

QUALITY IMPROVEMENT PLAN PROGRAM

Indicator Technical Specifications

2027/28

NOVEMBER 2026

Ontario Health

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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 the Quality Improvement Plan Program Guidance Document 2027/28, which describes the Ontario Health QIP program.

Abbreviations

AI: artificial intelligence

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CCRS: Continuing Care Reporting System

CIHI: Canadian Institute for Health Information

CTAS: Canadian Triage and Acuity Scale

DAD: Discharge Abstract Database

ED: emergency department

ERNI: Emergency Room National Ambulatory Reporting System Initiative

HbA1c: glycated hemoglobin

HPV: human papillomavirus

HRM: Health Report Manager

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

ICD-O-3: International Classification of Diseases for Oncology, 3rd edition

interRAI: International Resident Assessment Instrument

interRAI LTCF: International Resident Assessment Instrument – Long-Term Care Facilities

IRRS LTC: Integrated interRAI Reporting System – Long-Term Care

MIS: Management Information System

N/A: not applicable

NACRS: National Ambulatory Care Reporting System

OHIP: Ontario Health Insurance Plan

OLIS: Ontario Laboratories Information System

QIP: Quality Improvement Plan

RAI-MDS: Resident Assessment Instrument – Minimum Data Set 2.0

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 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 2027/28 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 are important elements of quality.
- **Safety:** A high-quality health system ensures people receive care in a way that is safe and effective.

Indicators

Some indicators have been defined as a priority for a specific sector based on consultations between the Ministry of Health, the Ministry of Long-Term Care, and Ontario Health. For priority indicators, organizations should compare current performance data to provincial benchmarks (e.g., the provincial average or target set by the Ministry of Health based on sector-wide data) or regional targets (i.e., targets set within a specific Ontario Health region based on local system priorities or historical performance trends). Optional indicators can be considered as a starting point; organizations may wish to consider including these indicators in their QIP but are not required to do so.

Collectively, these indicators support a shared focus on key system issues in Ontario. Both priority and optional indicators are listed by priority issue in the matrix for each sector (Tables 1–4), and details for each indicator are specified in the subsequent tables.

Table 1: 2027/28 Quality Improvement Plan Indicator Matrix – Access and Flow

Sector	Indicators
Hospital	• 90th percentile ambulance offload time **(priority)** **(prepopulated)** • 90th percentile ED length of stay (non-admitted, high-acuity patients) **(priority)** **(prepopulated)** • 90th percentile ED length of stay (non-admitted, low-acuity patients) **(priority)** **(prepopulated)** • 90th percentile time to physician initial assessment **(priority)** **(prepopulated)** Daily average number of patients waiting for an inpatient bed at 8 a.m. **(priority)** **(prepopulated)** • 90th percentile ED length of stay (admitted patients) **(prepopulated)** • Percentage of patients who visited the ED and left without being seen by a physician **(prepopulated)** • Percentage of people who undergo hip fracture surgery within 48 hours of first arrival at any hospital **(prepopulated)**
Interprofessional primary care	• Number of newly attached patients/clients **(priority)** • Patient/client perception of timely access to care **(priority)** • Percentage of patients/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 breast screening • Percentage of screen-eligible people who are up to date with cervical cancer screening (updated definition) • Percentage of screen-eligible people who are up to date with colorectal tests
Long-term care	• Rate of potentially avoidable ED visits for long-term care residents **(priority)** **(prepopulated)**

Table 2: 2027/28 Quality Improvement Plan Indicator Matrix – Equity

Sector	Indicators
Hospital	• Average ED wait time to physician initial assessment for individuals with sickle cell disease **(prepopulated)** • Percentage of staff (executive level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education
Interprofessional primary care	• Completion of sociodemographic data collection • Number of events and participants for traditional teaching, healing, or ceremony • Percentage of patients/clients actively receiving mental health care from a traditional provider • Percentage of staff (executive level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education
Long-term care	• Percentage of staff (executive level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education

Table 3: 2027/28 Quality Improvement Plan Indicator Matrix – Experience

Sector	Indicators
Hospital	• Did patients feel that they received adequate information about their health and their care at discharge?
Interprofessional primary care	• Do patients/clients feel comfortable and welcome at their primary care office?
Long-term care	• Do residents feel they can speak up without fear of consequences? • Do residents feel they have a voice and are listened to by staff?

Table 4: 2027/28 Quality Improvement Plan Indicator Matrix – Safety

Sector	Indicators
Hospital	• Rate of delirium onset during hospitalization **(prepopulated)** • Rate of hospital-acquired pressure injuries (stage 3, stage 4, and unstageable) **(prepopulated)** • Rate of medication reconciliation at discharge • Rate of workplace violence incidents resulting in lost-time injury
Interprofessional primary care	• Number of faxes sent per 1,000 attached patients/clients **(priority)** • Percentage of clinicians in the primary care practice using eReferral **(priority)** • Provincial digital solutions suite (5 indicators): percentage of clinicians in the primary care practice using eConsult, OLIS, HRM, online appointment booking, or AI scribe
Long-term care	• Percentage of long-term care residents in daily physical restraints **(prepopulated)** • Percentage of long-term care residents not living with psychosis who were given antipsychotic medication **(prepopulated)** • Percentage of long-term care residents who fell in the last 30 days **(prepopulated)** • Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened **(prepopulated)**

Summary of Changes to Indicators for 2027/28

HOSPITALS

- Access and flow:
  - **Retired**: 90th percentile ED wait time to inpatient bed
- Equity:
  - **Updated**: "CTAS 1 or 2" removed from "average emergency department wait time to physician initial assessment for individuals with sickle cell disease"
    to avoid missing care for patients triaged as CTAS 3, 4, or 5
- Safety:
  - **New, optional**: Rate of hospital-acquired pressure injuries (stage 3, stage 4, and unstageable) **(prepopulated)**

INTERPROFESSIONAL PRIMARY CARE

- Access and flow:
  - **Updated**: Number of newly attached patients/clients (indicator title updated to include "attached"; definition and indicator calculation remain unchanged)
- Safety:
  - **Prioritized**: Percentage of clinicians using eReferral
  - **Retired**: Percentage of clinicians using electronic prescribing

LONG-TERM CARE

- There are no changes to long-term care indicators

General Notes

Risk Adjustment

To optimally reflect performance over time in an organization, QIP indicators are not risk adjusted.

Considerations for Target Setting

- In a QIP, a *target* is a quality improvement goal that an organization strives to meet. Unlike accountability targets, which may be tied to performance expectations, QIP targets are intended to guide improvement efforts and support learning over time. They provide a clear aim for change but are not used for performance management or accountability. Instead, they are meant to stretch organizations toward goals they aspire to achieve and exceed through continuous improvement.
- Considerations for target setting are included for some indicators. Where no target is specified, additional information on appropriate target setting can be found in Target Setting.[1]
- Organizations should strive for improvement and should avoid including corporate targets that represent performance worse than current performance.

How to Access Data

Where possible, organization-level data will be prepopulated in QIP Navigator. Where mentioned, eReport data are accessible via ONE ID.

Disclaimer

While indicator data are generally considered comparable and suitable for trending over time and across assessment instruments, differences in performance outcomes may arise. These variations could be influenced by factors such as enhanced education, evolving coding practices, or genuine changes in the quality of care. As such, indicator results should be interpreted with caution.

