Ontario Health

FAQs – OHT Performance Reports

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Section 1: Background Questions

1. Why has Ontario Health introduced an OHT Performance and Improvement Program?

Ontario Health has introduced a Performance and Improvement Program that is intended to help OH and OHTs to collaboratively assess progress and identify improvement opportunities.

The OHT Performance and Improvement Program consists of 'validated' and 'developmental' performance measures that were selected by OHT representatives, patients and scientific advisors as well as enabling processes, such as performance reporting, quality improvement planning and quarterly performance reviews.

Data related to **validated measures** is included in the quarterly performance reports and used by OH and OHTs to collaboratively assess performance. Additional developmental measures, including patient and provider experience measures, will be tested and validated and may be added to the reports in future years.

2. What is included in the OHT Performance Reports?

The FY25/26 Q2 reports include:
- A Summary Scorecard of how current quarterly performance has changed related to the same quarter last fiscal year in all validated performance measures.
- Three years of historical data for each measure as well as a comparison to the regional and provincial averages.
- Twelve months of monthly ALC data that reflects progress at preventing and discharging ALC patients

3. What is the purpose of the OHT Performance Reports?

These reports are intended to be shared with OHT and Primary Care Network Leadership and OHT Leadership Councils OHT, PCN and PFAC Leads, OHT Staff and OHT Leadership Council. A similar report has been produced for OH and MOH leadership, providing a summary of performance across the OHTs.

The quarterly OHT Performance Reports are intended to support **Quality Performance Reviews (QPRs)**, where OH and OHTs conduct a collaborative review of performance and improvement strategies across all validated measures. QPRs bring together OH, OHT, and PCN leadership to:

- Review OHT progress in advancing system priorities,
- OH and OHTs review results—considering performance trends alongside provincial and regional averages—to look for signals in the data, discuss variability, potential root causes and identify supports available to address identified gaps,
- Identify improvement opportunities (in progress or planned), and
- Discuss additional improvement supports needed by OHTs (e.g., from the **OH Performance and Improvement Program and OHT Support Partners)**

4. When are the OHT Performance Reports being distributed?

Reports are released approximately **three months** after the end of each quarter (i.e. a 3-month lag in the data). This timing aligns with hospital reporting cycles for admissions data.

5. Will the Regional Cancer Programs (RCPs) receive OHT Performance Reports?

Currently, RCPs receive their own reports that reflect their geographic patient populations. RCPs also receive annual improvement targets from OH. Since RCPs and OHTs have shared performance expectations for cancer screening, OHTs are encouraged to review their performance reports with RCPs and discuss and understand their RCPs' annual improvement targets and improvement initiatives. Starting Q2 reports, OH will add information about annual cancer screening provincial targets.

6. Can I share my OHT Performance Reports with my member organizations and providers?

Of course! At minimum, the reports should be shared with OHT's, PCN's and PFAC's leadership and the OHT's Leadership Council. However, OHT Leads are encouraged to distribute reports more broadly to staff, member organizations, and providers.

7. What is the difference between the OHT Data Dashboard and the OHT Performance Reports?

The OHT Data Dashboard is a self-serve tool intended to support OHTs with planning and performance monitoring at a local level. The dashboard includes a broader set of measures for OHTs, including (but not limited to) all the validated measures from the OHT Performance and Improvement Program. Additionally, OHTs can view peer OHT data through the dashboard. The OHT Data Dashboard is intended to be an enabling tool and are not used by MOH and OH leadership to assess OHT performance.

The OHT Performance Reports is a static report that includes a small number of performance measures that align with provincial OHT priorities (as reflected in OHT TPAs) and will be used by OH to assess performance and support performance discussions with OHTs. OHT performance data will also be shared with MOH and OH leadership.

8. Why is there different information between the OHT Data Dashboard and the OHT Performance Report?

Data that is included in the quarterly OHT Performance Reports (static PDF reports) uses the updated OHT Attribution Model (OHTAM), based on 2023–24 data.

Data on the OHT Data Dashboard has not been updated using the new OHT Attribution Model (including all cQIP related indicators) with the exception of the PCAT Data Package. The OH Population Health Data Strategy and Implementation Team is currently updating all reports and dashboards to align with the new OHTAM.

9. Will the measures outlined in the OHT Performance Reports change on FY 26/27?

Each year, OH reviews and refreshes the OHT performance measures. This process will be informed by consultations with OHTs and clinical and scientific advisors. OH will communicate annual performance measures in Q1 each year.

