Alliance for Healthier Communities
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Panel Size Handbook

Updated 2026

For more information, please contact EPIC@allianceon.org

Definitions

The following terms and definitions are used to calculate the target and actual panel size:

Primary care provider: Either a physician or nurse practitioner who is responsible for providing ongoing, comprehensive primary care to clients of a member organization.

Budgeted primary care provider full-time equivalents (FTEs): The number of primary care providers that a member organization receives funding to employ. Vacant primary care provider FTEs should be included as it reflects the budgeted or funded FTEs, not the actual or filled FTEs.

***Current* primary care client:** Any client of a member organization who has had an encounter with a primary care provider within the last three years. Clients who have not had an encounter with a primary care provider in that three-year period may remain as a registered primary care client, but they are not considered a current primary care client for the purposes of the panel size calculations.

***Registered* primary care client:** Any active client of a member organization who has previously had an encounter with a physician or nurse practitioner and for whom the member organization is still responsible for providing primary care services when required. This may include clients who have not had an encounter with a physician or nurse practitioner in the last three years.

Standardized ACG Morbidity Index (SAMI): Measures the complexity of the client population served by a member organization. It is a predictor of primary care utilization and is used in the calculation of target panel size. The SAMI is calculated by ICES using data for a two-year period and is included in the Practice Profile.

- A score above 1.0 indicates that the organization serves a client population that is sicker and requires more resources than the average Ontarian.
- A score below 1.0 indicates that the organization serves a client population that is less sick and requires fewer resources than the average Ontarian.

The SAMI is derived from the Johns Hopkins Adjusted Clinical Group (ACG) System, which is a population-based, case-mix/risk adjustment methodology used to describe the morbidity patterns of primary care clients.

Background

A target panel size is the number of clients for whom a primary care provider, typically a physician or nurse practitioner, is responsible for providing regular primary health care services. The target is set to establish an appropriate workload for primary care providers while balancing safety and quality of care for clients, as well as provider experience.

Community health centres and other organizations with multiple providers have a combined **target panel size,** which is based on the number of funded primary care provider roles as counted in full-time equivalents (FTE) and adjusted to reflect the medical complexity of the clients served. Organizations use their **SAMI score** to calculate their own **adjusted target panel size** and report it to Ontario Health (OH). They also calculate and report how close they are to their adjusted target (expressed as "**percent to panel**" and set a performance target for this measure, which is reflected in their Multi-Service Accountability Agreement (MSAA).The Panel Size Handbook provides an overview of how to calculate your organization's target panel size, adjusted panel size, and percent to panel, as well as additional indicators you may choose to track and report on to provide additional context. Following this methodology will ensure that all member organizations calculate their adjusted target panel size and percent-to-panel measure using a consistent formula, thereby allowing for meaningful comparisons and reliable projections.

The Handbook also includes responses to certain frequently asked questions (FAQs) around this methodology, as well as how panel size information is being used for accountability purposes within the Ontario Health regions.

The Handbook will be updated as needed to incorporate any adjustments made to calculations, reporting requirements, FAQs and lessons learned over time.

Methodology

Target panel size calculation

i. Baseline target panel size

The baseline panel for Alliance member organizations is 1,137.5 clients per full-time primary care provider (MDs + NPs).

This number is based on the lowest target roster for a full-time Family Health Team/Organization (FHT) physician in Ontario, which is 1,300 patients. It is pro-rated to reflect that primary care providers in Alliance member organizations have a shorter work week than FHT physicians (35 hours per week instead of. 37.5 hours per week, which is 87.5% as many hours). This generates the baseline panel size of 1137.5 clients per primary care provider.

> *NOTE: This number also differs from FHT panel size targets because it reflects an **expected number of active patients** (people actually accessing care), whereas the target number of patients for a FHT reflects the physicians' **expected roster size**, regardless of when those patients last accessed care.*

The following formula is used:

> **Baseline panel size (=1,37.5) = 1,300 * 0.875**

ii. Adjusted target panel size

All CHCs begin with the same baseline panel of 1,137.5 clients per full-time primary care provider. Because the workload associated with providing primary care to a more complex client population is greater than providing primary care to a less complex population, the baseline panel size is adjusted to account for the average complexity of each member organization's client population. This is done by dividing the target panel size by a number called the SAMI score. The more complex an organization's client population is, the higher their SAMI score will be. The higher an organization's SAMI score is, the lower their adjusted panel size will be.

The adjusted panel size is calculated by dividing the baseline panel size of 1,137.5 by the organization's specific SAMI score. The adjusted panel size is then multiplied by the number of primary care provider FTEs to calculate an organization's target panel size. The following formula is used:

Target panel size = Baseline panel size (=1,137.5) / SAMI score * Budgeted primary care provider FTEs

Actual panel size calculation

Actual panel size is obtained from the provincial repository for Alliance member organization data, called BIRT. A client is counted towards an organization's actual panel size if they have had an encounter with a CHC physician, nurse practitioner, registered nurse, registered practical nurse or physician assistant in the past 3 years AND have had an encounter with a CHC physician or nurse practitioner at any time.

