



QUALITY IMPROVEMENT PLAN PROGRAM

Indicator Technical Specifications

2026/27

NOVEMBER 2025

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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 *Quality Improvement Plan Program Guidance Document 2026/27*, which describes the Ontario Health QIP program.

Introduction

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

Priority Issues

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

Priority issues for 2026/27 are:

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

Indicators

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 (*Table 1*) for each sector, and details for each indicator are specified in the subsequent tables.

Table 1. Indicator matrix.

Priority issue	Indicators (optional unless marked priority), by sector		
	Hospital	Interprofessional primary care	Long-term care
 Access and flow	90th percentile ambulance offload time priority prepopulated 90th percentile emergency department wait time to physician initial assessment priority prepopulated - Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. priority prepopulated 90th percentile emergency department length of stay for nonadmitted patients triaged as low acuity priority prepopulated 90th percentile emergency department length of stay for nonadmitted patients triaged as high acuity priority prepopulated 90th percentile emergency department length of stay for admitted patients prepopulated 90th percentile emergency department wait time to inpatient bed prepopulated - Percentage of patients who visited the emergency department and left without being seen by a physician prepopulated - Percentage of patients with hip fracture whose time to surgery is less than 48 hours prepopulated	- Patient/client perception of timely access to care priority - Number of new patients/clients/enrolments priority - Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring - Percentage of screen-eligible people who are up to date with colorectal tests - Percentage of screen-eligible people who are up to date with cervical cancer screening (updated definition) - Percentage of screen-eligible people who are up to date with breast screening	Rate of potentially avoidable emergency department visits for long-term care residents priority prepopulated
 Equity	- Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education - Average emergency department wait time to physician initial assessment for individuals with sickle cell disease (CTAS 1 or 2) prepopulated	- Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education - Completion of sociodemographic data collection - Percentage of clients actively receiving mental health care from a traditional provider - Number of events and participants for traditional teaching, healing, or ceremony	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education
 Experience	Did patients feel they received adequate information about their health and their care at discharge?	Do patients/clients feel comfortable and welcome at their primary care office?	- Do residents feel they can speak up without fear of consequences? - Do residents feel they have a voice and are listened to by staff?
 Safety	- Rate of delirium onset during hospitalization prepopulated - Rate of medication reconciliation at discharge - Rate of workplace violence incidents resulting in lost-time injury	- Number of faxes sent per 1,000 rostered patients priority Provincial digital solutions suite (7 indicators): Percentage of clinicians in the primary care practice using... [eReferral, eConsult, OLIS, HRM, electronic prescribing, online appointment booking, AI scribe]	- 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 - Percentage of long-term care residents in daily physical restraints prepopulated

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

Summary of Changes to Indicators for 2026/2027

FOR HOSPITALS

- Access and flow:
 - **Prioritized** – 90th percentile emergency department length of stay for nonadmitted patients triaged as low acuity
 - **Prioritized** – 90th percentile emergency department length of stay for nonadmitted patients triaged as high acuity
 - **New, optional** – Percentage of patients with hip fracture whose time to surgery is less than 48 hours
- Equity:
 - **Retired** – Percentage of emergency department visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2)
 - **Retired** – Rate of emergency department 30-day repeat visits for individuals with sickle cell disease

FOR INTERPROFESSIONAL PRIMARY CARE

- Access and flow:
 - **Prioritized** – Patient/client perception of timely access to care
 - **Prioritized** – Number of new patients/clients/enrolments
 - **Updated** – Percentage of screen-eligible people who are up to date with cervical cancer screening (updated definition)
- Safety:
 - **Prioritized** – Number of faxes sent per 1,000 rostered patients
 - **New, optional** – Percentage of clinicians in the primary care practice using AI scribe

FOR LONG-TERM CARE

- Access and flow:
 - **Prioritized** – Rate of potentially avoidable emergency department visits for long-term care residents
- Safety:
 - **New, optional** – Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened
 - **New, optional** – Percentage of long-term care residents in daily physical restraints

General Notes

Risk adjustment

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

Considerations for target-setting

- Considerations for target setting are included for some indicators. Where no target is specified, additional information on appropriate target setting can be found in [Target Setting](#).
- 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 OneID.

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:
 - Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS), which are submitted to the Continuing Care Reporting System, or
 - interRAI Long-Term Care Facilities (interRAI LTCF) assessment, which are submitted to the Integrated interRAI Reporting System

As part of a phased transition, some long-term care facilities have already shifted from the Continuing Care Reporting System (RAI-MDS assessment data) to the Integrated interRAI Reporting System (interRAI LTCF assessment data). The legacy Continuing Care Reporting System is scheduled to be fully decommissioned by March 2026.



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.

Hospital

Access and Flow

90th percentile ambulance offload time

Abbreviated name	90th percentile AOT
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	<i>Ambulance offload time</i> is the duration (time elapsed) between the time of ambulance arrival at the emergency department and the time the ambulance transfer of care process is complete. Evaluation metric: 90th percentile
Unit of measure	Minutes
Calculation methods	To obtain the <i>90th percentile ambulance offload time</i>: 1) Calculate the <i>ambulance offload time</i> as the time elapsed between ambulance arrival (<i>Ambulance Arrival Date/Time</i>) and completion of the ambulance transfer of care process (<i>Ambulance Transfer of Care Process Date/Time</i>) for applicable cases (i.e., applying data inclusion and exclusion criteria). 2) Sort the cases by <i>ambulance offload time</i> (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 <i>ambulance offload time</i> of the nth case in the sorted list.) Inclusions: Cases where • Ambulance arrival for the emergency department visit is by air, ground, or a combination (<i>Admit via Ambulance</i> = A, G, or C) Exclusions: Cases where • Date or time of registration and triage are both invalid or unknown (<i>Registration Date/Time</i> = 9999 or missing and <i>Triage Date/Time</i> = 9999 or missing) • The <i>Visit MIS Functional Centre Account Code</i> is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0) • Date or time of either ambulance arrival or transfer of care is invalid or unknown (<i>Ambulance Arrival Date/Time</i> or <i>Ambulance Transfer of Care Process Date/Time</i> = 9999 or missing) • The calculated <i>ambulance offload time</i> is negative • The calculated <i>ambulance offload time</i> is greater than or equal to 1,440 minutes
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program
Considerations for target-setting	30 minutes or less is the target suggested by Ontario Health, in consultation with Emergency Medical Services and Paramedic Services.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

