

Measuring Up

A yearly report on how Ontario's health system is performing

About Us

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by this single-minded purpose: Better health for all Ontarians.

Who We Are.

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

What We Do.

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voice of patients, caregivers and those who work each day in the health system. As well, we make

recommendations on how to improve care using the best evidence. Finally, we support large scale quality improvements by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

Why It Matters.

We recognize that, as a system, we have much to be proud of, but also that we often fall short of being the best we can be. Truth be told, there are instances where it's hard to evaluate the quality of the care and times when we don't know what the best care looks like. Last but not least, certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better... has no limit.

Health Quality Ontario's Performance Monitoring and Public Reporting

Since 2006, Health Quality Ontario has been creating a better health system by reporting on its performance. Our public reporting not only gives

Ontarians the information they need to understand about their health system, it can also lead to direct improvements. Our public reporting products include: *Measuring Up*, our yearly report on the health system's performance, theme reports that delve into focused topics and online reporting of health system indicators.

The Common Quality Agenda

The Common Quality Agenda is the name for a set of measures or indicators selected by Health Quality Ontario in collaboration with health system partners to focus performance reporting. Health Quality Ontario uses the Common Quality Agenda to focus improvement efforts and to track long-term progress in meeting health system goals to make the health system more transparent and accountable. The indicators promote integrated, patient-centred care and form the foundation of our yearly report, *Measuring Up*. As we grow our public reporting on health system performance, the Common Quality Agenda will evolve and serve as a cornerstone for all of our public reporting products.

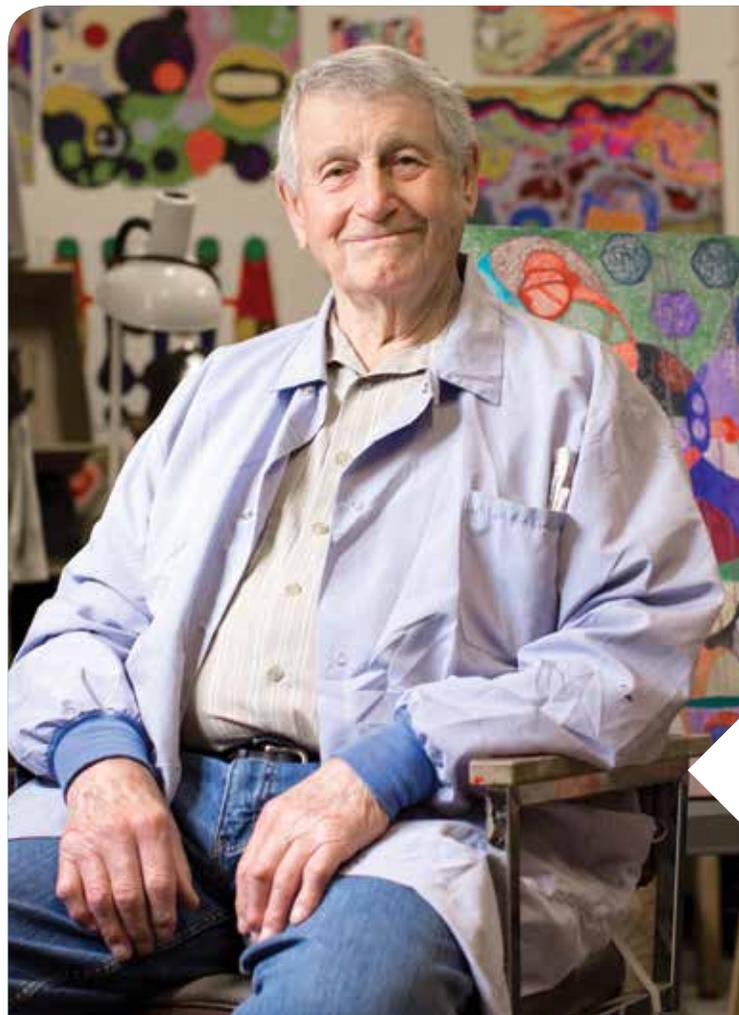
Health Quality Ontario is the operational name for the Ontario Health Quality Council, an agency of the Ministry of Health and Long-Term Care.

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While this is a report about numbers, behind all the data are people who receive health care and people who deliver it. For that perspective, we include stories from patients, family members, caregivers and health care providers who experience the challenges in the province's health system and are often working to improve it.



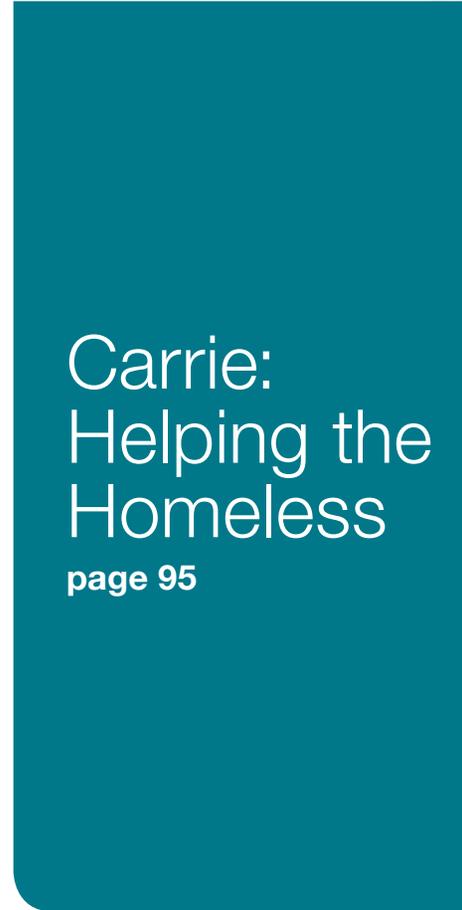
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Message from the Minister of Health and Long-Term Care



I am pleased to offer my congratulations to Health Quality Ontario on the release of the 2015 edition of *Measuring Up*: A yearly report on how Ontario's health system is performing.

The report's findings provide much to be proud of, but also show us where important work remains to be done to improve Ontarians' access to the health system, and to improve health care experiences and outcomes for patients. Indeed, the findings in *Measuring Up* are an example of how transparency in reporting can be a powerful and motivating tool for enhancing performance in our health system.

My plan, *Patients First: Action Plan for Health Care* recognizes that the health system belongs to patients, and aims to transform the health care system to improve access to care, better integrate care in the community, protect its universal availability to all Ontarians and provide people with the information they need to make the right decisions about their health. *Measuring Up* provides us with the data to track progress towards improving the priority areas identified in *Patients First*.

Serving as the province's advisor on quality in Health Care, Health Quality Ontario's objective work, monitoring, evaluating and publicly reporting on health system performance will help guide that transformation. Through reports such as *Measuring Up*, Health Quality Ontario is helping to build a foundation for evidence-based health policy decisions, as well as increasing transparency and accountability for the health system.

While the data in *Measuring Up* are extremely valuable, the report also enriches the numbers with stories from patients about their first-hand

experiences with the health system, showing us what all the figures and graphs mean in real life for patients, families and caregivers. Their stories serve to remind us that putting people and patients first must be the core value driving innovation and improvement in Ontario's health system.

In order to improve the system we need to first identify what is working and what could be better. *Measuring Up* provides both the hard facts and stats, and patient, family and health professional perspectives, providing an objective robust view of where we can all work together to achieve excellent care for all in Ontario.

A handwritten signature in black ink, appearing to read "Eric Hoskins".

Dr. Eric Hoskins
Minister of Health and Long-Term Care
October 2015

Foreword

Welcome to *Measuring Up 2015*, Health Quality Ontario's yearly report on how the health system in Ontario is performing and the health status of Ontarians.

This year's report is our second based on the Common Quality Agenda, a set of more than 40 indicators that Health Quality Ontario uses to measure how the health system is performing. Developed in partnership, these indicators enable us to determine whether the quality of care is changing in Ontario, and how we compare with the rest of Canada and other countries.

Building on last year's report, we have added two new chapters. One examines the system's performance in mental health and addictions, and the other looks at health care spending. In addition, there are new indicators measuring behavioural health risks (e.g., inadequate fruit and vegetable intake) and home care (e.g., informal caregiver distress and low-needs placement in long-term care).

In reviewing this year's data, Health Quality Ontario has looked at what the indicators reveal about the direction of Ontario's health system performance over recent years – whether care has improved,

deteriorated or remained unchanged. While there were some bright spots, many areas showed no change over time. Some of the flat results indicate no progress (e.g., timely access to a primary care provider and regular eye exams for adults with diabetes), while other indicators that are flat may actually reflect good news: for cardiac procedures and cancer surgeries wait times are meeting their targets even with an increase in the number of procedures performed, so steady performance is a good thing.

As Health Quality Ontario continues to expand and enhance its reporting on health system performance, we will keep working to understand the reasons for the good and bad results. To that end, we are now producing theme reports that examine in detail how the system is performing in specific areas of care, and continue to expand our online reporting which presents a broader and deeper array of information.

We also continue to enhance our reporting by providing a human perspective on the issues raised by the performance data we are presenting. *Measuring Up* includes stories from patients, family members, caregivers and health care providers – the people who have encountered first-hand the



Dr. Joshua Tepper



Dr. Andreas Laupacis

challenges of the province's health system and who are often working hard to improve it. Their stories turn the report's numbers and analysis into real experiences that we can all understand and relate to.

Measuring Up is part of Health Quality Ontario's responsibility to monitor health system performance and report to the public about our findings. We also have been entrusted to make recommendations on how to improve care using the best evidence, and to help scale and spread best practices, enabling health care providers to learn from each other and share health quality innovation.

Of course we can't do this work alone. HQO works in partnership with health care professionals, administrators, policy makers, academic experts and patients with their families. We hope *Measuring Up 2015* will help guide all of us forward toward high quality health care for all Ontarians.

Dr. Joshua Tepper
President and CEO

Dr. Andreas Laupacis
Board Chair

Executive Summary

Whether Ontarians are in good health or have health problems, they expect the health system to be there for them when they need it.

As the provincial advisor on the quality of health care, Health Quality Ontario has been entrusted to report to the public each year on the performance of the health system and the health status of Ontarians. The foundation for these yearly reports, entitled “Measuring Up,” is the Common Quality Agenda, a set of key indicators selected in collaboration with our health system partners. We use the Common Quality Agenda to track long-term progress in meeting health system goals, to make the health system more transparent and accountable, and to promote integrated, patient-centred care.

But the data from these indicators are only part of the story. In this report, we also include stories from patients, caregivers and providers that bring the numbers to life. The stories illustrate the experiences of people who rely on and work in Ontario’s health system and are working to improve it.

With more than 40 indicators of how Ontario’s health system is performing, this report highlights some areas where quality of care is improving and some where it has slipped. On many of the indicators, performance has been flat over the last four to 10 years. In some cases, the flat line should be interpreted as a lack of progress. In others, it tells us that the health system is holding steady despite the challenging current of increasing numbers of patients, often with more complex needs.

For many of the indicators, we can compare performance in Ontario to other provinces and countries, across Ontario’s regions, and among groups of people in the province. These comparisons provide important information that helps to identify areas where we are doing well and where we are falling behind.

Some areas of poor performance

In every sector, performance on some indicators is not where we want it to be. For example, although wait times for a place in a long-term care home have decreased considerably for patients applying from home (as opposed to applying from hospital), more

than half of them wait more than three months. In the interim, many of these patients will receive home care services, but how quickly those services start varies widely depending on where the patient lives.

The collective burden on friends and family who help to support a home care patient is mounting: the number of informal caregivers who feel distressed or unable to continue their role has doubled in the most recent four-year period. Meanwhile, for patients moving directly from hospital to long-term care, the median wait time has increased and is now more than two months, although it remains shorter than the time that patients wait to enter long-term care from home.

Drug spending provides another example of poor performance. Compared internationally, Ontario — like Canada overall — spends a lot on drugs and a much larger share is privately rather than publicly funded. Without public coverage for drug costs, some patients may not be able to afford their prescribed medication. Ontario adults under age 65, the age group not covered by a provincial drug plan, are almost three times more likely than those over the

age of 65 to not fill a prescription or skip a dose of their medication due to costs.

Flat results

“Measuring Up” also identifies a number of areas in various parts of the health system where we are not seeing improvement. For example, about half of Ontarians are not able to schedule a timely visit to their primary care provider when they need care or to easily get an after-hours appointment. In addition, almost one-third of Ontario adults with diabetes are not having regular eye exams to prevent diabetes-related blindness, and this rate has been flat for more than five years.

Other indicators that have not improved over the past five years include several that reflect how patients are cared for as they transition from one provider or setting of care to another. For example, only one-third of patients hospitalized for a mental illness or an addiction have a follow-up visit with a doctor within seven days after they leave hospital. For patients who have been hospitalized for heart failure or chronic lung disease, less than half see a doctor within the week after discharge. The percentage of acute care days that hospital patients are designated as alternate level of care (meaning they are waiting to move to another type of care) has stabilized in the last two years but is still high enough to be a concern.

Bright spots

Among the good news in the report, the overall health of Ontarians continues to improve. Rates of smoking and physical inactivity continue to go

down, and Ontario now has one of the lowest rates of smoking in Canada. There has also been a decrease in the percentage of Ontarians who are overdue for colorectal cancer screening, meaning more people in the target age group are being screened for a cancer that can be effectively treated when caught early.

Hospital admissions for chronic conditions that can often be managed outside of hospital (known as ambulatory care sensitive conditions) continue to decrease and are substantially lower than in most other provinces. In addition, Ontario has a relatively low rate of potentially avoidable deaths (deaths from preventable or treatable conditions). Another improvement is the decrease in the use of physical restraints for residents of long-term care homes and for patients hospitalized for a mental illness or an addiction.

Unequal progress

At the same time, some of the good performance we see at the provincial level is not consistent across regions or groups. For example, the rate of potentially avoidable deaths is twice as high in some regions as in others, with particularly high rates in northern Ontario. Rates of hospitalization for ambulatory care sensitive conditions showed similar large regional differences. The use of physical restraints in long-term care homes also varies widely across the province, and smoking rates are much lower among women compared to men and among people with post-secondary degrees compared to people with less than a high school education.

Towards greater improvement

The many flat results reported here require us to take a hard look at why we’re not seeing improvement. Is it that improving care in these areas is just very difficult to achieve? Are we monitoring the wrong things? Are there pockets of good work underway in the province but we’re not doing a good job of spreading that improvement? Is it because some groups of Ontarians do not have the same access to health services as others do? Or does the increasing frailty or complexity of the patients involved mean that, in some cases, stable results actually indicate that the system is improving? As we continue to monitor performance, we will keep working with health system stakeholders to understand what is driving the good, the bad, and the flat results, and to ensure we are monitoring what matters.

Monitoring and reporting on the performance of the health system helps to identify where best to focus these efforts. Keeping an eye on how the system is measuring up is also an integral part of the process of quality improvement. We seek to understand how well the health system is meeting Ontarians’ needs, whether they are healthier as a result, and whether the system is sustainable for future generations. For the past three years, Ontario has held the line on per capita spending on health care. In an environment of cost constraint, a critical challenge is to ensure that quality of care is not compromised and continues to improve. Work is underway across the province to address these and other challenges identified in this report.



Why this report

Ontario has a large, complex health system with many moving parts. To guide our monitoring of health system performance in this province, Health Quality Ontario worked with key stakeholders to develop a set of more than 40 indicators called the Common Quality Agenda, which form the basis for this report. The indicators were chosen to tell us about the quality of care across our health system. They include indicators of system integration that highlight how well the various parts of the system are working together, along with other indicators that look at elements supporting the health system as a whole (such as the health workforce, health care spending and public health).

As we reviewed the data for this year's report, we kept several key questions in mind: What has improved in recent years? What needs improving? Where has there been no change? In comparing regions and groups of people within Ontario, and Ontario to other provinces and countries, do we see big differences that might signal opportunities to improve, or areas of excellence?

Figure 1.1 outlines the indicators that make up the Common Quality Agenda, the foundation of this report. A technical appendix to this report with details on the methodology and indicators is available on Health Quality Ontario's website.

Real-world experiences

While this is a report about numbers, behind all the data are people who receive health care and people who deliver it. For that perspective, we include stories from patients, caregivers and health care providers who experience the day-to-day challenges in the province's health system and in some cases are working to improve it.

What's new this year

As in the first edition of *Measuring Up*, we start with a chapter on the health of Ontarians. We have provided updates on a number of vital signs on the health of the province's population and have added indicators that measure behavioural health risks (smoking, physical inactivity, diet and obesity). We do not report on immunization indicators this year, due to changes in the data

collection system, but we will return to reporting on this very important aspect of public health in future reports.

This is followed by a look at indicators designed to tell us about system integration, emphasizing some of the ways that the health system's many parts need to work together to deliver high-quality care. We have also added two new chapters. One measures performance in mental health and addictions, an area of care that often crosses multiple health settings such as hospital care and primary care. The other new chapter looks at health care spending, providing a foundation for understanding whether the money is being spent efficiently and effectively. Other chapters include updates on the number of nurses and doctors working in Ontario and updates organized by sector of the health system — primary care, home care, hospital care, long-term care — including some new home care performance indicators.

Also new this year, we look more closely at three indicators (suicide rates, smoking rates, and rates

FIGURE 1.1
Common Quality Agenda

Health of Ontarians*

Smoking

Physical inactivity

Obesity

Inadequate fruit and vegetable intake

Life expectancy at birth

Infant mortality

Self-reported health status

Potentially avoidable deaths

System Integration

Doctor visit within seven days of hospital discharge

30-day readmission rates for medical and surgical patients

Hospitalizations for ambulatory care sensitive conditions

Percentage of acute care hospital days spent as alternate level of care

Primary Care

Having a primary care provider

Timely access to primary care

Accessing after-hours primary care

Patients' involvement in decisions regarding their care

Colorectal cancer screening

Diabetes eye exams

Mental Health

Hospital admissions for a mental illness or an addiction

Doctor visit within seven days of hospital discharge for mental illness or an addiction

Readmission rates for a mental illness or an addiction

Use of physical restraints in acute mental health care

Suicide rates

Home Care

Patient experience

Waiting for some home care services

Placement in long-term care homes

Informal caregiver distress

Hospital Care

Patient experience

Emergency department's length of stay

Hip or knee replacements completed within target wait time (Wait times for procedures)

Cardiac procedures completed within target time frame (Wait times for procedures)

Cancer surgery wait times (Wait times for procedures)

Clostridium difficile infections acquired in hospital

Caesarean section deliveries

Long-Term Care

Waiting for a bed in a long-term care home

Use of daily physical restraints in long-term care homes

Falls in long-term care homes

New or worsening pressure ulcers

Health Workforce

Nurses

Family doctors and specialists

Lost time injury rates

Health Spending

Total health expenditure per capita

Health expenditure per capita on drugs

Prescription or dose of medicine skipped due to cost

*Immunization on indicators are not presented in this year's edition of *Measuring Up*, due to changes in the data collection on system, but will be included in future editions.

for periodic eye exams recommended for people with diabetes) by breaking down the Ontario results by population characteristics such as age, sex, income, education, and rural or urban residence. This type of comparison helps to show important differences between groups in the province and can tell us how well the health system is serving each of these groups.

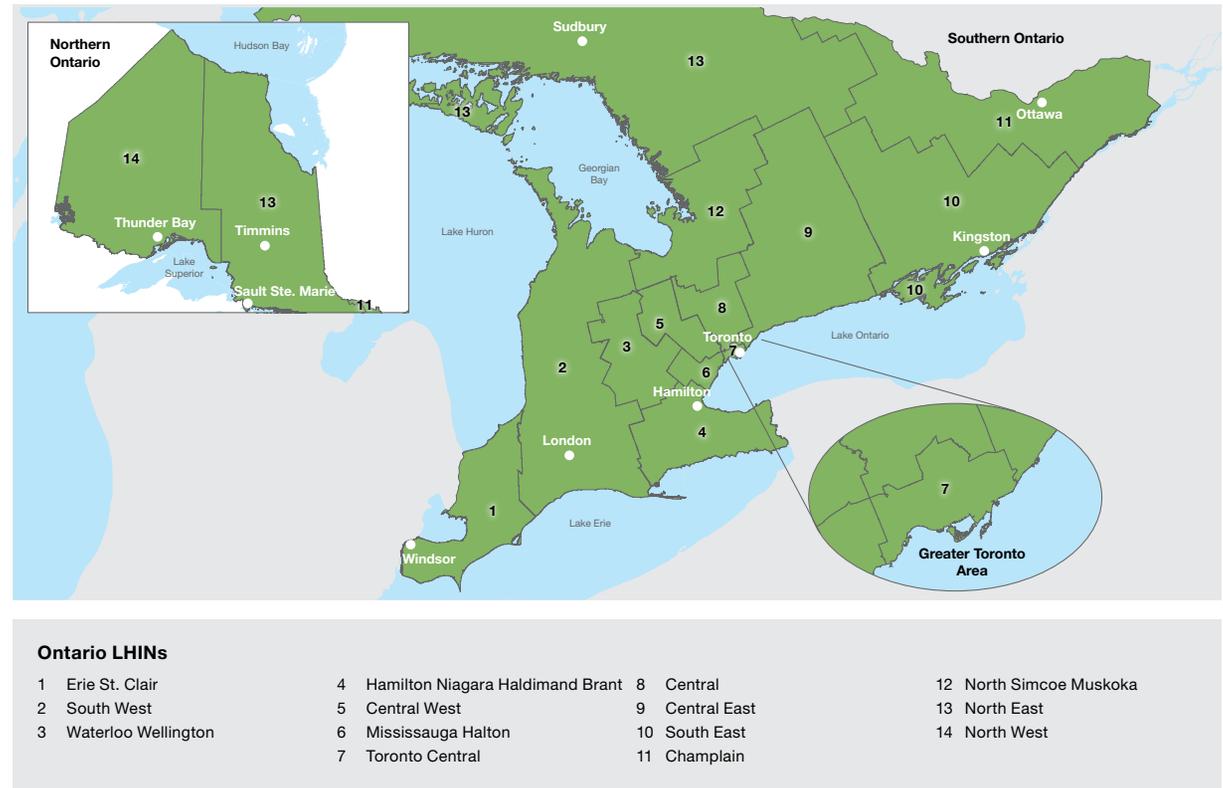
How we measure performance

To create this yearly report, we partnered with many organizations that maintain data on different parts of Ontario’s health system. We seek the most recent data available and, whenever possible, data that allow us to compare health system performance over a number of years. In addition, for some indicators we report regional comparisons in Ontario using data for the geographical areas of each of Ontario’s 14 Local Health Integration Networks (LHINs) (Figure 1.2). Each LHIN is responsible for planning, integrating and funding health care within its area. The LHINs are themselves funded by the Ministry of Health and Long-Term Care.[1]

For a broader view on how Ontario’s health system performs, we compare Ontario with other provinces in Canada, with Canada overall and with other countries. We do not report data for the Canadian territories because the numbers are often too small to make valid comparisons.

For international comparisons, we compare Ontario’s performance with other developed countries. Some comparisons are possible through our ongoing collaboration with the

FIGURE 1.2
Map of Local Health Integration Networks in Ontario



Commonwealth Fund to expand Ontario’s participation in their annual international health policy surveys. These surveys are conducted in Canada, Australia, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. For other indicators, we use data collected

by the Organisation for Economic Co-operation and Development for the same 11 countries. Because these countries have many economic and demographic similarities with Canada, they are generally considered to be a good basis for comparing how our health systems perform.

Health of Ontarians



In this chapter, we report on eight Common Quality Agenda indicators related to the health of Ontarians: the rates of smoking, physical inactivity, obesity, inadequate fruit and vegetable intake, life expectancy, infant mortality, self-reported health status and potentially avoidable death.

Healthy living

A healthy population is the ultimate goal of a high-quality health system.

Health is not just about doctors, nurses, tests and procedures; it is also about preventing disease and promoting well-being. It is about how well and how long people are living. Healthy living is associated with longer life expectancy and reduces the burden on the health system by reducing people's risk of developing a number of chronic health conditions such as diabetes and heart disease.[2]

Key findings

18.1% of Ontarians smoke, the second lowest rate in Canada after British Columbia (16.9%) and lower than the Canadian average (19.6%)

Ontarians without a high school diploma are more than twice as likely to smoke (34.9%) as those with post-secondary education (15.5%)

Life expectancy is five years shorter in one LHIN region (78.6 years) compared to the regions with the longest average lifespans (83.6 years)

Healthy living is associated with longer life expectancy and reduces the burden on the health system.

Indicators of behavioural health risk

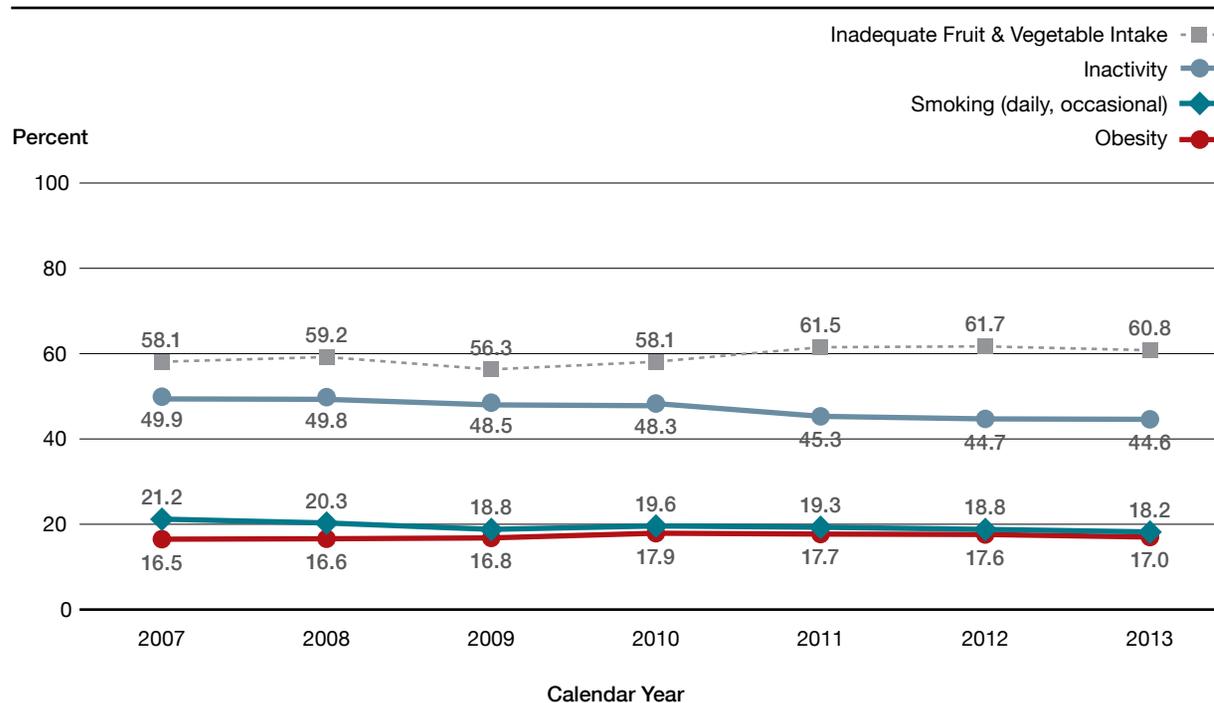
Rates of cigarette smoking vary by sex, income, education, age group and area of residence

Smoking, poor diet, physical inactivity and obesity are risk factors associated with a number of preventable chronic diseases such as cancer, heart disease and stroke. Unhealthy behaviours are risks that, ideally, people can change. But these behaviours are also subject to influences beyond individual control. For example, socioeconomic factors can affect someone's ability to adopt healthier habits: a healthy diet depends on the availability of affordable, nutritious food.

Between 2007 and 2013, Ontarians had mixed results for four important behavioural health risks (Figure 2.1).

FIGURE 2.1

Percentage[†] of the population aged 12 and older who report smoking cigarettes daily/occasionally, being physically inactive, and having inadequate fruit and vegetable intake, and percentage[†] of the population aged 18 and older who report being obese, in Ontario, 2007 to 2013



Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Sciences. [†]Age-adjusted.

Physical inactivity, defined as doing the equivalent of less than half an hour of walking per day, is linked to a range of chronic health problems, including heart disease, cancer and diabetes.[4,5] In 2013, 44.6% of Ontarians aged 12 and over reported being physically inactive, an improvement from 49.9% in 2007 (Figure 2.1).

People who are obese are at a higher risk of developing heart disease, stroke, high blood pressure, diabetes and arthritis.[6] In 2013, 17.0% of Ontarians were reported to be obese, similar to 16.5% in 2007 (Figure 2.1).

Not eating enough fresh fruits and vegetables, which can be a rich source of nutrients, has been linked to poorer overall health and a greater chance of early death.[7] In 2013, 60.8% of Ontarians reported having inadequate fruit and vegetable consumption, slightly worse than the 58.1% reported in 2007 (Figure 2.1).

Smoking is responsible for half a million days that Ontarians spend in hospital every year.[3] In 2013, 18.2% of Ontarians aged 12 and older reported they were daily or occasional cigarette smokers, a slight decrease from 21.2% in 2007 (Figure 2.1). For a more detailed breakdown of smoking in Ontario, see the sidebar in this chapter, “Focus on variations in cigarette smoking.”

How Ontario compares: within Canada

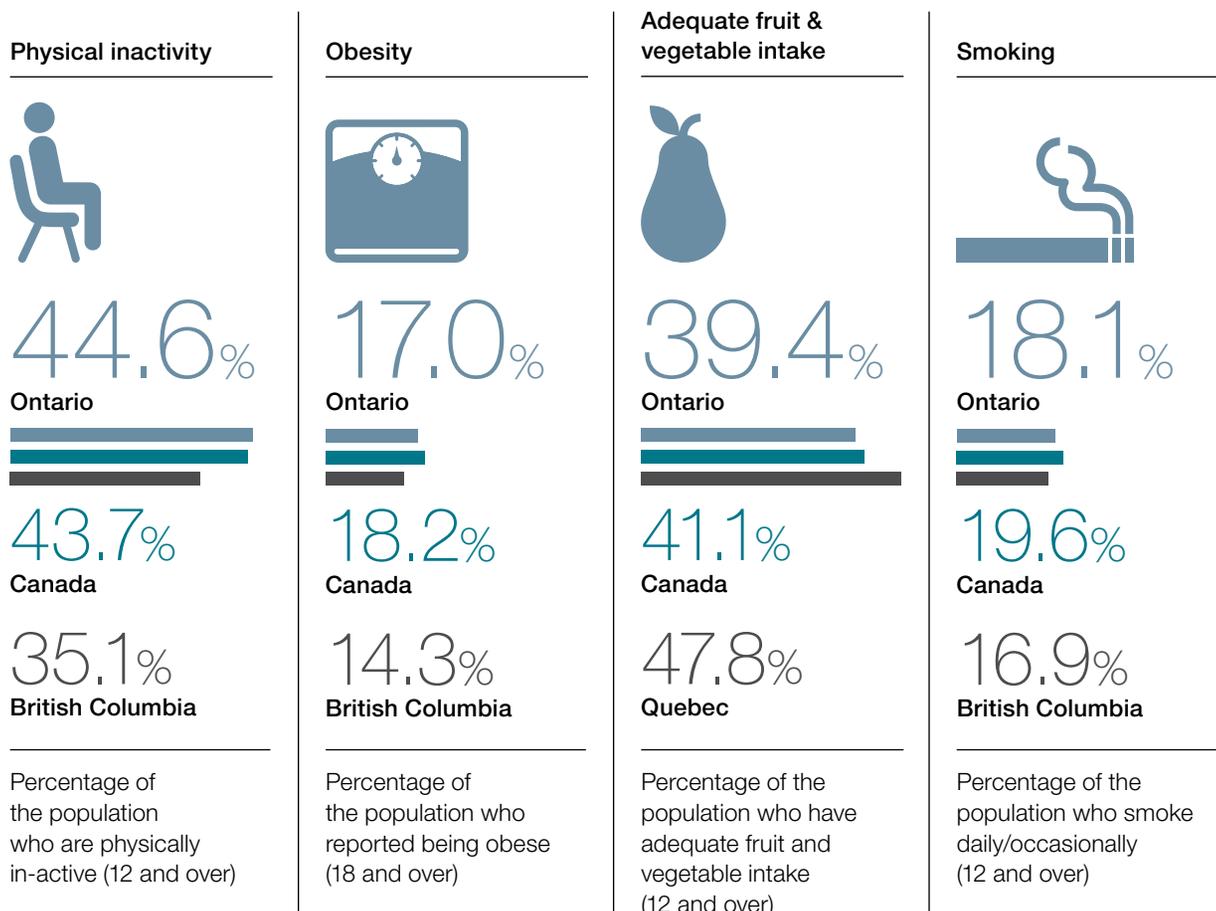
The rate of physical inactivity varies across Canada. Ontario’s rate of 44.6% in 2013 was worse (higher) than in British Columbia which, at 35.1%, had the lowest rate of physical inactivity in Canada (Figure 2.2).

The rate of obesity in Ontario (17%) was among the best in Canada in 2013, but worse (higher) than the best-performing province, British Columbia (14.3%) (Figure 2.2).

To compare eating habits in Ontario with other provinces, we look at adequate (rather than inadequate) fruit and vegetable consumption because the data are provided this way at the national level. In Ontario in 2013, 39.4% of people reported adequate fruit and vegetable consumption, similar to the national rate of 41.1%. The best (highest) rate is found in Quebec (47.8%) (Figure 2.2).

The smoking rates in Ontario (18.1%) and British Columbia (16.9%) were the lowest in Canada in 2013, both better (lower) than the Canadian average of 19.6% (Figure 2.2).

FIGURE 2.2
Percentage[†] of the population aged 12 and older who report being physically inactive, having adequate fruit and vegetable intake, and smoking cigarette daily/occasionally, and percentage[†] of the population aged 18 and older who report being obese, in Canada, 2013



Focus on variations in cigarette smoking

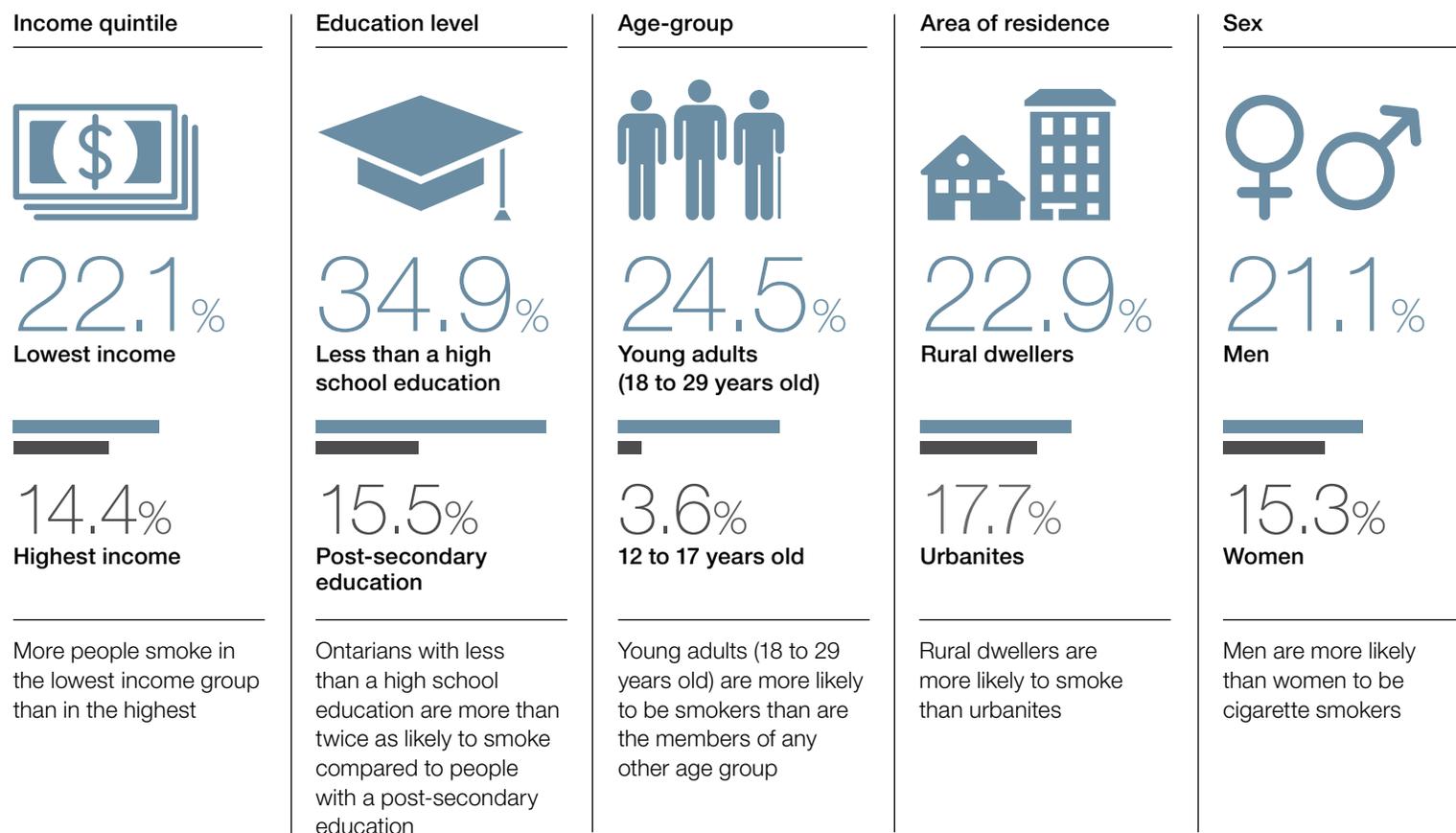
We take a closer look at smoking rates to examine differences by socioeconomic and demographic characteristics such as income, education, age and sex.

Men are more likely than women to be cigarette smokers. In Ontario, 21.1% of men smoked cigarettes in 2013, compared to 15.3% of women (Figure 2.3). Smoking prevalence also varies by income, education, age group and residence in an urban or rural area. More people smoke in the lowest income group (22.1%) than in the highest (14.4%). Ontarians with less than a high school education are more than twice as likely to smoke (34.9%) compared to people with a post-secondary education (15.5%). Young adults (18 to 29 years old) are more likely to be smokers (24.5%) than are the members of any other age group, and rural dwellers are more likely to smoke than urbanites (22.9% versus 17.7%).

Data source: Canadian Community Health Survey, 2013, provided by Statistics Canada. Table 105-0503 - Health indicator profile, age-standardized rate, annual estimates, by sex, Canada, provinces and territories, occasional, CANSIM (database). [†]Age-adjusted. ^{*}The Ontario rates reported in Figure 2.1 and Figure 2.2 are different because different methods were used for these calculations. See the technical appendix on HQO's website for details.

