ontario Health Screening Activity Report methodology, which is slightly different from the previously used ICES methodology for the same indicator.
Unit of measure	Percentage
Calculation method	(Numerator ÷ Denominator) × 100

Numerator	Number of screen-eligible people aged 50 to 74 years who completed at least 1 screening mammogram within the within the 2 years leading up to the last day of the reporting period.
	• Screening mammograms identified as follows:
	  ○ Ontario Breast Screening Program mammograms identified in ICMS
	  ○ Non–Ontario Breast Screening Program mammograms identified in OHIP databases using fee codes *X178* (screening bilateral mammogram) and *X185* (diagnostic bilateral mammogram)
	• With all mammograms in ICMS counted, including those with partial views, and
	• Each person counted once regardless of the number of mammograms performed within the 2 years leading up to the last day of the reporting period years

Denominator	Total number of screen-eligible people aged 50 to 74 years in the reporting period in Ontario. **Inclusions:** • Screen-eligible people aged 50 to 74 years at the index date in Ontario; the *index date* is defined as the midpoint of the reporting period **Exclusions:** • People with a missing or invalid health insurance number, date of birth, region, or postal code • People with a prior diagnosis of breast invasive cancer or ductal carcinoma in situ before the reporting period (prior diagnosis of breast cancer [ICD-O-3 code: *C50*] and a morphology indicative of ductal carcinoma in-situ or invasive breast cancer, microscopically confirmed with a pathology report) • People with a mastectomy before the reporting period; mastectomy is defined using OHIP fee codes *E505*, *E506*, *E546*, *R108*, *R109*, and *R117*
Risk adjustment	None
Current reporting period	Q2 (covering 2 years of participation up to September 2024)
Data source	ICMS–Ontario Breast Screening Program, Ontario Cancer Registry, Registered Persons Database, OHIP databases
How to access data	Data can be accessed from the OHT Data Dashboard. Data will also be prepopulated in QIP Navigator by January 2025.

Abbreviations: ICD-O-3, International Classification of Diseases for Oncology Third Edition; ICMS, Integrated Client Management System; LHIN, local health integration network; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Team; PHU, public health unit.

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

Status	Optional for 2025/26
Dimension of quality	Effective
Direction of improvement	Increase (higher)
Type	Process
Description	This indicator measures the percentage of Ontario screen-eligible people aged 50 to 74 years who had a fecal immunochemical test within the previous 2 years, a colonoscopy within the previous 10 years, or a flexible sigmoidoscopy within the previous 10 years. Data for this indicator can be stratified by characteristics such fiscal year, quarter, Ontario Health Team, forward sortation area, Ontario Health region, LHIN, PHU, marginalization index, age, and sex. This indicator is calculated using the Ontario Health Screening Activity Report methodology, which is slightly different from the previously used ICES methodology for the same indicator.
Unit of measure	Percentage
Calculation method	(Numerator ÷ Denominator) × 100

Numerator	Number of screen-eligible people aged 50 to 74 years in Ontario who had a FIT within 2 years, colonoscopy within 10 years, or flexible sigmoidoscopy within 10 years of the last day of the reporting period.
	Inclusions:
	• Individuals are considered up to date with colorectal cancer screening if they:
	  ○ Had a FIT within the 2 years leading up to the last day of the reporting period or
	  ○ Had a colonoscopy within the 10 years leading up to the last day of the reporting period or
	  ○ Had a flexible sigmoidoscopy within the 10 years leading up to the last day of the reporting period
	• FITs identified in Fecal Immunochemical Test Data Submission Portal
	• Only valid FITs included; FITs with either normal or abnormal results are considered valid
	• Colonoscopies identified using OHIP fee codes *Z555A*, *Z491A–Z499A*, or in the Colonoscopy Interim Reporting Tool or Gastrointestinal Endoscopy Data Submission Portal
	• Flexible sigmoidoscopies identified using OHIP fee code *Z580A*
	• Multiple claims with the same health insurance number and service date assumed to be for a single procedure
	• Each individual counted once regardless of number of tests performed

Denominator	Total number of screen-eligible people aged 50 to 74 years in the reporting period in Ontario. **Inclusions:** • Ontario residents aged 50 to 74 years at the index date; the *index date* is defined as the midpoint of the reporting period **Exclusions:** • Individuals with a missing or invalid health insurance number, date of birth, or postal code • Individuals diagnosed with an invasive colorectal cancer prior to the reporting period (prior diagnosis of colorectal cancer [ICD-O-3 codes: *C18.0*, *C18.2–C18.9*, *C19.9*, *C20.9*] and a morphology indicative of colorectal cancer, microscopically confirmed with a pathology report) • Individuals with a total colectomy prior to the reporting period (total colectomy is defined in OHIP databases by fee codes *S169A*, *S170A*, *S172A*)
Risk adjustment	None
Current reporting period	Q2 (covering 2 years of participation for FIT and 10 years of participation for flexible sigmoidoscopy or colonoscopy up to September 2024)
Data source	Fecal Immunochemical Test Data Submission Portal, Gastrointestinal Endoscopy Data Submission Portal, Ontario Cancer Registry, Registered Persons Database, OHIP databases

How to access data	Data can be accessed from the OHT Data Dashboard. Data will also be prepopulated in QIP Navigator by January 2025.