10. What is the role of Performance Reports in Quality Improvement?

Performance reports play a critical role in quality improvement (QI) because they provide data and insights needed to monitor progress, identify areas for improvement, and guide decision-making and discussion to better understand potential performance gaps.

With this knowledge, teams can work collaboratively with partners using QI/diagnostic tools to explore root causes, and leverage evidence-based change ideas to determine appropriate improvement interventions.

Section 2: Technical Questions

11. Is the data in the OHT Performance Reports based on the patient attribution model?

Yes, the data included in FY 25/26 and future reports is based on the updated 2024/25 Ontario Health Team Attribution Model (OHTAM). For context, in August 2025, the OHTAM was updated by ICES/Ministry of Health for the first time. The original OHTAM was based on 2019-20 data, and the updated one is based on 2023-24 data.

However, there are **3 measures** in the reports based on geographic model:
1. *% Attached to Primary Care,*
2. *of HCC patients referred to a Primary Care provider*
3. *% reduction of the HCC waitlist*:

Each Forward Sortation Area (FSA) has been assigned to the OHT with the largest share of attributed population. Please refer to the "Release Notes" page of the report for further details on the attribution model.

On the other hand,
4. *# and Rate of change of ALC Discharged cases*

Based on an aggregation of the discharged caseloads across the hospitals geographically located in an OHT (not based on OHTAM). This is because the discharge happens from a hospital hence it's more accurate to trace back these caseloads to the member hospitals.

12. What is the 1%-point threshold (as seen in the Summary Scorecard)?

On the Summary Scorecard, a green/red/grey dot has been used to showcase variation in performance (current quarter vs. same quarter last fiscal year). A **1%** threshold has been used to determine the variation as follows:

- **Green Dot:** If there is a performance improvement of more than **1%**
- **Red Dot:** If there has been a performance decline of more than **1%**
- **Grey Dot:** No significant change in performance (within **1%** range)

OH considered both academic literature and existing practices within the organization when deciding on a threshold. The "1%" change **refers to a relative change** between the current period and the reference period, which according to the indicator, can be the previous quarter or the same quarter in the previous year.

This is meant to just show the **directionality** in performance, whether performance has improved or declined, and is not an assessment of good or bad performance, nor an indication of progress relative to targets.

13. Why do most of the indicators compare quarterly performance relative to the same quarter in the previous fiscal year rather than the previous quarter of the same fiscal year?

The decision to compare the same quarters across fiscal years was made to account for potential seasonal variations. Certain indicators may exhibit fluctuations based on the time of year, for example, increased hospital admissions in the winter months. In this case, comparing Q2 to Q2 each year ensures that any difference observed is less likely to be influenced by seasonal patterns and more reflective of actual performance changes. This approach is applied to the following indicators: CHF admissions per 100 population, COPD admissions per 100 population, ACSC admissions per 10,000 population, as well as breast, cervical, and colorectal cancer screening rates.

14. Do the green dots in the scorecard mean "good" performance?

In the scorecard, the **green** color of the dot signifies that the **direction** of the change in performance is positive when compared to the same quarter in the previous year. On its own, it does not indicate whether the result is "good" or not.

For example, in cases where an OHT is already performing well, maintaining existing performance (e.g., a grey dot) can also be an indicator of strong performance. Conversely, an OHT can show improvement in the latest quarter for an indicator (green dot) but still be below a target.

15. In the quarterly trend charts, what do the different trend lines represent?

- **Light Blue:** Quarterly trend for the specific OHT's performance.
- **Purple dotted line:** Quarterly trend for the average performance across all 58 OHTs.
- **Dark blue line:** Quarterly trend for the average performance within the OHT's region.
- **Gray vertical stripe** on Q1 FY24/25: Flags the point at which the updated OH Attribution Model (OHTAM 2023/24) came into effect. As of April 1, 2024, all indicator calculations are based on the updated model, replacing the 2019/20 version.

16. Why does a positive % change indicate improvement for some indicators but worsening performance for others?

% change is considered good or bad depending on the goal of each specific indicator. Different indicators interpret change differently. For measures where higher values are better—such as cancer screening rates—a positive % change reflects improvement because more people are being screened.

For measures where lower values are better—such as CHF, COPD, or ACSC hospital admissions—a positive % change means outcomes have worsened, since more people were admitted compared to the reference period.

17. Does the data on chronic disease hospital admissions reflect admissions to the member hospitals within my OHT or admissions of patients attributed to any hospital in the province?

