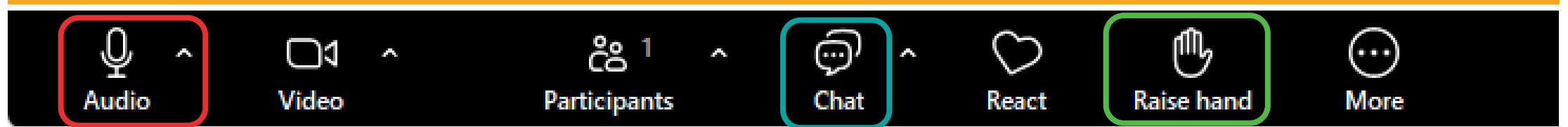


# New Common QIP Indicator 2026 - 2027

---

February 10<sup>th</sup>, 2026

# Housekeeping

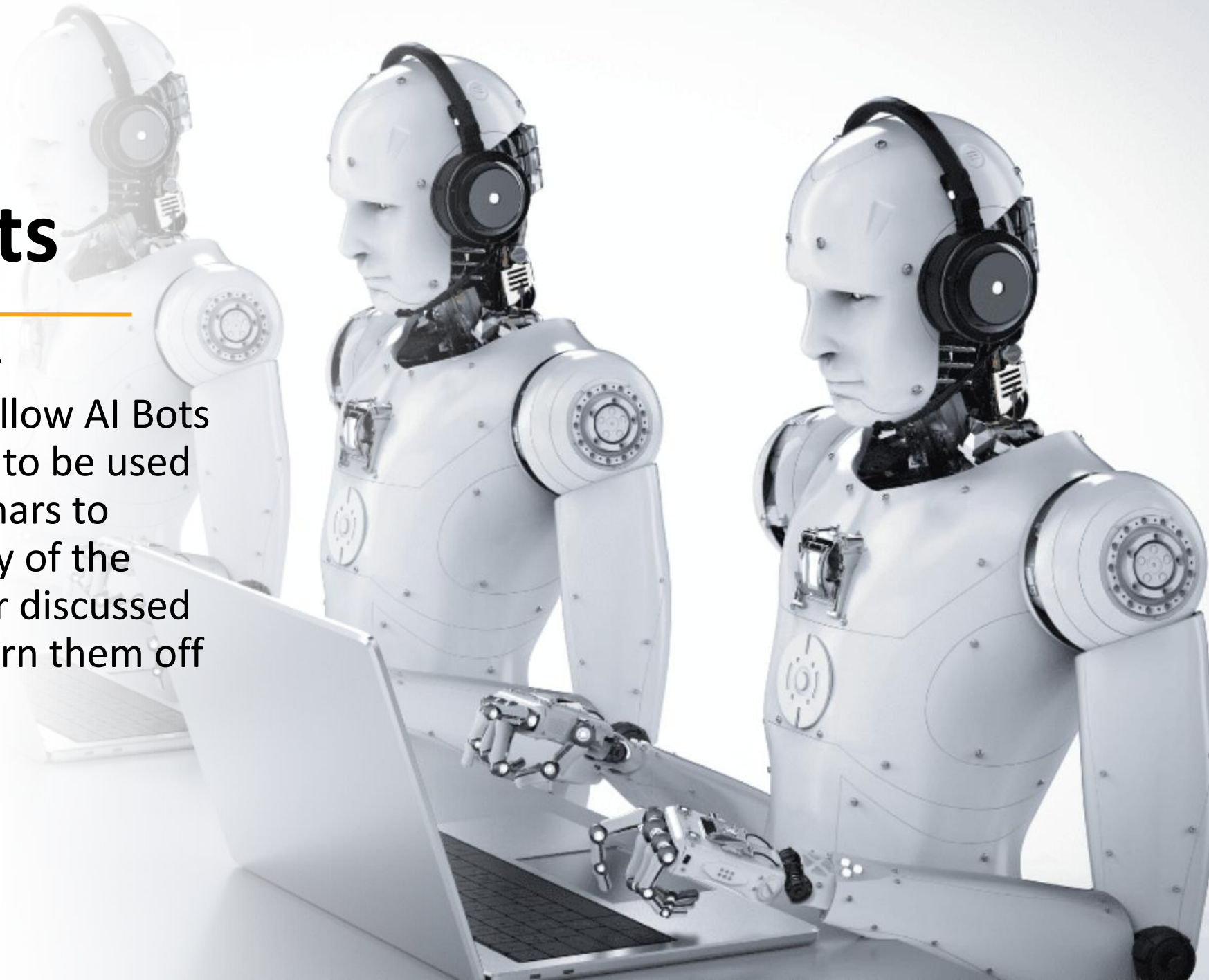


- You may enter questions through the **Chat** at any time.
- If you prefer to ask your question aloud You can use the **Raise Hand** function. We'll call on you at an appropriate time and unmute your microphone.
  - *Please don't forget to mute your microphone when you're done.*
- You may also use the **Chat** function for technical assistance.

# Use of AI Bots

---

The Alliance for Healthier Communities does NOT allow AI Bots (including AI note takers) to be used during Alliance-run webinars to protect the confidentiality of the content presented and/or discussed and ask participants to turn them off if activated.



# Acknowledgement of Traditional Indigenous Territories

---

We recognize that the work of the Alliance for Healthier Communities and Alliance members takes place across what is now called Ontario on traditional territories of the Indigenous people who have lived here since time immemorial and have deep connections to these lands. We further acknowledge that Ontario is covered by 46 treaties, agreements and land purchases, as well as unceded territories. We are grateful for the opportunity to live, meet and work on this territory.

Ontario continues to be home to vibrant, diverse Indigenous communities who have distinct and specific histories and needs, as well as constitutionally protected and treaty rights. We honour this diversity and respect the knowledge, leadership and governance frameworks within Indigenous communities. In recognition of this, we commit to building allyship relationships with First Nation, Inuit and Métis peoples in order to enhance our knowledge and appreciation of the many histories and voices within Ontario. We also commit to sharing and upholding responsibilities to all who now live on these lands, the land itself and the resources that make our lives possible.

