OHT Performance Report

FY 25/26 Q2 Report

February 2026

Ontario Health

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Release Notes

Methodology

This report has been created to enable each Ontario Health Team and Ontario Health to collaboratively monitor progress and identify performance improvement opportunities. The report should be shared with OHT Leads, Primary Care Network Clinical Leads, OHT Leadership Councils and Patient Family and Caregiver Advisory Councils (PFACs).

Please send any questions or enhancement requests to your OH Regional Lead or OHTanalytics@ontariohealth.ca

Ontario Health

Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

% Attached to Primary Care

Attachment status as of June 30, 2025

88.4%

Patients on HCC waitlist referred to a primary care provider

25

QoQ HCC Waitlist % Reduction: -29.1%

CHF Admissions per 100

CHF-specific admissions

2.3

Last Year Same Quarter	% Change
2.1	+11.3%

COPD Admissions per 100

COPD-specific admissions

1.1

Last Year Same Quarter	% Change
0.7	+50.2%

ACSC Admissions per 10,000

8.2

Last Year Same Quarter	% Change
7.6	8.9%

Breast Cancer Screening Rate

Rate below the provincial target (65%)

61.9 %

Last Year Same Quarter	% Change
64.5 %	-4.0%

Cervical Cancer Screening Rate

Rate above the provincial target (60%)

62.2 %

Last Year Same Quarter	% Change
63.2 %	-1.6%

Colorectal Cancer Screening Rate

Rate around the provincial target (65%)

64.3 %

Last Year Same Quarter	% Change
65.4 %	-1.7%

Notes:

The dot colours indicate the change in the OHT performance relative to the comparison period. This is meant to show directionality, whether performance has improved or declined, and is not an assessment of good or bad performance, nor an indication of progress against targets.

Colour codes:

- Green dot: Performance improvement of more than 1%
- Red dot: Performance decline of more than 1%
- Grey dot: No change in performance (or within 1%)

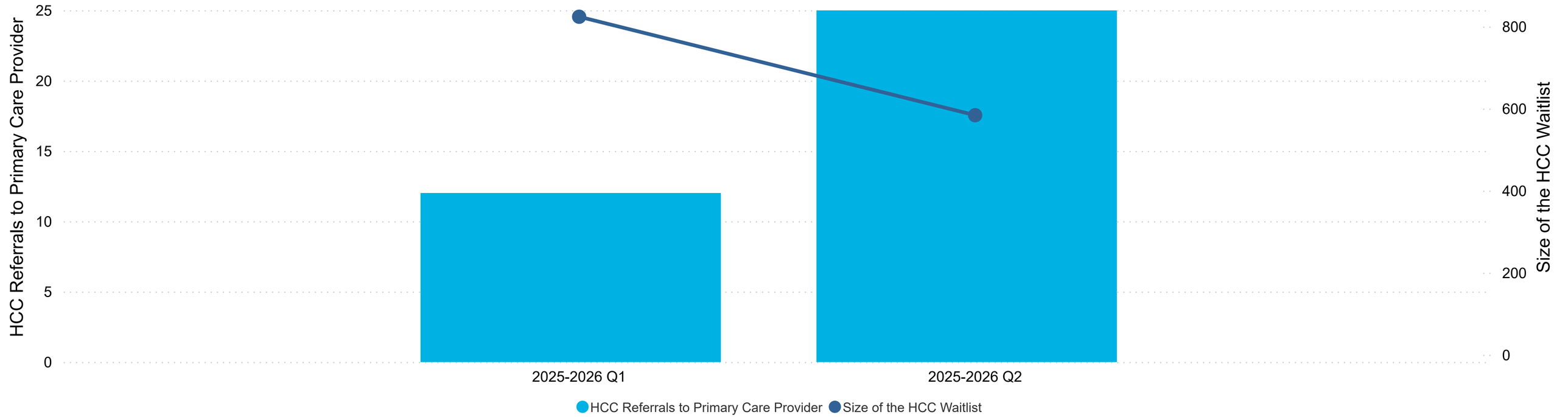
Notes on the indicators:

1. # Patients on HCC Waitlist referred to a primary care provider: # referred during Q2 (from June to September, 2025)
2. % Reduction in HCC Waitlist (vs previous quarter): % decrease is based on the quotient between June and September, 2025
3. % Attached to Primary Care: Attachment status reported as of June 30, 2025

Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

Health Care Connect Number of Patients Referred to PCP and size of Waitlist

Data reported as of Q2 2025/26 - HCC list as of January 2025



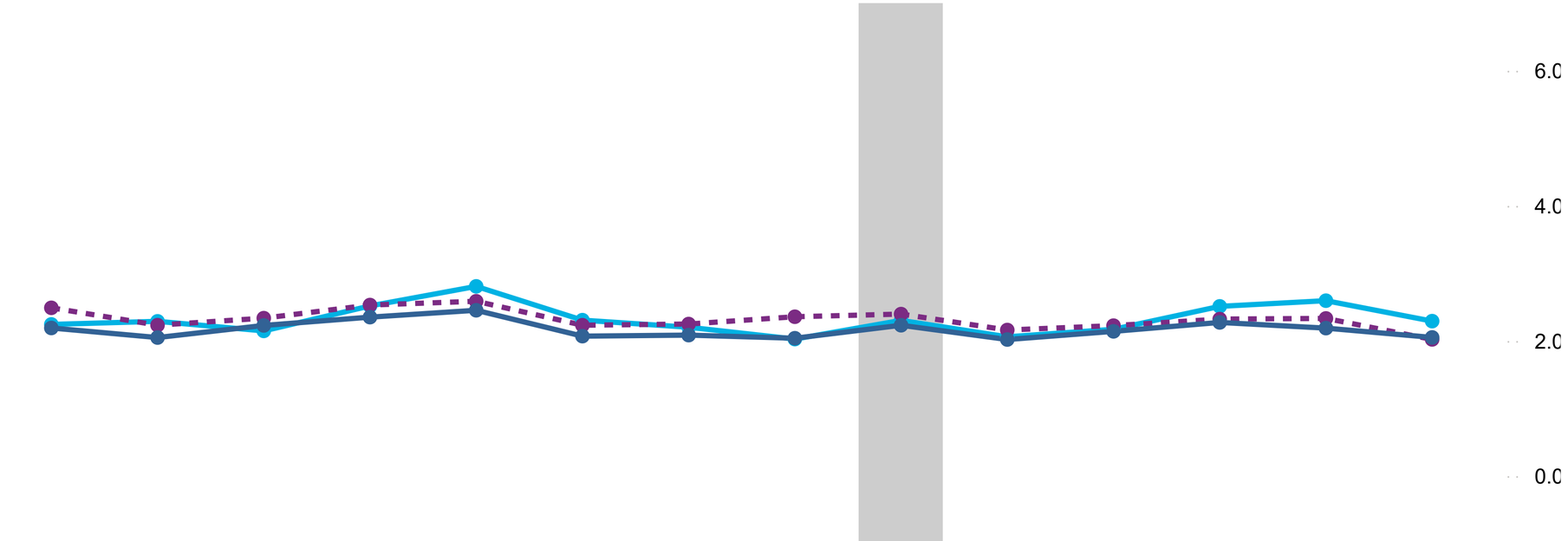
	2024-2025 Q4	2025-2026 Q1	2025-2026 Q2
HCC Referrals to PC	25	12	25
Size of the HCC Waitlist	861	824	584

Data for counts between 1 and 5 is suppressed to meet privacy standards
The decrease in HCC waitlist size can be attributed to factors other than 'referrals to Primary Care Provider'

<u>Please note:</u> due to differences in RPDB files, HCC referral to primary care and pending referral values from this report may not align with the Ministry of Health's HCC Waitlist Executive Tactical Report.

Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

CHF specific Admissions per 100 patients



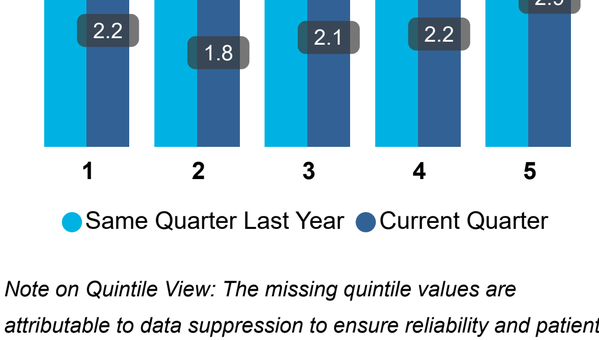
	2022-2023 Q1	2022-2023 Q2	2022-2023 Q3	2022-2023 Q4	2023-2024 Q1	2023-2024 Q2	2023-2024 Q3	2023-2024 Q4	2024-2025 Q1	2024-2025 Q2	2024-2025 Q3	2024-2025 Q4	2025-2026 Q1	2025-2026 Q2
Selected OHT	2.2	2.3	2.1	2.5	2.8	2.3	2.2	2.0	2.3	2.1	2.2	2.5	2.6	2.3
Ontario	2.5	2.2	2.3	2.5	2.6	2.2	2.3	2.4	2.4	2.2	2.2	2.3	2.3	2.0
Region	2.2	2.1	2.2	2.4	2.5	2.1	2.1	2.0	2.2	2.0	2.1	2.3	2.2	2.1

Effective April 1, 2024, all indicator calculations are based on the updated Ontario Health Team Attribution Model (OHTAM 2023/24), replacing the previous 2019/20 Model

Equity Stratification

Health Equity Quintiles

Due to suppression, some quintiles may be missing



Note on Quintile View: The missing quintile values are attributable to data suppression to ensure reliability and patient privacy when cell sizes are less than or equal to 6.

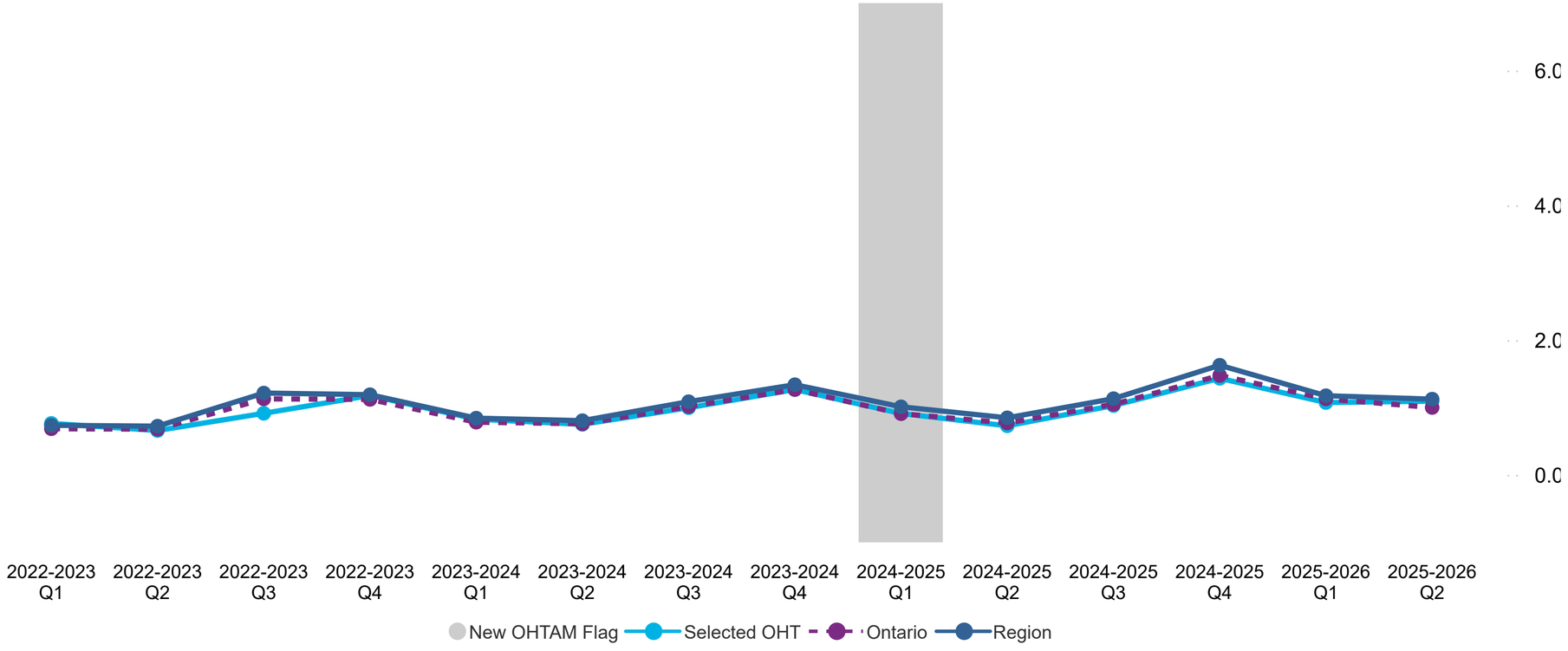
Slope Index of Inequality

2024-2025 Q2	2025-2026 Q2
0.1	0.8

*Note on SII: OHTs with fewer than 200,000 attributed persons **and/or** a missing quintile are marked as "N/A".*

Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

COPD specific Admissions per 100 patients



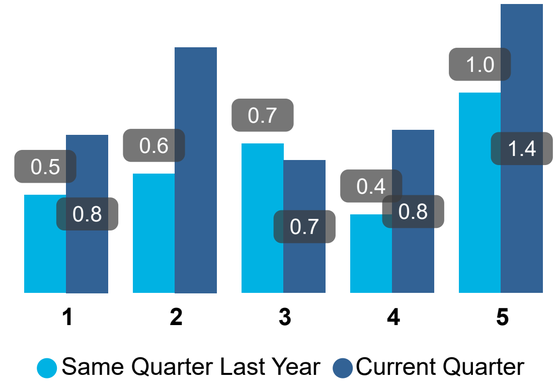
	2022-2023 Q1	2022-2023 Q2	2022-2023 Q3	2022-2023 Q4	2023-2024 Q1	2023-2024 Q2	2023-2024 Q3	2023-2024 Q4	2024-2025 Q1	2024-2025 Q2	2024-2025 Q3	2024-2025 Q4	2025-2026 Q1	2025-2026 Q2
Selected OHT	0.8	0.7	0.9	1.2	0.8	0.7	1.0	1.3	0.9	0.7	1.0	1.4	1.1	1.1
Ontario	0.7	0.7	1.1	1.1	0.8	0.8	1.0	1.3	0.9	0.8	1.0	1.5	1.1	1.0
Region	0.7	0.7	1.2	1.2	0.8	0.8	1.1	1.3	1.0	0.8	1.1	1.6	1.2	1.1