Percent to panel calculation

Percent to panel reflects how close your organization is to reaching their target panel size (adjusted for SAMI). In other words, it the current number of clients who received primary care services (actual panel size) as a percentage of the total number of clients the organization is expected to provide primary care services to (target panel size). It is calculated using the following formula:

Percent to panel = Actual panel size / Target panel size * 100

Technical specifications for the Percent to panel indicator can be found in Appendix A.

Performance standards: Target and Corridor

Each CHC has an organization-specific performance target for percent to panel, which is negotiated with Ontario Health, based on local contextual factors.

Additionally, each organization has a performance corridor, which indicates how much their percent to panel may deviate from their specific performance target. As of the 2023-24 MSAA, this corridor is:

- Organizations designated for rapid growth: ± 10% of performance target
- Organizations designated for continued high performance: ±5% of performance target

Additional indicators (optional explanatory indicators)

Studies indicate that levels of support staff, the number of exam rooms, need for interpretation services, and other factors significantly influence the number of clients that can be provided primary care. As such, the MSAA includes optional explanatory and contextual measures, which CHCs in some OH regions can select and report on. These are meant to further describe primary care services at the organization and to ensure that quality of care and access is being maintained and that panel sizes are sustainable.

The approved additional indicators are presented with brief descriptions in the table below. The full technical specifications used to calculate these additional indicators can be found the *2023-24 Multi-Sector Service Accountability Agreement Indicator Technical Specifications* document.

Indicator	Description
Client experience of access to primary care	Percent of clients who reported having same day or next day access to their primary care provider.
Interpretation services	Percent of encounters by a primary care provider or primary care clinician that include interpretation services.
Non-insured clients	Percent of clients who do not have Ontario Health Insurance (OHIP) coverage.
Third next available appointment	Average length of time in days between the day a client makes a request for an appointment with a primary care provider and the third next available appointment.
Clinic support staff per primary care provider	Number of clinical support staff per primary care provider.
Exam rooms per primary care provider	Number of exam rooms per primary care provider or primary care clinician.
High risk urban population	Identifies organizations who provide services to clients who are homeless or at risk of being homeless, living with mental health issues or mental illness, living with an addition, living in poverty or with low income, or are street-involved youth.
New grads/new hires	Percent of primary care providers who are a new grad or are newly hired.
Non-clinical activities	Percent of primary care provider time spent on non-primary care activities, including clinical management, teaching/research, and/or community development activities.
Number of new clients	Percent of primary care clients who had their first encounter with a primary care provider within the last 3 years.
Number of registered clients	Number of clients registered to a primary care provider.
Specialized care	Percent of primary care provider time spent on specialized care, including specialty clinics (e.g., palliative care, obstetrics, etc.) and care for priority populations (e.g., geriatric).
Student supervision	Percent of primary care provider time spent supervising students.
Travel time	Percent of primary care provider and primary care clinician time spent travelling for the purpose of direct service delivery to clients.
Vacancies	Percent of primary care provider FTE positions that are not occupied over the reporting period.

Frequently Asked Questions

How should this data be monitored internally?

Target panel size, actual panel size, and percent to panel should be calculated on an ongoing basis within your organization as new data becomes available to monitor performance.

- **Target panel size** can be updated annually once your organization's new SAMI score has been released in the Practice Profile.

- **Actual panel size** can be obtained quarterly from the BIRT M-SAA Dashboard or pulled directly from your organization's EMR reporting solution
- **Percent to panel** can be monitored by dividing your organization's actual panel size by its most recent target panel size

Is there an expectation that all member organizations will reach 100% of their target panel size?

All organizations are expected to be working towards 100% of their target panel size. Your current performance target and corridor from OH region may be below 100%, and the percent to panel you report to OH will still be based on this. However, as health system priorities have shifted to focus on ensuring everyone is attached to a primary health care provider, your internal quality improvement goal should be to keep working towards 100% of your adjusted panel size.

There may be structural barriers (such as provider vacancies) that make it especially difficult for your organization to approach 100% of their panel-size target. If your organization is experiencing such barriers, please contact QI@AllianceON.org. We are committed to working directly with our members to help them reach 100% of their target panel size.

Does the Panel Size query include all clients, including people without health insurance or people who are not on-going primary care clients (OPCC)?

The panel size query includes all individuals who have had an encounter with a Physician, Nurse Practitioner, Registered Nurse/Registered Practical Nurse or Physician Assistant over a three-year period. The query includes everyone, regardless of OPCC and insurance status.

Why does the indicator include funded positions and not filled positions?

OH is interested in measuring a member organization's full capacity, which reflects the number of primary care positions that they have provided funding for. This helps plan primary care in the region, understand resource allocation and ensure that there is continued access to primary care.

If a member organization has non-OH funded primary care provider staff, should they be included in the FTE count?

Only OH-funded staff are included in the FTE count.

- *Includes Funded FTE count of Primary Care Providers (Physician+ Nurse Practitioner) (M-SAA 2023-24)*
- *Excludes Any practitioner that is not funded to provide clinical services as part of an approved budget for a member organization (M-SAA 2023-24)*

How does the SAMI adjust for complexity and why not use revisit rate?