FIGURE 2.3

Percentage[†] of the population aged 12 and older who report smoking cigarettes daily/occasionally, in Ontario, 2013



Data source: Canadian Community Health Survey, 2013, provided by the Institute for Clinical Evaluative Sciences. [†]The rates are age-adjusted.

How Ontario compares: within Canada and with other countries

Life expectancy at birth is similar across Canada and in other developed countries. In 2011, life expectancy among selected countries in the Organisation for Economic Co-operation and Development ranged from 80.8 years in Germany to 82.8 years in Switzerland, with the exception of the United States where estimated life expectancy was 78.7 years. Life expectancy for Canada was in the middle, at 81.5 years.[10]

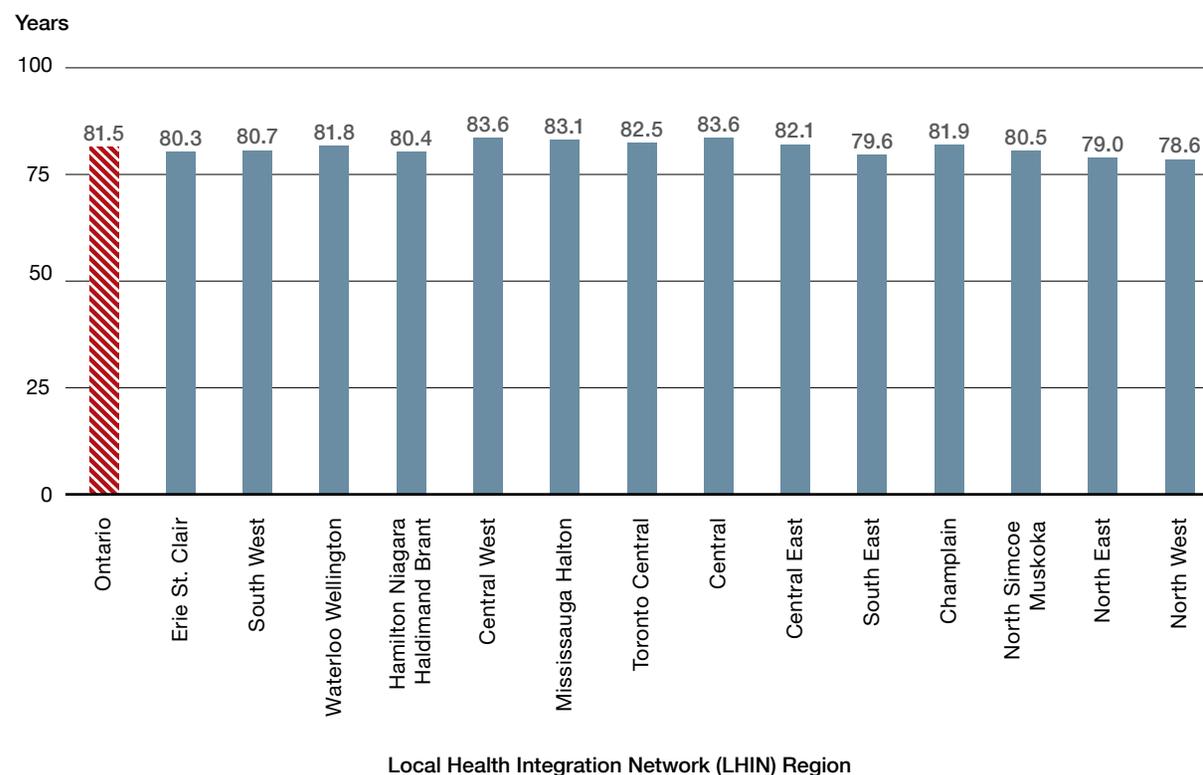
Life expectancy at birth

Life expectancy at birth in Ontario has risen to more than 81 years

Babies born today in Ontario live longer, on average, than those born 10 or 20 years ago. Life expectancy at birth in Ontario rose to 81.5 years in 2007/2009 (the most recent data available) from 80.5 years in 2003/2005.[8,9]

Across Ontario, life expectancy varies by LHIN region, ranging from 78.6 years in the North West LHIN region to 83.6 years in the Central LHIN and Central West LHIN regions (Figure 2.4).

FIGURE 2.4
Life expectancy at birth, in Ontario, by LHIN region, 2007/2009



Data source: Statistics Canada. Table 102-4307. Life expectancy, at birth and at age 65, by sex, three-year average, Canada, provinces, territories, health regions and peer groups, occasional, CANSIM (database).

FIGURE 2.5

Infant mortality rate, in Ontario and internationally, 2011

Infant mortality rate per 1,000 live births



Ontario's infant mortality rate is midway among the other provinces, where rates ranged between 3.5 and 7.7 infant deaths per 1,000 live births

4.6

Ontario

6.1

United States

2.1

Sweden

Infant mortality

Ontario's infant mortality rate decreased between 2007 and 2011

The rate of deaths among infants has declined substantially in most developed countries over the past several decades. Canada and Ontario are part of this trend as rates continue to improve. Infant mortality (deaths to babies under one year of age) is often used as an indicator of the health of a population because it reflects both the general health of the population as well as the quality of health care.[11]

The infant mortality rate in Ontario has declined from 5.2 per 1,000 live births in 2007 to 4.6 per 1,000 live births in 2011.[12]

How Ontario compares: within Canada and with other countries

Ontario's infant mortality rate (4.6 per 1,000 live births in 2011) is midway among the other provinces, where rates ranged between 3.5 and 7.7 infant deaths per 1,000 live births.[13]

Compared with selected countries in the Organisation for Economic Co-operation and Development, Canada and Ontario have among the highest rates of infant mortality. Ontario is lower than the United States at 6.1 per 1,000 and higher than Sweden, the lowest of the selected countries, at 2.1 per 1,000 (Figure 2.5).

*6.1 estimated. Data source: OECD Health Statistics, Organization for Economic Co-Operation and Development.

Self-reported health status

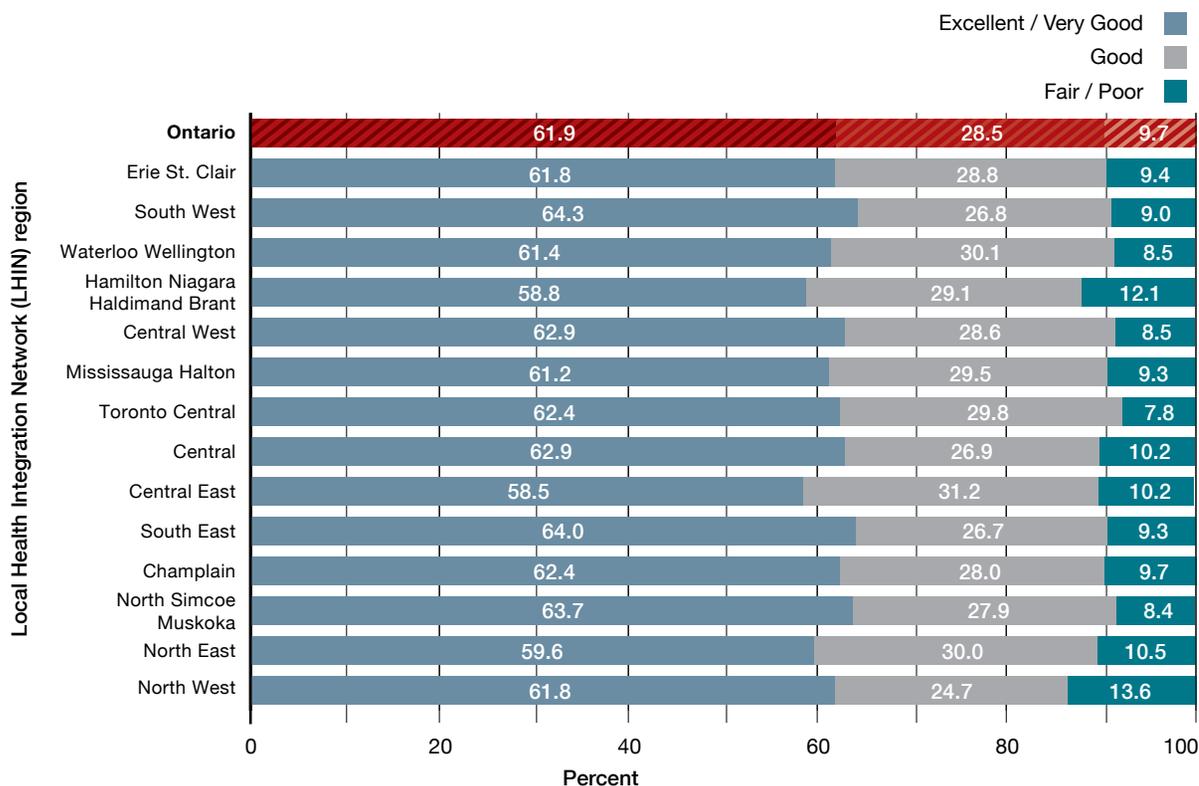
Nearly two-thirds of Ontarians rate their health as excellent or very good

The Canadian Community Health Survey asks respondents to rate their general state of health using one of three categories: excellent/very good, good or fair/poor. This self-reported indicator is useful in understanding a population's perceived health status and can help predict rates of future disability and premature death.[14,15]

In 2013, 61.9% of Ontario respondents said their health was excellent or very good (Figure 2.6), a level that has remained stable over the last six years.[16]

Self-reported health varies across Ontario. A high of 64.3% of respondents in the South West LHIN region reported their health as excellent or very good in 2013, compared to a low of 58.5% in the Central East LHIN region (Figure 2.6).

FIGURE 2.6
Self-reported health status for population aged 12 and older,[†] in Ontario, by LHIN region, 2013



Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Science. [†]Age-adjusted. *The rates reported for Ontario in Figures 2.6 and 2.7 are slightly different because different surveys were used for the provincial and international comparisons.

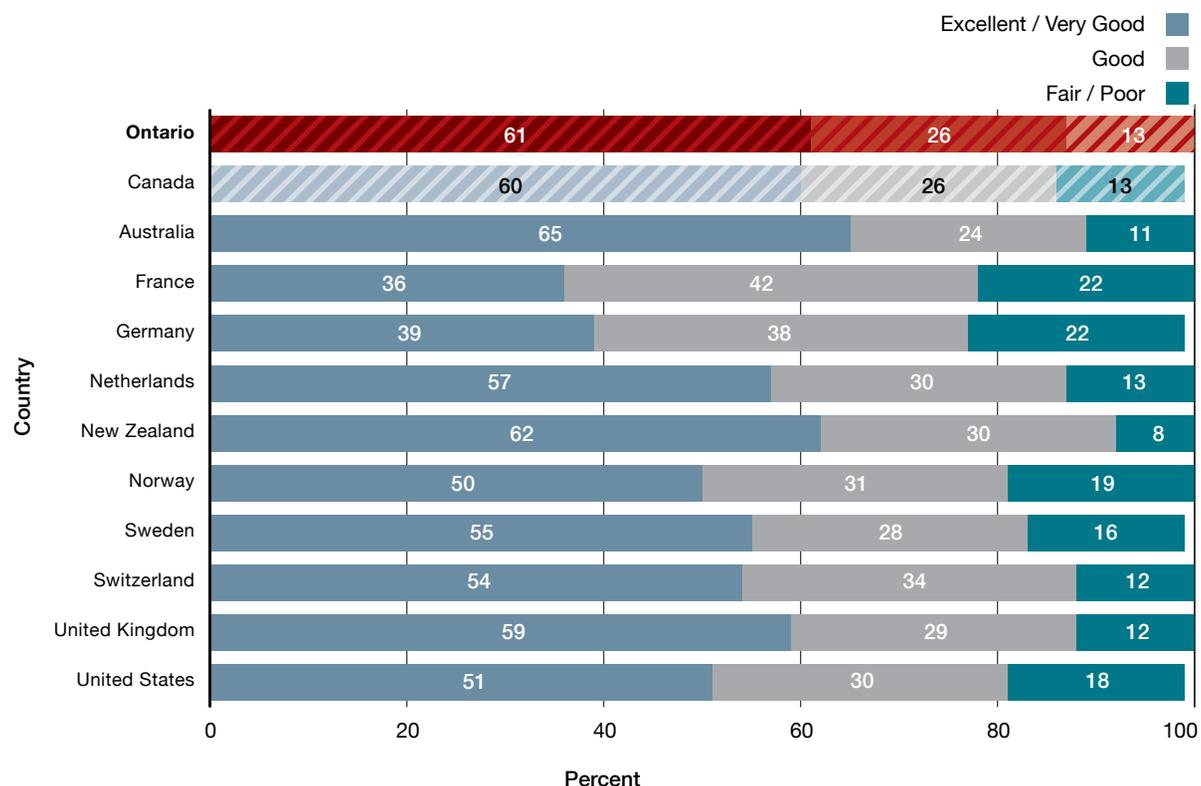
How Ontario compares: within Canada and around the world

The proportion of Ontarian survey respondents who report their health as excellent or very good is similar to the Canadian average and to respondents in other provinces.[17]

Based on the 2013 Commonwealth Fund International Health Policy Survey, Ontarians and Canadians rank high among respondents in 11 countries in reporting their health as excellent or very good. These percentages are similar to New Zealand (62%) and the United Kingdom (59%) (Figure 2.7). Australians report the highest rate of excellent or very good health status among the countries surveyed (65%).

FIGURE 2.7

Self-reported health status, in Ontario, Canada and internationally, by province or country, 2013



Data source: Commonwealth Fund International Health Policy Survey, 2013. *The rates reported for Ontario in Figures 2.6 and 2.7 are slightly different because different surveys were used for the provincial and international comparisons.

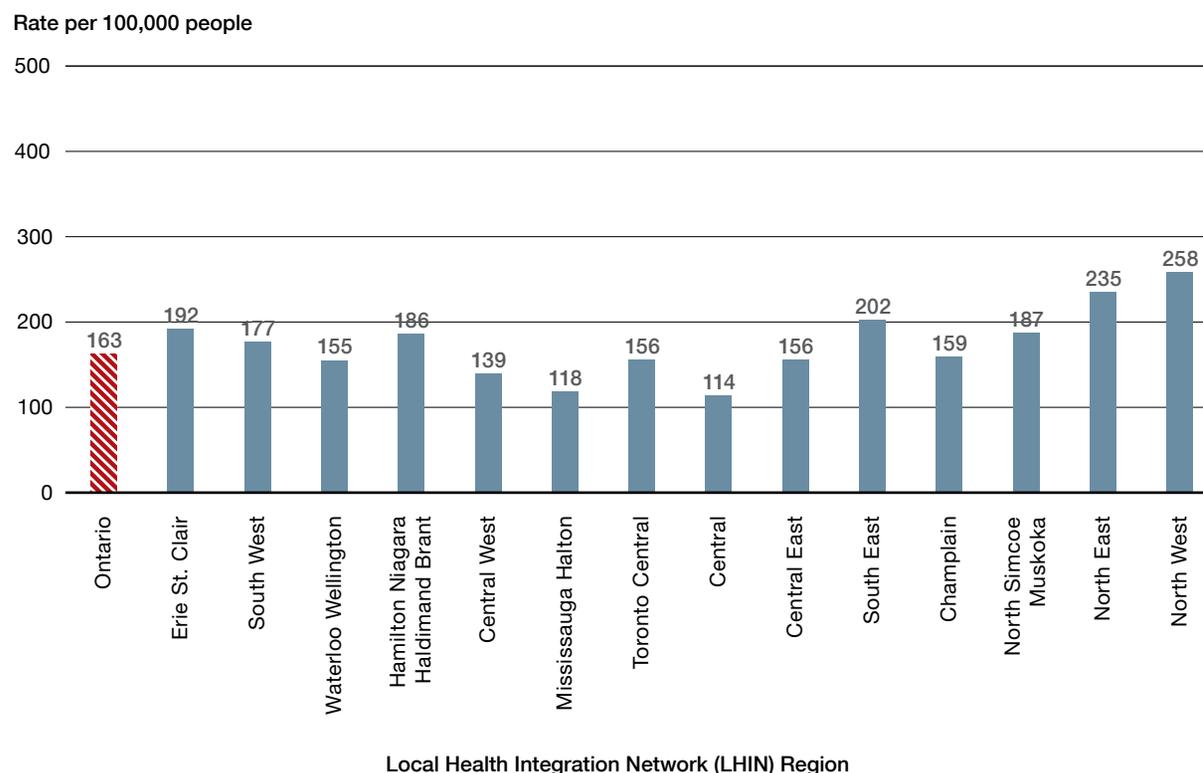
Potentially avoidable deaths

Potentially avoidable deaths are up to twice as high in some LHIN regions than in others

This indicator includes the number of deaths per 100,000 people under age 75 that could potentially have been avoided with proper preventive interventions and medical treatment. The indicator includes deaths from preventable or treatable conditions such as heart attack, as well as from diseases that can be prevented through public health interventions that promote healthy behaviours or vaccinations. Rates of premature or avoidable death signal possible shortcomings in the health care system.[18]

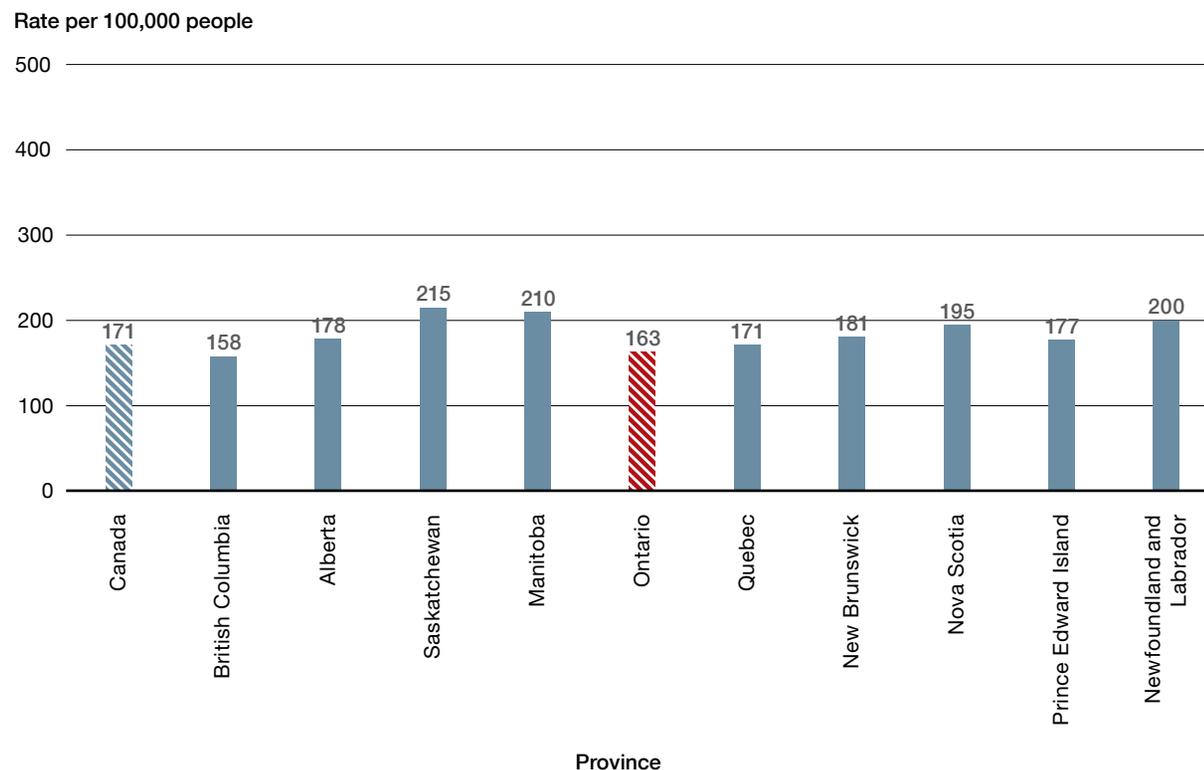
Rates of potentially avoidable death varied widely across Ontario, from a low of 114 per 100,000 people in the Central LHIN region to a high of 258 per 100,000 people in the North West LHIN region (three-year average, 2009–2011) (Figure 2.8).

FIGURE 2.8
Rate of potentially avoidable death,[†] in Ontario, by LHIN region, 2009/2011



Data source: Statistics Canada. Table 102-4311. Premature and potentially avoidable mortality, three-year average, Canada, provinces, territories, health regions and peer groups, occasional. CANSIM (database). [†]Age-adjusted.

FIGURE 2.9
Rate of potentially avoidable death,[†] in Canada, by province, 2009/2011



Data source: Statistics Canada. Table 102-4311. Premature and potentially avoidable mortality, three-year average, Canada, provinces, territories, health regions and peer groups, occasional. CANSIM (database). [†]Age-adjusted.

How Ontario compares: within Canada

Ontario's rate of potentially avoidable death is 163 per 100,000 people (three-year average, 2009–2011), lower than the Canadian rate of 171 per 100,000 people. British Columbia has the lowest rate in Canada at 158 deaths per 100,000 people (Figure 2.9).

In summary

By some measures, the health of Ontarians is good and getting better, although the overall picture is mixed. Nearly two-thirds of Ontarians say their health is excellent or very good, a rate that has held steady over the past six years and is relatively high compared with 10 other countries. Rates of smoking and physical inactivity in this province have declined modestly over this period. But they are still high enough to be a concern, and big differences in smoking rates by income and education point to opportunities to target prevention initiatives for groups most at risk. Ontario rates of obesity and poor diet have not improved.

Life expectancy in this province is at an all-time high, and the number of potentially avoidable deaths — deaths to people under age 75 from preventable and treatable conditions — is among the lowest in Canada. However, these rates vary considerably across Ontario's regions, telling us that the improvements in health have not reached all parts of the province to the same degree.

System Integration

A healthcare professional in blue scrubs is holding a tablet and a pen. Another person's hands are visible in the foreground, possibly typing on a keyboard. The background is a blurred clinical setting.

In this chapter, we report on four Common Quality Agenda indicators that provide information about how well the various parts of the health system are working together: follow-up after a hospital stay, readmissions to hospital, hospitalizations that might not be necessary and use of hospital beds by patients who could be treated elsewhere.

Real-World Experiences

Discharged

Everything had gone smoothly with Charlie's [not his real name] coronary artery bypass surgery at a hospital in eastern Ontario. He was recovering well and the hospital care team was ready to send him home the next day. That's when John Lott, the hospital's director of patient safety, got an email from Charlie's daughter, saying that her father is homeless. The daughter went on to say that she and her sister live far away, and she wanted to know if there was anywhere else her father could go after leaving the hospital so he wouldn't end up back on the street.

The daughter's email implied that the hospital had a responsibility to help transfer her father to another institution, Lott says. Despite the fact that the hospital had provided excellent care by performing the surgery within a relatively short wait time, Lott recognized that Charlie could end up being readmitted to hospital because of a lack of follow-up care.

"The system still isn't working for this guy," Lott says about Charlie. "We can discharge him from the hospital and he might go back to his tough life. We can look at his treatment and say we're awesome, he's walking out and we're done. But we're not done."

The hospital does the best it can to measure and improve quality of care, Lott says, maintaining about 500 or 600 different measures and closely following up on 27 measures that form the basis of a scorecard. But the hospital has only so much control over some of the measures. There is a measure for readmissions to hospital within 30 days of leaving, but it goes beyond the hospital, Lott says, and that is how people like Charlie can fall through the cracks.

"Here's this guy who for all intents and purposes we fixed in the hospital," Lott says. "It highlights the challenges to the system. We can't hold that bag as a hospital. The community needs to get involved — and even they have their challenges. Care doesn't stop when someone leaves the hospital."

"Here's this guy who for all intents and purposes we fixed in the hospital ... [But] care doesn't stop when someone leaves the hospital."

Moving from many parts to one system

For a health system to work well for patients, it is not enough that each part of the system works well independently but also that all the parts work well together. Many people have needs that cross different settings and involve various care providers. Indicators of health system integration can tell us where the bridges between various parts of the system are solid and where there may be gaps. It is in these gaps that patients' health and the quality of their care can suffer.

On the surface, some of the indicators we report in this chapter appear to measure only hospital care, but they reflect the collective effort of many players. For example, readmissions to hospital within 30 days of a previous hospitalization is an indicator that is measured in the hospital. While it may simply reflect a worsening of the patient's condition, unrelated to the quality of care, it also speaks to what happens in the community after the patient is discharged. Performance on this indicator reflects the support the patient receives in the community from primary care providers, home care or long-term care.

Key findings

Rates of hospitalization for ambulatory care sensitive conditions continue to improve

Less than half of patients hospitalized for two common chronic conditions see a doctor for follow-up within a week of leaving the hospital

About one in seven acute care hospital beds is used by a patient considered to be ready to receive care outside the hospital

Many people have needs that cross different parts of the health system. Measuring system integration can tell us where they may be gaps.

Doctor visit within seven days of leaving hospital

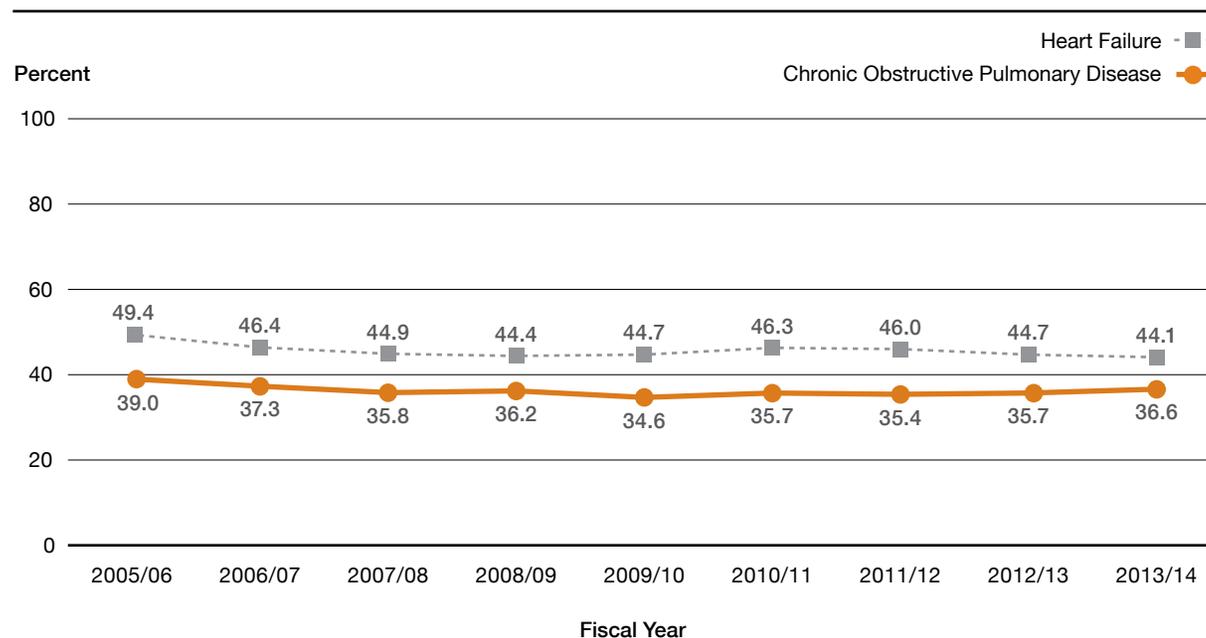
Less than half of patients hospitalized for heart failure or chronic obstructive pulmonary disease see a doctor for follow-up within seven days of leaving the hospital

For patients with chronic conditions, care after leaving the hospital is very important. A follow-up visit with a doctor shortly after leaving the hospital gives the patient an opportunity to ask questions and discuss any problems, and it allows the doctor to see whether their patient is progressing as expected. Here we provide information about follow-up visits to either a family doctor or a specialist doctor for patients hospitalized for heart failure and chronic obstructive pulmonary disease, two conditions that account for many hospital stays and readmissions. [19,20]

Despite the importance of early follow-up, less than half of the patients in Ontario discharged from hospital after treatment for heart failure or chronic obstructive pulmonary disease see a doctor within seven days (Figure 3.1). The rates have declined slightly over an eight-year period: for patients with heart failure, rates decreased from 49.4% in 2005/06 to 44.1% in 2013/14, and for patients with chronic obstructive pulmonary disease, the rates went from 39.0% to 36.6% over the same period.

FIGURE 3.1

Rate of follow-up with a doctor within seven days of leaving hospital for heart failure or chronic obstructive pulmonary disease,[†] in Ontario, 2005/06 to 2013/14

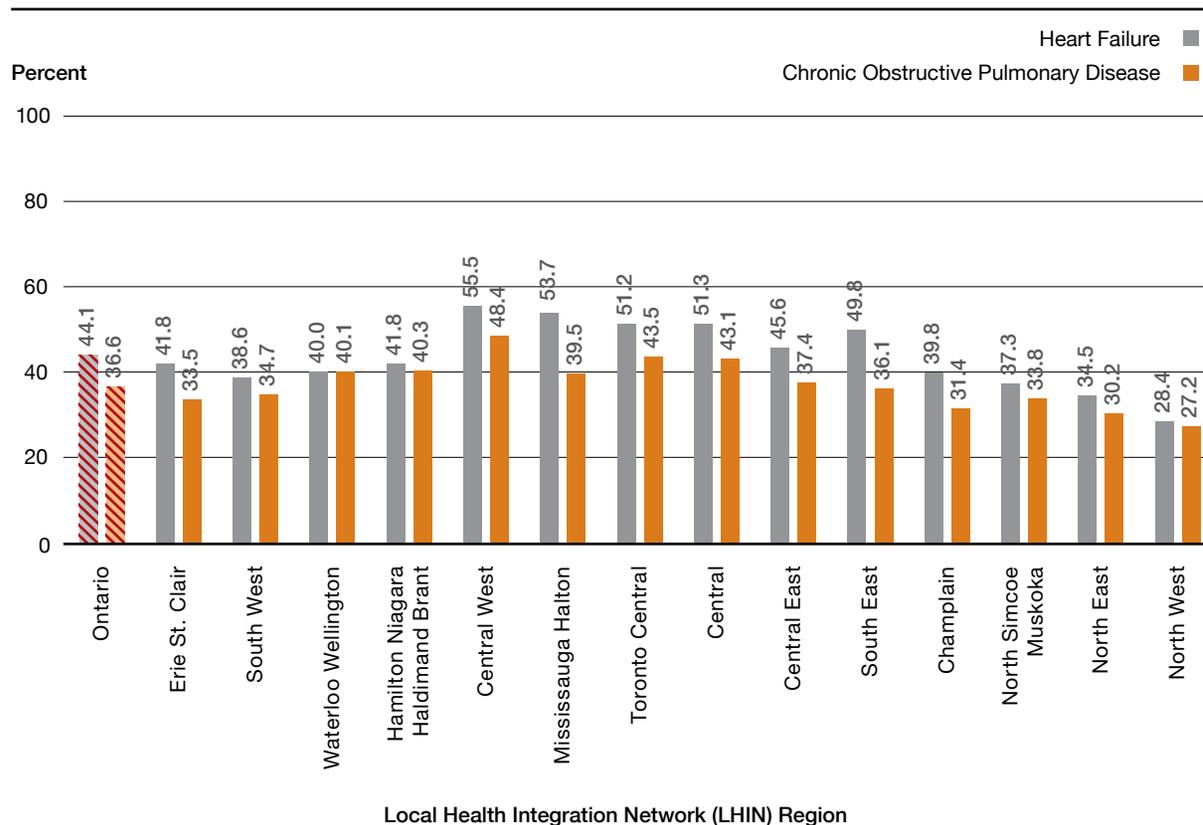


Data sources: Discharge Abstract Database, Ontario Health Insurance Plan Claims History Database, Institute for Clinical Evaluative Sciences Physician Database provided by the Institute for Clinical Evaluative Sciences. [†]Age- and sex-adjusted. Note: The rates we report are based on physician billing data and may not capture follow-up visits at nurse practitioner-led clinics or community health centres. Therefore, these results may underestimate the actual rate of follow-up visits within seven days of leaving hospital.

For both of these conditions, the percentage of patients who had a physician visit within seven days of leaving hospital in 2013/14 varied by LHIN region. For patients with heart failure, the rate of follow-up in the North East and North West LHIN regions are significantly lower and the rate in the Central West LHIN region is significantly higher compared with the provincial average (Figure 3.2).

For patients who left hospital after treatment for chronic obstructive pulmonary disease, the Champlain, North East and North West LHIN regions have rates of follow-up visits to a doctor within seven days that are significantly below the provincial average in 2013/14. The Central West and Toronto Central LHIN regions have rates significantly higher than the provincial average (Figure 3.2).

FIGURE 3.2
Rate of follow-up with a doctor within seven days of leaving hospital, for heart failure or chronic obstructive pulmonary disease,[†] in Ontario, by LHIN region, 2013/14



Data sources: Discharge Abstract Database, Ontario Health Insurance Plan Claims History Database, Institute for Clinical Evaluative Sciences, Physician Database provided by the Institute for Clinical Evaluative Sciences. [†]Age- and sex-adjusted. Note: The rates we report are based on physician billing data and may not capture follow-up visits at nurse practitioner-led clinics or community health centres. Therefore, these results may underestimate the actual rate of follow-up visits within seven days of leaving hospital.

Hospital readmission rates within 30 days of leaving hospital for medical and surgical patients

The percentage of medical and surgical patients who return to hospital within 30 days has changed little in the last four years

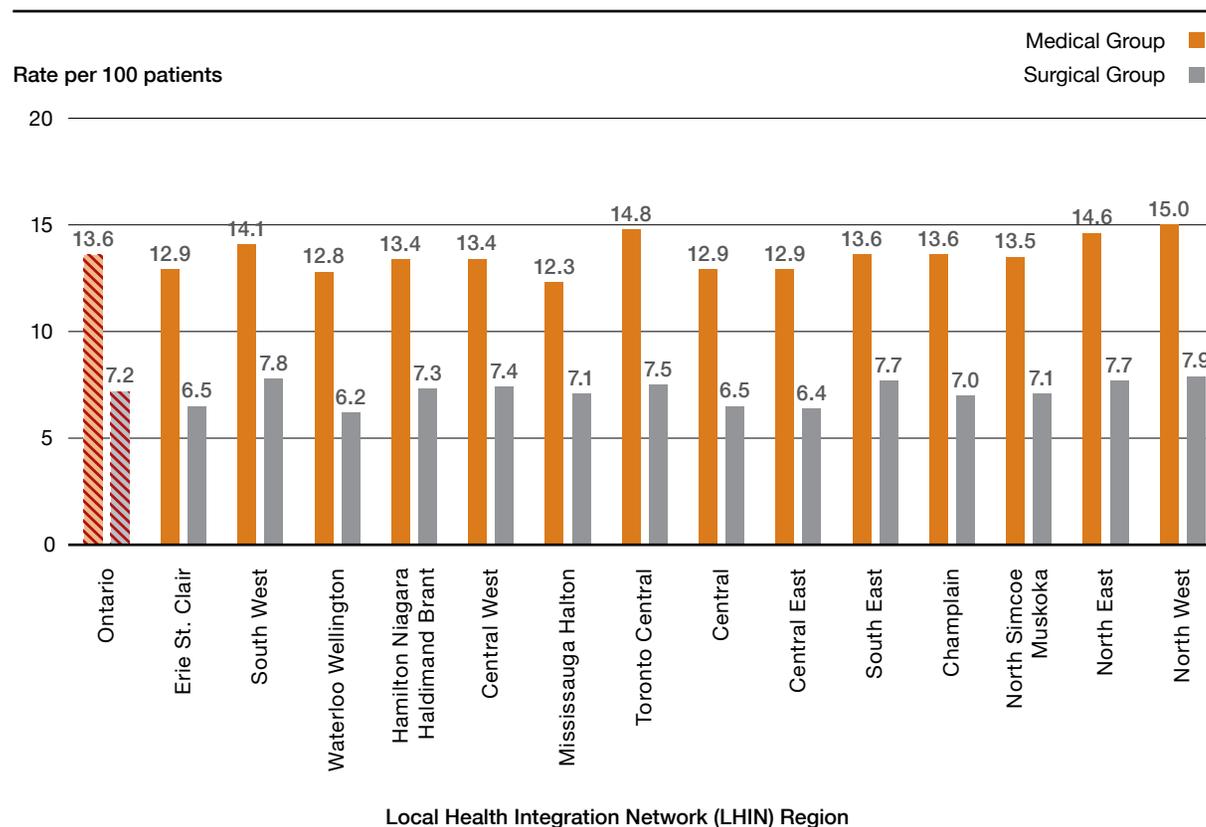
Sometimes patients need to be hospitalized again soon after being discharged from a previous hospitalization; this is called a readmission. Readmissions are sometimes unavoidable due to a worsening of the patient's condition unrelated to care. In other cases, readmissions indicate problems in the quality of care patients received, either while in hospital or during follow-up after leaving hospital. While this indicator does not give us an absolute picture of the readmissions due to inadequate care, improving or worsening performance does suggest improvement or worsening of the quality of care received.

We report rates of readmissions within 30 days of a previous hospitalization for medical or surgical treatments. These treatments account for 90% of all 30-day readmissions.

Readmission rates in Ontario have remained fairly stable over the last four years. The 30-day readmission rate for medical patients was 13.6% in 2013/14 and for surgical patients, the readmission rate was 7.2%.^[19]

There is slight variation across Ontario for medical and surgical readmissions (Figure 3.3). For medical patients, the lowest readmission rate is in the Mississauga Halton LHIN region, at 12.3%, while for

FIGURE 3.3
Hospital readmission rates within 30 days of leaving hospital for medical or surgical treatment,[†] in Ontario, by LHIN region, 2013/14



Data sources: Discharge Abstract Database and National Ambulatory Care Reporting System, provided by the Canadian Institute for Health Information. [†]Risk-adjusted. Note: Readmissions are attributed to a region based on where the initial hospitalization occurred, not on where the patient lives.