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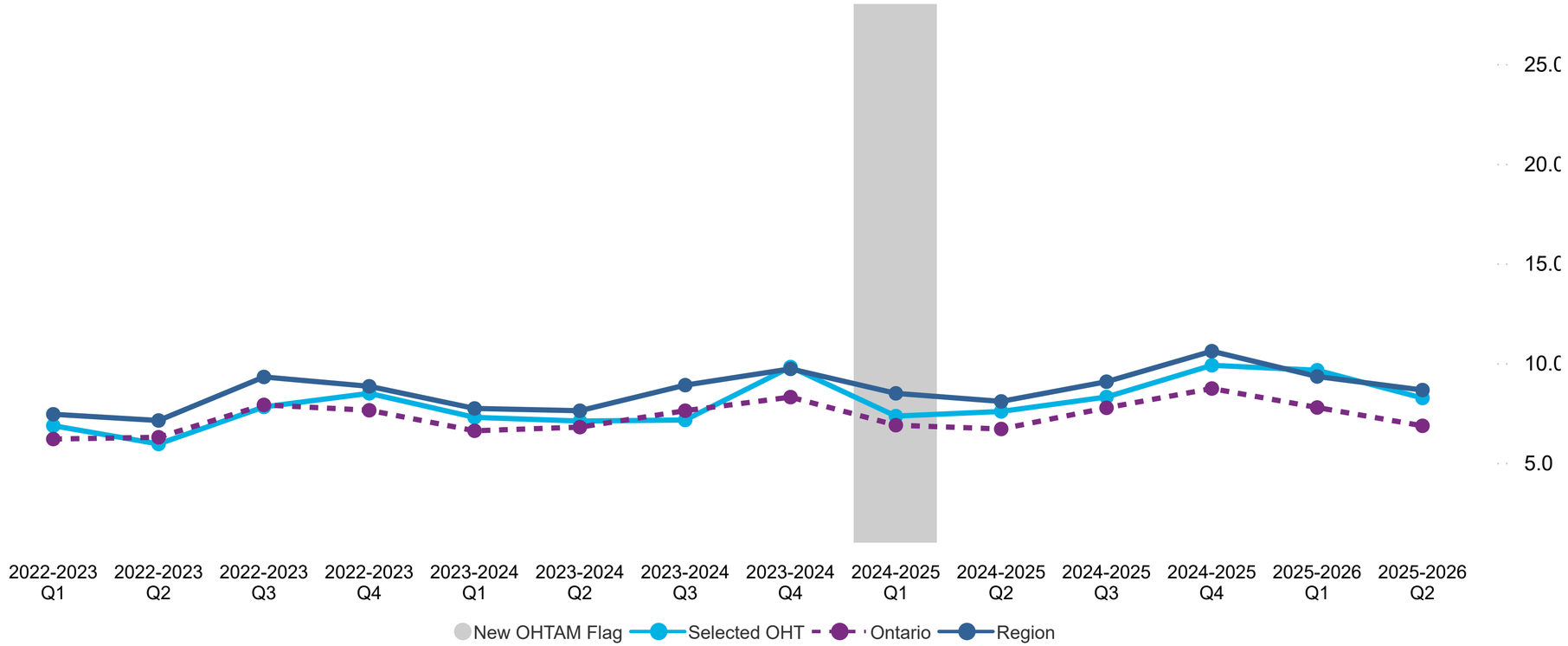
Slope Index of Inequality

2024-2025 Q2	2025-2026 Q2
0.1	0.8

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Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

Ambulatory Care Sensitive Condition (ACSC) Admissions per 10,000 Population



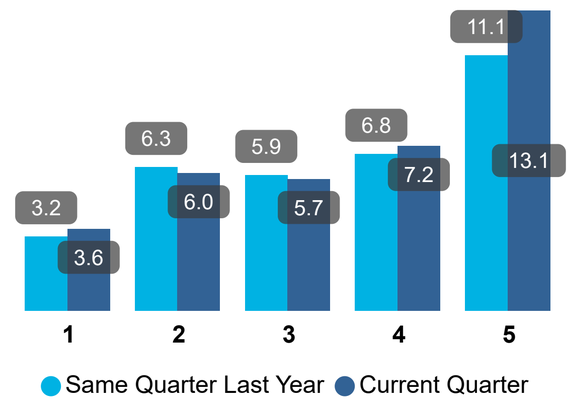
	2022-2023 Q1	2022-2023 Q2	2022-2023 Q3	2022-2023 Q4	2023-2024 Q1	2023-2024 Q2	2023-2024 Q3	2023-2024 Q4	2024-2025 Q1	2024-2025 Q2	2024-2025 Q3	2024-2025 Q4	2025-2026 Q1	2025-2026 Q2
Selected OHT	6.9	5.9	7.8	8.5	7.3	7.1	7.1	9.8	7.3	7.6	8.3	9.9	9.6	8.2
Ontario	6.2	6.3	7.9	7.6	6.6	6.8	7.6	8.3	6.9	6.7	7.8	8.7	7.8	6.9
Region	7.4	7.1	9.3	8.8	7.7	7.6	8.9	9.7	8.5	8.1	9.1	10.6	9.3	8.6

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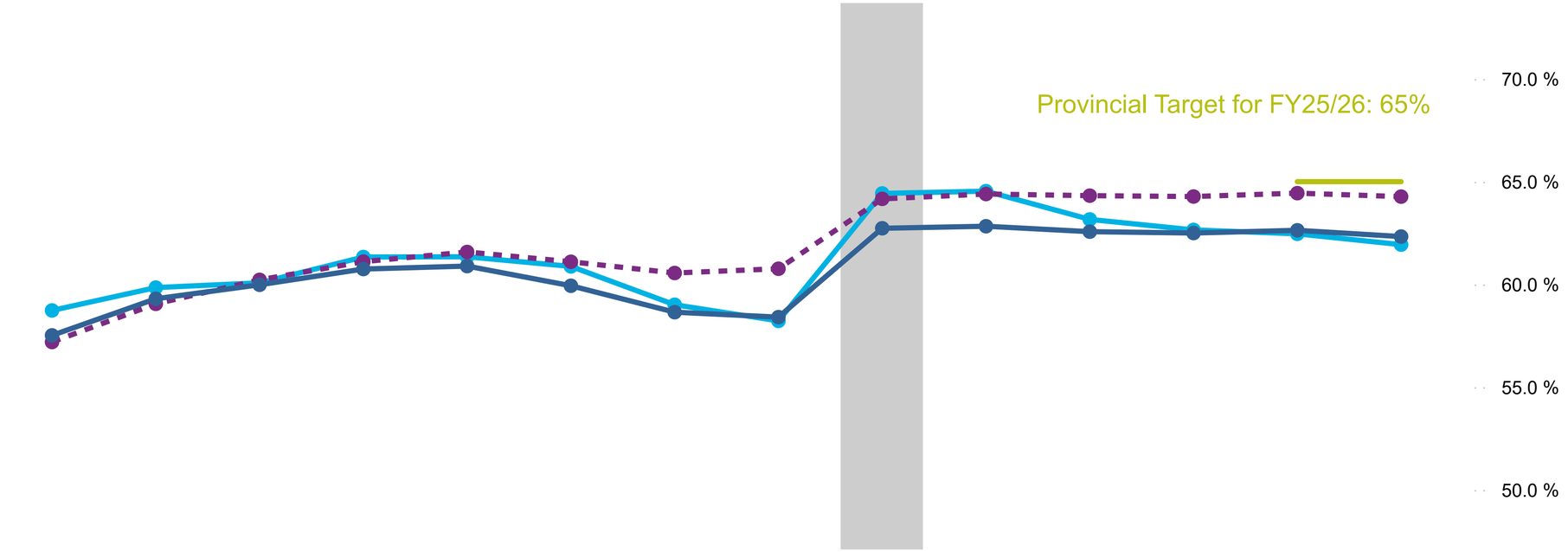
Slope Index of Inequality

2024-2025 Q2	2025-2026 Q2
8.2	10.1

*Note on SII: OHTs with fewer than 200,000 attributed persons **and/or** a missing quintile are marked as "N/A".*

Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

Breast Cancer Screening Rate (%)



