

# Measuring Up

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

*Let's make our health system healthier*

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.

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**On the cover:** Sarah, an outreach registered nurse next to her car in the Durham region. See page 121 for her story. We thank Sarah and the other people who share with us their experiences in Ontario's health system. (Cover photo by Roger Yip)

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# Foreword



Dr. Joshua Tepper



Dr. Andreas Laupacis

**It's a milestone year for *Measuring Up*. This 2016 edition marks the 10-year anniversary of Health Quality Ontario's yearly report on the performance of our health system and the health status of Ontarians. In that time, we've seen encouraging improvements in quality in some areas. This year's report also reveals other aspects of the health system that need urgent attention.**

Patients and caregivers form the heart of *Measuring Up 2016*. A series of personal experiences with the health system frame each of the chapters to provide context for the numbers and motivation for change.

The 2006 report listed several things we wanted to measure in the future to improve the quality of care for patients, including whether people in rural and remote areas were getting equitable access to necessary care, and whether we had enough

supports for mental health, home care, long-term care, and for underserved communities. Fast-forward 10 years to this year's report, we can now answer a lot of these questions. In some areas, although we are doing well overall, disparities between regions or groups of people persist. Focusing collectively on reducing these disparities should be a system priority.

Ontario's population has changed in our last decade of public reporting. We're older, we live longer, people in long-term care homes are more likely to have complex health conditions that require different types and levels of care, and more people are getting home care services and for longer. In the last few years of *Measuring Up*, we have focused our set of indicators – called the Common Quality Agenda – and are using more accurate and appropriate performance measures that reflect these changes in demographics and in the health system.

Over the past 10 years, health system measurement has led to improvements in the system, and changes in how health care is delivered in the province – some of which are reflected in the results of this report, such as the performance measures in our recently added chapters on mental health and palliative care. Reassuringly, we've seen the quality of care improve in targeted areas where concerted efforts have been directed. However, areas without progress have often not benefitted from the same type of collaborative efforts.

Work is well underway in many parts of the health system to improve care and outcomes, and how we measure them. The Ministry of Health and Long-Term Care's *Patients First: Action Plan for Health Care* aims to bring about system changes to better integrate care and meet the needs of local populations. The Ontario Mental Health and Addictions Strategy, including the work of its Leadership Advisory Council, is developing new and better ways of measuring the quality of our mental health and addictions system. The Ontario Palliative Care Network, a new partnership between health care sector stakeholders, including providers, patients and caregivers, aims to ensure people throughout Ontario have access to high-quality palliative care. Health system reforms are in progress in both primary care and home care.

We've come a long way in 10 years, but we're certainly not done yet. As we engage with patients and work with our partners to continually improve our reporting, patients, caregivers, health care professionals and system leaders will be better equipped to focus on what needs to be done to improve our health system and the health of everyone in Ontario.

**Dr. Joshua Tepper**  
President and CEO

**Dr. Andreas Laupacis**  
Board Chair

# Executive Summary

**Health is a common part of all our lives, but each of us has a unique health story to tell. This is one of those stories:**

*Malvina sits alone on her bed, casting a long, vacant stare at the mirror before her. “What are you doing?” asks Lina, Malvina’s daughter, who had just arrived at her mom’s apartment. “I’m keeping her company,” Malvina replies, completely unaware the face in her mirror is her own. Lina turns away, not wanting her mother to see her eyes welling with tears.*

*Once a devoted homemaker with a vibrant personality, Malvina is now 91 and has dementia. The brain disease, which affects one in 10 older adults in Ontario,[1] has caused Malvina to suffer from intense mood swings, loss of memory and paranoid thoughts. For a year and a half, Lina, a social worker by training, cared for her mother on her own, while juggling career demands. Groceries, banking, cleaning – she did it all.*

*“My mom worked very hard for me and I am her only child,” Lina says, her voice breaking. “I am her only source of support.”*

*When Malvina fell and fractured her hip, Lina could no longer care for her mom on her own. Mother and daughter embarked on a sometimes confusing and difficult journey through the health system that involved Malvina’s family doctor, various specialists, nursing care, hospital care and long-term care. The transition from hospital to a long-term care home was the most difficult, Lina says. She continued to help care for her mom during her time in the hospital’s rehabilitation ward, acting as a translator for her and bringing her food, while searching frantically for the right long-term care home.*

*Lina eventually found a long-term care home that was a good fit for her mother for now, but says the pressure to transition her out of the hospital in a hurry really took its toll on her, emotionally and physically.*

Malvina and Lina’s story is just one of many in Ontario that illustrates the health system’s complexity and how varied each experience can be within it. These stories also show the many parts of the health system we may need to access at different times of our lives, and how each of us has a unique journey. The challenge is to continually improve our health system, so it’s there for each of us when and where we need it.

People in Ontario, especially patients, caregivers like Lina, and everyone working in and for the health system, need to know how well our health system is performing, so we can identify challenges and make improvements. As the provincial advisor on the quality of health care, Health Quality Ontario reports yearly on the performance of our health system.

*Measuring Up 2016* marks the 10th anniversary of such a report. In this report, we use an evolving, focused set of performance measures called the Common Quality Agenda, to look at the health system in categories such as population health, hospital care, home care, long-term care, primary care, palliative care and mental health care, and how the various sectors work together.

In the past decade of reporting on the performance of Ontario’s health system, we’ve seen exciting leaps in progress in some areas, such as shorter wait times for surgery despite more people needing surgery, and better quality of care for long-term care home residents despite those residents having more complex health needs. But the results of this year’s report also reveal key areas that demand attention:

## 1. Smooth out the transitions

Too often, people experience disconnections in the health system, and when we compare Ontario's results internationally, we see that other countries have found ways of better connecting the parts of their health system. Here are some areas where Ontario needs to do better as patients transition from one place of care to another:

### Providing comprehensive care for people with mental illness and addictions:

- Less than one-third (30.2%) of patients hospitalized for a mental illness or addiction saw a doctor within seven days after discharge in 2014/15. This rate has not changed in the past five years.
- The percentage of patients who were readmitted within 30 days after being discharged from hospital for a mental illness or addiction remained mostly the same for the past five years at around 13% (13.1% in 2014/15). Better follow-up care for patients, soon after being discharged from hospital for a mental illness or addiction, may help avoid some of these readmissions.

### Providing palliative care services and supports for people to die at home:

- Nearly two-thirds (64.9%) of patients who received palliative care die in hospital, despite the fact that surveys of patients and caregivers have shown repeatedly that most people would prefer to die at home.

- Nearly two-thirds (62.7%) of patients who received palliative care had an unplanned emergency department visit in their last month of life. Although some unplanned emergency department visits may be unavoidable and appropriate, these can be a sign that people are not receiving enough supports at home or elsewhere in the community.

## 2. Improve access to care

Primary care and home care play a big role in providing care for Ontario patients in the community. But we continue to lag behind 10 comparable countries in terms of patients getting access to primary care. Here are some areas where we should focus on connecting patients with the care they need:

### Providing access to frontline care (such as family doctors):

- In 2015, less than half (43.6%) of people aged 16 or older were able to get appointments with their primary care provider (or another primary care provider in their office) the same day or next day when they were sick or had a health concern. This remains unchanged over two years and is the worst rate compared with people in 10 other Commonwealth countries.
- In 2015, only just over half (52.0%) of people aged 16 or older reported having after-hours access to primary care, which is unchanged over two years. Timely access to primary care is an important part of patient care, and can reduce strain on other parts of the health system.[2,3]

### Providing quality home care to meet the needs of patients and caregivers:

- In 2014/15, 85% of the adult complex home care patients (aged 19 and older) who received personal support service received it within the five-day target, however there was substantial variation between regions. The aim is that all these patients receive the service within target.
- More than one-third (35.0%) of unpaid caregivers of some home care patients say they are unable to continue caring activities, or expressed feelings of distress, anger or depression, in 2014/15. Caregiver distress is worsening in Ontario, increasing from 21.0% in 2010/11.

## 3. Reduce inequities

Our health system struggles to reach everyone who needs it. While Ontario's overall numbers look good in many areas, we continue to see unacceptable variation by geography and population groups, such as those living in rural areas, the north, and in poorer neighbourhoods.

### Ensuring equitable access to care for people in the north:

- Less than one-quarter (23.8%) of adults in the north west region of the province (covering the district of Thunder Bay over to the Manitoba border) were able to see their primary care provider on the same day or next day when they were sick, compared with more than half (53.0%) of adults in the central west region (covering the Greater Toronto Area).

- In the north west region (covering the district of Thunder Bay over to the Manitoba border), less than two out of 10 (17.0%) patients had a follow-up visit with a doctor within seven days of being discharged from hospital for a mental illness or addiction, compared with nearly four out of 10 (39.5%) patients in the Toronto Central (downtown core of Toronto).

### Ensuring equitable care for people in poorer neighbourhoods and for people with lower levels of education:

- The suicide rate is 67% higher among men who live in the poorest neighbourhoods compared with those in the richest neighbourhoods (18.4 per 100,000 men vs. 11.0 per 100,000 men). The suicide rate is 45% higher among women who lived in the poorest neighbourhoods compared to women in the richest neighbourhoods (6.8 per 100,000 women vs. 4.7 per 100,000 women).
- Nearly nine out of 10 (85.7%) people aged 12 to 64 living in the richest neighbourhoods had prescription medication insurance, compared with fewer than six out of 10 (56.0%) people living in the poorest neighbourhoods. The ability to afford medication is an important aspect of care, especially among people with multiple chronic conditions.

- People with less than a high school diploma are more than twice as likely to smoke compared with people with a post-secondary degree (36.3% vs. 13.4%), and more likely to be physically inactive (61.5% vs. 45.2%), to be obese (24.6% vs. 19.5%) and to not consume enough fruits and vegetables (72.9% vs. 57.8%).
- The number of years of life lost per 100,000 for people who live in neighbourhoods where residents had the lowest level of education is 1.5 times higher than the number of years of life lost in the neighbourhoods where residents had the highest level of education.

### Improvement is possible

While it's challenging to achieve change, we can't afford to become complacent to the status quo.

There is good reason to hope for a better future. One of the key findings of this report is that concerted efforts for change have led directly to big improvements. These areas include cancer care, cardiac health, emergency department care, smoking rates, and quality in long-term care homes.

The best-performing parts of our health system and the aspects that have seen remarkable improvements in recent years came about through a combination of public demand, political will, and the collective efforts of many people working together in the system. These achievements were informed by transparency and evidence. They were also driven by many organizations actively working to make improvements on the indicators in this report. The 1,040 Quality Improvement Plans developed by

health care providers in Ontario, which are publicly available, illustrate these efforts. Highlights of the plans are presented in Health Quality Ontario's *Insights to Quality Improvement* series.

With *Measuring Up 2016*, we continue to strive for quality in our health system. Here we highlight some areas where policy, quality improvement initiatives and measurement have aligned for success:

**Population health:** Significant policy changes, regulations and public health interventions – some of them in primary care – led to a reduction in smoking, which is one of the main risk factors of poor health and early death.

- The smoking rate in Ontario decreased to 17.2% in 2014 from 20.5% in 2007.

**Some wait times/lengths of stay:** Ontario's Wait Time Strategy was developed to improve access to targeted health services by reducing the amount of time people spend waiting for some procedures or the length of their visit. One of the strategy's successes was reducing the time people spend in the emergency department.

- For patients with more complex needs, nine out of 10 patients (90th percentile) spent 10.1 hours or less in the emergency department in 2014/15, which is 3.2 hours less than it was in 2008/09. For patients with less complex needs, nine out of 10 patients spent 4.0 hours or less in the emergency department in 2014/15, almost an hour (0.8 hours) less than it was in 2008/09.

**Long-term care:** Ontario's *Long-Term Care*

*Homes Act, 2007* and its Regulation that came into effect in 2010 include requirements for long-term care homes to develop and maintain medication management systems, to support residents through a pain management program, and to minimize the restraining of residents. Improvements for residents have been seen in medication use, pain reduction and the use of physical restraints:

- The percentage of residents without psychosis using antipsychotic medication improved to 22.9% in 2015/16 from 35.0% in 2010/11; the percentage of residents who experienced moderate pain daily or any severe pain improved to 6.1% in 2015/16 from 11.9% in 2010/11; and the percentage of residents who were physically restrained daily improved to 6.0% in 2015/16 from 16.1% in 2010/11.

## We can do better

These successes demonstrate how concerted efforts for change can improve the health system. They show us that we must focus on the persistently problematic areas, or the regional and population disparities that can hide beneath the averages. By identifying challenges, collectively committing to strategies that are well-aligned and that work, and by measuring our progress, we can do better. For Malvina, for Lina, and for all of us.

# Health system performance in Ontario 2016 highlights

## Bright spots

- Health risks (smoking, physical inactivity)
- Population health (infant mortality, life expectancy, potential years of life lost)
- Colorectal cancer screening
- Patient experience with home care and hospital care
- Length of stay in emergency departments and wait times for cardiac procedures and cancer surgeries
- C. difficile infections acquired in hospital
- Waiting to be cared for in a long-term care home from home
- Physical restraint of patients with mental illness or addiction
- Quality of care in long-term care homes (use of antipsychotic medications, pain management, use of physical restraints)
- Hospitalization for conditions that could be managed outside hospital
- Patients in hospital who could be receiving care elsewhere
- Lost-time injury rates among health workers

## Room for improvement

- Health risks (inadequate fruit and vegetable intake, obesity)
- Distress among unpaid caregivers of home care patients
- Access to palliative care (palliative-specific home care services, home visits by a doctor, unplanned visits to the emergency department, location of death)
- Inequities**
- Health risks (smoking rates, physical inactivity, fruit and vegetable consumption) among those with lower education
- Population health (infant mortality, life expectancy, potential years of life lost) disparities based on education
- Screening (colorectal cancer screening, diabetes eye exam) disparities based on age group
- Suicide rates, follow-up and readmission after hospitalization for mental illness or addiction in low-income neighbourhoods
- Prescription medication insurance disparities based on education, income and immigration status

The Common Quality Agenda indicators, which are the basis of Health Quality Ontario's examination of Ontario's health system performance, have been grouped in the above table to provide an at-a-glance overview of: 1) The **bright spots** – the indicators that have shown steady improvement over time. 2) The indicators that suggest **room for improvement** since they have worsened over time or, in the case of palliative care indicators, where there are no data shown over time but where access to services could be improved. It also includes indicators where some notable differences or inequities across education level, income level, age group or immigration status were identified. 3) The indicators that have been relatively stable over time, showing **no change** – that have not gotten better or worse.

## No change

- Health status (self-reported health status, chronic conditions)
- Having a primary care provider, timely access to primary care and patient involvement in decisions about their own care
- Diabetes eye exam
- Depression and falls among long-term care homes residents
- Waiting to be cared for in a long-term care home from hospital
- Suicide rates, follow-up and readmission after hospitalization for mental illness or addiction
- Wait times for some home care services
- Patients with low to moderate care needs who entered a long-term care home
- Wait times for hip and knee replacements
- Caesarean section deliveries rates
- Follow-up after hospitalization for chronic obstructive pulmonary disease or heart failure
- Hospital readmission of medical or surgical patients
- Having prescription medication insurance

# Introduction



Photo of Emilie taken by Roger Yip.  
Please see her story on the page 39.

## Why monitor health system performance?

Most people in Ontario likely consider themselves fortunate to be living in a province that has a large, modern health system to look after their health needs. And, most expect the health care they require to be available for them if and when they become ill or disabled.

However, a large and modern health system is of necessity a very complex one. It needs to address a vast quantity and range of health needs among a large and extremely diverse population. Such a system may not always adapt easily to individual circumstances, or deal easily with changes such as new medical technologies or an aging population. Sometimes, people needing care might fall through the cracks.

The purpose of Health Quality Ontario's yearly *Measuring Up* report is to assess the province's health system to identify when, where and for whom it works well, as well as when, where and for whom

it falls short. Identifying these points can begin a process of adjustment to improve performance where necessary, sometimes by using lessons learned from instances where performance met or exceeded expectations.

*Measuring Up's* examination of Ontario's health system is based on the Common Quality Agenda, a set of more than 45 performance indicators developed in association with health care experts and health system partners such as doctors, nurses, hospitals, home care providers, and long-term care homes - as well as input from patients, families and the general public.

The indicators measure performance across the health system in key areas such as after-hours access to health care, wait times for surgeries, the rate of hospital-acquired infections, and life expectancy. Some focus on how well the various parts of the health system work together by measuring, for example, the percentage of patients who received follow-up care from a doctor after being discharged from hospital. A

technical appendix to this report, with details on the methodology and indicators used, is available on Health Quality Ontario's website.

## More than just numbers

While all the graphs and figures in *Measuring Up* may make it seem like evaluating health system performance is all about numbers, health care is all about people. A simple story about a cardiac patient's experience may convey what pages of statistics can't tell us about the impact of a long wait for cardiac surgery. *Measuring Up* includes stories from patients, caregivers and health care providers, detailing the challenges they face in navigating Ontario's health system, or the work they are doing to lessen those challenges for others.

## What's new in 2016

There is an additional chapter in *Measuring Up* this year, on Palliative Care. It looks at the care people in Ontario receive at the end stage of a life-limiting illness, when they face immense physical and emotional challenges and may require a high level

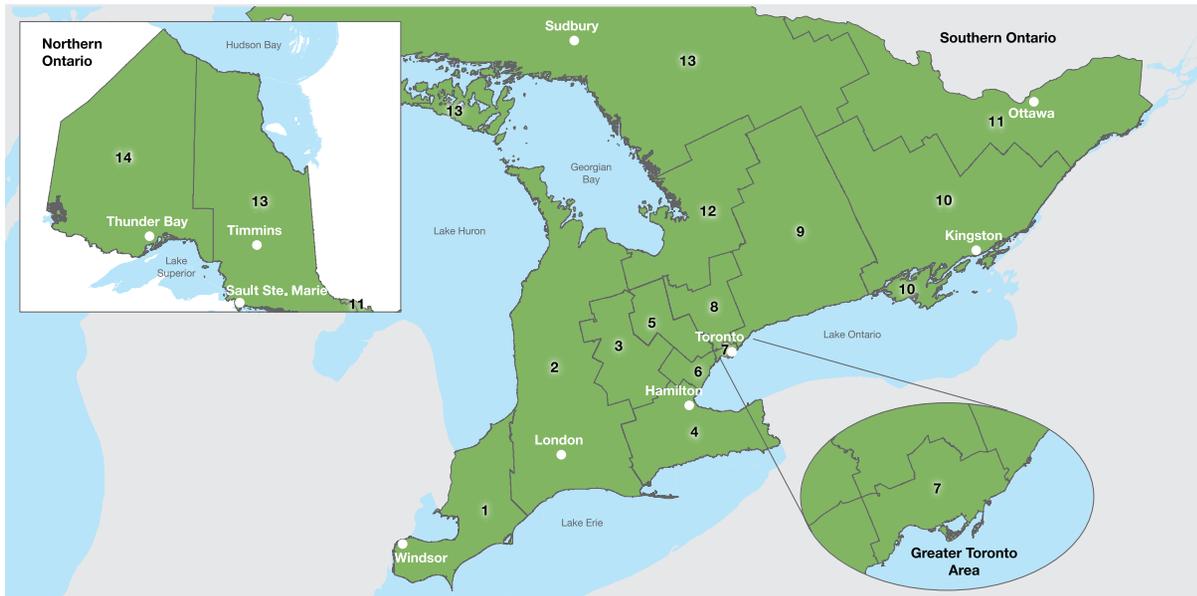
of complex care. The indicators in the new Palliative Care chapter are meant to help lay the foundation for public reporting on this key area of the health system.