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

90th percentile emergency department wait time to physician initial assessment

Abbreviated name	90th percentile ED wait time to PIA
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	<i>Emergency department wait time to physician initial assessment</i> is the duration (time elapsed) between a patient being triaged or registered (whichever comes first) and physician initial assessment. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	To obtain the <i>90th percentile emergency department wait time to physician initial assessment</i>: 1) Calculate the emergency department wait time to physician initial assessment as the time elapsed between triage or registration (<i>Triage Date/Time</i> or <i>Registration Date/Time</i>, whichever occurs first) and the <i>Date/Time of Physician Initial Assessment</i>,^a applying inclusion and exclusion criteria. 2) Sort the cases by wait time to physician initial assessment (from shortest to longest). 3) Identify the time by which 90% had a physician initial assessment (If N is the total number of cases in the list, and $n = 0.9 \times N$, then the 90th percentile value is the wait time to physician initial assessment of the nth case in the sorted list.) Exclusions: Cases where • Date or time of registration and triage are both invalid or unknown (<i>Registration Date/Time</i> = 9999 or missing and <i>Triage Date/Time</i> = 9999 or missing) • The <i>Visit MIS Functional Centre Account Code</i> is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0) • Time of assessment is invalid or unknown (<i>Date/Time of Physician Initial Assessment</i> = 9999 or missing) or the patient left without being seen (<i>Visit Disposition</i> = 61 or 63) • <i>Date/Time of Physician Initial Assessment</i> is after either <i>Disposition Date/Time</i> or <i>Date/Time Patient Left ED</i> • 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
Risk adjustment	None
Current performance reporting period	December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program
Considerations for target-setting	3.4 hours or less is the target suggested by Ontario Health.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

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

^aIf 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.

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

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	The number of patients in the emergency department waiting for an inpatient bed at 8 a.m. (also known as <i>no bed admits</i>) is the number of people who had been admitted but who, by 8 a.m., had been waiting at least 2 hours since disposition, were still in the emergency department (i.e., not yet in an inpatient bed), and then left the emergency department. Evaluation metric: average
Unit of measure	Number of patients per day
Calculation methods	Inclusions: Cases where - Admitted patients waited in conventional and unconventional emergency department spaces for a bed in the hospital (include all service or bed types) - The emergency department visit resulted in admission (<i>Visit Disposition</i> = 06 or 07) - The admitted patient waited more than 2 hours since disposition decision was made (if time elapsed from <i>Disposition Date/Time</i> to <i>Date/Time Patient Left ED</i> > 2 hours) Exclusions: Cases where - The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0) - Date or time of disposition is invalid or unknown (<i>Disposition Date/Time</i> = 9999 or missing) - Date or time of the patient left is invalid or unknown (<i>Date/Time Patient Left ED</i> = 9999 or missing) - The time elapsed from <i>Disposition Date/Time</i> to <i>Date/Time Patient Left ED</i> was greater than 1,666 hours (100,000 minutes)
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	April 1, 2024, to March 31, 2025 (i.e., FY 2024)
Considerations for target-setting	A 25% reduction from baseline^a is the target suggested by Ontario Health.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

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

^a Defined as the most recent and relevant performance data available (either the organization's or that of comparable institutions, i.e., similar care settings and patient demographics). When such data are not available or not applicable, a baseline may be established using reference values from published literature or recommended by clinical experts.

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

Abbreviated name	90th percentile ED LOS for nonadmitted patients, low acuity
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	<i>Emergency department length of stay for nonadmitted patients triaged as low acuity</i> is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the emergency department. It is limited to patients whose condition is triaged as less severe and who leave the emergency department without being admitted. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	To obtain the <i>90th percentile emergency department length of stay for nonadmitted patients triaged as low acuity</i>: 1) Calculate the <i>emergency department length of stay</i> as the time elapsed between triage or registration (<i>Triage Date/Time</i> or <i>Registration Date/Time</i>, whichever occurs first) and departure from the emergency department (<i>Date/Time Patient Left ED</i>) for each patient visit, applying inclusion and exclusion criteria. Subtract any time spent in a clinical decision unit (where <i>Clinical Decision Unit Flag</i> = Yes, and time spent in clinical decision unit is calculated as <i>Clinical Decision Unit Date Out/Time Out</i> – <i>Clinical Decision Unit Date In/Time In</i>). 2) Sort the cases by <i>emergency department length of stay</i> (from shortest to longest). 3) Identify the time by which 90% had completed their stay in the emergency department. (If N is the total number of cases in the list, and $n = 0.9 \times N$, then the 90th percentile value is the <i>emergency department length of stay</i> of the nth case in the sorted list.) Inclusions: Cases where • The emergency department visit did not result in the patient being admitted (<i>Visit Disposition</i> not equal to 06 or 07), and the patient was triaged as low acuity (<i>Triage Level (CTAS)</i> = 4 or 5) Exclusions: Cases where • Date or time of registration and triage are both invalid or unknown (<i>Registration Date/Time</i> = 9999 or missing and <i>Triage Date/Time</i> = 9999 or missing) • The <i>Visit MIS Functional Centre Account Code</i> is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0) • Date or time the patient left the emergency department is invalid or unknown (<i>Date/Time Patient Left ED</i> = 9999 or missing) • The patient left without being seen (<i>Visit Disposition</i> = 61 or 63) • The calculated <i>emergency department length of stay</i> is greater than or equal to 1,666 hours (100,000 minutes)
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program
Considerations for target-setting	4 hours is the target set by the Ontario Health Pay for Results program.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