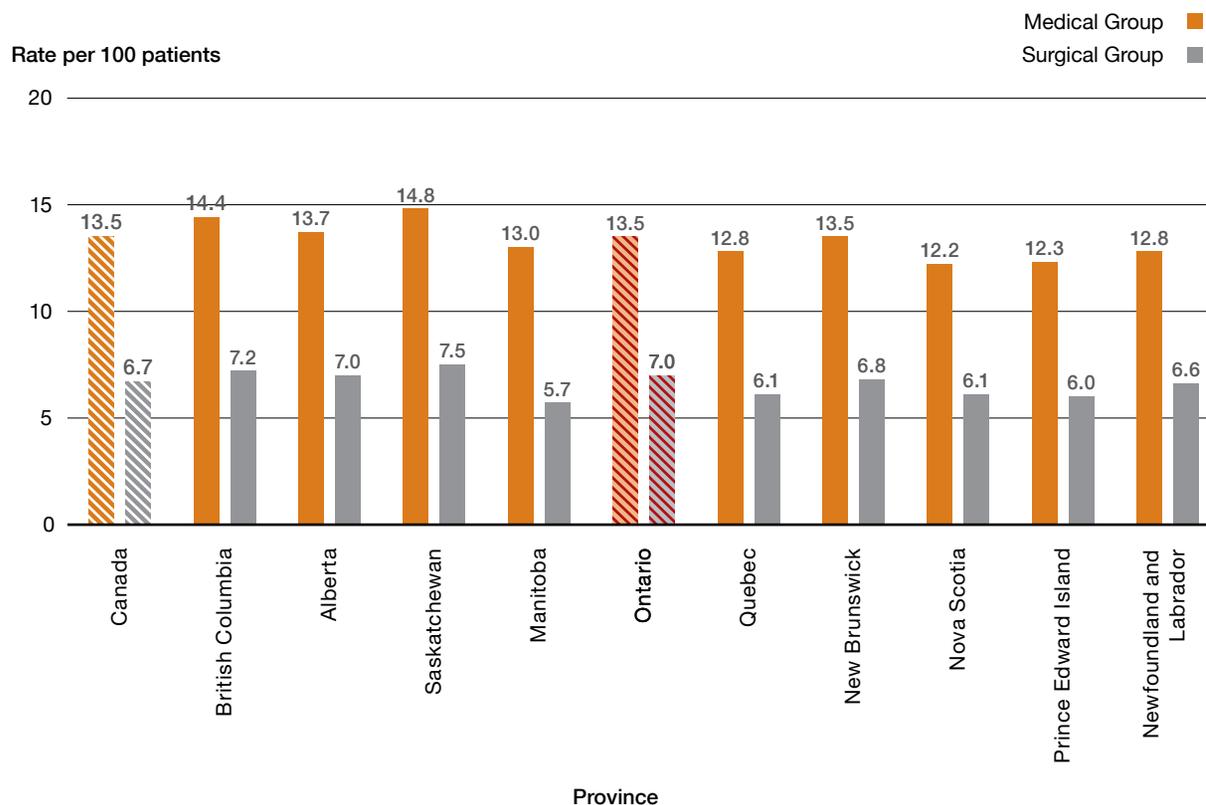
surgical patients the lowest readmission rate is in the Waterloo Wellington LHIN region (6.2%). The North West LHIN region has the highest readmission rates for both groups, with medical readmissions at 15.0% and surgical readmissions at 7.9%.

See this chapter's Real-World Experiences story, "Discharged," to see that it is not only what happens in the hospital that matters for readmissions.

How Ontario compares: within Canada

Ontario's 30-day readmission rate for medical patients was 13.5% in 2012/13, the same as the national average (Figure 3.4). Nova Scotia and Prince Edward Island have the lowest rates of readmission for medical patients compared to other provinces (just above 12%). For surgical patients, Ontario's readmission rate (7.0%) was close to the national average (6.7%). Manitoba, Quebec, Nova Scotia and Prince Edward Island have comparably low rates of readmission for surgical patients (around 6%).

FIGURE 3.4
Hospital readmission rates within 30 days of leaving hospital for medical or surgical treatment,[†] in Canada, by province, 2012/13



Data source: Canadian Institute for Health Information. Your Health System website. [†]Risk-adjusted.

Hospitalizations for ambulatory care sensitive conditions

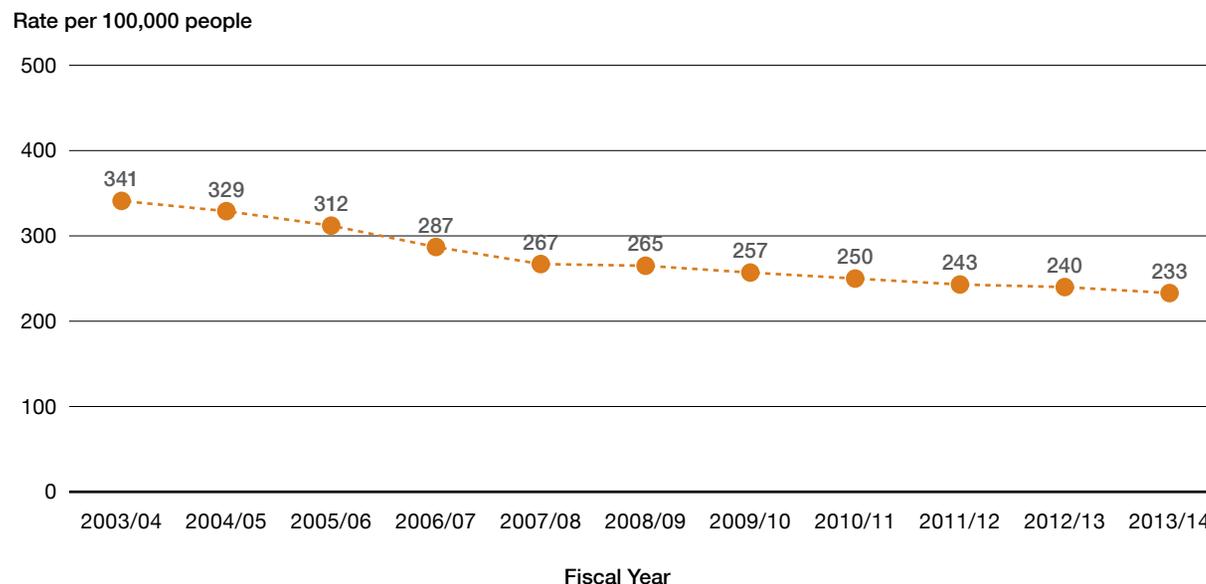
The rate of hospitalizations for medical conditions that could be managed outside of hospital has decreased by one-third over the last decade

Ambulatory care sensitive conditions are health conditions for which hospital admissions can often be avoided if patients receive appropriate, timely care in the community. Asthma, heart failure, chronic obstructive pulmonary disease, epilepsy, hypertension, diabetes and angina are common conditions that have been shown to be sensitive to the availability and quality of community-based, or ambulatory care.[21]

This indicator also speaks to the overall health of Ontarians, since healthier groups of people, such as those who don't smoke, are hospitalized less often.

The rate of hospitalizations for ambulatory care sensitive conditions has substantially improved (decreased) over the past decade in Ontario, from 341 per 100,000 people in 2003/04 to 233 per 100,000 in 2013/14 (Figure 3.5).

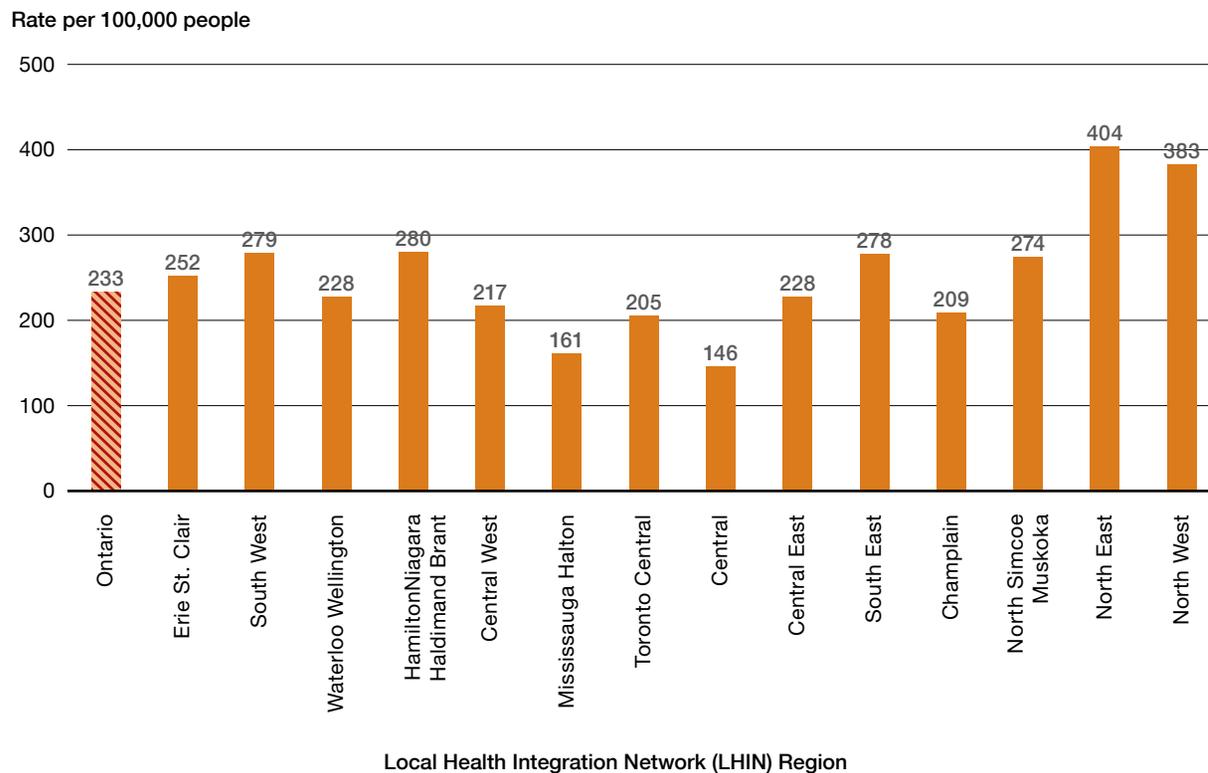
FIGURE 3.5
Hospitalization rate for ambulatory care sensitive conditions,[†] in Ontario, 2003/04 to 2013/14



Data source: Discharge Abstract Database, provided by the Institute for Clinical Evaluative Sciences. [†]Age- and sex-adjusted. *The difference in the Ontario rate for 2012/13 in Figures 3.5 and 3.7 is due to different methods used by data providers to calculate this rate. See the technical appendix on HQO's website for details.

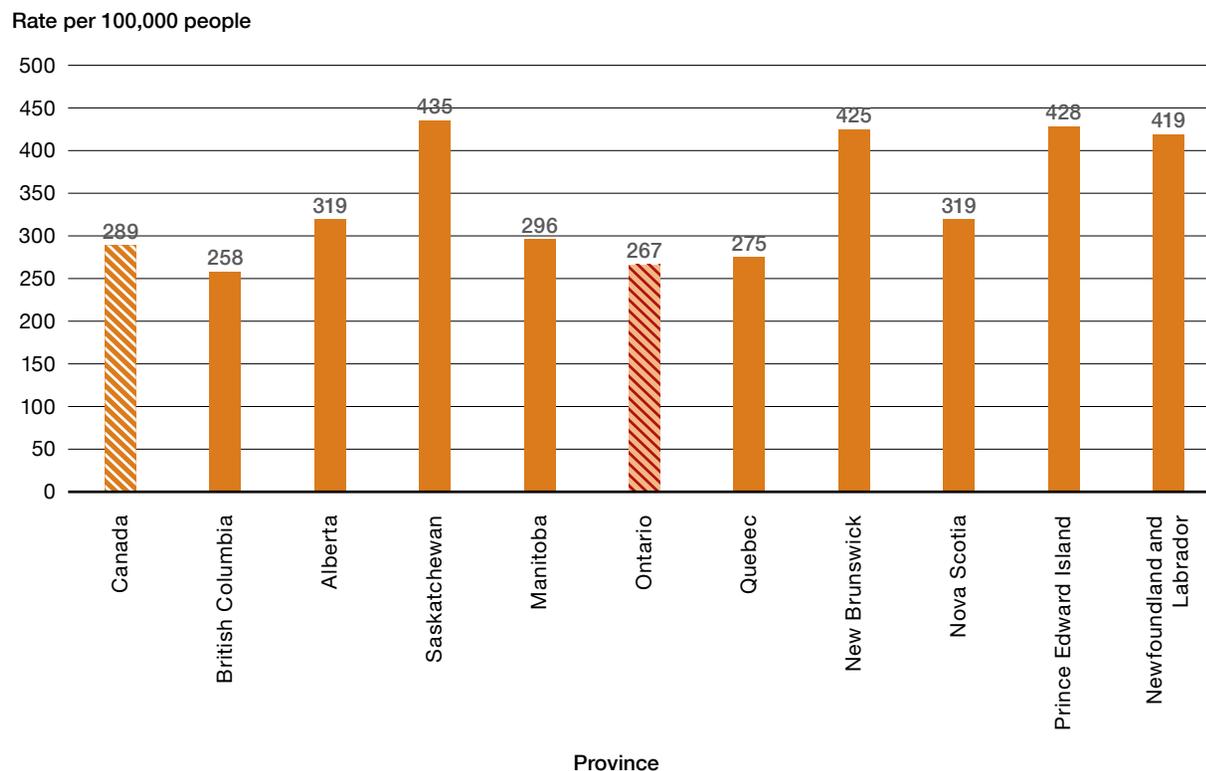
Across Ontario's LHIN regions in 2013/14, there is substantial variation in hospitalization rates for ambulatory care sensitive conditions, ranging from 146 per 100,000 people in the Central LHIN region to 404 in the North East LHIN region (Figure 3.6).

FIGURE 3.6
Hospitalization rate for ambulatory care sensitive conditions,[†] in Ontario, by LHIN region, 2013/14



Data source: Discharge Abstract Database, provided by the Institute for Clinical Evaluative Sciences. [†]Age- and sex-adjusted.

FIGURE 3.7
Hospitalization rate for ambulatory care sensitive conditions,[†] in Canada, by province, 2012/13



Data sources: Discharge Abstract Database, Canadian Institute for Health Information; Fichier des hospitalisations MED-ÉCHO, Ministère de la Santé et des Services sociaux du Québec MED-ÉCHO. Health Indicators Interactive Tool, Canadian Institute for Health Information. [†]Age-adjusted. *The difference in the Ontario rate for 2012/13 in Figures 3.5 and 3.7 is due to different methods used by data providers to calculate this rate. See the technical appendix on HQO's website for details.

How Ontario compares: within Canada

Ontario had the second-best hospitalization rate for ambulatory care sensitive conditions among all Canadian provinces in 2012/13. At 267 per 100,000 people, the Ontario rate was lower (better) than the national average of 289 per 100,000 people and just behind the top performer, British Columbia, where the rate was 258 per 100,000 people (Figure 3.7).

Percentage of acute care hospital days spent as alternate level of care

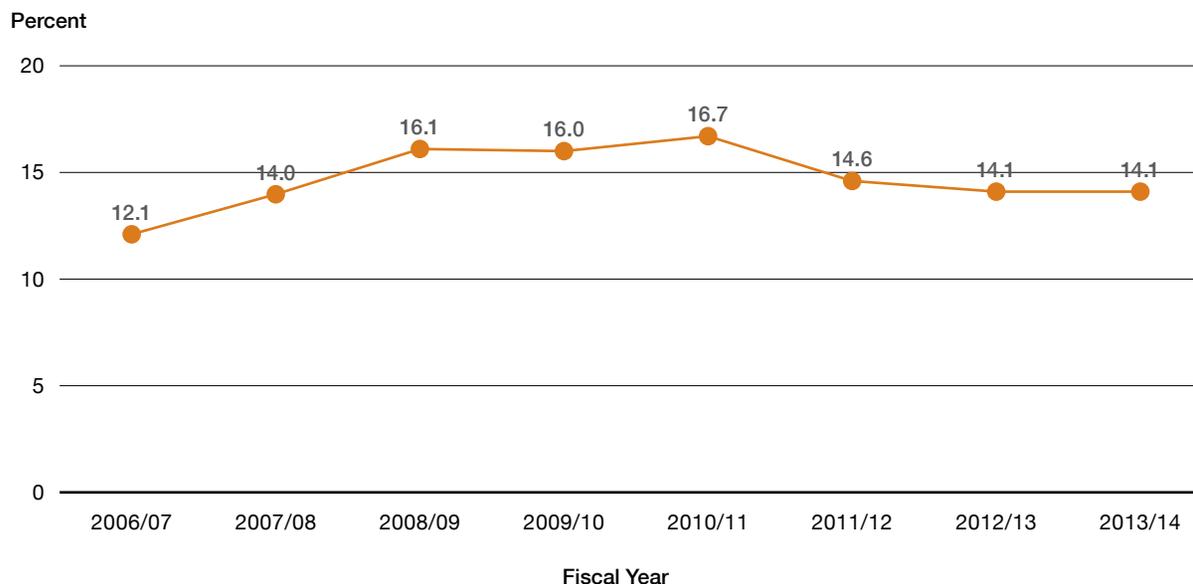
About one in seven hospital beds in Ontario is occupied by a patient who is well enough to receive care outside the hospital

Most hospital stays end when patients no longer need the type of care that hospitals provide. But sometimes their departure is delayed because the next stage of care they need, such as rehabilitation, home care or long-term care, is not immediately available. When this occurs, each day that the patient remains in hospital is designated as “alternate level of care.”[22]

Hospitals strive to reduce the number of days that beds are designated as alternate level of care. Waiting in a hospital for another level of care is often not good for patients: they may lose some ability to perform daily activities, feel socially isolated and lose independence. It can also mean reduced access for new patients. In many cases, solutions require the various parts of the health care system — hospitals, community care providers and long-term care homes — to work together to move patients to more appropriate settings as quickly as possible.[23-28]

The percentage of acute care days designated as alternate level of care in Ontario (14.1% in 2013/14) has improved slightly compared to 2010/11, when it reached a peak of 16.7%, but there has been no further improvement in the past two years (Figure 3.8).

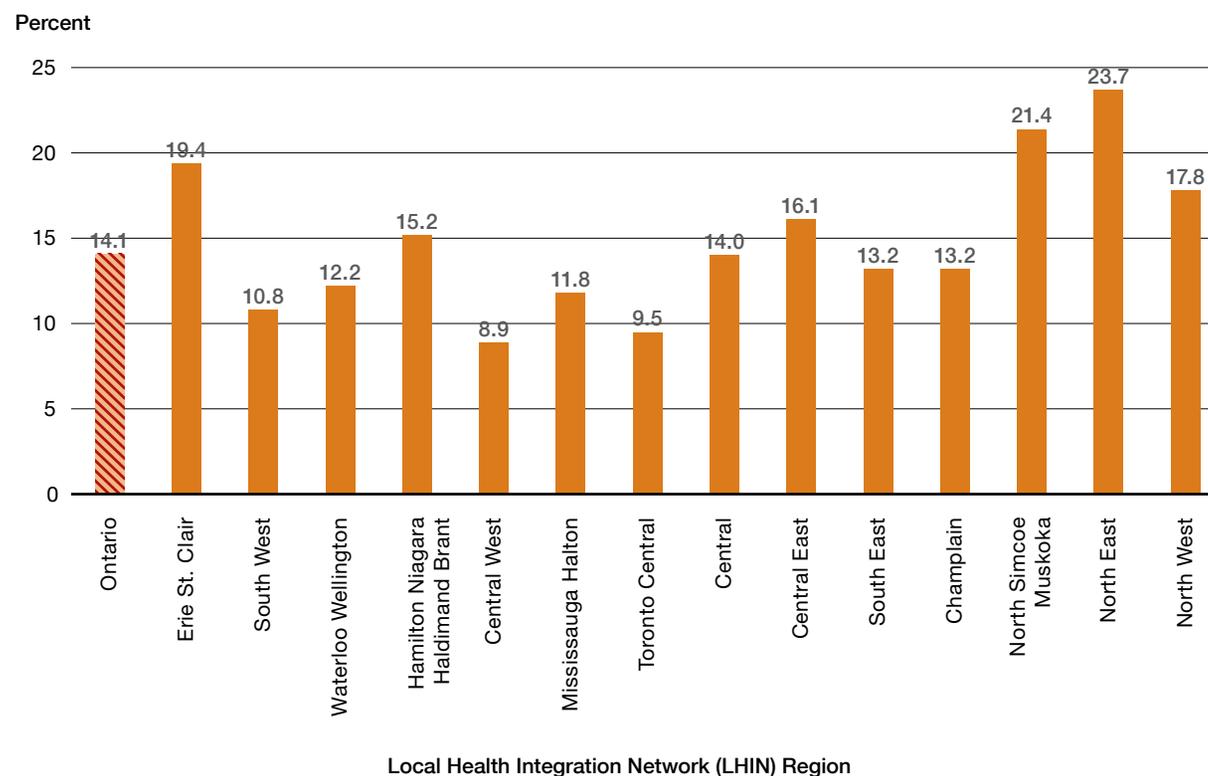
FIGURE 3.8
Percentage of acute care days spent as alternate level of care, in Ontario, 2006/07 to 2013/14



Data source: Discharge Abstract Database, provided by Ministry of Health and Long-Term Care. *The difference in the Ontario rate for 2013/14 in Figures 3.8, 3.9 and 3.10 is due to different methods used by data providers to calculate this rate. See the technical appendix on HQO's website for details.

Variation in the percentage of acute care days designated as alternate level of care is evident across Ontario, with highs of 23.7% in the North East LHIN region and 21.4% in the North Simcoe Muskoka LHIN region, and lows of 8.9% in the Central West LHIN region and 9.5% in the Toronto Central LHIN region (Figure 3.9).

FIGURE 3.9
Percentage of acute care days spent as alternate level of care, in Ontario, by LHIN region, 2013/14

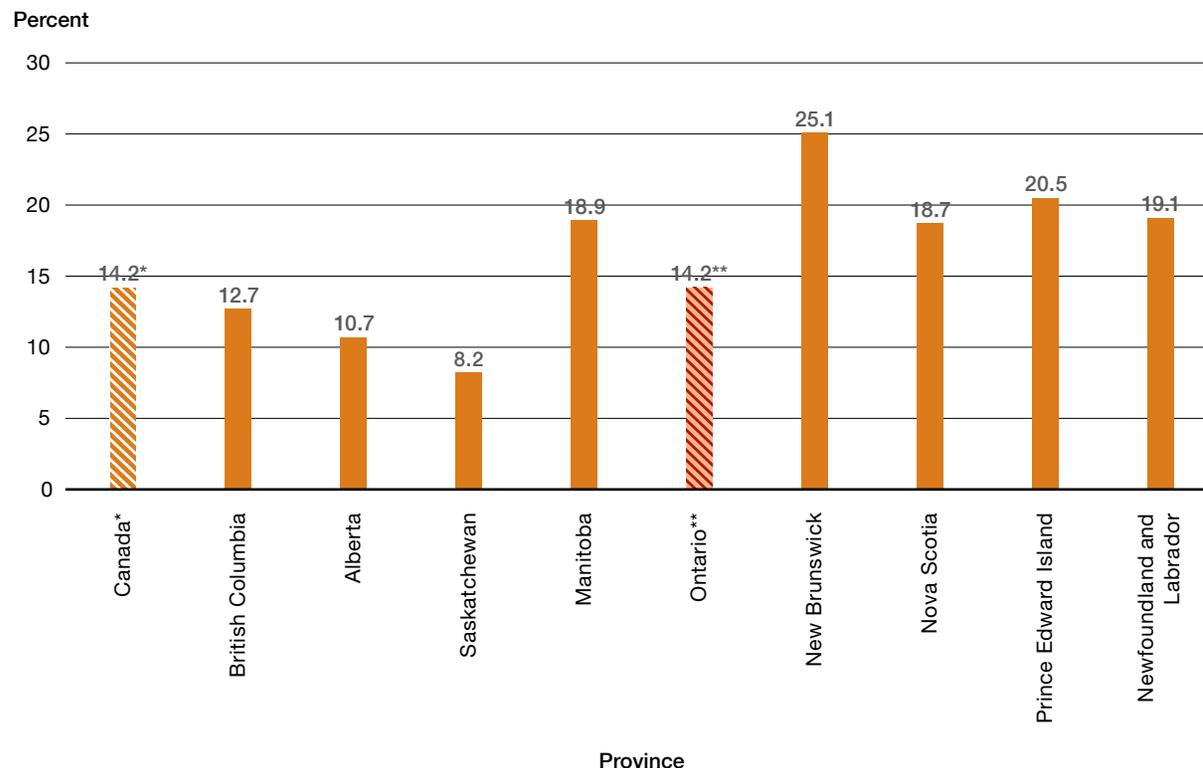


Data source: Discharge Abstract Database, provided by Ministry of Health and Long-Term Care. *The difference in the Ontario rate for 2013/14 in Figures 3.8, 3.9 and 3.10 is due to different methods used by data providers to calculate this rate. See the technical appendix on HQO's website for details.

How Ontario compares: within Canada

There is wide variation across Canada in the percentage of acute care days designated as alternate level of care. The percentage ranges from 8.2% in Saskatchewan to 25.1% in New Brunswick. Ontario, at 14.2%, is at the Canadian average (Figure 3.10).

FIGURE 3.10
Percentage of acute care days spent as alternate level of care, in Canada, by province,* 2013/14



Data source: Discharge Abstract Database, eDAD report, provided by the Canadian Institute for Health Information. *Quebec data were not available and are not included in the Canadian rate. **The difference in the Ontario rate for 2013/14 in Figures 3.8, 3.9 and 3.10 is due to different methods used by data providers to calculate this rate. See the technical appendix on HQO's website for details.

Another Look at Alternate Level of Care

The Common Quality Agenda indicator we report here — the percentage of acute-care hospital days spent as alternate level of care — looks at all patients who have been discharged from acute care hospital beds over the course of a year and calculates the percentage of days that patients were designated “alternative level of care,” meaning they no longer needed the intensity of care provided in that setting. We use this measure to compare performance in Ontario to other provinces in Canada.

Since 2011, many Ontario hospitals, LHINs and other organizations also use an indicator called the alternate level of care rate to help them understand, in near real-time, how their beds are being used. This rate measures, as a percentage of all days that hospital beds are occupied, the number of days that beds are occupied by patients who do not need the intensity of care provided in that setting. The advantage of this indicator is that it provides more timely information for hospitals because

it includes patients still in hospital as well as those recently discharged. It also provides a more complete picture of the alternate level of care situation in the hospital by looking at both acute care and post-acute care (recovery and continuing care) beds.

Measured in this way, the alternate level of care rate for Ontario hospitals overall has not changed over the past two years, but it has substantially decreased (improved) in some LHIN regions. For instance, in the Erie St. Clair LHIN region, the alternate level of care rate, including both acute care and post-acute care beds, improved from 27.4% in March 2013 to 18.8% in March 2015.[29]

Hospitals also collect information on a near real-time basis about what services these patients are waiting for (e.g., long-term care, home care) and where they go after leaving hospital. This information helps hospitals identify bottlenecks in the system and design action plans to move patients more quickly to the next stage of care.

In summary

Some indicators of health system integration show signs of progress. Hospitalization rates for chronic conditions that can often be managed outside of hospital (ambulatory care sensitive conditions) have improved considerably in Ontario over the last decade. The percentage of acute care days that hospital patients are designated as alternate level of care (meaning they no longer need the intensity of care provided in that setting) has improved slightly but with no change in the past two years. At 14.1%, it is still a concern.

Other indicators in this chapter point to weaknesses in the health system. Follow-up visits after hospitalization remain a challenge: less than half of patients in Ontario with heart failure or chronic obstructive pulmonary disease see a doctor within seven days of hospital treatment for those conditions. Also, the rates of readmission to hospital have remained fairly stable over a four-year period for both medical and surgical patients. Care following a hospital stay, which should be planned before the patient leaves the hospital, needs to improve in Ontario to reduce readmissions that might be prevented by more timely, appropriate care.

Primary Care

In this chapter, we report on six Common Quality Agenda indicators related to access to primary care: having a primary care provider, access to care, patient involvement in decisions about their care, and whether patients receive recommended screening tests for some preventable diseases.

Photo by Roger Yip

Real-World Experiences

Christa: A New Outlook

Christa's eyes were often dry and itchy, and she began to have trouble focusing and seeing at night. Christa was diagnosed with juvenile diabetes at age 6, and primary care plays an important role in the ongoing management of her chronic disease. Her family doctor referred her to an optometrist for eye exams every one or two years, the recommended time frame for someone with diabetes.

She didn't think much of vision problems until she was diagnosed with diabetic retinopathy at age 23. At the time, Christa had never heard of the condition, the most common eye disease among people with diabetes. High blood sugar levels cause blood vessels in the eye to swell or burst, leading to retina damage and vision loss. "I don't think I took it too seriously," she says. "I thought that if I did what they said to do, it wouldn't get any worse."

Although Christa received the recommended care from her family doctor and optometrists, it still wasn't enough. Doctors told Christa there

was nothing they could do to save the vision that she had lost, but they would do what they could to stop her from losing any more. She went for laser injections and surgeries, but her vision did get worse. Within a year, she was legally blind in both eyes, with no vision in her right eye and severe tunnel vision in the left.

Through support from the Canadian National Institute for the Blind, Christa trained to use a white cane and learned braille. Independent living specialists helped her get more comfortable in the kitchen and to travel by bus. After completing her cane training, Christa was able to get a guide dog. "She's a big part of my life and helps me get around," Christa says. "I'm always more comfortable travelling with her."

Now 28, Christa graduated from college, got a job as a customer service representative, and recently moved out of her parents' house into her own apartment in downtown London, Ontario.

Despite her outcomes, Christa's advice to other people with diabetes: "Keep your blood sugar in check and make sure to get your eye exams."

Although Christa received the recommended care from her family doctor and optometrist, it was not enough.

On the front line

Primary care providers — including family doctors and nurse practitioners — are, for most Ontarians, the entry point to the health system and the main contact for follow-up and ongoing care. Primary care providers assess and diagnose patients, provide counselling, prescribe drugs and other treatments, give vaccinations, perform minor procedures and serve as a point of access to other care providers. They also screen patients for certain diseases, promote healthy lifestyles and play a key role in coordinating other services their patients need.[30]

Key findings

94% of Ontarians have a primary care provider, but only about half can easily get a timely appointment when they are sick or need after-hours care

The percentage of Ontarians overdue for colorectal cancer screening has decreased (improved) by 4.7%

33% of Ontarians with diabetes (43% for 20- to 64-year-olds) do not get regular screening for diabetic retinopathy

For most Ontarians, primary care is the entry point to the health system and their main contact for ongoing care.

Having a primary care provider

94% of adults report having a primary care provider

Patients who have access to coordinated, comprehensive and regular primary care tend to have better health than those who do not. Not only does primary care contribute to better health, it can also reduce total costs for the health care system. Lack of access to primary care may create problems in other parts of the system, such as crowding of emergency departments and inefficient use of health care resources.[31-33]

In 2014, 94.0% of adults reported having a primary care provider, very similar to the previous year (93.6% in 2013). The results by LHIN region in 2014 show moderate variation, ranging from a low of 87.3% in the North West LHIN region to a high of 97.3% in the South East LHIN region, with very little change compared to 2013.[34]

Timely access to primary care

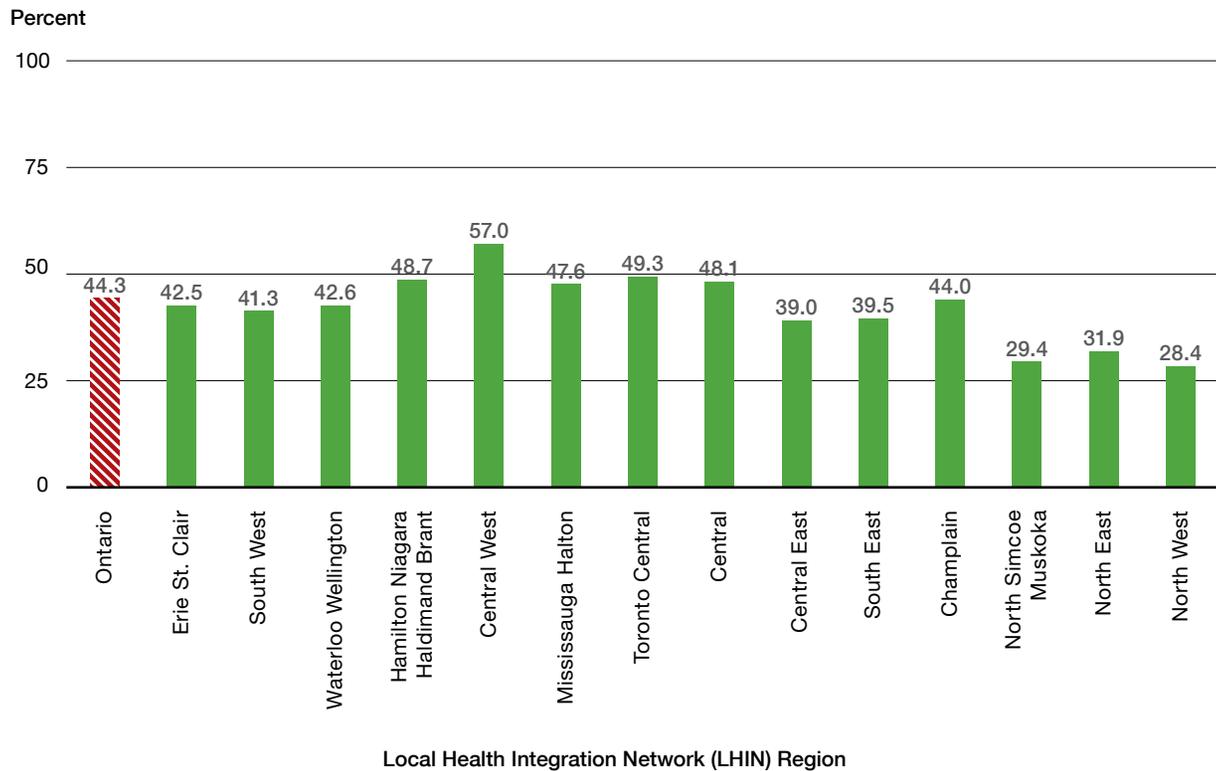
Less than half of adults in Ontario are able to see their primary care provider on the same day or next day when they are sick

Although most Ontarians have a regular primary care provider, this does not mean they can get care quickly when they need it. Timely access to primary care is a key element of an integrated health system, and patients consider it very important that they are able to see their primary care provider easily when they need care.[35]

In Ontario, only 44.3% of adults in 2014 report that they are able to see their primary care provider on the same day or next day if they are sick (Figure 4.1). This result is similar to the previous year (45.3% in 2013).[34]

Across Ontario, the proportion of people who report being able to get a same- or next-day appointment for primary care when they are sick varies substantially, from a low (less favourable) of 28.4% in the North West LHIN region to a high (more favourable) of 57.0% in the Central West LHIN region (Figure 4.1).

FIGURE 4.1
Percentage of adults who were able to see their primary care provider on the same day or next day when they were sick, in Ontario, by LHIN region, 2014



Data source: Health Care Experience Survey, provided by the Ministry of Health and Long-Term Care.

Accessing after-hours primary care

Ontario patients continue to have difficulty getting primary care on evenings and weekends

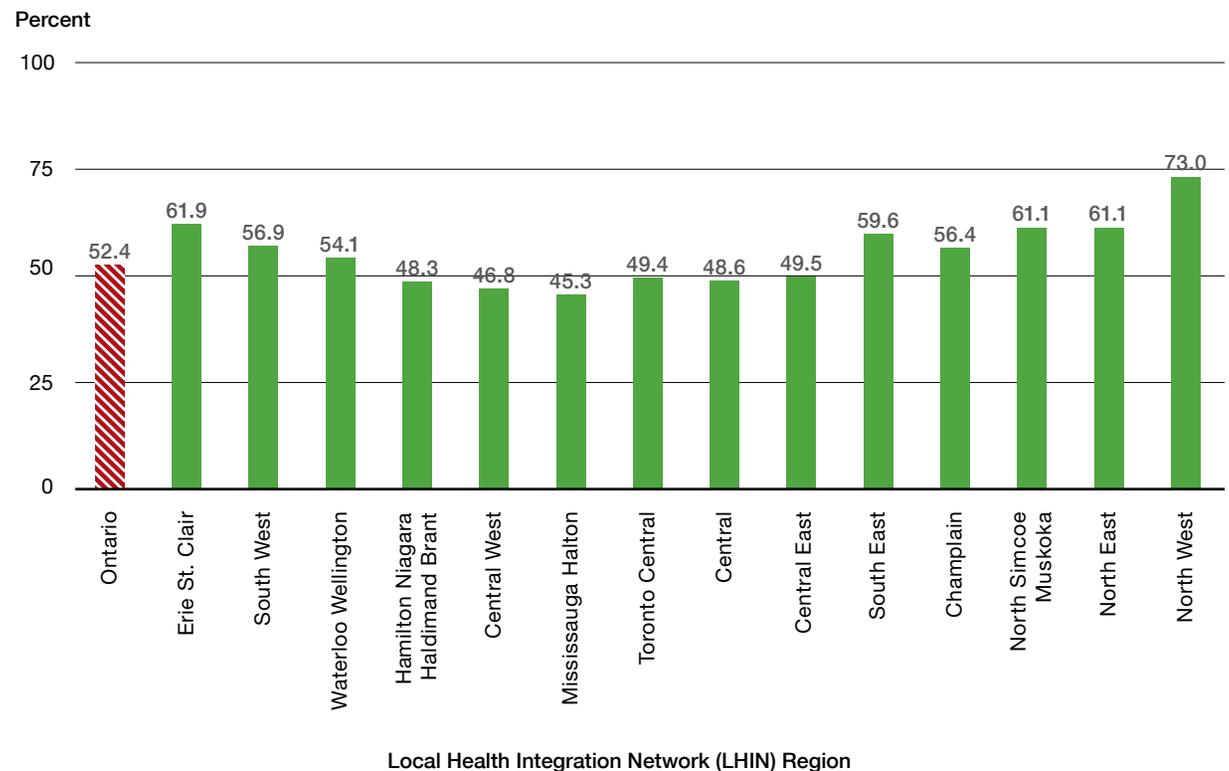
People can get sick at any time of the day or night and any day of the week. Having access to primary care outside of usual office hours can ensure the right care is available when it is needed, reduce strain on other parts of the health system, and reduce visits to emergency departments.[36,37]

Just over half (52.4%) of adults in Ontario in 2014 reported that it is very or somewhat difficult for them to get evening or weekend access to primary care without going to a hospital emergency department (Figure 4.2). This percentage barely changed compared to the previous year (53.7% in 2013).[34]

There is substantial variation across Ontario in the percentage of adults who report difficulty accessing primary care on evenings or weekends, ranging from 45.3% (more favourable) in the Mississauga Halton LHIN region to 73.0% (least favourable) in the North West LHIN region (Figure 4.2).

FIGURE 4.2

Percentage of adults who report that getting access to care on an evening or weekend, without going to the emergency department, was very or somewhat difficult, in Ontario, by LHIN region, 2014



Data source: Health Care Experience Survey, provided by the Ministry of Health and Long-Term Care.

How Ontario compares: **within Canada and around the world**

The 2013 Commonwealth Fund International Health Policy Survey allows us to look at Ontarians' access to primary care compared to other provinces in Canada and to other countries.

Having a primary care provider:

The percentage of Ontarians surveyed who have a regular doctor or regular place they go for primary care (96%) is slightly above the overall Canadian rate (93%). Compared to 11 countries surveyed, Ontario is in the middle; the proportion in other countries ranges from 87% in the United States to 98% in France, the Netherlands and Norway (Figure 4.3).