Abbreviations: FIT, fecal immunochemical test; ICD-O-3, International Classification of Diseases for Oncology Third Edition; LHIN, local health integration network; OHIP, Ontario Health Insurance Plan; OHT, Ontario Health Team; PHU, public health unit.

Supplementary ALC Indicators

These indicators can be used as "custom" indicators in QIP Navigator if desired and are available on the OHT Data Dashboard in the supplementary tabs.

1. Alternate level of care rate (using the Wait Time Information System)

Status	Supplementary for 2025/26
Dimension of quality	Efficient
Direction of improvement	Reduce (lower)
Type	Process
Description	This indicator measures the proportion of time (in days per fiscal quarter) in which acute and postacute care inpatient beds were occupied by patients designated as *ALC*. This indicator includes patients designated *ALC* both still waiting (open) and discharged/discontinued (closed) and is different from priority indicator 4 (*Alternate level of care days expressed as a percentage of all inpatient days in the same period (also known as % ALC days*)), which uses data from the Discharge Abstract Database. Data for this indicator can be stratified by characteristics such as hospitals, discharge destination, and type of inpatient care.
Unit of measure	Percentage
Calculation method	(Numerator ÷ Denominator) × 100
Numerator	Total number of days patients spent designated *ALC* within the specified time period. For OHTs, the Numerator associated with this indicator is presented as *ALC days per 10,000 population*.

Denominator	Total number of inpatient bed days contributed by patients within the specific time period.
	To calculate the total number of inpatient days, an extract of the Daily Bed Census Summary is taken on the 6th business day of each reporting month to coincide with the Wait Time Information System data cut-off date.
	The following guiding principles are then used to calculate inpatient bed days by designated bed type:
	• Acute
	  ○ Total number of days patients occupy beds for acute care, inclusive of beds occupied by children or adolescents for mental health care
	• Postacute
	  ○ Total number of days patients occupy beds for complex continuing care + general rehabilitation + special rehabilitation + adult mental health care
	• Complex continuing care
	  ○ Total number of days patients occupy complex continuing care beds
	• Rehabilitation
	  ○ Total number of days patients occupy general rehabilitation + special rehabilitation beds
	• Mental health
	  ○ Total number of days patients occupy beds for adult mental health care

Risk adjustment	None
Reporting frequency	Quarterly
Data source	Daily Bed Census, Wait Time Information System–ALC
How to access data	Data can be accessed from the OHT Data Dashboard.

Abbreviations: ALC, alternate level of care; OHT, Ontario Health Team.

2. Cumulative alternate level of care days

Status	Supplementary for 2025/26
Dimension of quality	Efficient
Direction of improvement	Reduce (lower)
Type	Process
Description	This indicator measures the total number of days patients are actively waiting for an alternate level of care (a less intensive level of care than an acute care hospital bed). Data for this indicator can be stratified by characteristics such as month, Ontario Health Team, type of inpatient care, discharge destination (e.g., by most appropriate discharge destination), and wait time (e.g., long wait: *ALC Length of Stay* ≥ 30 days).
Unit of measure	Number
Calculation method	Total number of days patients are actively waiting for an alternate level of care
Numerator	Not applicable
Denominator	Not applicable
Risk adjustment	None
Reporting frequency	Quarterly
Data source	Wait Time Information System
How to access data	Data can be accessed from the OHT Data Dashboard.

Abbreviations: ALC, alternate level of care; OHT, Ontario Health Team.

3. Volume of open alternate level of care cases

Status	Supplementary for 2025/26
Dimension of quality	Efficient
Direction of improvement	Reduce (lower)
Type	Process
Description	This indicator measures the number of patients waiting for an alternate level of care at a specified point in time. Data for this indicator can be stratified by characteristics such as month, Ontario Health Team, type of inpatient care, discharge destination (e.g., by most appropriate discharge destination), and wait time (e.g., long wait: *ALC Length of Stay* ≥ 30 days).
Unit of measure	Number
Calculation method	Number of patients waiting for an alternate level of care at a specified point in time
Numerator	Not applicable
Denominator	Not applicable
Risk adjustment	None
Reporting frequency	Quarterly
Data source	Wait Time Information System
How to access data	Data can be accessed from the OHT Data Dashboard.

Abbreviations: ALC, alternate level of care OHT, Ontario Health Team.