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

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

Abbreviated name	90th percentile ED LOS for nonadmitted patients, high acuity
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	<i>Emergency department length of stay for nonadmitted patients triaged as high acuity</i> is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the emergency department. It is limited to patients whose condition is triaged as more severe and who leave the emergency department without being admitted. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	To obtain the <i>90th percentile emergency department length of stay for nonadmitted patients triaged as high acuity</i>: 1) Calculate the <i>emergency department length of stay</i> as the time elapsed between triage or registration (<i>Triage Date/Time</i> or <i>Registration Date/Time</i>, whichever occurs first) and departure from the emergency department (<i>Date/Time Patient Left ED</i>) for each patient visit, applying inclusion and exclusion criteria. Subtract any time spent in a clinical decision unit (where <i>Clinical Decision Unit Flag</i> = Yes, and time spent in clinical decision unit is calculated as <i>Clinical Decision Unit Date Out/Time Out</i> – <i>Clinical Decision Unit Date In/Time In</i>). 2) Sort the cases by <i>emergency department length of stay</i> (from shortest to longest). 3) Identify the time by which 90% had completed their stay in the emergency department. (If <i>N</i> is the total number of cases in the list, and $n = 0.9 \times N$, then the 90th percentile value is the <i>emergency department length of stay</i> of the <i>n</i>th case in the sorted list.) Inclusions: Cases where • The emergency department visit did not result in the patient being admitted (<i>Visit Disposition</i> not equal to 06 or 07), and the patient was triaged as high acuity (<i>Triage Level (CTAS)</i> = 1, 2, or 3) Exclusions: Cases where • Date or time of registration and triage are both invalid or unknown (<i>Registration Date/Time</i> = 9999 or missing and <i>Triage Date/Time</i> = 9999 or missing) • The <i>Visit MIS Functional Centre Account Code</i> is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0) • Date or time the patient left the emergency department is invalid or unknown (<i>Date/Time Patient Left ED</i> = 9999 or missing) • The patient left without being seen (<i>Visit Disposition</i> = 61 or 63) • The calculated <i>emergency department length of stay</i> is greater than or equal to 1,666 hours (100,000 minutes)
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program
Considerations for target-setting	7 hours is the target set by the Ontario Health Pay for Results program.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

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

90th percentile emergency department length of stay for admitted patients

Abbreviated name	90th percentile ED LOS for admitted patients
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	<i>Emergency department length of stay for admitted patients</i> is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the emergency department to go to an inpatient bed or operating room. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	To obtain the <i>90th percentile emergency department length of stay for admitted patients</i>: 1) Calculate the <i>emergency department length of stay</i> as the time elapsed between triage or registration (<i>Triage Date/Time</i> or <i>Registration Date/Time</i>, whichever occurs first) and departure from the emergency department for admission to an inpatient bed (<i>Date/Time Patient Left ED</i>), applying inclusion and exclusion criteria. Subtract any time spent in a clinical decision unit (where <i>Clinical Decision Unit Flag</i> = Yes, and time spent in clinical decision unit is calculated as <i>Clinical Decision Unit Date Out/Time Out</i> – <i>Clinical Decision Unit Date In/Time In</i>). 2) Sort the cases by <i>emergency department length of stay</i> (from shortest to longest). 3) Identify the time by which 90% had completed their stay in the emergency department. (If <i>N</i> is the total number of cases in the list, and $n = 0.9 \times N$, then the 90th percentile value is the <i>emergency department length of stay</i> of the <i>n</i>th case in the sorted list.) Inclusions: Cases where • The emergency department visit resulted in patient admission (<i>Visit Disposition</i> = 06 or 07) Exclusions: Cases where • Date or time of registration and triage are both invalid or unknown (<i>Registration Date/Time</i> = 9999 or missing and <i>Triage Date/Time</i> = 9999 or missing) • The <i>Visit MIS Functional Centre Account Code</i> is not under General Emergency Department or Urgent Care Centre • The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0) • Date or time the patient left the emergency department is invalid or unknown (<i>Date/Time Patient Left ED</i> = 9999 or missing) • The patient left without being seen (<i>Visit Disposition</i> = 61 or 63) • The calculated <i>emergency department length of stay</i> is greater than or equal to 1,666 hours (100,000 minutes)
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program
Considerations for target-setting	25 hours is the target set by the Ontario Health Pay for Results program.
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

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

90th percentile emergency department wait time to inpatient bed

Abbreviated name	90th percentile ED wait time to inpatient bed
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Decrease (lower is better)
Description	<i>Emergency department wait time to inpatient bed</i> is the duration (time elapsed) between the time of visit disposition, as determined by the main service provider, and the time that the patient left the emergency department to be admitted to an inpatient bed or operating room. Evaluation metric: 90th percentile
Unit of measure	Hours
Calculation methods	To obtain the <i>90th percentile emergency department wait time to inpatient bed</i>: 1) Calculate the <i>wait time to inpatient bed</i> as the time elapsed between <i>Disposition Date/Time</i> and <i>Date/Time Patient Left ED</i> for admission to an inpatient bed (or operating room) for each case, applying inclusion and exclusion criteria. 2) Sort the cases by <i>wait time to inpatient bed</i> (from shortest to longest). 3) Identify the time by which 90% had left the emergency department to be admitted to an inpatient bed (or operating room). (If N is the total number of cases in the list, and $n = 0.9 \times N$, then the 90th percentile value is the <i>wait time to inpatient bed</i> of the nth case in the sorted list.) Inclusions: Cases where • The emergency department visit resulted in an admission (<i>Visit Disposition</i> = 06 or 07) Exclusions: Cases where • The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0) • Date or time of visit disposition is invalid or unknown (<i>Disposition Date/Time</i> = 9999 or missing) • Date or time the patient left the emergency department is invalid or unknown (<i>Date/Time Patient Left ED</i> = 9999 or missing) • The <i>Visit MIS Functional Centre Account Code</i> is not under General Emergency Department or Urgent Care Centre • The calculated <i>emergency department wait time to inpatient bed</i> is greater than or equal to 1,666 hours (100,000 minutes) • The calculated <i>emergency department wait time to inpatient bed</i> is negative
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program
Considerations for target-setting	None specified
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

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

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

Abbreviated name	% patients who visited ED and LWBS by a physician
Priority issue	Access and flow
Indicator type	Optional
Dimension	Timely
Direction of improvement	Decrease (lower is better)
Description	The percentage of visits to the emergency department that resulted in the patient leaving before being assessed or treated by a physician.
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$ Inclusions: - All triage levels (<i>Triage Level (CTAS)</i> = 1, 2, 3, 4, or 5) Exclusions: Cases where - The <i>Visit MIS Functional Centre Account Code</i> is not under General Emergency Department or Urgent Care Centre - The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0)
Numerator	Number of emergency department visits where the patient left without being seen by a physician, during the reporting period. Inclusions: Cases where - The patient left the emergency department without being seen (<i>Visit Disposition</i> = 61 or 63) Exclusions: Cases where - The patient left against medical advice (<i>Visit Disposition</i> = 62 or 64)
Denominator	Total number of emergency department visits during the reporting period (in accordance with general inclusion and exclusion criteria)
Risk adjustment	None
Current performance reporting period	April 1, 2024, to March 31, 2025 (i.e., FY 2024)
Considerations for target-setting	None specified
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. For ERNI hospitals: Site-level data are also available in Ontario Health's ED Fiscal Year Report.