This year's report also highlights indicator results that focus on equity - the ideal state in which all people are able to reach their full health potential and receive high-quality care that is fair and appropriate from each person's perspective. We look at differences between geographic regions and population groups, examining the comparative quality of care received by, for example, people who live in low-income neighbourhoods, people with limited formal education, recent immigrants, or people who live in remote or rural areas of the province.

As with previous editions of *Measuring Up*, a chapter on the overall health and health risk factors of people in Ontario begins the report. It's followed by chapters on primary care, mental health and addictions, home care, hospital care, long-term care, palliative care, health system integration, the health workforce, and health spending.

Three indicators included in the report for the first time provide new perspectives on what it's like to be a resident in a long-term care home. They measure symptoms of depression among residents, pain experienced by residents, and the use of antipsychotic medications in long-term care homes. Another new indicator, in the health spending chapter, examines what proportion of people in Ontario have prescription health insurance and which population groups are more or less likely to have it.

FIGURE 1.1  
Map of Local Health Integration Networks in Ontario



#### Ontario LHINs

- |                       |                                    |                |                         |
|-----------------------|------------------------------------|----------------|-------------------------|
| 1 Erie St. Clair      | 4 Hamilton Niagara Haldimand Brant | 8 Central      | 12 North Simcoe Muskoka |
| 2 South West          | 5 Central West                     | 9 Central East | 13 North East           |
| 3 Waterloo Wellington | 6 Mississauga Halton               | 10 South East  | 14 North West           |
|                       | 7 Toronto Central                  | 11 Champlain   |                         |

## Putting it all together

In order to prepare this report, Health Quality Ontario worked in partnership with several organizations that collect and maintain data on the province's health system. The most recent data available are used for the report, and where possible, data that allow comparison of performance over a number of years.

For several indicators, regional comparisons in performance are based on data available for the geographic areas covered by each of Ontario's 14 Local Health Integration Networks (LHINs) (Figure 1.1). The LHINs are responsible for planning, integrating and funding health care services within their designated regions, and are funded themselves by the Ministry of Health and Long-Term Care.

# The Health of Ontarians

In this chapter, we report on the following Common Quality Agenda indicators related to the health of people living in Ontario:

- Risk factors (smoking, inactivity, inadequate fruit and vegetable intake and obesity)
- Self-reported health status
- Chronic conditions
- Infant mortality
- Life expectancy
- Premature mortality

Photo of Mike and Shelly taken by Roger Yip.  
Please see Mike's story on the next page.

## Real-World Experiences

### Life savers: Mike's story

“Uncle Mike, I don't want to lose you,” Lisa said. “You need to do something about your weight.” Her words would ultimately change the course of Mike's life.

At 68 and with a history of heart problems, Mike took his beloved niece's advice. He connected with dietitian Shelly Amato through a wellness program at a Windsor hospital and after three months shed 25 pounds. “It's a really good program and I feel the quality of my life has improved immensely,” Mike says.

But Mike's life wasn't always steeped in wellness. As a hardworking real estate broker and investor for 40 years, he had a lot of stress. He had little time for exercise, ate few vegetables and had a sweet tooth. Mike was living a life full of health risk factors, namely inactivity, poor diet and stress, all of which increase the likelihood of developing a disease or health disorder.

In 2003, Mike had a heart attack, followed by a second one a few weeks later. After successful cardiac stent procedure, he began an exercise regimen, but his work schedule was still demanding and obesity continued to be an issue.

A year ago, Mike went for a regular check-up, where his doctor identified some issues with his heart, and a procedure was performed successfully. It was shortly after this when Mike's niece Lisa, a registered nurse, implored her uncle to lose weight. “I knew I couldn't do that myself,” Mike says. Working with Shelly, Mike says he has totally changed his eating habits.

“I used to be a big sweets eater, but I don't do that anymore. I eat vegetables and fruit, and I don't have second-helpings anymore. They even took us to shopping centres and taught us how to read food labels.”

The wellness program also has Mike and other people in similar situations come to exercise twice a week. Mike supplements this with his own trips to the gym. “I try to exercise five to six times a week,” he says. He's down to 215 pounds from 240 and has a goal of reaching 185 pounds.

In reflecting on what he has been through, Mike realizes his case is common and understands how fortunate he is to have had a second chance. “Many people have the kinds of risk behaviours I had,” Mike says. “I know I am the only one who can save my life by taking the necessary steps to change these behaviours. These changes are lifelong.”

“I've been seeing a dietitian at the wellness centre and she's helped me totally change my eating habits, **I used to be a big sweets eater, but I don't do that anymore.**”

# Examining the health of people living in Ontario

From the moment a person is born, their health and wellness are shaped by many factors — including behaviours such as exercising or not, smoking or not, and eating healthfully or not.

Monitoring these factors can be a useful tool for anticipating to the population as a whole.[4] So can measuring people’s personal assessments of their own health, which have been shown to be strong predictors of their future health. In addition, tracking long-established indicators such as life expectancy and infant mortality rates provides information about the health of the population.

Examining data on health-related factors, self-reported health status and longevity provides opportunities to identify health trends, examine when and where people’s health is at risk, and intervene accordingly with appropriate health policies and disease prevention measures.

For many of the indicators, overall results for the province have remained relatively stable over the last five years. Beyond the general trends, however, deeper insight can be gained by looking at how the indicator results vary in relation to various factors such as income, sex and education. Analysis of the effects of these factors showed that education had a significant impact on all the indicator results, so this chapter highlights variations by education.

**This section reports on four key health risk factors:**

- Smoking
- Physical inactivity
- Obesity
- Inadequate fruit and vegetable intake

## Health risk factors

Health risk factors are activities or associated to activities that can lead to poor health outcomes. Smoking and obesity are examples of health risk factors that can increase the likelihood a person will have heart disease, cancer or other illnesses.

If people are able to limit these factors and have the opportunity to make healthy choices, it would increase their chances of a longer, healthier life. But we know that changing these factors isn't always straightforward.

Geographic, socioeconomic and cultural factors can affect people's behaviour and choices. For example, people living with low income may have a more difficult time affording healthy vegetables and fruit, which may limit their ability to make healthy decisions about their diet. Or, high prices for fruit and vegetables at local grocery stores in certain neighbourhoods could make it financially challenging to eat well even for those residents whose income would not be considered low.[5]

<b>i</b> Indicators for risk factors	What they show
Smoking	The percentage of the population aged 12 and older who reported currently smoking cigarettes, daily or occasionally
Physical inactivity	The percentage of the population aged 12 and older who reported being physically inactive, as measured by Statistics Canada's index of average daily physical activity, which categorizes respondents as "active", "moderately active" or "inactive" in their leisure time based on total daily energy spent, based on responses about the nature, frequency, and duration of participation in leisure-time physical activity[6]
Obesity	The percentage of the population aged 18 and older who were obese based on reported height and weight
Inadequate fruit & vegetable intake	The percentage of the population aged 12 and older who reported inadequate fruit and vegetable intake, defined as consuming less than five servings of fruits and vegetables a day

## Did you know?

If everyone changed their behaviour to deal with only their most important health risk, such as smoking, alcohol consumption, physical inactivity, diet, or stress, life expectancy in Ontario as a whole would increase by up to 3.7 years.[7]

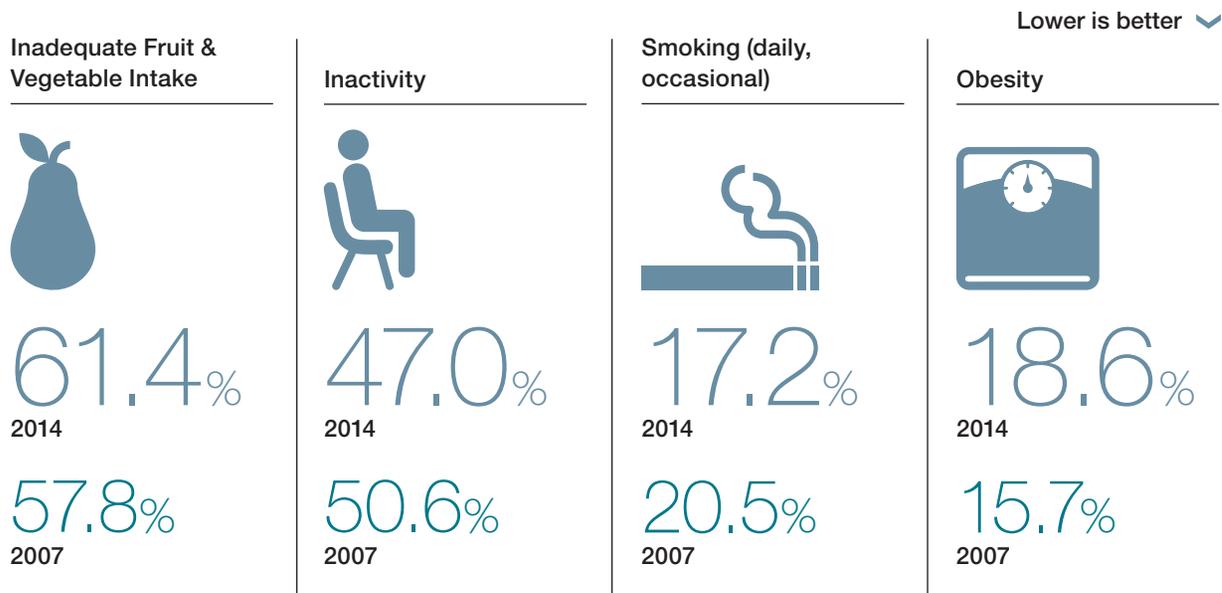
Overall, from 2004 to 2013, close to \$90 billion in health care costs could be attributed to health behaviours such as physical inactivity, smoking, unhealthy alcohol consumption and poor diet.[8]

## Findings and variations

Between 2007 and 2014, rates of physical inactivity and smoking have improved, while rates of inadequate fruit and vegetable intake and obesity have increased (Figure 2.1).

FIGURE 2.1

**Percentage\* of the population aged 12 and older who report smoking cigarettes daily/occasionally, having inadequate fruit and vegetable intake, and being physically inactive, and percentage of the population aged 18 and older who were obese based on reported weight and height, in Ontario, 2007 and 2014**



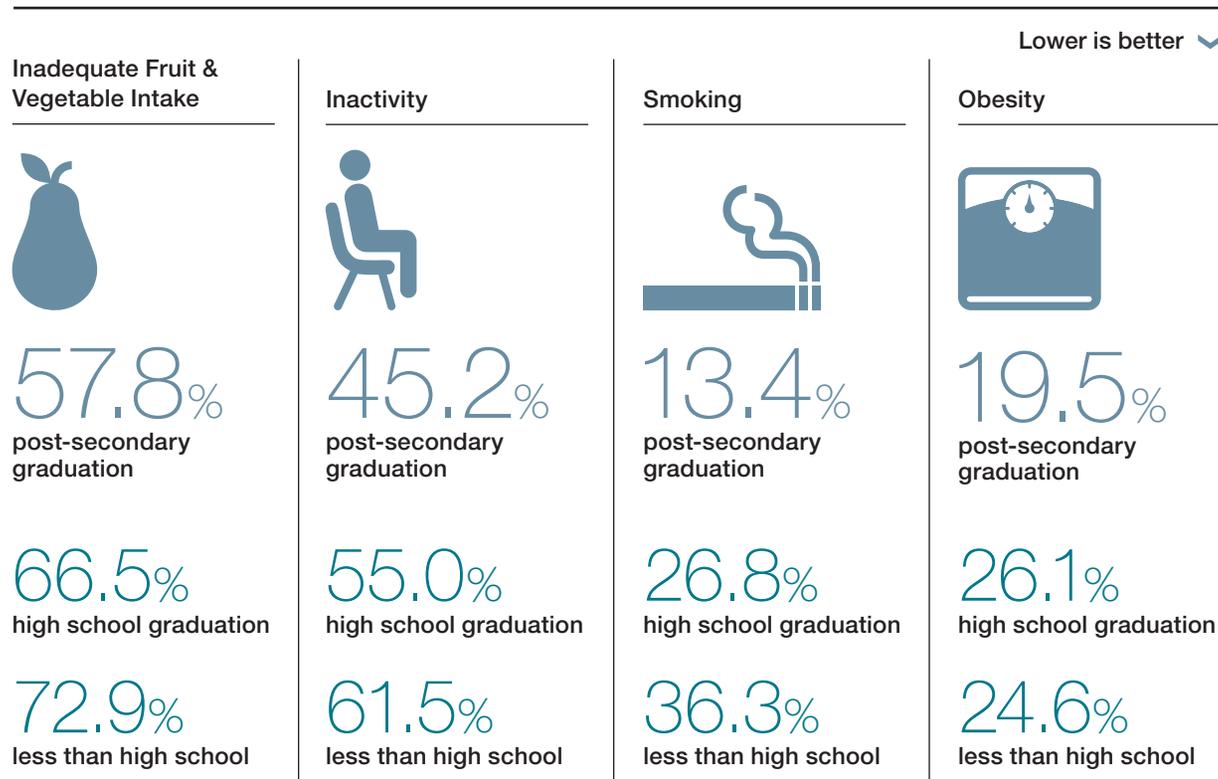
Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Sciences  
 Note: \*Age-adjusted, analysis by education is restricted to 25 and older

## Variations by education

The data showed **post-secondary graduates were the least likely to engage in the four key risk factors**. This was particularly pronounced for smoking, for which the rates were almost three times higher among those with less than high-school education than among those with post-secondary education (Table 2.1).

TABLE 2.1

**Percentage\* of the population aged 25 and older who report smoking cigarettes daily/occasionally, having inadequate fruit and vegetable intake, being physically inactive and percentage\* of the population aged 25 and older who are obese based on reported weight and height, in Ontario, by education level, 2014**



Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Sciences  
Note: \*Age-adjusted

## Self-reported health status

How we see the state of our own health can often provide a lens into how well we actually are and will be in the future. Research shows that when people are asked to rate their health as excellent, very good, good, fair or poor, their answers tend to accurately predict their future health outcomes, including the risk of having certain conditions and of dying prematurely.[9, 10] Although people’s perceptions are subjective, the fact they are accurate can be important for the health system. Those perceptions can be used, for example, to help calculate the required capacity of the support system that needs to be in place for people who will be disabled in the future.

## Findings and variations

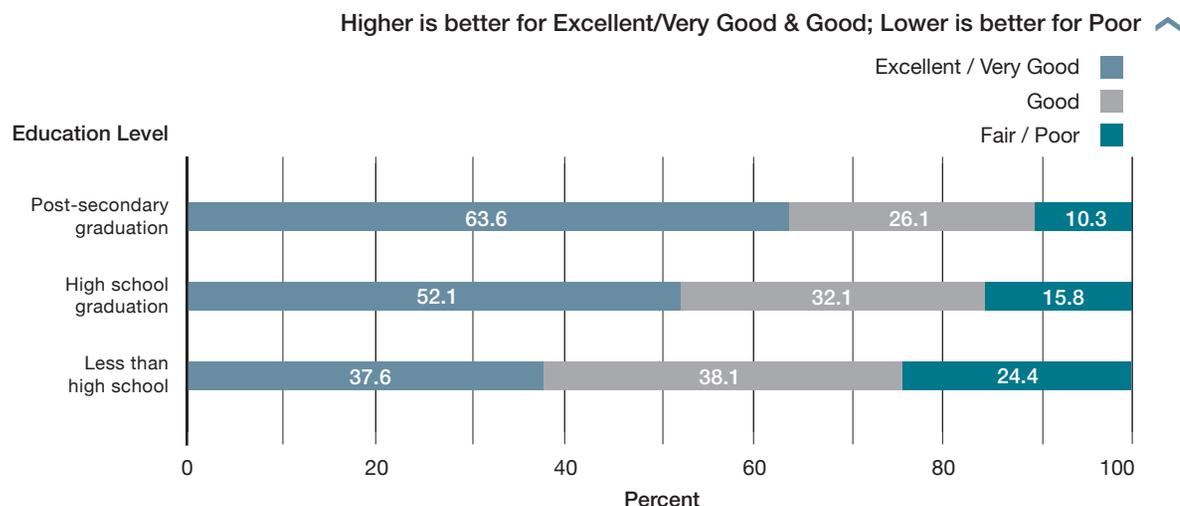
Overall in Ontario, the percentage of people who reported their health status as either excellent/very good, good, or fair/poor has remained stable for each health status since 2007.[11]

## Variations by education

People with less than high-school education were least likely, at 37.6%, to rate their health as excellent/very good compared to those with high-school or post-secondary education, among whom 52.1% and 63.6%, respectively, rated their health that way (Figure 2.2).

FIGURE 2.2

Percentage\* of the population aged 25 and older reporting excellent/very good, good, or fair/poor health, in Ontario, by education level, 2014



Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Sciences  
 Note: \*Age-adjusted, analysis by education is restricted to 25 and older

### **i** Indicator: Self-reported health status

This indicator measures the percentage of the population of Ontario aged 12 and older who rated their general health as either excellent/very good, good, or fair/poor.

