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1* WORKLOAD

Account	Name	Definition
102 ** *0	Nursing Service Recipient Workload **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	This account is used to identify nursing workload in all inpatient nursing, ambulatory care and community care functional centres. The unit of measure is minutes which is a standard unit of measure to express workload activity, spent by nursing unit producing personnel (UPP) performing service recipient activities in all inpatient nursing, ambulatory care and community care functional centres. Refer to the Nursing Conceptual Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.
102 ** 20	Nursing Service Recipient Workload- Elderly	See 102 ** *0 definition
102 ** 40	Nursing Service Recipient Workload- Adult	See 102 ** *0 definition.
102 ** 60	Nursing Service Recipient Workload- Pediatric	See 102 ** *0 definition.
102 ** 80	Nursing Service Recipient Workload- Newborn	See 102 ** *0 definition.
107 ** **	Diagnostic Standard Time Service Recipient Workload **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7Th digits represents modality.**	This account is used to identify diagnostic, electro diagnostic, and other diagnostic workload in all diagnostic, electro diagnostic, and other diagnostic functional centres. The unit of measure is minutes which is a standard unit of measure for expressing workload activity spent by diagnostic, electro diagnostic, and other diagnostic unit producing personnel (UPP) performing service recipient activities in all diagnostic, electro diagnostic, and other diagnostic functional centres, regardless of who performs the workload. Refer to the Diagnostic, Electro Diagnostic, and Other Diagnostic Conceptual Model, for a list of service recipient activities, and the unit values, as per 2013 CIHI MIS Standards.

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107 ** 10	Med. Imaging SR Workload – Radiography	See 107 ** ** definition.
107 ** 34	Med. Imaging SR Workload – Computed Tomography	See 107 ** ** definition.
107 ** 36	Med. Imaging SR Workload – Other Tomography	See 107 ** ** definition.
107 ** 37	Med. Imaging SR Workload – Interventional/Angio.Studies	See 107 ** ** definition.
107 ** 38	Med. Imaging SR Workload – Mammography	See 107 ** ** definition.
107 ** 39	Med. Imaging SR Workload – Nuclear Medicine	See 107 ** ** definition.
107 ** 40	Med. Imaging SR Workload – Ultrasound	See 107 ** ** definition.
107 ** 46	Med. Imaging SR Workload Magnetic Resonance Imaging	See 107 ** ** definition.
107 ** 47	Med. Imaging SR Workload - Positron Emission Tomography	See 107 ** ** definition.
107 ** 48	Med. Imaging SR Workload Miscellaneous	See 107 ** ** definition.
107 ** 90	Med. Imaging SR Workload Cardiac Cath- Angiography	See 107 ** ** definition.

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107 ** 70	Electro diagnostic Labs Workload Electroencephalography (EEG)	See 107 ** ** definition.
107 ** 71	Electro diagnostic Labs Workload – Electromyography (EMG)	See 107 ** ** definition.
107 ** 72	Electro diagnostic Labs Workload – Evoked Potentials	See 107 ** ** definition.
107 ** 73	Electro diagnostic Labs Workload – Polysomnography (Sleep Studies)	See 107 ** ** definition.
107 ** 74	Electro diagnostic Labs Workload – Intensive Monitoring	See 107 ** ** definition.
107 ** 75	Electro diagnostic Labs – Electronstagmography / Electro-oculography (ENG/EOG)	See 107 ** ** definition.
107 ** 77	Non Invasive Cardiology and Vascular Lab Workload – Echocardiography	See 107 ** ** definition.
107 ** 78	Non Invasive Cardiology and Vascular Lab Workload – Amb. Monitoring (Holter)	See 107 ** ** definition.
107 ** 79	Non Invasive Cardiology and Vascular Lab Workload – Exercise Tolerance Testing	See 107 ** ** definition.

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107 ** 80	Non Invasive Cardiology and Vascular Lab Workload – Electrophysiology	See 107 ** ** definition.
107 ** 81	Non Invasive Cardiology and Vascular Lab Workload – Electro cardio (ECG)	See 107 ** ** definition.
107 ** 82	Non Invasive Cardiology and Vascular Lab Workload – Non-Inv. Vascular	See 107 ** ** definition.
~~**108 ** 10**~~	~~Respiratory SR Workload – Diagnostic~~	~~This account is used to identify respiratory diagnostic workload in all respiratory functional centres. The unit of measure is minutes which is a standard unit of measure to express workload activity, spent by unit producing personnel (UPP) performing service recipient activities in respiratory.~~ ~~Refer to the Respiratory Services Conceptual Model, for a list of service recipient activities, and the unit values, per 2013 CIHI MIS Standards.~~
~~**108 ** 20**~~	~~Respiratory SR Workload – Therapeutic~~	~~This account is used to identify respiratory therapeutic workload in all respiratory functional centres. The unit of measure is minutes which is a standard unit of measure to express workload activity, spent by unit producing personnel (UPP) performing service recipient activities in respiratory.~~ ~~Refer to the Respiratory Services Conceptual Model, for a list of service recipient activities, and the unit values, as per 2013 CIHI MIS Standards.~~
109 ** 20	CV Perfusion SR Workload - Therapeutic	This account will be used to identify cardiovascular perfusion therapeutic workload. The unit of measure is minutes which are a standard unit of measure to express workload activity spent by unit producing personnel (UPP) performing service recipient activities. As CV Perfusion per CIHI is included in the Respiratory Services Conceptual Model, refer to that framework for a list of service recipient activities, and the unit values, per 2013 CIHI MIS Standards.

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111 ** *0	Non-Designated Therapeutic Service Recipient Workload **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	This account is used to record the workload of staff in ambulatory care and community functional centres who are **not** nurses and do not have a designated therapeutic functional centre found in framework 4. For example, chiropody. The unit of measure is minutes which is a standard unit of measure to express workload activity spent by unit producing personnel (UPP) performing service recipient activities. Refer to the Generic Conceptual Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.
111 ** 20	Non-Designated Therapeutic Service Recipient Workload Centre-Elderly	See 111 ** *0 definition.
111 ** 40	Non-Designated Therapeutic Service Recipient Workload Centre-Adult	See 111 ** *0 definition.
111 ** 60	Non-Designated Therapeutic Service Recipient Workload Centre-Pediatric	See 111 ** *0 definition.
111 ** 80	Non-Designated Therapeutic Service Recipient Workload Centre-Newborn	See 111 ** *0 definition.
112 ** *0	Community Support Service Recipient Workload **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	**Under review and development.**

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116 ** *0	Therapy and Respiratory Service Recipient Workload **Required for the following functional centres:** Clinical Nutrition, Psychology, Therapeutic Recreation, Child Life, Social Work, Speech Language Pathology and Audiology, Physiotherapy, Occupational Therapy, Pastoral Care, Genetic Counselling, Addictions. **Where ** the 4th and 5Th digits represents service recipient. Where * the 6th digit represents age category.**	This account is used to record the workload of therapists with a designated 7*4* functional centre. It cannot be recorded in 7*2* and 7*3* functional centres. If therapeutic staff are performing service recipient care in 7*5*, then record workload in the 7*5* functional centres, as identified in the sector specific chapter. The unit of measure is minutes which is a standard unit of measure to express workload activity spent by therapeutic unit producing personnel (UPP) performing service recipient care activities in a 7*4* functional centre. Refer to the Generic Conceptual Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.
116 ** 11 **116 ** 12** **116 ** 18**	Drug Distribution Service Recipient Activities – Non-Sterile Clinical Pharmacy Service Recipient Activities Drug Distribution Service Recipient Activities – Sterile **Required for the following Functional centre:** Pharmacy **Where ** the 4th and 5Th digits represents service recipient.**	This account is used to record the workload of pharmacists and pharmacy technicians, those unit producing personnel spent performing drug distribution and clinical pharmacy activities of the functional centre. The unit of measure is minutes which are a standard unit of measure to express workload activity spent by unit producing personnel (UPP) performing service recipient care activities in a Pharmacy functional centre. Refer to the Pharmacy Conceptual Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.

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116 ** 53	Rehab Engineering Service Recipient Workload – Orthotics General **Where ** the 4th and 5Th digits represents service recipient.**	This account is used to record the workload associated with the provision of orthotics services. Refer to the Rehab Engineering Interim WMS Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.
116 ** 57	Rehab Engineering Service Recipient Workload – Prosthetics – General **Where ** the 4th and 5Th digits represents service recipient.**	This account issued to record the workload associated with the provision of prosthetics services. Refer to the, Rehab Engineering Interim Workload Measurement System (WMS) Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.
116 ** 74	Radiation Oncology SR Workload Mould Room **Where ** the 4th and 5Th digits represents service recipient.**	This account is used to record the workload associated with the provision of mould room services. Refer to the Rehab Engineering Interim WMS Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.
116 ** 75	Radiation Oncology SR Workload Simulator **Where ** the 4th and 5Th digits represents service recipient.**	This account is used to record the workload associated with the provision of simulator services. Refer to the Radiation Therapy Conceptual Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.
116 ** 76	Radiation Oncology SR Workload Planning/Dosimetry **Where ** the 4th and 5Th digits represents service recipient.**	This account is used to record the workload associated with the provision of planning / Dosimetry services. Refer to the Radiation Therapy Conceptual Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.

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116 ** 77	Radiation Oncology SR Workload Radiation Therapy **Where ** the 4th and 5Th digits represents service recipient.**	This account is used to record the workload associated with the provision of radiation services. Refer to the Radiation Therapy Conceptual Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.
116 ** 78	Radiation Oncology SR Workload Brachytherapy **Where ** the 4th and 5Th digits represents service recipient.**	This account is used to record the workload associated with the provision of Brachytherapy. Refer to the Radiation Therapy Conceptual Model, for a list of service recipient activities, as per 2013 CIHI MIS Standards.
118 ** **	Laboratory Service Recipient Workload **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents modality.**	The standard units of time used to express the workload of a service as measured by an appropriate workload measurement system. In Laboratory Services, one workload unit is equivalent to one minute of unit producing personnel time spent in the provision of service recipient care. Refer to the Clinical Laboratory Services Conceptual Model, for a list of service recipient activities and the unit values, as per 2013 CIHI MIS Standards.

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190 00 00	Non Service Recipient Workload Units	This account is used to record non-service recipient workload, that unit producing personnel spent performing non-service recipient activities, includes, functional centre activities, organizational/professional activities, teaching/in-service activities, and research. Examples include, but are not limited to, Board activities, caseload management, quality improvement activities, administrative activities, and staff travel. Includes travel to/from the place where service recipient activities are provided to a service recipient or a group of service recipients. The unit of measure is minutes which is a standard unit of measure to express workload activity spent by UPP performing non-service recipient workload. Refer to the specific Workload Conceptual Model, for a list of non service recipient activities, as per 2013 CIHI MIS Standards.
239 00 00	Volunteer Hours of Service	The number of hours spent by volunteers performing activities without paid compensation.
242 10 00	Kg Clean Laundry Issued – By Facility for Facility	The kilograms of clean laundry for which the health care organization provided in-house. Includes the weight for the individual units, for example, lab coats.
242 30 00	Kg Clean Laundry Issued – Contracted Out	The kilograms of clean laundry for which the health care organization remunerated a contracted-out third party provider. Includes the weight for the individual units, for example, lab coats.

2* STAFF ACTIVITY

244 20 00	Area Cleaned	The square metres of floor space. **Note:** not a MOHLTC reporting level.
246 ** 00	Meals (number of) Contracted-Out **Where ** the 4th and 5Th digits represents service recipient values 1* and 4*.**	The number of meals for which the health care organization remunerated a contracted-out third party provider. To be captured for inpatients and residents service recipient categories.
248 ** 10	Meals Delivered - Combined	The number of delivered combined meals as hot, frozen or side dishes. For 1 hot meal, count as 1; for 1 frozen meal, count as 1; for side dish (additional order) – count every 2 side dishes as 1 meal. Use service recipient 80-Community Support Services.

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248 ** 12	Meals Delivered - Hot Meals	The number of delivered meal packages with a hot entrée and can be up to a 3-course meal Use service recipient 80-Community Support Services.
248 ** 14	Meals Delivered - Frozen Meals	The number of delivered frozen meal packages with a main dish and it usually comes with a side dish. Use service recipient 80-Community Support Services.
248 ** 16	Meals Delivered - Side Dishes	The number of delivered additional meal orders, excluding beverage, such as a salad, soup or dessert. Count only when purchased separately, i.e., when not included under the 3-course hot meal or frozen meal. Use service recipient 80-Community Support Services.
255 ** 50	Registrations **Where ** the 4th and 5Th digits represents service recipient.**	The service recipients officially accepted by the health care organization either through the capture of personal identifiable data and/or the assignment of a unique identifier, the confirmation of an existing unique identifier, or the opening of a unique file or record for the service recipient.
256 ** 10	OR Bookings **Where ** the 4th and 5Th digits represents service recipient.**	The appointments booked in advance for service recipients to undergo operative procedures.
256 ** 20	Other Bookings **Where ** the 4th and 5Th digits represents service recipient.**	The appointments booked in advance for service recipients to undergo diagnostic testing, therapy appointments, if appointments are arranged by registration staff.
259 ** 00	Health Records Abstracted **Where ** the 4th and 5Th digits represents service recipient.**	The service recipient health records processed, including their collection, review, maintenance and the abstraction of pertinent information.