Timely access to primary care:

About 40% of Ontarians surveyed report being able to get a same-day or next-day primary care appointment if they are sick,

similar to the result for Canadians overall (38%); British Columbia has the best performance among the provinces (45%). However, all other countries in the survey report better access to same-day or next-day appointments compared to Ontario; Germany has the highest percentage (72%) (Figure 4.3).

Accessing after-hours primary care:

In all provinces, more than half of people surveyed report having difficulty getting care on evenings or weekends without going to a hospital emergency department; the proportion in Ontario (56%) is similar to the proportion in Canada overall (60%). In most of the other countries surveyed, however, people have substantially less difficulty accessing after-hours care; the lowest (best) rate is in the United Kingdom (29%) (Figure 4.3).

FIGURE 4.3
Primary Care Access, in Ontario, Canada, and internationally, 2013

Having a primary care provider



96%

Ontario



93%

Canada

98%

France

The percentage of people surveyed who have a regular doctor or regular place they go for primary care

Timely access to primary care



40%

Ontario



38%

Canada

72%

Germany

The percentage of people surveyed report being able to get a same-day or next-day primary care appointment if they are sick

Accessing after-hours primary care



56%

Ontario



60%

Canada

29%

United Kingdom

The percentage of people surveyed report having difficulty getting care on evenings or weekends without going to a hospital emergency department

Data source: 2013 Commonwealth Fund International Health Policy survey. The Ontario results from this survey differ slightly from those from the province's Health Care Experience Survey, our source for Figures 4.1 and 4.2.

How Ontario compares: within Canada and around the world

According to the 2013 Commonwealth Fund International Health Policy Survey, 83% of Ontarians surveyed say that their provider always or often involves them in decisions about their care (Figure 4.4). This is close to the Canadian average of 81%.

Compared to the other countries in the Commonwealth Fund survey, Ontario sits in the middle, with the best countries reaching 87% (United Kingdom) and 88% (New Zealand). (Figure 4.4).

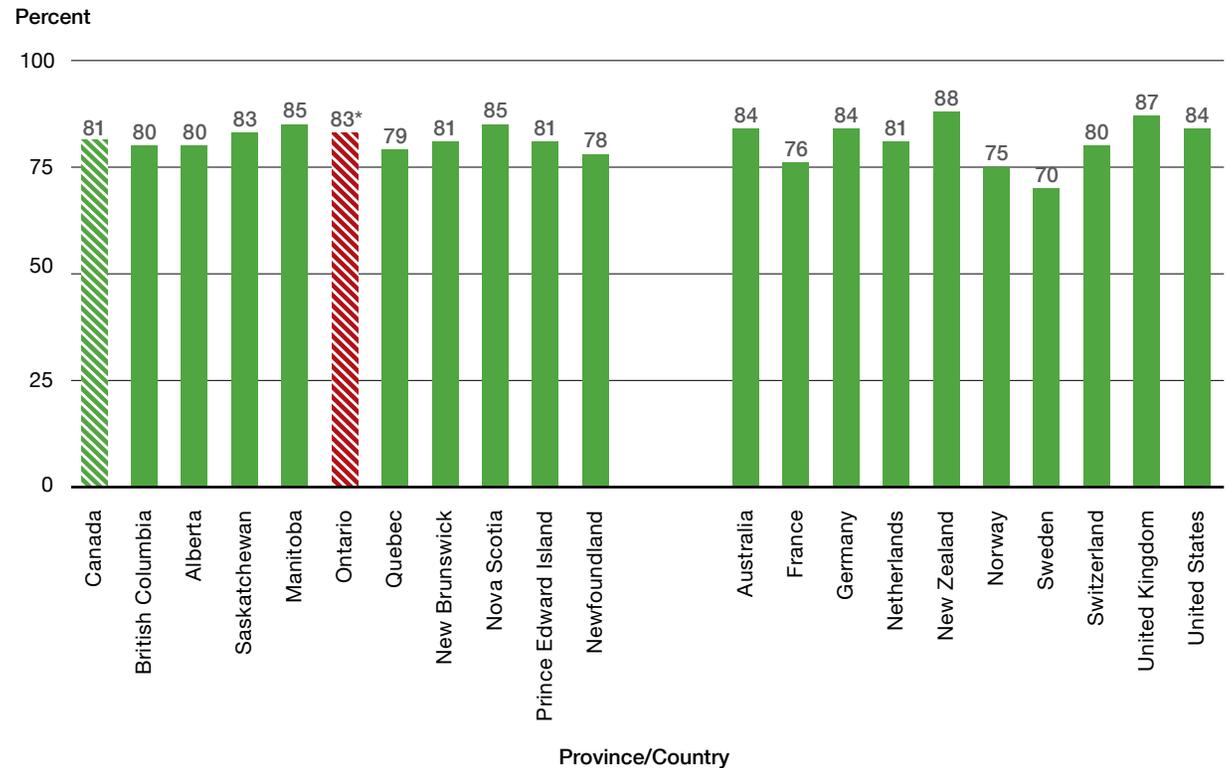
Patients' involvement in decisions about their care

86% of adults in 2014 said their provider always or often involves them in decisions about their health care

A key element of a high-performing health system is patient-centred care. Patient-centred care can be defined in various ways, but there is general agreement that an essential ingredient is ensuring that the patient is an active participant in his or her care. Measuring this involvement gives us an indication of how well the health system responds to patients' needs, and it is a valuable indicator as Ontario moves toward more patient-focused health care delivery.[38-40]

FIGURE 4.4

Percentage of adults who report that their provider always or often involves them in decisions about their care, in Canada and internationally, by province or country, 2013



Data source: 2013 Commonwealth Fund International Health Policy Survey. *The Ontario rates may differ due to the use of different surveys and different years of data. See the technical appendix on HQO's website for details.

In 2014, most adults (86.2%) reported that their primary care provider always or often involves them in decisions about their care. This is comparable to the 2013 result on this survey question (85.0%). There is little variation across Ontario.[41]

Colorectal cancer screening

The percentage of Ontarians overdue for colorectal cancer screening decreased by 5% between 2010 and 2013

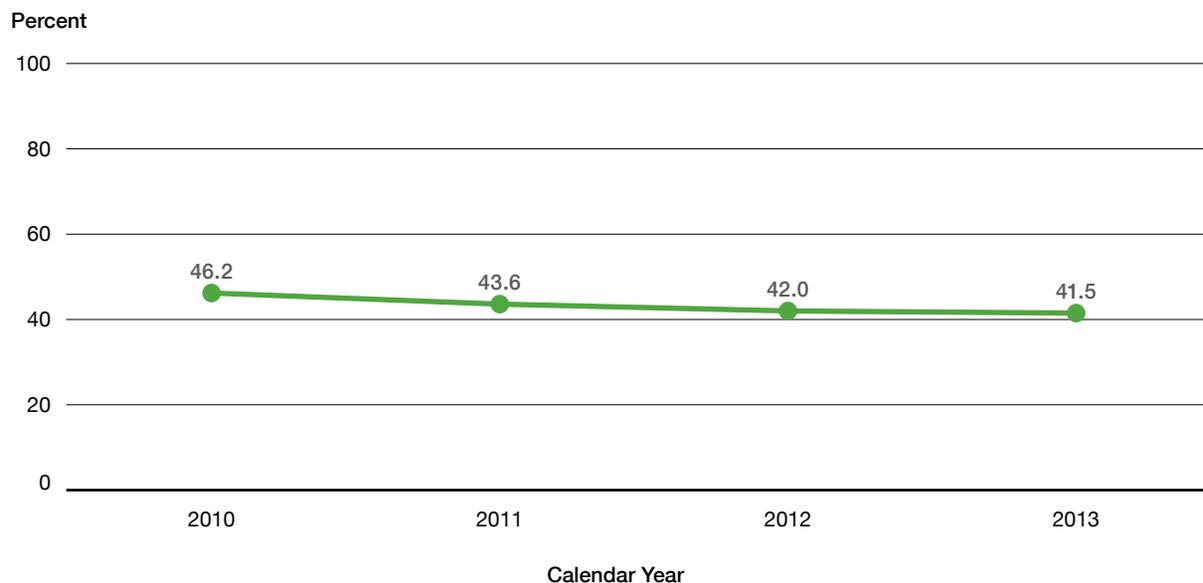
Colorectal cancer is a leading cause of cancer deaths in Ontario: 3,130 people died from colorectal cancer in 2009 and an estimated 3,400 in 2014. Screening for colorectal cancer can help to detect the disease so that treatment can start at the earliest possible stage, and primary care providers play an important role in informing and encouraging people to be screened.[42-44]

ColonCancerCheck, Ontario's province-wide screening program, recommends that people between the ages of 50 and 74 and at average risk of colon cancer (i.e., without a parent, sibling or child with colorectal cancer) have a test every two years that checks for blood in the stool (fecal occult blood testing). This indicator looks at the percentage of Ontarians who are in this age group and risk category but are overdue for colorectal cancer screening.[42]

The percentage of Ontarians overdue for colorectal cancer screening continues to decrease (improve). While 46.2% of the target group was overdue for screening in 2010, this has dropped to 41.5% in 2013, a sizeable improvement (Figure 4.5).

FIGURE 4.5

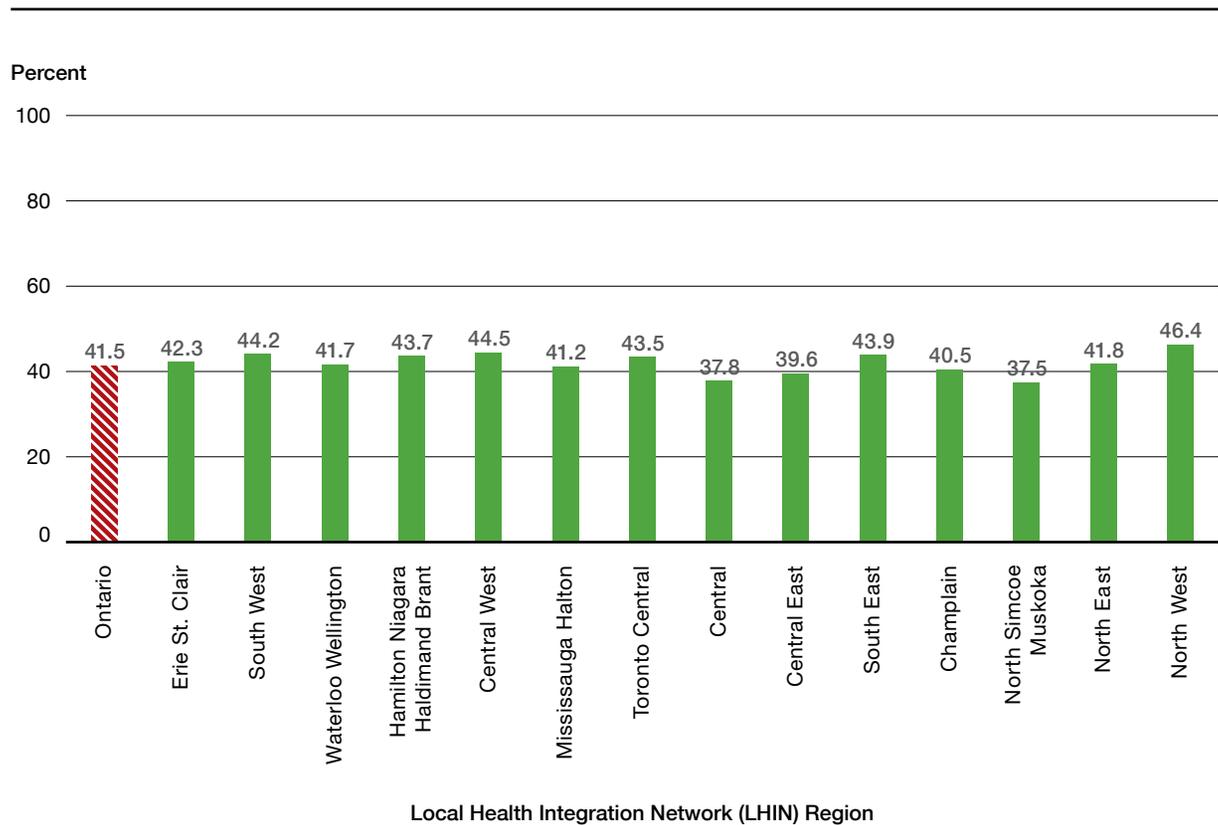
Percentage of people aged 50–74 overdue for colorectal cancer screening,[†] in Ontario, 2010 to 2013



Data sources: Colonoscopy Interim Reporting Tool, Laboratory Reporting Tool, Ontario Health Insurance Plan, Ontario Cancer Registry, Registered Persons Database, Postal Code Conversion File Plus Version 6A, provided by Cancer Care Ontario. [†]Age-adjusted. Note: Eligible people are considered overdue for screening if they have not had a fecal occult blood test within the past two years, or colonoscopy within the past 10 years, or a flexible sigmoidoscopy within the past five years.

Across Ontario's LHIN regions, there is modest variation in colorectal cancer screening rates. The LHIN regions with the smallest percentage of people overdue for colorectal cancer screening were North Simcoe Muskoka (37.5%) and Central (37.8%). The LHIN region with the highest percentage of people overdue for screening was North West (46.4%) (Figure 4.6).

FIGURE 4.6
Percentage of people aged 50–74 overdue for colorectal cancer screening,[†] in Ontario, by LHIN region, 2013



Data sources: Colonoscopy Interim Reporting Tool, Laboratory Reporting Tool, Ontario Health Insurance Plan, Ontario Cancer Registry, Registered Persons Database, Postal Code Conversion File Plus version 6A, provided by Cancer Care Ontario. [†]Age-adjusted. Note: Eligible people are considered overdue for screening if they have not had a fecal occult blood test within the past two years, or colonoscopy within the past 10 years, or a flexible sigmoidoscopy within the past five years.

Diabetes eye exams

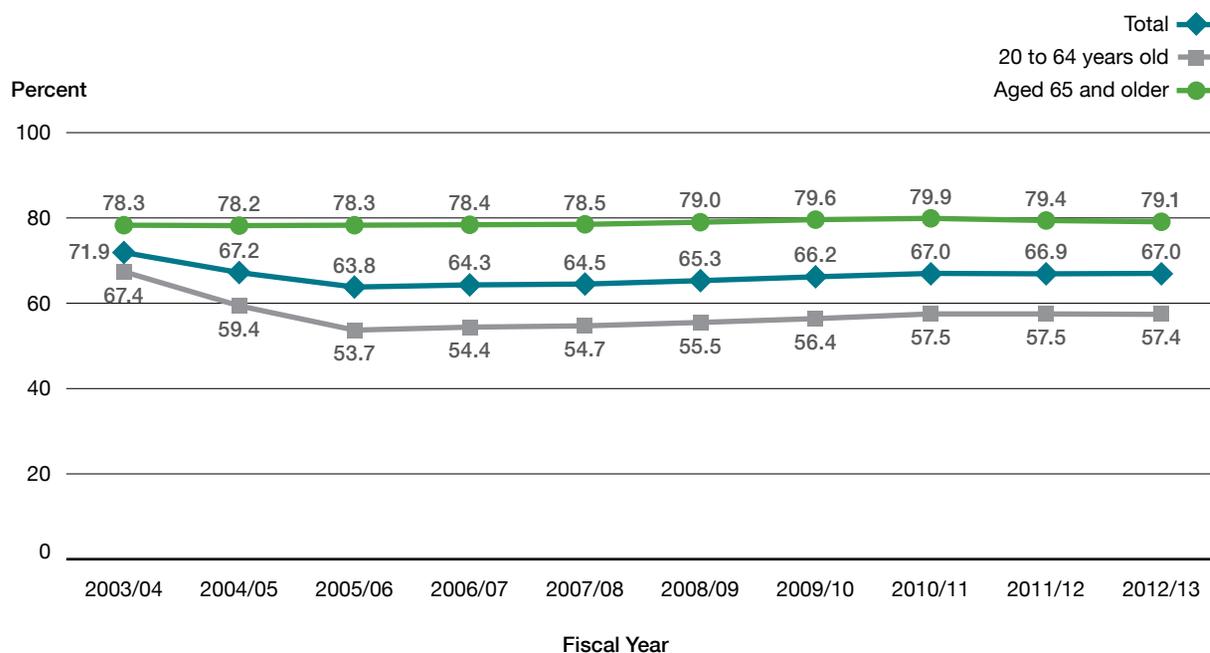
33% of all Ontarians with diabetes do not get regular eye exams for diabetic retinopathy, and the rate is worse (43%) for people 20 to 64 years old

Diabetes can damage the eyes. A common eye problem with diabetes, called diabetic retinopathy, is the most common cause of blindness in working-aged adults in Canada and now affects more than one million Ontarians. Since treatment for diabetic retinopathy is much more successful when detected early, clinical practice guidelines recommend that patients with diabetes be screened for retinopathy every one to two years. Primary care physicians are in a unique position to encourage diabetic patients to get regular eye exams.[45-47]

Only two-thirds of Ontarians aged 20 and older with diabetes are screened for diabetic retinopathy within the recommended two-year period, and this rate has improved very little over the past three years (Figure 4.7). Patients' age and whether they live in a rural or an urban area make a difference in the rates. In 2012/13, a higher proportion (79.1%) of older Ontarians with diabetes had received an eye exam in the past two years, compared to 57.4% for the patients aged 20 to 64 years (Figure 4.7). Also in 2012/13, more rural residents with diabetes (71.8%) had received their eye exam within the past two years, compared to urban residents (66.3%) (Figure 4.8).

FIGURE 4.7

Percentage of people aged 20 and older with diabetes who received an eye exam within a two-year period, in Ontario, total and by age group, 2003/04 to 2012/13



Data sources: Ontario Health Insurance Plan and the Ontario Diabetes Database, provided by the Institute for Clinical Evaluative Sciences.

FIGURE 4.8
Percentage of people with diabetes who received an eye exam within a two-year period



In 2012/13, more rural residents with diabetes had received their eye exam within the past two years, compared to urban residents

71.8%
Rural residents

66.3%
Urban residents

Data sources: Ontario Health Insurance Plan and the Ontario Diabetes Database, provided by the Institute for Clinical Evaluative Sciences.

The drop from 71.9% in 2003/04 to 63.8% in 2005/06 (Figure 4.6) could be related to the delisting of routine eye exams for healthy adults in 2003/04. Although patients with diabetes remained eligible for free eye exams regardless of their age, the change in coverage may have confused some physicians and patients, particularly for patients 20 to 64 years old. The rates for this age group have slowly increased again but have not returned to the level they were a decade ago.[48]

The screening rate for diabetic retinopathy varies moderately across Ontario, ranging from 61.8% in the Toronto Central LHIN region to 72.3% in the North East and South East LHIN regions in 2012/13.[49]

In summary

For the Common Quality Agenda indicators of primary care in Ontario, the messages are mixed. While most people in the province have a regular primary care provider, being seen quickly when needed or on evenings or weekends remains a challenge. Many of the countries surveyed by The Commonwealth Fund do better at ensuring timely access to primary care.

Overall, people in Ontario report having good communication with their primary care provider, but there is room for improvement. And while more Ontarians in the target age and risk group are getting screened for colorectal cancer, there has been no change in the last three years of the proportion of Ontarians with diabetes who get regular screening for diabetic retinopathy every one to two years, as recommended. Younger adults with diabetes are less likely to get this preventive eye test compared to those over age 65.

Mental Health

In this chapter we report on five Common Quality Agenda indicators related to treatment of mental illness and addictions: hospital admissions for a mental illness or an addiction, seven-day follow-up after leaving hospital, 30-day readmission, hospital use of physical restraints, and suicide rates.

Photo by Roger Yip

Real-World Experiences

Catherine: A Call to Care

It took one phone call for Trevor [not his real name] to know that people cared about him. Trevor, who has schizophrenia, had been regularly in and out of hospital in the Ottawa area. Each visit was a tough experience for Trevor and also a difficult ordeal for his mother, Catherine.

Each time Trevor left the hospital, there was a missing connection, Catherine says. No one in the health care system followed up to ask him how he was doing. “In all of his hospitalizations, I certainly never saw a discharge plan,” Catherine says. “When he was 17 or 18, they didn’t even let me know when he left the hospital.”

That all changed after Trevor’s last hospitalization. A new initiative ensured that patients leaving the hospital for a mental health condition receive follow-up calls from a mental health representative.

Some patients receive a call from one of the Ottawa-area crisis line team members. Calls usually last about 15 minutes. If the call-back team cannot reach the patient, they will leave a message and try back again or use an alternative phone number, says Bella Andersson, the program coordinator at the Distress Centre of Ottawa and Region. “The big thing we hear is

that it’s very different to come home again, so it’s good to have someone looking out for you,” Andersson says. “People are very thankful.”

Catherine says it was a big deal for Trevor to receive follow-up calls because it marked one of only a handful of positive experiences that her son has had with the health care system, among hundreds of unpleasant interactions. “Follow-up calls made a huge difference,” Catherine says. “Most of the people doing the calls are very friendly. They ask ‘How are you doing?’ It’s not very often people say that. Anyone who is saying ‘I care,’ makes a difference.”

The call-back initiative was created to prevent some readmissions to the hospital. Mireille Delorme, the hospital’s mental health services director, says it is too early to say for sure that the program is having an effect on readmissions. She also sees a challenge in reaching some of the patients who may be homeless or who do not have regular access to a phone. Those patients who do get the call-back, however, really seem to appreciate it, Delorme says.

Perhaps not a result of follow-up calls but still good news: Trevor is on the right medication and has landed a full-time job, Catherine says. He hasn’t been hospitalized in a year.

“Follow-up calls made a huge difference ... Anyone who is saying ‘I care,’ makes a difference.”

Treating mental illness and addictions

About one in five Canadians experience a mental illness or an addiction problem in any given year. In Ontario, the impact of mental illness and addictions on patients' quality of life and length of life is considerable. Mental illness covers a broad range of conditions, including anxiety, depression, personality disorders and substance addiction. Mental illness is among the top causes of disability in Canada and is more common among adolescents and young adults (15 to 24 years of age) and people with lower incomes.[50-53]

The data we report in this chapter are related to hospital and physician care only; this does not include care from community services for mental illness and addictions. Comparable data on community services are not currently available, although they account for a sizable proportion of the mental health support and services that Ontarians use.

Key findings

Rates of hospitalization for a mental illness or an addiction in Ontario vary widely by region

More than two-thirds of patients hospitalized for a mental illness or an addiction do not see a doctor for follow-up within a week of leaving the hospital

Ontario's suicide rate has not changed in a decade

The impact of mental illness and addictions on Ontarians is considerable but reporting on the quality of care is challenging.

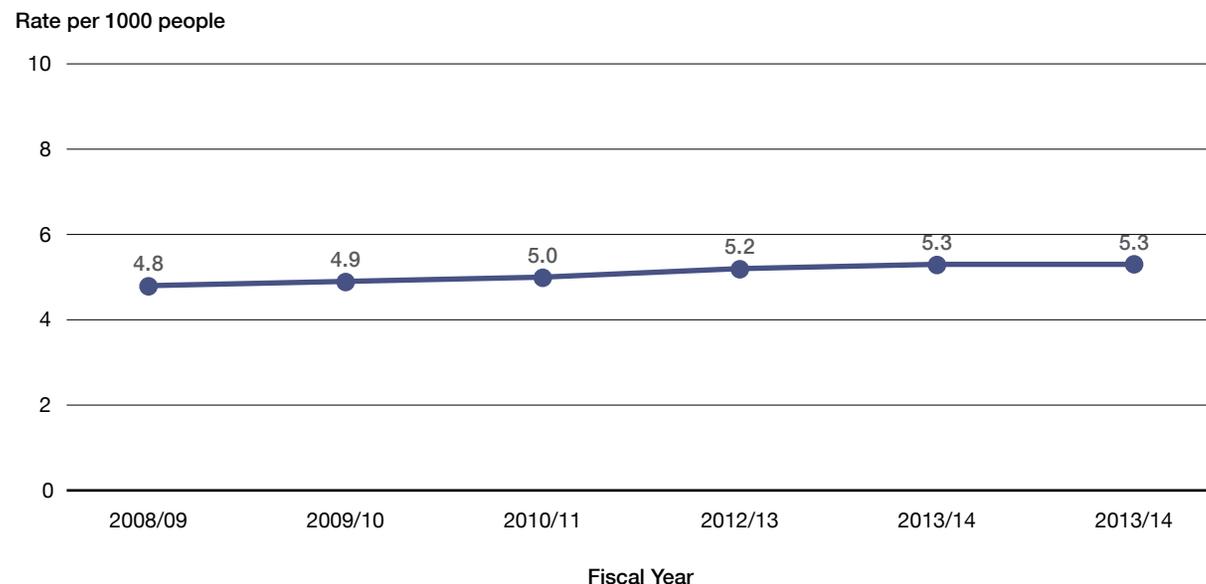
Hospital admissions for a mental illness or an addiction

People in some regions are two to three times more likely than in other regions to be hospitalized for a mental illness or an addiction

By the time someone is admitted to hospital for a mental illness or an addiction, they are usually in serious condition. With enough community supports and other early interventions, some hospital visits could be avoided. However, a robust hospital system is still required to provide care for patients with mental illness or addictions when they are in need. [54-56]

The rate of patients admitted to hospital for a mental illness or an addiction has remained fairly stable in Ontario, at around 5 admissions per 1,000 people, between 2008/09 and 2013/14 (Figure 5.1).

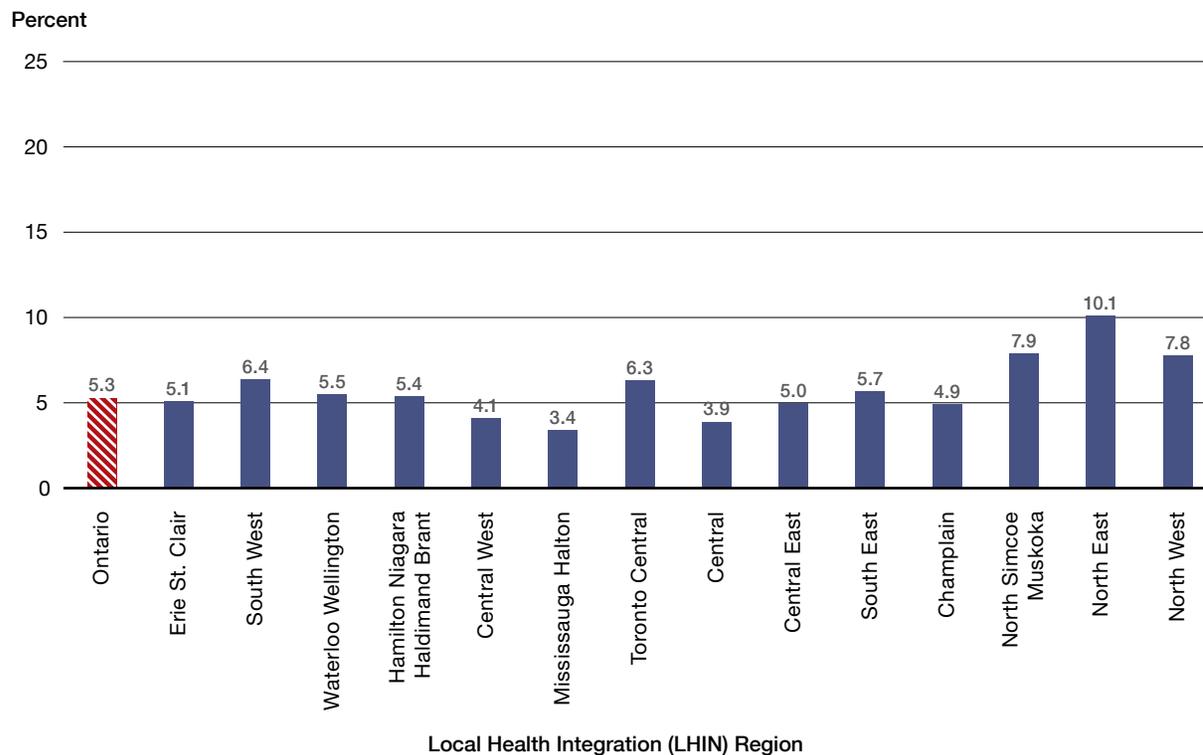
FIGURE 5.1
Hospital admission rate for a mental illness or an addiction,[†] in Ontario, 2008/09 to 2013/14



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Registered Persons Database, and yearly Ontario intercensal and postcensal population estimates and projection, provided by the Institute for Clinical Evaluative Sciences. [†]Age- and sex-adjusted. Note: Dementia and developmental disabilities are not included.

Regional rates vary substantially, ranging from 3.4 admissions per 1,000 people in the Mississauga Halton LHIN region in 2013/14 to 10.1 per 1,000 in the North East LHIN region (Figure 5.2).

FIGURE 5.2
Hospital admission rate for a mental illness or an addiction,[†] in Ontario, by LHIN region, 2013/14



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Registered Persons Database, provided by the Institute for Clinical Evaluative Sciences. [†]Age- and sex-adjusted. Note: The rate by LHIN region for this indicator is based on where people live, even if they went to a hospital in a different region. Rates are not adjusted for regional differences in the prevalence of various diagnoses.

Doctor visit within seven days of leaving hospital after treatment for a mental illness or an addiction

More than two-thirds of patients hospitalized for a mental illness or addiction do not see a doctor for follow-up within seven days of leaving the hospital

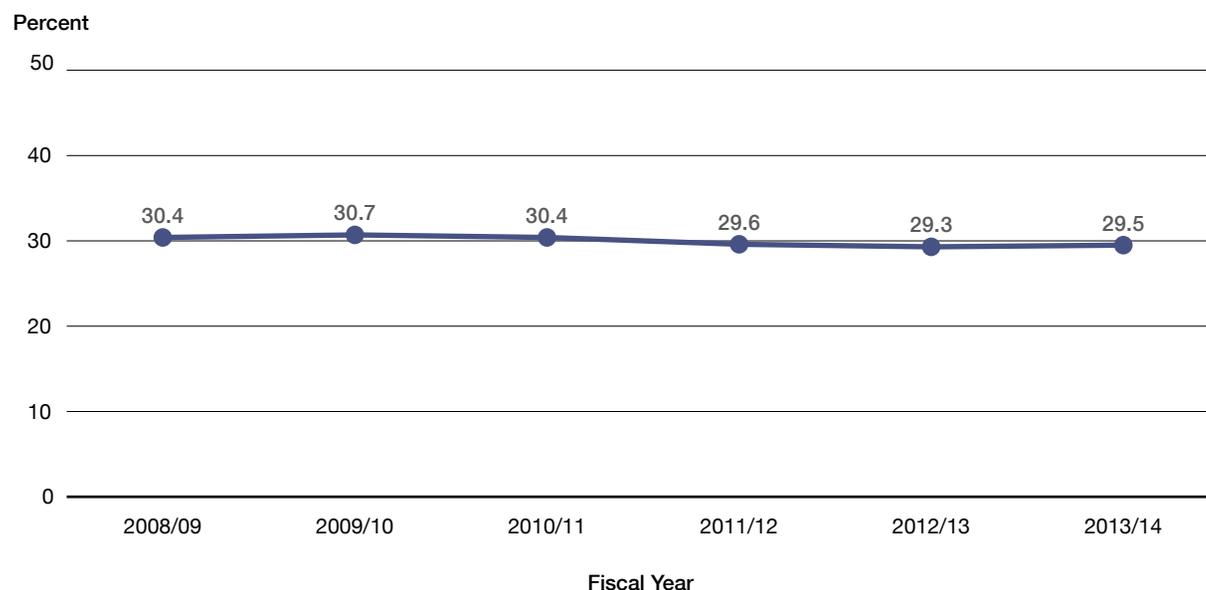
Ensuring that patients who have been hospitalized for a mental illness or an addiction see a doctor for follow-up within a week of leaving the hospital is recognized as a measure of quality for mental health and addictions care. As we saw in Chapter 3, follow-up visits after hospitalization are also a measure of how well different parts of the health system are working together. Follow-up visits with a family doctor or a specialist such as a psychiatrist can help to smooth the patient's transition from around-the-clock care in hospital to managing on their own back at home or elsewhere in the community.[57,58]

Since the rates we report here are based on physician billing data; they do not capture follow-up visits to clinics led by nurse practitioners, community health centres, psychologists or community mental health and addiction programs. Therefore, these results likely under report the extent of follow-up care after hospitalization for a mental health or addiction condition in Ontario.

About 30% of Ontario patients hospitalized for treatment of a mental illness or an addiction saw a doctor within seven days of discharge from hospital. This rate did not improve between 2008/09 and

FIGURE 5.3

Rate of follow-up with a doctor within seven days of leaving hospital, for a mental illness or an addiction,[†] in Ontario, 2008/09 to 2013/14

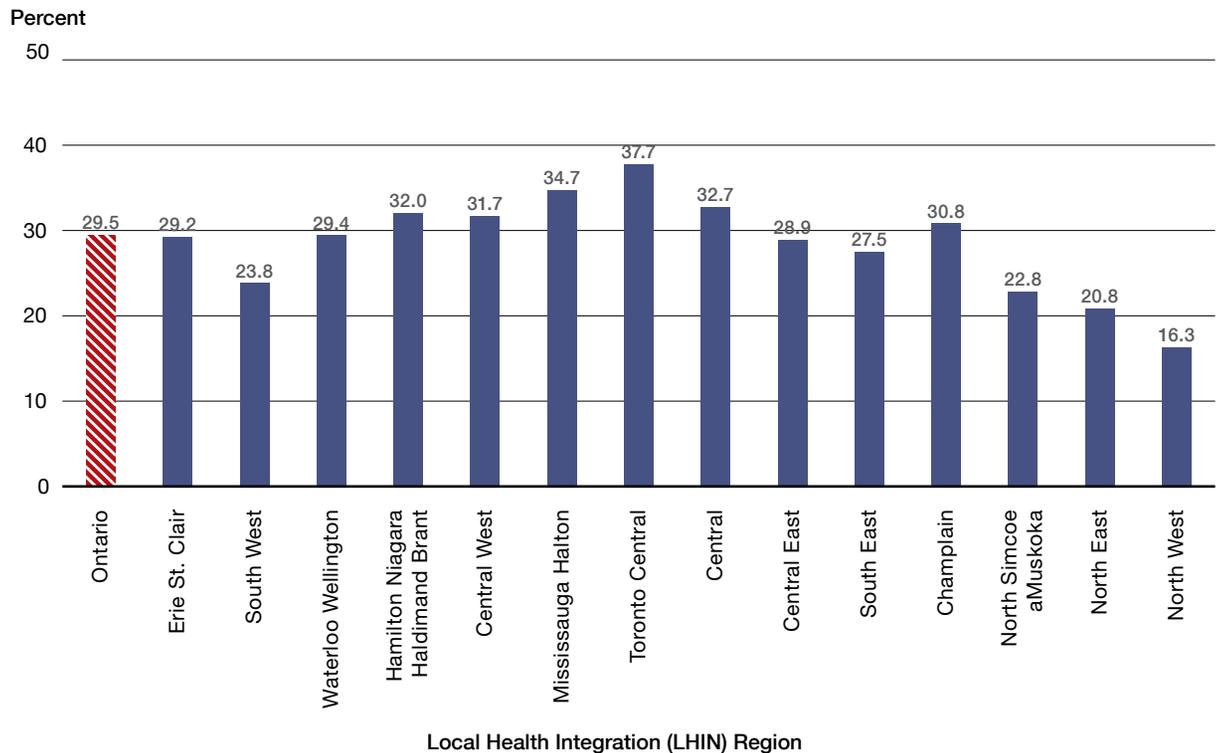


Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Registered Persons Database, provided by the Institute for Clinical Evaluative Sciences. [†]Age- and sex-adjusted.

2013/14 (Figure 5.3), and it is lower than the follow-up rate for other chronic conditions such as heart failure (44.1%) and chronic obstructive pulmonary disease (36.6%) (Figure 3.1). Results vary substantially by region in 2013/14, from a low of 16.3% in the North West LHIN region to a high of 37.7% in the Toronto Central LHIN region (Figure 5.4).

See this chapter's Real-World Experiences story, "A Call to Care," about an alternative way to follow-up and what it means to patients and their families

FIGURE 5.4
Rate of follow-up with a doctor within seven days of leaving hospital, for a mental illness or an addiction,[†] in Ontario, by LHIN region, 2013/14



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Registered Persons Database, provided by the Institute for Clinical Evaluative Sciences. [†]Age- and sex-adjusted.

Hospital readmission rates for a mental illness or an addiction

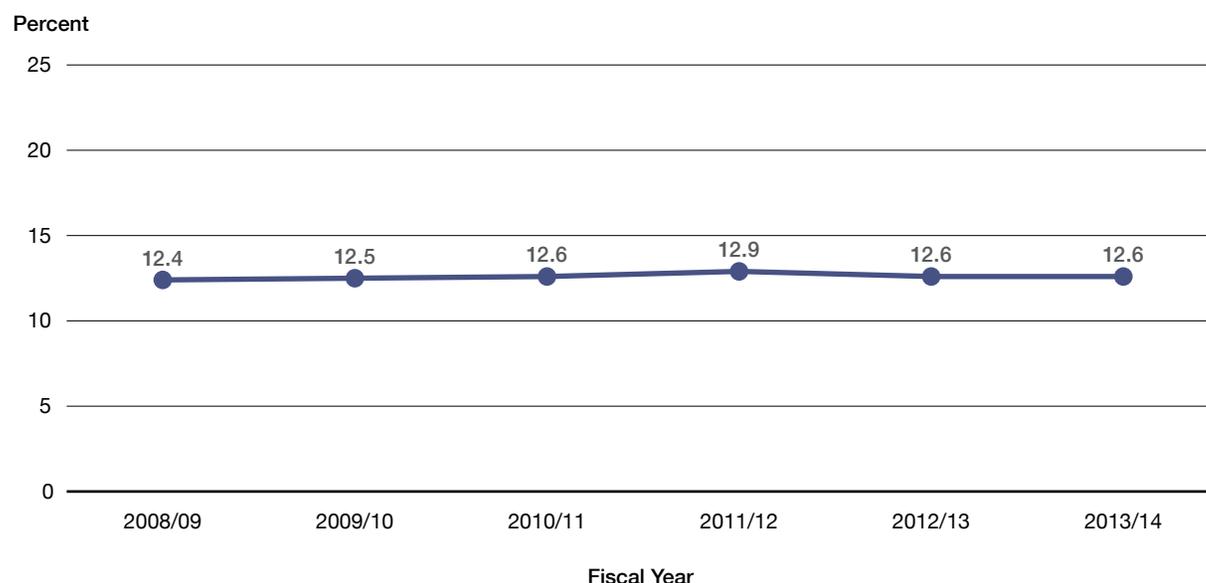
At 12.6%, the 30-day readmission rate for patients with a mental illness or an addiction has not improved during the latest five-year period

Some readmissions for mental illness or addiction are unavoidable, but in some cases, when patients receive the right care and follow-up after their first hospitalization, readmissions can be prevented. As we noted in looking at readmissions for medical and surgical patients (Chapter 3), a reduction in the rate of readmission to hospital within 30 days of a previous hospitalization is typically considered an improvement.