# Today's presenters

---

**Stéphanie Lamothe** – *Quality Improvement and Performance Lead*

**Denis Tsang** – *Quality Improvement and Performance Lead*

**Kathleen Frame** – *Quality Improvement and Performance Lead*

**Christine Randle** – *Provincial Data Management Coordinator*

**Catherine Macdonald** – *Knowledge Translation Specialist*

# Agenda for today

---

- Current Common QIP Indicators
- New indicator
- Technical specification
- Common QIP Data Report
- Workplan submission on QIP Navigator
- Supports for your 2026-27 QIPs
- Q&A

# Background: Common QIP Indicators

---

- 5 indicators chosen by the Alliance's EL Network and the Performance Management Committee (now known as the EPIC Learning Health System Steering Committee)
- Goal: Improve comparability of QI efforts across the sector - an issue identified by Auditor General in 2017
- Selection criteria:
  - Included in the OH QIP Navigator
  - Reflects shared improvement priorities for Alliance members
  - Reflects health system priorities
  - Provides opportunities to demonstrate sector leadership
  - Comparable data available despite sector diversity

# Common QIP Indicators 2019-2024

Indicator	Data Source
Completion of sociodemographic data collection	BIRT (Common QIP Data Report)
Cervical cancer screening stratified by income and stratified by racial/ethnic group	BIRT (Common QIP Data Report)
Client feeling comfortable and welcome at the CHC	Client Experience Survey
Client involvement in care decisions	Client Experience Survey
Client ability to get appointment on date wanted	Client Experience Survey

# Common QIP Indicators 2025

Indicator	Data Source
Completion of sociodemographic data collection	BIRT (Common QIP Data Report)
Cervical cancer screening stratified by income and stratified by racial/ethnic group	BIRT (Common QIP Data Report)
Client feeling comfortable and welcome at the CHC	Client Experience Survey
Client ability to get appointment on date wanted	Client Experience Survey