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260 ** 10	Interpretation/Translation Assignments **Where ** the 4th and 5Th digits represents service recipient.**	The number of interpretation/ translation assignments completed by a qualified interpreter for clients/service recipients. This account is reported only under functional centre 7*179 AS Interpretation/Translation or functional centre 7*110 Administrative Services.
265 ** **	Service Provider Interactions (SPI) with Time Intervals **Where 4th and 5th digit represents service recipient** **Where 6th and 7th digit represents time intervals** **00 – Time Interval Not Reported** **01 – More than 5 Minutes to 30 Minutes** **02 – 31 Minutes to 1 Hour** **03 – More than 1 Hour to 2 hours** **04 – More than 2 Hours to 5 Hours** **05 – More than 5 Hours**	A service provider interaction (SPI) is reported each time service recipient activity (S4* series) is provided. The service recipient and/or significant other(s) must be present during the interaction. If a service provider serves the service recipient multiple times, report each service provider interaction. If a multi disciplinary team provides service to a service recipient in the same functional centre, report a service provider interaction for each member of the team who provided the service. Service provider interactions are only provided by UPP/MED/NP staff. Each interaction may be reported according to the length of time a service provider provides direct service to the service recipient. **Note:** The term “present” does not only refer to the SR who is present during the face to face interaction; it also includes interactions via telephone or emails/ chats/videoconferencing. The service must be provided longer than five minutes.

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266 00 **	Service Provider Group Interactions (SPGI) with Time Intervals **Where 6th and 7th digit represents time intervals** **00 – Time Interval Not Reported** **01 – More than 5 Minutes to 30 Minutes** **02 – 31 Minutes to 1 Hour** **03 – More than 1 Hour to 2 hours** **04 – More than 2 Hours to 5 Hours** **05 – More than 5 Hours**	A service provider group interaction (SPGI) is reported each time service activity is provided to the participants during a group session. If a multi disciplinary team provides service in a group session in the same functional centre report a service provider group interaction for each member of the team who provided the service. Each group interaction may be reported according to the length of time a service provider provides service to the group participants.
290 00 00	Hours of Service Contracted Out	The hours spent delivering the mandate of the functional centre for which the health care organization remunerated a contracted-out third party provider. To be captured for 7*145* Housekeeping, 7*1 55* Plant Operation, 7*160* Plant Security, and 7*165* Plant Maintenance, functional centres.
295 10 00	Operating Room Days – Elective	The calendar days when operating room services are available for booked procedures.
295 20 00	Operating Room Days – Emergency	The calendar days when operating room services are available for only emergency procedures.

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297 ** 00	Case Minutes-Operating Room **Where ** the 4th and 5Th digits represents service recipient.**	The duration of all cases performed in the main (FC 7126) and day surgery (FC 7136) operating rooms reported by either acute inpatient or day surgery SR code. The case minutes are from the data elements "Patient in Room Time" to "Patient out of Room Time". The minutes are year to date accumulative and reconcile or balance to Surgical Efficiency Targets Program (SETP) Program reporting mandated by Access to Care at Cancer Care Ontario.

3 * EARNED HOURS = external recovery of earned hours + worked + benefit + purchased
(3 ** ** 00 = 3 02 00 + 3 ** 10 00 + 3 ** 30 00 + 3 ** 90 00)**

3 02 00**	**External Recovery of Earned Hours** **Where ** is equal to:** **10 = MOS** **50 = UPP** **80 = NP** **90 = MED**	These accounts are used to report the external recovery of earned hours for employees for whom the external recovery of compensation (F12022) is reported. The number of hours reimbursed would be reported as a negative value in the same functional centre of the paid hours. The statistic would be used for shared service arrangements and when the salary recovery is significant or material. The reporting of the recovered earned hours as a negative will reduce the total earned hours and ensure that the total hours reported match to the total compensation reported. This will ensure the accurate calculation of the number of full time equivalent staff (FTEs) and cost per hour indicators.
3 ** 10 00	Employee Worked Hours **Where ** is equal to:** **10 = MOS** **50 = UPP** **80 = NP** **90 = MED**	The hours spent carrying out the mandate of the functional centre. They include regular scheduled hours, overtime, worked call back, coffee breaks and worked statutory holiday hours. Worked hours do not include the lunch hours, stand-by hours, or on-call hours. Worked hours are those hours when staff is present and available to carry out the service mandate. Worked hours are captured by the following broad occupational groups: Management & Operational Support (MOS), Unit Producing Personnel (UPP), Nurse Practitioner (NP) and Medical Personnel (MED).

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3 ** 30 00	Employee Benefit Hours **Where ** is equal to:** **10 = MOS** **50 = UPP** **80 = NP** **90 = MED**	The hours of entitlement to paid absence which accrue to the credit of the employee. It includes vacation, statutory holiday, sick leave, education hours received. Does not include % in lieu, paternity top up, these benefits are recorded as employee benefit contribution (F 3**4*), which have no hours associated with them. Benefit hours are those hours when staff are not present but receive pay. Benefit hours are captured by broad occupational groups: Management & Operational Support (MOS), Unit Producing Personnel (UPP), Nurse Practitioner (NP) and Medical Personnel (MED).
3 ** 90 00	Purchased Service Hours **Where ** is equal to:** **10 = MOS** **50 = UPP** **80 = NP** **90 = MED**	The hours spent carrying out the mandate of a functional centre by personnel hired from a purchased third party provider for which the external agency/organization will receive remuneration for services provided. Purchased service accounts are used when the facility hires individuals to perform tasks, which are normally provided by health care organization staff. This service is normally provided within the facility. When a purchased service compensation account is used, there is a requirement to report worked hours for all categories of workers and workload data if applicable. In essence a service is considered "purchased" when the facility is responsible for the quality and productivity of the service (i.e., staff are under the direction of facility supervisors). This explains the need for workload and worked hours. Organization responsible for the supervision of the staff. Purchased service hours are captured by the following broad occupational groups: Management & Operational Support (MOS), Unit Producing Personnel (UPP), Nurse Practitioner (NP) and Medical Personnel (MED).

4* SERVICE RECIPIENT ACTIVITY

401 ** *0	Inpatient/Resident Admissions **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The official acceptance into the health care organization of an adult/resident/child/newborn/postnatal newborn, which requires medical and/or health services on a time limited basis. The admission procedure involves the assignment of a bed, bassinet or incubator. Admission of a newborn is deemed to occur at the time of birth, or in the case of postnatal newborns, at the time of admission of the mother to the health care organization.

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Account	Term	Definition
403 ** *0	Inpatient/Resident Days **Where ** the 4th and 5Th digits represents service recipient** **Where * the 6th digit represents age category.**	The days during which services are provided to an inpatient/resident, between the census taking hours on successive days. The day of admission is counted as an inpatient/resident day but the day of separation is not an inpatient/resident day. When the service recipient is admitted and separated (discharged or died) on the same day, one inpatient/resident day is counted.
404 ** *1	Inpatient/Resident Leave Days **Approved** **Where ** the 4th and 5Th digits represents service recipient** **Where * the 6th digit represents age category.**	The **approved** days during which services are provided but the patient/resident is absent at census taking time. These leave days include short-term leaves and any leaves for which the (inpatient) bed is being held and is not available for admission by another patient/resident. These days are a subset of, and included in, Inpatient/Resident Days. For Hospitals, patient Leave Days may be reported in any inpatient functional centres except 7* 2 05 Administrative, 7* 2 06 Program Management and 7* 2 07 Medical Resources and 7* 2 6* OR/PARR. Hospitals with Mental Health (SR 15) and Forensic Mental Health (SR 14) must report Inpatient/Resident Leave Days approved.
404 ** *2	Inpatient/Resident Leave Days **Unapproved** **Where the 4th and 5th digits represent service recipient** **Where * the 6th digit represents age category.**	The unapproved days during which the patient/resident is absent at census taking time. These leave days include short-term leaves and any leaves for which the (inpatient) bed is being held and is not available for admission by another patient/resident. These days are a subset of, and included in, Inpatient/Resident Days. For Hospitals, patient Leave Days may be reported in any inpatient functional centres except 7* 2 05 Administrative, 7* 2 06 Program Management and 7* 2 07 Medical Resources and 7* 2 6* OR/PARR. Hospitals with Mental Health (SR 15) and Forensic Mental Health (SR 14) must report Inpatient/Resident Leave Days Unapproved.
405 ** **	Inpatient/Resident Isolation Days **Where ** the 4th and 5th digits represents service recipient** **Where * the 6th digit represents age category**	Subset of patient/resident days patients are in isolation (i.e. when a patient is isolated due to infection control).

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406 ** 10	Individuals Currently Waiting for Initial Assessment **Where ** the 4th and 5Th digits represents service recipient.**	Number of individuals who are currently **waiting for initial assessment** (i.e., they have an application/referral date but do **not** yet have an assessment complete date). This reflects the number of individuals on the waiting list on the last day of reporting period. This is a snap shot at a point in time, at the end of a reporting period, as at September 30 (Q2), December 31 (Q3), March 31 (YE). It is not a cumulative number. This statistic does not refer to the clinical abstract count, i.e. MDS.
406 ** 20	Individuals Currently Waiting for Service Initiation **Where ** the 4th and 5Th digits represents service recipient.**	Number of individuals referred/accepted to receive service and currently **waiting for service.** These individuals have had their assessment/intake and have been referred or booked for a service but have not yet had their first service (i.e., to the date of the first actual service –not the booked date) and thus are still waiting for service. This statistic is recorded in the client/service functional centre. This is a snap shot at a point in time, at the end of a reporting period, as at September 30 (Q2), December 31 (Q3), March 31 (YE). It is not a cumulative number. Refer to applicable sector chapters for specific reporting instructions.
407 ** 10	Days Waited For Assessment **Where ** the 4th and 5Th digits represents service recipient.**	The number of days waited for assessment (from the application/referral date to the assessment complete date). This is a cumulative number, year-to-date value. This statistic is used to produce the average time it takes to assess a client.
407 ** 20	Days Waited for Service Initiation **Where ** the 4th and 5Th digits represents service recipient.**	The number of days waited from service referral date /assessment complete date to service initiation date (date of the actual first service received). These days can only be counted after the service has started and the client is no longer waiting for service. This statistic is recorded in the client/service functional centre. This is to be recorded from the date that the client is deemed eligible for the service, rather than from the date the case manager or coordinator orders/books a service. This is a cumulative number, year-to-date value. This statistic is used to calculate/approximate the number of days waiting for service by the eligible clients. Refer to applicable sector chapters for specific reporting instructions.

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408 ** **	Individuals Currently Waiting LTC Placement in Preferred Choice **Where 47 represents service recipient.** **Where the 6Th and 7th digits represents where the client is waiting.**	The number of individuals currently waiting for LTC Home placement in their preferred choice location. This account reflects the number waiting on the last day of the reporting period (for Q2 September 30th, for Q3 December 31st, for Year End March 31st). This is a point in time count. It is not a cumulative number. **Where the 6Th and 7th digits represents where the client is waiting.** 10 within catchment area in another CCAC 20 within catchment area within the same CCAC 30 outside catchment area within the same CCAC
409 ** **	Days Waited for LTC Placement in Preferred Choice **Where 47 represents service recipient.** **Where the 6Th and 7th digits represents where the client is waiting.**	The number of days from eligibility date for LT Placement until the LT placement service process is complete and the file is closed. Placement is not considered complete until the client has been placed in their preferred choice Home or the file is closed for other valid file-closed reasons. This is a cumulative number, year-to-date value. **Where the 6Th and 7th digits represents where the client is waiting.** 10 within catchment area for in another CCAC 20 within catchment area within the same CCAC 30 outside catchment area within the same CCAC
410 ** *0	Inpatient/Resident Discharges **Where ** the 4th and 5Th digits represents service recipient Where * the 6th digit represents age category.**	The official departure of live inpatients from the health care organization. Discharge of a newborn is deemed to occur at the time of official release from the health care organization.
411 ** *0	Deaths **Where ** the 4th and 5Th digits represents service recipient. Where * the 6th digit represents age category.**	The official separation of inpatients deemed deceased after admission and before discharge from a health care organization. Inpatient deaths do not include stillbirths.

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412 ** *1	Inpatient/Resident Functional Centre **Transfers In**	The transfer in and out of inpatients/residents which occur within a functional centre regardless of the service recipient code of the patient. All inpatient/resident service codes may be reported within an inpatient functional centre.
412 ** *2	Inpatient/Resident Functional Centre **Transfer Out** **Where ** the 4th and 5Th digits represents service recipient. Where * the 6th digit represents age category.**	
415 ** 10	Outbreak Days	The number of resident days impacted by infectious disease outbreak during a reporting period and subjected to temporary restrictions on admissions and transfers. For LTCH, report in the LTCH Nursing FC 7*5 92 * to reflect the number of resident days impacted by outbreak occurrences which may result in reduction of resident days due to admission or transfer restrictions.
415 ** 20	Outbreak - Number of Occurrences	The number of occurrences of infectious disease outbreak during a reporting period that led to temporary restrictions on admissions and transfers. For LTCH, report in the LTCH Nursing FC 7*5 92 * to reflect the number of outbreak occurrences in the nursing units.
422 00 00	Dead on Arrival	This statistic is reported when a patient arrives at the hospital without vital signs and death is pronounced prior to implementation of any intervention. If hospital staff attempts to revive the patient and attempts are not successful, an Emergency outpatient death is recorded. Use only in Emergency or Anatomical Pathology functional centre.
425 00 00	Inpatients Admitted through Emergency	The number of patients admitted to the organization through the Emergency Department directly to an inpatient unit. S 425* is a subset of S 401* admissions.
427 00 00	Total Waiting Time for Admission to Inpatient Bed	The time the patient is registered in Emergency until the time the patient is either admitted or transferred to an inpatient bed (if admitted to Emergency). This is recorded in hours.