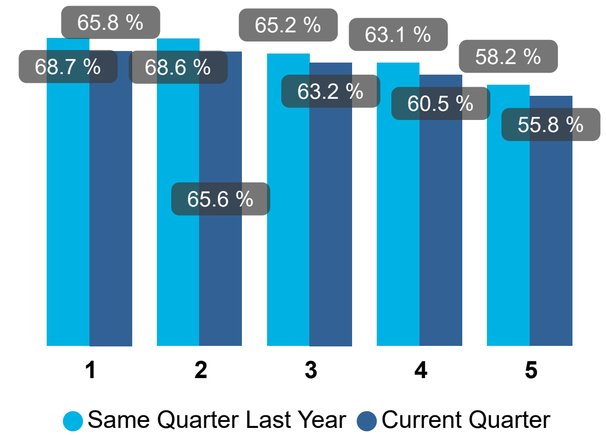
	2022-2023 Q1	2022-2023 Q2	2022-2023 Q3	2022-2023 Q4	2023-2024 Q1	2023-2024 Q2	2023-2024 Q3	2023-2024 Q4	2024-2025 Q1	2024-2025 Q2	2024-2025 Q3	2024-2025 Q4	2025-2026 Q1	2025-2026 Q2
Selected OHT	58.7 %	59.8 %	60.1 %	61.3 %	61.3 %	60.9 %	59.0 %	58.2 %	64.4 %	64.5 %	63.2 %	62.7 %	62.5 %	61.9 %
Ontario	57.2 %	59.1 %	60.2 %	61.1 %	61.6 %	61.1 %	60.6 %	60.8 %	64.2 %	64.4 %	64.3 %	64.3 %	64.4 %	64.3 %
Region	57.5 %	59.3 %	60.0 %	60.7 %	60.9 %	59.9 %	58.6 %	58.4 %	62.7 %	62.8 %	62.6 %	62.5 %	62.6 %	62.3 %

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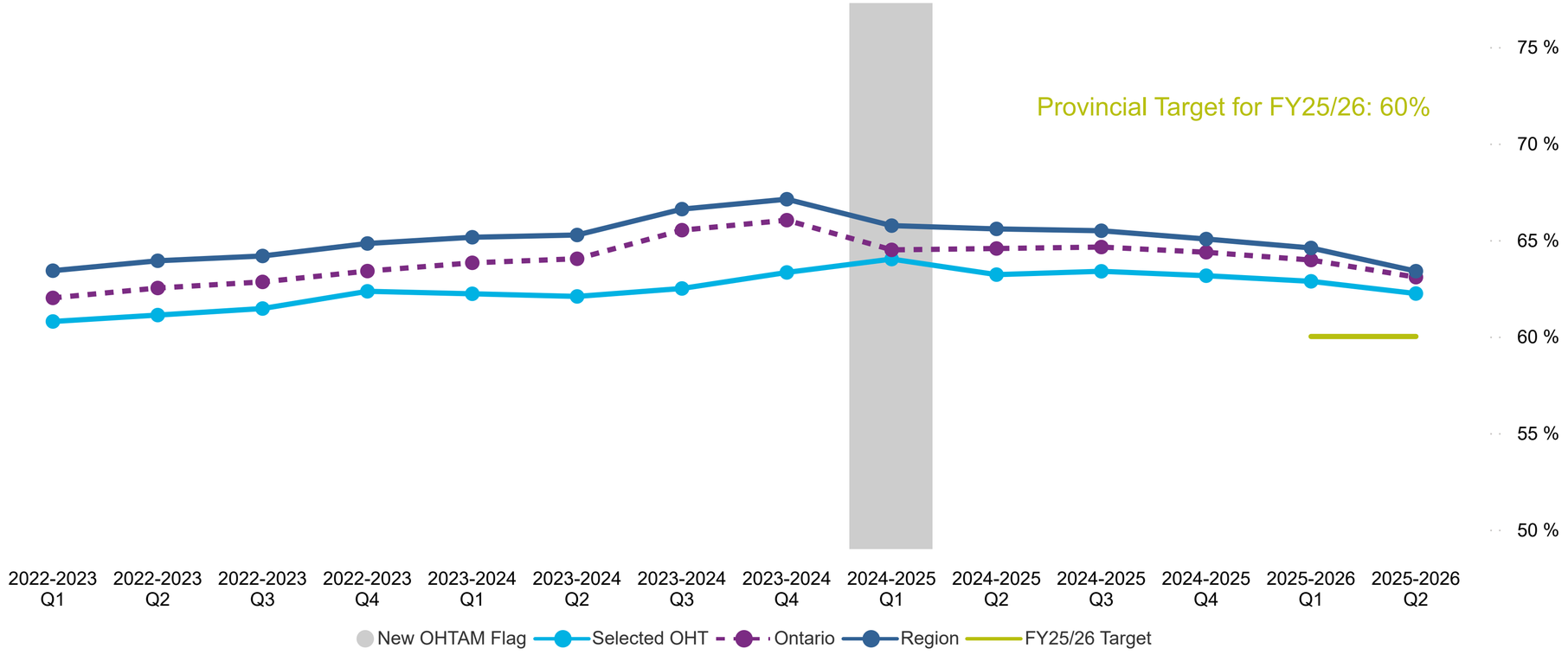
Slope Index of Inequality

2024-2025 Q2	2025-2026 Q2
-0.1	-0.1

*Note on SII: OHTs with fewer than 200,000 attributed persons **and/or** a missing quintile are marked as "N/A".*

Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

Cervical Cancer Screening Rate (%)



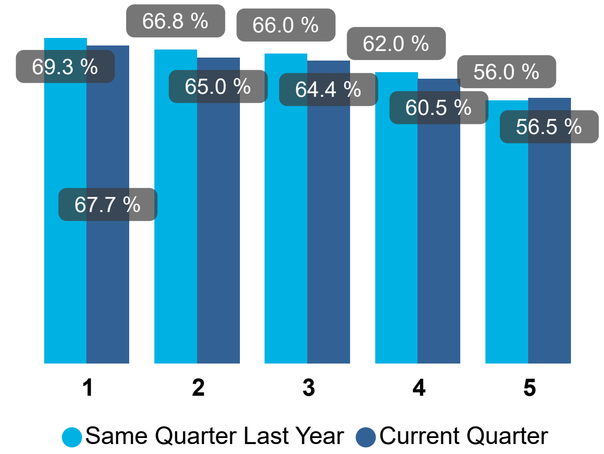
	2022-2023 Q1	2022-2023 Q2	2022-2023 Q3	2022-2023 Q4	2023-2024 Q1	2023-2024 Q2	2023-2024 Q3	2023-2024 Q4	2024-2025 Q1	2024-2025 Q2	2024-2025 Q3	2024-2025 Q4	2025-2026 Q1	2025-2026 Q2
Selected OHT	60.8 %	61.1 %	61.4 %	62.3 %	62.2 %	62.1 %	62.5 %	63.3 %	64.0 %	63.2 %	63.4 %	63.1 %	62.9 %	62.2 %
Ontario	62.0 %	62.5 %	62.8 %	63.4 %	63.8 %	64.0 %	65.5 %	66.0 %	64.5 %	64.6 %	64.6 %	64.4 %	64.0 %	63.1 %
Region	63.4 %	63.9 %	64.2 %	64.8 %	65.1 %	65.3 %	66.6 %	67.1 %	65.7 %	65.6 %	65.5 %	65.0 %	64.6 %	63.4 %