Notes for Long-Term Care

Data Source

Long-term care safety indicators (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, percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened, percentage of long-term care residents in daily physical restraints) use data collected with either of the following:

- RAI-MDS (data are submitted to the CCRS)
- interRAI LTCF (data are submitted to the Integrated interRAI Reporting System)

As part of a phased transition, some long-term care facilities have already shifted from the CCRS (RAI-MDS assessment data) to the Integrated interRAI Reporting System (interRAI LTCF assessment data). The legacy CCRS is scheduled to be fully decommissioned in the near future.

Hospitals

Access and Flow

90th Percentile Ambulance Offload Time

DESCRIPTION

Abbreviated name: AOT (90th percentile)

Explanation: Ambulance offload time is the duration (time elapsed) between the time of ambulance arrival at the ED and the time the ambulance transfer of care process is complete.

Priority issue: Access and flow

Indicator type: Priority

Dimension of quality: Timely

Direction of improvement: Decrease (lower is better)

Evaluation metric: 90th percentile

Unit of measure: Minutes

Risk adjustment: None

Current performance reporting period: December 1, 2025, to November 30, 2026, in alignment with the Pay-for-Results program

Considerations for quality improvement target setting: Maintain or improve performance from previous year

Data source: NACRS

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.

CALCULATION

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 nth case in the sorted list.)

Inclusions

Cases where:

- Ambulance arrival for the ED 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 ED 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)
- The calculated ambulance offload time is negative
- The calculated ambulance offload time is greater than or equal to 1,440 minutes

Numerator

N/A

Denominator

N/A

90th Percentile ED Length of Stay (Non-admitted, High-Acuity Patients)

DESCRIPTION

Abbreviated name: Non-admitted, high-acuity ED LOS (90th percentile)

Explanation: ED length of stay for non-admitted patients triaged as high acuity is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the ED. It is limited to patients whose condition is triaged as more severe and who leave the ED without being admitted.

Priority issue: Access and flow

Indicator type: Priority

Dimension of quality: Timely

Direction of improvement: Decrease (lower is better)

Evaluation metric: 90th percentile

Unit of measure: Hours

Risk adjustment: None

Current performance reporting period: December 1, 2025, to November 30, 2026, in alignment with the Pay-for-Results program

Considerations for quality improvement target setting: Maintain or improve performance

Data source: NACRS

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.

CALCULATION

To obtain the 90th percentile ED length of stay for non-admitted patients triaged as high acuity:

1) Calculate the ED length of stay as the time elapsed between triage or registration (Triage Date/Time or Registration Date/Time, whichever occurs first) and departure from the ED (Date/Time Patient Left ED) for each patient visit, applying inclusion and exclusion criteria. Subtract any time spent in a clinical decision unit (where Clinical Decision Unit Flag = Yes, and time spent in clinical decision unit is calculated as Clinical Decision Unit Date Out/Time Out − Clinical Decision Unit Date In/Time In).
2) Sort the cases by ED length of stay (from shortest to longest).
3) Identify the time by which 90% had completed their stay in the ED. (If N is the total number of cases in the list, and $n = 0.9 \times N$, then the 90th percentile value is the ED length of stay of the nth case in the sorted list.)

Inclusions

Cases where:

- The ED 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 ED visit was scheduled (ED Visit Indicator = 0)
- Date or time the patient left the ED is invalid or unknown (Date/Time Patient Left ED = 9999 or missing)
- The patient left without being seen (Visit Disposition = 61 or 63)
- The calculated ED length of stay is greater than or equal to 1,666 hours (100,000 minutes)

Numerator

N/A

Denominator

N/A

90th Percentile ED Length of Stay (Non-admitted, Low-Acuity Patients)

DESCRIPTION

Abbreviated name: Non-admitted, low-acuity ED LOS (90th percentile)

Explanation: ED length of stay for nonadmitted patients triaged as low acuity is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the ED. It is limited to patients whose condition is triaged as less severe and who leave the ED without being admitted.

Priority issue: Access and flow

Indicator type: Priority

Dimension of quality: Timely

Direction of improvement: Decrease (lower is better)

Evaluation metric: 90th percentile

Unit of measure: Hours

Risk adjustment: None

Current performance reporting period: December 1, 2025, to November 30, 2026, in alignment with the Pay-for-Results program

Considerations for quality improvement target setting: Maintain or improve performance

Data source: NACRS

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.

CALCULATION

To obtain the 90th percentile ED length of stay for nonadmitted patients triaged as low acuity:

1) Calculate the ED length of stay as the time elapsed between triage or registration (Triage Date/Time or Registration Date/Time, whichever occurs first) and departure from the ED (Date/Time Patient Left ED) for each patient visit, applying inclusion and exclusion criteria. Subtract any time spent in a clinical decision unit (where Clinical Decision Unit Flag = Yes, and time spent in clinical decision unit is calculated as Clinical Decision Unit Date Out/Time Out − Clinical Decision Unit Date In/Time In).
2) Sort the cases by ED length of stay (from shortest to longest).
3) Identify the time by which 90% had completed their stay in the ED. (If N is the total number of cases in the list, and n = 0.9 × N, then the 90th percentile value is the ED length of stay of the nth case in the sorted list.)

Inclusions

Cases where:

- The ED 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 ED visit was scheduled (ED Visit Indicator = 0)
- Date or time the patient left the ED is invalid or unknown (Date/Time Patient Left ED = 9999 or missing)
- The patient left without being seen (Visit Disposition = 61 or 63)
- The calculated ED length of stay is greater than or equal to 1,666 hours (100,000 minutes)

Numerator

N/A

Denominator

N/A

90th Percentile Time to Physician Initial Assessment

DESCRIPTION

Abbreviated name: Time to PIA (90th percentile)

Explanation: ED 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.

Priority issue: Access and flow

Indicator type: Priority

Dimension of quality: Timely

Direction of improvement: Decrease (lower is better)

Evaluation metric: 90th percentile

Unit of measure: Hours

Risk adjustment: None

Current performance reporting period: December 1, 2025, to November 30, 2026, in alignment with the Pay-for-Results program

Considerations for quality improvement target setting: Maintain or improve performance

Data source: NACRS

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.

CALCULATION

To obtain the 90th percentile ED wait time to physician initial assessment:

1) Calculate the ED 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, applying inclusion and exclusion criteria.
    - *Note:* If assessment by a physician (Date/Time of Physician Initial Assessment) is less than 24 hours prior to triage or registration (Triage Date/Time or Registration Date/Time), the case is included with wait time to physician initial assessment set to 0. If assessment by a physician (Date/Time of Physician Initial Assessment) is more than 24 hours prior to triage or registration (Triage Date/Time or Registration Date/Time), the case is excluded.
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 nth 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 ED 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
- The calculated wait time to physician initial assessment is greater than or equal to 1,666 hours (100,000 minutes)

Numerator

N/A

Denominator

N/A

Daily Average Number of Patients Waiting for an Inpatient Bed at 8 a.m.

DESCRIPTION

Abbreviated name: Daily Avg # Pts Waiting for IPB @ 8 AM

Explanation: The number of patients in the ED waiting for an inpatient bed at 8 a.m. 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 ED (i.e., not yet in an inpatient bed), and then left the ED.

Priority issue: Access and flow

Indicator type: Priority

Dimension of quality: Timely

Direction of improvement: Decrease (lower is better)

Evaluation metric: Average

Unit of measure: Number of patients per day

Risk adjustment: None

Current performance reporting period: December 1, 2025, to November 30, 2026, in alignment with the Pay-for-Results program

Considerations for quality improvement target setting: Maintain or improve performance. (If current performance is not available or not applicable, a baseline may be established using reference values from published literature or recommended by clinical experts.)