Abbreviations: CTAS, Canadian Triage and Acuity Scale; ED, emergency department; ERNI, Emergency Room National Ambulatory Reporting System Initiative; FY, fiscal year; MIS, management information system.

Comments

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

Percentage of patients with hip fracture whose time to surgery is less than 48 hours

Abbreviated name	% patients with hip fracture whose time to surgery < 48 h
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Description	<i>Time to hip fracture surgery</i> is the duration (time elapsed) between first arrival to any hospital and the start of surgery for hip fracture.
Unit of measure	Percentage
Calculation methods	To obtain <i>time to hip fracture surgery</i>: - For eligible hip fracture hospitalizations (see inclusion and exclusion criteria), calculate <i>time to surgery</i> as the time elapsed between - First emergency department arrival (<i>Triage Date/Time</i> or <i>NACRS Registration Date/Time</i>) and surgery start (<i>DAD Intervention Episode Start Date/Time</i>), if the patient entered care via the emergency department (<i>DAD Entry Code</i> = E) - Inpatient admission (<i>DAD Admission Date/Time</i>) and surgery start (<i>DAD Intervention Episode Start Date/Time</i>), if the patient did not enter care via the emergency department (direct admission, admitted via the day surgery department, or admitted via a clinic of the reporting institution [<i>Entry Code</i> = D, P, or C])^a - Calculate the <i>percentage of patients with hip fracture whose time to surgery is less than 48 hours</i> as $(\text{Numerator} \div \text{Denominator}) \times 100\%$ Inclusions: Cases where - All criteria listed in the Cohort Definition section of Quality Standards: Hip Fracture Technical Specifications are fulfilled (i.e., <i>DAD Diagnosis Code</i> [ICD-10-CA code] = S72.01, S72.08, S72.09, S72.10, S72.19, or S72.2) - Admission is urgent or elective (<i>DAD Admit Category</i>) Exclusions: Cases where - Health card province (<i>Province/Territory Issuing Health Care Number</i>) is not Ontario or health number is invalid (<i>Health Care Number</i> = -99 or missing)^b - Sex is missing^c - Age ≥ 105 years^d or missing - Date or time of triage, admission, or surgery is invalid or unknown (<i>NACRS Triage Date/Time</i>, <i>DAD Admission Date/Time</i>, or <i>DAD Intervention Episode Start Date/Time</i> = 9999 or missing) <i>DAD Diagnosis Code</i> [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
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2025 (Q1 and Q2)
Considerations for target-setting	None specified
Data source	National Ambulatory Care Reporting System and Discharge Abstract Database
How to access data	Indicator data will be prepopulated in QIP Navigator.

Abbreviations: DAD, Discharge Abstract Database; ICD-10-CA, International Statistical Classification of Diseases and Related Health Problems Tenth Revision Canada; NACRS, National Ambulatory Care Reporting System.

^aEntry to care not via the emergency department 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 Discharge Abstract Database, further investigation is recommended to warrant a more conclusive judgment.

^bA valid Ontario health care number is required to perform data linkage between DAD and NACRS.

^cCases 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 re-identification through back-calculation.

^dData from people older than 105 years are typically excluded from analysis due to concerns regarding data quality at extreme ages.

Comments

Ontario Health [eReport](#) data for other indicators related to hip fracture care ([Quality Standards: Hip Fracture Technical Specifications](#)) are also available.

Equity

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education (info sessions, training courses, online modules, webinars, etc.)
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$
Numerator	Number of staff^a who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period Exclusions: Partial completions, if equity, diversity, inclusion, and antiracism education was required of staff
Denominator	Total number of staff targeted^a for equity, diversity, inclusion, and antiracism training Inclusions: Staff (workers) actively working at the organization at any point within the reporting period
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	None specified
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

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

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Decrease (lower is better)
Description	<i>Emergency department wait time to physician initial assessment</i> is the duration (time elapsed) between triage and physician initial assessment for patients with sickle cell disease whose condition was triaged as CTAS level 1 or 2. Evaluation metric: average
Unit of measure	Minutes
Calculation methods	Numerator ÷ Denominator Inclusions: Cases - With ICD-10-CA codes (in <i>Main Problem</i> or <i>Other Problem</i>) for sickle cell disease: D570, D571, D572, D578 - Where the patient's condition was triaged as <i>resuscitation</i> or <i>emergent</i> (<i>Triage Level (CTAS)</i> = 1 or 2) Exclusions: Cases where <i>Registration Date/Time</i> = 9999 or missing and <i>Triage Date/Time</i> = 9999 or missing - The <i>Visit MIS Functional Centre Account Code</i> is not under General Emergency Department or Urgent Care Centre - The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0) - Date or time of initial assessment by physician is unknown (<i>Date/Time of Physician Initial Assessment</i> = 9999 or missing) or patient left without being seen (<i>Visit Disposition</i> = 61 or 63) - The calculated <i>time to physician initial assessment</i> is greater than or equal to 100,000 minutes (1,666 hours)
Numerator	Sum of the number of minutes waited for a physician initial assessment for emergency department visits made by patients with sickle cell disease triaged CTAS level 1 or 2
Denominator	Total number of emergency department visits made by patients with sickle cell disease triaged CTAS level 1 or 2
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2025 (Q1 and Q2)
Considerations for target-setting	Target times to physician initial assessment by CTAS level have been defined by the Canadian Association of Emergency Physicians²: - For CTAS level 1 – immediate (e.g., within 5 minutes) - For CTAS level 2 – within 15 minutes - For CTAS level 3 – within 30 minutes - For CTAS level 4 – within 60 minutes - For CTAS level 5 – within 120 minutes
Data source	National Ambulatory Care Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator for hospitals with at least 6 unscheduled emergency department visits for patients with sickle cell disease.

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

Comments

Ontario Health [eReport](#) data are available for other indicators related to sickle cell disease care ([Quality Standards: Sickle Cell Disease Measurement Guide](#)) are also available.