# Common QIP Indicators 2026

Indicator	Data Source
Completion of sociodemographic data collection	BIRT (Common QIP Data Report)
Cervical cancer screening stratified by income and stratified by racial/ethnic group	BIRT (Common QIP Data Report)
Client feeling comfortable and welcome at the CHC	Client Experience Survey
<b>Number of NEW clients/patients</b>	<b>BIRT (Common QIP Data Report)</b>
Client ability to get appointment on date wanted	Client Experience Survey

# New Indicator: Number of NEW clients/patients

---

## Description:

"Number of *new* clients/patients attached or enrolled to a community primary care organization (CHC/NPLC/cFHT/IPHCO) within the reporting period"

## Calculation:

Clients/Patients with an “**OPCC**” (for CHCs and NPLCs) or “**FHO Enrolled**” (for community FHTs) *member status* and an “**Enrollment date**” within the reporting period

## Reporting Period:

Last 12 months (calendar year)

# New Indicator: Number of NEW clients/patients

---

- An OH Access and Flow priority indicator
- Target corridor is not applicable, but a target could be calculated and set internally by an organization for measuring attachment efforts and monitoring improvement
- This indicator is linked to the **Evaluation Framework Direct Outcome of:**  
***Increased access to primary care for those newly attached people who have experienced barriers.***

# Technical Specification (EN & FR)

## Number of NEW clients/patients

INDICATOR NAME	NUMBER OF NEW CLIENTS/PATIENTS
INDICATOR DESCRIPTION	Number of <b>new</b> clients/patients attached or enrolled to a community primary care organization (CHC/NPLC/cFHT/IPHCO) within the reporting period.
INDICATOR THEME	Access and Attachment
PERFORMANCE TARGET	An increased number of <b>NEW</b> clients.
TARGET CORRIDOR	N/A for the sector, but a target could be calculated and set internally by an organization for measuring attachment efforts and monitoring improvement. <i>Specify the desired calculated rate range (e.g., 75-90%), the direction of improvement, etc.</i> <b>To note:</b> an increase for this indicator is the desired outcome (i.e., higher is better).
INDICATOR CALCULATION	Count the total number of <b>new</b> ongoing primary care clients (OPCC for CHCs and NPLCs) or <b>new</b> patients enrolled (for community FHTs) within the reporting period. <b>Includes:</b> Clients/Patients with an “OPCC” (for CHCs and NPLCs) or “FHO Enrolled” (for community FHTs) member status and an “Enrollment date” within the reporting period.  <div style="border: 1px solid gray; padding: 2px; width: fit-content;"> <p><b>Member status:</b> Ongoing primary care client</p> <p><b>Enrollment date:</b> Dec 5, 2019</p> </div>
NUMERATOR	N/A
DENOMINATOR	N/A
DATA SOURCE	EMR/BIRT
REPORTING PERIOD	One (1) calendar year from January 1 <sup>st</sup> to December 31 <sup>st</sup> (or Q4 of last fiscal year and Q1 to Q3 of current fiscal year).
TIMING/FREQUENCY OF RELEASE	Updated and reported yearly. <i>Organizations may choose to monitor their data more frequently (e.g., every month or every quarter) using reports created by their DMC/Analyst in LogiReport.</i> <i>How often, and when, are data being released</i>