Data source: NACRS

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.

CALCULATION

Inclusions

Cases where:

- Admitted patients waited in conventional and unconventional ED spaces for a bed in the hospital (include all service or bed types)
- The ED visit resulted in admission (Visit Disposition = 06 or 07)
- The admitted patient waited more than 2 hours since disposition decision was made (if time elapsed from Disposition Date/Time to Date/Time Patient Left ED > 2 hours)

Exclusions

Cases where:

- The ED 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

90th Percentile ED Length of Stay (Admitted Patients)

DESCRIPTION

Abbreviated name: Admitted ED LOS (90th percentile)

Explanation: ED 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 ED to go to an inpatient bed or operating room.

Priority issue: Access and flow

Indicator type: Optional

Dimension of quality: Timely

Direction of improvement: Decrease (lower is better)

Evaluation metric: 90th percentile

Unit of measure: Hours

Risk adjustment: None

Current performance reporting period: December 1, 2025, to November 30, 2026, in alignment with the Pay-for-Results program

Considerations for quality improvement target setting: Maintain or improve performance

Data source: NACRS

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.

CALCULATION

To obtain the 90th percentile ED length of stay for admitted patients:

1) Calculate the ED length of stay as the time elapsed between triage or registration (Triage Date/Time or Registration Date/Time, whichever occurs first) and departure from the ED for admission to an inpatient bed (Date/Time Patient Left ED), applying inclusion and exclusion criteria. Subtract any time spent in a clinical decision unit (where Clinical Decision Unit Flag = Yes, and time spent in clinical decision unit is calculated as Clinical Decision Unit Date Out/Time Out − Clinical Decision Unit Date In/Time In).
2) Sort the cases by ED length of stay (from shortest to longest).
3) Identify the time by which 90% had completed their stay in the ED. (If N is the total number of cases in the list, and n = 0.9 × N, then the 90th percentile value is the ED length of stay of the nth case in the sorted list.)

Inclusions

Cases where:

- The ED 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 ED visit was scheduled (ED Visit Indicator = 0)
- Date or time the patient left the ED is invalid or unknown (Date/Time Patient Left ED = 9999 or missing)
- The patient left without being seen (Visit Disposition = 61 or 63)
- The calculated ED length of stay is greater than or equal to 1,666 hours (100,000 minutes)

Numerator

N/A

Denominator

N/A

Percentage of Patients Who Visited the ED and Left Without Being Seen by a Physician

DESCRIPTION

Abbreviated name: % patients who visited ED and LWBS by a physician

Explanation: The percentage of visits to the ED that resulted in the patient leaving before being assessed or treated by a physician.

Priority issue: Access and flow

Indicator type: Optional

Dimension of quality: Timely

Direction of improvement: Decrease (lower is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: December 1, 2025, to November 30, 2026, in alignment with the Pay-for-Results program

Considerations for quality improvement target setting: Maintain or improve performance

Data source: NACRS

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.

CALCULATION

(Numerator ÷ Denominator) × 100%

Inclusions

- All triage levels (triage level [CTAS] = 1, 2, 3, 4, or 5)

Exclusions

Cases where:

- The Visit MIS functional centre account code is not under General Emergency Department or Urgent Care Centre
- The ED visit was scheduled (ED Visit Indicator = 0)

Numerator

Number of ED visits where the patient left without being seen by a physician, during the reporting period

Inclusions

Cases where:

- The patient left the ED without being seen (Visit Disposition = 61 or 63)

Exclusions

Cases where:

- The Visit MIS functional centre account code is not under General Emergency Department or Urgent Care Centre
- The ED visit was scheduled (ED Visit Indicator = 0)

Denominator

Total number of ED visits during the reporting period (in accordance with general inclusion and exclusion criteria)

COMMENTS

This indicator does not capture patients who visit the ED and leave without any interaction (i.e., without registration, triage, assessment, or treatment).

Percentage of People Who Undergo Hip Fracture Surgery Within 48 Hours of First Arrival at Any Hospital

DESCRIPTION

Abbreviated name: % patients with hip fracture whose time to surgery is < 48 h of first arrival at any hospital

Explanation: Time to hip fracture surgery is the duration (time elapsed) between first arrival at any hospital and the start of hip fracture surgery.This indicator uses 48 hours as the benchmark.

Priority issue: Access and flow

Indicator type: Optional

Dimension of quality: Timely

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: April 1 to September 30, 2026 (Q1 and Q2)

Considerations for quality improvement target setting: Maintain or improve performance

Data sources: DAD, NACRS

How to access data: Indicator data will be prepopulated in QIP Navigator.

CALCULATION

To obtain time to hip fracture surgery:

1) For eligible hip fracture hospitalizations (see inclusion and exclusion criteria), calculate time to surgery as the time elapsed between:
    - First ED arrival (Triage Date/Time or NACRS Registration Date/Time) and surgery start (DAD Intervention Episode Start Date/Time) if the patient entered care via the ED (DAD Entry Code = E)
    - Inpatient admission (DAD Admission Date/Time) and surgery start (DAD Intervention Episode Start Date/Time) if the patient did not enter care via the ED (direct admission, admitted via the day surgery department, or admitted via a clinic of the reporting institution [Entry Code = D, P, or C])
        - *Note:* Entry to care not via the ED might also involve transfer from other health care facilities (DAD Institution From), even if this detail is not explicitly captured. Because of the challenges in tracking such cases accurately in the DAD, further investigation is recommended to warrant a more conclusive judgment.
2) Calculate the percentage of patients with hip fracture whose time to surgery is less than 48 hours as (Numerator ÷ Denominator) × 100%

Inclusions

Cases where:

- All criteria listed in the Cohort Definition section of the *Hip Fracture* quality standard technical specifications are fulfilled (i.e., DAD Diagnosis Code [ICD-10-CA code] = S72.01, S72.08, S72.09, S72.10, S72.19, or S72.2)
  - For the *Hip Fracture* quality standard technical specifications, please contact QualityStandards@OntarioHealth.ca
- Admission is urgent or elective (DAD Admit Category)

Exclusions

Cases where:

- Health card province (Province/Territory Issuing Health Care Number) is not Ontario or health number is invalid (Health Care Number = −99 or missing)
  - *Note:* A valid Ontario health care number is required to perform data linkage between DAD and NACRS.
- Sex is missing
  - *Note:* Cases with missing sex cannot be appropriately handled or imputed within the analytical framework. For nonbinary sex, sample size is typically below the minimum threshold required for reporting, and inclusion could pose a privacy risk due to potential reidentification through back calculation.
- Age ≥ 105 years or missing
  - *Note:* Data from people older than 105 years are typically excluded from analysis due to concerns regarding data quality at extreme ages.
- Date or time of triage, admission, or surgery is invalid or unknown (NACRS Triage Date/Time, DAD Admission Date/Time, or DAD Intervention Episode Start Date/Time = 9999 or missing)
- DAD Diagnosis Code [ICD-10-CA code] = S72.00

Numerator

The number of hip fracture hospitalizations with duration between hospital arrival and surgery less than 48 hours

Denominator

Total number of eligible hip fracture hospitalizations, in accordance with inclusion and exclusion criteria

COMMENTS

Ontario Health eReport data for other indicators related to hip fracture care are also available.