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437 ** *1	Surgical Cases In-House **Where ** the 4th and 5Th digits represents service recipient 11 or 22.** **Where * the 6th digit represents age category.**	The service recipients who have had a surgical intervention in an operating room. If an individual returns to the operating room for further surgery during the same calendar day, this intervention will be counted as another case. Refer to Chapter 8 for details.
437 22 *2	Surgical Cases Contracted Out Day Surgery **Where * the 6th digit represents age category.**	The surgical interventions for which the health care organization remunerated a contracted-out third party provider.
438 ** *1	Medical Cases In-house **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The service recipients who have had a medical procedure in the recovery room for which a NACRS abstract is created. Examples are electro-convulsive therapy and cardioversions.
439 ** *1	Post Anesthetic Recovery Room Visit **Where ** the 4th and 5Th digits represents service recipient 11 or 22.** **Where * the 6th digit represents age category.**	The service recipients who receive post-anesthetic recovery room services after a surgical intervention (case) in an operating room or in a NACRS mandated day surgery functional centre. If an individual returns to the recovery room for further services during the same calendar day, this episode will be counted as another visit. Refer to Chapter 8 for details.

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**442 11 ** **	Mothers Delivered in the facility **Where * the 6th digit represents age category.** **Where * the 7Th digit represents location where mother delivered.** **1=in LDRP** **2=in Main OR** **3=in ER** **4=at Home**	The women delivered of a single live birth or stillbirth, or multiple live births or stillbirths, or a combination of these, resulting from one pregnancy. Multiple births are counted as one delivery. Includes delivery by caesarian section. Excludes deliveries that take place prior to admission.
443 ** *0	**In Home** Visit - Face to Face In House **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	Each occasion during which **in home** service recipient activities are provided **by the Community Care Access Centre (CCAC) employees** as face-to-face or by videoconferencing on an individual basis to individuals who are uniquely identified. This includes service to the service recipient and/or significant other(s) **in attendance** on behalf of the service recipient. These services are documented according to the health care organization's policy and are provided for longer than five minutes.
444 ** *0	**In Home** Visit - Non Face to Face In House **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	Each occasion during which **in home** service recipient activities are provided **by the Community Care Access Centre (CCAC) employees** by mean other than by face-to-face to service recipients and/or significant others in attendance who are uniquely identified. These occasions take the place of a visit face-to-face. Examples may include visits via telephone, email or other forms of electronic communication. These services are documented according to the health care organization's policy and are provided for longer than five minutes.

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445 ** 0	**In Home**-Visit - Face to Face – Contracted- Out **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	Each occasion during which **in home** service recipient activities are provided **by the Community Care Access Centre (CCAC) third party service providers, and specifically billed for,** as face-to-face or by videoconferencing on an individual basis to individuals who are uniquely identified. This includes service to the service recipient and/or significant other(s) **in attendance** on behalf of the service recipient. These services are documented according to the health care organization's policy and are provided for longer than five minutes.
446 ** *0	**In Home** Visit –Non Face to Face - Contracted-Out **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	Each occasion during which **in home** service recipient activities are provided by the **Community Care Access Centre (CCAC) third party service providers, and specifically billed for**, by means other than face-to-face to service recipients and/or significant others in attendance who are uniquely identified. These services are documented according to the health care organization's policy and are provided for longer than five minutes.
447 ** * 0	Visit - Face to Face – MD/PA/NP Only **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	A MD/PA/NP Only Visit occurs when a service recipient is treated in a 7 *3* or a 7 *5* functional centre and the only service care provider is a physician (MD), or physician assistant (PA) or nurse practitioner (NP) providing service in place of a physician. There are no unit producing personnel (UPP) in the functional centre. There must be documentation of the interaction in the patient record, the record must be owned by the facility, and the facility must assume the responsibility for the care of the patient. Report the MD/PA/NP Only visit (S 447*) and do not report an In House visit (S 450*), UPP Worked Hours (S 350*), or UPP Worked Compensation (F 350*) within the same functional centre.

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Account	Title	Definition
448 ** *0	Visit – Non Face to Face - Contracted-Out **Where ** the 4th and 5Th digits represents service recipient. Where * the 6th digit represents age category.**	A Visit – Non Face to Face Contracted - Out is recorded when a uniquely identified service recipient or significant other(s) in attendance receives service on **an individual basis** from **third party service providers, and specifically billed for**, by means other than face-to-face. These occasions take the place of a visit face-to-face. Examples may include visits via telephone, email or other forms of electronic communication. The service is documented according to the health care organization's policy and-is provided for longer than five minutes. **When a service recipient receives service more than once on the same calendar day in the same functional centre for the same need or condition/treatment only one visit is reported.** Excludes non face to face interactions with service recipients who are not uniquely identified (service recipient codes 60 or 65). **Note:** Refer to applicable sector chapters for specific reporting instructions.
449 ** *0	Visit - Face to Face – Contracted-Out **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	A Visit – Face to Face – Contracted-out is recorded when a uniquely identified service recipient is present to receive service from third **party service providers, and specifically billed for,** as face-to-face or by videoconferencing **on an individual basis.** This includes service to the service recipient and/or significant other(s) in attendance on behalf of the service recipient. The service is documented according to the health care organization's policy and is provided for longer than five minutes. **A visit is each occasion when a service recipient is provided service in a functional centre (FC) regardless of number of service providers present and the length of service. When a service recipient is present to receive the service more than once on the same calendar day in the same functional centre for the same need or condition/treatment, only one visit is reported.** Excludes face-to-face interactions with service recipients who are not uniquely identified (service recipient codes 60 or 65). This account cannot be used if service is provided by a Physician only. **Note:** Visits are to be accrued at the end of each period to match the accrual of the contracted-out services expense. **Note**: Refer to applicable sector chapters for specific reporting instructions.

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Account	Name	Description
450 ** *0	Visit - Face to Face In House **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	A Visit –Face to Face in House is recorded when a uniquely identified service recipient (SR) is present to receive service from **an organization's employees** as face-to-face or by videoconferencing on an **individual basis.** This includes service to the service recipient and/or significant other(s) **in attendance** on behalf of the service recipient. The service is documented according to the health care organization's policy and is provided for longer than five minutes. **A visit is each occasion when a service recipient is provided service in a functional centre regardless of the number of service providers present and the length of service. When a service recipient is present to receive service more than once on the same calendar day in the same functional centre for the same need or condition/treatment, only one visit is reported.** Excludes face-to-face interactions with service recipients who are not uniquely identified (service recipient codes 60 or 65). This account cannot be used if service is provided by a Physician only. **Note:** Refer to applicable sector chapters for specific reporting instructions.
451 ** *0	Visit - Non Face to Face In House **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	A Visit – Non Face to Face in House is recorded when a uniquely identified service recipient (SR) and/or significant other(s) in attendance receives service **on an individual basis** from an **organization's employees** by means other than by face-to-face. These occasions take the place of a visit face-to-face. Examples may include visits via telephone, email or other forms of electronic communication. The service is documented according to the health care organization's policy and-is provided for longer than five minutes. **When a service recipient receives service more than once on the same calendar day in the same functional centre for the same need or condition/treatment, only one visit is reported.** Excludes interactions with service recipients who are not uniquely identified (service recipient codes 60 or 65). **Note:** Refer to applicable sector chapters for specific reporting instructions.

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452 6* 00	**Not Uniquely Identified Service Recipient Interactions** **Where ** the 4th and 5Th digits represents service recipient.**	The number of interactions face to face, or non face-to-face with a service recipient/client or significant other who is not uniquely identified. This statistic is used when a health record has not been generated and /or there is no documentation according to the health care organization policy. Only service recipient codes 60 and 65 can be used with this account. Examples of functional centres where this account can be used are Education (7* 8), Health Promotion and Education (7* 5 50) and Information & Referral (7* 5 70)
4 53 ** *0	Hours of Care / Hours of Service Contracted Out **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The number of hours of care or service provided by third party service providers, e.g., in the in-home health shift nursing (7*5 30 40 12), school shift nursing (7*5 30 42 12) or personal support care (7*5 35 40*) functional centres. The cost of the third party providers with service recipients is recorded in the F 8* series of accounts. **Note:** Report the hours of service received by the service recipient (SRs).
4 54 ** *0	Hours of Care / Hours of Service In House **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The hours of care or service provided by in-house service providers, e.g., the in-home health shift nursing (7*5 30 40 12), school shift nursing (7*5 30 42 12) or personal support care (7*5 35 40*) functional centres. **Note:** Report the hours of service received by the service recipient (SRs).
455 ** *0	Individuals Served by Functional Centre **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	This statistical account is a year-to-date count of the number of individuals served by the functional centre in a reporting period and identified by a unique identifier. Individuals are counted only once within the functional centre within a fiscal year, regardless of how many different services they have received or the number of times they were admitted and discharged within the reporting period. This account is reported in the functional centre where the service was received. An individual may receive services from several functional centres during the same reporting period. This count **cannot** be summed for a "total" for the whole organization to report S 855** Total Individuals Served by the Organization.

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457 ** **	Diagnostic (IH) Exams **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents modality.**	A defined technical investigation using an imaging modality to study one body structure, system or anatomical areas that yields one or more views for diagnostic and/or therapeutic purposes. Refer to the 2013 CIHI MIS Standards for values of exams.
457 ** 10	Med. Imaging IH Exams – Radiography	See 457 ** ** definition.
457 ** 34	Med. Imaging IH Exams – Computed Tomography	See 457 ** ** definition.
457 ** 36	Med. Imaging IH Exams – Other Tomography	See 457 ** ** definition.
457 ** 37	Med. Imaging IH Exams – Interventional/Angio.Studies	See 457 ** ** definition.
457 ** 38	Med. Imaging IH – Mammography	See 457 ** ** definition.
457 ** 39	Med. Imaging IH – Nuclear Medicine	See 457 ** ** definition.
457 ** 40	Med. Imaging IH Exams – Ultrasound	See 457 ** ** definition.
457 ** 46	Med. Imaging IH Exams – Magnetic Resonance Imaging	See 457 ** ** definition.
457 ** 47	Med. Imaging IH Exams - Positron Emission Tomography	See 457 ** ** definition.

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457 ** 48	Med. Imaging IH Exams – Miscellaneous	See 457 ** ** definition.
457 ** 90	Med. Imaging IH Exams – Cardiac Catheterization – Angiography	See 457 ** ** definition.
457 ** 70	Electro diagnostic Labs Exams Electroencephalography (EEG)	See 457 ** ** definition.
457 ** 71	Electro diagnostic Lab Exams Electromyography (EMG)	See 457 ** ** definition.
457 ** 72	Electro diagnostic Lab Exams Evoked Potentials	See 457 ** ** definition.
457 ** 73	Electro diagnostic Lab Exams Polysomnography (Sleep Studies)	See 457 ** ** definition.
457 ** 74	Electro diagnostic Lab Exams Intensive Monitoring	See 457 ** ** definition.
457 ** 75	Electro diagnostic Lab Exams Electronstagmography / Electrooculography (ENG/EOG)	See 457 ** ** definition.
457 ** 77	Non-Invasive Cardiology and Vascular Lab Exams Echocardiograph	See 457 ** ** definition.
457 ** 78	Non-Invasive Cardiology and Vascular Lab Exams Amb. Monitoring (Holter)	See 457 ** ** definition.

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457 ** 79	Non-Invasive Cardiology and Vascular Lab Exams Exercise Tolerance Testing	See 457 ** ** definition.
457 ** 80	Non-Invasive Cardiology and Vascular Lab Exams Electrophysiology	See 457 ** ** definition.
457 ** 81	Non-Invasive Cardiology and Vascular Lab Exams Electro card. (ECG)	See 457 ** ** definition.
457 ** 82	Non-Invasive Cardiology and Vascular Lab Exams Non Invasive Vascular	See 457 ** ** definition.
459 ** 54	Rehabilitation Engineering – Orthotics Procedures **Where ** the 4th and 5Th digits represents service recipient.**	The number of procedures as defined therapeutic activity performed in-house for inpatients, clients, or referred-in patients. Refer to the 2013 CIHI MIS Standards., for value of procedures.
459 ** 57	Rehabilitation Engineering – Prosthetics Procedures	See 459 ** 54 definition.
459 ** 74	Radiation Oncology In-House Procedures – Mould Room	See 459 ** 54 definition.
459 ** 75	Radiation Oncology In-House Procedures – Simulator	See 459 ** 54 definition.

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459 ** 76	Radiation Oncology In-House Procedures – Planning/Dosimetry	See 459 ** 54 definition.
459 ** 77	Radiation Oncology In-House Procedures – Radiation Therapy	See 459 ** 54 definition.
459 ** 78	Radiation Oncology In-House Procedures – Brachytherapy	See 459 ** 54 definition.
460 ** **	Medical Imaging Contracted Out Exams **Where ** the 4th and 5Th digits represents service recipient.**	The number of exams for which the health care organization remunerated a contracted-out third party provider.
460 ** 10	Medical Imaging Contracted Out Exams – Radiography	See 460 ** ** definition.
460 ** 34	Medical Imaging Contracted Out Exams – Computed Tomography	See 460 ** ** definition.
460 ** 36	Medical Imaging Contracted Out Exams – Other Tomography	See 460 ** ** definition.
460 ** 37	Medical Imaging Contracted Out Exams – Interventional/Angio. Studies	See 460 ** ** definition.
460 ** 38	Medical Imaging Contracted Out Exams – Mammography	See 460 ** ** definition.
460 ** 39	Medical Imaging Contracted Out Exams – Nuclear Medicine	See 460 ** ** definition.

