New Common QIP Indicator 2026 - 2027

February 10th, 2026

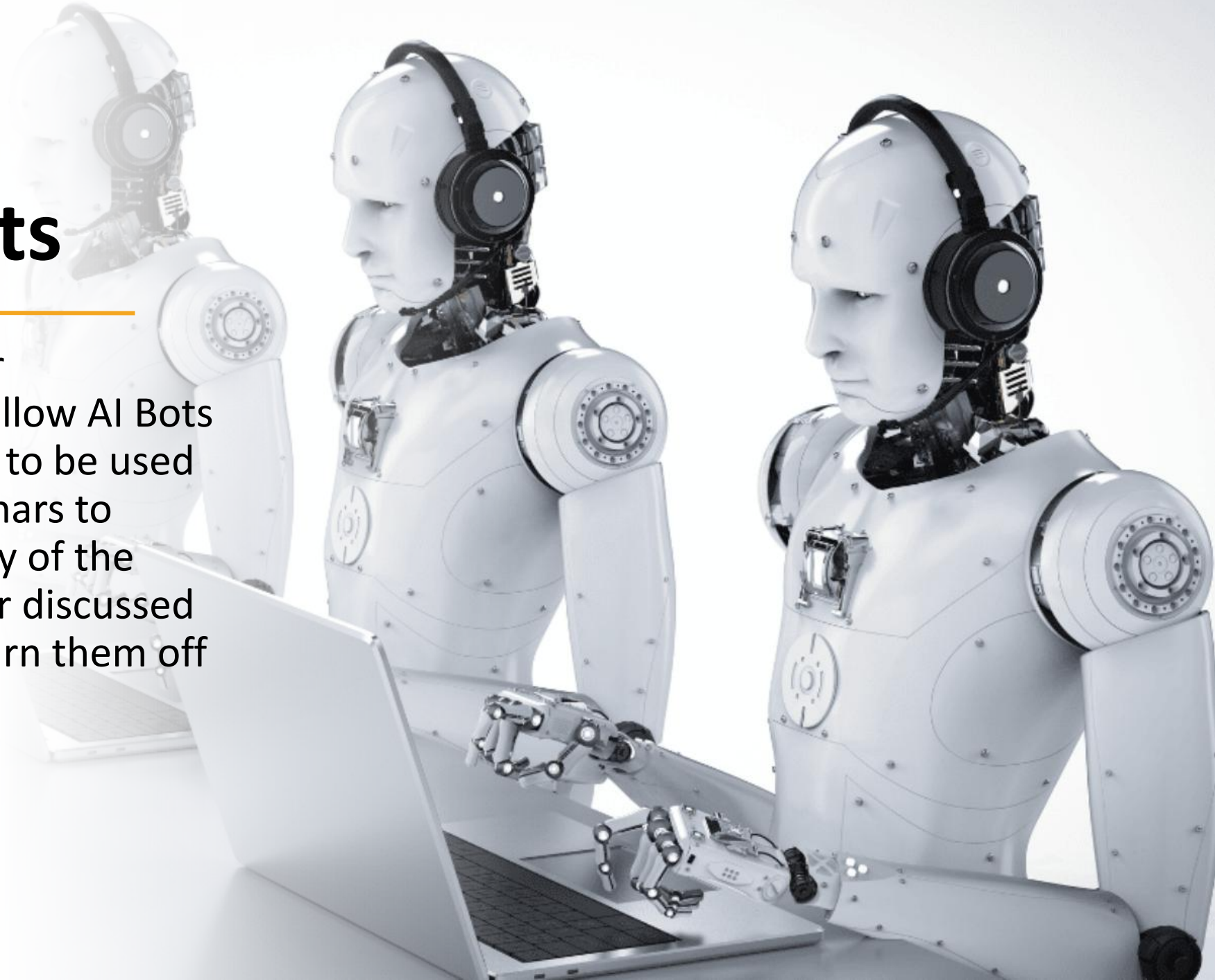
Alliance for Healthier Communities
Alliance pour des communautés en santé