Equity

Average ED Wait Time to Physician Initial Assessment for Individuals With Sickle Cell Disease

DESCRIPTION

Abbreviated name: N/A

Explanation: ED wait time to physician initial assessment is the duration (time elapsed) between triage and physician initial assessment for patients with sickle cell disease

Priority issue: Equity

Indicator type: Optional

Dimension of quality: Equitable

Direction of improvement: Decrease (lower is better)

Evaluation metric: Average

Unit of measure: Minutes

Risk adjustment: None

Current performance reporting period: April 1 to September 30, 2026 (Q1 and Q2)

Considerations for quality improvement 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

Data source: NACRS

How to access data: Indicator data will be prepopulated in QIP Navigator for hospitals with at least 6 unscheduled ED visits for patients with sickle cell disease.

CALCULATION

(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:

- 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 ED 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)
- The calculated 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 ED visits made by patients with sickle cell disease

Denominator

Total number of ED visits made by patients with sickle cell disease

COMMENTS

All CTAS levels (1–5) are included to capture care across the full range of patient acuity. Limiting the indicator to higher-acuity cases could miss gaps in care among patients triaged at CTAS levels 3 to 5, for whom delays or differences in care can still matter. This approach ensures that opportunities for improvement are not missed among lower-acuity groups, who may still experience disparities in access or timeliness of care.

Ontario Health eReport data are available for other indicators related to sickle cell disease care are also available.

For the *Sickle Cell Disease* quality standard technical specifications, please contact QualityStandards@OntarioHealth.ca.

Percentage of Staff (Executive Level, Management, or All) Who Have Completed Relevant Equity, Diversity, Inclusion, and Antiracism Education

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education (e.g., information sessions, training courses, online modules, webinars)

Priority issue: Equity

Indicator type: Optional

Dimension of quality: Equitable

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve performance

Data source: These data should be accessed from within your own organization, from your organization's learning management system or by using training platform participation and completion rates for assigned modules.

How to access data: Local data collection

CALCULATION

(Numerator ÷ Denominator) × 100%

Numerator

Number of staff who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period

Note: 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).

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

Note: 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).

Inclusions

- Staff (workers) actively working at the organization at any point within the reporting period

COMMENTS

Teams that include this indicator year over year are often measuring different populations or different training initiatives each year. Doing so may result in a new iteration of the indicator rather than a continuation of previous improvement efforts. In some cases, targets may be adjusted to reflect shifting organizational priorities; therefore, absolute improvement may not be observed consistently. It is acceptable for targets to be lower if priorities have changed.

Experience

Did Patients Feel That They Received Adequate Information About Their Health and Their Care at Discharge?

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of respondents who responded "Completely" to the 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?"

Priority issue: Experience

Indicator type: Optional

Dimension of quality: Patient-centred

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve performance

Data source: Patient experience survey administered by your organization

How to access data: Local data collection

CALCULATION

(Numerator ÷ Denominator) × 100%

- From CIHI's Canadian Patient Experiences Survey on Inpatient Care[3]:
  - Question 30: "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?"
  - Response options: Not at all, Partly, Quite a bit, Completely
  - *Note:* This question is also found in the Ontario Hospital Association's Ontario Adult Inpatient Short-Form Patient Experience Survey (question 7).[4]

Numerator

Number of respondents who answered "Completely"

Inclusions

- 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)

COMMENTS

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

DESCRIPTION

Abbreviated name: N/A

Explanation: Hospital-acquired delirium among inpatient hospitalizations in acute care as percentage of all hospitalizations

Priority issue: Safety

Indicator type: Optional

Dimension of quality: Safe

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.

Evaluation metric: N/A

Unit of measure: Percentage per year

Risk adjustment: None

Current performance reporting period: April 1 to September 30, 2026 (Q1 and Q2), based on the discharge date (Discharge Date/Time)

Considerations for quality improvement target setting: Maintain or improve performance

Data source: DAD

How to access data: Indicator data will be prepopulated in QIP Navigator.

CALCULATION

(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 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

COMMENTS

As of April 1, 2026, CIHI has mandated the assignment of a code for delirium whenever delirium is documented. As a result, hospital delirium rates are expected to increase in 2026/27 and 2027/28. Hospitals may want to re-establish their baseline in 2027/28 and aim for improvement in 2028/29.

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.[5] Although 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 R41.8x (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 Hospital-Acquired Pressure Injuries (Stage 3, Stage 4, and Unstageable)

DESCRIPTION

Abbreviated name: Rate of hospital-acquired pressure injuries

Explanation: Hospital-acquired pressure injuries are injuries to the skin and underlying tissue that develop after admission to hospital, often because of prolonged pressure, shear, or friction. These injuries are considered largely preventable and are associated with increased patient harm and length of stay.

Priority issue: Safety

Indicator type: Optional

Dimension of quality: Safe

Direction of improvement: Decrease (lower is better)

Evaluation metric: Rate of inpatients who develop a new pressure injury during their hospital stay

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: April 1 to September 30, 2026 (Q1 and Q2)

Considerations for quality improvement target setting: Maintain or improve performance

Data source: DAD

How to access data: Indicator data will be prepopulated in QIP Navigator.

CALCULATION

To obtain the rate of hospital-acquired pressure injuries:

1) Calculate the number of relevant hospitalizations (denominator).
2) Of the relevant hospitalizations, calculate the number of hospital-acquired pressure injuries (numerator).
3) Divide the number of hospital-acquired pressure injuries by the total number of relevant hospitalizations (n). Then, multiply the quotient by 100,000 to obtain the rate.

Rate of hospital-acquired pressure injuries = (# pressure injuries ÷ total # hospitalizations) × 100,000

Inclusions

Cases with:

- ICD-10-CA codes for stage 3, stage 4, or unstageable decubitus (pressure) ulcer (L89.2, L89.3, L89.8)
- People between ages 0 and 105 years
- Records with an admit category of urgent/emergent
- Records with an institution type of inpatient care

Exclusions

Cases where:

- Records have an out-of-province health card number
- Records have an invalid health card number
- Records have an entry code of newborn, day procedure, still birth, or cadaveric donor

Numerator

Number of hospitalizations with a hospital-acquired pressure injury identified using ICD-10-CA diagnosis code L89 (L89.2 [stage III], L89.3 [stage IV], L89.8 [unstageable]) for which the postadmission diagnostic type was considered hospital-acquired

Denominator

Number of relevant hospitalizations

COMMENTS

Ontario Health eReport data are available for other indicators related to pressure injury care.

For the *Pressure Injuries* quality standard technical specifications, please contact QualityStandards@OntarioHealth.ca.

Rate of Medication Reconciliation at Discharge

DESCRIPTION

Abbreviated name: N/A

Explanation: Number of discharged patients for whom a Best Possible Medication Discharge Plan was created out of the total number of patients discharged

Priority issue: Safety

Indicator type: Optional

Dimension of quality: Safe

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage per year

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve performance

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

CALCULATION

(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

- Hospital discharge that is death, newborn, or stillborn

Note: Any additional exclusions should be documented in the comments section in QIP Navigator.

Denominator

Number of patients discharged from hospital

Exclusions

- Hospital discharge that is death, newborn, or stillborn

Note: Any additional exclusions should be documented in the comments section in QIP Navigator.

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

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage 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.[6]

Priority issue: Safety

Indicator type: Optional

Dimension of quality: Safe

Direction of improvement: Decrease (lower is better). However, if your organization is focused 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.

Evaluation metric: N/A

Unit of measure: Percentage per year

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve performance

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

CALCULATION

(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.[6]

Numerator

Number of workplace violence incidents that result in a lost-time injury reported by hospital workers.