LEVELS OF COMPARABILITY	The data will be presented at the organization level. <i>Organizations may choose to compare their data using reports created by their DMC/Analyst in LogiReport. For example, data could be stratified by OH region, OHT, or compared to an average number among similar organizations/peers or compared to a province-wide average.</i>
TRENDING	January 2025 <i>Organizations may choose to look at their data overtime using reports created by their DMC/Analyst in LogiReport.</i> <i>Years available for trending</i>
LIMITATIONS	Recognizing some community primary care organizations do not, or are not expected to (as per their funding agreements), provide <b>ongoing primary care</b> to individuals within the regions and communities they serve – such as those organizations who provide episodic care to individuals accessing and using shelters – this indicator may not be relevant and would not be included in their annual QIP submission. <i>Specific limitations</i>
STRATEGIC LINKAGES	Community primary care organizations (CHC/NPLC/cFHT/IPHCO) are mandated to serve marginalized populations. This indicator is linked to the Evaluation Framework Direct Outcome #2. In other words, increased access to primary care for those newly attached people who have experienced barriers. Information about the type and magnitude of health disparities can inform the development of strategies to reduce disparities by: <ul style="list-style-type: none"> <li>Aligning practices with unmet needs;</li> <li>Providing evidence-driven input for advocacy, policy development and service planning.</li> </ul>
COMMENTS	This indicator supports the Ministry of Health and Ontario Health's Primary Care Action Plan and the commitment to attach 2 million more people to primary care by 2029. <i>Additional information regarding the calculation, interpretation, data source, etc.</i>
References	<a href="https://www.hqontario.ca/Portals/0/documents/qi/qip/2025/Technical%20Specifications%20EN.pdf">https://www.hqontario.ca/Portals/0/documents/qi/qip/2025/Technical%20Specifications%20EN.pdf</a> <a href="https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025">https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025</a> <a href="https://www.ontario.ca/page/ontarios-primary-care-action-plan-1-year-progress-update">https://www.ontario.ca/page/ontarios-primary-care-action-plan-1-year-progress-update</a>

# Scenario 1 - Uninsured Clients

---

A client who is new to the community experiences housing instability and does not have a health card.

This month they become registered as an OPCC client and are receiving primary health care services.

---

Q: Is this person counted as a new client without OHIP?

Q: What if they are covered under the IFHP?

# Scenario 2 – Transition of Clients from RPCE to OPCC

---

- Clients in your neighbourhood have been participating in the cardiac rehab and diabetes education program at your organization
- They are considered clients who "Receive Primary Care Elsewhere (**RPCE**)"
- As capacity increases, the primary care program resumes client registration to attach clients to a MD or NP
- Using your organization's complexity triaging, you've determined these RPCE clients meet the eligibility criteria to become "Ongoing Primary Care Clients (**OPCC**)"

# Scenario 2 - Questions

---

- Which clients are captured in this common QIP indicator?
- How can data be extracted to support progress monitoring and reporting?

# Workplan Submission on QIP Navigator

PROGRESS REPORT NARRATIVE WORKPLAN

2026/27 Quality Improvement Plan for Ontario Primary Care

Status: IN PROGRESS

To enter data in the Workplan, click on the cell or the "Add" button. In the Measure/Indicator column, the indicators that appear in red font are the priority indicators.

Organization:

EXPORT WORKPLAN
EXPORT EXTERNAL COLLABORATION REPORT

FILLABLE TEMPLATES : [MY DRAFT WORKPLAN](#) [BLANK WORKPLAN TEMPLATE](#)

ID AIM		MEASURE								CHANGE				
QUALITY DIMENSION	MEASURE / INDICATOR	TYPE	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	EXTERNAL COLLABORATORS	PLANNED IMPROVEMENT: CHANGE IDEA	METHOD(S)	PROCESS MEASURE(S)	TARGET FOR PROCESS MEASURE(S)	COMMENTS
ⓘ M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = custom (add any other indicators you are working on)														
<b>ACCESS AND FLOW</b>														
1	<b>Efficient</b>	Number of new patients/client s/enrolments	P	Number / PC patients/client s	EMR/Chart Review / Most recent consecutive 12-month period	91509								
										<span style="border: 1px solid #00a651; padding: 2px 5px; color: #00a651;">+ Add New Change Idea</span>				
										<span style="border: 1px solid #00a651; padding: 2px 5px; color: #00a651;">We are not working on this indicator</span>				
										<span style="border: 1px solid #00a651; padding: 5px 15px; color: #00a651; font-weight: bold;">+ Add New Measure</span>				

# Workplan Submission on QIP Navigator

**Measure**

Issue, Measure / Indicator [?](#) **> GOTO CHANGE IDEA**

Quality Dimension [?](#) Efficient

Sector \* [?](#) Primary Care

Issue \* [?](#) Access and Flow

Measure / Indicator  
Priority \* [?](#) Number of new patients/clients/enrolments