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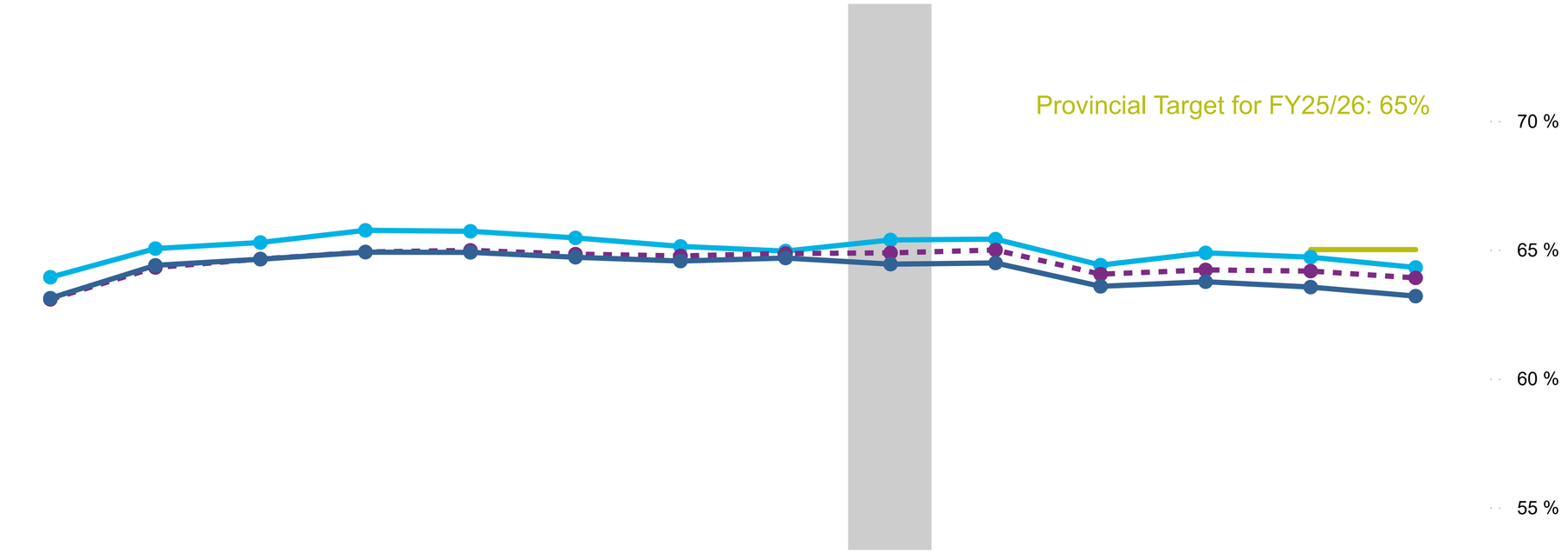
Slope Index of Inequality

2024-2025 Q2	2025-2026 Q2
-0.2	-0.1

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Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

Colorectal Cancer Screening Rate (%)



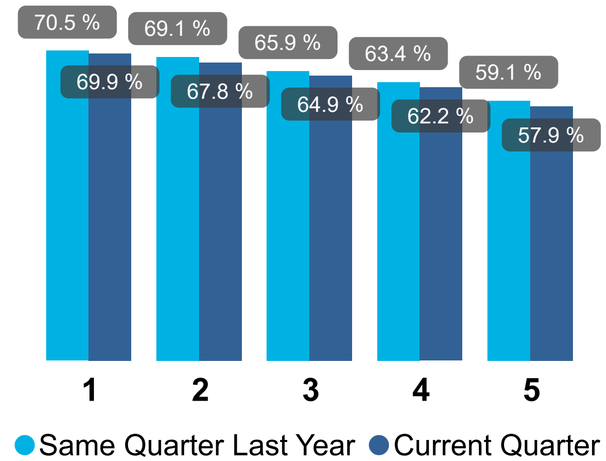
	2022-2023 Q1	2022-2023 Q2	2022-2023 Q3	2022-2023 Q4	2023-2024 Q1	2023-2024 Q2	2023-2024 Q3	2023-2024 Q4	2024-2025 Q1	2024-2025 Q2	2024-2025 Q3	2024-2025 Q4	2025-2026 Q1	2025-2026 Q2
Selected OHT	63.9 %	65.0 %	65.3 %	65.7 %	65.7 %	65.5 %	65.1 %	64.9 %	65.4 %	65.4 %	64.4 %	64.9 %	64.7 %	64.3 %
Ontario	63.1 %	64.3 %	64.6 %	64.9 %	65.0 %	64.8 %	64.8 %	64.8 %	64.9 %	65.0 %	64.0 %	64.2 %	64.2 %	63.9 %
Region	63.1 %	64.4 %	64.6 %	64.9 %	64.9 %	64.7 %	64.6 %	64.7 %	64.4 %	64.5 %	63.6 %	63.8 %	63.5 %	63.2 %

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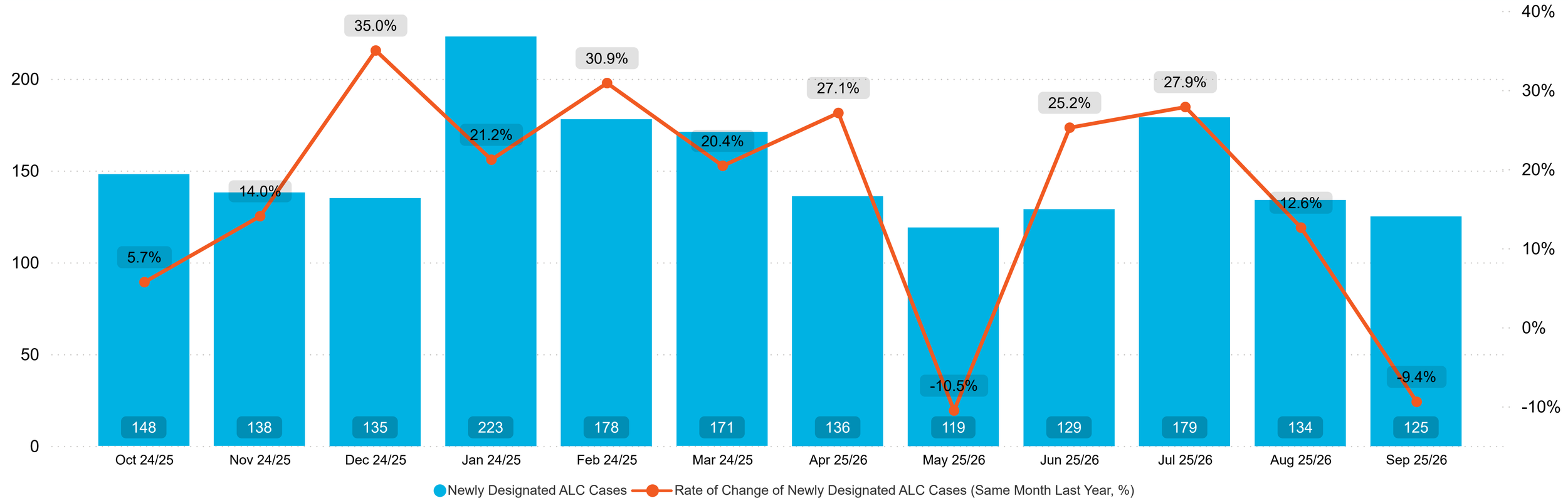
Slope Index of Inequality

-0.1	-0.1
2024-2025 Q2	2025-2026 Q2

*Note on SII: OHTs with fewer than 200,000 attributed persons **and/or** a missing quintile are marked as "N/A".*

Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

Newly Designated ALC Cases

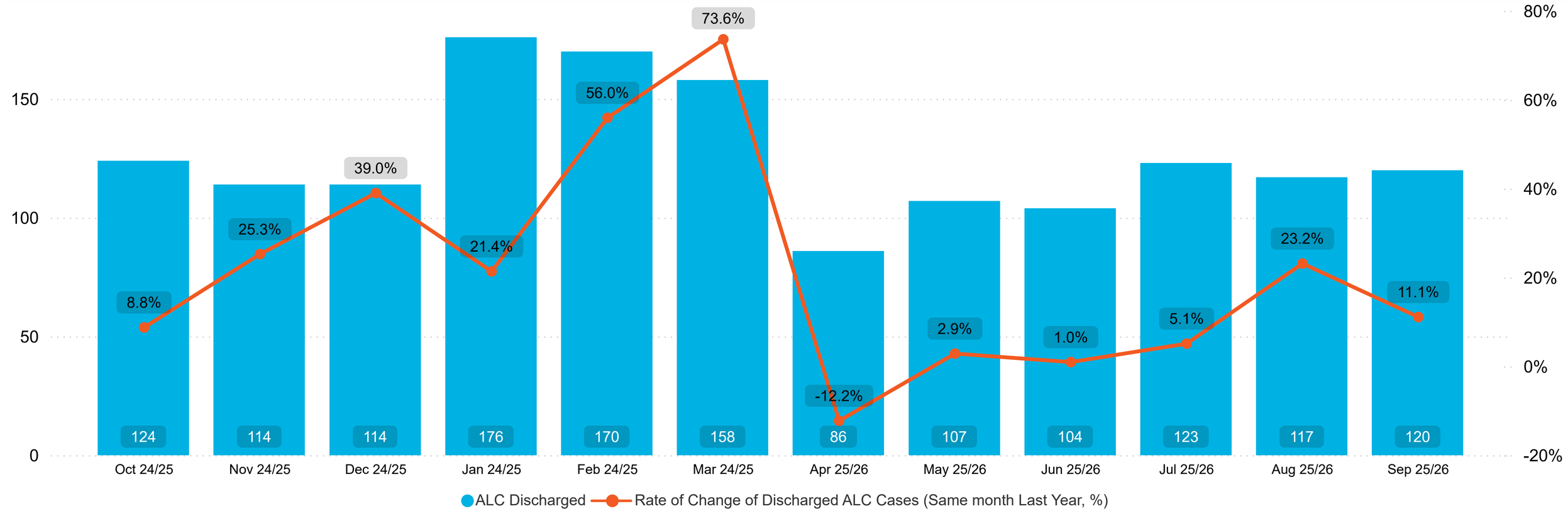


	Oct 24/25	Nov 24/25	Dec 24/25	Jan 24/25	Feb 24/25	Mar 24/25	Apr 25/26	May 25/26	Jun 25/26	Jul 25/26	Aug 25/26	Sep 25/26
Selected OHT	5.7%	14.0%	35.0%	21.2%	30.9%	20.4%	27.1%	-10.5%	25.2%	27.9%	12.6%	-9.4%
Ontario	-0.9%	-7.6%	-5.4%	-3.5%	-6.3%	1.4%	-12.2%	-12.5%	-3.2%	-1.2%	-7.4%	0.2%

This measure and visual is "developmental" in nature. OH invites feedback on the visual and the measure which can be considered for the future versions of the report.
The measure is aligned with the FY 25/26 TPA objective of "ALC prevention"; the numbers are based on the latest OHT Attribution Model.

Quarterly Summary Scorecard FY2025-2026 Q2 - Windsor Essex OHT

Discharged ALC Cases



	Oct 24/25	Nov 24/25	Dec 24/25	Jan 24/25	Feb 24/25	Mar 24/25	Apr 25/26	May 25/26	Jun 25/26	Jul 25/26	Aug 25/26	Sep 25/26
Selected OHT	8.8%	25.3%	39.0%	21.4%	56.0%	73.6%	-12.2%	2.9%	1.0%	5.1%	23.2%	11.1%
Ontario	0.6%	-2.9%	-9.3%	-1.2%	-7.7%	2.4%	-11.7%	-13.4%	-7.0%	0.3%	-10.0%	2.6%

This measure and visual is "developmental" in nature. OH invites feedback on the visual and the measure which can be considered for the future versions of the report.
The measure is aligned with the FY 25/26 TPA objective of "ALC Discharge Management"; the numbers are based on the aggregate caseloads of member hospitals of the OHTs and not the OHT Attribution Model.

Release Notes

Introduction

The Ontario Health Team (OHT) Performance Dashboard is designed to support the Ontario government's commitment to integrated, patient-centered care.

This dashboard enables OHTs to access comprehensive, up-to-date information on health outcomes, resource utilization, and population health indicators for their attributed populations. Through this tool, OHTs can make data-informed decisions to improve service delivery, coordinate care, and support health system planning.

The data presented in this dashboard includes aggregated information from Ontario Health's various administrative databases, including the Registered Persons Database (RPDB), Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS), and Ontario Health Insurance Plan (OHIP).

These datasets provide insights into key performance indicators, such as hospitalization rates and preventative screening uptake.

This dashboard is intended for OHTs to monitor and compare their own performance with provincial benchmarks. It is also a tool for identifying opportunities to collaborate with other OHTs and improve health outcomes for the people of Ontario.

Report Governance

The aggregate data incorporated in the indicator reports was provided by Ontario Health, a crown agency under the Ministry of Health. The data in this report should not be shared or disclosed to any third-party organizations or individuals outside of your organization without prior written approval from Ontario Health.

The recipient of this report is strictly prohibited from using the de-identified data to attempt to identify individuals. This includes any attempts to link information with other datasets to decrypt encrypted data or infer the identity of individuals based on prior knowledge or unencrypted information.

Patient Attribution to OHTs

Ontario Health Teams Attribution Model (OHTAM 2023/24) was developed using ICES methodology, which assigns each eligible Health Care Number (HCN) to an Ontario Health Team (OHT). Additional refinements were applied by the Health Analytics & Insights Branch (HAIB) at the Ministry of Health.

Attribution is determined using ICES methodology, which links patients to OHTs based on healthcare utilization patterns, not geography. Patients are assigned based on primary care physician affiliations, care seeking behaviors, and hospital networks. This approach aligns with actual patient-provider relationships, ensuring OHT populations represent true care patterns.

Effective April 1, 2024, all indicator calculations are based on the updated Ontario Health Team Attribution Model (OHTAM 2023/24), replacing the previous 2019/20 model.

The attribution of patients to an OHT does not impact how care is provided nor does it limit patient choice; patients can choose to receive care in any OHT. Rather, the attribution methodology aligns with

historical patient-provider relationships, which do not always adhere to catchment areas or municipal boundaries.

Physician network information and patient attribution will be recalculated regularly to ensure that up-to-date information informs the calculation of OHT data over time.

Suppression

Data is suppressed in accordance with privacy regulations. In any tab where an indicator's count falls below the minimum threshold, data suppression is applied to protect confidentiality. For example, when stratifying by Material Resources Marginalization Index.

Legal Disclaimers

This data is provided to support Ontario Health Teams and is restricted for use by authorized individuals. It is strictly prohibited to use this information, alone or in combination with other data, to attempt to identify individuals. This includes any attempt to decrypt, link, or infer identities based on the provided information.

Please note that this dashboard may contain sensitive data, including information related to First Nations, Inuit, and Métis populations. Users are encouraged to adhere to the OCAP® principles (Ownership, Control, Access, and Possession) and engage with relevant Indigenous communities to ensure respectful use of their data.

For data inquiries or further information, please contact: OHTanalytics@ontariohealth.ca

Methodology

Background of the OHT Performance Framework

The development of a performance framework for OHTs was first identified in the 2019 OHT guidance. Ontario Health Teams – The Path Forward (2022) and the Minister's Update on OHT Acceleration (2023) renewed the importance of developing a standardized performance framework with the goal of demonstrating how OHTs are collectively improving patient care. The performance framework will be implemented in phases and will enable OH and OHTs to collaboratively assess progress and support continuous improvement. The intent of the performance framework is to replace the self-selected indicators that are currently part of the OHT Implementation Funding Transfer Payment Agreements (TPAs). Ontario Health is continuing to encourage OHTs to measure progress on local priorities.

Overview

The data in this dashboard is provided by Ontario Health, using a range of administrative sources, including the Registered Persons Database (RPDB), Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS), and Ontario Health Insurance Plan (OHIP). The indicators are designed to monitor health outcomes and service utilization across Ontario Health Teams (OHTs), with provincial benchmarking for context. This data is de-identified and aggregated to protect individual privacy, and distribution of this report is restricted without Ontario Health's written consent.