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
Number of NEW clients/patients	**BIRT (Common QIP Data Report)**
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 **new** 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 **NEW** clients.
TARGET CORRIDOR *Specify the desired calculated rate range (e.g., 75-90%), the direction of improvement, etc.*	N/A for the sector, but a target could be calculated and set internally by an organization for measuring attachment efforts and monitoring improvement. ***To note:** an increase for this indicator is the desired outcome (i.e., higher is better).*
INDICATOR CALCULATION	Count the total number of **new** ongoing primary care clients (OPCC for CHCs and NPLCs) or **new** patients enrolled (for community FHTs) within the reporting period. **Includes:** 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. **Member status:** Ongoing primary care client **Enrollment date:** Dec 5, 2019
NUMERATOR	N/A
DENOMINATOR	N/A
DATA SOURCE	EMR/BIRT
REPORTING PERIOD	One (1) calendar year from January 1st to December 31st (or Q4 of last fiscal year and Q1 to Q3 of current fiscal year).
TIMING/FREQUENCY OF RELEASE *How often, and when, are data being released*	Updated and reported yearly. *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.*
LEVELS OF COMPARABILITY	The data will be presented at the organization level. *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.*
TRENDING *Years available for trending*	January 2025 *Organizations may choose to look at their data overtime using reports created by their DMC/Analyst in LogiReport.*
LIMITATIONS *Specific limitations*	Recognizing some community primary care organizations do not, or are not expected to (as per their funding agreements), provide ***ongoing primary care*** 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.
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: • Aligning practices with unmet needs; • Providing evidence-driven input for advocacy, policy development and service planning.
COMMENTS *Additional information regarding the calculation, interpretation, data source, etc.*	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.
References	https://www.hqontario.ca/Portals/0/documents/qi/qip/2025/Technical%20Specifications%20EN.pdf https://www.ontario.ca/page/ontarios-primary-care-action-plan-january-2025 https://www.ontario.ca/page/ontarios-primary-care-action-plan-1-year-progress-update

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?

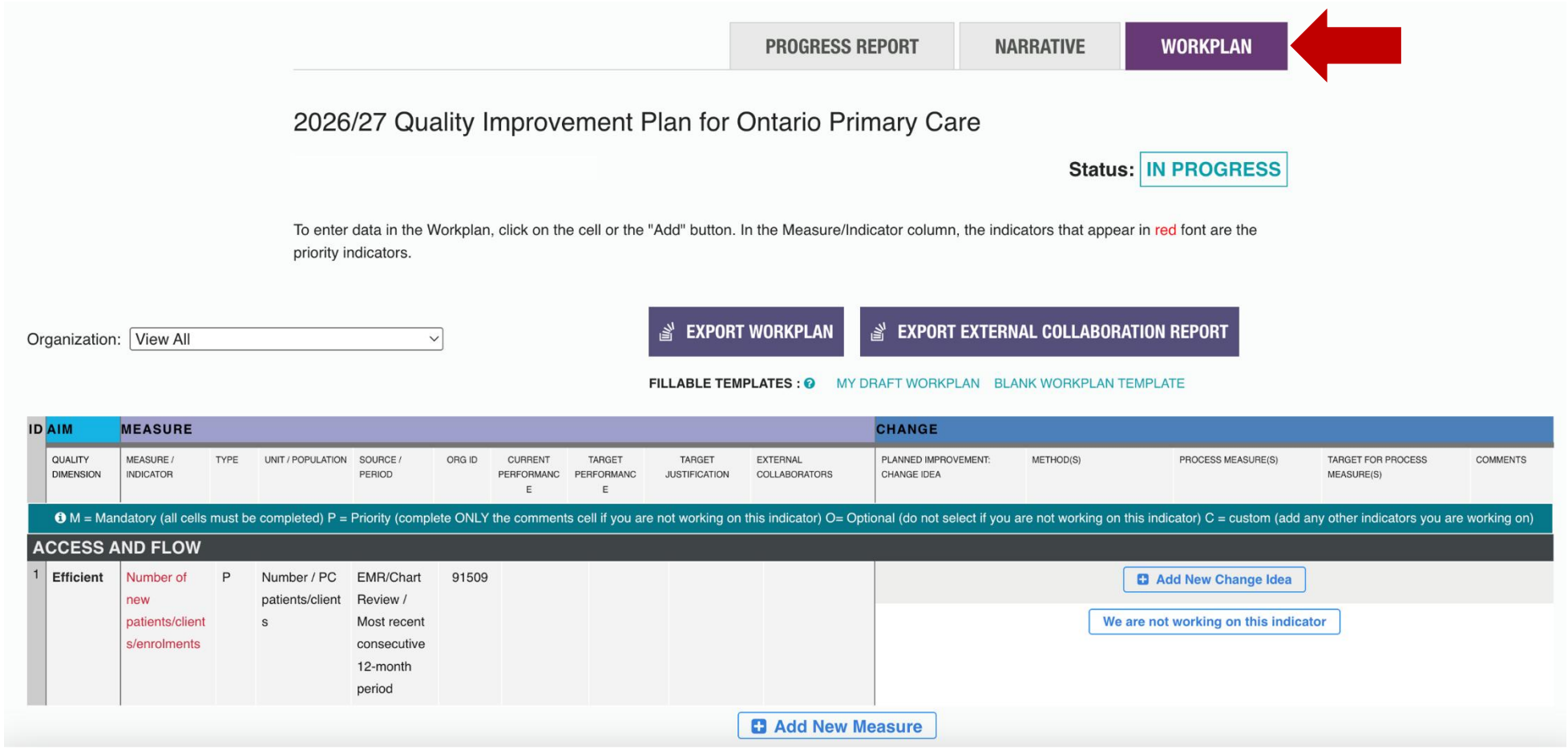
Scenario 2 – Transition of Clients from RPCE to OPCC