## Did you know?

An estimated 65 out of 100 people living in Ontario in 2014 rated their health as excellent or very good.[11]

## Chronic Conditions

There are millions of Canadians living with chronic diseases such as diabetes, arthritis and mental illness. The numerous medications and treatments made available in our advanced health system, allow many people to lead productive lives despite their illnesses. Still, chronic diseases may contribute to a lower quality of life, physical limitations, increased hospitalization and greater health care costs, as well as premature death.[12]

## Findings and variations

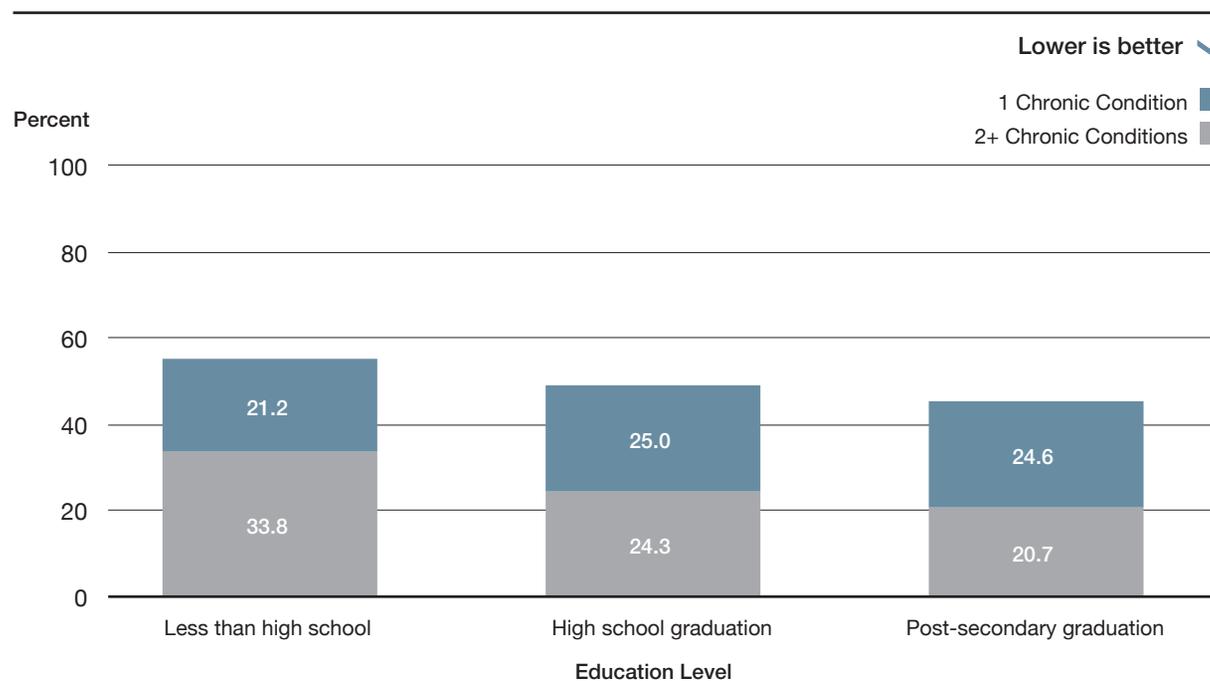
Chronic condition rates have remained stable in Ontario since 2007. More than half, or 57.4%, of the population reported no chronic condition in 2014, 23% reported having one and 20% reported having two or more.[11]

## Variations by education

While the percentage of people who reported one chronic condition was similar at all education levels, there were variations for two or more chronic conditions. Those with less than high-school education were significantly more likely to report having two or more chronic conditions (Figure 2.3).

FIGURE 2.3

Percentage\* of the population aged 25 and older reporting having one chronic condition or two or more chronic conditions, in Ontario, by education level, 2014



Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Sciences  
Note: \*Age-adjusted, analysis by education is restricted to 25 and older

### **i** Indicator: Chronic conditions

This indicator measures the percentage of people aged 12 and older who reported having one or two or more of the selected chronic conditions such as anxiety, arthritis, asthma, chronic obstructive pulmonary disease, diabetes, heart disease, hypertension and depression.

## Did you know?

An estimated 2.3 million people living in Ontario had two or more chronic conditions in 2014, based on a survey of self-reported health status.[11]

## Infant mortality

Infant mortality rates are not just a reflection of infant health. They speak to the health of mothers and of the health system more broadly. Rates of infant mortality reflect the conditions mothers are exposed to during and even prior to pregnancy, including their socio-economic status and ability to access the resources needed to avoid health risk factors. These rates can also help us understand how effective and equitable our health system is, for example, if they are used to examine whether there is equal access between different socioeconomic groups to high-quality obstetric and pediatric care.[13]

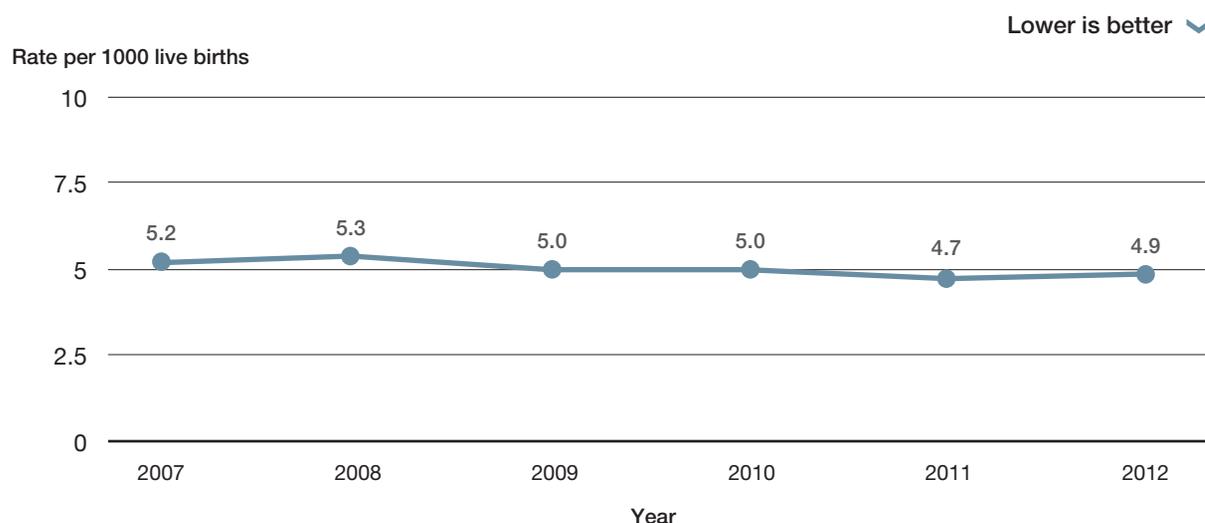
## Findings and variations

The infant mortality rate in Ontario declined between 2007 and 2012, to 4.9 infant deaths per 1,000 live births, from 5.2 per 1,000 live births (Figure 2.4).

## Did you know?

Infant mortality in Canada decreased steadily from 1979, when there were 10.9 infant deaths per 1,000 live births, to 2012, when there were 4.9 infant deaths per 1,000 live births.[14]

FIGURE 2.4  
Infant mortality per 1000 live births, in Ontario, 2007 to 2012



Data source: Statistics Canada, Canadian Vital Statistics, Birth and Death Databases and population estimates, CANSIM table 102-0504

### *i* Indicator: Infant mortality

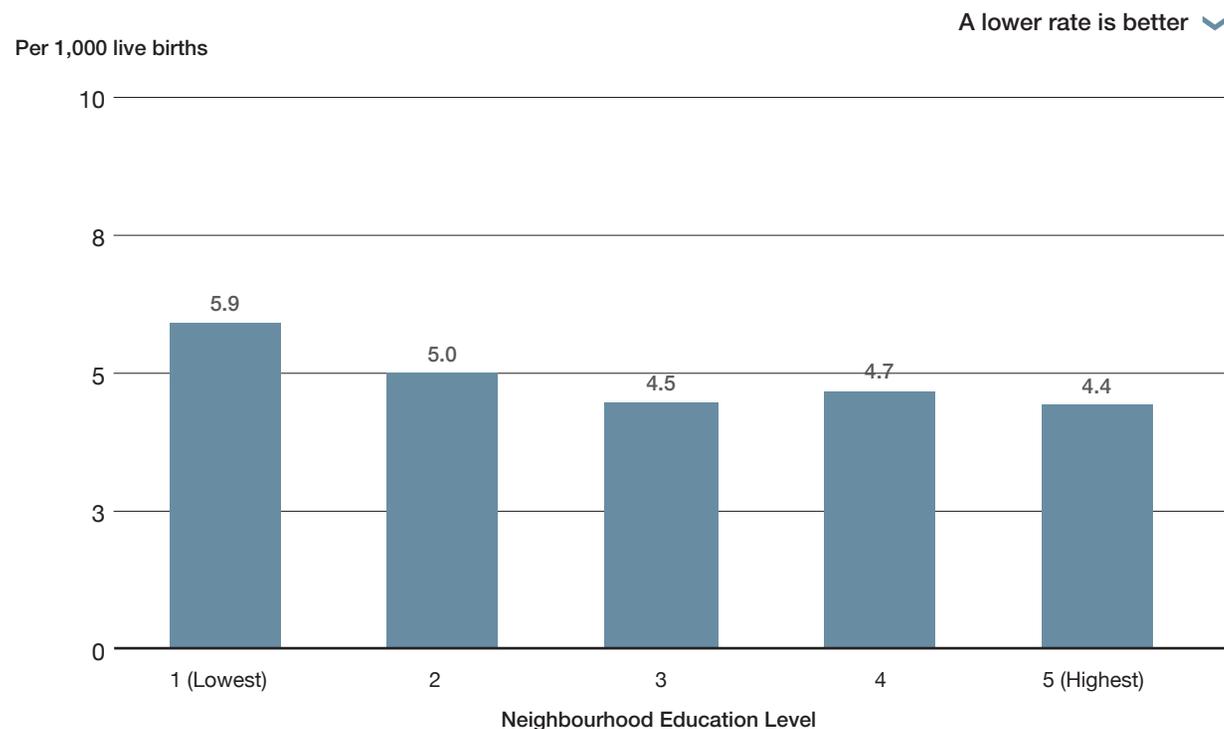
This indicator measures the number of deaths among children less than one year of age per 1,000 live births in the same year.

## Variations by education

Combining two years of data (2009 to 2011), the infant mortality rate was 5.9 per 1,000 live births for children whose mothers lived in neighbourhoods where residents had the lowest level of education, compared to 4.4 per 1,000 live births for children whose mothers lived in neighbourhoods where residents had the highest level of education. This amounted to a 35% higher rate of infant mortality in the neighbourhoods where residents had the lowest level of education (Figure 2.5).

FIGURE 2.5

### Infant mortality per 1000 live births, in Ontario, by neighbourhood education level, 2009-2011



Data source: Canadian births database, Canadian mortality database, sourced from the Public Health Agency of Canada's Health Inequalities Data Cube

## Life expectancy

Life expectancy is used worldwide as an indicator of the general health of a population. In 2011, Canada ranked 11th among the 44 countries in the Organisation for Economic Co-operation and Development (OECD).[15]

## Findings and variations

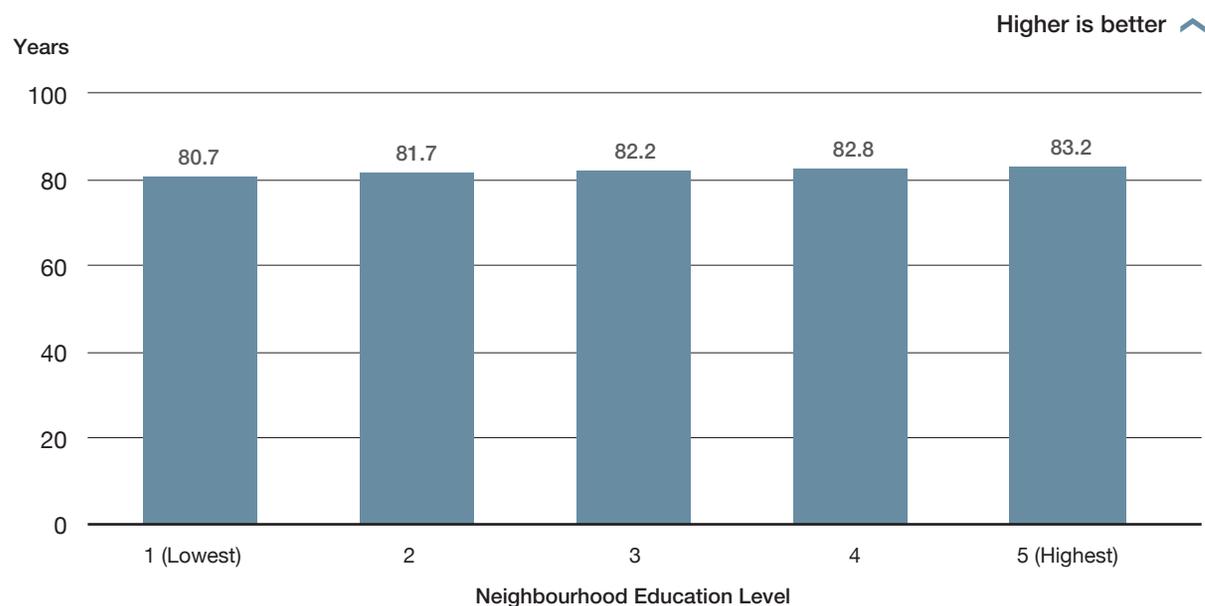
The overall life expectancy for people living in Ontario increased to 82.1 years in 2009/2011 from 80.5 years in 2003/2005.[16]

## Variations by education

In 2009/2011, people living in the neighbourhoods where residents had the lowest level of education had a life expectancy of 80.7 years, while those living in the neighbourhoods where residents had the highest level of education had a life expectancy of 83.2 years (Figure 2.6).

FIGURE 2.6

### Life expectancy, in Ontario, by neighborhood education level, 2009-2011



Data source: Canadian Mortality Database, sourced from the Public Health Agency of Canada's Health Inequalities Data Cube

## Did you know?

Since 1920, the life expectancy of Canadians has increased by over 20 years.[17]

### **i** Indicator: Life expectancy

This indicator measures the average number of years a person is expected to live, starting at birth.

## Potential years of life lost

When and how people die is affected by our health system, particularly by disease prevention efforts and by how health problems are managed. For example, measures to encourage healthy eating and exercise habits in a population can reduce the prevalence of conditions such as diabetes that can lead to premature death.[18]

In this section, we look at the potential years of life lost when people die prematurely — that is before age 75 in Canada. Someone who died at age 50 would be reported as having lost 25 years of life, while someone who died at age 74 would have lost one year of life.

## Findings and variations

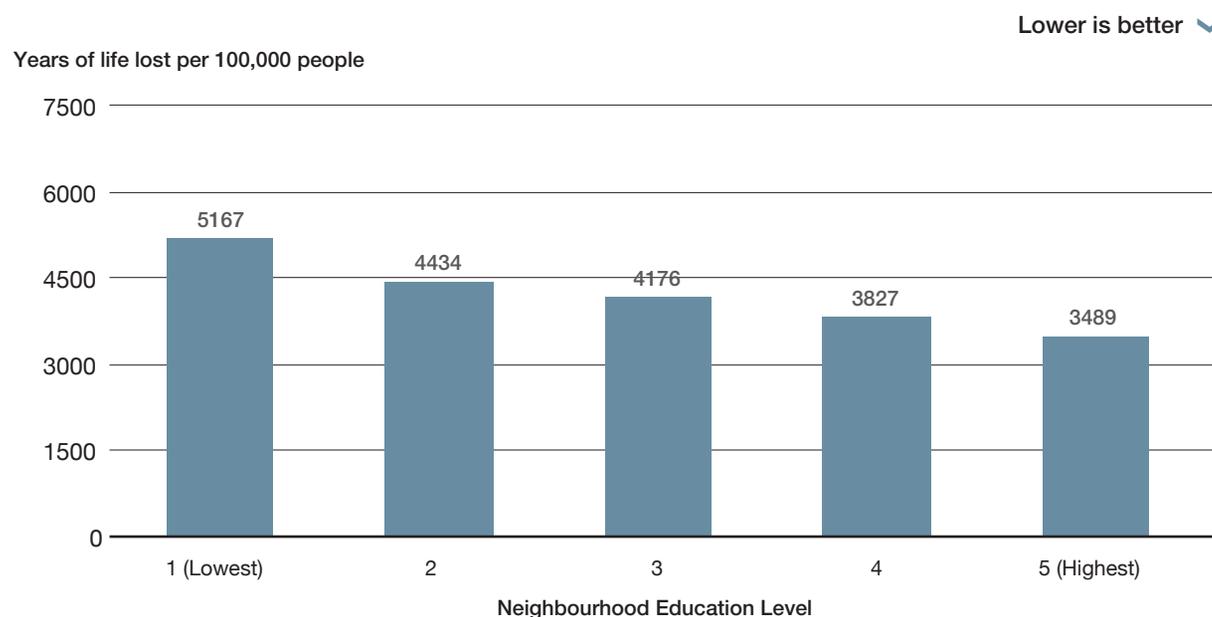
The total number of potential years of life lost for all people living in Ontario dropped steadily to 4,330 years in 2011 from 5,208 years in 2001.[19]

## Variations by education

People who lived in neighbourhoods where residents had the lowest level of education lost a total of 5,167 years of life per 100,000 people, while those who lived in neighbourhoods where residents had the highest level of education lost 3,489 years per 100,000 people. This amounted to a 48% higher rate of years of life lost in the neighbourhoods where residents had the lowest level of education (Figure 2.7).

FIGURE 2.7

### Potential years of life lost per 100,000 people,\* in Ontario, by neighbourhood education level, 2009-2011



Data source: Canadian Mortality Database, sourced from the Public Health Agency of Canada's Health Inequalities Data Cube  
\*Age-adjusted

## Did you know?

In 2011, more than 91,900 people in Canada died prematurely — before the age of 75 — so that almost 38% of all deaths were premature.[19]

### **i** Indicator: Potential years of life lost

This indicator measures the total number of years of life lost prematurely — before the age of 75 — per 100,000 people.

## How Ontario measures up to other jurisdictions

Looking at how population health indicators for Ontario compared with indicators for the rest of Canada or other jurisdictions in recent years is another way to assess the health of the people living in the province.

### Obesity



19.7%

Ontario

15.3%

British Columbia

Ontario's obesity rate was 19.7%, the third lowest in Canada. British Columbia had the lowest rate at 15.3%.[20]

### Smoking



17.8%

Ontario

15.1%

British Columbia

In Canada, only British Columbia had a significantly lower smoking rate (15.1%) than Ontario (17.8%).[20]

### Health



61%

Ontario

63.5%

Alberta

The percent of people in Ontario who rated their health as excellent or very good was comparable to other provinces, at 61%. Alberta led the country at 63.5%.[11]

### Infant Mortality



4.7

Ontario

6.1

United States

In 2011, with an infant mortality rate of 4.7 per 1,000 live births, Ontario ranked roughly in the middle for infant mortality rates relative to comparable international jurisdictions. Sweden has the lowest rate with 2.1 and the United States has the highest rate with 6.1.[21]

### Inadequate Fruit & Vegetable Intake



Inadequate fruit and vegetable intake were similar in Ontario compared to most provinces.[20]

### Years of Life Lost



Ontario had the lowest figure in Canada for potential years of life lost.[22]

### Life Expectancy



Life expectancy in Ontario was comparable to other provinces.[17]

## In summary

The people of Ontario generally perceive their health in a positive light, which is reason to be optimistic about both the present and future health of people living in Ontario. While the health risk factors of smoking and physical inactivity have improved since 2007, the rates of obesity and inadequate fruit and vegetable intake have increased. However, there is a need for improvement in eating habits and obesity rates. Infant mortality rates have steadily decreased, but the difference in infant mortality rates between the neighbourhoods with the lowest education level and the ones with the highest education level suggest there is room to reduce some of the gaps. Life expectancy has slightly increased.

People with higher levels of education report higher rates of healthy factors than people with lower levels of education. In addition, rates of infant mortality are lowest for children born to mothers living in neighbourhoods where residents have the highest level of education, and people living in neighbourhoods where residents have the highest level of education have the fewest potential years of life lost, and the longest life expectancy.

Greater understanding of these trends can be used to develop targeted health promotion initiatives to ensure all people living in Ontario have opportunities for better health.

# Primary Care



In this chapter, we report on the following Common Quality Agenda indicators for primary care:

- Having a primary care provider
- Same-day or next-day access to primary care
- After-hours access to care
- Patient involvement in decisions about their own care
- Overdue for colorectal cancer screening
- Diabetes eye exam

Photo of Nicolette taken by Roger Yip. Please see her story on the next page.