Constant at around 12.5%, the 30-day readmission rate for mental illness and addictions in Ontario has not improved over a five-year period (Figure 5.5). It is comparable to the 30-day readmission rate for medical patients (13.6%) and above the readmission rate for surgical patients (7.2%).^[59] Regional rates vary slightly across the province in 2013/14, from a low of 10.7% in the North West LHIN region to a high of 14.7% in the Toronto Central LHIN region (Figure 5.6).

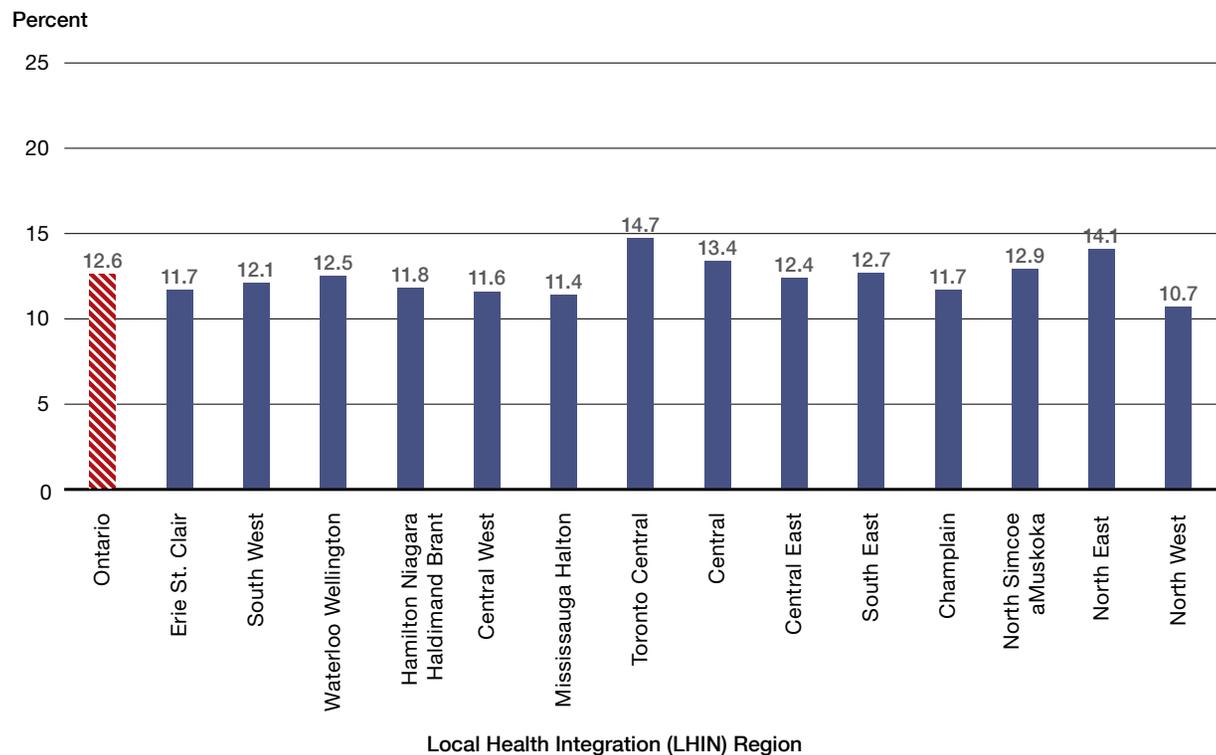
FIGURE 5.5

Hospital readmission rate within 30 days for a mental illness or an addiction,[†] in Ontario, 2008/09 to 2013/14



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System and Registered Persons Database, provided by the Institute for Clinical Evaluative Sciences. [†]Risk-adjusted.

FIGURE 5.6
Hospital readmission rate within 30 days for a mental illness or an addiction,[†] in Ontario, by LHIN region, 2013/14



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Ontario Health Insurance Plan, Registered Persons Database, provided by the Institute for Clinical Evaluative Sciences. [†]Risk-adjusted.

Use of physical restraints in facilities providing acute mental health care

The rate of physical restraint use with patients hospitalized with a mental illness has improved, dropping from 8.5% to 5.5% in six years

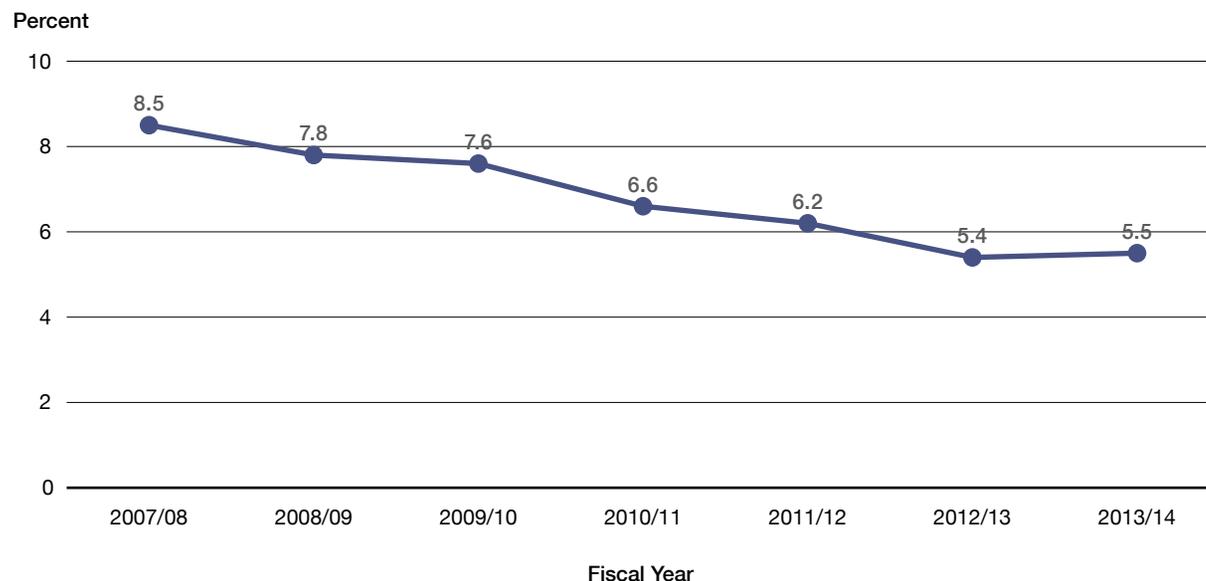
The use of physical restraints is never part of the preferred treatment plan for mental illness, but the practice is sometimes used as a last resort to prevent patients from harming themselves or others. Based on the *Patient Restraint Minimization Act*, the *Mental Health Act* and the *Health Care Consent Act*, Ontario facilities providing acute mental health care have developed guidelines for the use of physical restraints. These guidelines include a “least-restraint approach” that calls for exploring all possible alternatives before physically restraining a patient.[60]

Certain medications are informally referred to as chemical restraints because they can be used for their restraining effect. Our results do not include these medications since they can also be used to treat a patient’s symptoms, and data that separate the different uses of these drugs are not available.

The use of physical restraints during acute mental health care has improved (decreased) from 8.5% in 2007/08 to 5.5% in 2013/14 (Figure 5.7). The variation in use of physical restraints across LHIN regions has also been decreasing over time. In 2007/08, the spread was 8.7% (from 3.0% in the Erie St-Clair LHIN region to 11.8% in the South West LHIN region). In 2013/14, this gap was only 3.5%, with the lowest rate again in the Erie St-Clair LHIN region (3.9%) and the highest rate in Central East LHIN region (7.4%).[61]

FIGURE 5.7

Percentage of patients in mental health designated beds who were physically restrained,[†] in Ontario, 2007/08 to 2013/14



Data source: Ontario Mental Health Reporting Systems, provided by the Institute for Clinical Evaluative Sciences. [†]Age- and sex-adjusted. Note: Results show where patients live, not where the hospital they went to is located.

How Ontario compares: within Canada

Statistics Canada reports suicide rates for each province. Compared with other provinces, Ontario has the second lowest rate (8 per 100,000 people) after Prince Edward Island (6 per 100,000) (Figure 5.9). Ontario's rate is lower than the national average of 10 suicides per 100,000.

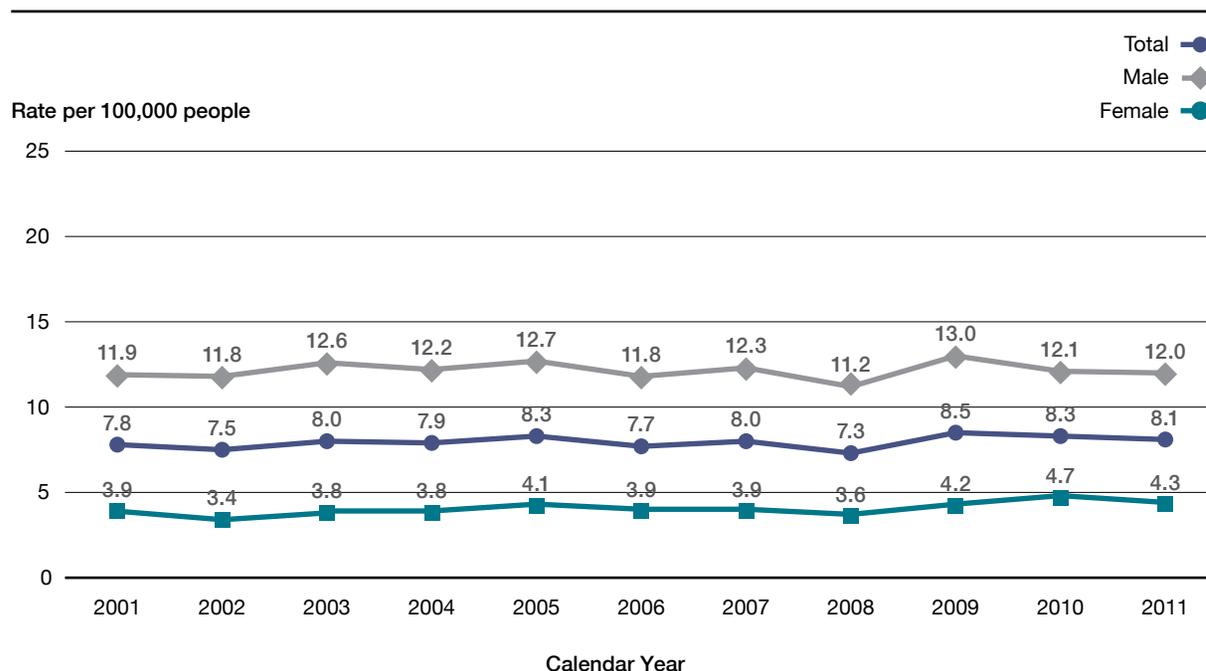
Suicide rates

Ontario's suicide rate of 12 per 100,000 among men is nearly three times higher than among women

Worldwide, suicide is the fourth-leading cause of death for people aged 15 to 44 years. Some studies have estimated that nine out of 10 people who have died as a result of suicide have a diagnosable mental illness. Men are generally at a much higher risk than women of dying from suicide.[62-64]

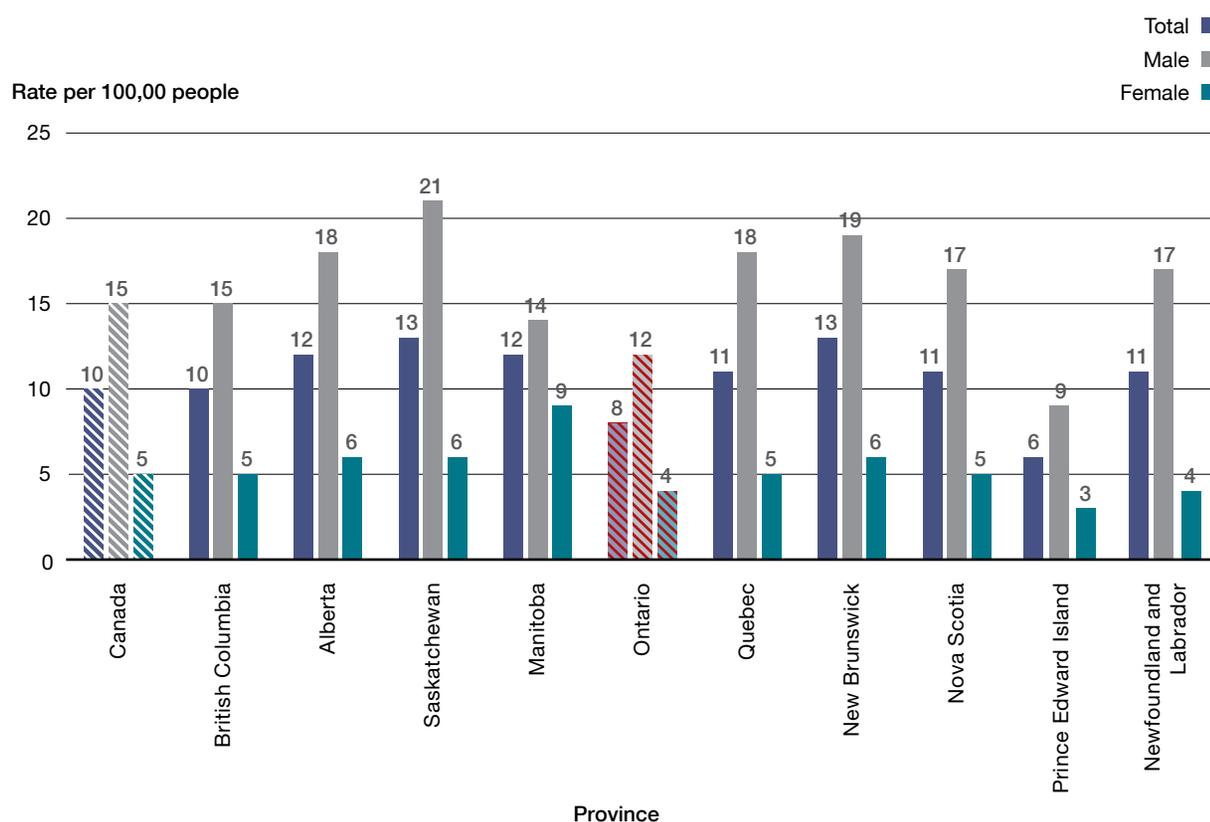
The suicide rate in Ontario has remained constant over 10 years, with a rate of 8.1 per 100,000 people in 2011, the most recent year for which we have data (Figure 5.8). The suicide rate for men (12.0 per 100,000 people) was almost three times higher than the rate for women (4.3 per 100,000 people) in 2011.

FIGURE 5.8
Suicide rate per 100,000 population,[†] in Ontario, total and by sex, 2001 to 2011



Data source: Statistics Canada. Table 102-0552. Deaths and mortality rate, by selected grouped causes and sex, Canada, provinces and territories, annual, CANSIM (database). [†]Age-adjusted.

FIGURE 5.9

Suicide rates per 100,000 population,[†] in Canada, by province, total and by sex, 2011

Data source: Statistics Canada. Table 102-0552. Deaths and mortality rate, by selected grouped causes and sex, Canada, provinces and territories, annual, CANSIM (database). [†]Age-adjusted.

In summary

Each year, about one in 200 Ontarians are hospitalized for a mental illness or an addiction. This number has changed very little in the last five years, but rates in some regions are substantially higher, compared to the provincial average, and much lower in others. Far fewer of these patients are being physically restrained during their hospital care compared to six years ago, and this improvement has resulted in much less variation across the LHIN regions. Ontario's suicide rate is relatively low compared to the other provinces, but it has not decreased over the past decade.

Over the last six years, less than one-third of patients hospitalized for a mental illness or an addiction has had a follow-up visit with a doctor within seven days after leaving hospital. Regional rates vary on this indicator, which may suggest that follow-up services are less available or accessible in some areas of the province than in others. Reporting on the quality of care for mental illness and addictions is challenging because there are large gaps in the information available, especially data on community services.

Home Care

In this chapter, we report on four Common Quality Agenda indicators related to home care: patient satisfaction with home care services, the waiting period for some home care services, placement in long-term care homes, and distress among informal caregivers.

Photo by Roger Yip

Real-World Experiences

Janice: Caring for the Caregivers

Janice first noticed something was odd about her husband Derry when the usually quick-witted 55-year-old began interjecting things into conversations related to topics that had been discussed much earlier. Things got worse from there, as Derry, a computer industry program manager, lost one job contract after another. He was eventually diagnosed with a dementia.

Janice had heard about the Alzheimer Society and called to see what services were available. They helped her a lot by providing information about the disease and suggested going to a geriatric psychiatrist. “But in terms of supports and respite, I really had to do it all myself,” Janice says.

For almost 13 years after the diagnosis, Janice was her husband’s main caregiver while the disease progressed from bad to unmanageable. She kept a diary of her experiences and now finds it almost unbelievable to read about what she and Derry went through every day. Janice would rush around taking care of everything in the house, while also trying to help Derry perform basic tasks that became increasingly difficult for him. He tried to wash the dishes but ended up putting dirty plates in the drainer tray. He decided to work on

the garden but ended up destroying it. He would forget to put on his pants, couldn’t make a taco and never flushed the toilet.

The worst part, Janice says, was not knowing how much Derry could do. “You still have a sense that he can do something and then when he can’t do it, you get frustrated, then you get angry and then you feel guilty,” she says. “And I think that anger and guilt and then hopelessness are what gets to you.”

In 2010, Alzheimer Society Peel launched a program, First Link, to help people like Janice when they find out a family member has dementia. First Link helps connect patients and caregivers to supports as soon as they leave the office of their doctor, occupational therapist, physiotherapist or nurse practitioner. Often, people will get a call on the way home, says Katie, an outreach counsellor with Alzheimer Society Peel.

With a limited number of long-term care home beds and with people with dementia wanting to stay at home for as long as possible, Katie says First Link is trying to help families navigate caring for people at home. “This isn’t a disease where you can journey on alone,” Katie says. “There are so many people along the way who can provide support.”

“This isn’t a disease where you can journey on alone. **There are so many people along the way who can provide support.**”

When it became impossible for Janice to continue caring for Derry at home, she took him to the hospital, where he stayed for six months, before being admitted to a new behavioural support unit in Mississauga.

Janice is a member of the Caregiver Respite Program Collaborative which is working to identify opportunities to enhance and develop respite options for caregivers. “That was one thing at the end that was missing for me,” Janice says. “I had used everything that I could and then things escalated for me and when I truly needed it, I couldn’t find the appropriate respite.”

Shifting care home

In recent years, a deliberate effort to shift away from caring for people in hospitals and long-term care homes has increased the demand for home care services in Ontario. This shift in care from institution to home has increased not only the number of people seeking home care, but also the level of care they need.

Today, about two-thirds of home care patients are classified as having high care needs, up from just over one-third five years ago.[65] Patients often have to rely on family or friends for support, especially if their care needs aren't met. This can place a huge burden on those informal caregivers and may reduce their ability to support their loved ones. But when patients receive the right services and care in their home in a timely way, this can help to avoid caregiver burnout. For patients, the right care at home can reduce the need for hospitalizations, for long stays if people are hospitalized, or for moves to long-term care.

Key findings

The percentage of people who enter a long-term care home with low to moderate care needs varies substantially across the province

One-third of informal caregivers are distressed, twice as many as four years ago

While the majority of home care patients with complex needs receive personal support services within the five-day target, it varies substantially across Ontario

Ontario has 14 Community Care Access Centres (CCACs) that coordinate and provide a wide range of home care services, including nursing, case management, personal support, physiotherapy, occupational therapy, speech-language therapy, social work, nutritional counselling and medical supplies. Publicly funded home care services are provided either by CCAC staff or by organizations contracted by the CCACs. The centres also work with primary care providers, hospitals and community support services to help home care patients navigate the health system and manage transitions from one setting to another.[65] The 14 CCACs have the same geographical boundaries as the LHINs and share the same geographical names (see Figure 1.2).

This chapter includes indicators of nursing and support services provided by CCACs in Ontario, but we don't have indicators of other community supports such as meal delivery or home-making services, which some home care patients rely on to stay at home.

Waiting for home care services

Most home care patients receive services within the five-day target

Providing home care in a timely manner is key to helping people remain in their homes and avoiding visits to emergency departments. In 2013, Ontario introduced five-day wait time targets for nursing services for all home care patients and for personal support services for patients with complex needs.[69]

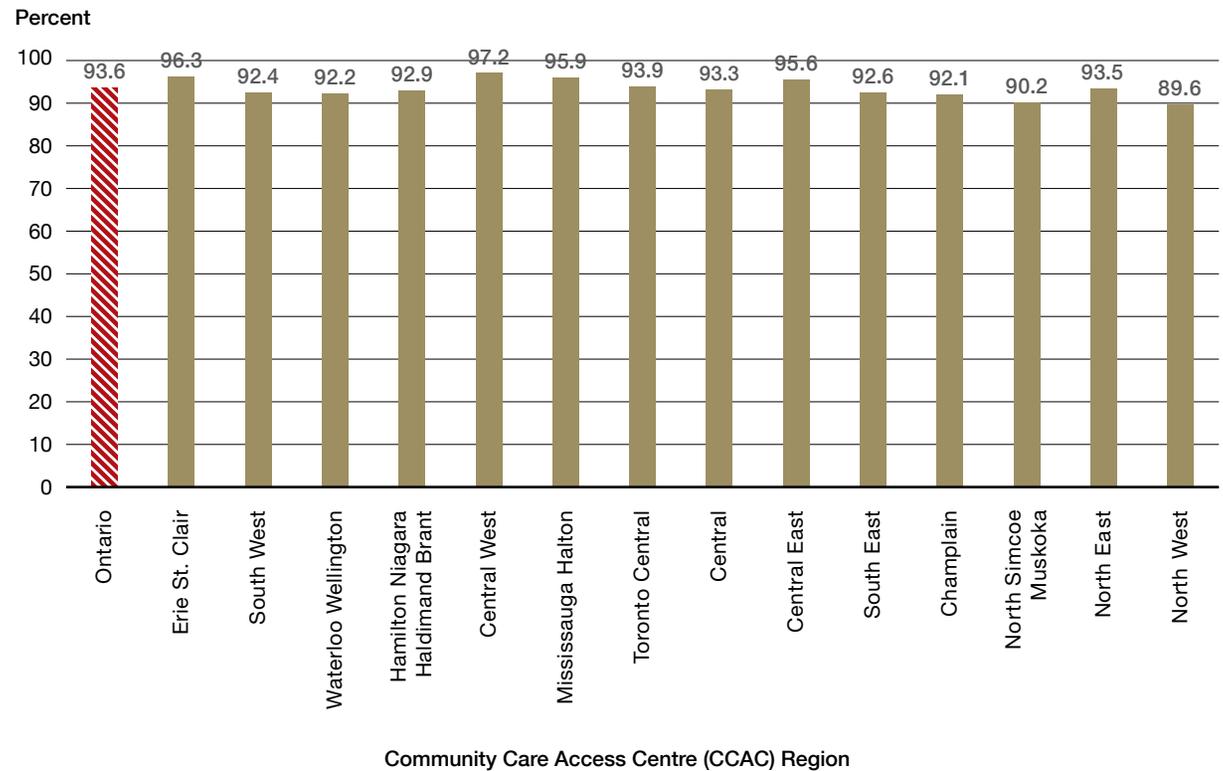
There are several steps that must occur before a patient receives home care in Ontario. Typically, a patient first receives a referral for home care, a care coordinator then performs an assessment, an authorization follows for a service provider to deliver one or more services, and then services can start. The wait time indicator reported here covers only the time from service authorization to the start of nursing and personal support services for new and existing adult home care patients. It does not cover wait times that might occur at other steps of the process or for patients waiting for other types of home care services.

In 2013/14, 93.6% of Ontario home care patients requiring nursing services received their first nursing visit within five days. The proportion is similar to the previous year (2012/13), when it was 94.0%.[70]

Among the CCAC regions, there is moderate variation in the percentage of home care patients who received nursing services within five days in 2013/14, ranging from a low of 89.6% in the North West CCAC region to a high of 97.2% in the Central West CCAC region (Figure 6.1).

FIGURE 6.1

Percentage of home care patients aged 19 and older who received their first nursing visit within five days of authorization to receive nursing services, in Ontario, by CCAC region, 2013/14

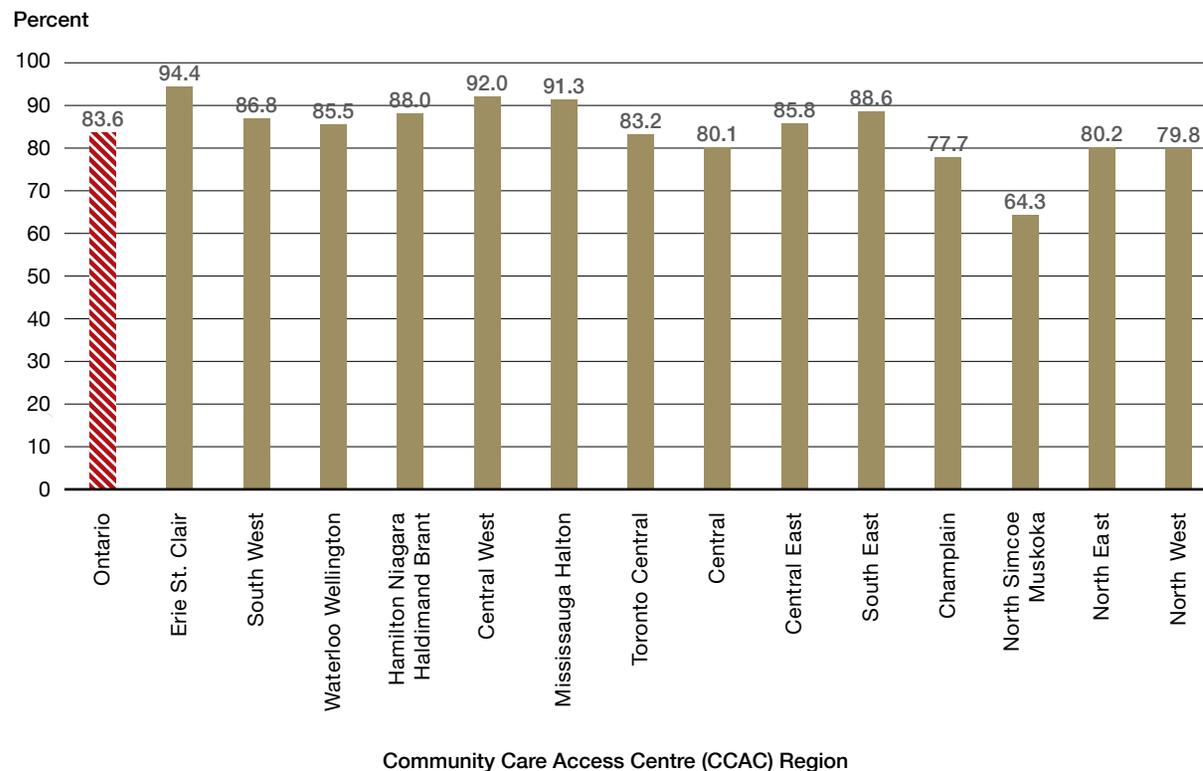


Data source: Home Care Database, provided by the Ministry of Health and Long-Term Care.

For patients with complex needs who required personal support services, 83.6% received the services within five days of authorization in 2013/14. This rate varies substantially across Ontario, ranging from a low of 64.3% in the North Simcoe Muskoka CCAC region to a high of 94.4% in the Erie St. Clair CCAC region (Figure 6.2).

FIGURE 6.2

Percentage of home care patients aged 19 and older with complex needs who received their personal support visit within five days of authorization to receive personal support services, in Ontario, by CCAC region, 2013/14



Data source: Home Care Database, provided by the Ministry of Health and Long-Term Care.

Placement in long-term care homes

The percentage of people with low to moderate care needs who enter a long-term care home varies substantially across the province

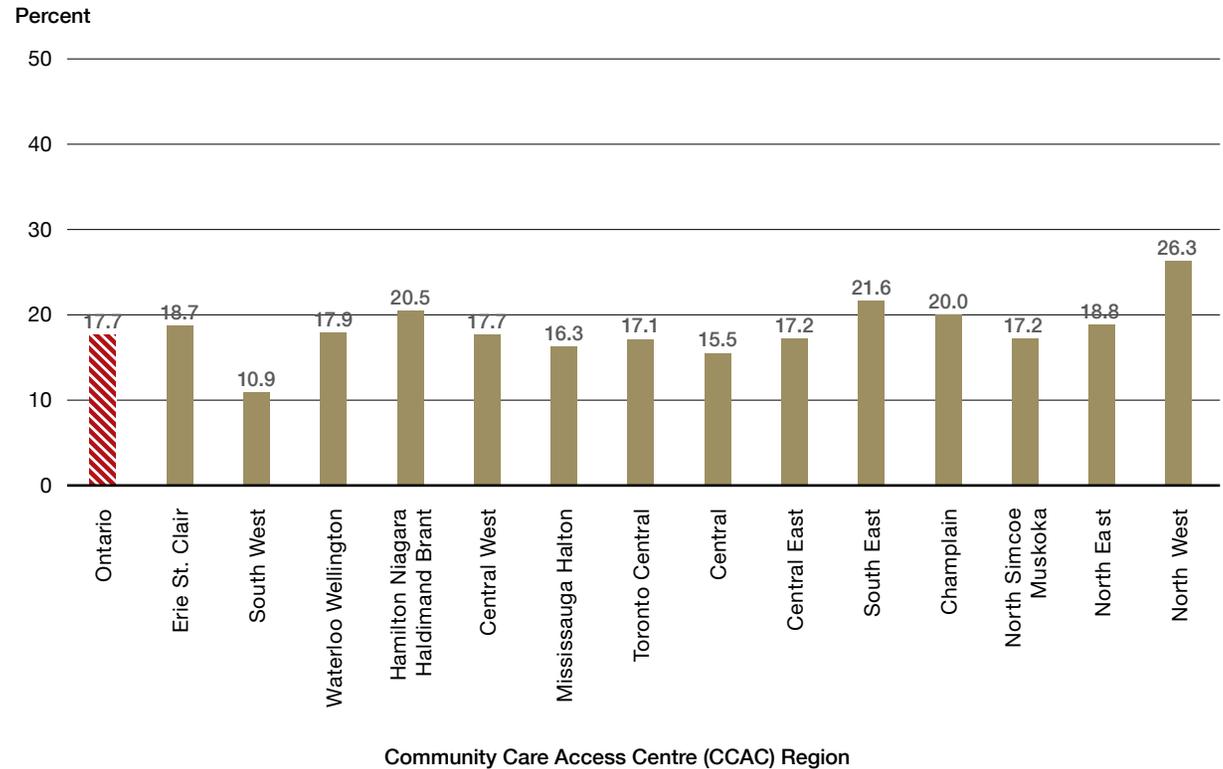
Many people want to stay in their homes for as long as possible and delay, or avoid, moving to a long-term care home. For the health system, long-term care is more costly than home or community care.[71,72]

The CCACs use a standardized assessment tool both to prioritize access to home care services and to help manage placement in long-term care homes in Ontario. People with low to moderate scores are usually able, with the right support, to remain at home or somewhere else in the community, such as retirement homes or assisted living facilities. On this indicator, a lower result is positive: fewer people with low to moderate scores are entering long-term care. [73,74]

In 2013/14, 17.7% of the people who entered a long-term care home had low to moderate care needs (Figure 6.3). This percentage is the same as the previous year (17.8% in 2012/13).[75]

This percentage varies substantially across CCAC regions with the rate in the North West CCAC region (26.3%) more than double the rate of the South West CCAC region (10.9%) (Figure 6.3).

FIGURE 6.3
Percentage of people with low to moderate care needs who entered a long-term care home, in Ontario, by CCAC region, 2013/14



Data sources: CCAC Client Management System and RAI-HC via Long Stay Assessment Software, provided by the Ontario Association of Community Care Access Centres.

Informal caregiver distress

The percentage of distressed informal caregivers has more than doubled over four years

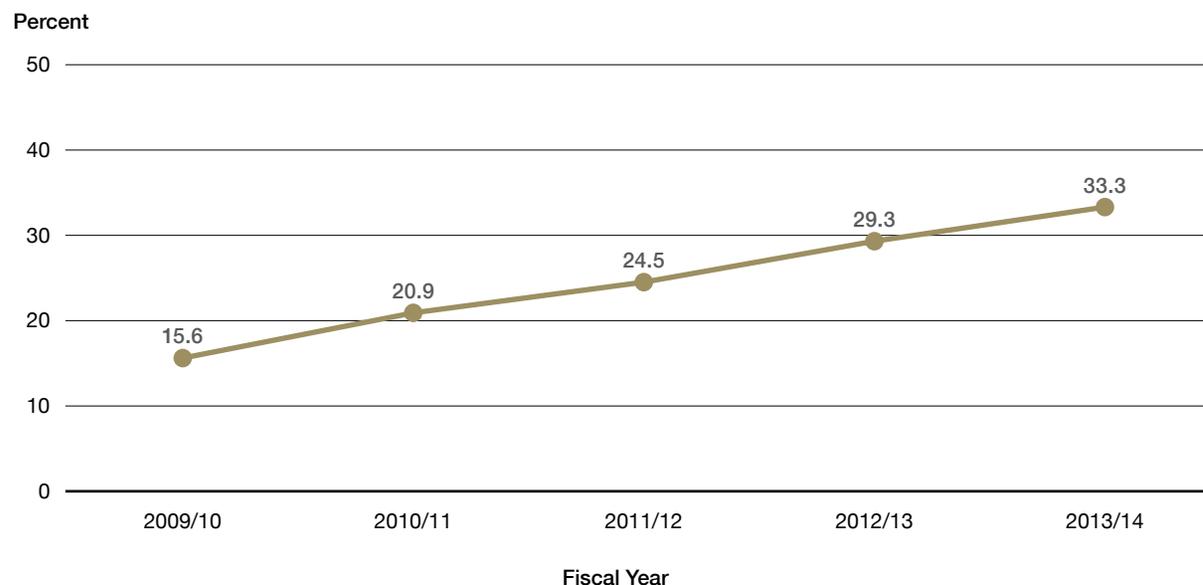
Almost all home care patients (97%) receive support from an informal caregiver who may be a family member, a friend, or a neighbour. In addition to providing emotional comfort, informal caregivers also support home care patients through grocery shopping, cleaning, transporting, managing medication and helping with toileting. Not only do they play a key role in supporting patients, they are an integral part of home care.[76,77]

Being an informal caregiver can be highly challenging and stressful. So part of the home care assessment is determining the level of distress of the patient's primary informal caregiver — the person who the patient relies on the most.

In 2013/14, 33.3% of primary informal caregivers supporting home care patients who require care over a long period of time (long-stay home care clients) in Ontario expressed feelings of distress, anger or depression or were unable to continue providing care (Figure 6.4). This percentage has more than doubled over a four-year period, climbing from 15.6% in 2009/10.

FIGURE 6.4

Percentage of home care patients with a primary informal caregiver whose caregiver is unable to continue in caring activities or expresses feelings of distress, anger or depression, in Ontario, 2009/10 to 2013/14



Data source: Home Care Reporting System, provided by the Canadian Institute for Health Information.

Patient experience

More than nine out of 10 Ontario patients surveyed continue to report having a positive experience with their home care

Surveying patients about their experience with the health care services they receive has become a widespread practice to improve quality of care. A positive patient experience often leads to better outcomes.[66,67]

Ontario has developed a common approach to measuring the experience of home care patients. Patients are reported to have a positive experience if they rate their services as good, very good or excellent.

In 2013/14, 92% of home care patients surveyed in Ontario reported a positive experience with the services they received from both care coordinators and service providers. This is stable compared to the previous year's rate of 93% (2012/13).[68]

There is only slight variation in patients' experiences with home care services across the province. The proportion reporting a positive experience ranges from 91% in the Mississauga Halton, Central and Central West CCAC regions to 94% in the South West and South East CCAC regions.[68]

In summary

In an environment of increasing demand for home care services, most of the home care indicators did not improve since the previous year. At the same time, the vast majority of home care patients continue to report a positive experience with the home care they receive. In addition, most nursing services and personal support services (for patients with complex needs) start within five days of authorization, the target set by the Ministry of Health and Long-Term Care for these services.

However, a growing proportion of family and friends who act as the primary informal support for home care patients are feeling the stress of that role: caregiver distress has more than doubled over a four-year period. The regional variation in the percentage of new long-term care residents needing low to moderate levels of care, along with the overall lack of improvement for that indicator, also points to unaddressed needs. This highlights opportunities to integrate home care and other services better so that people without complex needs can remain at home longer.

Hospital Care

In this chapter, we report on seven Common Quality Agenda indicators related to emergency and acute inpatient care in hospitals: patient experience, time spent in the emergency department, wait times for some procedures performed in hospital (joint replacements, cardiac procedures, cancer surgeries), hospital-acquired infections, and rates of Caesarean section deliveries.

Real-World Experiences

Brian: Heart of the Matter

Brian was playing an intense game of competitive-league tennis when he realized he was feeling unusually tired. “I remember going down on one knee and looking up at the tennis dome roof and wondering to myself what a heart attack felt like,” recalls the Whitby IT sales manager. “I tried to continue the match and I actually got to the point where I just couldn’t breathe and I had to forfeit.”

The next day, Brian felt better, but his wife persuaded him to visit the family doctor, who didn’t find anything alarming in his initial examination but sent Brian for further testing. “I didn’t look like your typical candidate for heart disease. At the age of 46 going on 47, I was fairly fit,” says Brian, noting he had no risk factors such as smoking, high blood pressure, high cholesterol, diabetes or being overweight, though there was heart disease in his family.

After five weeks of tests, an angiogram revealed that three of Brian’s four main arteries were clogged almost 100%. When he was told he needed triple bypass surgery, it hit Brian hard: “Everybody’s life continued – my kids still went

to school, my wife was going to work – and I’m walking around the house like a human ticking time bomb.”

Brian’s initial intense anxiety during the wait was eased somewhat by a reassuring call from his family doctor, but his condition was deteriorating. “I remember walking down the street maybe five minutes – not even, two minutes – and I said to my wife, ‘I have to turn around, I can’t breathe.’”

After waiting six weeks, Brian had surgery at a Toronto hospital. It went smoothly, but afterward, Brian had to spend two extra nights in the intensive care unit, which was noisy, bright and anything but restful, because there were no beds available on the recovery floor. Overall, he says, the hospital staff were great and he was well taken care of. He went home five days after surgery.