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460 ** 40	Medical Imaging Contracted Out Exams – Ultrasound	See 460 ** ** definition.
460 ** 46	Medical Imaging Contracted Out Exams – Magnetic Resonance Imaging	See 460 ** ** definition.
460 ** 47	Medical Imaging Contracted Out Exams – Positron Emission Tomography	See 460 ** ** definition.
460 ** 48	Medical Imaging Contracted Out Exams – Miscellaneous	See 460 ** ** definition.
460 ** 90	Medical Imaging Contracted Out Exams – Cardiac Catheterization – Angiography	See 460 ** ** definition.
460 ** 70	Electro diagnostic Labs Contracted Out Exams Electroencephalography (EEG)	See 460 ** ** definition.
460 ** 71	Electro diagnostic Lab Contracted Out Exams Electromyography (EMG)	See 460 ** ** definition.
460 ** 72	Electro diagnostic Lab Contracted Out Exams Evoked Potentials	See 460 ** ** definition.
460 ** 73	Electro diagnostic Lab Contracted Out Exams Polysomnography	See 460 ** ** definition.

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460 ** 74	Electro diagnostic Lab Contracted Out Exams Intensive Monitoring	See 460 ** ** definition.
460 ** 75	Electro diagnostic Lab Contracted Out Exams Electronstagmography / Electro-oculography (ENG/EOG)	See 460 ** ** definition.
460 ** 77	Non-Invasive Cardiology and Vascular Labs Contracted Out Exams – Echocardiography	See 460 ** ** definition.
460 ** 78	Non-Invasive Cardiology and Vascular Labs Contracted Out Exams Amb. Monitoring	See 460 ** ** definition.
460 ** 79	Non-Invasive Cardiology and Vascular Labs Contracted Out Exams Exercise Tolerance Testing	See 460 ** ** definition.
460 ** 80	Non-Invasive Cardiology and Vascular Labs Contracted Out Exams Electrophysiology	See 460 ** ** definition.
460 ** 81	Non-Invasive Cardiology and Vascular labs Contracted Out Exams – Electrocardiography (ECG)	See 460 ** ** definition.
460 ** 82	Non-Invasive Cardiology and Vascular Labs Contracted Out Exams – Non Invasive Vascular	See 460 ** ** definition.

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463 ** **	LAB IH Interventions **Where ** the 4th and 5th digits represents service recipient.** **Where ** the 6th and 7th digits represents modality.**	The defined diagnostic activities performed in a clinical laboratory to assist in the diagnosis, monitoring and treatment of disease on service recipients. The laboratory intervention may be an encounter, a diagnostic analysis or group of diagnostic analyses, a product issued or a case depending on the functional centre. Refer to the 2013 CIHI MIS Standards., for detailed information.

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464 ** ** 	Lab CO Interventions **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents modality.**	The laboratory interventions for which the health care organization remunerated a contracted-out third party provider.
466 ** 00	Autopsies Performed **Where ** the 4th and 5Th digits represents service recipient.**	The post-mortem examination of bodies, including the internal organs and structures after dissection, so as to determine the cause of death or the nature of pathological changes.
467 ** 00	Autopsies Contracted Out **Where ** the 4th and 5Th digits represents service recipient.**	The autopsies for which the health care organization remunerated a contracted-out third party provider.

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~~**468 ** 10**~~	~~Respiratory Therapy Services In House Service Recipient Procedures – Diagnostic~~ ~~**Where ** the 4th and 5Th digits represents service recipient**~~	~~The defined diagnostic/therapeutic procedures performed by the health care organization's personnel.~~
~~**468 ** 20**~~	~~Respiratory Therapy Services In House Service Recipient Procedures – Therapeutic~~ ~~**Where ** the 4th and 5Th digits represents service recipient.**~~	~~The defined diagnostic/therapeutic procedures performed by the health care organization's personnel.~~
~~**469 ** 10**~~	~~Respiratory Therapy Services Contracted Out Procedures – Diagnostic~~ ~~**Where ** the 4th and 5Th digits represents service recipient.**~~	~~The defined diagnostic/therapeutic procedures for which the health care organization remunerated a contracted-out third party provider.~~

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~~**469 ** 20**~~	~~Respiratory Therapy Services Contracted Out Procedures – Therapeutic~~ ~~**Where ** the 4th and 5Th digits represents service recipient.**~~	~~The defined diagnostic/therapeutic procedures for which the health care organization remunerated a contracted-out third party provider.~~
4 83 ** *1	Attendance Days – Face to Face – In House **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The number of service delivery days (count once per 24-hour calendar day) which primary service recipient activities are provided face-to-face, or by videoconference, on an individual or group basis to a service recipient and /or significant other(s) provided by facility therapy staff. These services are documented according to the health care organization's policy and are provided for longer than five minutes. This statistic counts days during which services occurred rather than number of services. **Note:** • If services are provided face-to-face as well non face-to-face on the same calendar day, only an Attendance Day Face-to-Face is recorded regardless of which occurred first. • If a patient/client has both a group session and an individual session on the same calendar day, only an Attendance Day Face-to-Face is recorded regardless of which occurred first.

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Account	Name	Definition
483 ** *2	Attendance Days Face-to-Face – Contracted Out **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The number of service delivery days (count once per 24-hour calendar day) which primary service recipient activities are provided face-to-face, or by videoconference, on an individual or group basis to a service recipient and /or significant other(s) **provided by third party provider** . These services are documented according to the health care organization's policy and are provided for longer than five minutes. This statistic counts days during which services occurred rather than number of services. **Note:** • If services are provided face-to-face as well by non face-to-face on the same calendar day, only an Attendance Day Face-to-Face is recorded regardless of which occurred first. • If a patient/client has both a group session and an individual session on the same calendar day, only an Attendance Day Face-to-Face is recorded regardless of which occurred first.
484 ** *0	Attendance Days – Non Face-to-Face **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The number of calendar days (count once per 24-hour calendar day) which primary service recipient activities are provided by means other than by face-to-face to a service recipient and /or significant other(s) provided by facility therapy staff. These calendar days take the place of an attendance day face-to-face. Examples may include attendance days via telephone, email or other forms of electronic communication. These services are documented according to the health service organization's policy and are provided for longer than five minutes. This statistic counts days during which services occurred rather than number of services. **Note:** If services are provided face-to-face as well by non face-to-face on the same calendar day, only an Attendance Day Face-to-Face is recorded regardless of which occurred first.
487 ** 10	Therapy Initiation - Initial Assessment **Where ** the 4th and 5Th digits represents service recipient.**	The number of service recipients that received therapy initial assessments.

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487 ** 20	Therapy Initiation - Service Assessment **Where ** the 4th and 5Th digits represents service recipient.**	The number of service recipients that received therapy service initiations.
4 88 ** **	Initial Assessment Referral **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represent the referral source location and the residence of the client.** **31 = Hospital, client resides within catchment area** **32 = LTC Home** **33 = Hospital, client resides outside catchment area** **70 = Community** **90 = School**	This account is intended to capture the initial eligibility assessment activity for the following three services (Home Care, Placement, or School); they are reported in the case management functional centre. Any time a client is referred to any of the following three services (Home Care, Placement, or School) an "initial assessment referral" is required, or if the client is currently on one service and needs to be reviewed for another service, an "initial assessment referral" is required. If the client seeks services more than once in a fiscal year, each eligibility assessment referral is reported.
489 *0**	New Referral **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The number of service recipients, registered with a functional centre during the current year, which have been referred/accepted to receive services. This would not include anyone who was counted as an Active Carryover as of April 1 **, and receiving continuous services from the functional centre since the prior year. This is a cumulative value, that is reported each quarter and year-end. There may be multiple referrals to various functional centres (i.e., Nursing, Physio, and OT) during an admission to an organization. If a client has been referred/accepted to receive service and later discharged from a functional centre and then re-admitted again to the same FC within the same reporting period, both referrals for the same client can be reported using new referral statistic in the functional centre.

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490 ** *0	Active Carryover **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The number of registered service recipients who were new referrals in the prior fiscal year(s) and who received services or were admitted to a functional centre during the new fiscal period and who are still receiving services or admitted as of period end. Ontario's information is collected annually starting April 1, ** for each reporting period quarterly or year-end. This is not a cumulative amount; the number would be the same for each quarter in a fiscal year.
491 ** 10	Group Participants, **Non-Registered Client Attendance** **Where ** the 4th and 5Th digits represents service recipient.**	This is reported when a not uniquely identified service recipient (non registered client) receives services in a group session. (I.e., in the 7*4* Therapy CTC sector only and 7*5 Community Services framework). A health record is not generated for these non-registered clients. Service recipient 60 or 65 should be used to capture these individuals. **NOTE:** The number of group sessions S 492 00 10 would also be reported in order to determine the average size of the group sessions.
491 ** 20	Group Participants, **Registered Client Attendance** **Where ** the 4th and 5Th digits represents service recipient.**	This is reported when a uniquely identified service recipient (registered client) receives services in a group session. (I.e., in the 7*4* Therapy for CTC sector only and 7*5 Community Services framework) The service is documented according to the health care organization's policy. **NOTE:** The number of group sessions S 492 00 10 would also be reported in order to determine the average size of the group sessions.
492 00 10	Group Sessions – Number of Sessions	The formal service activities that are material in length, and are planned and delivered by one or more service providers to two or more service recipients, at the same time. The individuals in the group can be registered and/or non-registered. Group sessions can be recorded in 7*2, 7*3, although it will generally be used by 7*4 Therapy for CTC sector only and 7*5 Community Services for education, prevention and control and health promotion sessions.
493 ** *0	Initial Assessment Referral Carryover	These are service recipients whose initial assessments have **NOT** been completed as of March 31st and as a result need to be carried over to April 1st. Their eligibility assessment may or may not have been started.

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495 10 00	Inpatient Revenue Days Provincial Ministry of Health (Global)	The inpatient days, for which there is revenue due from global operations funding (MOHLTC)**,** where the revenue expected per day is at the standard ward rate.
495 30 00	npatient Revenue Days Federal Government	The inpatient days, for which there is revenue due from the Federal Government departments and the Department of Veteran's Affairs, where the revenue expected per day is at the standard ward rate.
495 50 00	Inpatient Revenue Days WSIB	The inpatient days, for which there is revenue due from WSIB (Workers Safety & Insurance Board), where the revenue expected per day is at the standard ward rate.
495 60 00	Inpatient Revenue Days Non-Resident of Province	The inpatient days, for which there is revenue due from all the provincial plans of Canadian provinces including Quebec, where the revenue expected per day is at the standard ward rate, as listed in the Interprovincial Billing Rates.
495 65 00	Inpatient Days Non-Residents of Canada	The inpatient days, for which there is revenue due from Non-Residents of Canada, where the revenue expected per day is at the standard ward rate.
495 70 00	Inpatient Revenue Days Uninsured Residents of the Province	The inpatient days, for which there is revenue due from the Uninsured Residents of the Province, where the revenue expected per day is at the standard ward rate.
495 80 00	Inpatient Revenue Days Insured Residents – Self-Pay	The inpatient days, for which there is revenue due from the Insured Residents – Self-Pay, where the revenue expected per day is at the standard ward rate.
495 90 00	Inpatient Revenue Days Other Payment Sources	The inpatient days, for which there is revenue due from Other Payment Sources, where the revenue expected per day is at the standard ward rate.
496 10 00	IP Co-payment Revenue Days – Complex Continuing Care	The inpatient days for which there is revenue due from Complex Continuing Care service recipients' co-payment portion, where the revenue expected per day is the difference between the extended stay and the standard ward rate.

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496 15 00	IP Co-payment Revenue Days – ELDCAP/ILTC (elderly capital assistants program) (Interim Long Term Care)	The inpatient days, for which there is revenue due from ELDCAP/ILTC service recipients' co-payment portion, where the revenue expected per day is at the standard ward rate.
496 20 00	IP Co-Payment Revenue Days – Alternative Level of Care (ALC)	The inpatient days, for which there is revenue due from ALC (Alternate Level of Care) service recipients' co-payments portion, where the revenue expected per day is at the standard ward rate.
494 00 00	IP Differential Revenue Days Melded Rate	The inpatient days, for which there is revenue due from the service recipient or other payer, where the revenue expected per day is a melded rate which both services are charged for semi private or private accommodation.
497 00 00	IP Differential Revenue Days Semi-Private	The inpatient days, for which there is revenue due from the service recipient or other payer, where the revenue expected per day is the difference between the semi-private and the standard ward rate.
498 00 00	IP differential Revenue Days Private	The inpatient days, for which there is revenue due from the service recipient or other payer, where the revenue expected per day is the difference between the private and the standard ward rate.
499 00 01	LTCH Resident Days by Accommodation Type-Basic	The LTCH resident days in basic accommodations for residents who are not in overbedding, short stay interim or spousal reunification accommodations. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.
499 00 02	LTCH Resident Days by Accommodation Type-Semi-Private	The LTCH resident days in semi-private accommodations for residents who are not in overbedding, short stay interim or spousal reunification accommodations. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.
499 00 03	LTCH Resident Days by Accommodation Type- Private	The LTCH resident days in private accommodations for residents who are not in overbedding, short stay interim, or spousal reunification accommodation. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.