Experience

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

Abbreviated name	N/A
Priority issue	Experience
Indicator type	Optional
Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
Description	Percentage of respondents who responded “Completely” to the following question: “Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?”
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$ From the Canadian Institute of Health Information Canadian Patient Experiences Survey—Inpatient Care³ the Ontario Hospital Association’s Adult Inpatient Short-form survey: Question 38: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? – Completely – Quite a bit – Partly – Not at all
Numerator	Number of respondents who responded “Completely” Inclusions: • Use the top-box method (i.e., count only respondents who choose the most positive response)
Denominator	Number of respondents who registered any response to this question (do not include nonrespondents)
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	None specified
Data source	Patient experience survey administered by your organization
How to access data	Local data collection

Comments

This question, from the Canadian Patient Experiences Survey — Inpatient Care, is also found within the Ontario Hospital Association’s Adult Inpatient Short-form survey (question 7).

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

Safety

Rate of delirium onset during hospitalization

Abbreviated name	N/A
Priority issue	Safety
Indicator type	Optional
Dimension of quality	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.
Description	Hospital-acquired delirium among inpatient hospitalizations in acute care as percentage of all hospitalizations.
Unit of measure	Percentage per year
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$
Numerator	Number of hospitalizations included in the denominator, with the onset of delirium during that hospitalization (i.e., hospital-acquired delirium). Note that if a patient has hospital-acquired delirium in multiple different hospitalizations, all instances will be counted in the numerator. Inclusions: Hospitalizations - For delirium not induced by alcohol and other psychoactive substances (ICD-10-CA codes F05.x; i.e., F05.0, F05.1, F05.8, F05.9) - With <i>Diagnosis Type</i> = 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 (<i>Admit Category</i> = N), stillbirths (<i>Admit Category</i> = S), and cadaveric donors (<i>Admit Category</i> = R) - In reactivation care centres or alternative health facilities
Risk adjustment	None
Current performance reporting period	April 1 to September 30, 2025 (Q1 and Q2), based on the discharge date (<i>Discharge Date/Time</i>)
Considerations for target-setting	None specified
Data source	Discharge Abstract Database
How to access data	Indicator data will be prepopulated in QIP Navigator.

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

Comments

The ability to accurately identify delirium in patients is critical to being able to initiate optimal health care. Evidence suggests that delirium is often unrecognized and misdiagnosed as another disorder or misattributed to dementia.⁴ Although International Statistical Classification of Diseases and Related Health Problems Tenth Revision Canada (ICD-10-CA) F05.x codes have a high positive predictive value for the identification of delirium, the sensitivity is low, resulting in underreporting of delirium.

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

To apply a more sensitive case definition, possible delirium cases can be captured using the F05.x codes along with proxy codes, such as R41.0 (Disorientation) and R41.8x (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 medication reconciliation at discharge

Abbreviated name	N/A
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safe
Direction of improvement	Increase (higher is better)
Description	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created out of the total number of patients discharged.
Unit of measure	Percentage per year
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$ To ensure a standardized approach to measurement, hospitals will be asked to enter the numerator and denominator in their organization's QIP workplan, and QIP Navigator will calculate the indicator value
Numerator	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created Exclusions^a: Hospital discharge that is death, newborn, or stillborn
Denominator	Number of patients discharged from hospital Exclusions^a: Hospital discharge that is death, newborn, or stillborn
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	None specified
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

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

Comments

Organizations should report current performance and set targets for medication reconciliation at discharge at the organization level (i.e., for the entire hospital). Hospitals are also asked to identify any programs or patients that are not included in their medication reconciliation calculation.

Rate of workplace violence incidents resulting in lost-time injury

Abbreviated name	N/A
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safe
Direction of improvement	Decrease (lower is better); however, if your organization is focussed on building your reporting culture, improvement may be defined as an increase. If your organization's reporting culture is already well-developed, improvement may be defined as a decrease.
Description	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 <i>Occupational Health and Safety Act</i> . ⁵
Unit of measure	Percentage per year
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$ 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 <i>worker</i> and <i>workplace violence</i> as defined in the Occupational Health and Ontario Healthy Act . ⁵
Numerator	Number of workplace violence incidents ^a that result in a lost-time injury reported by hospital workers. Exclusions: Fatalities
Denominator	Total number of hospital full-time equivalent workers
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	None specified
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

^aIf the count of incidents is greater than 0 but less than or equal to 5, the value requires suppression.

Comments

Worker and *workplace violence* are defined by the [Occupational Health and Safety Act](#).

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

Interprofessional Primary Care

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

Access and Flow

Patient/client perception of timely access to care

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Description	Percentage of patients (or clients) who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted.
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$ Organizations are expected to measure progress on this indicator using the following survey question wording (from the Primary Care Patient Experience Survey⁵): - Q6 “The last time you were sick or were concerned you had a health problem, did you get an appointment on the date you wanted?” a. Yes b. No
Numerator	Number of patients (or clients) who responded “Yes” to the survey question, indicating that the last time they were sick or were concerned they had a health problem, they got an appointment on the date they wanted
Denominator	Total number of patients (or clients) who responded to the survey question Exclusions: Nonrespondents
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	85% to 100% is the target corridor that has been set by the Alliance for Healthier Communities. ⁶
Data source	Patient or client experience survey, such as the Primary Care Patient Experiences Survey
How to access data	Local data collection

Comments

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

Use of the [Primary Care Patient Experience Survey](#) is encouraged. The survey was developed by Ontario Health (formerly Health Quality Ontario) in collaboration with Association of Family Health Teams of Ontario, Alliance for Healthy Communities, the Ontario College of Family Physicians, and the Ontario Medical Association. The survey is designed to be administered by practices and can be monitored at the organizational level to support their quality improvement efforts. A comprehensive [Survey Support Guide](#) and [an alternative version of the survey for community health centres and Aboriginal Health Access Centres](#) are also available.

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

Number of new patients/clients/enrolments

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Efficient
Direction of improvement	Increase (higher is better)
Description	Net number of new patients (or clients) attached or enrolled to a primary care physician or nurse practitioner within the primary care organization or community health centre within the last 12 months. This indicator takes into account patients (or clients, enrolments, etc.) that have been newly added to the primary care organization or community health centre, as well as those who have left.
Unit of measure	Number of patients
Calculation methods	To obtain the <i>net number of new patients</i> (or clients, enrolments, etc.): 1) Count the number of patients (or clients) newly attached or enrolled within the reporting period. 2) Subtract the patients (or clients) who have left the primary care organization or community health centre (e.g., passed away, unenrolled).
Numerator	N/A
Denominator	N/A
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	None specified
Data source	These data should be accessed from within your own organization, from the information management system or electronic medical record system.
How to access data	Local data collection

Abbreviations: N/A, not applicable.