The method of adjusting panel size by SAMI assumes a linear relationship for workload – that is, that an individual with a score of 2 would be seen twice as frequently as one with a score of 1.

The SAMI includes all diagnoses that have been recorded in the health system over a two-year period. The SAMI should come close to representing the number of primary care encounters expected for that person. The ACG software has been adjusted for any non-linearity and has been widely validated. The use of revisits would need to assume that all encounters are appropriate, rather than basing the adjustment factor on what is expected based on client characteristics.

The SAMI is provided for the entire organization – how do we account for providers who see considerably more complex clients?

The adjusted panel sizes are per member organization and not per provider. This means that there is flexibility for different providers within a particular member organization to have different panel sizes. However, this requires an understanding of the characteristics of each provider's panel.

Other primary care models suggest that nurse practitioners should have a lower panel size – why are the expectations the same for both physicians and nurse practitioners in Alliance-member organizations?

Data does not suggest that Nurse Practitioners see fewer clients. On average, Nurse Practitioners have similar or higher client panels compared to physicians in the sector.

Who is included in the clinical support measure?

This includes staff that provide specific clinical support to the primary care providers - activities such as checking clients in and out of primary care appointments, obtaining vital signs, collecting medical information, nursing activities, and telephone triage or advice.

- *Includes: Physician Assistants, Registered Nurses, Registered Practical Nurses, Medical Secretaries, Pharmacists, Medical Assistants, Health Technicians, and Lab Technicians. (M-SAA, 2023-24)*

Staff time dedicated to business office functions, file room activities, or supporting non-primary care clinics should not be included or should be pro-rated for time spent supporting PC.

- *Excludes: Any practitioner that is not funded to provide clinical services (MSAA, 2023-24)*

Appendix: Technical Specifications for Percent to Panel-Size Indicator

INDICATOR NAME		PERCENT TO PANEL
INDICATOR DESCRIPTION		The indicator calculates the current number of clients provided clinical services as a percentage of the total number of clients the member organization is expected to serve. The "expected" client count or full potential of the member organization assumes a fully staffed clinical team, and client complexity is factored into the count.
INDICATOR CALCULATION		Numerator / Denominator * 100
CLASSIFICATION		Performance
PERFORMANCE STANDARD		Performance Target: OH-negotiated target Performance Corridor: • Rapid Growth*: ±10% of Target Value • Continue High Level of service: ± 5% of Target *Rapid growth is defined when a target percentage is agreed to, and the target exceeds the current value by more than 10% of the current value. For example, if the current level is 45%, and the agreed target is 60%, this represents a 33% increase. (60-45)/45 = .33
NUMERATOR	CALCULATION	Number of clients that have had an encounter with a physician, nurse practitioner, registered nurse, registered practical nurse, or physician assistant within the last 3 years AND have had an encounter with a physician or nurse practitioner at any time.
	DATA SOURCE	Provincial data repository for Alliance member organizations (BIRT)
	INCLUSION/ EXCLUSION CRITERIA	Includes all clients who meet the criteria described above under "Calculation"

INDICATOR NAME		PERCENT TO PANEL
DENOMINATOR	CALCULATION	Target panel size = 1,137.5 / SAMI score * Budgeted primary care provider FTEs
	DATA SOURCE	Manual calculation • The SAMI score for your organization can be obtained from the CHC Practice Profile. • The budgeted primary care provider FTE count can be obtained from your organization's approved budget from Ontario Health.
	INCLUSION/ EXCLUSION CRITERIA	Includes: Budgeted FTE count of primary care providers (physicians and nurse practitioners). Vacant primary care provider FTEs are included, as this reflects the budgeted or funded FTEs, not the actual or filled FTEs. Excludes: Any primary care provider that is not funded to provide primary care services
LIMITATIONS		The denominator is updated annually, once a new SAMI score is released in the Practice Profile, whereas the numerator is updated quarterly. As there is no way of distinguishing a Physician, Nurse Practitioner, Registered Nurse, Registered Practical Nurse, or Physician Assistant who delivers primary care services from those who do not, this indicator may inadvertently capture individuals who are not primary care clients. It is anticipated that since the client was seen at one time by a Physician or Nurse Practitioner that they continue to be primary care clients, however, this may not always be the case. It is projected that the impact of this limitation will be low.
ADDITIONAL COMMENTS		The target panel size will vary depending on the complexity of the client population served, as measured by the SAMI score. New organizations or organizations that are in a period of growth may have changing SAMIs that will therefore impact target panel size. This indicator does not describe the full picture of the clients receiving primary care such as equity, sustainability and quality. Therefore, this indicator has been implemented with additional explanatory indicators.
REFERENCES		Glazier RH, Zagorski BM, Rayner J. *Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10*. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences; 2012. Muldoon L, Dahrouge S, Russell G, Hogg W, Ward N. How many patients should a family doctor have? Factors to consider in answering a deceptively simple question. *Healthcare Policy* 2012 7(4) *Family Health Teams Guide to Physician Compensation:* https://www.rtso.ca/wp-content/uploads/2015/06/MOHLTC-fht_inter_provider-Oct-2013.pdf