## Real-World Experiences

### Technology changing the face of primary care: Nicolette's story

Nicolette Skaarup, a registered practical nurse in Chatham, recalls a mother who was worried about her sons, aged 2 and 5, and daughter, 9. The kids were complaining of painful ears, but the woman couldn't get an appointment with their family doctor for more than a week. So the family headed to Chatham's new walk-in clinic, the youngsters dragging their feet, until Nicolette welcomed them into the exam room, where they saw "videos" and "games" on a computer screen. They had entered the world of the Ontario Telemedicine Network.

Nicolette took photos of the children's eardrums with a digital otoscope that plugs directly into the computer. "They thought I was sticking a video game in their ears," Nicolette says. She then emailed the images to the offsite doctor, and entered patient information into the electronic medical records shared by the Chatham clinic and the doctors. After a quick web-chat message from Nicolette to one of several doctors available online (mostly in Toronto and Ottawa), they were ready for the tele-consult.

While the family doctor, sitting in his office 150 kilometres away, reviewed the notes and pictures, Nicolette reassured the mother about privacy: Patients must give consent for photos. They make every effort not to identify the patient in any photo, all images are deleted from the computer as soon as they're sent to the doctor; and the secure video-conferencing network adheres to Ontario's Personal Health Information Act and Canada's Personal Information Protection and Electronic Documents Act.

Within a few minutes, the computer in the Chatham clinic started to beep, "The kids thought it sounded like a game show," Nicolette recalls. The face and voice of a family doctor appeared on the computer screen. "The kids were asking me, 'Are you doing FaceTime or is the doctor on YouTube?'" Nicolette laughs. "They thought it was so cool." The doctor chatted with the family and Nicolette, and wrote an antibiotics prescription for their ear infections, which printed out a couple of minutes later on Nicolette's end.

For other patients, Nicolette sometimes uses a digital camera to take photos of body parts the doctor cannot see on the webcam, and emails them

to the doctor. Her older patients are just as impressed with the telemedicine service as the kids, Nicolette says. "They can hardly believe that it's an option. They're thrilled it isn't going to take them six hours sitting in the emergency department" to see a doctor – often their only choice given a shortage of same-day, next-day and after-hours access to family doctors in Chatham.

About half the people Nicolette sees at the walk-in clinic are "orphans in the primary care system – they have no family doctor at all," she says. Aside from regions such as Chatham-Kent that are underserved in primary care, telemedicine and other technologies helps patients with limited mobility.

"These aren't doctors in a call centre, they're working out of their family practice office or from their private study," Nicolette says. "I don't like it when people say the telemedicine doctor isn't physically with the patient. They see each other and are talking, just like they're in the same room."

## Real-World Experiences

### Mixed messages: Bill's story

Bill gets mixed messages sometimes from health care providers in the small town of Chatham where he's lived all his life.

Once when he had a very sore throat, Bill waited eight days for an appointment with his family doctor, which was the normal wait time, but was told he should have gone to the emergency department instead of waiting. Another time, when Bill went directly to the emergency department with a painful blocked ear, a nurse told him he shouldn't be there, and advised him to "go see your family doctor tomorrow or Monday." Shaking his head, Bill says, "if that was possible, I wouldn't be at emergency in the first place."

The 69-year-old says "I try not to overuse emergency," adding that he, his wife and his elderly mother have used the emergency department about a half dozen times the last couple of years, waiting about eight hours each visit. The emergency department "gets pretty clogged up," Bill says. "There are about 20 beds back there. You put in a couple of heart patients, a couple of broken limbs, doctors get preoccupied and everything grinds to a halt" for the people waiting in emergency at Chatham's sole hospital. About 45 minutes' drive east and west are very small

community hospitals, with the region's largest hospitals in the city of London, an hour away.

Small towns can run into different resource shortages than cities, like the time Bill had a mild heart attack and there was no transportation available to take him to a hospital in London for an angiogram. Bill says he had to wait an extra day and night at the Chatham hospital until an ambulance became available.

It's not just the long waits in the emergency that bother Bill – it's having to repeat his medical history. "I would be asked in triage about my medical history, then most of the same questions would be asked by the nurse assigned to you [in the emergency department]," he says. "If your assigned nurse was on break, or during shift change, you would have to explain it again. Then the doctor goes back to square one when he comes in and asks a lot of the same questions." Bill sighs. "My family doctor knows all that about me," he says, adding that he wishes he could see him for non-urgent matters in a more timely fashion.

Bill's long-time family doctor recently retired, and he and wife, Dona, now see a new doctor – a Chatham native who recently moved back from the

U.S. – who is part of a family health team. Smiling, Bill shows a flyer from the team that reads: "We provide same-day access for our patients who have urgent care needs. That is something my old doctor never offered." Although urgent care isn't defined, Dona recently called the office with a sinus infection, and she was seen the same day by their family doctor.

Still, there is room for improvement in after-hours primary care, says Bill. His family health team has appointments Monday through Thursday from 5 to 8 p.m., but they're "often booked up and you are told to go to the emergency department," says Bill, adding that "they really only want to see a stuffed nose or stubbed toe" during evening appointments due to limited time and resources. Meanwhile, a walk-in clinic recently opened in downtown Chatham that uses telemedicine to reach family doctors in other cities (see story on page 27) to help meet the needs of residents who don't have access to primary care. However, since the new walk-in clinic closes at 6 p.m. on weekdays and is not open on weekends, after-hours access remains a challenge for Chatham residents, Bill says.

"We're all in the same boat in this town," Bill says. "We all end up at the emergency department more than we should."

# On the front line: Primary care

Most patient experiences with the health system start with seeing a family doctor, nurse practitioner or other primary care provider. This puts primary care providers in a unique position to support patients. Not only does primary care include a range of services to patients such as assessment, diagnosis, counselling, treatment, screening and health promotion, it also plays a central role as a point of access to other health care providers.

## Having a primary care provider

Having access to primary care that is comprehensive, consistent and coordinated with other health care providers has a positive impact on people's health.[23] As well, ensuring people have access to primary care can reduce overall costs for the health system.[2] People who don't have access to primary care may end up having to use other parts of the system that are already under pressure from heavy use, such as crowded hospital emergency departments.[3]

Although having a primary care provider does not necessarily mean it is easy for a patient to get an appointment and see their primary care provider, it is a significant step to getting access.

**i** **Indicator: Having a primary care provider**

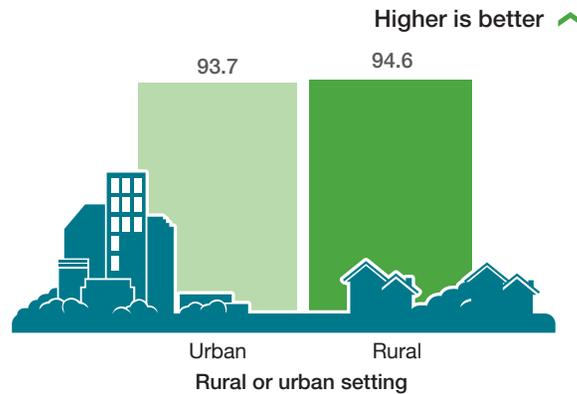
This indicator measures the percentage of people 16 years of age and older who reported having a family doctor or other primary care provider.

**Findings and variations**

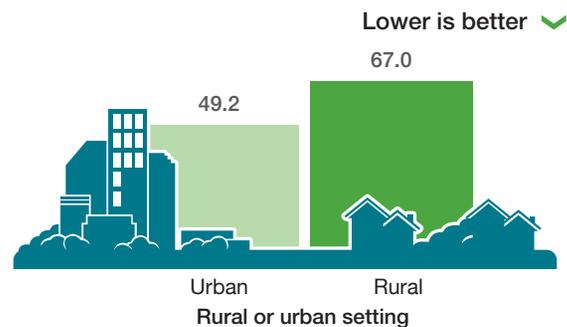
In 2015, about 94% of people aged 16 and over in Ontario reported that they had a family doctor or other primary care provider, a percentage that has remained stable over the last two years.[24] There was no difference between people living in urban or rural areas in the proportion who had a provider (Figure 3.1A).

However, how long a person had lived in Canada was a factor in whether they reported having a family doctor or other primary care provider. Among recent immigrants — those in Canada less than a decade — 84.6% reported having a provider, compared to 94% of people born in Canada and 95.1% of established immigrants.[24] This picture may not capture the full range of recent immigrants. People without an Ontario’s health card, like refugees, or people who are unable to speak French or English would not have been part of the survey.

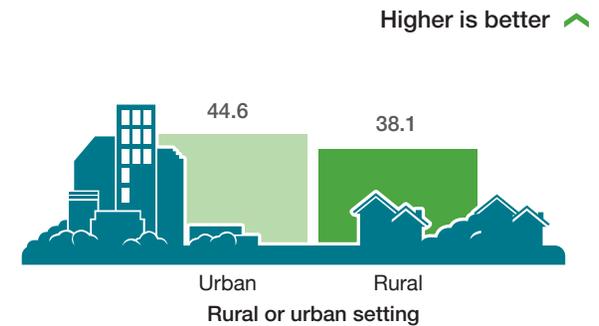
**FIGURE 3.1A**  
Percentage of people aged 16 and older who have a primary care provider, in Ontario, by rural or urban setting, 2015



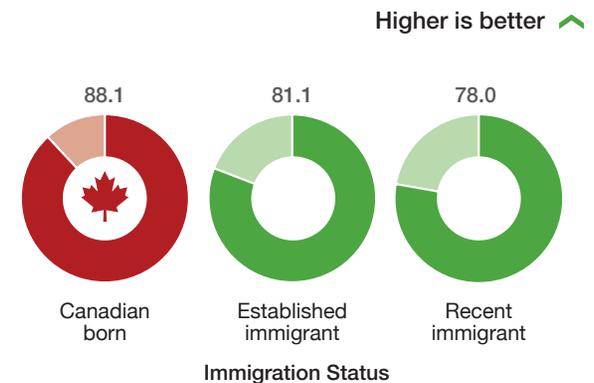
**FIGURE 3.1C**  
Percentage of people aged 16 and older reported that getting access to care on an evening or weekend, without going to the emergency department, was very difficult or somewhat difficult, in Ontario, by urban/ rural status, 2015



**FIGURE 3.1B**  
Percentage of people aged 16 and older who were able to see their primary care provider or another primary care provider in their office, on the same day or next day when they were sick, in Ontario, by rural or urban setting, 2015



**FIGURE 3.1D**  
Percentage of people aged 16 and older who report that their provider always often involves them in decisions regarding their care, in Ontario, by immigration status, 2015



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

## Same-day or next-day access to a primary care provider

Primary care helps prevent illness and death.[23] However, simply having a primary care provider is not enough because it does not ensure people can get an appointment with the provider when they are sick. About 20% of people in Ontario who have a regular doctor still make use of walk-in clinics, a pattern which may be related to lack of timely access to their regular primary care provider.[25]

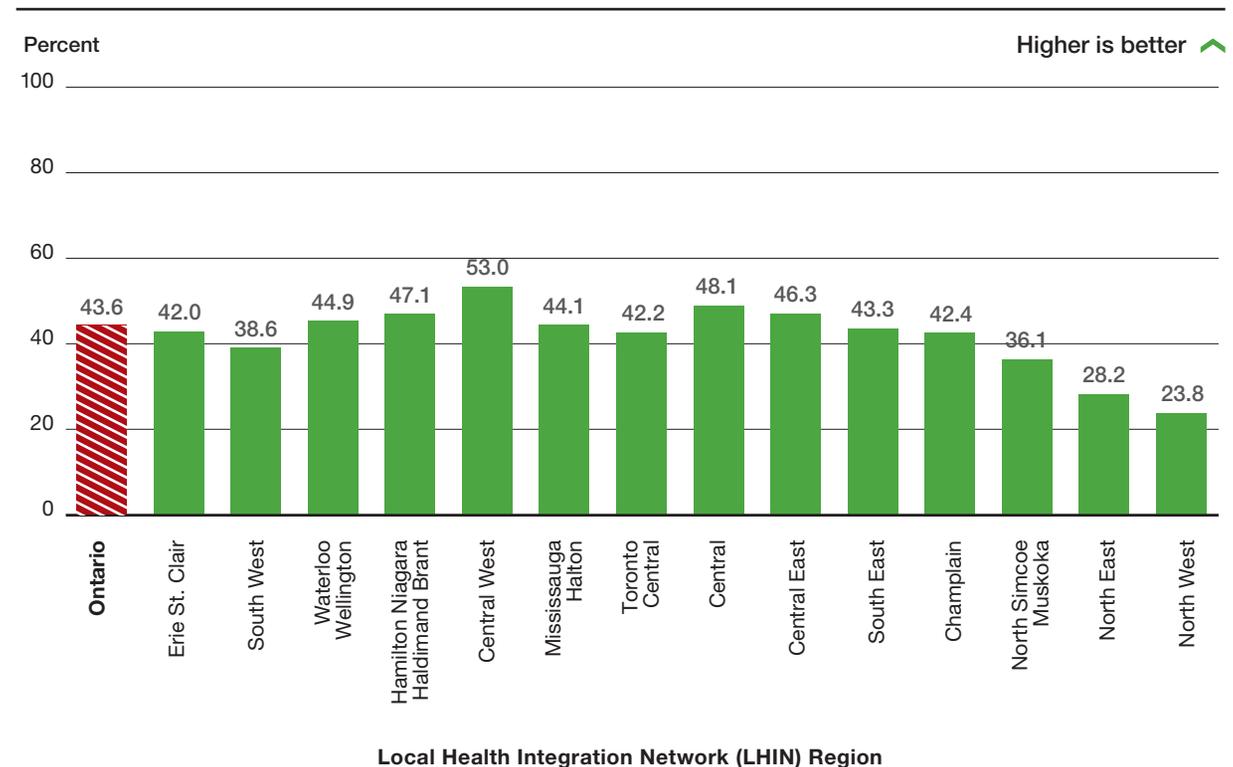
### Findings and variations

In 2015, less than half of people aged 16 or older in Ontario, or 43.6%, were able to get appointments with their primary care provider, or another primary care provider in their office, the same day or next day when they were sick or had a health concern. This situation has remained unchanged over two years.[24]

A greater proportion of people living in urban areas reported having same-day or next-day access to primary care, at 44.6%, compared to 38.1% of people living in rural parts of Ontario (Figure 3.1B).

There were also differences that depended on the region in Ontario where people lived (Figure 3.2). The greatest proportion of people, 53%, reported same-day or next-day access in the Central West LHIN region, while the lowest proportion, 23.8%, reported prompt access in the North West LHIN region.

FIGURE 3.2  
Percentage of people aged 16 and older who were able to see their primary care provider, or another primary care provider in their office, on the same day or next day when they are sick, in Ontario, by LHIN region, 2015



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

### **i** Indicator: Same-day or next-day access to a primary care provider

This indicator measures the percentage of people aged 16 and older who reported being able to see their family doctor or another primary care provider in their office, on the same day or next day when they were sick.

## After-hours access to care

People's need to see a family doctor or other primary care provider does not always fall within the regular schedule many medical offices and clinics maintain. When people get sick and require medical care after-hours or on the weekend, they may go to their local emergency department because they don't have or know about any alternatives. Better access to after-hours primary care services can reduce visits to emergency departments for health conditions that would normally be managed by a family doctor, for example.[26]

## Findings and variations

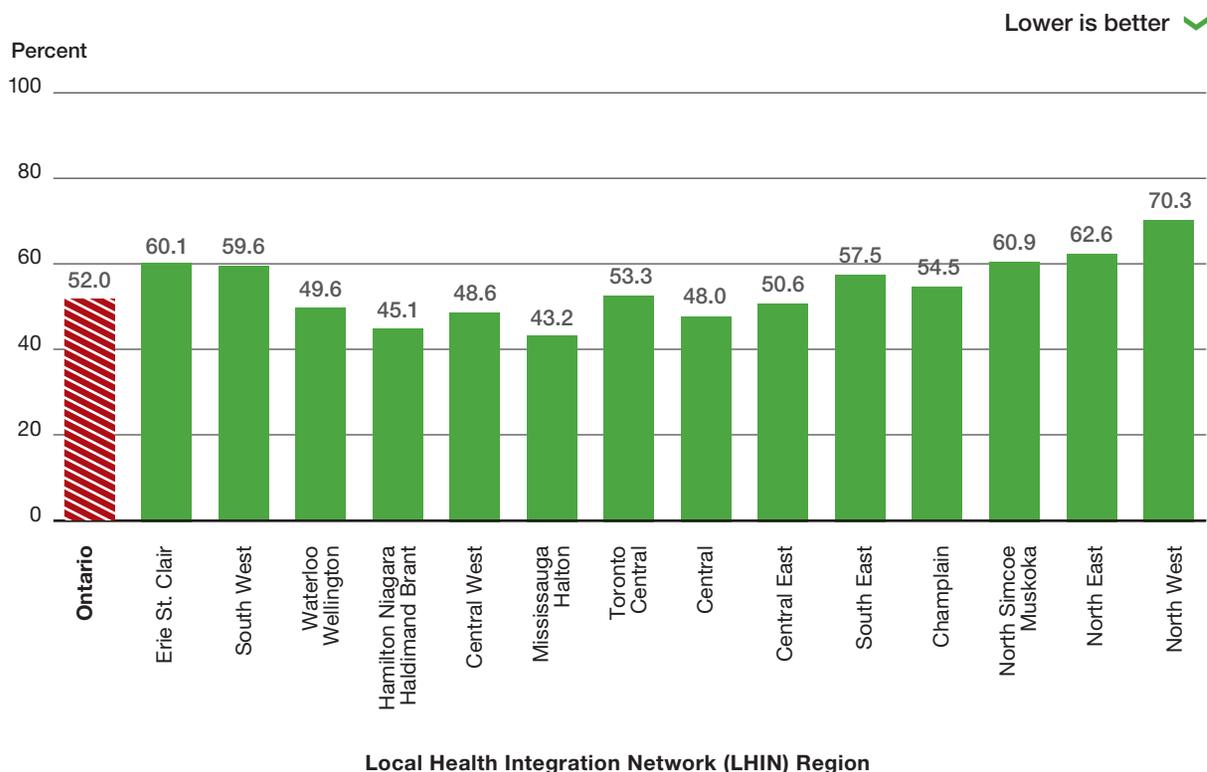
In 2015, 52% of people living in Ontario reported having difficulty getting after-hours access to care without going to an emergency department, a percentage that had remained stable over two years.[24]

A significantly greater proportion of people living in rural Ontario had difficulty getting after-hours access to care, at 67%, compared to 49.2% of people living in urban areas (Figure 3.1C).

There were regional differences across Ontario in the percentage of people who reported difficulty getting access to care on evenings or weekends without going to the emergency department. In the Mississauga Halton LHIN region, fewer than half, or 43.2%, of residents reported having difficulties in getting after-hours access. In the more remote area of the North West LHIN region, more than two-thirds, or 70.3%, of people said they had difficulty getting after-hours care (Figure 3.3).

FIGURE 3.3

**Percentage of people aged 16 and older who reported that getting access to care on an evening or weekend, without going to the emergency department, was very difficult or somewhat difficult, in Ontario, by LHIN region, 2015**



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

### **i** Indicator: After-hours access to primary care

This indicator measures the percentage of people aged 16 and older who reported having difficulty getting care in the evening or on a weekend without going to an emergency department.