Comments

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

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

Abbreviated name	% clients with type 2 diabetes mellitus who are up to date with HbA1c blood glucose monitoring
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Efficient
Direction of improvement	Increase (higher is better)
Description	Percentage of clients with type 2 diabetes mellitus for whom HbA1c blood glucose level monitoring has been completed at least 2 times during the past 12 months
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$
Numerator	Number of clients with type 2 diabetes mellitus for whom HbA1c blood glucose level monitoring has been completed at least 2 times during the reporting period
Denominator	Number of active clients with type 2 diabetes mellitus
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	None specified
Data source	These data should be accessed from within your own organization, from the information management system or electronic medical record system.
How to access data	Local data collection. Family health teams: Data can be accessed via MyPractice: Primary Care Reports . Community health centres and nurse practitioner-led clinics: Data can be accessed by electronic medical record query within organization.

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

Comments

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

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

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Description	Percentage of screen-eligible people who are up to date with colorectal tests
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$
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
Risk adjustment	None
Current performance reporting period	Q2 2025 (covering 2 years of participation for FIT and 10 years of participation for flexible sigmoidoscopy or colonoscopy up to September 2025)
Considerations for 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: Data can be accessed via MyPractice: Primary Care Reports 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: Data can be accessed by electronic medical record query within organization.

Abbreviations: FIT, fecal immunochemical test.

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](#).

Percentage of screen-eligible people who are up to date with cervical cancer screening (updated definition)

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Description	Percentage of eligible clients who have been screened for cervical cancer in the past 5 years.
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$
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. The index date is 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
Risk adjustment	None
Current performance reporting period	Q2 2025 (covering 42 months of participation for cytology (Pap) testing, and 66 months of participation for HPV testing up to September 2025)
Considerations for 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: Data can be accessed via MyPractice: Primary Care Reports 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: Data can be accessed by electronic medical record query within organization.

Abbreviations: HPV, human papillomavirus; ICD-O-3, *International Classification of Diseases for Oncology Third Edition*; OHIP, Ontario Health Insurance Plan.

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. During the transition period, a blended approach that incorporates both Pap tests and HPV screening will be used for cervical screening indicators, depending on the individual's stage in the screening cycle.

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: [First Nations, Inuit, Métis and Urban Indigenous Cancer Screening Resources](#).

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

Abbreviated name	N/A
Priority issue	Access and flow
Indicator type	Optional
Dimension of quality	Timely
Direction of improvement	Increase (higher is better)
Description	Percentage of screen-eligible people who have been screened for breast cancer with a mammogram in the past 2 years.
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$
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
Risk adjustment	None
Current performance reporting period	Q2 2025 (covering 2 years of participation for mammography up to September 2025)
Considerations for 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: Data can be accessed via MyPractice: Primary Care Reports 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: Data can be accessed by electronic medical record query within organization.

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: [First Nations, Inuit, Métis and Urban Indigenous Cancer Screening Resources](#).

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

Equity

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education (info sessions, training courses, online modules, webinars, etc.)
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$
Numerator	Number of staff^a who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period Exclusions: Staff with partially completed training
Denominator	Total number of staff targeted for equity, diversity, inclusion, and antiracism training Inclusions: Staff (workers) actively working at the organization at any point within the reporting period
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	None specified
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

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

Completion of sociodemographic data collection

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

Comments

This indicator can be used for all interprofessional primary care settings and is based on a question from the [Updated Health Equity \(Sociodemographic\) Questionnaire](#) by the Alliance for Healthier Communities.

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

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

Abbreviated name	% clients actively receiving mental health care from a traditional provider
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	Percentage of clients actively receiving mental health care from a traditional provider, out of all clients receiving care from a traditional provider
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$
Numerator	Number of clients who had an encounter with a traditional provider for mental health care
Denominator	Number of clients who had an encounter with a traditional provider. <i>Traditional provider</i> may include roles such as traditional healer, cultural coordinator, or similar
Risk adjustment	None
Current performance reporting period	Most recent quarter of data available
Considerations for target-setting	None specified
Data source	These data should be accessed from within your own organization, from the information management system or electronic medical record system.
How to access data	Local data collection

Comments

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

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	A 2-part indicator; item a is the number of events for traditional teaching, healing, or ceremony, and item b is the number of participants for traditional teaching, healing, or ceremony.
Unit of measure	Count
Calculation methods	Item a: Calculate the sum of the number of events for traditional teaching, healing, or ceremony ^a Item b: Calculate the sum of the number of clients who accessed traditional teaching, healing, or ceremony and the number of participants in events for traditional teaching, healing, or ceremony ^b
Numerator	For the population or cultural group of interest ^c : - Item a: Total of events for traditional teaching, healing, or ceremony - Item b: Total of the number of clients who accessed traditional teaching, healing, or ceremony plus the number of participants in events for traditional teaching, healing, or ceremony
Denominator	N/A
Risk adjustment	None
Current performance reporting period	Most recent quarter of data available
Considerations for target-setting	None specified
Data source	These data should be accessed from within your own organization, from the information management system or electronic medical record system.
How to access data	Local data collection

Abbreviations: N/A, not applicable.

^aItem a will appear in the comments section for this indicator.

^bThe *current performance* and *target performance* fields apply to item b.

^cThe population or cultural group of interest should also be specified in the *Primary Care Population* field.

Comments

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

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

Experience

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

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

Comments

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

Safety

Number of faxes sent per 1,000 rostered patients

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

Comments

This indicator is related to the [“Axe the fax”](#) and [“Patients Before Paperwork”](#) campaigns. A reduction in overall faxes reduces the number of failed or incorrect transmissions, which pose patient safety risks. A focus away from faxes also lessens administrative burden.