- 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**)"

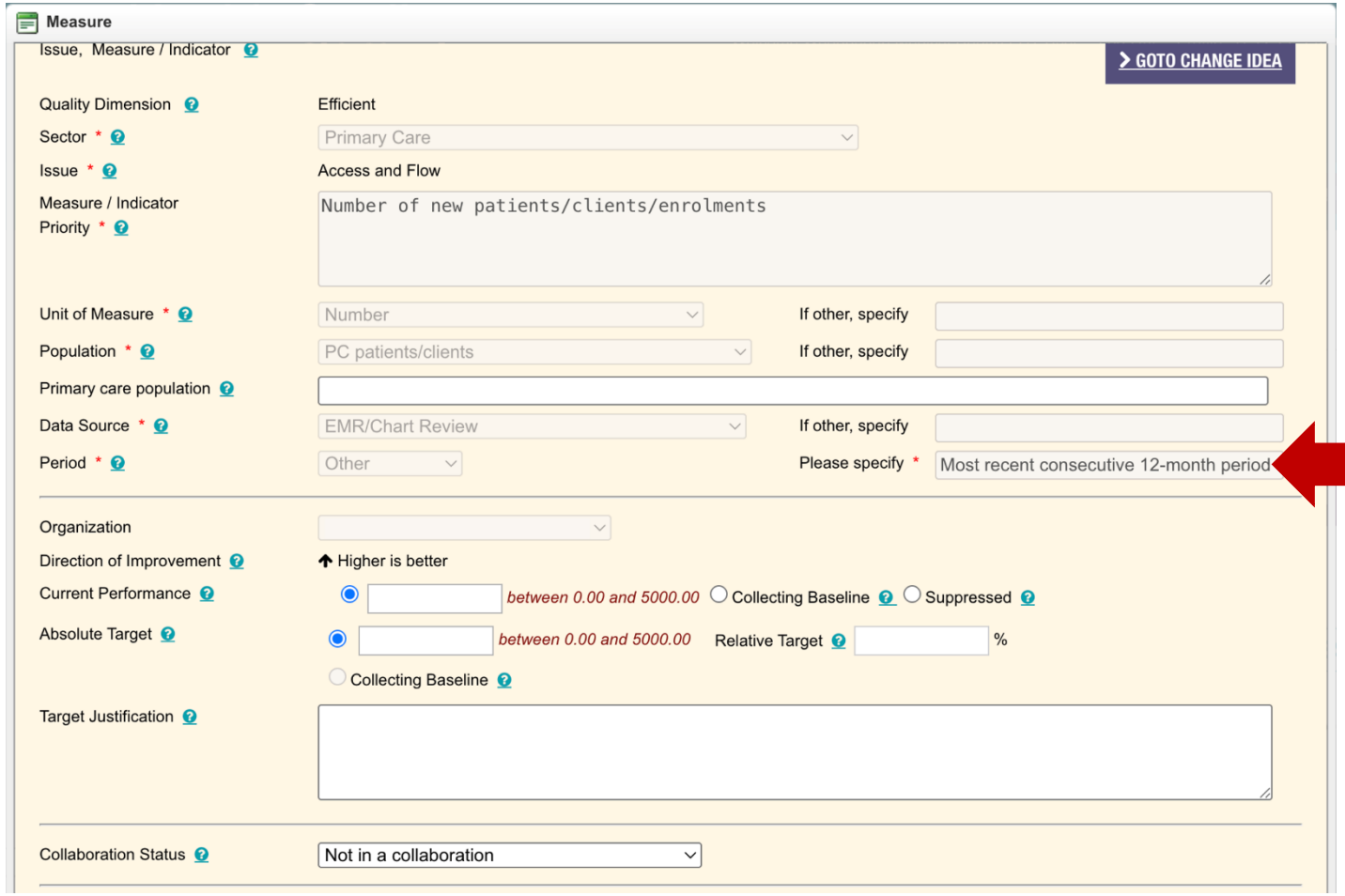
Scenario 2 - Questions

- 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



Workplan Submission on QIP Navigator



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

Q&A

Thank You!
Merci!
Miigwetch!

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Patient Demographics View in PSS