COHORT DEFINITION

CHF Cohort

- To identify patients within the HF cohort, query data from fiscal year (FY) 2008/09 to the most recent FY. For a given FY, the HF cohort comprises patients alive at any point during that fiscal year and diagnosed with HF any year prior to or during the FY of interest, based on the following criteria:
    - Patients aged > 20 years who had 1 inpatient admission for heart failure identified through the Discharge Abstract Database, or
    - Patients aged > 40 years who had 1 visit, identified through OHIP databases, with fee code Q050, or
    - Patients aged > 40 years who had 2 ambulatory records for heart failure (identified through the National Ambulatory Care Reporting System) within 1 year of each other. Qualifying ambulatory records include:
        - ED visits with 1 of the following diagnosis codes: I50*, I40*, I41*, I42*, I43*, or I255*
        - Visits identified through OHIP databases with diagnosis code 428

COPD Cohort

- Individuals were identified as having COPD through health administrative data from CIHI-DAD, OHIP and the RPDB. To be classified as having COPD, individuals must have met all of the following criteria:
    - Age from 35 to 99 years and living in Ontario;
    - Have a valid Ontario health card number; and
    - Have at least one health care interaction (emergency department visit, hospitalization or physician visit) that is specific to COPD.

Methodology

Indicator Descriptions

For Primary Care Attachment and HCC waitlist indicators, "OHT" represents the Primary OHT associated with each FSA. The Primary OHT is defined as the team with the largest share (plurality) of the FSA's attributed population. In a small number of cases, this assignment was adjusted following consultation with Ontario Health Regions. For all other indicators, OHT is assigned using the OHT Attribution Model.

VALIDATED INDICATORS

1. % Attached to Primary Care: ***IMPORTANT NOTE: Attachment status is a snapshot as of June 30, 2025***

- **Definition:** Percentage of 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. if the patient sees a primary care physician and has signed an enrolment form;
    ii. if the patient lives in an area where everyone can get primary care;
    iii. if the patient has been receiving care at a Community Health Centre;
    iv. if the patient is on the Nurse Practitioner-Led Clinic List;
    v. if they are consistently receiving comprehensive primary care from a fee-for-service physician, or (for children) from a paediatrician
- If the patient does not meet any of the criteria required for attachment, they are considered unattached.
- **Denominator:** Number of total OHT population
- **Numerator:** Number of people attached to a primary care provider.
- **Data Source:** Primary Care Attachment Methodology List (PCAML) via the Health Analytics and Insights Branch, Ministry of Health

2. # Patients on Health Care Connect (HCC) waitlist referred to a primary care provider

- **Definition:** The count of patients referred to a primary care provider reflects the total number of patients from the HCC waitlist that were referred to a primary care provider from June to September, 2025.
- **Data source:** Health Care Connect Database (HCCDB) via Health Analytics and Insights Branch, Ministry of Health

2.1. % Reduction in HCC Waitlist (vs previous quarter)

- **Definition:** The percentage decrease is the percent change comparing the number of patients on the HCC waitlist in June 2025 and September 2025.
- **Data Source:** Health Care Connect Database (HCCDB) via Health Analytics and Insights Branch, Ministry of Health

3. CHF-Specific Admissions per 100 Patients

- **Definition:** This indicator measures the rate of hospital admissions, due to CHF, per 100 CHF patients within each OHT. Multiple admissions per patient may lead to counts exceeding 100.
- **Purpose:** Assesses the burden of CHF on hospital services and allows benchmarking with provincial averages.
- **Denominator:** Number of people in CHF cohort in the reporting period (description above).
- **Numerator:** Number of hospital admission for Congestive Heart Failure (CHF), grouped by CHF cohort
    - Hospital admissions with 1 of the following MRDx: I50*, I40*, I41*, I42*, I43*, or I255*, OR
    - Hospital admissions with MRDx: I11* or I13*, AND diagnostic code: I50* with diagnosis type in (1, 2, W, X, Y)
- **Exclusions:**
    - Elective admissions (admcat in "L", with a Length of Stay of 0 days [ddate – admdate = 0] in the Discharge Abstract Database)
    - Length of Stay = 0 and transfer-through to another facility on the same day as discharge date
- **Data Source:** DAD, CHF Cohort (Definition in the previous page)

4. COPD-Specific Admissions per 100 Patients

- **Definition:** This indicator calculates hospital admissions, due to COPD, per 100 patients in the COPD cohort. Repeated admissions by a single patient are included, resulting in potential rates exceeding 100.
- **Purpose:** Assesses the burden of COPD on hospital services and allows benchmarking with provincial averages.
- **Denominator:** Number of people in COPD cohort in the reporting period (description above).
- **Numerator:** Number of hospital admissions due to COPD, grouped by COPD cohort (having record in DAD, with 1 of the following diagnosis codes (any diagnosis field): J41*, J42*, J43*, or J44*, as the most responsible diagnosis, admitting diagnosis, or pre-admit comorbidity)
- **Exclusions:**
    - Elective admissions (admcat in "L", with a Length of Stay of 0 days [ddate – admdate = 0] in the Discharge Abstract Database)
    - Length of Stay = 0 and transfer-through to another facility on the same day as discharge date
    - Discharge disposition with cadaveric donor or stillbirth
- Data Source: DAD, COPD Cohort (Definition in the previous page)

Methodology

5. ACSC Admissions per 10,000 Population

- **Definition:** Tracks admissions for Ambulatory Care Sensitive Conditions (ACSC), which can often be managed with effective outpatient care. Rates are reported per 10,000 population.
- **Purpose:** Reflects the effectiveness of primary and preventive care in reducing avoidable hospitalizations.
- **Denominator:** Total population younger than age 75 in the reporting period.
- **Numerator:** Total number of acute care hospitalizations for ambulatory care sensitive conditions in patients younger than age 75. The conditions include angina, asthma, chronic obstructive pulmonary disorder (COPD), diabetes, grand mal status and other epileptic convulsions, heart failure and pulmonary edema and hypertension.
- **Data Source:** DAD

6. Breast Cancer Screening Rate (%)

Prior to April 1, 2024 (FY 2024/25), under the Ontario Health Teams Attribution Model (OHTAM 2019/20), the time frame was 24 months (two years).

- **Definition:** Percentage of eligible women aged 50-74 who completed a mammogram within the past two years.
- **Purpose:** Assesses outreach and effectiveness of preventive screening for breast cancer.
- **Denominator:** Total number of Ontario screen eligible women aged 50-74 in the reporting period.
- **Numerator:** Number of screen-eligible women aged 50-74 who completed at least one screening mammogram within the past two years.
- **Data Sources:** ICMS-OBSP, OCR, RPDB, OHIP

Effective April 1, 2024 (FY 2024/25), the updated Ontario Health Teams Attribution Model OHTAM (2023/24) was implemented along with a new methodology. As part of these changes, the time frame was extended by six months, resulting in a time frame for breast cancer screening of 30 months.

- **Definition:** Percentage of Ontario screen-eligible people, ages 50-74, who completed at least one screening mammogram within a 30-month period.
- **Purpose:** Assesses outreach and effectiveness of preventive screening for breast cancer.
- **Denominator:** Total number of Ontario screen eligible women aged 50-74 in the reporting period.
- **Numerator:** Total number of Ontario screen-eligible women, aged 50-74, who completed at least one screening mammogram within a 30-month period.
- **Data Sources:** ICMS-OBSP, OCR, RPDB, OHIP

7. Cervical Cancer Screening Rate (%)

Before April 1, 2024 (FY 2024/25), calculations were based on the Ontario Health Teams Attribution Model (OHTAM 2019/20).