“The hardest part was really, as you can imagine, the bending and getting in and out of bed because you have to twist your torso and I had 80-odd staples holding my calf, my entire left forearm and my chest together.” Brian credits an “amazing” cardiac rehab program with helping him get back to the activities he loves. One year after surgery, he ran a 10-kilometre race.

“Everybody’s life continued – my kids still went to school, my wife was going to work – and I’m walking around the house like a human ticking time bomb.”

Emergency and inpatient care

Hospitals provide a wide range of services in both inpatient and outpatient care. In this chapter, we look at measures of care in the emergency department and acute care wards, where patients are treated (usually for a short period of time) for a disease, injury or severe episode of illness or where they undergo surgical procedures and receive recovery care if needed. The goal is to discharge patients as soon as it is appropriate for them to return home or to another care setting such as rehabilitation, home care or long-term care.

Key findings

More than 95% of patients waiting for an urgent cardiac procedure got it within recommended wait times in 2014/15

The rate of hospital-acquired *C. difficile* infections has decreased slightly in recent years

Almost one in five very-low-risk births is a Caesarean section delivery

People will seek care in hospital for a wide range of conditions, usually for a short period of time.

Patient experience

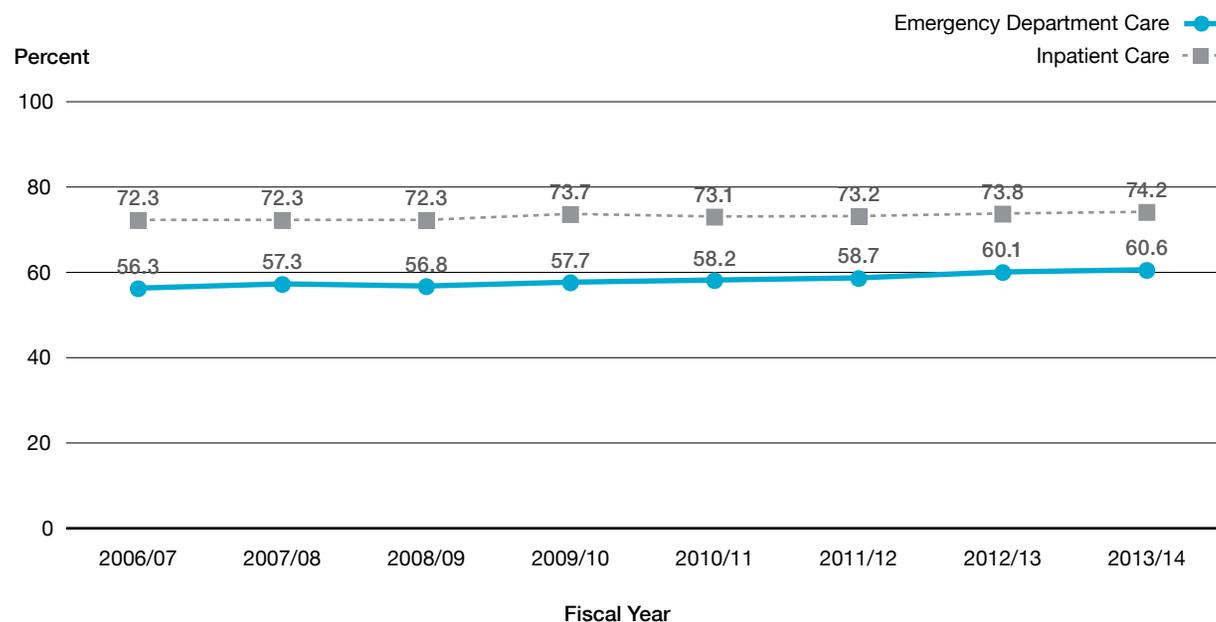
Nearly three-quarters of Ontario inpatients surveyed would recommend to family and friends the hospital where they received care

More than 80% of the hospitals in Ontario collect information about patient experience, using a common approach to survey patients after they have been discharged. Surveyed patients are asked whether they would recommend to their family and friends the hospital where they received care. Answer options include “Yes, definitely,” “Yes, probably,” and “No.”

Among people who visited a hospital emergency department, the percentage who said they would definitely recommend that hospital to family and friends has improved slightly over seven years, rising to 60.6% in 2013/14 from 56.3% in 2006/07. Among people discharged from inpatient care, the percentage who said they would definitely recommend that hospital was higher, but changed minimally over the same period, 74.2% in 2013/14 compared to 72.3% in 2006/07 (Figure 7.1).

FIGURE 7.1

Hospital experience: percentage of survey respondents who would “definitely” recommend hospital to family and friends, in Ontario, 2006/07 to 2013/14



Data source: National Research Corporation of Canada, provided by the Ontario Hospital Association.

Emergency department length of stay

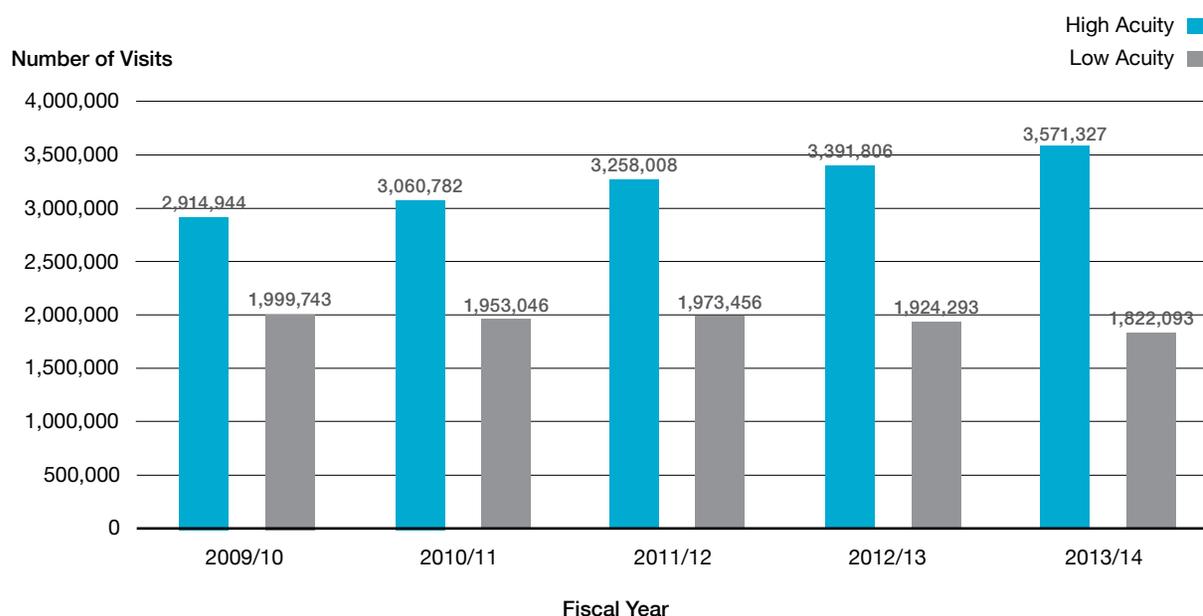
Despite growing numbers of emergency department visits, the maximum length of stay for 90% of patients continues to decrease

Measuring the use of hospital emergency departments and the length of patients' visits provides information not only about care within hospitals but also about how well other parts of the health system are working. Some patients have true emergency needs, but others may visit the emergency department because they can't get care elsewhere when they need it or because of complications from a chronic condition that is not being adequately managed. Primary care providers may also send patients to the emergency department to get faster access to specialists or certain tests.

About 10% of patients who visit Ontario emergency departments need to be admitted to hospital for further care.[78] Some of these patients may spend a long time in the emergency department because inpatient beds are not available. The lack of open beds could, in turn, be a result of other factors in the health system, such as patients not being able to leave the hospital for care in other places (for example, see Figure 3.8, "Percentage of acute care hospital days spent as alternate level of care").

In 2013/14, Ontario's emergency departments handled almost 5.4 million unscheduled visits (Figure 7.2). While the overall number of visits has risen slightly since 2009/10, there has been a shift in the

FIGURE 7.2
Number of visits to the emergency department by acuity level, in Ontario, 2009/10 to 2013/14



Data source: National Ambulatory Care Reporting System, provided by Cancer Care Ontario.

urgency of care that patients need. The number of people with more-urgent needs (high acuity) has been rising, while fewer people are coming to emergency departments with less-urgent needs (low acuity) (Figure 7.2). In 2013/14, low-acuity patients accounted for about 34% of emergency department visits in Ontario, and high-acuity patients accounted for about 66%.[79]

Emergency department length of stay measures the total time that someone who visits an emergency department spends there. The timing starts when a patient either registers or is assessed for the urgency of their needs (triaged), whichever happens first, and ends when the patient is discharged from the emergency department or transferred to an inpatient bed in the hospital for more care.

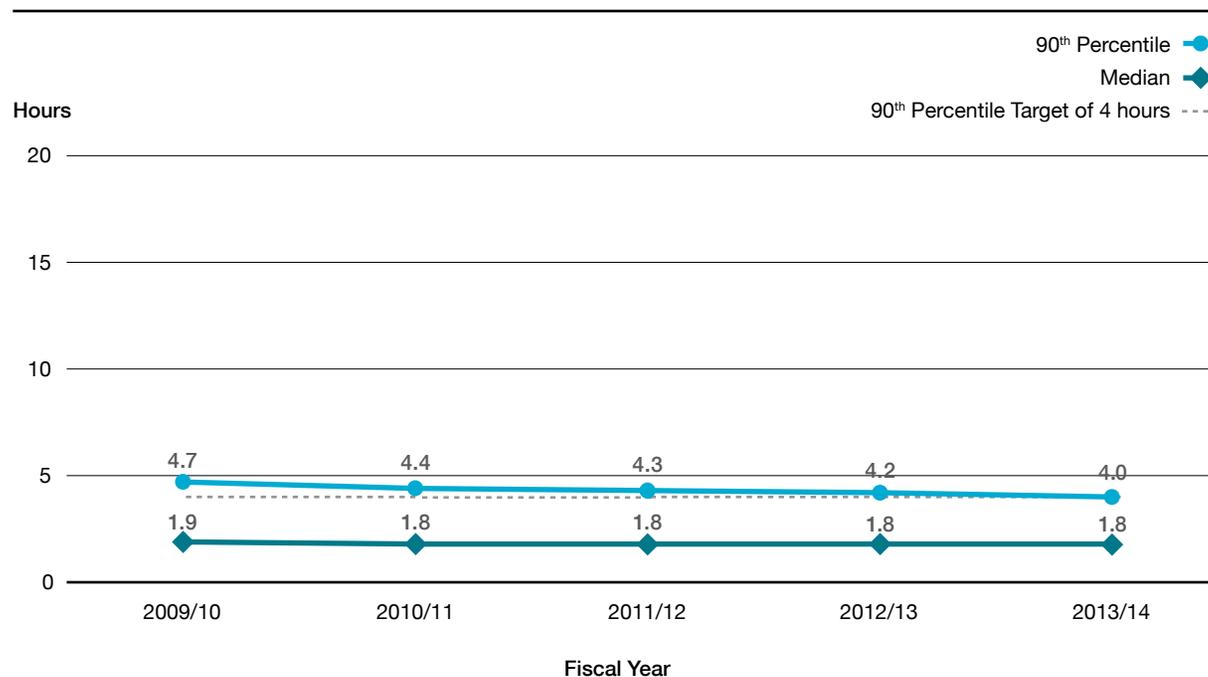
We report the median and 90th percentile emergency department length of stay. The 90th percentile length of stay is the maximum amount of time that nine out of 10 patients (90%) spend in the emergency department before they are either discharged or transferred to an inpatient bed. The other 10% stay longer than the 90th percentile time. The median length of stay is the mid-point of the amounts of time that patients spend in the emergency department: half the people spend less time than the median, and half stay longer. The 90th percentile is useful as a measure of a hoped-for maximum length of stay; the median provides a picture of how long people can usually expect to spend during an emergency department visit.[80]

Using the 90th percentile measure, the Ministry of Health and Long-Term Care sets targets for the amount of time patients should spend in the emergency department in Ontario.[80] These targets are:

- four hours for low-acuity patients (people with a medical condition that does not need to be assessed immediately); and
- eight hours for high-acuity patients (people who do need to be seen immediately or very soon); the target is longer for high-acuity patients because they typically need tests and care that take longer to complete.

Better performance on targets like these has been shown to reduce the risk of hospital admission and death within a week after emergency department care.[81]

FIGURE 7.3
Maximum amount of time nine of 10 patients (90th percentile) and five of 10 patients (median) spent in the emergency department for low-acuity conditions, in Ontario, 2009/10 to 2013/14



Data source: National Ambulatory Care Reporting System, provided by Cancer Care Ontario.

Low-acuity patients

Low-acuity patients in Ontario had a 90th percentile emergency department length of stay of 4.0 hours in 2013/14, meaning 90% of patients completed their treatment in the emergency department within 4.0 hours, meeting the ministry target for this group. This number has decreased (improved)

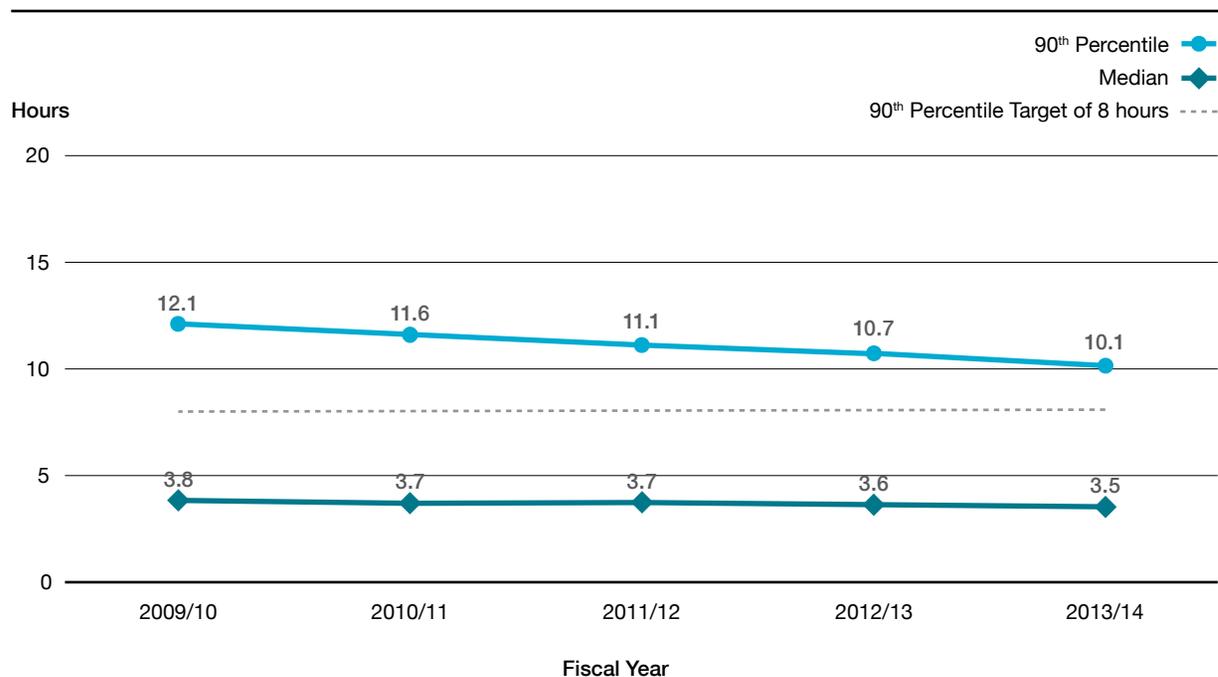
consistently each year since 2009/10, when it was 4.7 hours. The median length of stay for low-acuity patients has remained stable since 2009/10 and in 2013/14 was 1.8 hours, meaning 50% of patients were discharged within that length of time (Figure 7.3).

High-acuity patients

For high-acuity patients, the 90th percentile emergency department length of stay is 10.1 hours in 2013/14, an improvement from 12.1 hours in 2009/10 but still 2.1 hours longer than the eight-hour target (Figure 7.4). The median length of stay, which represents how long patients with more immediate needs can usually expect to spend in an emergency department, is 3.5 hours in 2013/14 and has slightly decreased since 2009/10.

FIGURE 7.4

Maximum amount of time nine of 10 patients (90th percentile) and five of 10 patients (median) spent in the emergency department for high-acuity conditions, in Ontario, 2009/10 to 2013/14



Data source: National Ambulatory Care Reporting System, provided by Cancer Care Ontario.

Wait times for procedures

The Ministry of Health and Long-Term Care has developed the Ontario Wait Time Strategy to improve access to selected diagnostic tests, procedures and surgeries. The strategy includes a set of wait time targets for non-emergency procedures: the recommended maximum time patients should wait, depending on the urgency of their condition. We report the percentage of Ontario patients who receive certain procedures within the target time frame.[82]

Hip or knee replacements completed within target wait times

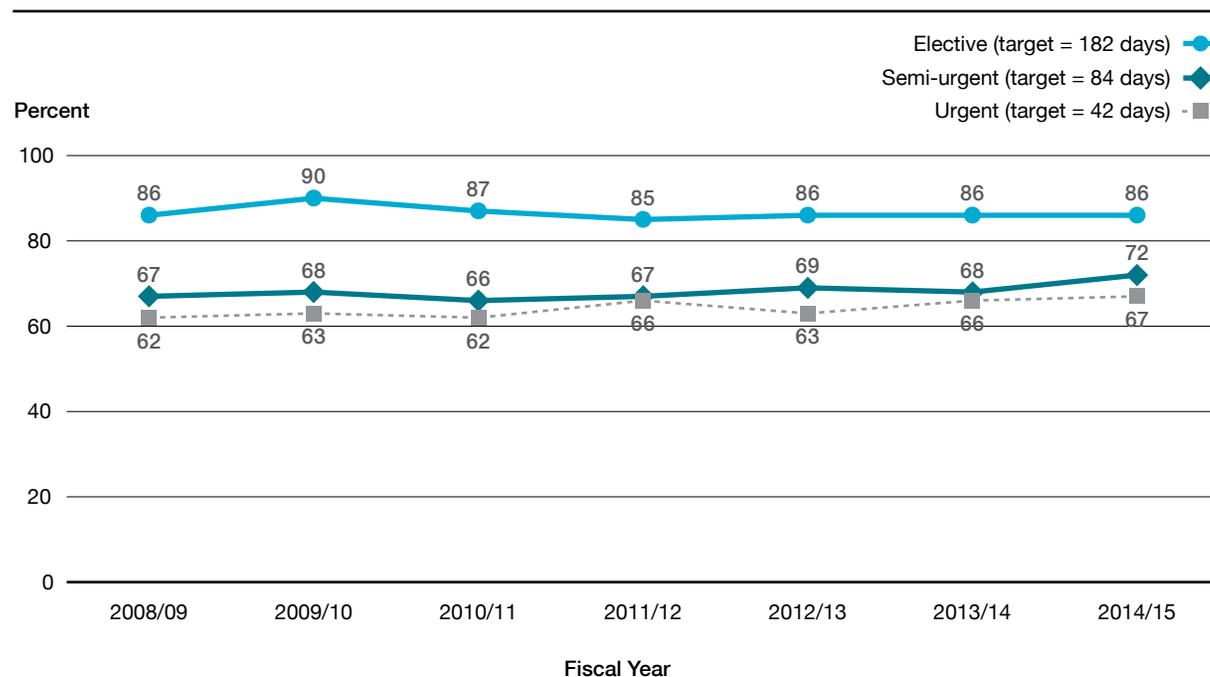
While the number of elective joint replacements has grown, the percentage completed within the target time frame has either remained stable or improved

A hip or knee replacement can significantly improve a patient's mobility and quality of life. Wait times for these surgeries are divided into two parts: first, the time from when a patient is referred to see a surgeon to when the surgeon first sees the patient, and, second, the time from when a patient and surgeon decide to go ahead with the surgery to the time the procedure is completed. Here, we report only on the second wait time.[83,84]

The total number of non-emergency hip replacement surgeries in Ontario has increased by 30%, from 11,292 in 2008/09 to 14,711 in 2014/15. These non-emergency hip replacements are divided into three levels of urgency: urgent, semi-urgent and elective. Elective procedures have tripled over the same six-year period, while semi-urgent and urgent surgeries

FIGURE 7.5

Percentage of hip replacements completed within the recommended maximum wait time by urgency level, in Ontario, 2008/09 to 2014/15



Data source: Wait Times Information System, provided by Cancer Care Ontario.

have both decreased considerably (by 39% and 46%, respectively).[79]

In spite of the large growth in the number of elective hip replacements, the percentage completed within the target of 182 days has been stable at about 86% since 2010/11 after a slight increase to 90% in 2009/10 (Figure 7.5). The percentage of semi-urgent hip replacements completed within the target (84 days) was

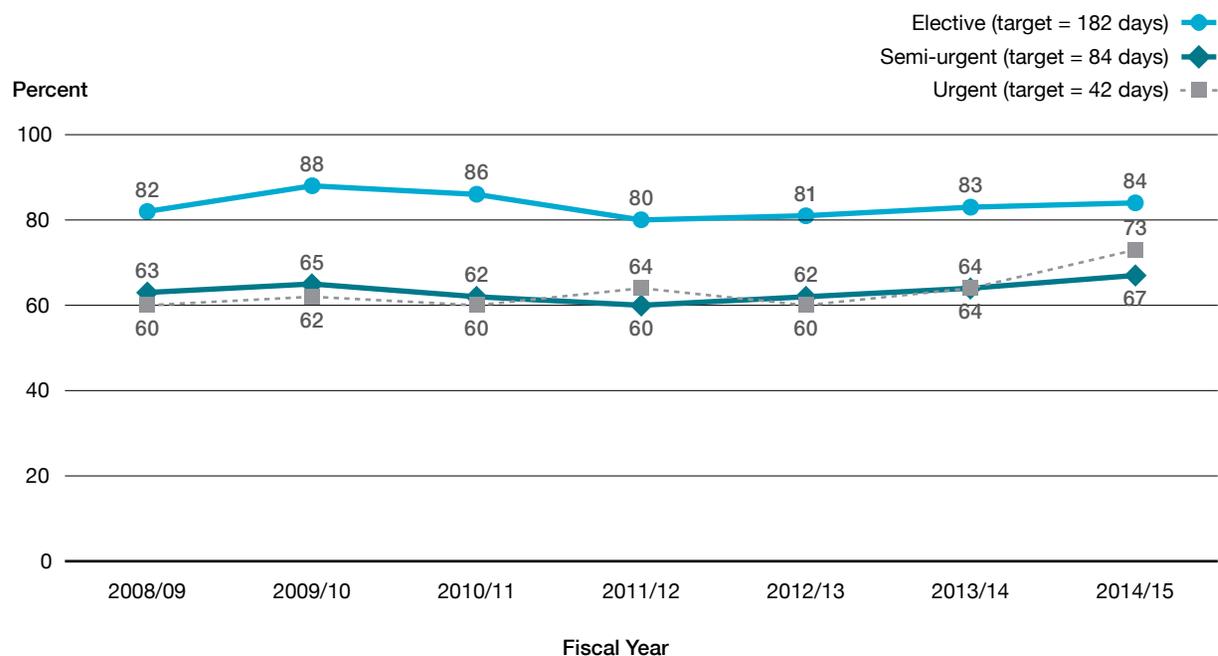
fairly stable between 2008/09 (67%) and 2013/14 (68%) and increased slightly to 72% in the most recent year. Still, more than one in four semi-urgent patients did not receive their hip replacement within the 84-day target in 2014/15 (Figure 7.5). For urgent hip replacements, the percentage completed within the 42-day target slightly increased between 2008/09 (62%) and 2014/15 (67%). In 2014/15, almost one-third of urgent patients did not receive their procedure within the 42-day target (Figure 7.5).

More knee replacement surgeries are performed in Ontario than hip replacements, but there has been a similar pattern of increase in the number of non-emergency procedures over the past six years. Overall, the total number of non-emergency knee replacement surgeries has grown by 25%, from 20,550 in 2008/09 to 25,631 in 2014/15. These non-emergency knee replacements are divided into three levels of urgency: urgent, semi-urgent and elective. While the number of elective knee replacements has more than doubled, the number of semi-urgent and urgent surgeries have each decreased by close to 50%. [79]

While the number of elective knee replacements increased considerably, the percentage completed within the 182-day target has increased slightly each year between 2011/12 and 2014/15, from 80% to 84% (Figure 7.6). For semi-urgent knee replacements, the percentage completed within the target (84 days) has moderately increased since 2011/12, from 60% to 67% (Figure 7.6). The percentage of urgent knee replacements completed within the 42-day target has been increasing moderately since 2012/13. In 2014/15, 73% of urgent knee replacements were completed within the target wait time, 9% more than in the previous year (Figure 7.6).

FIGURE 7.6

Percentage of knee replacements completed within the recommended maximum wait time by urgency level, in Ontario, 2008/09 to 2014/15



Data source: Wait Times Information System, provided by Cancer Care Ontario.

Cardiac procedures completed within access target

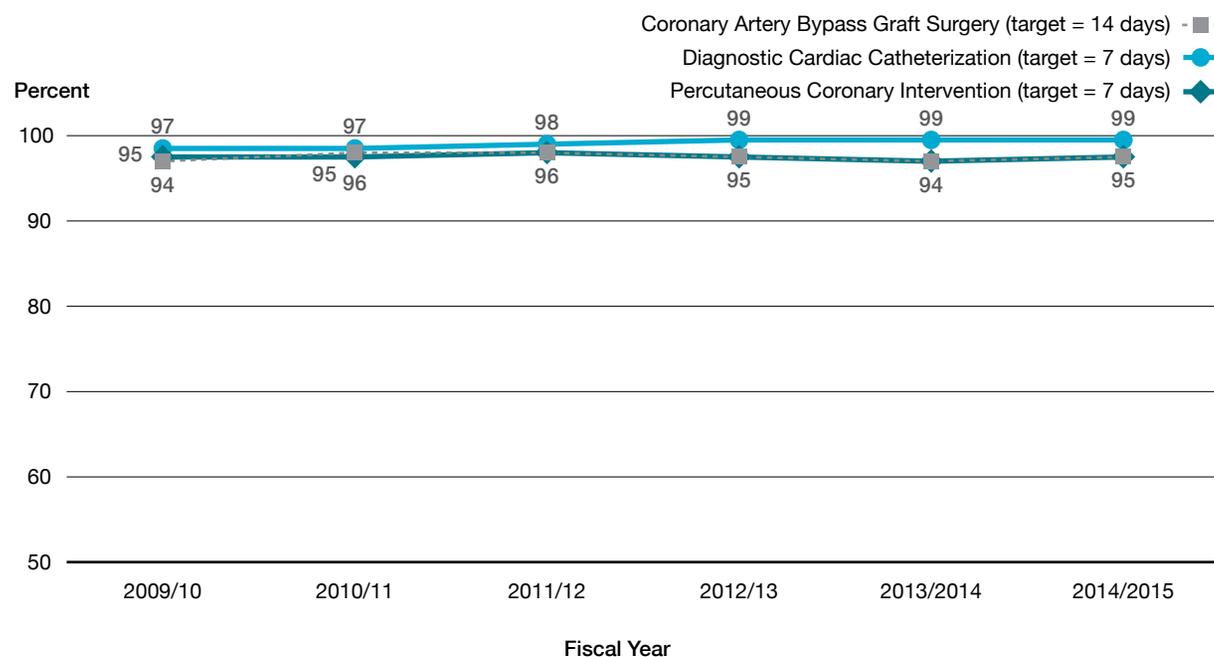
Almost all patients (99%) waiting for an urgent diagnostic cardiac catheterization had the procedure completed within the recommended wait time in 2014/15

Each patient waiting for a cardiac procedure is assigned to one of three urgency levels — urgent, semi-urgent or elective — and the Cardiac Care Network of Ontario has set access targets for each urgency level. We report on the percentage of patients who received care within the recommended access targets for three common cardiac procedures:

- **diagnostic cardiac catheterization:** a test that involves taking images of the coronary arteries so doctors can see how blood flows into the heart[85]
- **percutaneous coronary intervention:** a procedure that involves using a catheter to insert a stent to widen the blood vessels in the heart[86]
- **coronary artery bypass graft:** a surgery that involves creating a detour around a blocked part of the coronary artery by inserting a section of blood vessel from elsewhere in the body to the affected area of the heart[87]

For each of these cardiac procedures, the percentage of urgent procedures completed within the access target has remained stable over the past five years with almost every case completed within the target time frame. In 2014/15, 99% of patients waiting for urgent diagnostic cardiac catheterization had their procedures completed within the target time frame (a maximum of seven days), while 95% of

FIGURE 7.7
Percentage of urgent cardiac procedures completed within access target, in Ontario, 2009/10 to 2014/15



Data source: Cardiac Care Network of Ontario Cardiac Registry.

patients waiting for an urgent coronary artery bypass graft surgery or an urgent percutaneous coronary intervention had the procedure completed within the access targets (a maximum wait of 14 days for coronary artery bypass graft surgery, or seven days for percutaneous coronary intervention) (Figure 7.7). The results are similar for semi-urgent and elective procedures; at least 90% of cases were completed within the access targets in 2014/15.[88]

Cancer surgery wait times

The percentage of cancer surgeries completed within the target time has improved for all priority levels over six years

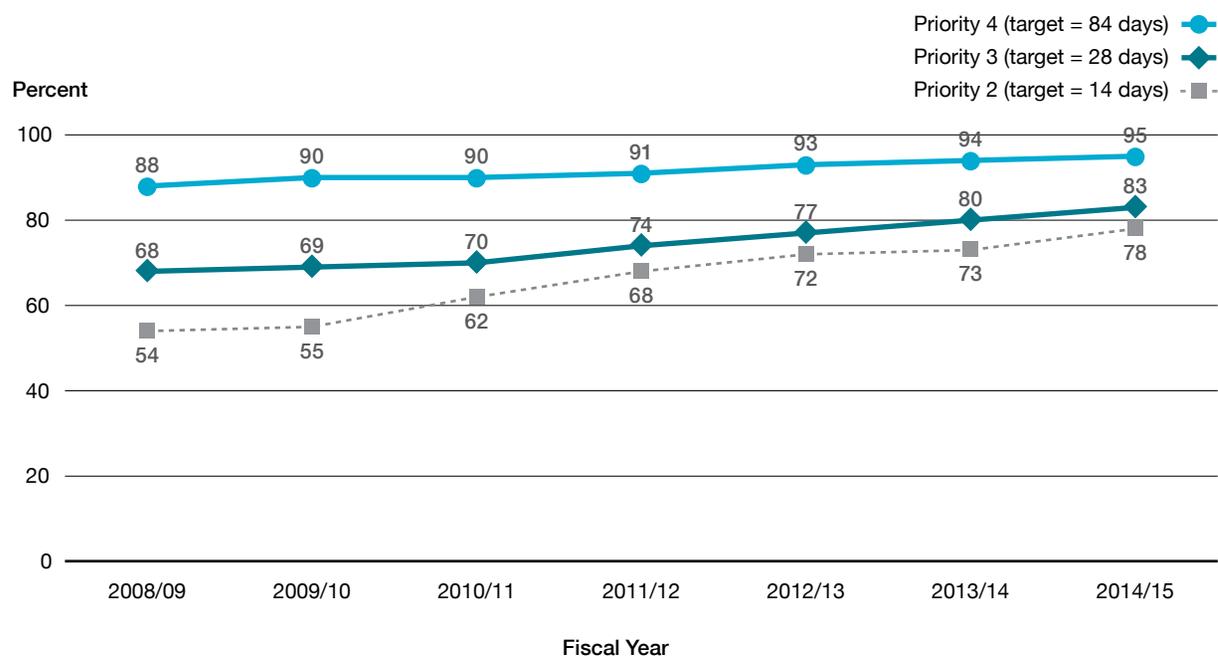
To achieve the best possible outcomes, it is important that cancer patients receive timely treatment. Patients with a more aggressive cancer typically need treatment more rapidly than patients with a slower-growing cancer, and wait time targets for cancer care in Ontario are based on priority levels, from 1 to 4, with priority 1 being the most urgent. We report on wait times for cancer surgery for three levels of urgency: priority 2 (maximum recommended wait, 14 days), priority 3 (28 days) and priority 4 (84 days).[82,89,90]

The total number of cancer surgeries completed in Ontario has grown each year since 2008/09, rising from 42,285 that year to 48,551 in 2014/15, a 15% increase.[79]

The percentage of cancer surgeries completed within target wait times has increased between 2008/09 and 2014/15 for all priority levels reported here: from 54% to 78% for priority 2, from 68% to 83% for priority 3, and from 88% to 95% for priority 4 (Figure 7.8).

FIGURE 7.8

Percentage of cancer surgeries completed within recommended maximum wait time, by priority level, in Ontario, 2008/09 to 2014/15



Data source: Wait Times Information System, provided by Cancer Care Ontario.

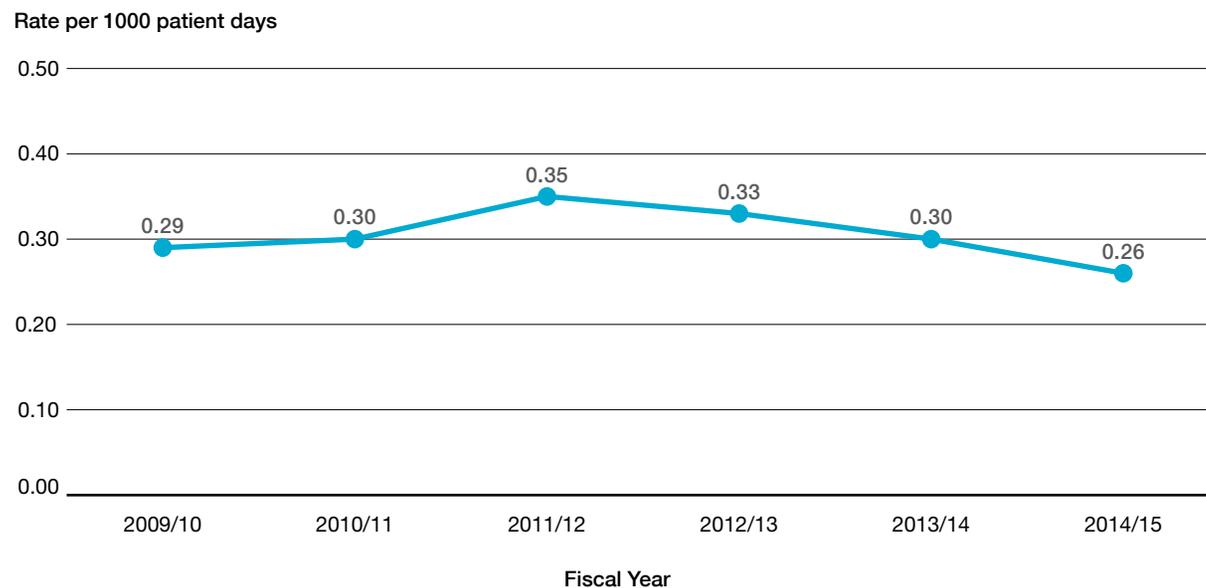
C. difficile infections acquired in hospital

The rate of hospital-acquired *C. difficile* infections has decreased slightly, amounting to more than 800 fewer cases, between 2011/12 and 2014/15

Hospital-acquired infections are serious, potentially deadly infections that can be present in the hospital environment and transmitted, directly or indirectly, from one patient to another. Patients do not have these infections when they are admitted but can be vulnerable to them while in hospital. *C. difficile* is one such germ; it can cause severe diarrhea, fever, and abdominal pain. While it is not possible to eliminate *C. difficile* infections, hospitals can reduce the spread of this germ by following recommended protocols. Hospitals regularly monitor and publicly report the number of infections among their patients.[91,92]

The rate of hospital-acquired *C. difficile* infection in Ontario has decreased slightly to 0.26 per 1,000 patient days in 2014/15 from 0.35 per 1,000 patient days in 2011/12. This small change in the rate represents a reduction of more than 800 cases across the province (Figure 7.9).

FIGURE 7.9
Rate of hospital-acquired *C. difficile* infection, in Ontario, 2009/10 to 2014/15



Data source: Health Analytics Branch, Ministry of Health and Long-Term Care.

Caesarean section deliveries

Almost one in four low-risk births is by Caesarean section, and the rate has changed little in seven years

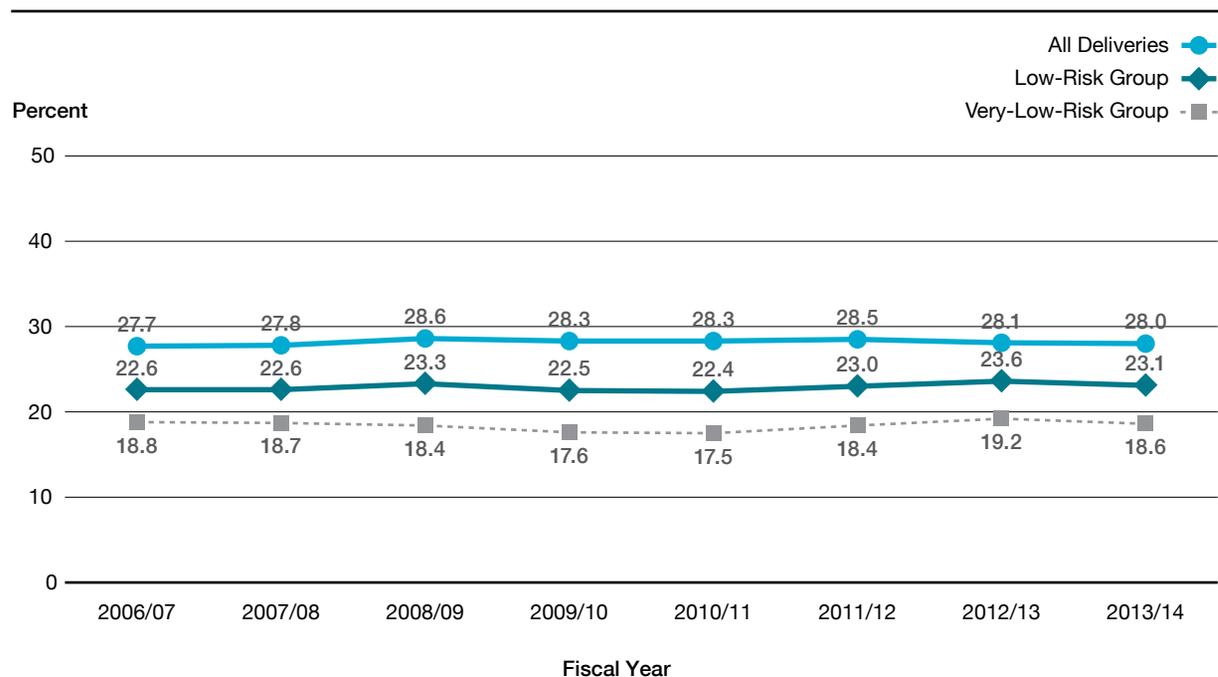
Caesarean section births are the most common inpatient surgeries in Canadian hospitals. Surgical delivery can save lives when medically required, that is, when a vaginal delivery would be risky for the mother or baby. However, there are risks and significant recovery time associated with the procedure, so it should only be performed when necessary.[93-95]

In recent decades, rates of delivery by Caesarean section have risen substantially in Canada from 17% in 1995 to more than 27% in 2013.[96,97] A number of factors have contributed to this increase: women tend to be older at age of first delivery, more pregnant women have higher body weight and/or chronic conditions, and more women are using fertility treatment to get pregnant. At the same time, variation in rates of Caesarean section within Ontario, across Canadian provinces and in other countries has raised the question as to whether the high rates are justified: are all of these procedures performed for women and babies who would have faced more risk from a vaginal delivery?