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

Exclusions

- Fatalities

Denominator

Total number of hospital full-time equivalent workers

COMMENTS

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

Number of Newly Attached Patients/Clients

DESCRIPTION

Abbreviated name: N/A

Explanation: Net number of new patients/clients attached to or enrolled with a primary care physician or nurse practitioner within the primary care organization or community health centre within the last 12 months.

This indicator takes into account patients/clients who have been newly added to the primary care organization or community health centre, as well as those who have left.

Priority issue: Access and flow

Indicator type: Priority

Dimension of quality: Efficient

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Number of patients/clients

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve performance

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

CALCULATION

To obtain the net number of new patients/clients:

1) Count the number of patients/clients newly attached or enrolled within the reporting period.
2) Subtract the patients/clients who have left the primary care organization or community health centre (e.g., died, unenrolled).

Numerator

N/A

Denominator

N/A

COMMENTS

Despite the addition of the word “attached” to the title of this indicator, the description and calculation methods remain unchanged from the 2026/27 indicator titled “Number of new patients/clients/enrolments.”

Information on identifying the number of new clients for Alliance for Healthier Communities community health centres can be found on page 4 of the Panel Size Handbook.[7]

Patient/Client Perception of Timely Access to Care

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted.

Priority issue: Access and flow

Indicator type: Priority

Dimension of quality: Timely

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: 85% to 100% is the target corridor set by the Alliance for Healthier Communities.[8]

Data source: Patient or client experience survey; e.g., the Primary Care Patient Experiences Survey

How to access data: Local data collection

CALCULATION

(Numerator ÷ Denominator) × 100%

Organizations are expected to measure progress on this indicator using the following question from the Primary Care Patient Experience Survey[9]:

- Question 6: "The last time you were sick or were concerned you had a health problem, did you get an appointment on the date you wanted?"
  - Response options: Yes, No

Numerator

Number of patients/clients who responded yes, indicating that the last time they were sick or were concerned they had a health problem, they got an appointment on the date they wanted

Denominator

Total number of patients/clients who responded to the survey question

Exclusions

- Nonrespondents

COMMENTS

This indicator can be used in all interprofessional primary care settings and is based on an indicator from the Alliance for Healthier Communities' Common Quality Improvement Plan Indicators for Comprehensive Primary Healthcare: Technical Specifications.[8]

Use of the Primary Care Patient Experience Survey is encouraged.[9] The survey was developed by Ontario Health (formerly Health Quality Ontario) in collaboration with Association of Family Health Teams of Ontario, the Alliance for Healthier 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 Primary Care Patient Experience Survey: Support Guide is also available.[10]

Percentage of Patients/Clients With Type 2 Diabetes Mellitus Who Are Up to Date With HbA1c (Glycated Hemoglobin) Blood Glucose Monitoring

DESCRIPTION

Abbreviated name: % patients/clients with type 2 diabetes mellitus who are up to date with HbA1c blood glucose monitoring

Explanation: Percentage of patients/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

Priority issue: Access and flow

Indicator type: Optional

Dimension of quality: Efficient

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve performance

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 may access data via MyPractice Primary Care Reports. Community health centres and nurse practitioner–led clinics may access data by electronic medical record query within their organizations.

CALCULATION

(Numerator ÷ Denominator) × 100%

Numerator

Number of patients/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 patients/clients with type 2 diabetes mellitus

COMMENTS

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

Percentage of Screen-Eligible People Who Are Up to Date With Breast Screening

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of screen-eligible people who have been screened for breast cancer with a mammogram in the past 2 years

Priority issue: Access and flow

Indicator type: Optional

Dimension of quality: Timely

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Q2 2026 (covering 2 years of participation for mammography up to September 2026)

Considerations for quality improvement target setting: 65% is the target set by Ontario Health.

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 may access data via MyPractice Primary Care Reports. For 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 tool. Nurse practitioner–led clinics may access data by electronic medical record query within their organization.

CALCULATION

(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 screen-eligible people aged 50 to 74 years who qualify for a screening mammogram within your organization at the index date. The index date is defined as the midpoint of the reporting period.

Inclusions

- People assigned female at birth and gender-diverse people who are receiving estrogen

Exclusions

- People who have had a mastectomy or who have a history of breast cancer

COMMENTS

This indicator has been adapted from the *Indigenous Primary Health Care Council (IPHCC) Funding Agreement Quarterly Indicators*. 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 from Ontario Health is available from First Nations, Inuit, Métis and Urban Indigenous Cancer Screening Resources.

Percentage of Screen-Eligible People Who Are Up to Date With Cervical Cancer Screening

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of eligible people who have been screened for cervical cancer in the past 5 years

Priority issue: Access and flow

Indicator type: Optional

Dimension of quality: Timely

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Q2 2026 (covering 42 months of participation for cytology [Pap] testing and 66 months of participation for HPV testing up to September 2026)

Considerations for quality improvement target setting: 60% is the target set by Ontario Health.

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 may access data via MyPractice Primary Care Reports. For 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 tool. Nurse practitioner–led clinics may access data by electronic medical record query within their organization.

CALCULATION

(Numerator ÷ Denominator) × 100%

Numerator

Total number of people in the denominator who had at least 1 screening HPV test in the past 66 months or cytology (Pap) test in the past 42 months

Inclusions

People:

- With a cervix aged 25 to 69 years
- Who had at least 1 cytology (Pap) test in the past 42 months or screening HPV test in the past 66 months

Denominator

Total number of screen-eligible people with a cervix aged 25 to 69 years within your organization at the index date (defined as the midpoint of the reporting period).

Exclusions

- People diagnosed with invasive cervical cancer prior to the reporting period; prior diagnosis of cervical cancer was defined as ICD-O-3 code: C53, a morphology indicative of cervical cancer, or microscopically confirmed with a pathology report
- People who had a colposcopy or treatment (OHIP fee codes: Z732, Z724, Z766, S744, Z729) within 18 months prior to the reporting period

COMMENTS

Ontario transitioned from cytology (Pap) testing to human papillomavirus (HPV) primary screening as the recommended cervical cancer screening method starting March 2025. As part of this shift, the initiation age for screening will move to 25 years with HPV testing, replacing the previous start age of 21 for Pap tests. With this change, the screening interval will also increase from every 3 years to every 5 years for most eligible individuals.

This indicator has been adapted from *Indigenous Primary Health Care Council (IPHCC) Funding Agreement Quarterly Indicators*. 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 from Ontario Health is available from First Nations, Inuit, Métis and Urban Indigenous Cancer Screening Resources.

Percentage of Screen-Eligible People Who Are Up to Date With Colorectal Tests

DESCRIPTION

Abbreviated name: N/A

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

Priority issue: Access and flow

Indicator type: Optional

Dimension of quality: Timely

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Q2 2026 (covering 2 years of participation for fecal immunochemical test and 10 years of participation for flexible sigmoidoscopy or colonoscopy up to September 2026)

Considerations for quality improvement target setting: 65% is the target set by Ontario Health.

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 may access data via MyPractice Primary Care Reports. For 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 tool. Nurse practitioner–led clinics may access data by electronic medical record query within their organization.

CALCULATION

(Numerator ÷ Denominator) × 100%

Numerator

Total number of people in the denominator who have been screened for colorectal cancer within the designated time frames (see inclusion criteria)

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 screen-eligible people aged 50 to 74 years within your organization at the index date. The index date is defined as the midpoint of the reporting period

Exclusions

- If feasible, people who have had a colectomy or who have a history of colorectal cancer

COMMENTS

This indicator has been adapted from the *Indigenous Primary Health Care Council (IPHCC) Funding Agreement Quarterly Indicators*. 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 from Ontario Health is available: First Nations, Inuit, Métis and Urban Indigenous Cancer Screening Resources.