The chronic disease hospital admission indicators in the OHT performance reports use the OHT attribution model (updated with FY23/24 data), meaning results reflect all individuals attributed to the OHT, regardless of where they received care.

18. How is equity reflected in performance reports and how is it interpreted?

This year, equity-stratified data will be available to all OHTs through the performance reports for all performance measures, through 2 measures: Health Equity Quintiles (On-Marg Material Resource Quintiles) and Slope Index of Inequality (SII)

Health Equity Quintiles
Performance data for each measure is stratified in five quintiles using On-Marg material deprivation quintiles, an area-based measure derived from Canadian Census data. On-Marg assigns deprivation quintiles based on the proportion of the population within a geographic area, called the dissemination area (DA), that experiences material deprivation: Q1 = least deprived, Q5 = most deprived.

OHTs can compare the performance measure values for each quintile for the current quarter with the same quarter in the previous year. The equity panel in the report shows a bar chart by quintile: Current vs. previous quarter values.

Some quintiles may be unavailable for certain measures within an OHT due to missing data or small cell sizes. Data is suppressed when counts fall below the minimum thresholds - 6 individuals for the CHF and COPD Admissions indicators, and 5 individuals for all other indicators. Ontario Health applies these suppressions to maintain data reliability and protect patient privacy.

Slope Index of Inequality (SII)
The SII is a measure used to show how an indicator changes across the full socioeconomic spectrum. Instead of comparing only the most and least marginalized groups, it looks at all quintiles and calculates the overall "slope" of inequality.
It tells you:
- How much an indicator increases or decreases as socioeconomic marginalization changes.
- Whether outcomes are better or worse for more marginalized groups.
- The overall size of the inequality gap, summarized in one number.

A value of 0 means there is no difference across socioeconomic groups.
A **positive SII** means the indicator is higher among more marginalized groups.
A **negative SII** means it is higher among less marginalized groups.
Larger absolute values indicate greater inequality, meaning that current interventions may not be reaching the populations with the greatest need. Goal should be to bring the SII to 0.

19. Why does the SII show "NA" for some indicators?

The SII uses a mixed methodology that requires both a minimum attributed population and complete ON Marg quintile data. An OHT must meet **both** of the following criteria to be included:
1. Have an attributed population of at least 200,000
2. Have all five ON Marg quintiles available

If an OHT does not meet either requirement, the system displays "NA" for that indicator.

Section 3: Indicator-Specific Questions

20. How is the "% Attached to Primary Care" indicator calculated, and why is its data reported with a time lag?

This indicator is defined as the percentage of the total population for a given OHT that is attached to a primary care provider.

A patient is considered attached if they meet one of the following criteria:

I. The patient sees a primary care physician and has signed an enrollment form
II. The patient lived in an area where everyone can receive primary care
III. The patient has been receiving care at a Community Health Centre
IV. The patient is on the Nurse Practitioner-Led Clinic List
V. The patient is consistently receiving comprehensive primary care from a fee-for-service physician or (for children) from a pediatrician.

For this measure, the lag can sometimes be more than 3 months as there is a dependency on MOH to provide data to OH. This indicator is derived from a comprehensive set of administrative health datasets that must be compiled, linked, and validated by the Ministry of Health's Health Analytics and Intelligence Branch (HAIB). Due to the complexity and volume of these datasets, additional time is required for processing, resulting in a later reporting date compared to other indicators.

Please refer to the "Methodology" page for further details on the definition and methodology.

21. Are CHF and COPD admission indicators based on all-cause hospitalizations or condition-specific admissions?

Starting in Q4–EOY FY24/25, both CHF and COPD admission indicators transitioned to condition-specific admissions to better reflect the focus of the integrated clinical pathways.

It means that the OHTs should anticipate significantly lower values for these performance measures compared to previous reports, which were based on all-cause admissions. Historical performance data aligned with the new condition-specific definitions will be available for reference.

22. How are the new Health Care Connect (HCC) indicators shown in the report?

The performance report includes two related Health Care Connect (HCC) indicators:
- The number of HCC patients that were referred to a primary care provider within the quarter.
Note: this measure doesn't include patients removed from the waitlist for other reasons.
- The % reduction of the HCC waitlist as of Jan 1st within the quarter. This measure enables OHTs to track their progress in reducing the waitlist to 0 by Spring 2026.