## Patient involvement in decisions about their own care

Patient-centred care is a crucial element of quality health care. It can be defined in many ways, but most definitions include patients participating in decision-making related to their own care.[27]

Patients who are involved in their own care as much as they want to be generally have a better experience with the health system.

### Findings and variations

In 2015, 85.9% of people aged 16 or older in Ontario reported being involved as much as they wanted to be in decisions about their own care.[24] This level of involvement has remained consistent since 2013.

Canadian-born patients were more likely (88.1%) than established (81.1%) or recent immigrants (78.0%) to be involved in their own care decisions (Figure 3.1D). This picture may not capture the full range of recent immigrants.[24] People without a health card, or people who were unable to speak French or English would not have been part of the survey. There was no significant variation in involvement between people living in rural and urban areas.

### **i** Indicator: Patient involvement in decisions about their own care

This indicator measures the percentage of people aged 16 and older who reported that their primary care provider always, or often, involved them as much as they wanted in decisions about their own care.

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## Overdue for colorectal cancer screening

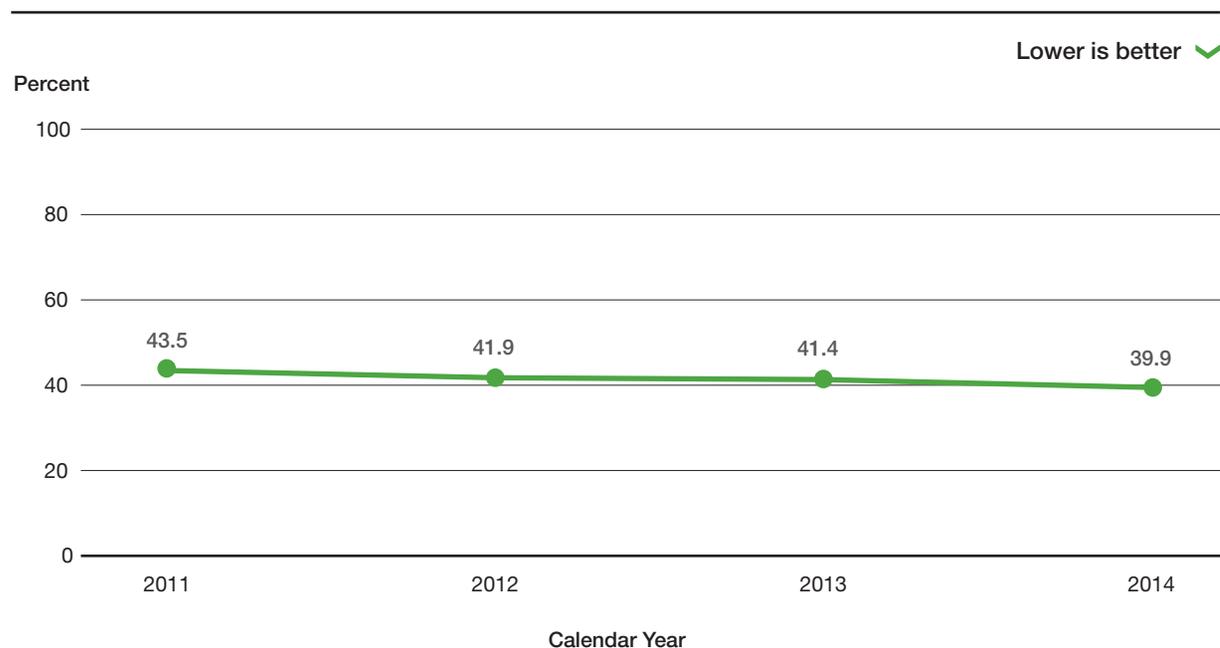
Colorectal cancer is a common cause of death.[28] Although this cancer is highly treatable if caught early, many people are not up to date on their screening for it.

Primary care providers can play a major role in informing their patients about the importance of getting screened for colorectal cancer and in supporting the Ontario's screening program for colorectal cancer, ColonCancerCheck. The program recommends that people between the ages of 50 and 74 years with an average risk of colon cancer have a test every two years that checks for blood in the stool (often called the "fecal occult blood test" or FOBT).[29] Other test options for colon cancer such as flexible sigmoidoscopy or colonoscopy are also available for cancer screening[30] and are included in this indicator.

### Findings and variations

There has been consistent improvement in this indicator over recent years, with the percentage of people aged 50 to 74 overdue for colorectal cancer screening shrinking to 39.9% in 2014 from 43.5% in 2011 (Figure 3.4).

FIGURE 3.4  
Percentage\* of people aged 50 to 74 overdue for colorectal cancer screening, in Ontario, 2011 to 2014



Data sources: Colonoscopy Interim Reporting Tool, Laboratory Reporting Tool, Ontario Health Insurance Plan, Ontario Cancer Registry, Registered Persons Database, Postal Code Conversion File version 6A, provided by Cancer Care Ontario  
\*Age-Adjusted

### **i** Indicator: Overdue for colorectal cancer screening

This indicator measures the percentage of people aged 50 to 74 who were overdue for colorectal cancer screening, meaning they did not have a fecal occult blood test within the previous two years, did not have a colonoscopy in the previous 10 years, and did not have a flexible sigmoidoscopy in the previous five years.

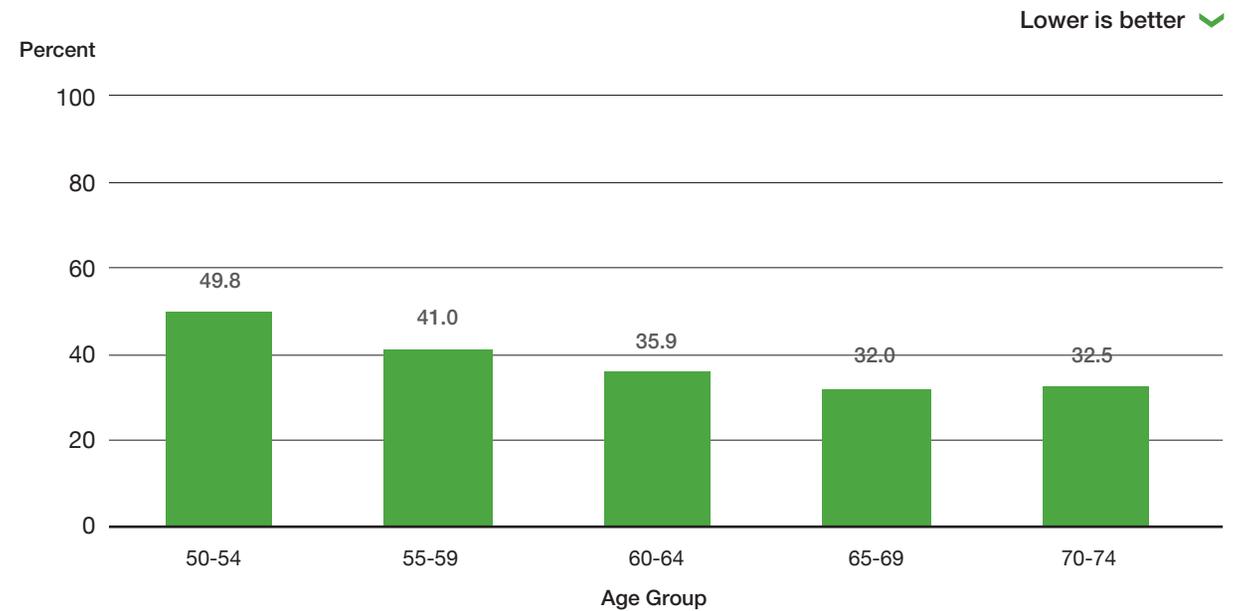
The youngest group included in these data — people aged 50 to 54 — had the lowest rate of colorectal screening. Close to half of this group, or 49.8%, were overdue for screening in 2014. That compares to about a third, or 32%, in the oldest 70-to-74 age group being overdue (Figure 3.5).

## Did you know?

The rate of colorectal cancer in Ontario is among the highest in the world.[29]

FIGURE 3.5

### Percentage of people aged 50 to 74 overdue for colorectal cancer screening, in Ontario, by age group, 2014



Data sources: Colonoscopy Interim Reporting Tool, Laboratory Reporting Tool, Ontario Health Insurance Plan, Ontario Cancer Registry, Registered Persons Database, Postal Code Conversion File version 6A, provided by Cancer Care Ontario

## Diabetes eye exam

For people who have diabetes, one important role their primary care provider plays is to ensure they are referred for regular eye exams to help prevent blindness from diabetic retinopathy, which is damage to the retina of the eye. The retina is light-sensitive tissue at the back of the eye. Chronically high blood sugar as a result of diabetes may damage the retina, causing swelling, bleeding and scarring which can lead to deterioration and loss of sight. Diabetic retinopathy affects more than one million people living in Ontario.[31]

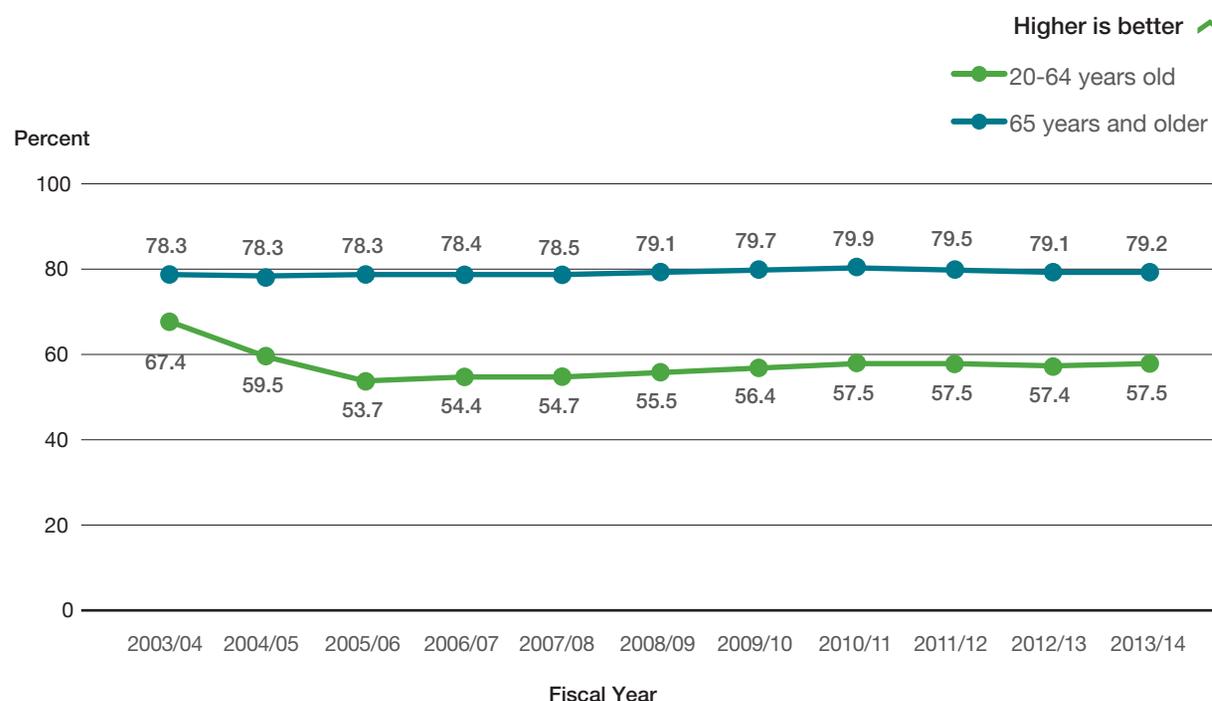
Treatment for diabetic retinopathy is much more successful when the condition is detected early, so screening is recommended every one to two years.

## Findings and variations

Between 2009/10 and 2013/14 in Ontario, the proportion of people with diabetes aged 20 or older who had not had an eye exam for retinopathy within a two-year period remained steady at about one-third.

Age makes a significant difference in whether a person with diabetes in Ontario gets an eye exam. Among adults aged 65 or older, the percentage having the exam grew slightly between 2003/04 and 2013/14, to 79.2% from 78.3%. However, the proportion of adults aged 20 to 64 having the exam shrank to 53.7% in 2005/06 from 67.4% in 2003/04. The eye-exam rate for this group increased after 2005/06 to 57.5% by 2013/14 — but was still below the 2003/04 rate (Figure 3.6).

FIGURE 3.6  
**Percentage\* of people aged 20 and older with diabetes who had a diabetes eye exam within a two-year period, in Ontario, by age group, 2003/04 to 2013/14**



Data sources: Ontario Health Insurance Plan and Ontario Diabetes Database, provided by the Institute of Clinical Evaluative Sciences  
 \*Age and sex adjusted

**i** **Indicator: Diabetes eye exam**

This indicator measures the percentage of people with diabetes, aged 20 or older, who had an eye exam within a two-year period.

A drop in the eye-exam rate for both age groups, to 63.8% in 2005/06 from 71.9% in 2003/04, could be related to the delisting of routine eye exams for healthy adults in 2003/04, which meant their cost was no longer covered under the Ontario Health Insurance Plan (OHIP). 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 in regard to how patients 20 to 64 years old were affected.[32] The eye-exam rate for this age group slowly increased again, but did not return to the level of a decade earlier.

## Did you know?

While diabetes is usually not recorded as the primary cause of death, many of its complications are associated with premature death.[33]

## In summary

The vast majority of people living in Ontario have a primary care provider. Most of them have one who involves them as much as they want in decisions about their own care, except for people new to Canada, a smaller proportion of whom say they have as much involvement as they want in decisions about their own care than those born in Canada. But for many people in Ontario, getting access to primary care the same day, next day, after regular office hours or on weekends, remains a challenge. It's particularly challenging for people who live in a rural area. Otherwise, there is little difference between people living in rural and urban areas when it comes to having a primary care provider or being involved in decisions about their own care.

There has been improvement in the area of colorectal cancer screening, with fewer people overdue for screening. However, the younger people among those who should be screened are more likely to be overdue for screening. Primary care organizations across Ontario are working hard to improve screening rates and other areas of primary care, as highlighted in Health Quality Ontario's *Insights into Quality Improvement: Primary Care*.

An increasing number of people with diabetes are getting eye exams. However, even though early detection is important in the treatment of diabetic retinopathy, people with diabetes who are 20 to 64-years-old are having eye exams at a lower rate than those 65 and over

# Mental Illness and Addictions

In this chapter, we report on the following Common Quality Agenda indicators for mental health and addictions:

- Follow-up with a doctor after hospitalization for mental illness or addiction
- Readmission within 30 days of discharge following hospitalization for mental illness or addiction
- Suicide rates
- Use of physical restraints on patients hospitalized for mental illness or addiction
- Increasing symptoms of depression among residents of long-term care homes

Photo of Emilie taken by Roger Yip.  
Please see her story on the next page.

## Real-World Experiences

### Now and then: Emilie's story

#### Emilie was 12 when her parents ended their marriage.

“At the time my parents were going through their divorce, I was depressed and anxious,” says Emilie, who is now 19. “I also started to develop an eating disorder.” A native of Ottawa, Emilie was referred to a psychiatrist at a children’s hospital. As her issues compounded, she saw her psychiatrist on a regular basis, as well as social workers and dietitians.

Throughout her adolescence and into her late teens, Emilie was admitted to the children’s hospital as a psychiatric in-patient 10 times. When she was 17, she attempted suicide twice. “I was going through a really bad bout of depression and dealing with withdrawal symptoms from alcoholism and I ended up overdosing,” she says. “They admitted me, and maybe three days after I was discharged, I did it again.”

Although these years were fraught with mental health and addiction problems, Emilie says the professional care she got was helpful, comforting

and ongoing. “They were really welcoming, which was great,” Emilie says. “When I was an in-patient, the nurses and doctors were always there for me. When I was discharged, the psychiatrist always followed up within a week. And my family also got counselling.”

When Emilie turned 19, she needed to transition to the “adult world” of psychiatric care. It wasn’t a smooth process. “Trying to get a referral to a new specialist was difficult because there are wait times and my referral ended up getting lost,” Emilie says. “I had to call and see what was going on because there was such a delay. And finally, after the referral took six months, I was put on a waiting list for a psychiatrist at the adult hospital.”

Emilie also initially found differences in the style of care and the system generally, from childhood services compared to the adult services. “You go from a very caring environment with children’s services and then once you get into adult services, it’s cold and distant,” Emilie says. “And when you try and connect all of your mental health professionals with your family doctor, it doesn’t

work well...Whenever I see my family doctor, I have to give an update on changes in medications, changes in services and generally what’s going on. I think they should be communicating (with each other) on their own.”

Eventually, Emilie linked with a hospital-based psychiatrist. She is on several medications, but the focus is on therapy. “It’s mainly working on anxiety, fears and boosting my mood,” she explains, adding that she sees a therapist on her own and meets once a week for group-based behaviour therapy. A lot of the therapy is also for her eating disorder and harm reduction, she says.

“I’m finally doing better now that I’ve connected with all the right services,” she says, speaking with a quiet confidence. “I’m studying social work at college and enjoying it.”

## Real-World Experiences

### The wind in his sails: George's story

George\* likes to joke. He calls the dining room table where he sits in the Sarnia long-term care home where he lives “the revolving door” ever since three table mates died in a short period of time. The 83-year-old's naturally gruff voice gets lower and quieter, though, when he talks about one of these former table mates – his best friend Susie.\*

“She mothered me,” he says. “She would put jam on my toast, add cream and sugar to his coffee, and check up on me.”

Susie died suddenly in mid-2016. “I didn't think she was that sick,” George says. “It was more or less a shock. It really took the wind out of my sails.” The only time he left his room for weeks afterwards was to attend Susie's funeral, in his full Navy dress uniform from his service in the Korean War. Very depressed, George told staff: “I want to go with my friend.”

A few months after Susie died, George started taking antidepressant medication. He also got through that low period with the help of Jill\*, a personal support worker. She let him linger in his private room for a couple of weeks after Susie died, keeping a close eye on him. Then “she said things like ‘OK, buddy, let's go get some ice cream,’” George says. “Enjoyable, not bossy like some people are.”

He's trusted Jill since the day he arrived, scared and angry, at the home in 2014. “I would yell at

people to get the hell out of my room,” George says. “I was used to that kind of Navy- talk in the mess tent all the time.” (Jill doesn't mind it, although she adds, laughing, “It isn't dining-room appropriate.”) Put in a bed with two side rails at first for his safety, George kept trying to get out of bed. He recalls, “I felt locked in, like I was in jail.” When Jill asked him why he kept trying to crawl out of bed, “I said ‘you have to get rid of these goddamn rails,’” and she did.

Paralyzed on his left side from a major stroke he suffered in 2013, George is confined to a wheelchair, which he finds frustrating, and also has arthritis, angina and hypertension. He recently learned through physiotherapy to stand alone against a wall and then take a few steps on his own. “He's just grinning when he does,” says Jill. George can now get onto the toilet, chairs or bed without a lift machine.

Before his stroke, George lived alone as a widower for five years, following half a century of married life and working as a truck driver. Tough and independent, he wants to be consulted about what happens to him.