Here we report on the percentage of all deliveries and of low-risk deliveries that were performed by Caesarean section in Ontario.

A total of 136,041 babies were born in Ontario in 2013/14, an increase of almost 10% compared to 2006/07, when there were 123,711 births.[98] In the same period, the proportion of deliveries by Caesarean

FIGURE 7.10
Percentage of deliveries by Caesarean section, in Ontario, total and by risk group, 2006/07 to 2013/14



Data source: Niday & BORN Information System, provided by Ontario's Better Outcomes Registry & Network.

section has remained stable; 28.0% of all deliveries were by Caesarean section in 2013/14 (Figure 7.10).

Women giving birth for the first time to a single, full-term baby who presents head down are considered to be at low risk of having difficulty with a vaginal delivery. The rate of Caesarean section among women with low-risk deliveries in Ontario was 23.1% in 2013/14 and has changed minimally since 2006/07 (Figure 7.10).

Within the low-risk group, some women are considered to be at very low risk: young mothers (20 to 34 years old) without any medical problems, such as diabetes, or obstetrical problems, such as anomalies of the placenta or umbilical cord. Even among this very-low-risk group, almost one in five (18.6%) has a Caesarean section delivery (Figure 7.10).

In summary

Trends in the hospital indicators are mostly positive. Despite increasing numbers of emergency department visits by patients with more urgent needs, the 90th percentile length of stay continues to improve. Access has also improved for some procedures that are a focus of the Ontario Wait Time Strategy. While the number of some of these procedures has grown over the past five years, the percentage completed within the target wait times has either remained steady (cardiac procedures) or improved (joint replacements and cancer surgeries). For cardiac procedures, nearly all are completed within the target time frames.

Some progress has been made in ensuring that patients do not contract dangerous infections during their stay in hospital. Ontario has seen a slight decline in the *C. difficile* infection rate in hospitals over three years. Patient surveys over the past seven years show a gradual increase in the number of people who are happy with their hospital experience.

Less positively, the percentage of babies born by Caesarean section has not decreased in Ontario in the last seven years. More than one-quarter of all births are by Caesarean section, and many of these surgeries are for women at low or very low risk of having a complicated delivery.

Long-Term Care

In this chapter, we report on four Common Quality Agenda indicators related to long-term care: wait times for placement in a home, use of physical restraints, falls, and pressure ulcers.

Photo by Joel Esposito

Real-World Experiences

Stan and Judith: Good Days

Judith's husband Stan has been on the wait lists at three long-term care homes for two years, but she doesn't think he is ready to go into a home just yet. "He's not gone from us," she says. "The old Stan is still there." If a spot opens up at one of the homes on the wait list, Judith and Stan will have to decide whether to take it or to start the wait process all over again from scratch.

Stan, an 86-year-old Toronto actor, was diagnosed eight years ago with vascular dementia – the second-most common form of dementia after Alzheimer's disease. Judith says her husband's condition is not deteriorating consistently, but rather, it gets worse and then plateaus. "He's at another plateau now where he sometimes doesn't know who I am," Judith says, "but is otherwise alert."

If it weren't for twice-a-week visits to the day program at a nearby long-term care home and 10 hours a week of home care coordinated by their local Community Care Access Centre, Judith is sure that Stan would have needed to be in a long-term care home much sooner.

The day program that Stan attends was created by the long-term care home to help people in the community who are facing long waits for long-term care, but who also may not want to go into a home right away if they can get enough supports while they wait.

At the day program, Judith says they really pay attention to each person's personality and needs. "Even though they have their set programming, they're flexible enough to deal with the individual and I think that's where the gift is," Judith says. "And they care – they really do care." They recognized that Stan was a natural leader and was happiest when he had some independence. He had been doing a lot of artwork at home, so they encouraged Stan to create drawings and to teach his skills to others in the program. "Once he was in the helping mode, it made all the difference," Judith says.

Even with the extra help, Judith still struggles mentally, physically and financially. "I'm not getting any younger and I'm so exhausted," she says. "I'm the sole wage earner – it's very hard. When [Stan] sees me, he even says, 'I feel sorry for you.'" But she is grateful for what she has:

"People are kind. I just wish people had more access the way I've had."

At home, Stan continues to channel his creativity into painting in their garage, which he and Judith converted into an art studio. "If you walk into our garage it just whaps you," Judith says. "There are all sizes and shapes of canvasses."

If a spot opens up at one of the homes on the wait list, Judith and Stan will have to decide whether to take it.

Homes for some of Ontario's frailest patients

In Ontario today, residents of long-term care homes have much higher needs than ever before. The number of long-term care residents who are older than 75 years of age is growing rapidly. So too is the proportion of residents with chronic conditions such as heart disease and arthritis, and approximately 70% of Ontarians in long-term care have some type of dementia.[99]

Managing wait times for a place in long-term care is an ongoing concern, and solutions depend not only on the ability of the long-term care sector to provide more beds but also on the ability of other parts of the system to manage the need for placement and help people remain at home where possible. Improving the quality of care in Ontario's long-term care homes remains a primary concern of the sector so that residents receive safe care that supports their quality of life and prevents unnecessary hospital admissions.

Key findings

The median wait time from home for a place in long-term care has improved (116 days in 2013/14) but has grown for patients waiting in hospital (69 days)

The practice of physically restraining residents of long-term care has decreased substantially but varies across LHIN regions, ranging from 2.7% to 14.4% in 2014/15

Quality indicators have held steady (wounds, falls) or improved (restraint use), despite increases in the complexity of residents' needs

Ontario's long-term care homes' residents **are older and have more chronic conditions than before.**

Waiting for a place in long-term care

The median wait time for long-term care is 116 days for people waiting at home and 69 days for people waiting in hospital

Waiting for a bed in a long-term care home is stressful for both patient and family, and delays can lead to health complications for the patient.[100,101]

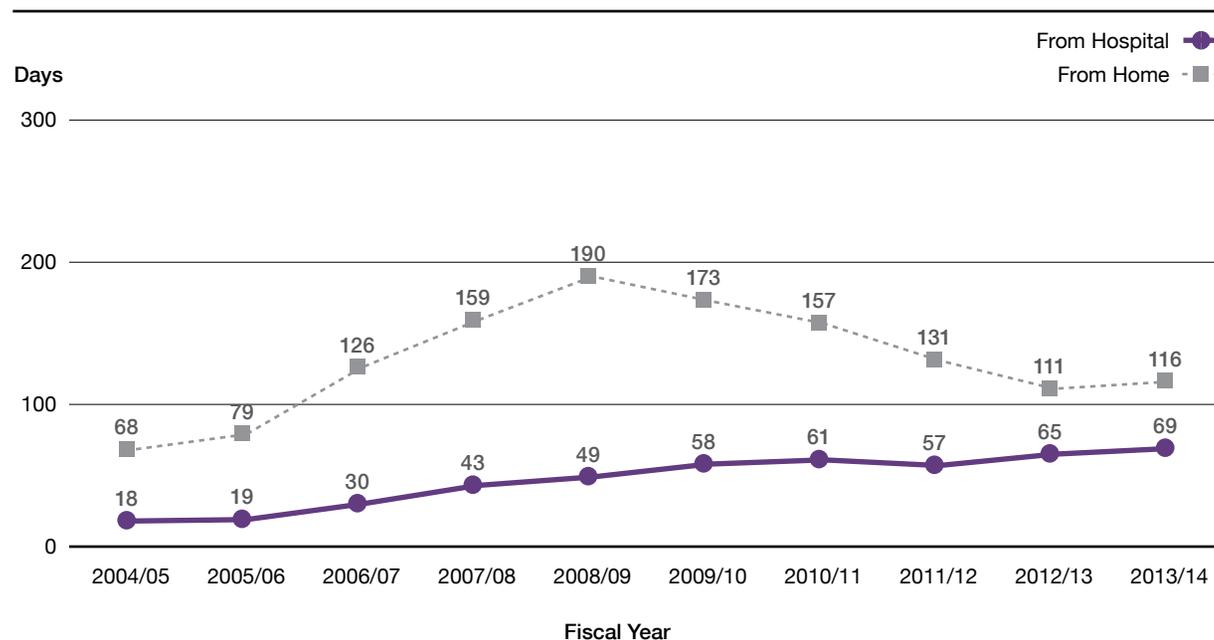
Wait times for long-term care are affected by the choices people make, as well as the availability of beds. In Ontario people can apply to up to five different homes. They can refuse an offered place and keep waiting for their preferred type of room or a more preferred home on their list. Some homes serve specific cultural, ethnic or religious groups that draw applicants from all over Ontario and therefore may have longer wait times.

The indicator of wait times for admission to a long-term care home looks at two groups: people waiting in a hospital and those waiting at home. It reports on the median number of days people waited, from the day they applied to the day they moved to the long-term care home. The median is the mid-point for a given year: half the people waited less time than the median number of days, and half waited longer.

Over the most recent five years of data (2008/09 to 2013/14), the median wait for admission to long-term care from home decreased by 74 days, going from 190 days to 116 days (Figure 8.1). Over the 10 years of data beginning in 2004/05, median wait times from home increased sharply to 190 days in 2008/09 and have since been coming down.

FIGURE 8.1

Median number of days to admission to a long-term care home from hospital or home, in Ontario, 2004/05 to 2013/14

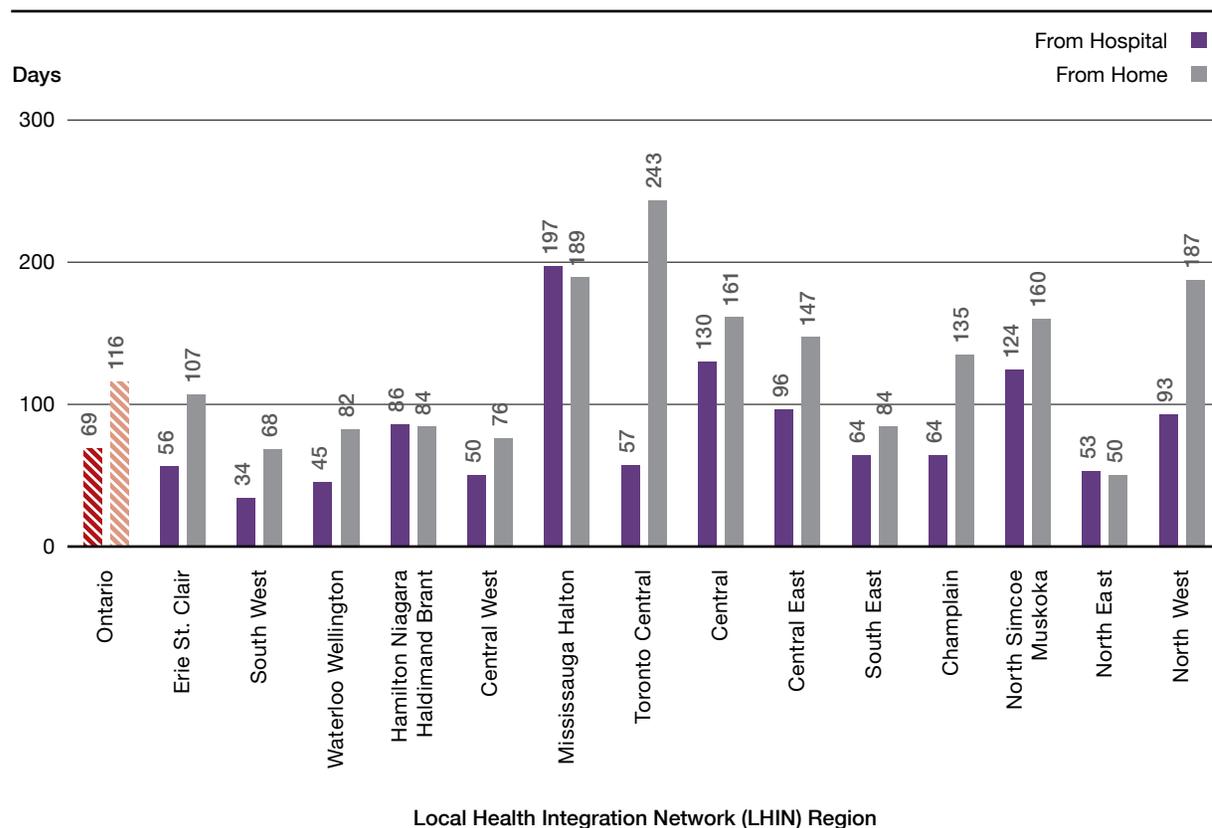


Data source: Client Profile Database, provided by the Ministry of Health and Long-Term Care.

From hospital, median wait times for long-term care have slowly but steadily increased over the last four years, rising from 58 days to 69 days between 2009/10 and 2013/14 (Figure 8.1). Over the decade since 2004/05, the increase has been 51 days. However, fewer people are now applying to long-term care from the hospital because of new programs to support people to return home after a hospital stay.[102]

Wait times for long-term care vary substantially across Ontario. In 2013/14, the wait time in the region with the longest wait for admission from home (243 days, median, in the Toronto Central LHIN region) is almost five times longer than in the region with the shortest waits (50 days, median, in the North East LHIN region). Median wait times from hospital range from a high of 197 days in the Mississauga Halton LHIN region to a low of 34 days in the South West LHIN region (Figure 8.2).

FIGURE 8.2
Median number of days to admission to a long-term care home from hospital or home, in Ontario, by LHIN region, 2013/14



Data source: Client Profile Database, provided by the Ministry of Health and Long-Term Care. Note: Wait times by LHIN region are based on the location of the long-term care home, not on where people lived before entering long-term care.

Use of daily physical restraints in long-term care homes

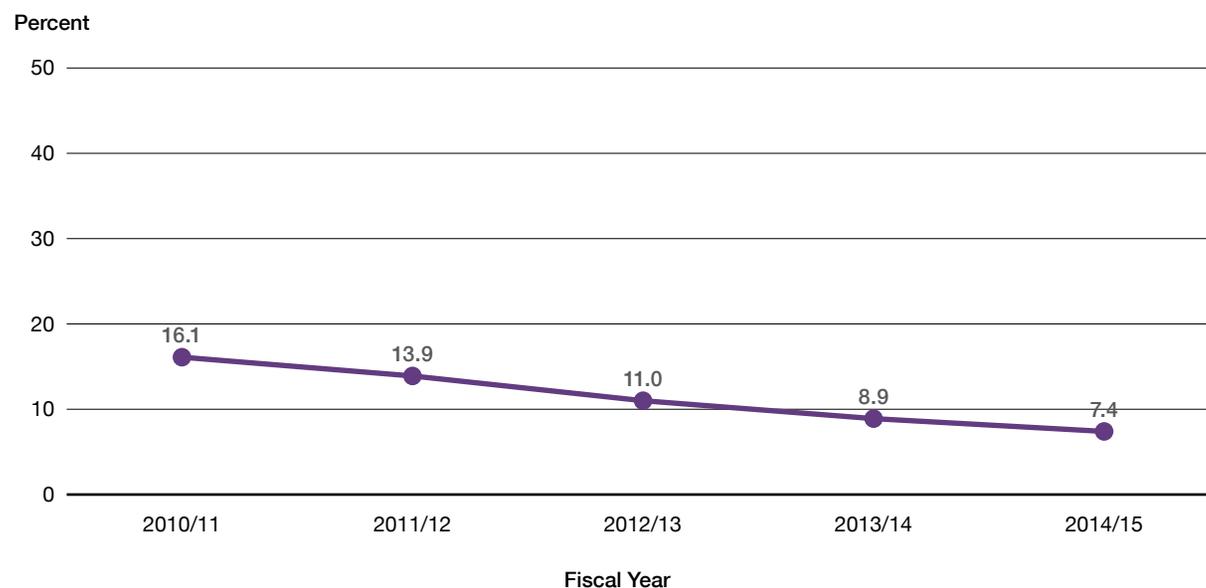
The daily use of physical restraints on residents in long-term care homes has improved substantially over a four-year period

Long-term care homes sometimes use physical restraints to protect residents from hurting themselves or others or to ensure a treatment is completed. *Ontario's Long-Term Care Homes Act, 2007* requires homes to have policies that minimize restraint use and to monitor and regularly re-evaluate the need for restraints. Besides the loss of autonomy and dignity, restraints can cause patients to lose physical function, which can then contribute to infections, pressure ulcers and agitation. Restraints can actually increase the risk of injury.[103-109]

Our single indicator covers the use of three types of physical restraints: trunk restraints, limb restraints and chairs that prevent rising. It measures the percentage of people in long-term care who have been restrained at least once a day during the seven days prior to the assessment.

The percentage of residents in Ontario long-term care homes who were physically restrained on a daily basis has decreased substantially, from 16.1% in 2010/11 to 7.4% in 2014/15 (Figure 8.3).

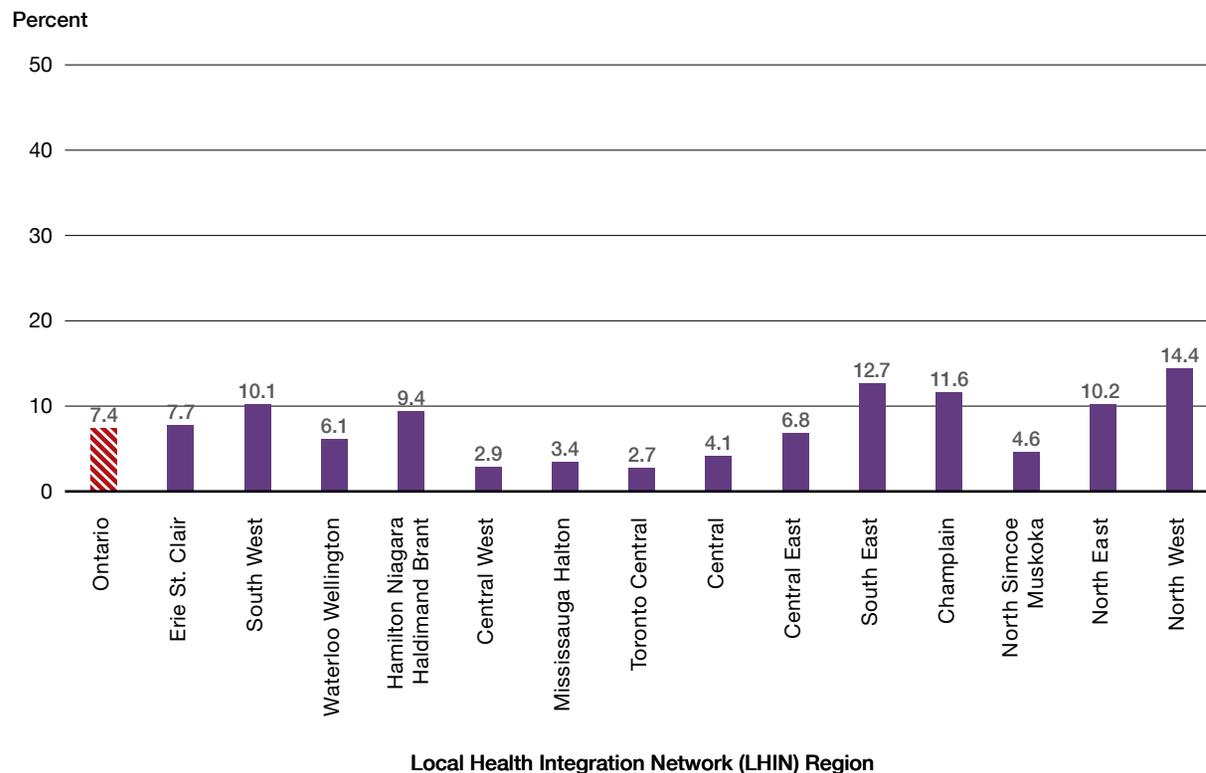
FIGURE 8.3
Percentage of long-term care home residents in daily physical restraints,[†] in Ontario, 2010/11 to 2014/15



Data source: Continuing Care Reporting System eReports, provided by the Canadian Institute for Health Information. [†]Risk-adjusted.

Rates vary substantially across Ontario in 2014/15, from a low of 2.7% in the Toronto Central LHIN region to a high of 14.4% in the North West LHIN region (Figure 8.4).

FIGURE 8.4
Percentage of long-term care home residents in daily physical restraints,[†] in Ontario, by LHIN region, 2014/15



Data source: Continuing Care Reporting System eReports, provided by the Canadian Institute for Health Information. [†]Risk-adjusted.

Falls in long-term care homes

About 15% of residents in Ontario long-term care homes have a fall in a given month

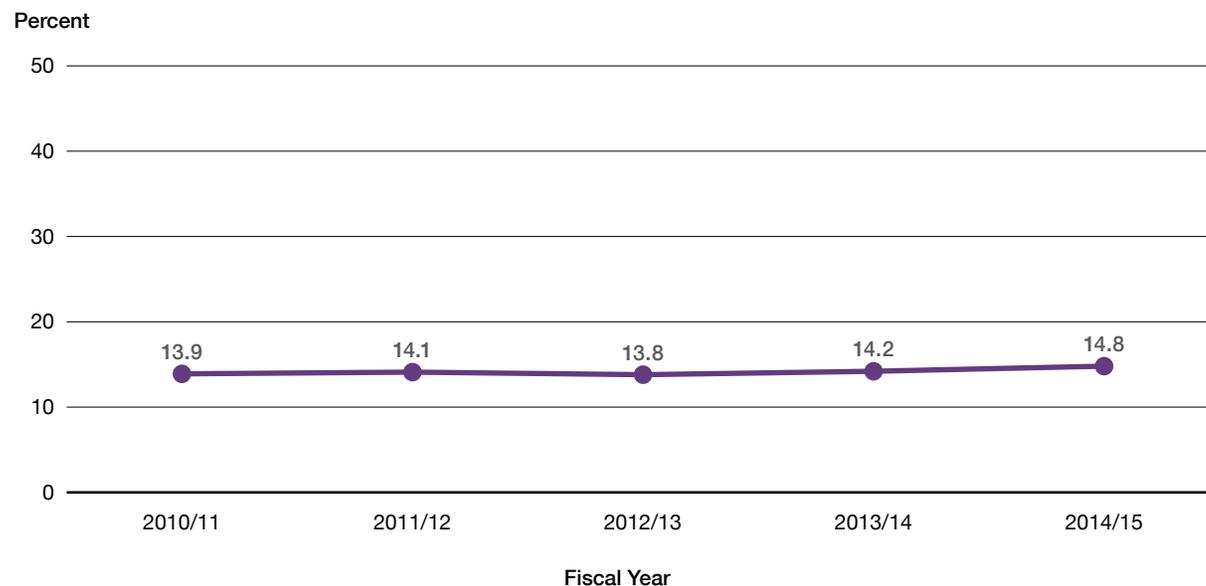
Falls are a common cause of injury among older people, especially long-term care home residents. Even a fall that does not result in an injury can trigger a fear of falling, which can reduce a resident's mobility, social interactions, and quality of life. While it might not be possible for long-term care homes to completely eliminate falls, particularly when they also strive to maximize residents' mobility and independence, all homes in Ontario are required to implement a falls prevention and management program.[110-113]

The falls indicator we report includes falls observed and reported in long-term care homes in Ontario, whether or not they resulted in harm or injury.

The percentage of Ontario long-term care home residents who fell in the last 30 days remained stable at just below 15% between 2010/11 and 2014/15 (Figure 8.5). The most recent results show little variation by LHIN region across the province.[114]

FIGURE 8.5

Percentage of long-term care home residents who fell in the last 30 days,[†] in Ontario, 2010/11 to 2014/15



Data source: Continuing Care Reporting System eReports, provided by the Canadian Institute for Health Information. [†]Risk-adjusted.

New or worsening pressure ulcers

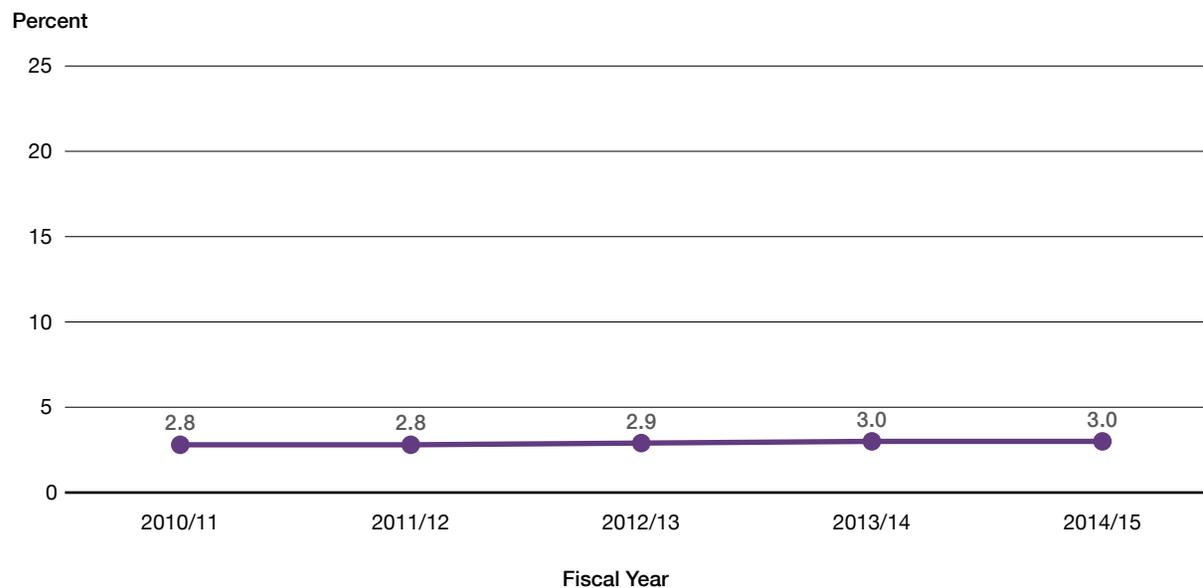
The percentage of Ontario long-term care residents with new or worsening pressure ulcers is stable at 3%

Pressure ulcers, often called bedsores, are injuries to the skin or underlying tissue. They are more likely to develop with age, especially when an older person lies or sits in one place for too long. Pressure ulcers can be very painful and become infected and costly to treat, but are largely preventable through frequent repositioning of residents who have restricted movement, using devices to redistribute pressure on the skin (such as a special mattress) and ensuring residents maintain good nutrition and hydration. By law, Ontario's long-term care homes must implement wound care strategies to prevent new or worsening pressure ulcers and other skin wounds.[104,115-120]

The percentage of long-term care residents with new or worsening pressure ulcers remained stable at around 3% across Ontario from 2010/11 to 2014/15 (Figure 8.6). The most recent data show little regional variation across the province.[114]

FIGURE 8.6

Percentage of long-term care home residents with new or worsening pressure ulcers,[†] in Ontario, 2010/11 to 2014/15



Data source: Continuing Care Reporting System eReports, provided by the Canadian Institute for Health Information. [†]Risk-adjusted.

FIGURE 8.7

Percentage of long-term home residents in daily physical restraints, who fell in the last 30 days, with new or worsening pressure ulcers in Ontario, Alberta and British Columbia, 2014/15

Daily physical restraint use



7.4%

Ontario



10.9%

British Columbia

8.6%

Alberta

Falls



14.8%

Ontario



16.1%

British Columbia

15.2%

Alberta

New or worsening pressure ulcers



3.0%

Ontario



3.3%

British Columbia

3.1%

Alberta

Data sources: Continuing Care Reporting system eReports, provided by the Canadian Institute for Health Information.

How Ontario compares: within Canada

For information on the quality of care in long-term care homes, Ontario has the largest and longest-running data collection and reporting system in the country. Some other provinces and territories are now reporting enough data to allow a comparison of results for indicators of restraint use, falls and pressure ulcers. In British Columbia and Alberta, close to 300 and 170 long-term care homes, respectively, reported in 2014/15, offering the best comparison to Ontario, where 630 homes reported. This represents most of the homes in each province. Overall, Ontario's performance on these indicators is similar to or better (lower) than British Columbia's and Alberta's (Figure 8.7).

In summary

System-wide efforts to reduce wait times for long-term care have seen some success. For people applying from home, wait times are considerably shorter than they were four years ago, although the median wait is still nearly four months. Wait times are shorter for people applying from hospital (the median is about two months), but have increased slightly. Wait times for long-term care vary substantially by LHIN region.

Quality of care indicators for long-term care homes in Ontario have improved or remained stable over the last four years. The daily use of physical restraints has decreased substantially, though it varies markedly across the LHIN regions. Rates of pressure ulcers and falls among long-term care residents have changed minimally across the province. Stability in these indicators can be seen as an improvement given that residents of Ontario's long-term care homes are increasing frail and have increasingly complex needs. For these three quality indicators, Ontario results remain comparable or better than the levels reported in Alberta and British Columbia.

Health Workforce



In this chapter, we report on three Common Quality Agenda indicators related to the health workforce: the number of nurses in Ontario, the number of doctors, and time lost to injury for various health care providers.

Photo by Roger Yip

Real-World Experiences

Carrie: Helping the Homeless

A man who recently came into the clinic at a homeless shelter in Ottawa where Carrie works was missing half his toe. He did not want to go to the hospital, so Carrie, a nurse practitioner, helped treat the wound at the clinic.

The people who visit the clinic are usually homeless, do not have a regular doctor and often have nowhere else to go for health care. “We do the best we can to manage clients who are pretty acute but who refuse to go to other care facilities,” Carrie says.

The homeless population often come in with complex health needs. Some have severe abscesses that are infected and require antibiotics and other treatments. A lot of people who visit the clinic have depression and other psychiatric conditions – Carrie estimates that close to 90% of her clients have mental health issues. Many also have substance abuse problems. Carrie helps to stabilize a lot people with alcohol addiction, and monitors injection drug users for infectious diseases.

“We’re a very non-judgemental group and they know it’s confidential,” Carrie says. “Our clients are honest with us, generally. They know we appreciate the position they’re in and we try to

meet them where they’re at and don’t pressure them.”

The clinic is led by a team of three nurse practitioners, but is funded as a Community Health Centre. The core team gets help from other professionals, including a psychiatrist who holds a regular mental health clinic, an HIV specialist who visits the clinic once a week, as well as a group of nurses who do outreach for clients who may be at other shelters in the area.

Once the nurse practitioners at the clinic stabilize their clients or get their addiction under control, Carrie says they are happy to move them on to more other health care services. But, she says, some clients just don’t want to go elsewhere. One woman who Carrie has been treating for two years told her: “There is no way I’m leaving. I will live and die with you.”

A former hospital-based nurse, Carrie became a nurse practitioner after moving into public health at a sexual health clinic, hoping that she could offer more services to people who did not have a regular doctor. She spent some time working in the north before doing a student placement at the clinic in Ottawa. “Now I’m here for life, I think,” she says. “It’s definitely

the population that I’m good working with and I think we’ve connected.”

Carrie says the clinic is working well to provide accessible care directly to people where they need it. “It’s a good model for sure,” she says. “It helps keep people out of the emergency room.”

More and more, Carrie sees perceptions changing around care for homeless people, especially at hospitals. “We used to send people to emergency and the door would be closed and they’d turn around and come right back to us,” she says. “That’s happening less and less. I think people are becoming more aware of the needs of the homeless and people with addictions.”

Carrie says the clinic is working well to provide accessible care directly to people where they need it “It helps keep people out of the emergency room.”

The people at the front lines of care

A health system depends on a healthy workforce that works effectively together across the many parts of the system. Having adequate numbers of the right kind of health professionals working in the right places is a first step in ensuring that Ontarians have access to high-quality care when and where they need it.

Here we report on the number of nurses and doctors in the province. Existing data allow us to compare these numbers to those in other provinces and across Ontario's regions, but the right number in one place may not be the right number in another, depending on factors such as how the health system is organized and the needs of the local population.

Key findings

The number of nurse practitioners, family doctors and specialists per 100,000 people continued to grow in 2013

Fewer registered nurses per 100,000 people but more registered practical nurses were working in Ontario in 2013 compared to 2005

Lost-time injury rates for the health care sector fell from 2.3 injuries per 100 workers in 2003 to 1.4 injuries in 2013

The people who provide health care in Ontario are the core strength of the province's health system.

Nurses

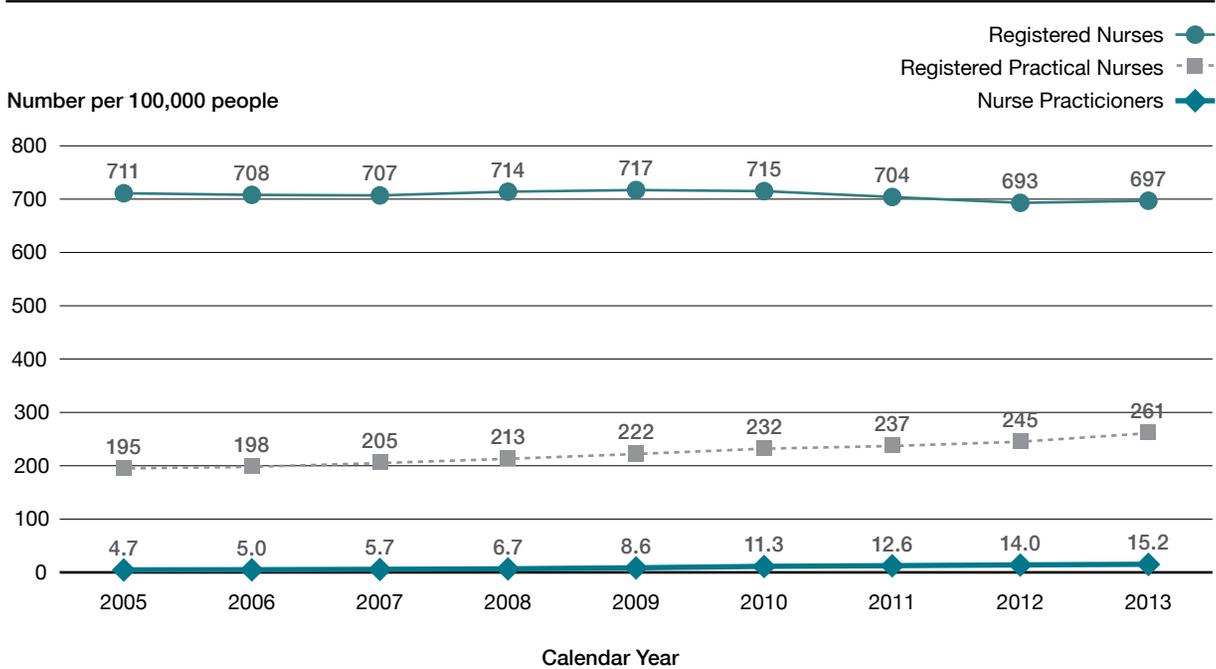
Over the most recent four years of data, the number of registered practical nurses and nurse practitioners continued to rise; the number of registered nurses has dropped slightly

Three groups of nurses are regulated to practise in Ontario — registered nurses, nurse practitioners and registered practical nurses — with each group offering different levels of care. The numbers we report for each group represent nurses who are registered with the College of Nurses of Ontario and have at least one nursing job in Ontario (full-time, part-time or casual).[121,122]

In 2013, two-thirds of registered nurses in Ontario (66.4%) and the majority of nurse practitioners (83.2%) worked full-time, but just over half of registered practical nurses worked full-time (56.8%). Most other registered nurses worked part-time (less than 30 hours a week) (26.1%) or as casual labour (7.5%). Only 2.2% of nurse practitioners worked as casual labour and 14.6% worked part-time. About one-third of registered practical nurses worked part-time (34.6%) and 8.6% worked as casual labour.[123]

The number of working registered nurses per 100,000 people decreased between 2009 and 2012 in Ontario but increased slightly from 2012 to 2013. The number of working nurse practitioners and registered practical nurses per 100,000 people in Ontario both increased substantially between 2005 and 2013 (Figure 9.1).

FIGURE 9.1
Number of employed nurses per 100,000 people, by nursing category, in Ontario, 2005 to 2013



Data sources: College of Nurses of Ontario Membership Statistics Highlights 2014; 2011 census-based population estimates from the Ministry of Finance.

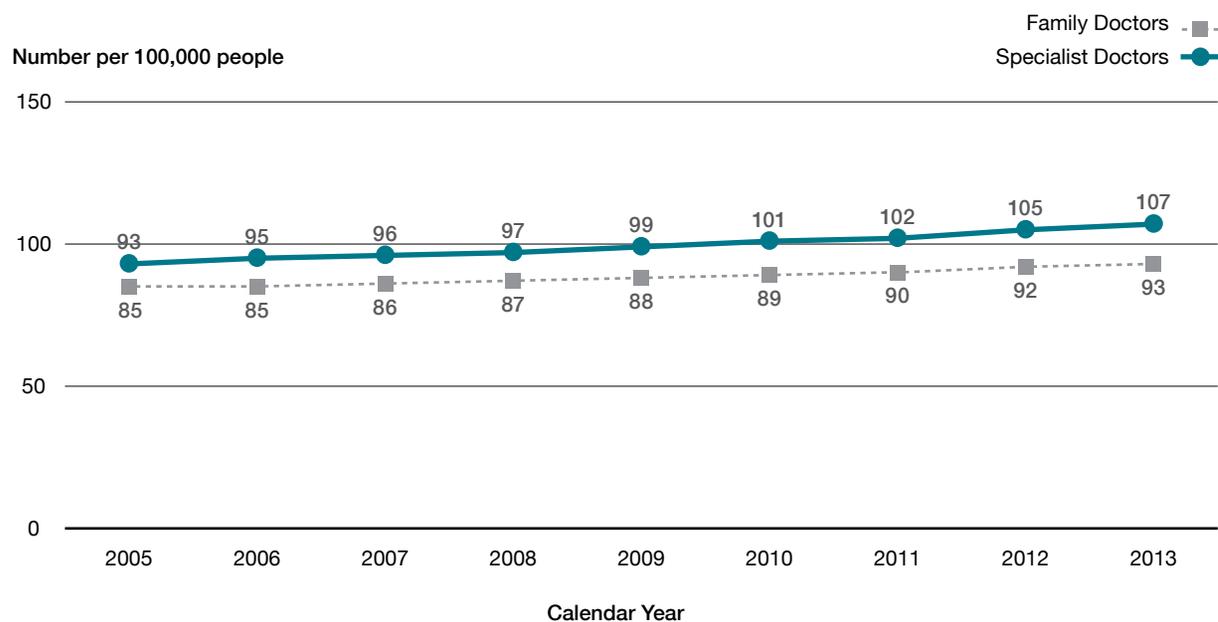
Family doctors and specialists

The number of family doctors and specialist doctors per 100,000 people has increased over eight years in Ontario

Physicians, like nurses and many other providers, need to be licensed to practise in Ontario. Depending on their training, they can practise as family physicians, providing ongoing comprehensive care to individuals and families, or as specialists, providing specific care such as pediatrics, surgery, or laboratory medicine. Some family physicians also focus their practice in specific areas such as psychotherapy or emergency department work. The indicator reported here presents the number of licensed physicians practising regularly in Ontario. It does not take into account how many hours they work or fully reflect the type of care they provide.