Equity

Completion of Sociodemographic Data Collection

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of patients/clients who responded to at least 1 of the 4 specified sociodemographic questions among clients who had an individual encounter with the primary care organization within the most recent consecutive 12-month period

Priority issue: Equity

Indicator type: Optional

Dimension of quality: Equitable

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: 65% to 100% is the target corridor set by the Alliance for Healthier Communities.[8]

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

CALCULATION

(Numerator ÷ Denominator) × 100%

Numerator

Number of patients/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/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/clients (e.g., not an individual patient [or client] visit)
- Patients/clients younger than 13 years
- Patients/clients who had unregistered encounters (e.g., nonrostered clients)
- Anonymous patients/clients
- Patients/clients who did not have an encounter with the primary care organization in the reporting period

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.

Number of Events and Participants for Traditional Teaching, Healing, or Ceremony

DESCRIPTION

Abbreviated name: N/A

Explanation: 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.

Priority issue: Equity

Indicator type: Optional

Dimension of quality: Equitable

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Count

Risk adjustment: None

Current performance reporting period: Most recent quarter of data available

Considerations for quality improvement target setting: Maintain or improve performance

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

CALCULATION

Item A: Calculate the sum of the number of events for traditional teaching, healing, or ceremony. (Item A will appear in the comments section for this indicator.)

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. (The current performance and target performance fields apply to item B.)

Numerator

For the population or cultural group of interest:

- Item A: Total number of events for traditional teaching, healing, or ceremony
- Item B: Total number of clients who accessed traditional teaching, healing, or ceremony plus the number of participants in events for traditional teaching, healing, or ceremony

Note: The population or cultural group of interest should also be specified in the Primary Care Population field.

Denominator

N/A

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. The inclusion of item B is a requirement for selecting this indicator, although organizations are encouraged to capture both items A and B.

Percentage of Patients/Clients Actively Receiving Mental Health Care From a Traditional Provider

DESCRIPTION

Abbreviated name: % patients/clients actively receiving mental health care from a traditional provider

Explanation: Percentage of patients/clients actively receiving mental health care from a traditional provider, out of all clients receiving care from a traditional provider

Priority issue: Equity

Indicator type: Optional

Dimension of quality: Equitable

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent quarter of data available

Considerations for quality improvement target setting: Maintain or improve performance

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

CALCULATION

(Numerator ÷ Denominator) × 100%

Numerator

Number of patients/clients who had an encounter with a traditional provider for mental health care

Denominator

Number of patients/clients who had an encounter with a traditional provider. ("Traditional provider" may include roles such as traditional healer, cultural coordinator, or similar.)

COMMENTS

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

Percentage of Staff (Executive Level, Management, or All) Who Have Completed Relevant Equity, Diversity, Inclusion, and Antiracism Education

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education (e.g., information sessions, training courses, online modules, webinars)

Priority issue: Equity

Indicator type: Optional

Dimension of quality: Equitable

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve performance

Data source: These data should be accessed from within your own organization, from your organization's learning management system or by using training platform participation and completion rates for assigned modules.

How to access data: Local data collection

CALCULATION

(Numerator ÷ Denominator) × 100%

Numerator

Number of staff who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period

Note: 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).

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

COMMENTS

Teams that include this indicator year over year are often measuring different populations or different training initiatives each year. Doing so may represent a new iteration of the indicator rather than a continuation of previous improvement efforts. In some cases, targets may be adjusted to reflect shifting organizational priorities; therefore, absolute improvement may not be observed consistently. It is acceptable for targets to be lower if priorities have changed.

Experience

Do Patients/Clients Feel Comfortable and Welcome at Their Primary Care Office?

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of patients/clients who report feeling comfortable and welcome at the primary care office

Priority issue: Experience

Indicator type: Optional

Dimension of quality: Patient-centred

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: 90% to 100% is the target corridor set by the Alliance for Healthier Communities.[8]

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

CALCULATION

(Numerator ÷ Denominator) × 100%

Numerator

Number of patients/clients who responded "Yes" to the statement "I always feel comfortable and welcome at [centre/office name]" (response options: yes, no)

Denominator

Total number of patients/clients who responded to the survey question

COMMENTS

This indicator can be used in all interprofessional primary care settings and was based on the Alliance for Healthier Communities' Common Quality Improvement Plan Indicators for Comprehensive Primary Healthcare: Technical Specifications.[8]

Safety

Number of Faxes Sent per 1,000 Attached Patients/Clients

DESCRIPTION

Abbreviated name: N/A

Explanation: Number of faxes in a quarter per 1,000 patients/clients attached to the primary care organization

Priority issue: Safety

Indicator type: Priority

Dimension of quality: Safe

Direction of improvement: Decrease (lower is better)

Evaluation metric: N/A

Unit of measure: Number of faxes

Risk adjustment: None

Current performance reporting period: Most recent quarter of data available (consecutive 3-month period)

Considerations for quality improvement target setting: Maintain or improve performance

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

CALCULATION

(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/clients rostered/attached to the primary care organization

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 transmissions, which pose patient safety risks. A focus away from faxes also lessens administrative burden.

Percentage of Clinicians in the Primary Care Practice Using eReferral

DESCRIPTION

Abbreviated name: eReferral

Explanation: Percentage of clinicians in the primary care practice using eReferral

Priority issue: Safety

Indicator type: Priority

Dimension of quality: Safe

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent information available

Considerations for quality improvement target setting: Maintain or improve performance

Data source: These data should be accessed from within your own organization via communication with clinicians.

How to access data: Local data collection

CALCULATION

(Numerator ÷ Denominator) × 100

The number of clinicians using eReferral divided by the total number of clinicians in the primary care practice

Note: Organizations will be asked to enter the numerators and the denominator in QIP Navigator.

Numerator

Number of clinicians in the primary care practice using eReferral

Denominator

Total number of clinicians in the primary care practice

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. Additionally, digital solutions have the potential to improve continuity and coordination of care by enabling more timely and reliable access to health information across providers, reducing duplication, and supporting more informed decision-making – ultimately contributing to a more connected care experience.

Provincial Digital Solutions Suite (5 Indicators): Percentage of Clinicians in the Primary Care Practice Using eConsult, OLIS, HRM, Online Appointment Booking, or AI Scribe

DESCRIPTION

Abbreviated name: N/A

Explanation: A suite of 5 indicators, each representing the percentage of clinicians in the primary care organization who are using the specified provincial digital solution:

- eConsult
- OLIS
- HRM
- Online appointment booking
- AI scribe

Priority issue: Safety

Indicator type: Optional

Dimension of quality: Safe

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent information available

Considerations for quality improvement target setting: Maintain or improve performance

Data source: These data should be accessed from within your own organization via communication with clinicians.

How to access data: Local data collection

CALCULATION

(Numerator ÷ Denominator) × 100

Number of clinicians using the digital solution divided by the total number of clinicians in the primary care practice.

Note: Organizations will be asked to enter the numerators and the denominator in QIP Navigator.

Numerator

Number of clinicians in the primary care organization using:

- eConsult
- OLIS
- HRM
- Online appointment booking
- AI scribe

Denominator

Total number of clinicians in the primary care organization

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. Additionally, digital solutions have the potential to improve continuity and coordination of care by enabling more timely and reliable access to health information across providers, reducing duplication, and supporting more informed decision-making – ultimately contributing to a more connected care experience.