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499 00 04	LTCH Resident Days by Accommodation Type – Short Stay/Respite Care	The LTCH resident days for Short Stay/Respite Care residents. The Short Stay/Respite Care service provides a caregiver with a break from care giving duties. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.
499 02 01	LTCH Resident Days by Accommodation Type- Overbedding - Basic	The LTCH resident days in basic accommodations for residents who are residing in an approved overbedding accommodation. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.
499 02 02	LTCH Resident Days by Accommodation Type- Overbedding - Semi-Private	The LTCH resident days in semi-private accommodations for residents who are residing in an approved overbedding accommodation. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.
499 02 03	LTCH Resident Days by Accommodation Type- Overbedding - Private	The LTCH resident days in private accommodations for residents who are residing in an approved overbedding accommodation. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.
499 04 02	LTCH Resident Days by Accommodation Type- Long Stay Semi-Private Exceptional Circumstances	The LTCH resident days in semi-private accommodations for approved couple residents who receive an exceptional circumstance spousal grant to live in a semi-private accommodation.
499 04 06	LTCH Resident Days by Accommodation Days - Short Stay Interim – 2-bed Room - Spousal Reunification	The LTCH resident days in Short Stay Interim care accommodation for approved couple residents who live in a 2-bed room accommodation. These licensed and approved interim beds are available to hospital patients who no longer require acute care and are on a wait list for a Long Stay bed. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.
499 06 01	LTCH Resident Days by Accommodation Days - Short Stay Interim – Basic	The LTCH resident days in basic accommodations for the Short Stay Interim Care residents. These licensed and approved interim beds are available to hospital patients who no longer require acute care and are on a wait list for a Long Stay bed. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.

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499 06 02	LTCH Resident Days by Accommodation Days - Short Stay Interim – Semi-Private	The LTCH resident days in semi-private accommodations for the Short Stay Interim Care residents. These licensed and approved interim beds are available to hospital patients who no longer require acute care and are on a wait list for a Long Stay bed. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.
499 06 03	LTCH Resident Days by Accommodation Days - Short Stay Interim – Private	The LTCH resident days in private accommodations for the Short Stay Interim Care residents. These licensed and approved interim beds are available to hospital patients who no longer require acute care and are on a wait list for a Long Stay bed. Includes the resident absences allowed by the Long-Term Care Home Act when residents continue to pay for the bed.

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5* CLIENT PROFILE ACCOUNTS

501 ** *0	Admission to Community Services **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The number of individuals that are accepted for community services. This is recorded each time an individual is accepted for service. Individuals are counted each time a new file is created upon their admission to the health care organization. There may be more than one admission per individual served per year. The decision date of eligibility is the admit date. A client can be counted as more than one admission per fiscal year due to discharges and re-admissions within the same sector service grouping i.e. CCACs, Home Care, Schools, Placement, as well as counting in each of the services. Every Admission must have a File Closed S 511* recorded when services end. These are reported in the Case Management FC 7*509*.
502 ** * 0	Resume CCAC Service **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The number of service recipients who resumed CCAC services during the period after being “on hold” up to and including fourteen (14) days due to a hospital admission for an acute illness, exacerbation of a chronic illness, or palliative services. Service recipient could be hospitalized more than once during the course of admission therefore must be counted each time service is resumed by the CCAC. This account should only be reported in Case Management FC 7* 5 09 30.
506 ** *0	Individuals Received First Service **Where ** the 4th and 5Th digits represents service recipient.** **Where * the 6th digit represents age category.**	The number of registered service recipients who have had their assessment/intake and **received their first service in the functional centre during current fiscal year**. This count includes the SRs who received their **first** service with or without waiting. This is a cumulative number, year-to-date count. Note: The days individuals have waited are reported in S407**20 Days Waited for Service Initiation only after the individual received the first service in the functional centre.

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Account	Name	Definition
~~**509 47 00**~~	~~LTC Placement Not Preferred Choice~~ ~~**Where 47 represents service recipient.**~~	~~This statistics records the number of placements which are not the client's preferred choice, during a reporting period. This covers all secondary placements made during the reporting period. As an individual moves between locations (none of which are their preferred choice) the individual can be counted 2 or 3 times during a reporting period. When the secondary placement becomes final it counts as file closed~~
511 ** **	File Closed **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7Th digits represents reason for closing file.**	The number of service recipients who are no longer the responsibility of the health care organization. A service recipient's file is closed when the need for service(s) has ended or the client no longer qualifies for services from the health care organization. This is recorded in the Case Management FC (7*509*). File must be closed at time of death. No additional visits can be charged to the client after date of death. This count will be captured through a system report which counts the total number of files closed regardless of service recipient category. **Where ** the 6th and 7Th digits represents reasons for closing a file.** 10 Service Plan Complete 18 Age Limit Reached 20 Death -while in the care of CCAC organization 22 Death while in the Hospital 30 Other CCAC 40 Admitted to LTC Home Hospitalized (> 14 days) 60 Client Preference (i.e. client is no longer available for service, has chosen to no longer receive service, or, has chosen to be withdrawn from waitlist). 70 Other Community Services 80 Vacation > 30 days 90 Other (i.e., unsafe environment, risky behaviour, admin.,/data errors)

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512 ****	Assessment Complete/Outcome **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7Th digits represents outcome of assessment.**	The number of initial assessments that have been completed, as well as the outcome of that assessment. The count occurs once the eligibility of the client has been determined. **Where ** the 6th and 7Th digits represents the outcome of the assessment.** **Subcategories of 1*** 1* Eligible In-Home Services 11 Client declined 12 Admitted 13 No Service Available 14 Other CCAC 15 LTC 16 Other **Subcategories of 2*** 2* Eligible Other Funded Services 21 Adult Day Program 22 Supportive Housing/Assisted Living 23 Enhanced Respite 29 Other Organizations **Subcategories of 3*** 3* Not eligible for funded Services 31 Did not meet Criteria 32 Referred to other Community Agency

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Subcategories of 4*

4* Assessment Incomplete, Eligibility Not Determined

41 Eligibility Not Determined, Process Stopped (SR 41, 99)

513 ** Service Discharge

Where ** the 4th and 5Th digits represents service recipient.

Where ** the 6th and 7Th digits represents reason for discharge.

Service Recipients are discharged from a service delivery functional centre (i.e., Home Care, and School) when the need for that service has ended or as per discharge criteria. No additional visits can be charged for the client **after date of death.**
Where ** the 6th and 7Th digits represents the reason for discharge.
10 Service Plan Complete
18 Age Limit Reached
20 Death while in the Care of the Organization
22 Death while in the Hospital
30 Transfer Other CCAC
40 Admitted to LTC Home
50 Hospitalized > 14 days
60 Client Preference
70 Community Services
80 Vacation > 30 days
90 Other

514 ** Placement File Closed

Where ** the 4th and 5Th digits represents service recipient.

Where ** the 6th and 7Th digits represents reason for service complete.

The file is closed when placement services have been completed. This may extend beyond the date of actual placement to ensure that the placement is satisfactory.

Where ** the 6th and 7Th digits represents the reason for service complete.
10 Placement File Closed – Placed in Preferred Choice
20 Placement File Closed – No Placement
50 Placement File Closed – Short Stay Respite Complete
60 Placement File Closed – Short Stay Convalescent/Transition Care Complete

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518 00**	Transferred FROM In-home SR category **Where ** the 4th and 5Th digits represents service recipient.**	The number of times that the service goal of a client changes during an Admission. The client will be Transferred FROM one service recipient sub-category to another. If the service goals change after admission, the client will be transferred to another service recipient category. A change in Service Recipient category will trigger statistics that record a “Transfer To” the new category and a “Transfer From” of the original service recipient category. S 518* must equal S 519*.
519 00**	SR Transferred TO In-home SR category **Where ** the 4th and 5Th digits represents service recipient.**	See 5 18 ** 00 definition.

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Detailed AMBULATORY Care Clinic Visits Face-to-Face

	Detailed Ambulatory Care Clinic Visits Face-to-Face	The detailed visits accounts are only required when reporting a general medical clinic (FC 7*3 50 10 and 7*3 50 10 10), general surgical clinic (FC 7*3 50 15 and 7*3 50 15 10), combined clinic functional centre (FC: 7*3 50 17 *), these functional centres use these detailed visits accounts to indicate type of service delivery. S 450* and S 5* ambulatory visits should not be reported within the combined functional centre. This account cannot be used if service is provided by a Physician only Each occasion (i.e., each registration), during which service recipient activities are provided, **by the organization's service care provider employees**, as face to-face or by videoconference on an individual basis, this includes service to the service recipient and/or significant other(s) in attendance. These services are documented according to the health care organization's policy and are provided for longer than five minutes.
510 ** **	Clinic Visits Face-to-Face-Medical	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
515 ** **	Clinic Visits Face-to-Face-Surgical	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
525 ** **	Clinic Visits Face-to-Face-Family Practice	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
535 ** **	Clinic Visits Face-to-Face-Gynecology	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. . **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**

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540 ** **	Clinic Visits Face-to-Face-Metabolic	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. . **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
542 ** **	Clinic Visits Face-to-Face-Cardiac	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
543 ** **	Clinic Visits Face-to-Face-Endocrinology	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
548 ** **	Clinic Visits Face-to-Face-Genetic Adult	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
550 ** **	Clinic Visits Face-to-Face-Obstetrics	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
561 ** **	Clinic Visits Face-to-Face-Neurology	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
562 ** **	Clinic Visits Face-to-Face-Ophthalmology	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**

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Account	Name	Definition
566 ** **	Clinic Visits Face-to-Face-Oncology	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
570 ** **	Clinic Visits Face-to-Face-Pediatric	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
572 ** **	Clinic Visits Face-to-Face-Orthopedic	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. . **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
575 ** **	Clinic Visits Face-to-Face-Plastic	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
576 ** **	Clinic Visits Face-to-Face-Mental Health/Addictions	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
581 ** **	Clinic Visits Face-to-Face-Rehabilitation	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**
595 ** **	Clinic Visits Face-to-Face-Rheumatology	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7th digits represents type of service.**

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596 ** **	Clinic Visits Face-to-Face-Geriatric	See definition for Detailed Ambulatory Care Clinic Visits Face to Face. **Where ** the 4th and 5Th digits represents service recipient. Where ** the 6th and 7th digits represents type of service.**

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6* PERSONNEL PROFILE

61* HEAD COUNT

611 ** ** MOS Head Count

615 ** ** UPP Head Count

618 ** ** NP Head Count

619 ** ** MED Head Count

These statistical account codes represent the number of unique employees on the organization's payroll in each functional centre 7*1* through 7*9* at the end of reporting period. It includes employees on short/long term disability or sick leave, WSIB, maternity/parental leave, leave of absence, and excludes employees terminated or on salary continuance. It is a snap shot at a point in time, as at September 30 (Q2), December 31 (Q3), or March 31 (YE). Required by occupational class and by employment status.

Where the 3rd digit represents Broad occupational group: 1=MOS, 5=UPP, 8=NP, 9=MED

Where the 4th and 5th digits represents occupational class.

Where the 6th and 7th digits represents employment status.

Refer to Full Provincial Statistical List of Accounts, for values defined in the 4th and 5th positions, and 6th and 7Th positions.

63* EARNED HOURS DETAILS

631 ** ** Earned Hours Details-MOS

635 ** ** Earned Hours Details-UPP

638 ** ** Earned Hours Details-NP

639 ** ** Earned Hours Details-MED

These statistical account codes represent the earned hours detail by occupational class, and by employment status within each functional centre. The detail type of earned hours captured are externally recovered hours, worked-overtime, worked-other, worked-combined, benefit-sick, benefit-vacation, benefit- education, benefit-orientation, benefit- other, benefit combined. **(See below for definition of type of earned hours).**

Where the 3rd digit represents Broad Occupational Group: 1=MOS, 5=UPP, 8=NP, 9=MED

Where the 4th and 5th digits represents occupational class

Where the 6th digit represents employment status

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Where the 7th digit represents type of earned hours.

Refer to Full Provincial Statistical List of Accounts, for values defined in the 4th and 5th positions, 6Th, and 7Th position.

Type of Earned Hours

Worked Hours

Where the 7th digit is equal to:	**Where the 7th digit represents type of earned hours.**
0 – Worked Hours –Combined Community Only	**Worked Hours Combined – Community Only** These hours include regular worked and overtime hours. Used by community sector only.
1-Worked Hours- Overtime	**Worked Hours- Overtime:** These are the overtime worked hours and call-back at straight time. These hours are actual worked hours regardless of the overtime rate paid.
2-Worked Hours-Exclude Overtime	**Worked Hours- Exclude Overtime:** These remaining hours include regular worked (including paid coffee breaks), informal education (in-service), scheduled statutory holidays worked and relief/replacement for vacation and sick.

Benefit Hours

Where the 7th digit is equal to:	
3 - Benefit-sick hours	**Benefit-sick Hours:** These are the hours that personnel have received remuneration regardless of the amount or portion of pay. These hours would be used to calculate the number of FTEs.
	Benefit-Vacation Hours: These are the hours that personnel have earned for vacation. These

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4 - Benefit-Vacation Hours

hours would be used to calculate the number of FTEs. Note: Vacations paid as a percentage are reported under benefit contribution F 3*0 82.