Although Jill recently moved to a different floor, she still stops by to see him. She points out that when George is in a low mood, all the staff have something to talk to him about because of his mounted collection of hats – his Korean War cap, dress Navy cap, and work cap – and more than a dozen photos from his war days and

Remembrance Day events in his room. George likes to talk about his five years in the Navy. “We got hit when I was over there [in Korea] ... I lost my gunman and two other guys, I could reach over and touch them when it happened ... I have a photo of their graves.” Jill makes sure George gets a ride to the local Legion Hall in full dress uniform every November.

To help with mood and overall quality of life, the home recently introduced residents to “iPod therapy,” providing each of them with an MP3 player for which they choose their own content. They can play their devices anytime and anywhere. George listens to old-time country and western music – Johnny Cash is his main man – as well as baseball and hockey broadcasts.

When his mood is good, George takes part in almost every group activity, including field trips to a local horse farm, car show, shopping, picnics under the Port Huron bridge, and the Windsor casino. “I like to see the outside world,” George says. “It brings back memories.” He also plays bingo and euchre, watches bands and choirs from the community and, his favourite, weekly piano-and-song recitals by a fellow wisecracking resident.

Despite all the group activities, George hasn't really tried to make new friends since Susie died. “It's hard to make new friends – they'll just die.” Still, he adds, “I feel OK most days now, just sleepy.”

*\*Names have been changed for privacy.*

# Treating mental illness and addictions

Today in Ontario, about two million people are affected by a mental illness or addiction such as depression, anxiety, bipolar disorder or substance use disorder.[34] This means many people living in Ontario are either living with a mental illness or addiction or know someone who is, be it a family member, friend or colleague.

The impact mental illness and addictions have on people, communities, the economy and the health system is considerable. For example, mental illnesses and addictions are among the top causes of disability in Canada.[35]

Most of the data in this chapter are related to mental health care provided by hospitals and doctors. The data do not cover non-physician community services for mental illness and addictions – which constitute a large proportion of mental health support and services in Ontario – because meaningful comparable data on community services are not widely available at this time.

## Follow-up after hospitalization for mental illness or addiction

Timely follow-up with a family doctor or psychiatrist can help smooth a patient's transition from receiving round-the-clock care in the hospital to managing on their own back at home or elsewhere in the community. Follow-up is commonly used as an indicator of quality of care.[36]

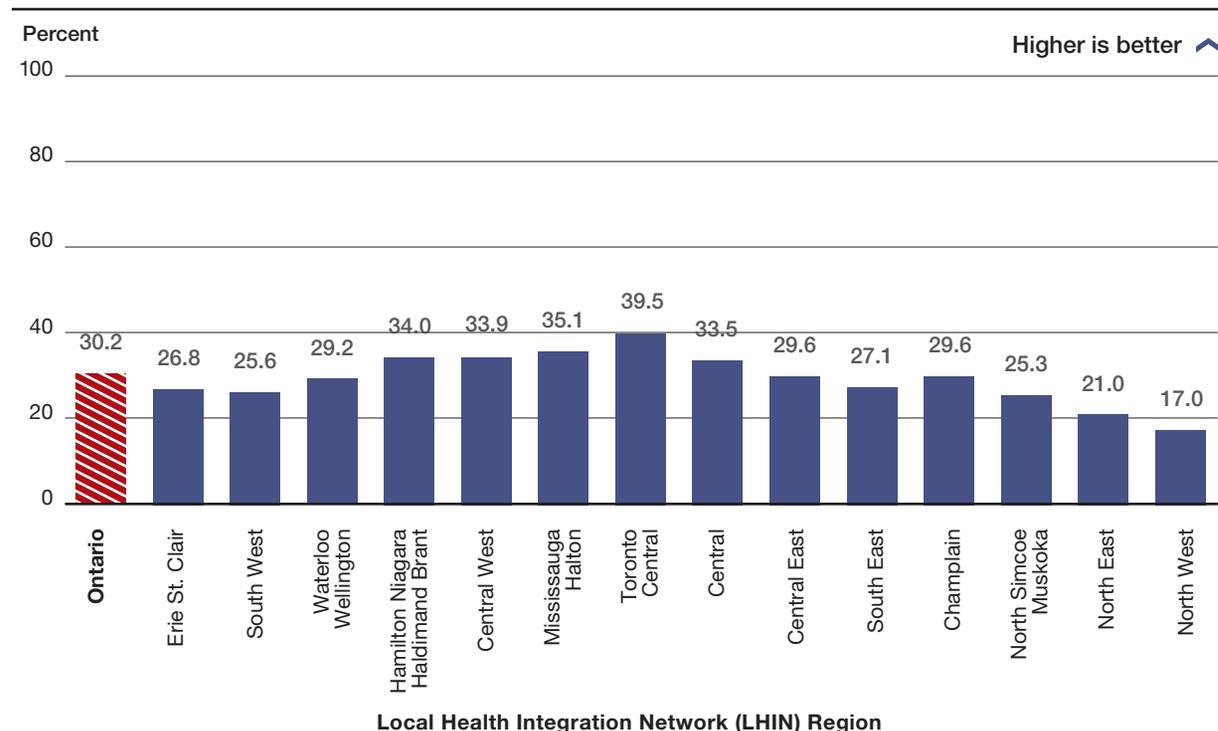
### Findings and variations

The proportion of patients hospitalized for a mental illness or addiction who saw a doctor within seven days after discharge remained stable for the past five years, at around 30%.[37] Notably, this rate was lower than the follow-up rates for other conditions such as chronic obstructive pulmonary disease and heart failure, which were 35.8% and 45.8% respectively.

The rate of follow-up with a doctor within seven days varied significantly across Ontario. The percentage ranged from 39.5% in the Toronto Central LHIN region to 17.0% in the North West LHIN region (Figure 4.1).

FIGURE 4.1

Percentage\* of patients who saw a family doctor or psychiatrist within seven days of discharge after hospitalization for mental illness or addiction, in Ontario, by LHIN region, 2014/15



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Registered Persons Database and Ontario Hospital Insurance Plan, provided by the Institute for Clinical Evaluative Sciences.

\*Age and sex-adjusted

### **i** Indicator: Seven-day follow-up after hospitalization

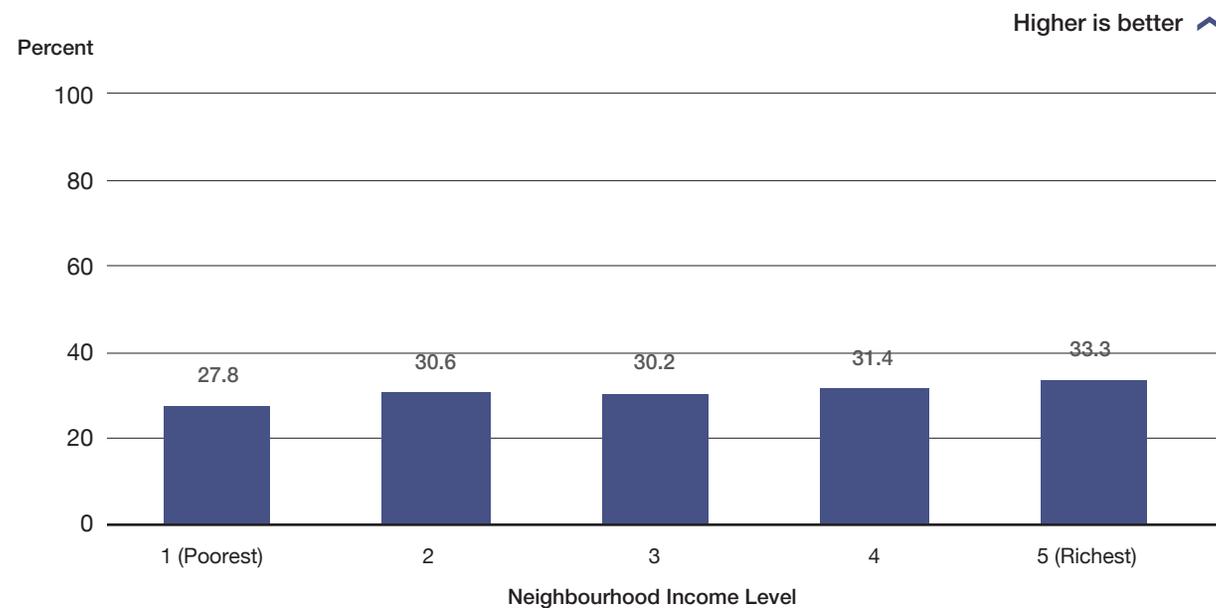
This indicator measures the percentage of patients who were hospitalized for a mental illness or addiction and were seen by a family doctor or psychiatrist within seven days after being discharged from hospital.

**Note:** This indicator does not capture follow-up visits to psychologists, clinics led by nurse practitioners, community health centres, or community mental health and addictions programs. Hence, the results reported here may underestimate the extent of follow-up care people receive after being hospitalized for a mental illness or addiction. This may be more significant in some regions, like the North, where such services may be more used.

Patients who lived in the poorest neighbourhoods had a significantly lower rate of follow-up with a doctor within seven days, at 27.8%, than those who lived in the richest neighbourhoods, for whom the rate was 33.3% (Figure 4.2).

FIGURE 4.2

**Percentage\* of patients who saw a family doctor or psychiatrist within seven days of discharge after hospitalization for mental illness or addiction, in Ontario, by neighbourhood income level, 2014/15**



Data source: Discharge Abstract Database, Ontario Mental Health Reporting System, Registered Persons Database and Ontario Hospital Insurance Plan, provided by the Institute for Clinical Evaluative Sciences.  
\*Age and sex-adjusted

## Hospital readmission for mental illness or addiction

While a patient may need to be readmitted after a hospitalization for mental illness or addiction, the health system generally seeks to reduce readmissions. This depends not only on the care received in the hospital, but also on what happens after a person is discharged from hospital. In some cases, patients end up back in hospital within a month. Readmission to hospital is widely used as a quality-of-care indicator for mental illness and addictions.

### Findings and variations

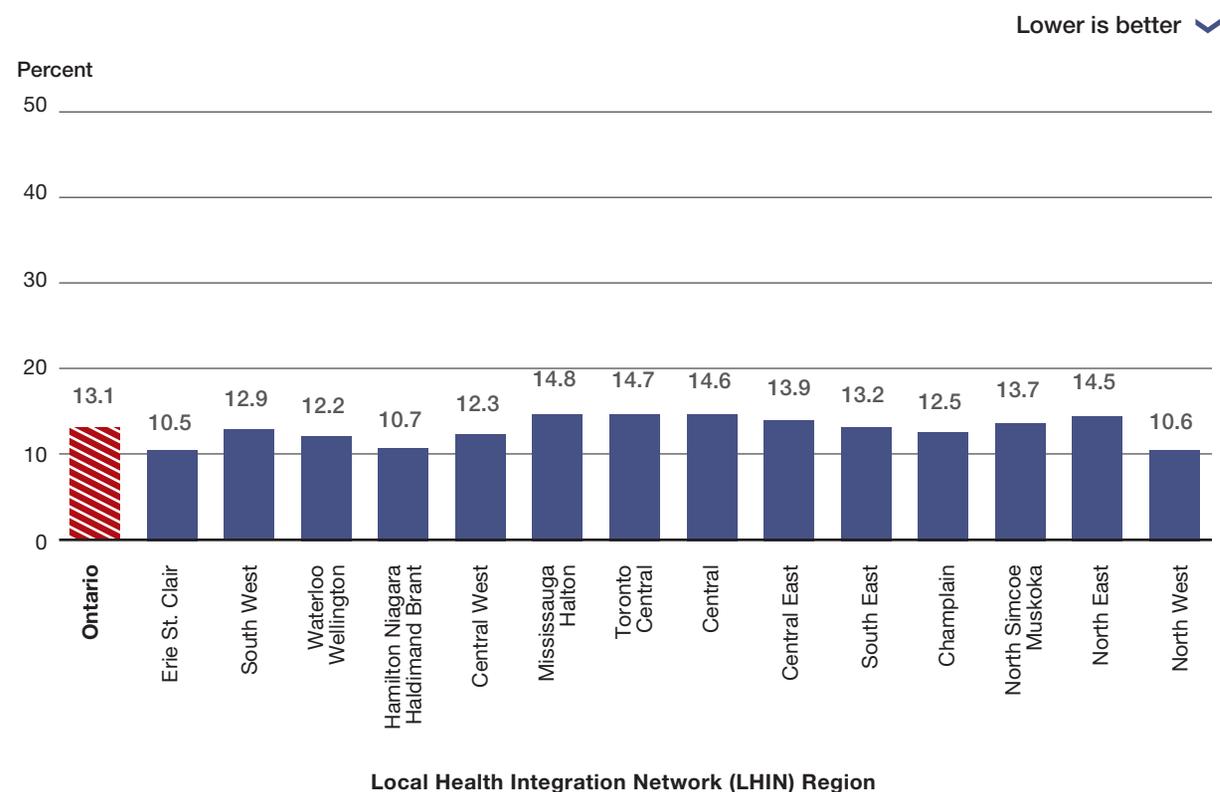
The percentage of patients who were readmitted within 30 days after being discharged from hospital for a mental illness or addiction remained stable for the past five years at around 13%.[37]

There was some regional variation, with the highest readmission rate of 14.8% found in the Mississauga Halton LHIN region, and the lowest rate of 10.5% found in the Erie St. Clair LHIN region (Figure 4.3).

#### **i** Indicator: Readmission to hospital

This indicator measures the percentage of patients hospitalized for a mental illness or addiction who were readmitted to hospital (the same or a different one) for a mental illness or addiction within 30 days after being discharged.

FIGURE 4.3  
Percentage\* of patients readmitted to hospital within 30 days of discharge after hospitalization for mental illness or addiction, in Ontario, by LHIN region, 2014/15



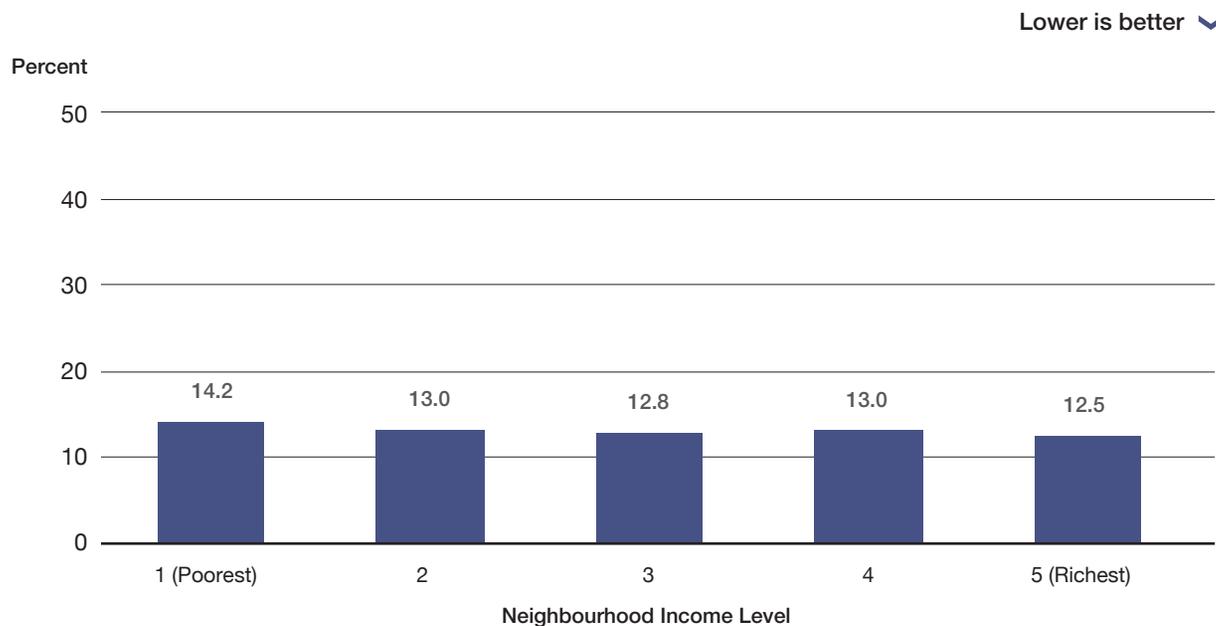
Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System and Registered Persons database, provided by the Institute for Clinical Evaluative Sciences.  
\*Risk-adjusted

People who lived in the poorest neighbourhoods had the highest 30-day readmission rate, at 14.2%, while people in the richest neighbourhoods had the lowest 30-day readmission rate, at 12.5% (Figure 4.4).

## Did you know?

More than 60% of patients hospitalized for a mental illness or addiction who are readmitted to hospital within 30 days go to a different hospital than the one from which they were most recently discharged.[38]

**FIGURE 4.4**  
**Percentage\* of patients readmitted to hospital within 30 days of discharge after hospitalization for mental illness or addiction, in Ontario, by neighbourhood income level, 2014/15**



Data source: Discharge Abstract Database, Ontario Mental Health Reporting System and Registered Persons database, provided by the Institute for Clinical Evaluative Sciences.

\*Risk-adjusted

## Suicides

Suicide is a major cause of premature and preventable death in Canada and around the world. This measure is an important indicator of population health but rates of suicide are not the same across groups. Some specific communities or groups may be more affected than others. For example, rates of suicides in some northern communities are many times higher than in southern communities.[39]

About 90% of people who commit suicide have a diagnosable mental illness, and men are generally at much higher risk than women from dying by suicide.[40] However, women have a higher rate of suicide attempts.[41] It is critical to look at suicide rates among different parts of the population in order to fully understand where there is the greatest need to provide mental health supports to prevent suicide.

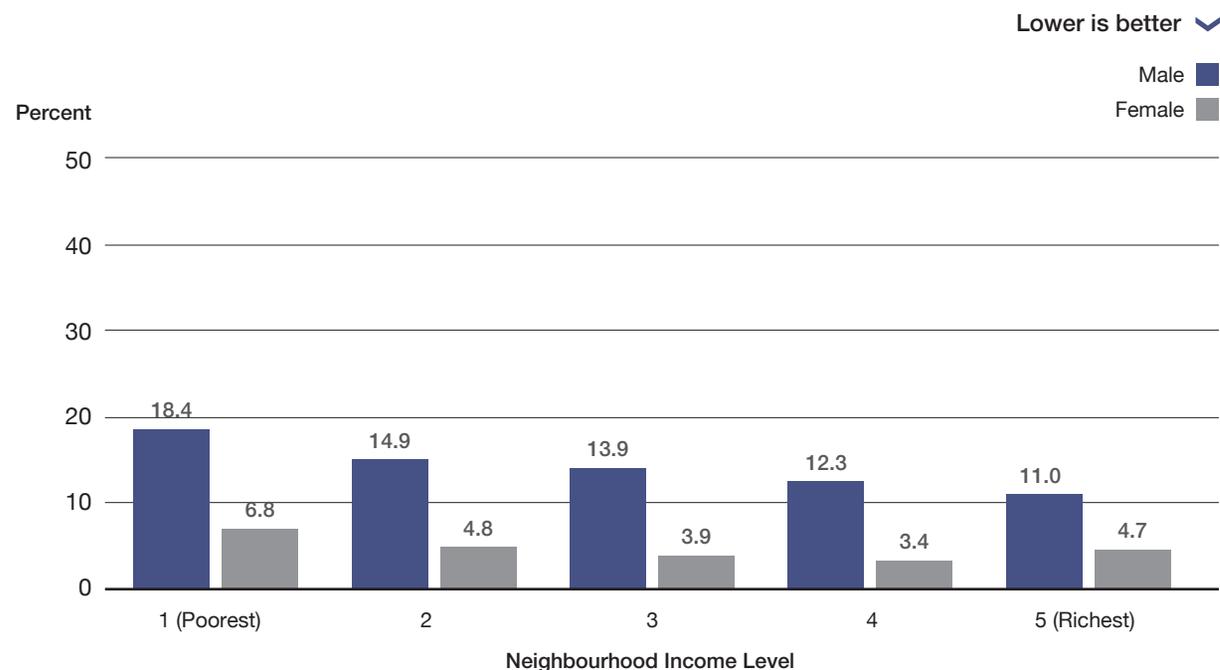
## Findings and variations

Suicide rates remained unchanged between 2007 and 2012. A large gap between men and women persisted, with the rates for men being more than triple the rates for women.[39]

Significant variation is observed when suicide rates are looked at in relation to income, with the poorest neighbourhoods having the highest rates (Figure 4.5).