Long-Term Care

Access and Flow

Rate of Potentially Avoidable ED Visits for Long-Term Care Residents

DESCRIPTION

Abbreviated name: Rate of potentially avoidable ED visits for LTC residents

Explanation: Number of ED visits for a modified list of ambulatory care–sensitive conditions per 100 long-term care residents

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

Priority issue: Access and flow

Indicator type: Priority

Dimension of quality: Efficient

Direction of improvement: Decrease (lower is better)

Evaluation metric: N/A

Unit of measure: Rate per 100 residents

Risk adjustment: None

Current performance reporting period: October 1, 2025, to September 30, 2026 (Q3 to the end of the following Q2)

Considerations for quality improvement target setting: Maintain or improve performance

Data sources: CCRS and NACRS data provided by the Health Analytics and Insights Branch of 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 of Long-Term Care via the Long-Term Care Homes Portal.

CALCULATION

(Numerator ÷ Denominator) × 100

The number of unscheduled ED visits made by long-term care home residents for the selected conditions divided by the population of long-term care home residents.

Numerator

Total unscheduled ED visits for a modified list of ambulatory care–sensitive conditions.

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

Inclusions

- Transfers between EDs and ED visits that resulted in admission or death, for all long-term care home residents in Ontario

Exclusions

- The ED 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

Equity

Percentage of Staff (Executive Level, Management, or All) Who Have Completed Relevant Equity, Diversity, Inclusion, and Antiracism Education

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education (e.g., information sessions, training courses, online modules, webinars)

Priority issue: Equity

Indicator type: Optional

Dimension of quality: Equitable

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve performance

Data source: These data should be accessed from within your own organization, from your organization's learning management system or by using training platform participation and completion rates for assigned modules.

How to access data: Local data collection

CALCULATION

(Numerator ÷ Denominator) × 100%

Numerator

Number of staff who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period

Note: 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).

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

COMMENTS

Teams that include this indicator year over year are often measuring different populations or different training initiatives each year. Doing so may represent a new iteration of the indicator rather than a continuation of previous improvement efforts. In some cases, targets may be adjusted to reflect shifting organizational priorities; therefore, absolute improvement may not be observed consistently. It is acceptable for targets to be lower if priorities have changed.

Experience

Do Residents Feel They Can Speak Up Without Fear of Consequences?

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of residents who responded positively to the statement "I can express my opinion without fear of consequences"

Priority issue: Experience

Indicator type: Optional

Dimension of quality: Patient-centred

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve 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

CALCULATION

(Numerator ÷ Denominator) × 100%

Homes using the interRAI Quality of Life Survey[11] should measure this domain by calculating the percentage of residents who responded positively to the statement "I can express my opinion without fear of consequences" (question F3).

- Response options:
  - 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 3 or 4

Denominator

Total number who registered any response to the statement (responses from 0 to 8), which includes nonrespondents (6, 7, 8)

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?

DESCRIPTION

Abbreviated name: N/A

Explanation: Percentage of residents who responded positively to the question "What number would you use to rate how well the staff listen to you?"

Priority issue: Experience

Indicator type: Optional

Dimension of quality: Patient-centred

Direction of improvement: Increase (higher is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None

Current performance reporting period: Most recent consecutive 12-month period

Considerations for quality improvement target setting: Maintain or improve performance

Data source: These data should be accessed from within your own organization using a tool such as the Nursing Home CAHPS Long-Stay Resident Survey.[12]

How to access data: Local data collection

CALCULATION

(Numerator ÷ Denominator) × 100%

Homes using the Nursing Home CAHPS Long-Stay Resident Survey[12] 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 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.

Denominator

For homes using the Nursing Home CAHPS Long-Stay Resident Survey, the total number of residents who registered any response to the question.

Exclusions

- Nonrespondents

COMMENTS

For more information about the Nursing Home CAHPS Long-Stay Resident Survey, refer to the Agency for Healthcare Research and Quality website.

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

Safety

Percentage of Long-Term Care Residents in Daily Physical Restraints

DESCRIPTION

Abbreviated name: % LTC residents in daily physical restraints

Explanation: Percentage of long-term care residents who were in daily physical restraints for the 7 days preceding their resident assessment

Priority issue: Safety

Indicator type: Optional

Dimension of quality: Safe

Direction of improvement: Decrease (lower is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None (unadjusted for QIP)

Current performance reporting period: July 1 to September 30, 2026 (Q2), as target quarter of rolling 4-quarter average.

Note: The indicator is calculated by CIHI as a rolling 4-quarter average. Q2 2026/27 is calculated based on data from Q3 2025/26, Q4 2025/26, Q1 2026/27, and Q2 2026/27.

Considerations for quality improvement target setting: Maintain or improve performance

Data source: IRRS LTC Secure Reporting tool (data provided by CIHI)

How to access data: Indicator data will be prepopulated in QIP Navigator. The summary data are publicly accessible at the CIHI Indicator Library.

CALCULATION

(Numerator ÷ Denominator) × 100%

Both the numerator and denominator are calculated using a rolling 4-quarter average (target quarter and the 3 preceding quarters).

Note: The indicator is calculated by CIHI as a rolling 4-quarter average. Q2 2026/27 is calculated based on data from Q3 2025/26, Q4 2025/26, Q1 2026/27, and Q2 2026/27.

Numerator

Inclusions

- Residents who were physically restrained daily in the 7 days prior to their target assessment with trunk (RAI-MDS P4c = 2; interRAI LTCF O7b ≥ 2), limb (RAI-MDS P4d = 2; interRAI LTCF: N/A), or Chair Prevents Rising (RAI-MDS P4e = 2; interRAI LTCF O7c ≥ 2) restraints

Exclusions

- Residents who are comatose (RAI-MDS B1 = 1; interRAI LTCF C1 = 5) or quadriplegic (RAI-MDS I1bb = 1; interRAI LTCF I1i = 1)

Denominator

Number of long-term care home residents with a valid RAI-MDS assessment.

Note: 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

Exclusions

- Residents who are comatose (RAI-MDS B1 = 1; interRAI LTCF C1 = 5) or quadriplegic (RAI-MDS I1bb = 1; interRAI LTCF I1i = 1)

COMMENTS

For the purposes of quality improvement planning, unadjusted rates (i.e., not risk-adjusted) should be used. When benchmarking externally, variations in patient age, socioeconomic status, and comorbidities act as noise that disrupts fair comparison. However, because the local patient population in a long-term care setting usually remains stable, unadjusted data are more reasonable for learning and execution in the context of quality improvement.

Ontario Health develops confidential practice reports for physicians who practice in long-term care facilities. These reports are intended to complement other sources of information physicians receive. For more information, please visit MyPractice Report: Long-Term Care.

Percentage of Long-Term Care Residents Not Living With Psychosis Who Were Given Antipsychotic Medication

DESCRIPTION

Abbreviated name: % LTC residents not living with psychosis who were given antipsychotic medication

Explanation: Percentage of long-term care home residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.

Priority issue: Safety

Indicator type: Optional

Dimension of quality: Safe

Direction of improvement: Decrease (lower is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None (unadjusted for QIP)

Current performance reporting period: July 1 to September 30, 2026 (Q2), as target quarter of rolling 4-quarter average

Note: The indicator is calculated by CIHI as a rolling 4-quarter average. Q2 2026/27 is calculated based on data from Q3 2025/26, Q4 2025/26, Q1 2026/27, and Q2 2026/27.