5 - Benefit- Education Hours

Benefit- Education Hours: These hours are paid to personnel while they are attending classes to enhance their personnel education qualifications. These are not intended to capture hours for in-service, conventions or conferences.

6 - Benefit-Orientation Hours

Benefit-Orientation Hours: These are hours that new employees or transferring staff within the facility would be learning about the policies and procedures of the corporation and or their specific functional centre. These hours are benefit hours and there would be no workload reported. These hours will vary by individuals and by functional centres.

7 - Benefit-Other Hours

Benefit-Other Hours: These remaining hours include paid statutory holidays and other such paid leaves as bereavement etc**.**

8 - Benefit – Combined Hours – Community Only

Benefit – Combined Hours – these hours include all benefit hours. Used by community sector only.

9- Externally Recovered Hours

Externally Recovered Hours- these hours include detailed earned hours that were externally recovered. Reported as a negative.

64* ** ** HIRES COUNT

641 ** ** Hires Count-MOS

645 ** ** Hires Count-UPP

648 ** ** Hires Count-NP

649 ** ** Hires Count-MED

The number of unique employees hired and is new to the organization's payroll during the reporting period; to be collected for all new staff. At the organizational level, it is a cumulative (YTD) number, reported at September 30 (Q2), December 31(Q3), or March 31 (YE).

Where the 3rd digit represents Broad occupational group: 1=MOS, 5=UPP, 8=NP, 9=MED.
Where the 4th and 5th digits represents occupational class.
Where the 6th digit represents employment status.

Refer to Full Provincial Statistical List of Accounts, for values defined in the 4th and 5th positions,

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6th, and 7Th position.

Further information is required for all nursing occupational class codes (11 RN, 12 RPN, 13 Nurse Manager, 14 Clinical Nurse Specialist, 15 Nurse Educator, 16 Nurse Practitioner and 17 Infection Control Professional RN) detailed in the 7th digit.

Where the 7th digit represents the type of graduate and position.

To be reported by New Graduate- New Position, New Graduate- Existing Position, Graduated > 1 yr. – New Position and Graduated > 1 yr. - Existing Position.

New Graduate - is defined as “graduated from an accredited nursing program within the last 12 months”.

Graduated > 1 yr. - is defined as “graduated from an accredited nursing program beyond 12 months”.

New Position - is defined as per union contract agreement

65* ** ** LAYOFF COUNT

651 ** *1 Layoff Count - MOS - **Planned**

655 ** *1 Layoff Count - UPP - **Planned**

658 ** *1 Layoff Count - NP - **Planned**

These statistical account codes represent the number of unique nursing (individuals) employees planned/ anticipated to leave the organization’s payroll on an involuntary or organization imposed basis, during the next reporting period; where the reporting period is equal to the full fiscal year. For example Q2 05/06 reporting would include the planned layoffs for the full fiscal year; to be reported by broad occupational group, includes MOS, UPP and NP; to be reported for all nursing staff within the organization. To be collected for all nursing occupational class codes (11 RN, 12 RPN, 13 Nurse Manager, 14 Clinical Nurse Specialist, 15 Nurse Educator, and 16 Nurse Practitioner).

Where the 3rd digit represents Broad occupational group: 1=MOS, 5=UPP, 8=NP.
Where the 4th and 5th digits represents occupational class.
Where the 6th digit represents employment status.
Where the 7th digit represents status of layoff: 1-Planned.

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Refer to Full Provincial Statistical List of Accounts, for values defined in the 4th and 5th positions.

Code	Description	Definition
651 ** *2 **655 ** *2** **658 ** *2**	Layoff Count - MOS - **Issued** Layoff Count –UPP - **Issued** Layoff Count - NP - **Issued**	These statistical account code represents the number of layoff notices issued from the organization to nursing employees during the current fiscal reporting period; to be reported by broad occupational group, includes MOS, UPP and NP; and reported for all nursing staff within the organization. To be collected for all nursing occupational class codes (11 RN, 12 RPN, 13 Nurse Manager, 14 Clinical Nurse Specialist, 15 Nurse Educator, and 16 Nurse Practitioner).It is a cumulative total, reported September 30 (Q2), December 31 (Q3), and March 31 (YE). **Where the 3rd digit represents Broad occupational group: 1=MOS, 5=UPP, 8=NP.** **Where the 4th and 5th digits represents occupational class.** **Where the 6th digit represents employment status**. **Where the 7th digit represents status of layoff: 2-Issued.** Refer to Full Provincial Statistical List of Accounts, for values defined in the 4th and 5th positions.
651 ** *3 **655 ** *3** **658 ** *3**	Layoff Count - MOS - **Actual** Layoff Count - UPP - **Actual** Layoff Count - NP - **Actual**	These statistical account codes represent the number of unique nursing employees left from the organization during the current reporting period due to a lay off notice issued to them; to be reported by broad occupational group, includes MOS, UPP and NP; to be reported for all nursing staff within the organization. To be collected for all nursing occupational class codes (11 RN, 12 RPN, 13 Nurse Manager, 14 Clinical Nurse Specialist, 15 Nurse Educator, and 16 Nurse Practitioner). It is a cumulative total, reported September 30 (Q2), December 31 (Q3), and March 31 (YE). **Where the 3rd digit represents Broad occupational group: 1=MOS, 5=UPP, 8=NP.** **Where the 4th and 5th digits represents occupational class.** **Where the 6th digit represents employment status**. **Where the 7th digit represents status of layoff: 3-Actual** Refer to Full Provincial Statistical List of Accounts, for values defined in the 4th and 5th positions.

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66* ** ** EMPLOYMENT SEPARATIONS

Account	Name	Description
661 ** *0	Employment Separations Count – MOS - by Occupational Class - by Employment Status - All	Number of unique employees that have left the employment of the organization during the reporting period including voluntary and involuntary departures. This includes resignations, retirements, terminations and layoffs. Note includes the Nursing Layoff Count - Actual 65* ** *3. **This number is a cumulative count.**
665 ** *0	Employment Separations Count – UPP - by Occupational Class - by Employment Status – All	**Where the 3rd digit represents Broad occupational group: 1=MOS, 5=UPP, 8=NP, 9=MED.** **Where the 4th and 5th digits represents occupational class.** **Where the 6th digit represents employment status**.
668 ** *0	Employment Separations Count – NP - by Occupational Class - by Employment Status – All	**Refer to Full Provincial Statistical List of Accounts, for values defined in the 4th and 5th positions.**
669 ** *0	Employment Separations Count – MED - by Occupational Class - by Employment Status - All	

7* FUNCTIONAL CENTER PROFILE

Account	Name	Description
710 ** 00	Capacity SR Approved Bed Complement **Where ** the 4th and 5Th digits represents service recipient.**	This account reflects the maximum number of beds and cribs, at the beginning of the year, on the basis of established standards of floor area per patient/resident to meet fire protection and safety standards. Required for Long Term Care Homes only. This number would not change during a fiscal year unless major long term changes occurred such as redevelopment, transfer. If there are significant changes, the account will reflect the number of approved beds at the end of the reporting period for each quarter.
711 ** 00	Capacity Neonatal/Nursery Approved Bassinet Complement **Where ** the 4th and 5Th digits represents service recipient.**	This account reflects the maximum number of bassinets for newborns at the beginning of the year, on the basis of established standards of floor area per patient to meet fire protection and safety standards.

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712 ** 00	Capacity Service Recipient (SR) - Physical – Inpatient Beds **Where ** the 4th and 5th digits represents service recipient.**	The actual number of beds and cribs that are physically available or in place at the beginning of the fiscal year. A bed is counted if the configuration for the bed includes basic services for the bed type (e.g. A medical/surgical bed requires at a minimum medical gases, emergency call, communication and power outlets) and is located in sufficient space to meet fire protection and safety standards. This statistic is not cumulative and is reported by functional centre. This number would not change during a fiscal year unless major redevelopment occurred.
713 ** 00	Capacity Service Recipient (SR) – Budget & Planned - Inpatient Beds **Where ** the 4th and 5th digits represents service recipient.**	The number of beds and cribs which are planned or budgeted to be operational for a fiscal year as submitted and approved via the LHIN and Hospital Accountability Agreements. A bed is counted if the bed/crib is physically available and the configuration for the bed/crib includes basic services for the bed type (e.g. A medical/surgical bed requires at a minimum medical gases, emergency call, communication and power outlets) and is located in sufficient space to meet fire protection and safety standards. This statistic is not cumulative and is reported by functional centre.
714 ** 00	Capacity Service Recipient (SR) – Physical – Neonatal/Nursery Bassinets **Where ** the 4th and 5th digits represents service recipient.**	The actual number of bassinets/incubators that are physically available or in place at the beginning of the fiscal year. A bassinet/incubator is counted if the configuration for the bassinet/incubator includes the required basic services (e.g. medical gases, emergency call, and communication and power outlets) and is located in sufficient space to meet fire protection and safety standards. This statistic is not cumulative and is reported by functional centre. This number would not change during a fiscal year unless major redevelopment occurred.
715 ** 00	Capacity Service Recipient (SR) – Budget & Planned – Neonatal/Nursery Bassinets **Where ** the 4th and 5th digits represents service recipient**	The number of bassinets/incubators which are planned or budgeted to be operational for a fiscal year as submitted and approved via the LHIN and Hospital Accountability Agreements. A bassinet/incubator is counted if the configuration for the bassinet/incubator includes the required basic services (e.g. medical gases, emergency call, and communication and power outlets) and is located in sufficient space to meet fire protection and safety standards. This statistic is not cumulative and is reported by functional centre.

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720 ** 00	Capacity Service Recipient (SR) Bed Days Available for Admission **Where ** the 4th and 5th digits represents service recipient.**	The cumulative calendar days that **beds and/or cribs** were available to provide services to **inpatients/residents** during the reporting period. **Includes** bassinets provided in the Pediatric functional centre. The total beds and/or cribs available each day of the month are added. Beds closed for admission are not included; for example, closed due to staff shortages, patient isolation, renovations or cost reduction. The total S 720* divide by 365 calendar days, produces the average beds available for admission for the fiscal year.
721 ** 00	Capacity Neonatal/Nursery Bassinet Days Available for Admission **Where ** the 4th and 5th digits represents service recipient 11-acute.**	The cumulative calendar days that **bassinets** were available to provide services to NICU and Nursery patients during the reporting period. **Excludes** bassinets provided in the Pediatric functional centre. The total bassinets available each day of the month are added. Bassinets/incubators closed for admission are not included. For example: closed due to staff shortages, patient isolation, renovations or cost reduction. The total S 721* divided by 365 calendar days, produces the average bassinets available for admission for the fiscal year.
722 00 00	ER Stretchers	The number of stretchers, which can be, accommodated according to emergency room space standards to meet fire protection and safety standards and for which staff are available. Includes those stretchers with call bells, and should not include those stretchers in the hallway.

723 86 ** Capacity OP – Dialysis Stations

723 86 10	Capacity OP – Dialysis Stations- Operating	The number of dialysis stations in operation with a primary designated dialysis machine. Unit of measure is machines.
723 86 20	Capacity OP Dialysis Stations – Training	The number of designated dialysis training stations in the facility. Unit of measure is machines.
723 86 30	Capacity OP Dialysis Stations – Acute	The number of acute dialysis machines that the facility has. Unit of measure is machines.
723 86 40	Capacity OP Dialysis Stations – Back-up	The number of back-up dialysis machines that the facility has. Unit of measure is machines.

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723 86 50	Capacity OP Dialysis Stations – Home	The number of conventional home Hemodialysis machines that the facility has in operation. Unit of measure is machines.
724 46 10	MRI Machines MOHLTC LHIN Funded	The number of MRI scanners at all sites of the hospital corporation that receive operating funds from MOHLTC and/or LHIN.
724 46 12	MRI Machines-Research	The number of MRI scanners at all sites of the hospital corporation that are used for research purposes and do not receive operating funds from MOHLTC and/or LHIN.
724 46 14	MRI Machines-Other	The number of MRI scanners at all sites of the hospital corporation that do not receive operating funds from MOHLTC and/or LHIN.
725 00 00	OR Suites – Number of Suites	The number of operating rooms normally in operation for the reporting period. Closures should only be taken into consideration when closed for a significant amount of time or for the entire reporting period. This statistic is not cumulative and must be reported for the main and day surgery operating rooms.
725 00 10	OR Suites – Physical Capacity	The total physical count of the number of operating room suites that exist. This statistic is not cumulative and must be reported for the main and day surgery operating rooms.
734 00 **	Operating Days	The calendar days, in a reporting period, during which the functional centre provided services. These days reported in each functional centre help identify the variation in hours the service is available.
737 00 10	Operating Locations – Within Primary LHIN	The number of operating locations within the boundary of the assigned/primary LHIN, in a reporting period, during which the functional centre provided ongoing services. The primary LHIN is defined as the LHIN which flows funding for the particular services, and for “Ministry Managed Services”, the geographic LHIN location of the reporting provider. Mandatory reporting requirement for the following functional centres: 7258*20, 7258240, 7258*45 and 7258280.