- **Definition:** Percentage of eligible women aged 21-69 who completed a Pap test within the past 3 years.
- **Purpose:** Evaluates preventive services aimed at reducing cervical cancer incidence.
- **Denominator:** Total number of Ontario screen eligible women aged 21-69 in the reporting period.
- **Numerator:** Number of screen-eligible women aged 21-69 who completed at least one Cytology (pap) test within the past 3 years.
- **Data Sources:** Cytobase, OHIP, OCR, RPDB

Effective April 1, 2024, calculations are based on the new methodology and the updated OHTAM (2023/24)

- **Definition:** Percentage of screen-eligible people, aged 25-69, in Ontario who completed at least one screening HPV test in the past 66 months or cytology (Pap) test in the past 42 months.
- **Purpose:** Evaluates preventive services aimed at reducing cervical cancer incidence.
- **Denominator:** Total number of screen-eligible females in the OHT, aged 25-69 in the reporting period
- **Numerator:** Total number of screen-eligible females in the OHT, aged 25-69, who have completed at least one cytology (Pap) test in the past 42 months (36 months + 6-month buffer period), or screening HPV test in the past 66 months (60 months + 6-month buffer period).
- **Data Sources:** Cytobase, OHIP, OCR, RPDB

8. Colorectal Cancer Screening Rate (%)

Effective April 1, 2024 (FY 2024/25) calculations are based on the updated Ontario Health Team Attribution Model (OHTAM 2023/24), replacing the previous model (OHTAM 2029/20).

- **Definition:** Percentage of Ontario screen-eligible individuals aged 50–74 who are up to date with colorectal screening, i.e., those who had a fecal test within the past 2 years, a colonoscopy within the past 10 years, or a flexible sigmoidoscopy within the past 10 years
- **Purpose:** Measures accessibility and effectiveness of preventive colorectal cancer screening.
- **Denominator:** Total number of Ontario screen eligible people aged 50-74 in the reporting period.
- **Numerator:** Number of screen-eligible people, aged 50–74, who had a fecal test in the past 2 years, a colonoscopy or flexible sigmoidoscopy in the past 10 years.
- **Data Sources:** FIT DSP, GI Endoscopy DSP, OCR, RPDB, OHIP, PCCF+

Methodology

DEVELOPMENTAL INDICATORS

9. Newly Designated ALC Cases and Rate of Change of Newly Designated ALC Cases

- **Definition of ALC Designation:** A patient who no longer requires the level of care provided in their current inpatient setting (Acute, CCC, Mental Health, or Rehabilitation) must be designated as Alternate Level of Care (ALC) by the physician or their delegate. Number of Newly Designated ALC Cases by Month reflects values for each OHT based on a 12-month.
- **Rate of Change of Newly Designated ALC Cases (%):** Measures the rate of change over time in the number of newly designated ALC cases within an OHT's population, indicating the inflow of patients into the system
- **Denominator:** #Patients designated as newly ALC in the same month of the previous fiscal year
- **Numerator:** # of patients designated as newly ALC within the current month - # of patients designated as Newly ALC in the same month of the previous fiscal year
- **Purpose:** Measures the effectiveness of the OHT to prevent potentially unnecessary hospitalizations and hence decrease overall acute care utilization; A negative rate of change may indicate progress at preventing ALC cases in the community
- **Exclusions:**
    - Patients designated as newly ALC in Reactivation Care Centers (RCC), Alternate Health Facilities (AHF) and Transitional Care Units (TCU)
    - Repeat or ongoing ALC cases that are not newly designated during the reporting period
    - Patients without a valid Health Card Number

10. Discharged Cases (Designated as ALC) and Rate of Change of Discharged Cases (Designated As ALC)

- **Definition of Discharged ALC Cases:** Discharged ALC-designated cases are attributed to the hospital from which the patient is discharged. OHT-level results are derived by aggregating discharged cases from all hospitals that belong to each OHT.
- **Rate of Change of Discharged ALC Cases:** Measures the rate of change over time in the number of Alternate Level of Care (ALC) designated patients discharged to an alternate level of care. Number of Discharged ALC Cases by Month is reported using a 12-month rolling period.
- **Denominator:** # of patients designated ALC discharged within the same month last year
- **Numerator:** # of patients designated as ALC discharged within the current month - # of patients designated ALC discharged within the same month last year
- **Purpose:** Measures the effectiveness of the OHT to effectively discharge the ALC designated patients into the community, and/or alternate care settings in collaboration with their member hospitals. A positive value of the 'rate of change' which is increasing with time may indicate of increased ability of the system to transition the ALC designated patients thereby increasing the bed capacity in acute care settings. Over time, the goal should be to increase the value of both the absolute number of discharged cases and the rate of change of discharged cases.
- **Exclusions:**
    - Patients in Reactivation Care Centers (RCC)
    - Alternate Health Facilities (AHF)
    - Transitional Care Units (TCU)

Please note that both the Newly Designated and Discharged volumes will be derived using a methodology that will differ from OH's Throughput methodology in the following ways:

- In this version of Newly designated and discharged volumes, a Wait List Entry (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.
- Cases transferred to an AHF/RCC are captured in the discontinued volume as in OH's 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
- Data snapshot of the end of each month is taken as of 6th business day of the following month

Data Source: WTIS-ALC Data Cut on December 8, 2025 (ALC Data as of 11:59 PM on December 7, 2025)

Methodology

Provincial Rates

The provincial rate for a given timeframe is calculated by dividing the total numbers in Ontario from the number of cases that meet certain criteria in Ontario by the timeframe. For example, Admissions per 100 CHF for provincial rate is calculated by: "total number of admissions from CHF cohort in Ontario / total number of CHF patients in Ontario".

Material resources (previously called 'Material deprivation') Stratification

Material resources are closely linked to poverty and represent the inability of individuals or communities to access basic necessities. This dimension includes indicators such as income, housing quality, educational attainment, and family structure.

In this report, the patients are grouped into 5 material resources indexes based on their postal code in OHTAM 2023/24 model.

Please note that due to data suppression, there are some indexes in OHTs that are not showed in the graph. See "Data Suppression" section below.

Data Source: Ontario Marginalization Index (2021) - (ON-Marg)

Data Suppression

In compliance with privacy regulations, data is suppressed for cells with counts of six or fewer.

Patient Attribution to OHTs

The Ontario Health Teams Attribution Model (OHTAM 2023/24) was developed using ICES methodology, which assigns each eligible Health Care Number (HCN) to an Ontario Health Team (OHT).

Attribution is determined using ICES methodology, which links patients to OHTs based on healthcare utilization patterns, not geography. Patients are assigned based on primary care physician affiliations, care seeking behaviors, and hospital networks. This approach aligns with actual patient-provider relationships, ensuring OHT populations represent true care patterns.

Effective April 1, 2024, all indicator calculations are based on the updated Ontario Health Team Attribution Model (OHTAM 2023/24), replacing the previous 2019/20 model.

Abbreviations

- FSA: Forward Sortation Area (first three characters of the postal code)
- OHT: Ontario Health Team
- OHTAM: Ontario Health Team Attribution Model
- DAD: Discharge Abstract Database
- NACRS: National Ambulatory Care Reporting System
- OMHRS: Ontario Mental Health Reporting System
- RPDB: Registered Persons Database
- NRS: National Rehabilitation System
- CCRS: Continuing Care Reporting System
- CHF: Congestive Heart Failure
- COPD: Chronic Obstructive Pulmonary Disease
- ACSC: Ambulatory Care Sensitive Conditions
- ALC: Alternative Level of Care

Annual Attribution Updates

The attributed population for each OHT is updated annually to remove deceased patients. New births will be added in future updates as data becomes available.

For additional details, please contact: OHTanalytics@ontariohealth.ca