Considerations for quality improvement target setting: Maintain or improve performance

Data source: IRRS LTC Secure Reporting tool (data provided by CIHI)

How to access data: Indicator data will be prepopulated in QIP Navigator. The summary data are publicly accessible at the CIHI Indicator Library.

CALCULATION

(Numerator ÷ Denominator) × 100%

Both the numerator and denominator are calculated using a rolling 4-quarter average (target quarter and the 3 preceding quarters).

Note: The indicator is calculated by CIHI as a rolling 4-quarter average. Q2 2026/27 is calculated based on data from Q3 2025/26, Q4 2025/26, Q1 2026/27, and Q2 2026/27.

Numerator

Number of long-term care home residents who received antipsychotic medication on 1 or more days in the week before their target assessment

Note: 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
- Not be an admission full assessment

Inclusions

- Residents who received an antipsychotic medication during the 7 days preceding assessment (RAI-MDS O4a = 1, 2, 3, 4, 5, 6, or 7; interRAI LTCF N7a = 1)

Denominator

Number of long-term care home residents with a valid RAI-MDS assessment

Note: 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
- Not be an admission full assessment

Exclusions

- Residents who have end-stage disease (RAI-MDS J5c = 1; interRAI LTCF J6c = 1) or are receiving hospice care (RAI-MDS P1ao = 1; interRAI LTCF O2m = 2 or 3)
- Residents who have a diagnosis of schizophrenia (RAI-MDS I1ii = 1; interRAI LTCF I1q = 1, 2 or 3) or Huntington's chorea (RAI-MDS I1x = 1; interRAI LTCF I2ab = G10 or G3080*), or those experiencing hallucinations (RAI-MDS J1i = 1; interRAI LTCF J2i = 1, 2, 3 or 4) or delusions (RAI-MDS J1e = 1; interRAI LTCF J2h = 1, 2, 3 or 4)
- ICD-10-CA codes for Huntington's chorea

COMMENTS

For quality improvement planning, unadjusted data (i.e., not risk-adjusted) should be used. When benchmarking externally, variations in patient age, socioeconomic status, and comorbidities act as noise that disrupts fair comparison. However, because the local patient population in a long-term care setting usually remains stable, unadjusted data are more reasonable for learning and execution in the context of quality improvement.

The Appropriate Use Coalition's national expert panel recommends targeting an annual decline of 15% year over year until an indicator value of 15 percentage points is obtained.[13]

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 Report: Long-Term Care.

Percentage of Long-Term Care Residents Who Fell in the Last 30 Days

DESCRIPTION

Abbreviated name: % LTC residents who fell in the last 30 days

Explanation: Percentage of long-term care home residents who fell in the 30 days leading up to their assessment

Priority issue: Safety

Indicator type: Optional

Dimension of quality: Safe

Direction of improvement: Decrease (lower is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None (unadjusted for QIP)

Current performance reporting period: July 1 to September 30, 2026 (Q2), as target quarter of rolling 4-quarter average

Note: The indicator is calculated by CIHI as a rolling 4-quarter average. Q2 2026/27 is calculated based on data from Q3 2025/26, Q4 2025/26, Q1 2026/27, and Q2 2026/27.

Considerations for quality improvement target setting: Maintain or improve performance

Data source: IRRS LTC Secure Reporting tool (data provided by CIHI)

How to access data: Indicator data will be prepopulated in QIP Navigator. The summary data are publicly accessible at the CIHI Indicator Library.

CALCULATION

(Numerator ÷ Denominator) × 100%

Both the numerator and denominator are calculated using a rolling 4-quarter average (target quarter and the 3 preceding quarters).

Note: The indicator is calculated by CIHI as a rolling 4-quarter average. Q2 2026/27 is calculated based on data from Q3 2025/26, Q4 2025/26, Q1 2026/27, and Q2 2026/27.

Numerator

Number of long-term care home residents who fell in the 30 days leading up to the date of their quarterly clinical assessment

Note: 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

Inclusions

- Residents who fell in past 30 days (RAI-MDS J4a = 1; interRAI LTCF J1a = 1 or 2)

Denominator

Number of long-term care home residents with a valid RAI-MDS assessment

COMMENTS

For the purposes of quality improvement planning, unadjusted rates (i.e., not risk-adjusted) should be used. When benchmarking externally, variations in patient age, socioeconomic status, and comorbidities act as noise that disrupts fair comparison. However, because the local patient population in a long-term care setting usually remains stable, unadjusted data are more reasonable for learning and execution in the context of quality improvement.

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 Report: Long-Term Care.

Percentage of Long-Term Care Residents Whose Stage 2 to 4 Pressure Ulcer Worsened

DESCRIPTION

Abbreviated name: % LTC residents with pressure ulcer (stage 2–4), worsened

Explanation: Percentage of long-term care residents who had a stage 2 to stage 4 pressure ulcer that worsened in the period between 2 assessments

Priority issue: Safety

Indicator type: Optional

Dimension of quality: Safe

Direction of improvement: Decrease (lower is better)

Evaluation metric: N/A

Unit of measure: Percentage

Risk adjustment: None (unadjusted for QIP)

Current performance reporting period: July 1 to September 30, 2026 (Q2), as reporting quarter for the rolling 4-quarter average

Note: The indicator is calculated by CIHI as a rolling 4-quarter average. Q2 2026/27 is calculated based on data from Q3 2025/26, Q4 2025/26, Q1 2026/27, and Q2 2026/27.

Considerations for quality improvement target setting: Maintain or improve performance

Data source: IRRS LTC Secure Reporting tool (data provided by CIHI)

How to access data: Indicator data will be prepopulated in QIP Navigator. The summary data are publicly accessible at the CIHI Indicator Library.

CALCULATION

(Numerator ÷ Denominator) × 100%

Both the numerator and denominator are calculated using a rolling 4-quarter average (current performance reporting period quarter and the 3 preceding quarters).

Note: The indicator is calculated by CIHI as a rolling 4-quarter average. Q2 2026/27 is calculated based on data from Q3 2025/26, Q4 2025/26, Q1 2026/27, and Q2 2026/27.

Inclusions

- Residents with ≥ 2 valid assessments (a target assessment and a prior assessment from the preceding quarter, with a period of 45 to 165 days between assessments. If multiple assessments from the previous quarter fall within this time frame, the most recent of these is selected as the prior assessment)

Numerator

Number of long-term care home residents who, for any given assessment (the target assessment), have a pressure ulcer stage 2–4 (RAI-MDS M2a = 2, 3, or 4; interRAI LTCF L1 = 2, 3, 4, or 5) and the stage at a valid prior assessment was lower

Note: 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

Exclusions

- Residents with a stage 4 pressure ulcer (RAI-MDS M2a = 4; interRAI LTCF L1 = 4, 5) at the earlier of the 2 assessments (cannot get worse)

Denominator

Number of long-term care home residents with valid RAI-MDS assessments

Note: 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

For the purposes of quality improvement planning, unadjusted rates (i.e., not risk-adjusted) should be used. When benchmarking externally, variations in patient age, socioeconomic status, and comorbidities act as noise that disrupts fair comparison. However, because the local patient population in a long-term care setting usually remains stable, unadjusted data are more reasonable for learning and execution in the context of quality improvement.

Ontario Health develops confidential practice reports for physicians who practice in long-term care facilities. These reports are intended to complement other sources of information physicians receive. For more information, please visit MyPractice Report: Long-Term Care.

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