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Account	Name	Description
737 00 20	Operating Location– Outside Primary LHIN	The number of operating locations outside the boundary of the assigned/primary LHIN, in a reporting period, during which the functional centre provided ongoing services. The primary LHIN is defined as the LHIN which flows funding for the particular services, and for Ministry managed services, the geographic LHIN location of the reporting provider. Mandatory reporting requirement for the following functional centres: 7258*20, 7258240, 7258*45 and 7258280.
740 00 **	Workload System	The last date of workload data review or revision is reported in this account code. Report as YYYY. All functional centres using a workload measurements system are required to report in this account.
750 00 00	Inter-Rater Reliability Percentage – Standard Time Systems	The inter-rater reliability score is normally expressed as percentage but for reporting a whole number is required. I.e., an 85% score is recorded as 85. The inter-rater reliability score is required for all functional centres using a standard time methodology for workload collection.
7 60 ** 00	Visits Face to Face by Third Party Provider **Where ** the 4th and 5Th digits represents third party provider status.** 10 - For Profit Organization 20 - Not For Profit Organization	The number of occasions that face-to-face service recipient activities are provided by a third party provider. This includes service to the service recipient and/or significant other(s) on behalf of the service recipient. Not used for shift nursing or support activities used for 3rd party providers only. The total of these visits should balance to the S 449* (Visit Face-to-Face Contracted Out). The cost of the third party providers with service recipients is recorded in the F 8* series of accounts.
7 61 ** 00	Visits Non Face-to-Face by Third Party Provider **Where ** the 4th and 5Th digits represents third party provider status.** 10- For Profit Organization 20- Not For Profit Organization	The number of occasions that service recipient activities are provided by means other than face-to-face to service recipients and/or significant others in attendance who are uniquely identified by a contracted third party provider. The total of these visits should balance to the S 448* (Visit Non Face to Face Contracted Out). The cost of the third party providers with service recipients is recorded in the F 8* series of accounts.

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7 63 **00	Hours by Third Party Provider **Where ** the 4th and 5Th digits represents third party provider status.** 10- For Profit Organization 20- Not For Profit Organization	The number of employee hours provided by the shift nursing or support care functional centres. Not used by other functional centres. The cost of the third party providers with service recipients is recorded in the F 8* series of accounts.
770 00 00	Accreditation Date	The date when the organization received official approval of the accreditation (YYYYMMDD). If the approval date is not available, then enter date of accreditation notice.
790 00 10	Payor Facility Number – Used by Payee	The Payor distributes the funds for the Ministry and/or LHIN. They can be referred to as the paymaster. Generally they are not involved with providing the service. Identify by using the three (3) digit facility code.
790 00 20	Payee Facility Number – Used by Payor	The organization/facility receiving funds for providing the services. They would submit a claim to the Payor requesting payment. Identify by using the three (3) digit facility code.

8 * HEALTH SERVICE ORGANIZATION PROFILE

**8 20 20 ** **	Employees by Union/ Non Union Affiliation	A statistical account that indicates the number of unique employees on the health care organization's payroll in each functional centre 7*1* through 7*9* at the end of the reporting period, by union and non-union category. It includes employees on short/long term disability or sick leave, WSIB, maternity/ parental leave, leave on absence, and excludes employees terminated or on salary continuance. It is a snap shot at a point of time as at Sept 30 (Q2), Dec 31 (Q3) and Mar 31 (YE). This count would be reported in the accounting centre 8*9 90. An individual is to be counted only once in their main category. **Where the 6th and 7th digits represents union/ non union type.** Refer to Full Provincial Statistical List of Accounts, for values defined in the 6Th and 7Th positions.

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Account	Name	Definition
8 30 10	Violent Incident Occurrences	Number of unique violent incidents applicable to health care organization's employees that have occurred during the reporting period and result in a WSIB lost-time injury claim. **This number is a cumulative count.**
8 55 ** **	Individuals Served by Organization **Where ** the 4th and 5Th digits represents service recipient.** **Where ** the 6th and 7Th digits represents type of organization.**	This statistical account is a year-to-date count of the number of individuals served by the organization, within a provincial sector code, and by Fund Type in a reporting period and identified by a unique identifier. Individuals are counted only once in the health care organization within a fiscal year, regardless of how many different services they have received or the number of times they were admitted and discharged within the reporting period. Age category reporting is not required. This account is reported in accounting centre 8* 990. **Where ** the 6th and 7Th digits represents type of organization.** Refer to Full Provincial Statistical List of Accounts, for values defined in the 6Th and 7Th positions.
8 56 ** 70	Referrals to CTC Organization	This records the referrals to the CTC identified by a unique identifier. The referral must be received and date stamped by the CTC. SR category is required. A service recipient can be referred more than once in a fiscal year but the original referral must be closed before a new referral can be opened.
8 61 ** 00	Total Days Stay **Where ** the 4th and 5Th digits represents service recipient.**	The accumulated inpatient/resident days since admission, of inpatients/residents who were discharged from the health care organization or who died in the health care organization during the reporting period. Includes service recipients admitted in a previous reporting period. The day of admission is counted as an inpatient/resident day but the day of separation is not counted as an inpatient/resident day. When the inpatient/resident is admitted and separated on the same day, one inpatient/resident day is counted. This account is reported in accounting centre 8* 990.
870 10 20	Plant Heating Utilities Purchased Steam – Mega Kilograms	The volume of steam or heat purchased from an external organization, which is consumed by the health care organization. Unit of measure is mega kilograms.
870 20 30	Plant Heating Utilities Fuel Oil – Litres	The volume of fuel oil consumed by the health care organization. Unit of measure is litres.

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870 30 40	Plant Heating Utilities Natural Gas – Cu Mt	The volume of natural gas consumed by the health care organization. Unit of measure is Cu Mt.
870 40 60	Plant Heating Utilities Electricity - KWH	The electricity consumed by the health care organization. Unit of measure is KWH,
896 00 00	Reporting Period (Fiscal or Calendar)	The month of the financial reporting yearend of the data reported. Only two options: Report 3 for a fiscal March 31st year end, OR Report 12 for a calendar December 31st yearend.
898 00 00	Calendar Days in Reporting Period	The days in a given reporting period, as defined by the health care organization, used for indicators. To be reported in accounting centre 8*990. With a 12 period fiscal year, for Q2, report a value of 183, for Q3 report a value of 275, for YE report a value of 365.
899 00 10	Service Locations/Sites (Own/Rent)	The total number of physical locations/sites where the health care organization provides service recipient / client services regularly on an ongoing basis in the reporting period, including the organization's main administration location. Excludes individual service recipients' home and/or residence. Excludes service access points (S 899 00 15). The organization incurs expenses in maintaining these service locations / sites, such as rent or utilities reported in Plant Operations / Maintenance functional centres, or maintenance for a mobile unit. Report in Accounting Centre 8*9 90
899 00 15	Service Access Points	The total number of physical access points or locations where the health care organization provides service recipient / client services in the reporting period excluding individual service recipients' homes and/or residence. Excludes service locations/sites (own/rent) –S 8 99 00 10. Examples of service access points include: usage of space in community locations, outreach locations and satellites of other providers. The organization may pay a minimal room usage fee as a courtesy, which is reported in the consuming functional centre(s). In most situations, the organization does not incur any expenses in maintaining these physical locations / sites. Report in Accounting Centre 8*9 90.
899 00 20	Publicly Funded Schools	Under review.

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899 00 30	Private/ Home Schools	Under review.

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9* SPECIALTY AND PRIORITY PROGRAM PROFILE

937 ** *1	ECT Procedures In-House	The number of ECT procedures done at the health care organization, required for service recipient: 14, 15, 25, 26, and 25. Age category required**.**
939 ** 10	Mental Health Sessions	The number of full sessions provided using psychiatric sessional fees. A full session is the intention to pay for services provided during a time period of three hours (minimum) and four hours (maximum). Partial sessions are not reported.
955 ** *1	ECT Unique Individuals- In House	The number of unique individuals had an ECT procedure at the health care organization. Count individual only once within the same functional centre per fiscal year.
955 12 12	Genetics Individuals Served	Number of Individuals served- genetics, for Ontario residents only.
937 25 11	Cochelear Implants- Primary	Number of primary implants.
937 25 12	Cochelear Implants-Revision	Number of secondary implants.
955 25 10	Visudyne- Patients	The number of unique eligible individuals receiving Visudyne treatment, regardless if one eye or two eyes are treated during one patient visit (unilateral or bilateral treatment)
959 25 10	Visudyne- Patient Eye Treatments	One eye treatment should be recorded for each eye treated during one patient visit. If a patient receives unilateral treatment during one visit, then one eye receives treatment and one eye treatment is recorded. If a patient receives bilateral treatment during one visit, then both eyes are treated and two patient eye treatments are recorded.

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989 25 10	Visudyne-New Eyes Treated	The number of eligible eyes receiving Visudyne treatment for the first time during a visit. If unilateral treatment involves one eye receiving treatment for the first time, then one new eye treatment is recorded. If bilateral treatment involves one eye receiving treatment for the first time, then one new eye treatment is recorded. If bilateral treatment involves two new eyes receiving treatment for the first time, then two new eye treatments are recorded.
990 25 11	CLP Dental- Registered Patients	The total number of patients registered in the program at fiscal year-end.
959 25 20	CLP Dental- Patient Treatments	The total number of treatments a patient receives in the fiscal year.
937 28 40	Trauma - Adult	Trauma cases are defined as those patient cases reported to the Ontario Trauma Registry with an Injury Severity Score (ISS>16), having a length of stay 2 days or greater (or died in hospital), and Ontario residents. Hospitals designated as Lead Trauma Hospital.
937 28 60	Trauma Pediatric	A trauma patient treated in a lead trauma hospital who: – has an ISS score>12, single system injuries excluded – age <18 – >2 days LOS or died in hospital Patients treated at site other than the primary trauma care site are excluded.
937 42 *	Cardiac Case	A surgical procedure on the heart, in which the patient goes on cardiac bypass or the bypass pump, is on standby (ready for use but the patient does not go on bypass). Does not include heart transplant cases
937 42 11	Cardiac Case-CABG only	Coronary bypass surgery.
937 42 12	Cardiac Case-CABG and Valve	Coronary artery bypass surgery & valve replacement or repair.
937 42 13	Cardiac Case-Valve only	Repair or replacement of a heart valve.

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937 42 14	Cardiac Case-Other Open Heart	Cardiac surgery other than isolated CABG, CABG and valve or valve cases.
937 42 15	Cardiac Case-CABG only-off Pump	Beating Heart Coronary artery bypass surgery.
937 42 2*	Implantable Defibrillator	Device is a small battery-powered electrical impulse generator which is implanted in patients who are at risk of sudden cardiac death due to ventricular fibrillation and ventricular tachycardia. The device is programmed to detect cardiac arrhythmia and correct it by delivering a jolt of electricity
937 42 21	Implantable Defibrillator – New	Number of new Internal Cardiac Defibrillators (ICD) – devices implanted.
937 42 22	Implantable Defibrillator – Replacement	Number of replacement ICD’s implanted.
937 44 30	Cardiac Catherization Cases	Attempts to catheterize a central or radial artery in the catheterization suite to measure heart pressures, perform a cardiac biopsy +/or perform coronary angiography. Unit of measure is cases.
952 44 **	**Cardiac Catherization- Patients**	Attempts to catheterize a central or radial artery in the catheterization suite to measure heart pressures, perform a cardiac biopsy +/or perform coronary angiography. Captured for inpatients, Outpatients, Referred In service recipients.
952 44 10	Inpatients- Cardiac Catherization	See 952 44 ** definition.
952 44 20	Outpatients- Cardiac Catherization	See 952 44 ** definition.
952 44 30	Referred in-Cardiac Catherization	See 952 44 ** definition.
958 44 **	**Interventional Cardiology- Procedure**	
958 44 10	PTCA Percutaneous Transluminal Coronary Angioplasty	Attempts to perform a Percutaneous coronary angioplasty.

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958 44 20	Stent Coronary Angioplasty- Non Drug Inter Cardio. Procedure	Attempts to insert one or more stents into a coronary artery (case did not utilize a drug eluting stent). Considered a case once the stent is placed in the guide catheter.
958 44 25	Stent Coronary Angioplasty- Drug Inter Cardio. Procedure	Attempts to insert one or more stents into a coronary artery (of which one of the stents used were drug eluting stents). Considered a case once the stent is placed in the guide catheter.
958 44 35	Septal defect closed with a device procedure	Percutaneous closure of cardiac septal defect with a device
958 44 40	EPS electrophysiological studies- inter-cardio procedure	Attempts to catheterize a central artery in a catheterization suite or arrhythmia suite for the purpose of performing diagnostic electrophysiological study. Included all cases done with ablation.
958 44 50	Ablations inter-cardio procedure without advanced mapping systems	Attempts to perform a catheter ablation without advanced mapping systems. Considered a case once ablating energy turned on for the purpose of correcting cardiac conduction disturbances.
958 44 55	Ablation procedure using advanced mapping systems	Catheter ablation using advanced mapping technology. Considered a procedure once ablating energy is turned on for the purpose of correcting cardiac conduction disturbances.
958 44 60	Pacemaker NEW- # of Implantable Procedure	Number of new permanent pacemakers implanted.
958 44 65	Pacemaker Removal – Laser Implantable Procedure	Removal of pacemaker leads with laser.
958 44 80	Pacemaker Replacement Implantable Procedure	Number of permanent pacemakers replaced.