Unit of Measure \* [?](#) Number If other, specify

Population \* [?](#) PC patients/clients If other, specify

Primary care population [?](#)

Data Source \* [?](#) EMR/Chart Review If other, specify

Period \* [?](#) Other Please specify \* Most recent consecutive 12-month period

Organization

Direction of Improvement [?](#)  Higher is better

Current Performance [?](#)  between 0.00 and 5000.00  Collecting Baseline [?](#)  Suppressed [?](#)

Absolute Target [?](#)   between 0.00 and 5000.00  Relative Target [?](#)  %

Collecting Baseline [?](#)

Target Justification [?](#)

Collaboration Status [?](#) Not in a collaboration

# Supports for your 2026-2027 QIPs

---

The following resources can be found on the Alliance website:

- [Supports for Your 2026-27 QIPs](#)
- [Technical Definitions: Common QIP Indicators for CHCs](#)
- [New Indicator Handout](#)
- [Key Information & FAQ: Common QIP Indicators](#)

# Upcoming Key Dates

---

Activity	Date
Release of Common QIP Data Report	Late Feb 2026
Deadline for QIP submission	April 1, 2026
Release of Common QIP Data Report	Winter 2027

The background features a repeating pattern of wavy lines. The colors of the waves alternate in a sequence: orange, green, teal, and red. Interspersed among these solid-colored waves are smaller, more complex waves composed of various colored triangles (including orange, green, teal, red, and dark grey) arranged in a geometric pattern.

**Q&A**




*Thank You!*  
*Merci!*  
*Miigwetch!*

**QI@AllianceON.org**

# Patient Demographics View in PSS

Patients ✕

Edit Find View Bill Print One Email Flags HCV

<b>Surname:</b> PSS	<b>Patient #:</b> 104	<b>Additional Information:</b>
<b>First name:</b> Cousin	<b>Chart number:</b> n/a	
<b>Middle name:</b>	<b>Registry Number:</b> 0	
<b>Preferred name:</b>	<b>SIN:</b> n/a	
<b>Maiden name:</b>	<b>Last billed date:</b> Oct 16, 2018	
<b>Birthdate:</b> Jan 1, 1985 <b>Age:</b> 41	<b>Recall date:</b>	
<b>Sex:</b> F <b>Title:</b> Ms. <b>Suffix:</b>		
<b>Pronouns:</b>		
<b>Mailing Address:</b>	<b>Second Address:</b>	
<b>Address line 1:</b> 320 Pinebush Street	same	
<b>Address line 2:</b>		
<b>City:</b> Cambridge		
<b>Province &amp; Country:</b> ON    CAN		
<b>Postal code:</b> N2H 1J5		
<b>Email:</b> n/a		
<b>HC Prov, HN, Vers:</b> ON    1212 121 220    n/a	<input type="checkbox"/> Appointment alert <input type="checkbox"/> Family Addressee	
<b>HC Eligibility:</b> eligibility unknown	<b>Insurance number:</b> n/a	
<b>HC Expiry date:</b> n/a	<b>Language (EN or FR):</b> EN	
★ <b>Home phone:</b> 800-265-8175	<b>Spoken language:</b>	
<b>Business phone:</b> <b>Ext:</b> n/a	<b>Member status:</b> Ongoing primary care client	
<b>Mobile:</b> n/a <b>Ext:</b> n/a	<b>Enrollment date:</b> Feb 4, 2026	
<b>Patient's MD/NP:</b> ** other doctor **	<b>Termination date:</b> n/a	
<b>Referring MD/NP:</b>	<b>Termination reason:</b> n/a	
<b>Family MD/NP:</b>	<b>Patient status:</b> Active	
<b>Diagnosis:</b> n/a	<b>Patient status date:</b> Aug 17, 2011	
<b>Next of kin:</b>	<b>Primary location:</b> Noelville	
<b>Comments:</b> PSS Test Patient		
<b>Preferred Pharmacy:</b>		

**Primary Provider**  **Other Provider**

Edit Cancel Save & Add Save Close