Men who lived in the poorest neighbourhoods had a much higher rate of death by suicide than men who lived in the richest neighbourhoods, at 18.4 per 100,000 people vs. 11.0 per 100,000 people – or 67% higher (Figure 4.5).

FIGURE 4.5  
Suicides per 100,000 people,\* in Ontario, by sex and neighbourhood income level, 2009-2011



Data source: Canadian Mortality Database, sourced from the Public Health Agency of Canada's Health Inequalities Data Cube  
\*Age-standardized

Women who lived in the poorest neighbourhoods also had an elevated risk of suicide compared to women who lived in the richest neighbourhoods, at 6.8 per 100,000 people vs. 4.7 per 100,000 people – or 45% higher (Figure 4.5).

### **i** Indicator: Suicide rate

This indicator measures the number of suicides per 100,000 people.

## Did you know?

Depression, schizophrenia, substance abuse and other mental illnesses and addictions increase the risk of suicidal behaviour.[42]

### Physical restraint of patients with mental illness or addiction

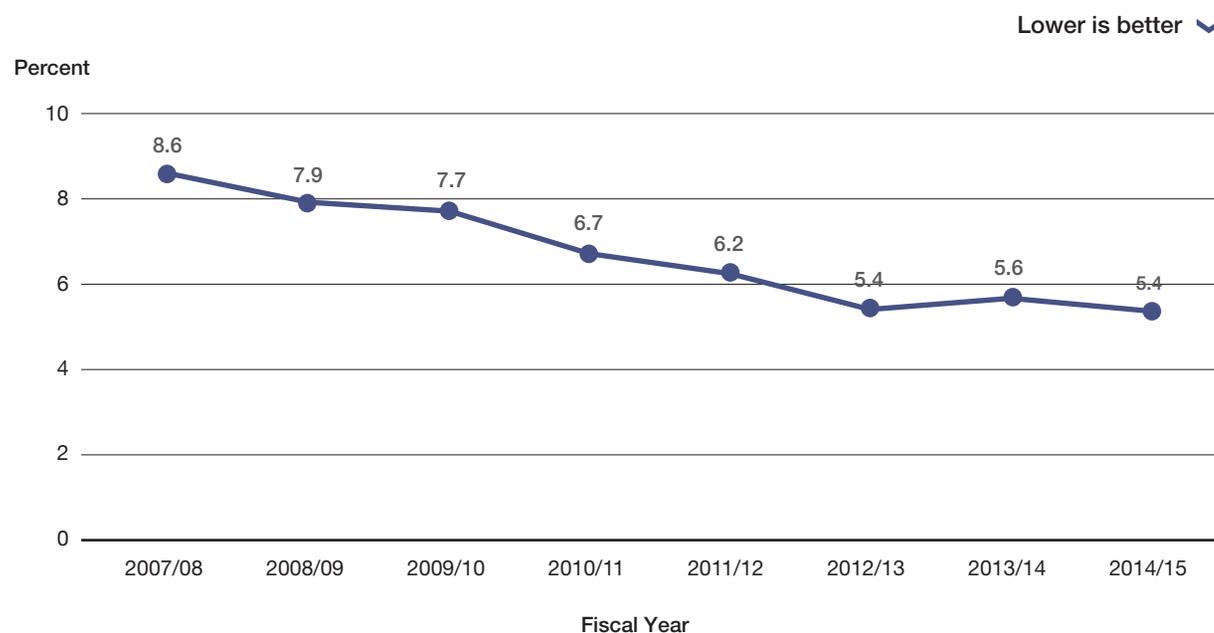
Physically restraining a patient is a last resort and the purpose of it is generally to protect patients with mental illness or addiction from self-harm or to prevent harm to another person. Using control interventions only when absolutely needed is an important objective for those who work in acute mental health care. The *Patient Restraint Minimization Act*[43], the *Mental Health Act*[44] and the *Health Care Consent Act*[45] have all helped facilities develop best practices and guidelines for the use of these control interventions.

### Findings and variations

The percentage of patients hospitalized for a mental illness or addiction who were physically restrained decreased steadily to 5.4% in 2012/13 from 8.6% in 2007/08. The rate has, however, been stable for the past two years (Figure 4.6).

FIGURE 4.6

Percentage\* of patients in mental-health-designated beds who were physically restrained, in Ontario, 2007/08-2014/15



Data source: Ontario Mental Health Reporting System, provided by the Institute for Clinical Evaluative Sciences.  
\*Age- and sex-adjusted

### **i** Indicator: Use of physical restraint

This indicator measures the percentage of patients hospitalized for a mental illness or addiction who were physically restrained in Ontario. Restraint use includes mechanical restraint, placing patients in a chair that prevents them from rising, and physical/manual restraint by staff. It does not include chemical restraint by methods such as the administration of sedative medications.

## Depression in long-term care homes

Depression is a common mental illness among residents of long-term care homes. It is estimated that more than 40% of Canadian seniors living in residential care facilities such as long-term care, nursing or personal care homes have depression or symptoms of it.[46] Additionally, evidence shows depression can contribute to a general deterioration of health in seniors and that seniors with depression are up to three times more likely to die.[47] It is important to assess depression among long-term care home residents so that their depression can be effectively managed and ultimately, their quality of life improved.

### Findings and variations

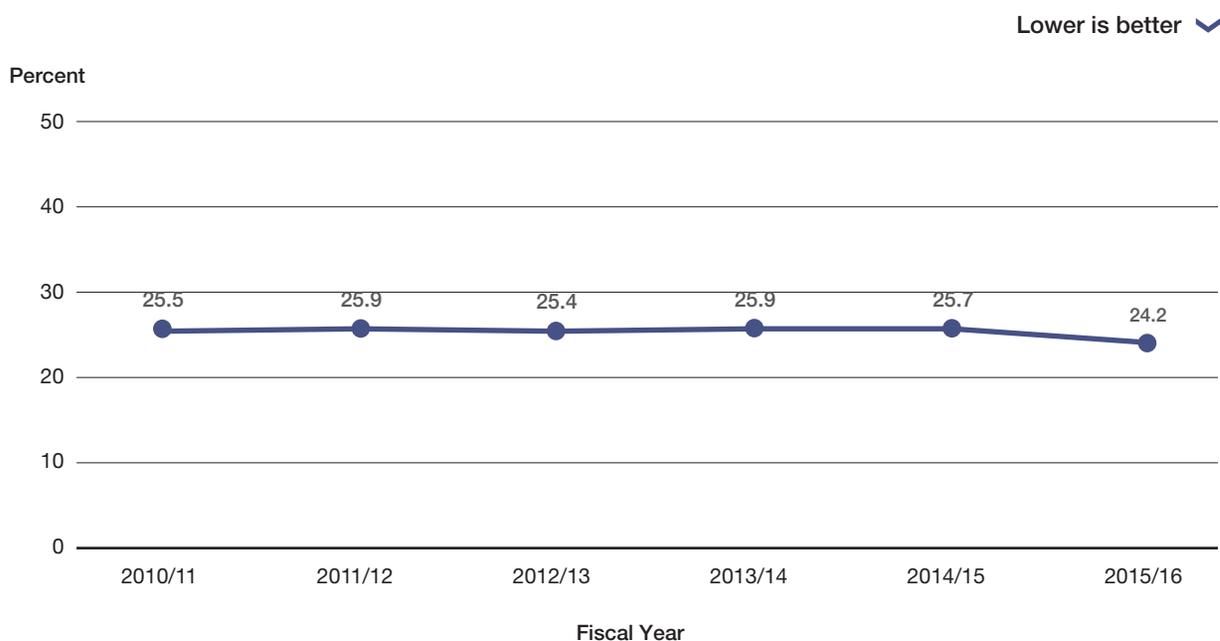
The percentage of residents who experienced increased symptoms of depression remained stable between 2010/11 and 2015/16, at 25.5% to 24.2% (Figure 4.7).

## Did you know?

Residents of long-term care homes who have symptoms of depression may experience a host of health challenges, including a decline in self-sufficiency, cognitive impairment, sleep disturbance and pain.[46]

FIGURE 4.7

Percentage\* of long-term care home residents who suffered increased symptoms of depression, in Ontario, 2010/11 to 2015/16



Data sources: Continuing Care Reporting System, provided by the Canadian Institute for Health Information  
\*Risk adjusted

### **i** Indicator: Increased depression among residents of long-term care homes

This indicator measures the percentage of long-term care home residents who, since their previous resident assessment, suffered increased symptoms of depression such as sadness, anger, anxiety or tearfulness.

In 2015/16, there was significant regional variation, with the lowest rate of increased depression symptoms found in the Toronto Central LHIN region, at 16.5%, and the highest found in the South East LHIN region, at 30.2% (Figure 4.8).

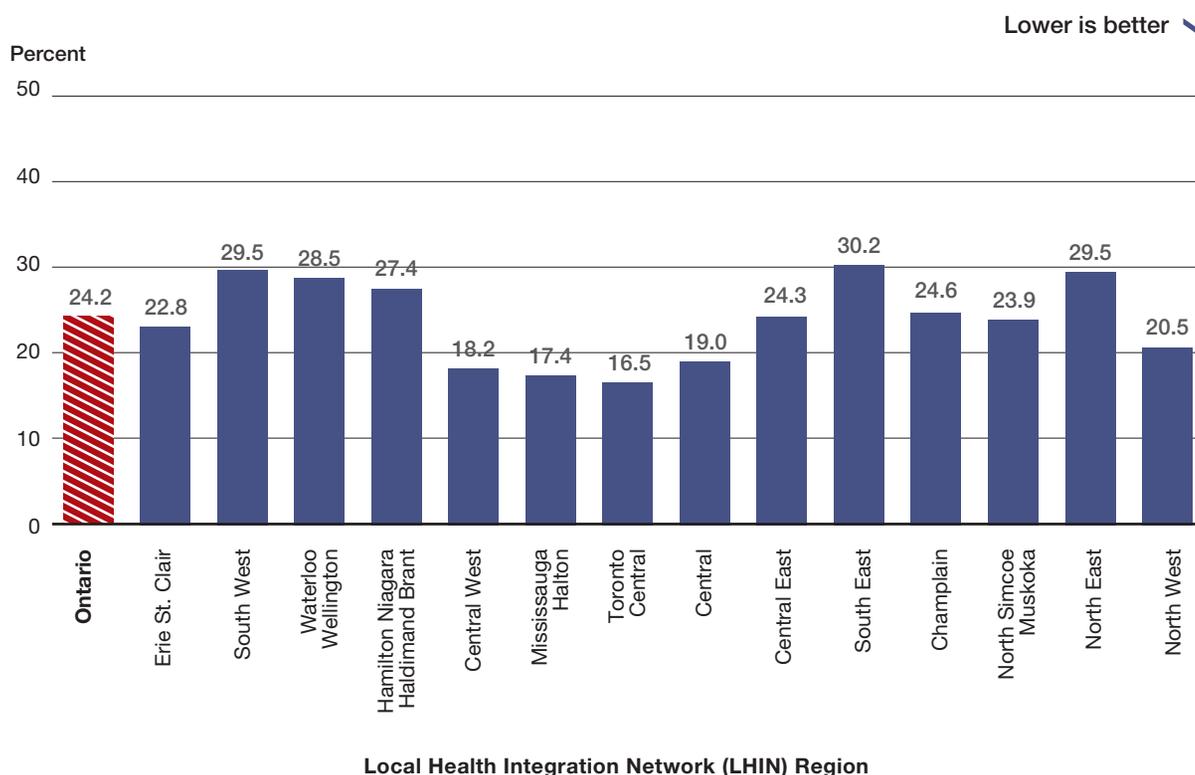
## In summary

In recent years, results for many of the mental illness and addictions indicators have remained unchanged, including follow-up after discharge from hospital, readmission to hospital, physical restraint use, and worsening symptoms of depression among residents of long-term care homes. The use of physical restraints has decreased substantially since 2007/08, but the decrease has slowed in the last two years.

There are clear trends illustrating gaps in the quality of care for patients living with mental illness and addictions and living in the poorest neighbourhoods. However, a large portion of mental illness and addictions services are provided in the community and there are limited data available regarding community services. Improved access to data on community-based care will enable us to get a better picture of the situation and develop focused efforts to improve care.

FIGURE 4.8

Percentage\* of long-term care home residents who suffered increased symptoms of depression, in Ontario, by LHIN region, 2015/16



Data sources: Continuing Care Reporting System, provided by the Canadian Institute for Health Information  
\*Risk adjusted

# Home Care

In this chapter, we report on the following Common Quality Agenda indicators for home care:

- Wait times for home care
- Patient experience
- Unpaid caregiver distress
- Placement in long-term care

Photo of Josephine taken by Westmount Photography.  
Please see her story on the next page.

## Real-World Experiences

### Quality time: Michelle and Josephine's story

**It's just before 9 a.m. on a weekday in Sudbury. Josephine, 48, walks sleepily to the door of the apartment she shares with her elderly mother, Michelle, to greet a personal supporter worker who comes to help with her mother's personal care, hygiene and mobility needs.**

Michelle, 84, suffers from dysphagia, a condition that limits her ability to swallow food, has Alzheimer's disease, is unable to get in and out of bed on her own, and suffered a stroke in 2014.

"It's been a year now that we've had the same worker come in the morning and she is on time," Josephine says. "It's because I have made a lot of noise that things have gotten better."

When Michelle was diagnosed with Alzheimer's in 2012, Josephine didn't hesitate to care for her mom. "My mother and I were always close," she says. "We did everything together – we were best friends." Josephine, who had worked in sales, resolved to stay at home full-time with Michelle and get support from various home care service

providers. She arranged for daily visits from a personal support worker, a nurse was to come to check Michelle's blood pressure, listen to her chest and other health care needs, and a nurse practitioner was supposed to make monthly home visits. Josephine would take care of the rest of Michelle's care needs.

Josephine received funding to have a proper hospital bed with rails set up in her apartment. A lift to help transfer Michelle in and out of bed was donated. Everything appeared to be in place. "I have the right tools and equipment to take care of her," Josephine says. "It's when I don't get the help I need from the people who are supposed to help, that's an issue for me and my mother."

There have been ongoing issues with the timing of services, missed appointments and a lack of consistency, Josephine says. "If they don't get there on time, my mother's breakfast is delayed, which runs almost into the time she's supposed to eat lunch. If she eats lunch late, she runs late for her nap and is too tired to eat her lunch, which leads to dehydration and a choking hazard."

Josephine adds that the personal support workers frequently cancel shifts, without finding a replacement. "I can't tell you how many times I've missed my respite visits," Josephine says. "It got to the point I was so burned out that I was physically sick from all the stress."

Born and raised in England, Michelle trained as a registered nurse and immigrated to Canada 40 years ago, raising four daughters. It's devastating for Josephine to watch her mother's health deteriorate as she cares for her. "Half the time now I can't allow myself to feel she is my mother in order to do what I need to do."

Josephine raised her concerns about her mother's home care repeatedly, the issues began to be resolved. Despite the challenges, Josephine says having her mom at home with her is still the best option. "I get to spend quality time with her. I get to spend the last few years of her life with her."

# Care at home

People in Ontario have access to publicly funded home care services to support them when they are sick or disabled and are having difficulty caring for themselves. The services available include nursing, personal support in areas such as bathing and eating, physiotherapy, occupational therapy, speech-language therapy, social work and nutritional counselling.

Hospitals, doctors and other health care providers may refer patients for home care, or patients or their families may request it. Receiving home care often allows those who need care, but prefer not to stay in a hospital or long-term care home, to remain in the familiarity and comfort of their own residence. This is one reason a deliberate effort has been made in recent years to provide more community health care resources such as home care that allow people to remain at home when possible. This emphasis on moving care from institutions to homes has increased the number of people who need home care services, as well as the level of care those services need to deliver.[48]

## Did you know?

Ontario provides 6.9 million nursing visits and 28.7 million hours of personal support and homemaking to approximately 650,000 people per year.[49]

## Waiting for home care services

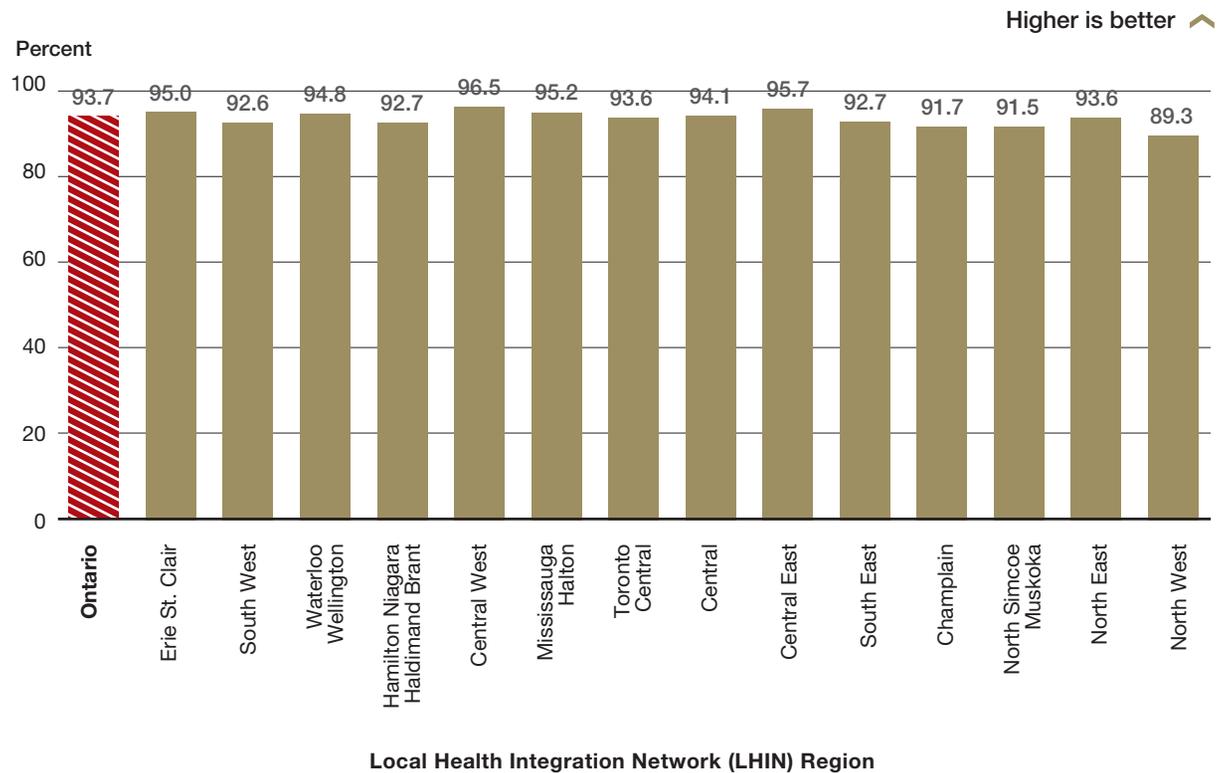
Providing home care to patients in a timely manner is key to ensuring they receive the right care when they need it. In 2013, Ontario created a five-day target for all patients waiting for nursing service, as well as for all complex patients waiting for personal support service. Complex patients are those who need a high level of care, usually because they have one or more health conditions combined with complicating factors such as physical, cognitive or other limitations.<sup>[50]</sup> The personal support service they receive may include personal service such as bathing or helping with eating, as well as homemaking.