The number of family doctors and specialist physicians increased steadily over the last eight years. Between 2005 and 2013 the number of family doctors increased from 85 per 100,000 to 93 per 100,000 people, and the number of specialist physicians increased from 93 per 100,000 to 107 per 100,000 (Figure 9.2).

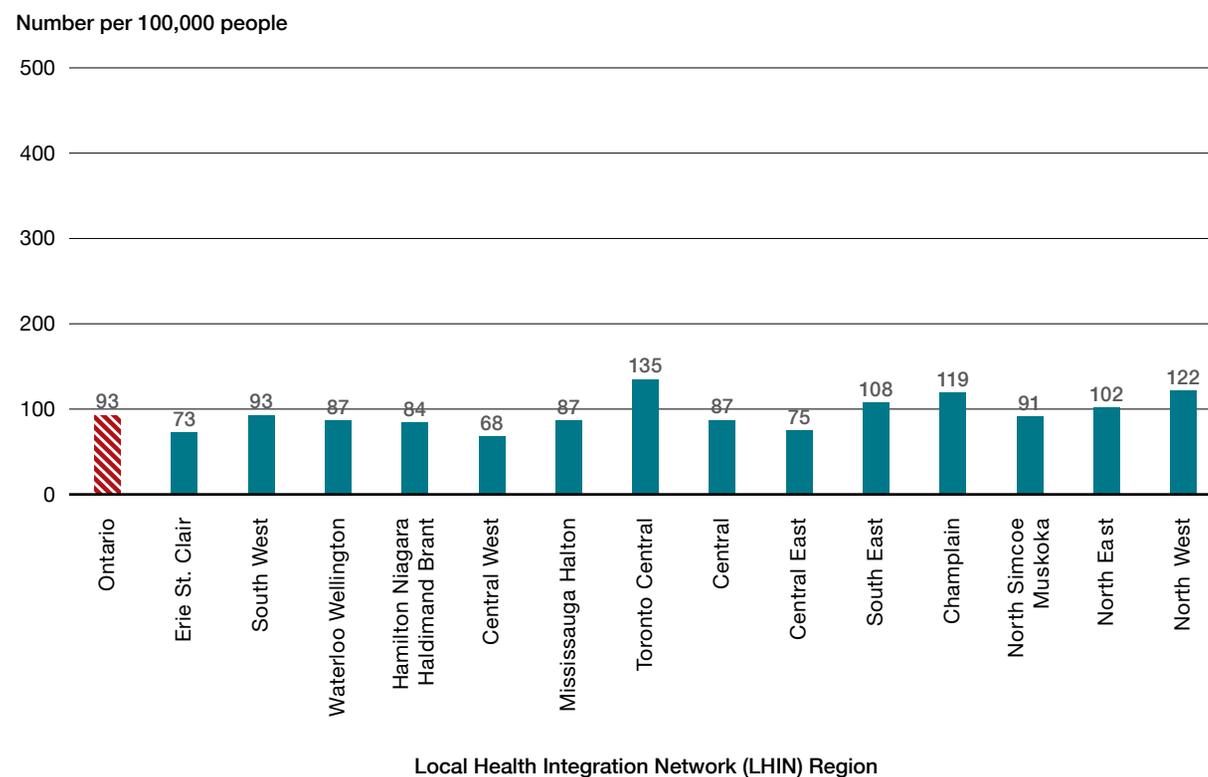
FIGURE 9.2
Number of family doctors and specialist doctors per 100,000 people, in Ontario, 2005 to 2013



Data sources: Ontario Physician Human Resources Data Centre; 2011 census-based population estimates from the Ministry of Finance.

The number of family doctors in each LHIN region varies across Ontario, from a low of 68 family doctors per 100,000 people in Central West to a high of 135 per 100,000 people in Toronto Central (Figure 9.3). This calculation is based on the location of the doctor's main practice. A doctor practising in more than one LHIN region is counted only once.

FIGURE 9.3
Number of family doctors per 100,000 people, in Ontario, by LHIN region, 2013



Data sources: Ontario Physician Human Resources Data centre; 2011 census-based population estimates from the Ministry of Finance.

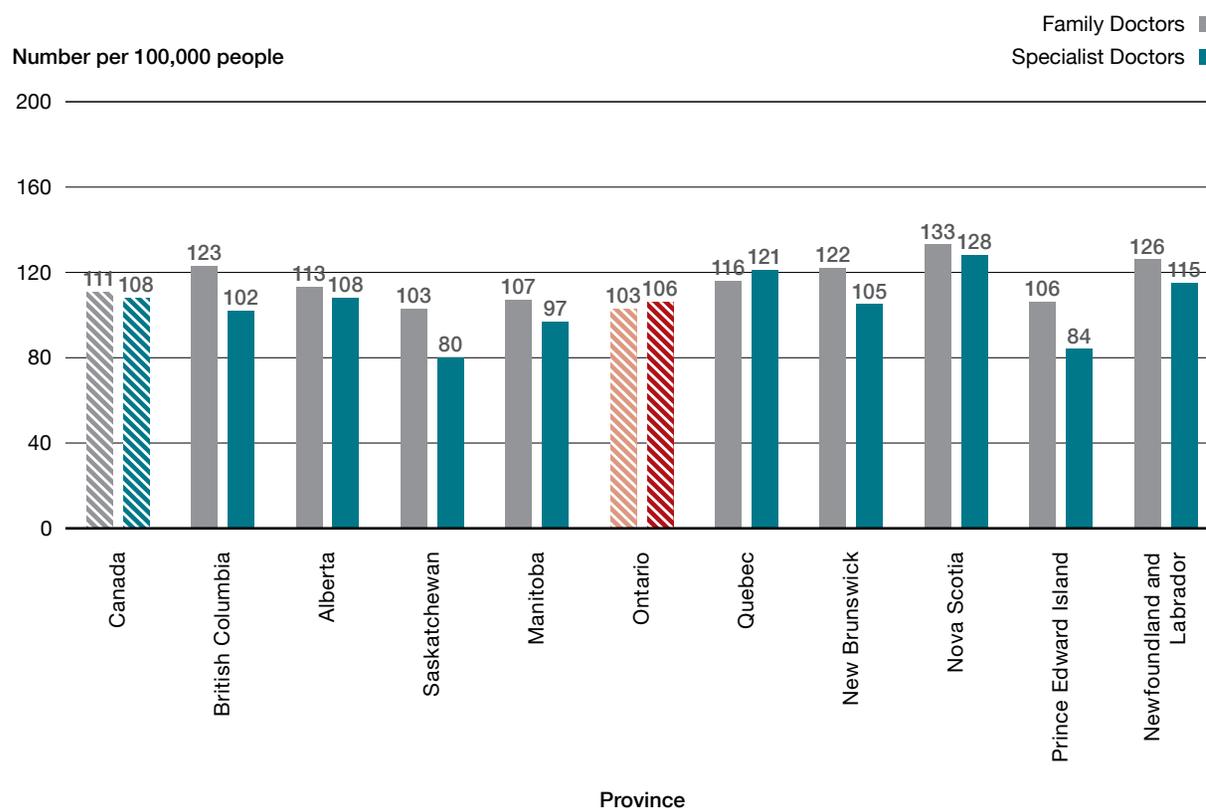
How Ontario compares: within Canada

The Canadian Institute for Health Information (CIHI) reports on physician supply across Canada.[124] Although CIHI's data sources and calculations are different from ours, their report allows us to compare Ontario with other provinces in Canada. Ontario and Saskatchewan share the lowest provincial rate of family physicians at 103 per 100,000 people, while Nova Scotia has the highest at 133 per 100,000 people (Figure 9.4).

The number of specialist doctors in Ontario is 106 per 100,000 people, slightly lower than the Canadian rate of 108 specialists per 100,000 people. Nova Scotia has the highest rate of specialist doctors, 128 per 100,000 people (Figure 9.4).

While these results allow us to compare Ontario's numbers with other provinces in Canada, the right number in one place may not be the right number in another, depending on factors such as how the health system is organized and the needs of each province's population.

FIGURE 9.4
Number of family doctors and specialist doctors per 100,000 people, in Canada, by province, 2013



Data sources: Scott's Medical Database and Statistics Canada Population Estimates (derived from Supply, Distribution and Migration of Canadian Physicians, 2013, Canadian Institute for Health Information).

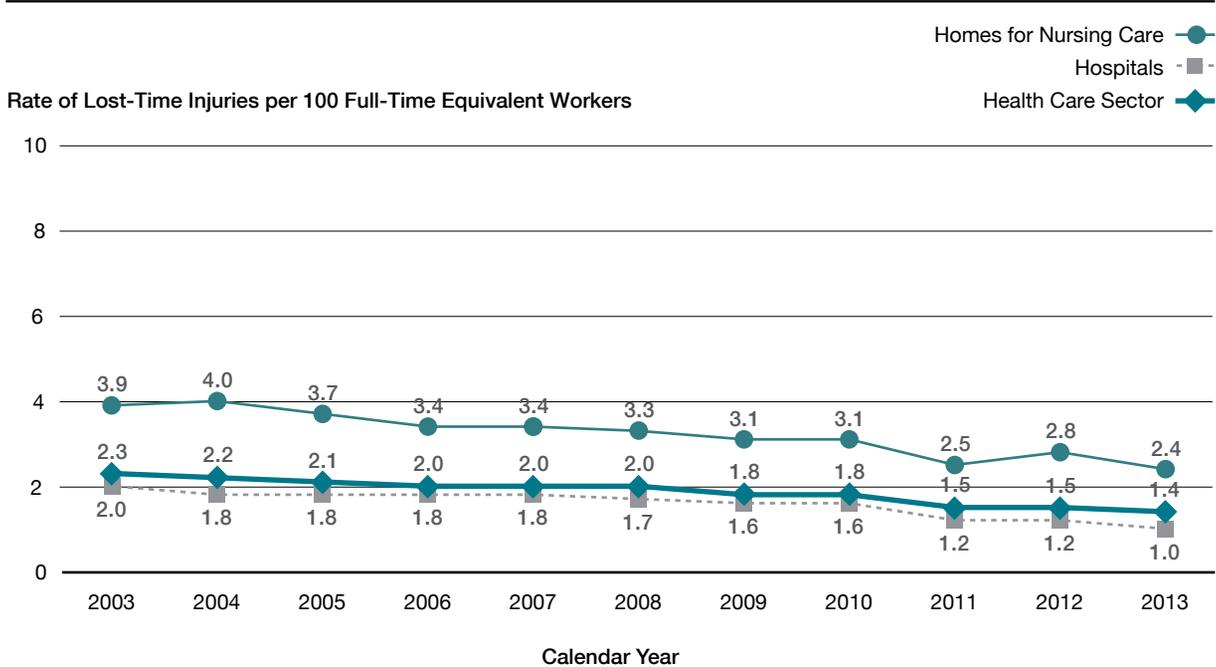
Lost-time injury rates

Lost-time injury rates for workers in the health care sector have decreased over a 10-year period

It is important that Ontario’s health workers provide care in environments that are as safe as possible. When a health worker sustains a work-related injury or illness that results in time off work, lost wages or a permanent disability, the employer is required to file a “lost-time injury” claim to the Workplace Safety Insurance Board. The lost-time injury rate is based on the number of claims approved per 100 workers (full-time equivalent, or FTE) in a given year.[125]

The lost-time injury rates in long-term care homes, hospitals and the health care sector as a whole in Ontario have all declined between 2003 and 2013. The overall rate decreased from 2.3 injuries per 100 FTE workers in 2003 to 1.4 injuries per 100 FTE workers in 2013. Hospitals, which account for the largest portion of the health workforce included in this indicator, also experienced a decrease in lost-time injury rates, from 2.0 injuries per 100 FTE workers in 2003 to 1.0 per 100 workers in 2013 (Figure 9.5). In the same period, long-term care homes (homes for nursing care) also saw a large decrease in work-related injuries, from 3.9 injuries per 100 FTE workers in 2003 to 2.4 injuries per 100 FTE workers in 2013, although the rate fluctuated somewhat over the decade (Figure 9.5).

FIGURE 9.5
Lost-time injury rates for health care sector overall, homes for nursing care and hospitals, in Ontario, 2003 to 2013



Data source: Workplace Safety and Insurance Board. By the Numbers: 2013 WSIB Statistical Report in 2013 Schedule 1 Statistical report (online).

In summary

The people who provide health care in Ontario are the core strength of the province’s health system. The number of registered practical nurses and nurse practitioners per capita in Ontario has increased from 2005 to 2013 in Ontario, while the number of registered nurses has decreased. The numbers of

family doctors and specialist doctors per capita in Ontario were below the Canadian averages in 2013 but have been increasing since 2005. Fewer health workers are being injured on the job in hospitals, long-term care homes, and the health sector overall, according to data available from injury claims.

Health Spending

A close-up photograph of a person's hands. The person is wearing a grey long-sleeved shirt. They are holding a small, dark brown glass pill bottle in their right hand, tilted to pour several white, round pills into their left hand. The background is blurred, showing the person's torso and arms.

In this chapter, we report on three Common Quality Agenda indicators related to the cost of health care in Ontario: total health spending, spending on drugs, and whether cost is a barrier to using prescribed medication.

Spending effectively and efficiently

Data on health spending can provide important information about the health care system. The overall performance of a health system can be determined by looking at its performance on quality of care indicators in combination with the amount of money spent on health care. When the parts of the system work well together, the system runs more efficiently.

Also, cost can sometimes affect access to care. For example, the cost of drugs is a growing concern and not everyone in Ontario has insurance to help pay for prescription drugs. If people don't take medication that has been prescribed for them because they can't afford to buy it, this can affect their health.

Key findings

After a steady climb for a decade, Ontario's health spending per capita has dropped slightly in the last two years

Average spending on drugs per person in Ontario is high compared to other surveyed countries

8% of Ontarians surveyed, aged 55 and older, did not fill a prescription or skipped a dose because of cost, three to four times more than in most countries in the survey

When parts of the system work well together, the **system runs more efficiently.**

Total health expenditure per capita

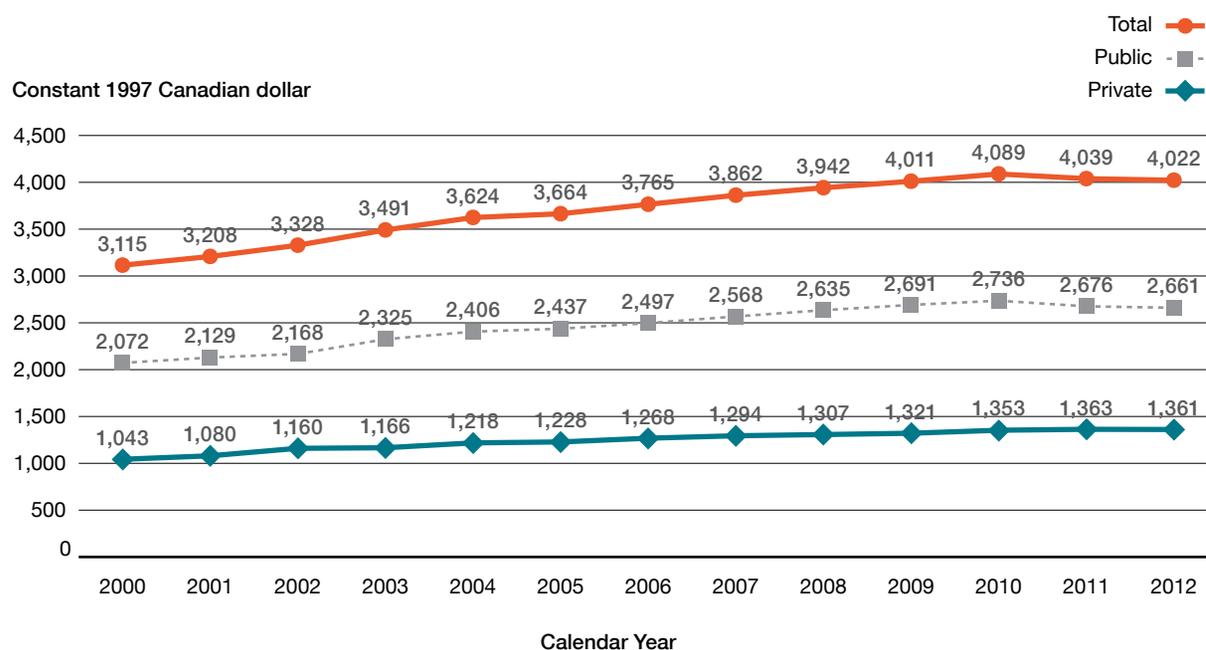
Total health spending per person in Ontario has been decreasing slightly since 2010

Total health expenditure per capita measures how much money is spent on average per person for health care. This indicator captures all health spending — both public and private — including services by health care providers, public health and prevention programs, administration, and capital investment on infrastructure such as hospital buildings. Private spending includes such things as drugs, devices and services that people pay for out-of-pocket or through private insurance coverage.[126]

After steady growth between 2000 and 2010, the total health expenditure per capita in Ontario has decreased in 2011 and 2012, after accounting for inflation. Measured in constant 1997 Canadian dollars, spending steadily increased by an average of \$97 each year over a decade, reaching \$4,089 per capita in 2010, before dropping to \$4,022 in 2012 (Figure 10.1).

The mix of public and private funding that makes up the total health spending in Ontario has been relatively stable, with about two-thirds from public sources (65% to 68%) and one-third from private sources, such as private health insurance and individual resources (35% to 32%).[127]

FIGURE 10.1
Total health expenditure per capita, in Ontario, by sector, 2000 to 2012

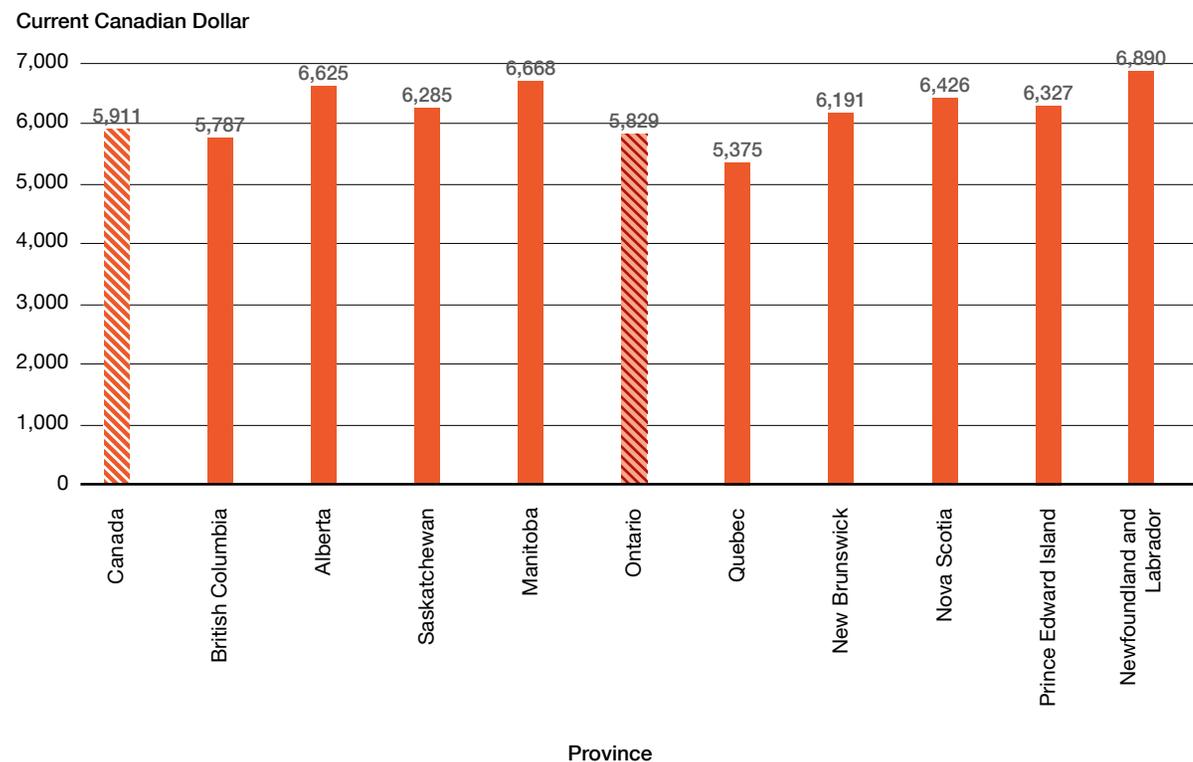


Data sources: National Health Expenditure Database, provided by Canadian Institute for Health Information; population and price indices, Statistics Canada.

Based on the latest data available (2012), Ontario has the third lowest total health expenditure per capita among the Canadian provinces. Measured in current 2012 Canadian dollars, Ontario spends about \$450 more on average per person than the lowest spending province (Quebec) and about \$1,000 less than the highest spending province (Newfoundland and Labrador) (Figure 10.2).

The relationship between health spending and health outcomes is complex. How much is spent on health depends on many factors, such as the health of the population, how the health system is structured and managed, and the value the public places on accessible, quality care relative to other public needs.

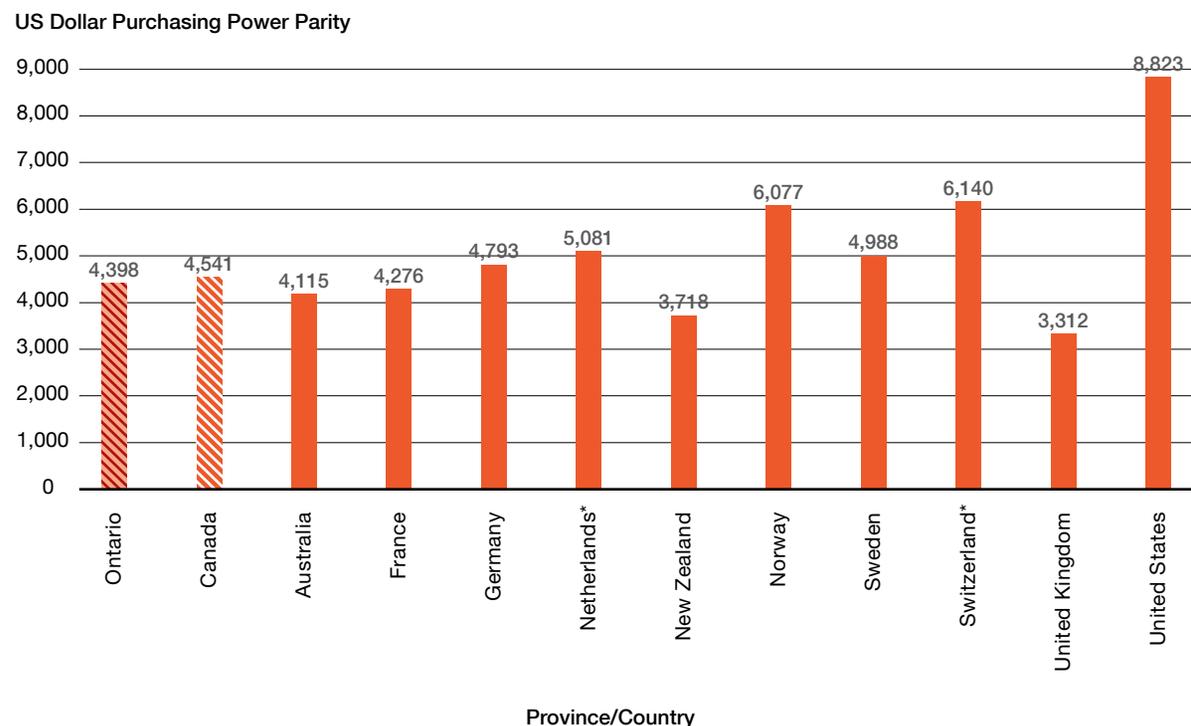
FIGURE 10.2
Total health expenditure per capita, in Canada, by province, 2012



Data sources: National Health Expenditure Database, provided by Canadian Institute for Health Information; population and price indices, Statistics Canada.

In an international comparison also using 2012 data, Ontario's total health expenditure falls in the middle of 11 countries (Figure 10.3). To make this comparison meaningful, each country's spending is given in US dollars and adjusted using a method called purchasing power parity to convert the different currencies. This is the rate at which a given amount of money can buy the same basket of goods and services in all countries. With purchasing power parity taken into account, Ontario spends about US\$1,100 more per person, on average, than the lowest spending country in the group (United Kingdom), about US\$4,400 per person less than the highest spending country (United States) and over US\$1,700 less than the second highest spending country (Switzerland).

FIGURE 10.3
Total health expenditure per capita, in Ontario, Canada and internationally, by province or country, 2012



Data sources: National Health Expenditure Database, Canadian Institute for Health Information; OECD Health Statistics 2015, Organisation for Economic Co-operation and Development. *Excluding capital.

Health expenditure per capita on drugs

Average health spending per person on drugs in Ontario is among the highest in the world

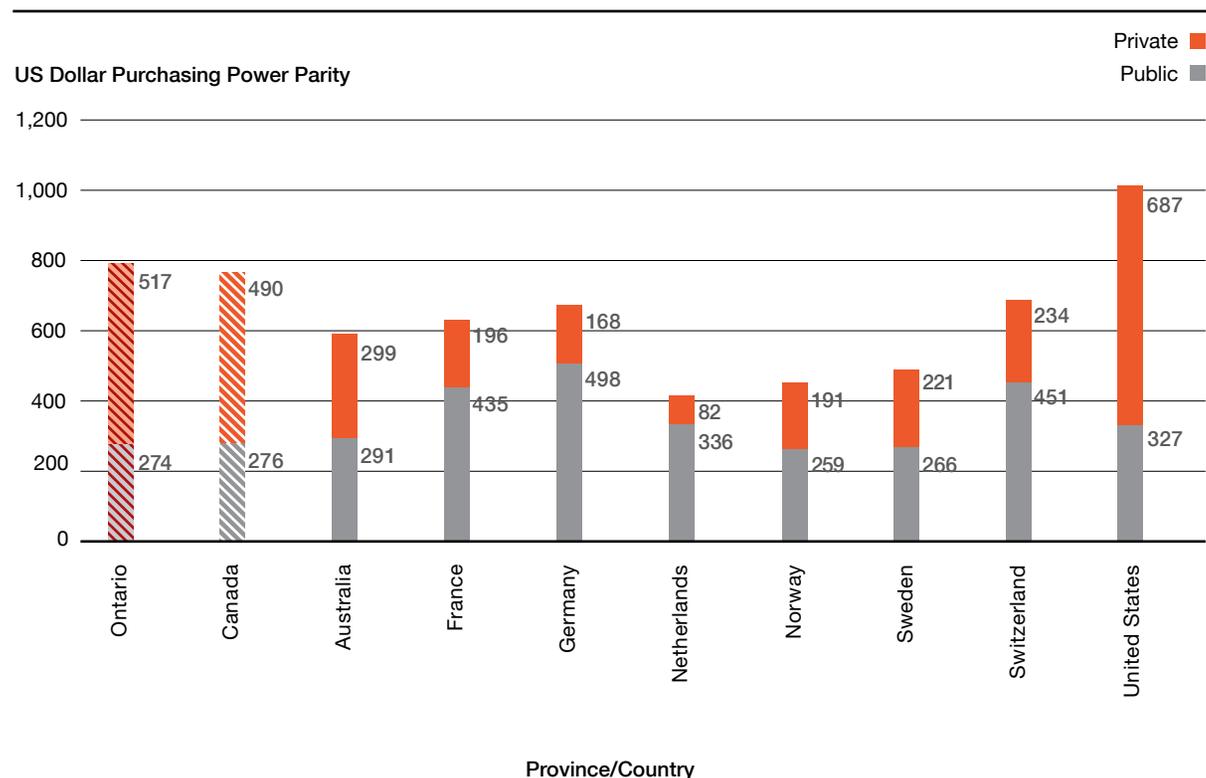
Prescription drugs are an important part of treatment for many Canadians and were one of the fastest-growing categories of health system spending between 2001 and 2013. Here we report on the average per-person spending on drugs. This includes prescribed drugs and over-the-counter products purchased in retail stores; it does not include drugs dispensed in hospitals and other institutions such as long-term care homes.[128-130]

Based on 2012 data, Ontario spends just below US\$800 per person, on average, on drugs (adjusted for purchasing power parity). In a comparison of 10 jurisdictions, this is the second highest amount after the United States, which spent just above US\$1,000 on drugs (Figure 10.4). Total spending on drugs reflects both the price of drugs and how much they are used. In general, prices for generic drugs in Canada have been found to be higher than in many other countries.[131]

Public drug plans in Ontario, as in Canada generally, cover only a small percentage of the population. As a result, drug spending in Ontario is one category of health spending where the private share is higher than the public share. While the public share of overall health spending per capita in Ontario in 2012 was 66.2%, the public share of spending per capita on drugs was only 34.6%.[127]

FIGURE 10.4

Health expenditure on drugs per capita, in Ontario, Canada and internationally, by province or country, 2012



Data sources: National Health Expenditure Database, provided by Canadian Institute for Health Information; OECD Health Statistics 2015, Organisation for Economic Co-operation and Development.

Prescription or dose of medicine skipped due to cost

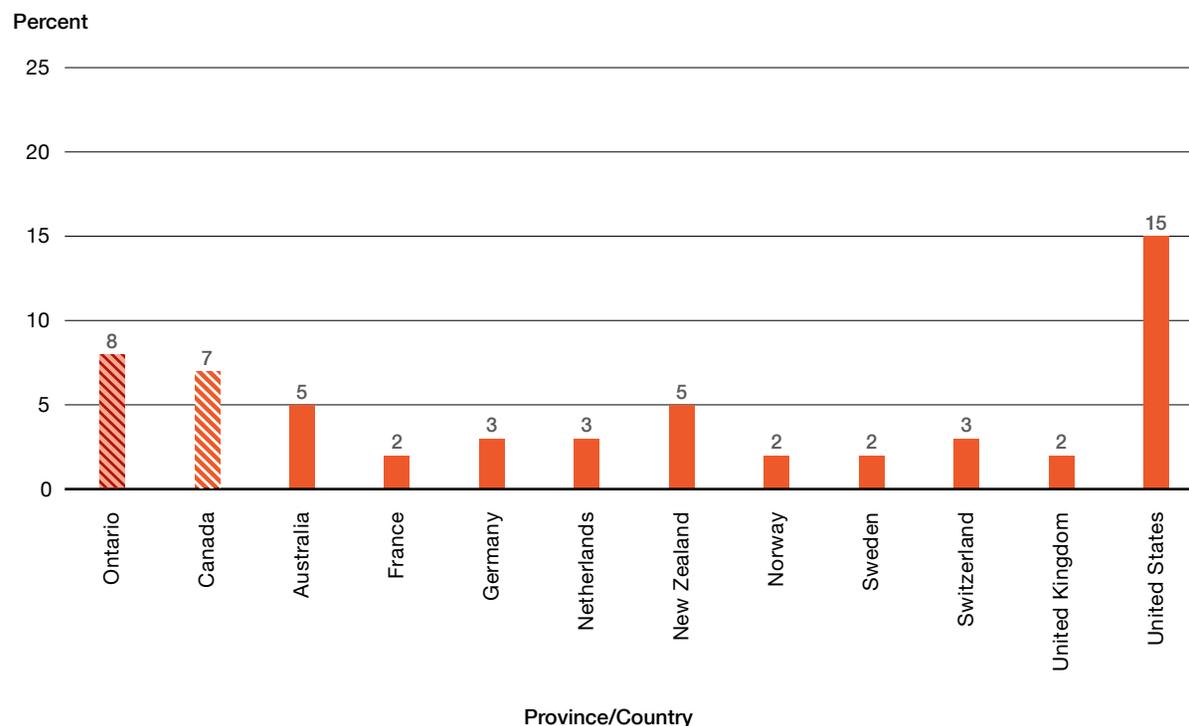
Almost one in 12 Ontarians aged 55 and older skipped medication because of cost — three to four times more than in most countries surveyed

Given the relatively high private share of spending on drugs in Ontario, it is worth considering whether cost prevents people from using medication that a health care provider has prescribed for them. In an international survey by The Commonwealth Fund in 2014, adults aged 55 and older were asked if they had ever not filled a prescription or skipped a dose of medicine because of cost. Of the Ontarians surveyed, 8% reported that cost had been a barrier to accessing medication. The Ontario rate is three to four times higher than in most of the 11 countries surveyed (Figure 10.5).

The percentage of Ontarians who report that they had not filled a prescription or had skipped doses of medicine because of cost varies by age group. The percentage for respondents aged 55 to 64 (11%) is almost three times higher than for respondents 65 and older (4%).^[132] One reason for this difference may be that Ontarians aged 65 and older receive support from the Ontario Drug Benefit Program, which covers most of the cost of prescription drugs, reducing the cost barrier.

FIGURE 10.5

Percentage of survey respondents aged 55 and over who did not fill/collect a prescription for medicine, or skipped doses of medicine because of the cost, in Ontario, Canada and internationally, by province or country, 2014



Data source: 2014 Commonwealth Fund International Health Policy Survey.

In summary

Since 2010, Ontario has limited the growth of total health expenditures per capita. At the same time, the health system has managed to continue to improve in some areas, as we've described in other chapters. Total spending on health per capita in Ontario (public and private costs combined) is now lower than in most Canadian provinces and near the middle of a group of countries in an international comparison.

Spending on drugs in Ontario is high compared to other countries, second only to the United States, and Ontarians have a much lower proportion of their drug costs covered by the public system compared to most other countries surveyed. Almost two-thirds of drug spending in this province (and Canada generally) is from private insurance or out-of-pocket by individuals. Cost barriers to the use of prescription medicine were much more common in Ontario than in most other countries, in a survey of people aged 55 and older in 11 countries in 2014.



The Road Ahead

We share the road ahead with all Ontarians.

What do the results of the indicators reported here say about the health of Ontarians and the performance of Ontario's health system? In general, Ontarians' health continues to improve and there are some bright spots in the performance of individual parts of the health system.

But a number of indicators have been persistently flat in recent years. Despite significant efforts, we still aren't seeing enough improvement. For other indicators, regional variations show us that not everyone in Ontario is getting the same quality of care: we may have pockets of improvement, but they are islands that are not spreading consistently across the province.

Addressing the challenges

Through stories of patients, caregivers and health care providers, we profile some of the work underway in Ontario to address the challenges they have experienced. Patients, their families, health care providers, administrators, community service groups

and policy makers are all aware that health care in Ontario could be better. The focus for everyone is on having our system deliver the best care to meet patients' needs.

Health Quality Ontario's role as the provincial advisor on health care quality places us in a unique position. Our work brings together into one organization the functions of monitoring and reporting on health system performance, promoting the use of scientific evidence, and supporting system-wide quality improvement. Organizations and providers across Ontario's health system are committed to improvements in quality. This year, more than 1,000 organizations formalized their commitments through the development of quality improvement. And our new report series, "Insights into Quality Improvement," draws on those plans to share successful, inspiring change ideas and tools within each sector. Our intent behind this work is to fuel and support continuous improvement in the quality of health care for every person in Ontario, regardless of who they are or where they live in the province.

Working towards better performance monitoring and reporting

Despite all the data we present this year, there remain important performance areas that we cannot report on. The Common Quality Agenda's set of performance indicators has evolved this year to include more home care indicators and a dedicated chapter on mental health and addictions indicators. However, we still don't have data about services that help key groups of people avoid hospitalizations by getting the care they need in the community, in particular Ontarians with mental health and addiction conditions, elderly people, and people with disabilities. And there continue to be few indicators of patient experience with care involving multiple providers or sectors or with transitions in care, the points where patients are the most vulnerable to gaps in the quality of care. In the future, we will work with partners to find better ways of reporting on these missing areas, and we will look more closely at particular groups of people who are most at risk.

Overall, Health Quality Ontario continues to expand its reporting on health system performance. We are producing theme reports that take a more focused look at how the system is performing in specific sectors or areas of care. Some of these reports expand on the indicators in the Common Quality Agenda, allowing us to dig deeper on a particular topic against this set of measures. Where possible, we also try to bring international and interprovincial comparisons into our reporting to gauge where we stand relative to other jurisdictions.

This past year, we released a report on patient experiences with communication and coordination of care (*Experiencing Integrated Care*) that expands our reporting on system integration and compares Ontario's performance to other countries. Another theme report shines a light on the use of antipsychotic medications in long-term care homes (*Looking for Balance*); that report fills a gap in the Common Quality Agenda indicators of long-term care and has led to emerging work between Health Quality Ontario and our partners.

We are also working on a report using indicators of primary care performance selected in partnership with the primary care sector. Along with the launch of online reporting of the same indicators, the publication of that report will mark the beginning of regular, focused reporting on primary care in Ontario. This will include an upcoming report on the experiences of primary care physicians, comparing Ontario with other countries through the 2015 international survey by The Commonwealth Fund. We will also continue to expand our online reporting, including more Common Quality Agenda indicators.

In the coming year we will examine health and health care through an equity lens by reporting more indicators for different groups of Ontarians, such as income or age groups. This helps us see whether positive changes are being shared equitably among Ontarians or whether some groups are being left behind.

Our mission: your health

Over the next year, our monitoring and reporting on health system performance will continue to grow and we will continue to strengthen the Common Quality Agenda. In this work, we rely on our partnerships with associations, policy makers, administrators, academic experts, health care providers and, most recently, patients, caregivers and the public. Our partners help us choose the best indicators to measure performance, provide guidance on how different sectors of the health system work, and connect us with those on the ground in health care — patients, caregivers, family members and providers. We now have a core group of patient, caregiver, and public advisors who help to keep patients at the centre of our work towards a better health system in Ontario.

At Health Quality Ontario, we share the road ahead with all Ontarians. On this road, we will continue to work together toward a healthier Ontario and better health for all Ontarians.

We will continue to work together toward a healthier Ontario and better health for all Ontarians.

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