Provincial digital solutions suite (7 indicators): Percentage of clinicians in the primary care practice using... [eReferral, eConsult, OLIS, HRM, electronic prescribing, online appointment booking, AI scribe]

Abbreviated name	N/A
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safe
Direction of improvement	Increase (higher is better)
Description	A suite of 7 indicators, each representing the percentage of clinicians in the primary care organization who are using the specified provincial digital solution: • eReferral • eConsult • Ontario Laboratories Information System • Health Report Manager • Electronic prescribing • Online appointment booking • AI scribe
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100$ Number of clinicians using the digital solution divided by the total number of clinicians in the primary care practice. Organizations will be asked to enter the numerators and the denominator in QIP Navigator.
Numerator	a. Number of clinicians in the primary care organization who are using eReferral b. Number of clinicians in the primary care organization who are using eConsult c. Number of clinicians in the primary care organization who are using the Ontario Laboratories Information System d. Number of clinicians in the primary care organization who are using Health Report Manager e. Number of clinicians in the primary care organization who are using electronic prescribing f. Number of clinicians in the primary care organization who are using online appointment booking g. Number of clinicians in the primary care organization who are using AI scribe
Denominator	Total number of clinicians in the primary care organization
Risk adjustment	None
Current performance reporting period	Most recent information available
Considerations for target-setting	None specified
Data source	These data should be accessed from within your own organization via communication with clinicians.
How to access data	Local data collection

Comments

This indicator is related to the [“Axe the fax”](#) and [“Patients Before Paperwork”](#) campaigns. Uptake of digital solutions helps reduce overall administrative burden and fax rate. It can also reduce patient safety risks by mitigating errors in information entry and communication. 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 emergency department visits for long-term care residents

Abbreviated name	Rate of potentially avoidable ED visits for LTC residents
Priority issue	Access and flow
Indicator type	Priority
Dimension of quality	Efficient
Direction of improvement	Decrease (lower is better)
Description	Number of emergency department visits for a modified list of ambulatory care–sensitive conditions ^a per 100 long-term care residents
Unit of measure	Rate per 100 residents
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100$ The number of unscheduled emergency department 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 emergency department visits for a modified list of ambulatory care–sensitive conditions^a Inclusions: - Transfers between emergency departments and emergency department visits that resulted in admission or death, for all long-term care home residents in Ontario Exclusions: - The emergency department visit was scheduled (<i>ED Visit Indicator</i> = 0) - Visits for residents who were first admitted to the long-term care home before the age of 65 years
Denominator	Total number of active residents of long-term care homes Exclusions: - Individuals with invalid health card numbers - Residents who were first admitted to the long-term care home before the age of 65 years
Risk adjustment	None
Current performance reporting period	October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)
Considerations for target-setting	None specified
Data source	Continuing Care Reporting System and National Ambulatory Care Reporting System 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 via the Ontario Long-term Care Homes Portal

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

Equity

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

Abbreviated name	N/A
Priority issue	Equity
Indicator type	Optional
Dimension of quality	Equitable
Direction of improvement	Increase (higher is better)
Description	Percentage of staff who completed relevant equity, diversity, inclusion, and antiracism education (info sessions, training courses, online modules, webinars, etc.).
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$
Numerator	Number of staff^a who have completed relevant equity, diversity, inclusion, and antiracism education during the reporting period Exclusions: Partial completions, if equity, diversity, inclusion, and antiracism education was required of staff
Denominator	Total number of staff targeted for equity, diversity, inclusion, and antiracism training Inclusions: Staff (workers) actively working at the organization at any point within the reporting period
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	None specified
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

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

Experience

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

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

Abbreviations: interRAI, International Resident Assessment Instrument.

Comments

For more information about the interRAI Quality of Life Survey, refer to the [interRAI website](#).

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

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

Abbreviated name	N/A
Priority issue	Experience
Indicator type	Optional
Dimension of quality	Patient centred
Direction of improvement	Increase (higher is better)
Description	Percentage of residents who responded positively (a response of 9 or 10) to the question: “What number would you use to rate how well the staff listen to you?”
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$ Homes using the Nursing Home CAHPS Long-Stay Resident Survey⁸ should measure this domain by calculating the percentage of residents who responded with a 9 or 10 (responses are coded from 0 to 10, where 0 = worst possible and 10 = best possible) to the following question: What number would you use to rate how well the staff listen to you?
Numerator	For homes using the Nursing Home CAHPS Long-Stay Resident Survey, the number of respondents who responded with a 9 or 10 to the question.
Denominator	For homes using the Nursing Home CAHPS Long-Stay Resident Survey, total number of residents who registered any response to the question. Exclusions: • Nonrespondents
Risk adjustment	None
Current performance reporting period	Most recent consecutive 12-month period
Considerations for target-setting	None specified
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.
How to access data	Local data collection

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

Comments

For more information about the Nursing Home CAHPS Long-Stay Resident Survey, refer to the [Agency for Healthcare Research and Quality's website](#).

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

Safety

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

Abbreviated name	% LTC residents not living with psychosis who were given antipsychotic medication
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safe
Direction of improvement	Decrease (lower is better)
Description	Percentage of long-term care home residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$ Both the numerator and denominator are calculated using a rolling 4-quarter average (target quarter and the 3 preceding quarters).^a
Numerator	Number of long-term care home residents who received antipsychotic medication on 1 or more days in the week before their target assessment^b Inclusions: Residents who received an antipsychotic medication during the 7 days preceding assessment (RAI-MDS <i>O4a</i> = 1, 2, 3, 4, 5, 6, or 7; interRAI LTCF <i>N7a</i> = 1)
Denominator	Number of long-term care home residents with a valid RAI-MDS assessment^b Exclusions: - Residents who have end-stage disease (RAI-MDS <i>J5c</i> = 1; interRAI LTCF <i>J6c</i> = 1) or are receiving hospice care (RAI-MDS <i>P1ao</i> = 1; interRAI LTCF <i>O2m</i> = 2 or 3) - Residents who have a diagnosis of schizophrenia (RAI-MDS <i>I1ii</i> = 1; interRAI LTCF <i>I1q</i> = 1, 2 or 3) or Huntington chorea (RAI-MDS <i>I1x</i> = 1; interRAI LTCF <i>I2ab</i> = G10 or G3080*), or those experiencing hallucinations (RAI-MDS <i>J1i</i> = 1; interRAI LTCF <i>J2i</i> = 1, 2, 3 or 4) or delusions (RAI-MDS <i>J1e</i> = 1; interRAI LTCF <i>J2h</i> = 1, 2, 3 or 4)
Risk adjustment	None. Unadjusted for QIP
Current performance reporting period	July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average ^a
Considerations for target-setting	None specified
Data source	Continuing Care Reporting System (data are provided by CIHI via CCRS eReports) or Integrated interRAI Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. Unadjusted data can also be accessed via your organization's CCRS eReports at the CIHI website

Abbreviations: CCRS, Continuing Care Reporting System; CIHI, Canadian Institute for Health Information; interRAI LTCF, International Resident Assessment Instrument Long-Term Care Facilities; RAI-MDS, Resident Assessment Instrument - Minimum Data Set 2.0.