23. Why does the HCC Referral indicator display "1–5" instead of an exact number?

Ontario Health applies data suppression rules to protect patient privacy and ensure reliability when cell sizes are very small. Specifically, any value between 1 and 5 is shown as "1–5" rather than the exact count. This suppression does not apply to zero—if there are 0 referrals, the indicator will display "0." Suppression only occurs when there are 1–5 individuals in a cell, helping maintain confidentiality in reporting.

24. What does "Rate is above/below/equal/around the provincial target" mean in the scorecard for the Cancer Screening Rates indicators?

These messages compare the OHT's screening rate to the provincial target using clear thresholds:

- Above the target: The OHT rate is more than 1.0 percentage point higher than the provincial target.
- Below the target: The OHT rate is more than 1.0 percentage point lower than the provincial target.
- Equal to the target: The OHT rate is the same as the provincial target.
- Around the target: The OHT rate is within ±1.0 percentage point of the target, inclusive (i.e., from target − 1.0 pp to target + 1.0 pp).

Example (Breast Cancer Screening Rate target = 65%)

- 67% → Above (more than 1.0 pp higher than 65%)
- 63% → Below (more than 1.0 pp lower than 65%)
- 65% → Equal (exact match)
- 64.0%, 64.5%, 65.8%, 66.0% → Around (within 64.0% to 66.0%, inclusive)

25. What are the new ALC measures, and what do they calculate?

Two new ALC indicators have been introduced to better reflect at both preventing and discharging ALC cases aligned to the FY 25/26 TPA deliverable.

1. ALC Prevention: Change in Newly Designated ALC Cases

This measure tracks the month over month number of newly designated ALC patients within an OHT's attributed population. It monitors the **inflow** of ALC cases into the system and its rate of change with respect to same month in previous fiscal year.

Understanding of the visual:
1. **Blue Bars**: Helps evaluate the month-on-month trend of the absolute # Newly Designated ALC cases (this will be reflective of the winter surge periods / seasonalities and might not give firm insights on the performance trends) – but is good to observe the # new cases entering the system month by month
2. **Orange Trend Line**: Helps evaluate the trend of the % change in the newly designated ALC cases (with respect to the same month last year). Over time, a **declining trend** line as we move right on the x-axis signifies that with time there are less newly designated ALC cases which indicates improvement on ALC prevention.

Target population: *OHT attributed population.*

2. ALC Discharge Management: Change in Discharged ALC Cases
This measure tracks the month-on-month number of ALC patients discharged to community or alternate care settings. It monitors the **outflow** of ALC cases from the system and its rate of change with respect to same month previous year.

Understanding of the visual
1. Blue Bars: Helps evaluate the month-on-month trend of the absolute # Discharged ALC Cases (this will be reflective of the winter surge periods / seasonalities and might not give firm insights on the performance trends over time) – but it is good to observe the # ALC cases existing the system month by month for a fiscal year

2. Orange Trend Line: Helps evaluate the trend of the % change in the discharged ALC cases (with respect to same month last year). Over time, a rising trend line as we move right on the x-axis signifies that with time there are more # ALC cases discharged from the system which indicates improvement in discharge effectiveness, helping the increase of beds capacity.

Target population: *Aggregation of discharged ALC cases across all member hospitals of an OHT.*

26. Is there a difference in the methodology used to calculate ALC indicators for OHT reports vs how the ALC Throughput is reported in other OH reports?

The volumes for the Newly Designated and Discharged ALC cases will be determined using a methodology that differs slightly from the approach used to report throughput in other provincial reports. The methodology will vary in the following ways:

1- In this version of Newly designated and discharged volumes, a WLE can be designated once, but redesignated/discontinued multiple times. However, in the formal throughput methodology, each WLE's designation/re-designation is counted only once.

2- Cases transferred to an AHF/RCC are captured in the discontinued volume as in our monthly reports. However, the data set used for this request includes discontinued cases. Monthly reports excluded any discontinued WLE from the throughput ratio which includes transfers to an AHF/RCC sites.

3- Data snapshot of the end of each month is taken as of 6th BD of the following month

27. Does the ALC data in the OHT Performance Report include all facilities, and how complete is the information?

The ALC data in the OHT Performance Report comes from the WTIS-ALC dataset, which captures information from over 95% of all hospital beds in Ontario, including acute and post-acute care. This means overall coverage is very comprehensive.

However, a small number of facilities (primarily in the **Northern regions**) are not yet reporting ALC data. Ontario Health is currently working to **onboard 18+ additional hospitals** in that region. These sites are expected to complete implementation and data stabilization by late Q1 of FY26/27. Until then, their ALC discharge information data will not be considered while calculating the ALC Discharge Management measures.