Appendices

Appendix A: HF Cohort Criteria

To identify patients within the HF cohort, query data from fiscal year (FY) 2008/09 to the most recent FY. For a given FY, the HF cohort comprises patients alive at any point during that fiscal year and diagnosed with HF any year prior to or during the FY of interest, based on the following criteria:

- Patients aged > 20 years who had 1 inpatient admission for heart failure identified through the Discharge Abstract Database, or
- Patients aged > 40 years who had 1 visit, identified through OHIP databases, with fee code *Q050*, or
- Patients aged > 40 years who had 2 ambulatory records for heart failure (identified through the National Ambulatory Care Reporting System) within 1 year of each other. Qualifying ambulatory records include:
    - ED visits with 1 of the following diagnosis codes: *I50**, *I40**, *I41**, *I42**, *I43**, or *I255**
    - Visits identified through OHIP databases with diagnosis code *428*

Qualifying Criteria for Inpatient Admissions and ED Visits

- Any diagnosis of *I50** (heart failure) and age >40 years or *Primary Diagnosis* = *I40**, *I41**, *I42**, *I43**, or *I255** and age > 20 years
- Valid health insurance number
- MCC partition = D (only for *Inpatient Admission*)

Appendix B: COPD Cohort Criteria

To identify patients within the COPD cohort, query data from fiscal year (FY) 2008/09 to the most recent FY. For a given FY, the COPD cohort comprises patients alive at any point during that fiscal year and diagnosed with COPD any year prior to or during the FY of interest. This cohort is based on "sensitive definition," meaning the patient will be included in the cohort if they meet any of the criteria below:

- Patients aged > 35 years who had 1 inpatient admission for COPD identified through the Discharge Abstract Database, with 1 of the following diagnosis codes (any diagnosis field): *J41**, *J42**, *J43**, or *J44**, or
- Patients aged > 35 years who had 1 visit, identified through OHIP databases, with fee code *491, 492,* or *496*, or
- Patients aged > 35 years who had 1 ambulatory record for COPD (identified through the National Ambulatory Care Reporting System) with 1 of the following diagnosis codes (any diagnosis field): *J41**, *J42**, *J43**, or *J44**

Appendix C: OHIP Fee Codes for Cytology Tests (Pap Tests)

The following are OHIP fee codes used to identify cytology tests (Pap tests) for optional indicator 2 (*Percentage of screen-eligible people who are up to date with Pap tests*):

- E430A: Add-on to A003, A004, A005, A006 when Pap test performed outside hospital
- G365A: Periodic – Pap smear
- E431A: When Papanicolaou smear is performed outside of hospital, to G394
- G394A: Additional for follow-up of abnormal or inadequate smears
- L713A: Lab/med/anat/path/hist/cyt/cytol/gynaecological specimen
- L733A: Cervicovaginal specimen (monolayer cell methodology)
- L812A: Cervical vaginal specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation
- Q678A: Gynaecology – pap smear – periodic – nurse practitioners

Appendix D: OHIP Fee Codes for Colposcopy and Treatment

The following are OHIP fee codes used to identify people who have had colposcopy and treatment, which are exclusion criteria for optional indicator 2 (*Percentage of screen-eligible people who are up to date with Pap tests*).

Colposcopy

- Z731: Initial investigation of abnormal cytology of vulva and/or vagina or cervix under colposcopic technique with or without biopsy(ies) and/or endocervical curetting
- Z787: Follow-up colposcopy with biopsy(ies) with or without endocervical curetting
- Z730: Follow-up colposcopy without biopsy with or without endocervical curetting

Treatment

- Z732: Cryotherapy
- Z724: Electro
- Z766: Electrosurgical excision procedure (LEEP)
- S744: Cervix – cone biopsy – any technique, with or without D&C
- Z729: Cryoconization, electroconization or CO_2 laser therapy with or without curettage for premalignant lesion (dysplasia or carcinoma in-situ), outpatient procedure

Appendix E: OHIP Fee Codes for Hysterectomy

The following are OHIP fee codes used to identify people who have had a hysterectomy, which is an exclusion criterion for optional indicator 2 (*Percentage of screen-eligible people who are up to date with Pap tests*):

- E862A: When hysterectomy is performed laparoscopically, or with laparoscopic assistance
- P042A: Obstetrics – labour – delivery – caesarean section including hysterectomy
- Q140A: Exclusion code for enrolled female patients aged 35–70 with hysterectomy
- S710A: Hysterectomy – with or without adnexa (unless otherwise specified) – with omentectomy for malignancy
- S727A: Ovarian debulking for stage 2C, 3B, or 4 ovarian cancer and may include hysterectomy
- S757A: Hysterectomy – with or without adnexa (unless otherwise specified) – abdominal – total or subtotal
- S758A: Hysterectomy – with or without adnexa (unless otherwise specified) – with anterior and posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered
- S759A: Hysterectomy – with or without adnexa (unless otherwise specified) – with anterior or posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered
- S762A: Hysterectomy – with or without adnexa (unless otherwise specified) – radical trachelectomy – excluding node dissection
- S763A: Hysterectomy – with or without adnexa (unless otherwise specified) – radical (Wertheim or Schauta) – includes node dissection
- S765A: Amputation of cervix
- S766A: Cervix uteri – exc – cervical stump – abdominal
- S767A: Cervix uteri – exc – Cervical stump – vaginal
- S816A: Hysterectomy – with or without adnexa (unless otherwise specified) – vaginal

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