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958 46 **	**MRI**	
958 46 15	MRI Exams – OHIP	MRI Exams - OHIP - Exams covered by OHIP
958 46 90	MRI Exams - Third party	MRI Exams - Third party - Exams covered by private insurance, WSIB, etc.
930 46 15	MRI Hours – OHIP	MRI Hours - OHIP - Hours operated to provide OHIP insured exams.
930 46 90	MRI Hours - Third Party	MRI Hours - Third Party - Hours operated to provide exams covered by private insurance, WSIB, etc
916 66 **	**Oncology Ontario Residents Only**	
916 66 11	Inpatient Oncology Visits	The number of inpatient visits in oncology functional centre.
916 66 20	Outpatient Oncology Visits	The number of outpatient visits in oncology functional centre.
900 70 **	**Children Treatment Centres**	
900 70 00	Completed ISA (Individual Service Agreements)	Refer to Chapter 6.
902 70 00	Hours of IBI Services	Refer to Chapter 6.
955 70 10	Pre Birth Referrals	Refer to Chapter 6.
955 70 20	Children Aged 0 - 5 years	Refer to Chapter 6.
955 70 30	Children Aged 3 - 5 years	Refer to Chapter 6.
955 70 31	IBI received from Service Provider	Refer to Chapter 6.

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955 70 32	IBI received from Private arrangements	Refer to Chapter 6.
955 70 42	Non Clinical Staff for FTEs (Staff or partners/subcontracts providing direct service.)	Refer to Chapter 6.

937 72 ** Orthopedics – Ontario Residents Only

937 72 1* Total Hip Replacements

937 72 11	Primary Elective Hip	First total joint replacement of that joint, Priority Services funding reimburses hospital for the prosthetic device for the total joint replacement. Partial joint replacement is **not** covered by Priority Services. Priority Services covers all elective joint replacements except those resulting from trauma or cancer.
937 72 12	Revision Elective Hip	Subsequent total joint replacement of that joint, Priority Services funding reimburses hospital for the prosthetic device for the total revision joint replacement. Partial joint replacement is **not** covered by Priority Services. Priority Services covers all elective revision joint replacements except those resulting from trauma or cancer.

937 72 2* Elective Total Knee Replacement

937 72 21	Primary Elective Knees	First total joint replacement of that joint, Priority Services funding reimburses hospital for the prosthetic device for the total joint replacement. Partial joint replacement is **not** covered by Priority Services. Priority Services covers all elective joint replacements except those resulting from trauma or cancer.
937 72 22	Revision Elective Knees	Subsequent total joint replacement of that joint, Priority Services funding reimburses hospital for the prosthetic device for the total revision joint replacement. Partial joint replacement is **not** covered by Priority Services. Priority Services covers all elective revision joint replacements except those resulting from trauma or cancer.

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920 79 Community Health Centres (CHC)

920 79 10	CHC – Community Health Centres - Non Insured Clients	The number of individuals receiving health care services without OHIP coverage or other insurance coverage.
920 79 21	CHC – Community Health Centres - Face-to-Face Service Provider Interactions (SPI) Location - CHC	Each occasion during which service recipient activities are provided by the organization's employee (service provider interaction) as face-to-face to an individual who is uniquely identified. This includes service to the service recipient and/or significant other(s) in attendance on behalf of the service recipient. These services are documented according to the healthcare organization policy and are provided for longer than five minutes. These services are provided in CHC (includes main and satellite locations). Excludes face-to-face SPI location home and outreach.
920 79 22	CHC – Community Health Centres Face-to-Face - Service Provider Interactions (SPI) Location - Home	Each occasion during which service recipient activities are provided by the organization's employee (service provider interaction) as face-to-face to an individual who is uniquely identified. This includes service to the service recipient and/or significant other(s) in attendance on behalf of the service recipient. These services are provided in a home. Home can be a private residence, a long-terms care home or other housing which is considered the service recipients residence; excludes shelter. The service is documented according to the healthcare organization policy and is provided for longer than five minutes. Excludes face-to-face SPI location CHC and outreach.
920 79 23	CHC – Community Health Centres Face-to-Face - Service Provider Interactions (SPI) Location - Outreach	Each occasion during which service recipient activities are provided by the organization's employee (service provider interaction) as face-to-face to an individual who is uniquely identified. This includes service to the service recipient and/or significant other(s) in attendance on behalf of the service recipient. These services are provided in an outreach location. Outreach can be street, school, shelter, any other community locations not owned by the CHC. The service is documented according to the healthcare organization policy and is provided for longer than five minutes. Excludes face-to-face SPI location CHC and home.
920 79 95	CHC – Community Health Centres - Unpaid Student Hours	The number of hours spent by students performing activities without paid compensation.

955 80* Community Support Services Individuals Served

955 80 10	CSS - Individuals Served – Physically Disability	The number of individuals who require assistance to perform routine activities of daily living as a result of a physical disability, including a sensory impairment.

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955 80 15	CSS - Individuals Served – Cognitive Impairment	The number of individuals who require assistance or supervision to perform routine activities of daily living safely or independently as a result of cognitive disorder, such as Alzheimer Disease, or a related dementia.
955 80 20	CSS - Individuals Served – Frail and/or Elderly	The number of individuals who require assistance or supervision to perform routine activities of daily living as a result of impairment or loss of functional abilities due to aging.
955 80 22	CSS – Individuals Served – High Risk Seniors	The number of individuals who are high risk seniors, receiving assistance or supervision to perform routine activities of daily living safely or independently, and meet the characteristics and ranges for a high risk senior as defined in the Assisted Living Services for High Risk Seniors Policy, 2011.
955 80 25	CSS - Individuals Served – Living with affects of HIV/AIDS	The number of individuals who require assistance or supervision to perform routine activities of daily living a result of impairment or loss of functional abilities as a result of HIV or AIDS.
955 80 30	CSS - Individuals Served – Specific Initiatives	This account is used to record/report the number of individuals admitted to, referred to and served by specific CSS service in the reporting period. These are unique individuals who received services in a specific functional centre. This statistic is reported in addition to S.455 ** *0 Individuals Served by Functional Centre for specific CSS programs/initiatives.
955 80 31	CSS – Individuals Served – Goal Oriented Initiatives	This account is used to record/report the number of individuals admitted to, referred to and served by specific CSS services in the reporting period. These are unique individuals who received services in a specific functional centre. This statistic is reported in addition to S455 ** *0 Individuals Served by Functional Centre for specific **goal oriented** CSS programs/initiatives
955 80 35	CSS - Individuals Served – ABI Individualized Funding	This account is used to record the number of individuals admitted to, referred to and served by a provider under the Acquired Brain Injury (ABI) Individualized Funding in the reporting period. These are unique individuals who received services in a specific functional centre.

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955 80 48	CSS – Attendance Days – Specific Initiatives	The number of service delivery days (count once per 24-hour calendar day) which primary service recipient activities are provided on an individual or group basis to a service recipient and /or significant other(s). This statistic counts days during which services occurred rather than number of services. This account is reported in addition to S483* or S484* Attendance Days for specific CSS programs/initiatives.
955 80 49	CSS – Attendance Days – Goal Oriented Initiatives	The number of service delivery days (count once per 24-hour calendar day) which primary service recipient activities are provided on an individual or group basis to a service recipient and /or significant other(s). This statistic counts days during which services occurred rather than number of services. This account is reported in addition to S483* or S484* Attendance Days for specific **goal oriented** CSS programs/initiatives.
955 80 53	CSS - Hours of Care/Services – Contracted Out - Specific Initiatives	This account is used to record/ report the number of hours of care or services provided by third party service providers as contracted by the organization. This statistic is reported in addition to S.453 ** *0 Hours of Care – Contracted Out in the functional centre where the service was received for specific CSS programs/initiatives. Required for Homemakers and Nurses Services (HNS).
955 80 54	CSS - Hours of Care/Services – In House - Specific Initiatives	This account is used to record/report the number of hours of care or services provided by in-house service providers. This statistic is reported in addition to S.454 ** *0 Hours of Care – In house in the functional centre where the service was received for specific CSS programs/initiatives. Required for Homemakers and Nurses Services (HNS).
955 80 73	CSS – Operating Days – Specific Initiatives	The calendar days, in a reporting period, during which the functional centre provided services for **specific initiatives**, in addition to S734* operating days by various operating hours. This statistic is reported for specific CSS programs/initiatives.
955 80 74	CSS – Operating Days – Goal Oriented Initiatives	The calendar days, in a reporting period, during which the functional centre provided services for initiatives, in addition to S734* operating days by various operating hours. This statistic is reported for specific **goal oriented** CSS programs/initiatives.

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955 80 77	CSS – Operating Locations - Specific Initiatives	The number of operating locations in a reporting period during which the functional centre provided ongoing services for specific CSS programs/initiatives. This statistic is reported in addition to S737* Operating Locations.
955 80 78	CSS – Operating Locations - Goal Oriented Initiatives	The number of operating locations in a reporting period during which the functional centre provided ongoing services for specific **goal oriented** CSS programs/initiatives. This statistic is reported in addition to S737* Operating Locations

Dialysis Ontario Residents Only

Hospitals Reporting– Refer to the current Chronic Kidney Disease (CKD) Funding Guide provided by the Ontario Renal Network (ORN)

916 86 **	**Dialysis Clinic Visits**
930 86 **	**Dialysis Machines**
932 86 **	**Home Installations**
952 86 **	**Dialysis Patients Maintenance of Annualized**
953 86 **	**Dialysis - Home Nursing & Technician Hours of Service**
956 86 **	**Dialysis Insertions**
958 86 **	**Dialysis Tests**
959 86 **	**Dialysis Treatments**
983 86**	**Dialysis Days of Training**

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Community Access Care Centres (CCAC) Reporting

954 86 10	Dialysis CCAC- CCPD New Clients from Hospital	A new client with renal failure who begins dialysis treatment with CCPD modality treatment and is referred by the CKD (Chronic Kidney Disease) Centres within hospital to the CCAC for Home Care services to support CCPD at home. This individual has been discharged from a hospital that is also a CKD Centre.
954 86 20	Dialysis CCAC- CCPD New Clients from Community	An individual who has been managing their CCPD treatment successfully at home in the past, but now has been referred by self/other to CCAC for CCPD support (new CCPD admission).
954 86 40	Dialysis CCAC – Other Home Peritoneal Dialysis (PD)	A new or an existing CCAC client who receives non-Continuous Cycler Peritoneal Dialysis (CCPD) CCAC services in the home.
954 86 50	Dialysis CCAC- CCPD New Service for Existing Clients	An existing CCAC client who was not originally admitted for support of the CCPD he/she is on but during the course of their CCAC admission complications arise which threaten their ability to stay on peritoneal dialysis; and the CCAC by virtue of adding/increasing services, is able to help prevent conversion to Hemodialysis.
954 86 60	Dialysis CCAC – Home Hemodialysis (HD)	All new and existing CCAC clients who receive hemodialysis (HD) services in the home.
937 87 10	Bone Marrow-Autogous	Refer to definition on Priority Program Form 5.
937 87 20	Bone Marrow-Allogenic Related	Refer to definition on Priority Program Form 5.
937 87 30	Bone Marrow- Allogenic Unrelated	Refer to definition on Priority Program Form 5.
937 87 40	Bone Marrow-Stem Cells Autolous	Refer to definition on Priority Program Form 5.

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916 88 ** Sexual Assault All Patients

916 88 40	Sexual Assault Adult Patients	Patients identified in Emergency (self referral or police accompanied) who require emergency medical care, forensic documentation and crisis support for sexual assault as defined under the criminal code.
916 88 60	Sexual Assault Peadiatric Patients	Patients < 15 years of age identified in Emergency (family or children's aid referral or police accompanied) who require emergency medical care, forensic documentation and crisis support for sexual assault or abuse as defined under the criminal code.
916 89 40	Domestic Violence Adult Patients	Patients identified in Emergency (self referral or police accompanied) who require emergency medical care, forensic documentation and crisis support for domestic violence as defined under the criminal code.
937 92 10	Transplant Cases-Heart	Surgically transplanting a donor heart from cadaveric or living donor into a patient with end stage cardiac disease. Measured by the number of procedures
937 92 20	Transplant Cases-Lung	Surgically transplanting a donor lung(s) from cadaveric or living donor into a patient with end stage respiratory disease. Measured by the number of procedures
937 92 30	Transplant Cases-Heart-Lung	Surgically transplanting a donor heart and lung(s (from cadaveric or living donor into a patient with end stage cardiac-respiratory disease. Measured by the number of procedures.
937 92 42	Transplant Cases-Liver-Cadaveric	Surgically transplanting a donor liver from cadaveric donor into a patient with end stage liver disease. Measured by the number of procedures
937 92 44	Transplant Cases-Liver- Living	Surgically transplanting a donor liver from living donor into a patient with end stage liver disease. Measured by the number of procedures

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937 92 5* **Kidney Transplant**

937 92 52	Transplant Cases-Kidney-Cadaveric	Surgically transplanting a donor kidney from cadaveric into a patient with end stage renal disease. Measured by the number of procedures, e.g., usually transplant one kidney.
937 92 54	Transplant Cases-Kidney Living	Surgically transplanting a donor kidney from living donor into a patient with end stage renal disease. Measured by the number of procedures, e.g., usually transplant one kidney
937 92 60	Transplant Cases-Pancreas	Surgically transplanting a donor pancreas from cadaveric or living donor into a patient with pancreatic disease. Measured by the number of procedures.
937 92 70	Transplant Cases-Kidney-Pancreas	Surgically transplanting a donor kidney and pancreas from cadaveric or living donor into a patient with end stage renal and pancreatic disease. Measured by the number of procedures, e.g. usually transplant one kidney.