^aThe indicator is calculated by the Canadian Institute for Health Information as a rolling 4-quarter average. Q2 2025/26 is calculated based on data from Q3 2024/25, Q4 2024/25, Q1 2025/26, and Q2 2025/26.

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

Comments

For quality improvement planning, unadjusted data should be used; however, this indicator is consistent with that reported by Ontario Health's [Long-Term Care Home Performance](#) website, which uses risk-adjusted data. For the risk-adjusted indicator, 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.

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

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

Abbreviated name	% LTC residents who fell in the last 30 days
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safe
Direction of improvement	Decrease (lower is better)
Description	Percentage of long-term care home residents who fell in the 30 days leading up to their assessment.
Unit of measure	Percentage
Calculation methods	$(\text{Numerator} \div \text{Denominator}) \times 100\%$ Both the numerator and denominator are calculated using a rolling 4-quarter average (target quarter and the 3 preceding quarters).^a
Numerator	Number of long-term care home residents who fell in the 30 days leading up to the date of their quarterly clinical assessment^b Inclusions: Residents who fell in past 30 days (RAI-MDS J4a = 1; interRAI LTCF J1a = 1 or 2)
Denominator	Number of long-term care home residents with a valid RAI-MDS assessment
Risk adjustment	None. Unadjusted for QIP
Current performance reporting period	July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average ^a
Considerations for target-setting	None specified
Data source	Continuing Care Reporting System (data are provided by CIHI via CCRS eReports) or Integrated interRAI Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. Unadjusted data can also be accessed via your organization's CCRS eReports at the CIHI website

Abbreviations: CCRS, Continuing Care Reporting System; CIHI, Canadian Institute for Health Information; interRAI LTCF, International Resident Assessment Instrument Long-Term Care Facilities; RAI-MDS, Resident Assessment Instrument - Minimum Data Set 2.0.

^aThe indicator is calculated by the Canadian Institute for Health Information as a rolling 4-quarter average. Q2 2025/26 is calculated based on data from Q3 2024/25, Q4 2024/25, Q1 2025/26, and Q2 2025/26.

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

Comments

This indicator is consistent with that reported by Ontario Health's [Long-Term Care Home Performance](#) website; however, the website includes adjusted rates. For the purposes of quality improvement planning, unadjusted rates (i.e., not risk-adjusted) should be used.

Ontario Health develops confidential practice reports for physicians who practice in long-term care facilities and includes indicators related to falls. These reports are intended to complement other sources of information physicians receive. For more information, please visit [MyPractice Long-Term Care](#).

Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened

Abbreviated name	% LTC residents with pressure ulcer (stage 2–4), worsened
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safe
Direction of improvement	Decrease (lower is better)
Description	Percentage of long-term care residents who had a stage 2 to stage 4 pressure ulcer that worsened in the period between 2 assessments.
Unit of measure	Percentage
Calculation methods	(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).^a Inclusions: Residents with ≥ 2 valid assessments (a <i>target assessment</i> and a <i>prior assessment</i> 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 <i>prior assessment</i>)
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^b 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. ^b
Risk adjustment	None. Unadjusted for QIP
Current performance reporting period	July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average ^a
Considerations for target-setting	None specified
Data source	Continuing Care Reporting System (data are provided by CIHI via CCRS eReports) or Integrated interRAI Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. Unadjusted data can also be accessed via your organization's CCRS eReports at the CIHI website

Abbreviations: CCRS, Continuing Care Reporting System; CIHI, Canadian Institute for Health Information; interRAI LTCF, International Resident Assessment Instrument Long-Term Care Facilities; RAI-MDS, Resident Assessment Instrument - Minimum Data Set 2.0RAI-MDS, Resident Assessment Instrument - Minimum Data Set 2.0.

^aThe indicator is calculated by the Canadian Institute for Health Information as a rolling 4-quarter average. Q2 2025/26 is calculated based on target assessment data from Q3 2024/25, Q4 2024/25, Q1 2025/26, and Q2 2025/26.

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

Comments

This indicator is consistent with that reported by Ontario Health's [Long-Term Care Home Performance](#) website; however, the website includes adjusted rates. For the purposes of quality improvement planning, unadjusted rates (i.e., not risk-adjusted) should be used.

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

Percentage of long-term care residents in daily physical restraints

Abbreviated name	% LTC residents in daily physical restraints
Priority issue	Safety
Indicator type	Optional
Dimension of quality	Safe
Direction of improvement	Decrease (lower is better)
Description	Percentage of long-term care residents who were in daily physical restraints for the 7 days preceding their resident assessment.
Unit of measure	Percentage
Calculation methods	(Numerator ÷ Denominator) × 100% Both the numerator and denominator are calculated using a rolling 4-quarter average (target quarter and the 3 preceding quarters). ^a
Numerator	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. ^b Exclusions: Residents who are comatose (RAI-MDS B1 = 1; interRAI LTCF C1 = 5) or quadriplegic (RAI-MDS I1bb = 1; interRAI LTCF I1i = 1)
Risk adjustment	None. Unadjusted for QIP
Current performance reporting period	July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average ^a
Considerations for target-setting	None specified
Data source	Continuing Care Reporting System (data are provided by CIHI via CCRS eReports) or Integrated interRAI Reporting System
How to access data	Indicator data will be prepopulated in QIP Navigator. Unadjusted data can also be accessed via your organization's CCRS eReports at the CIHI website

Abbreviations: CCRS, Continuing Care Reporting System; CIHI, Canadian Institute for Health Information; interRAI LTCF, International Resident Assessment Instrument Long-Term Care Facilities; N/A, not applicable; RAI-MDS, Resident Assessment Instrument - Minimum Data Set 2.0.

^aThe indicator is calculated by the Canadian Institute for Health Information as a rolling 4-quarter average. Q2 2025/26 is calculated based on data from Q3 2024/25, Q4 2024/25, Q1 2025/26, and Q2 2025/26.

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

Comments

This indicator is consistent with that reported by Ontario Health's [Long-Term Care Home Performance](#) website; however, the website includes adjusted rates. For the purposes of quality improvement planning, unadjusted rates (i.e., not risk-adjusted) should be used.

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

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ISBN 978-1-4868-9239-6 (PDF)
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