The wait time for service is measured from the date a service is authorized to the date it is first provided. However, before a service is authorized, it must first be applied for by a health care provider, the patient or their caregiver, and a home care coordinator must determine whether the patient is eligible for the service. The time required for the application process and determination of eligibility is not included in the wait time target.

## Findings and variations

In 2014/15 in Ontario, 93.7% of the adult home care patients (aged 19 and over) who received in-home nursing received it within the five-day target, and 85.4% of the adult complex home care patients who received personal support service received it within the target period (Figure 5.1 and Figure 5.2).

**FIGURE 5.1**  
**Percentage of home care patients aged 19 and older who received their first nursing visit within five days of authorization, in Ontario, by LHIN region, 2014/15**



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

**i** Indicators: A) Wait time for in-home nursing and B) Wait time for personal support service for complex patients

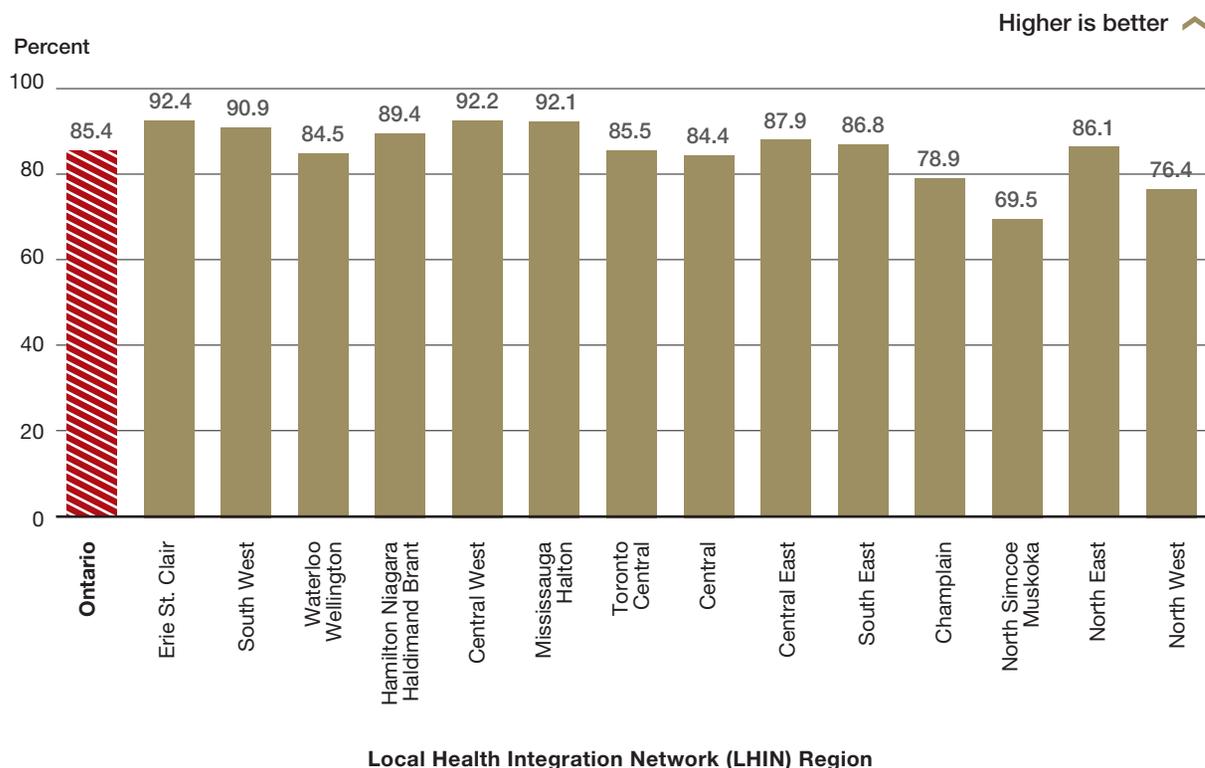
These wait time indicators measure:

- the percentage of home care patients aged 19 and over authorized for in-home nursing service who received their first nursing visit within five days
- the percentage of complex home care patients aged 19 and over authorized for personal support service who received their first personal support service visit within five days

There was substantial variation between regions in the percentage of adult complex-needs patients who received personal support service within five days of authorization, from 69.5% in the North Simcoe Muskoka LHIN region to 92.4% in the Erie St. Clair LHIN region (Figure 5.2). The proportion of adult home care patients who received in-home nursing within five days of authorization ranged from 89.3% in the North West LHIN region to 96.5% in Central West LHIN region (Figure 5.1).

Wait times for these services have not changed substantially since 2013/14, when 94% of eligible adult home care patients received in-home nursing within the five-day target and 84% of eligible adult complex patients received personal support service within the target.

**FIGURE 5.2**  
Percentage of home care patients aged 19 and older with complex needs who received their first personal support visit within five days of authorization, in Ontario, by LHIN region, 2014/15



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

## Patient experience with home care

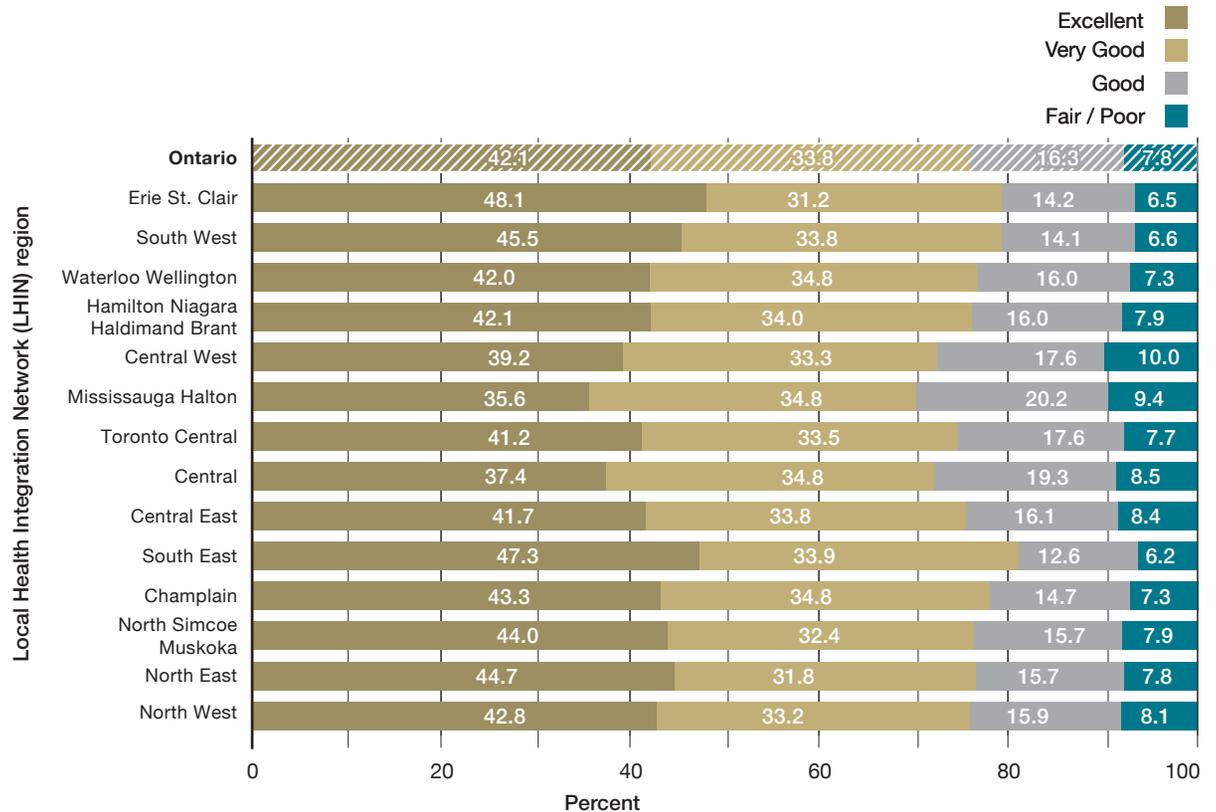
Asking home care patients about their experience with the services they receive is vital to improving quality of care. Patients who have positive experiences often have better health outcomes.[51,52] To help gather data on their experiences, patients across Ontario may participate in a phone survey which asks them to rate the home care services they receive. A caregiver such as a family member or friend may provide responses if the patient is unable to do so themselves. Response options are “Excellent,” “Very Good,” “Good,” “Fair,” or “Poor.”

## Findings and variations

Overall, home care patients’ experiences were positive. Among those who had a positive experience –rating it as “Excellent,” “Very Good” or “Good” – over half rated their care as “Excellent.”

The total percentage of positive responses ranged from 90% in the Central West LHIN region to 94% in the South East and Erie St. Clair LHIN regions. More than 90% of the responses were positive for 98% of Ontario’s 182 home care service providers with reportable data. For Ontario as a whole, the percentage of positive patient experiences has remained stable at 92% since 2013/14 (Figure 5.3).

FIGURE 5.3  
Patient experience with care coordinators and service providers, in Ontario, by LHIN region, 2014/15



Data sources: National Research Corporation Canada Client and Caregiver Experience Evaluation Survey, provided by the Ontario Association of Community Care Access Centres

### **i** Indicator: Patient experience

This indicator measures the percentage of home care patients who found the care they received from care coordinators and service providers to be “Excellent,” “Very Good,” “Good,” “Fair,” or “Poor.”

## Did you know?

In 2014/15, Community Care Access Centres across Ontario provided 38,687,656 visits/hours of care. Most of the home care patients receive is in the form of personal support service.[53]

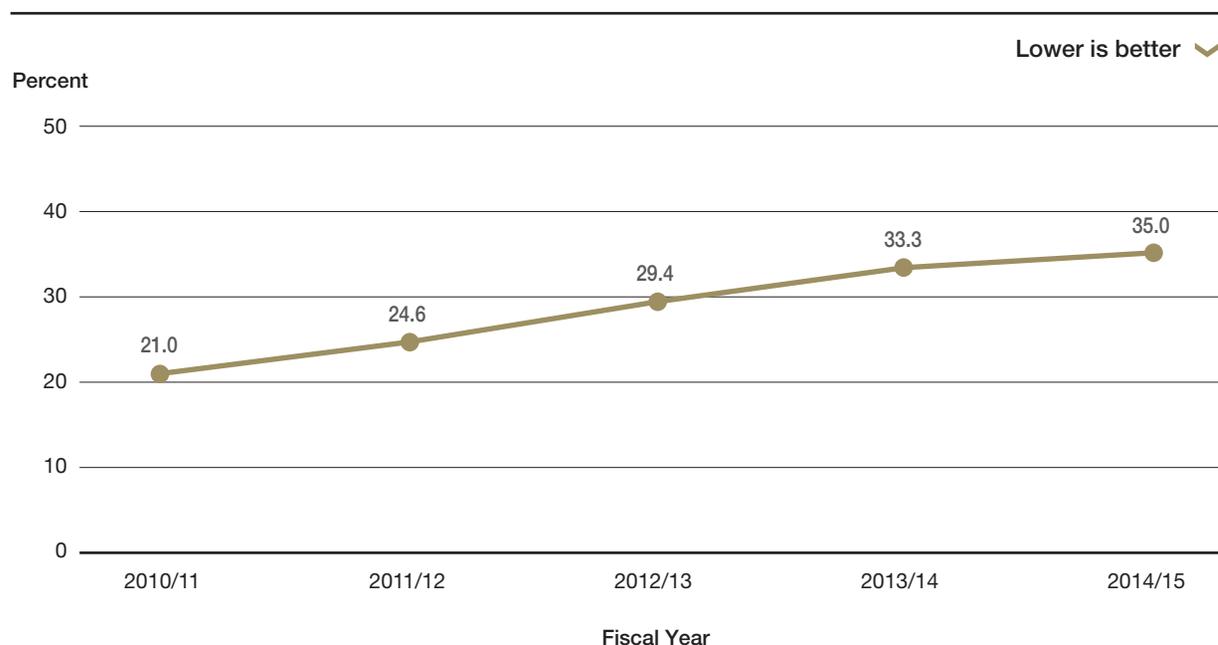
### Distress among unpaid caregivers of home care patients

Among long-stay home care patients who receive services over a long or indefinite period of time, 97% have at least one unpaid caregiver. The caregiver may be a family member, friend or neighbour and often plays an essential role in looking after the patient, who may be dealing with frail health, physical disability, cognitive impairment, or a combination of these conditions.

Caregivers may do everything from helping with shopping, cooking, banking and housekeeping to managing medications and helping the patient with bathing, dressing, eating and toileting.[54] These responsibilities can be stressful, particularly when the person being cared for at home requires a lot of assistance. That's why it's important to monitor caregiver distress and consider its potential impact on caregivers as well as on the people they look after.

FIGURE 5.4

Percentage of long-stay home care patients\* with a primary unpaid caregiver whose caregiver is unable to continue caring activities or expresses feelings of distress, anger or depression, in Ontario, 2010/11 to 2014/15



Data source: Home Care Reporting System, provided by the Canadian Institute for Health Information  
\*Patients who receive home care for a long or indefinite period of time

### Findings and variations

Among long-stay home care patients with at least one unpaid caregiver, the percentage who had a primary caregiver who expressed feelings of distress, anger or depression or was unable to continue caring activities increased to 35% in 2014/15 from 21% in 2010/11 (Figure 5.4).

#### **i** Indicator: Caregiver distress

This indicator measures, among long-stay home care patients who had at least one unpaid caregiver, the percentage of patients whose primary unpaid caregiver experienced distress, anger or depression in relation to their caregiving role or were unable to continue in that role.

The persistence of caregiver distress over time can also be measured, by comparing the patient's most recent assessment to the previous one. The data show that the rate of persistent caregiver distress has also increased over the last five years.[55]

The increases in both distress and persistent distress are likely due to the fact that home care patients collectively have more complex health needs than they did five years ago, as they have in recent years become a group that is collectively older, sicker, more physically and cognitively impaired and less able to perform ordinary day-to-day tasks.[56]

## Did you know?

Close to one in three people in Ontario aged 15 and older, or 29%, provide unpaid care to a family member or friend with a long-term health condition, disability or aging need.[57]

## Moving into long-term care homes

In Ontario, the amount of care home care patients need is regularly assessed by their home care providers using standardized methods. Patients with low to moderate care needs can usually remain at home with some support.

Still, in some regions of Ontario, one-fifth to one-quarter of the people who move into long-term care homes have been assessed as having low to moderate care needs.

There are circumstances under which it could be more appropriate for such patients to live in long-term care homes. Factors that might be taken into consideration include the availability of family caregivers, sufficiency of financial resources, caregivers' and patients' ability to cope, and patients' own personal choices.

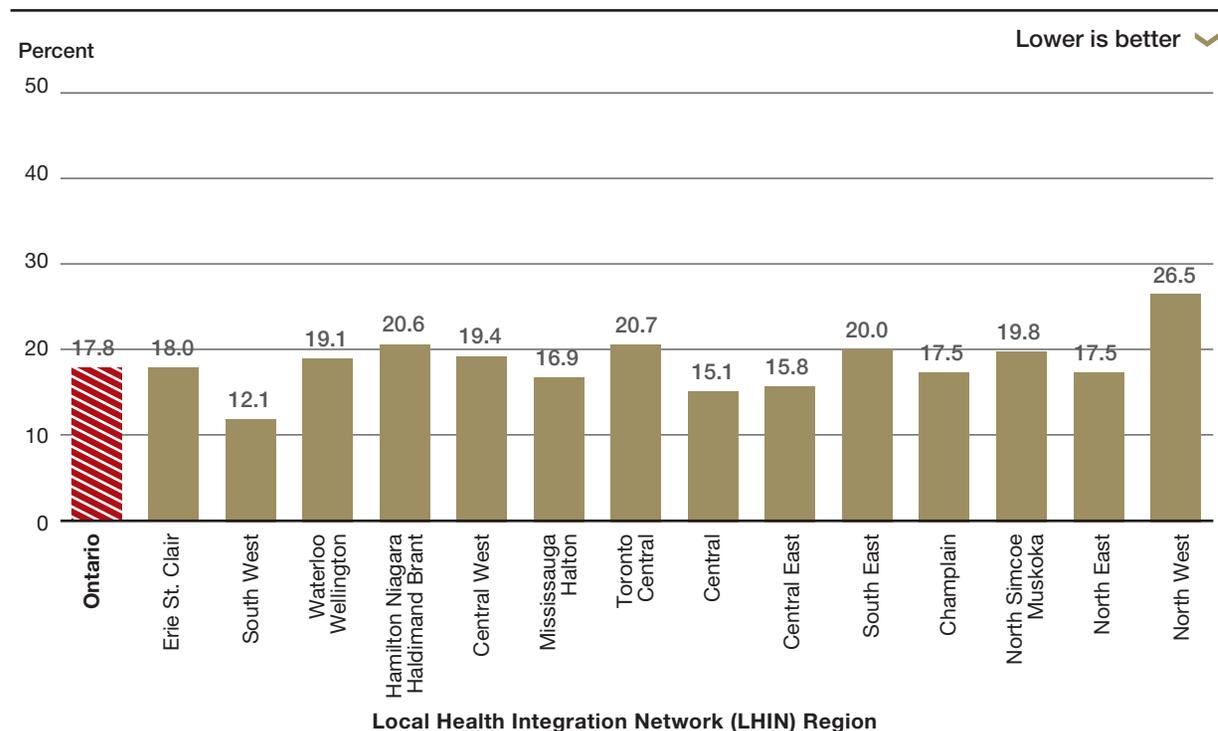
Studies suggest most people who require ongoing care for significant health issues prefer to receive it in their own homes.[58] As well, home care is usually seen as less costly for the health system than placement in a long-term care home. So although individual circumstances may vary, having fewer patients with low to moderate care needs entering long-term care homes is seen as a positive when it comes to measuring health system performance.

## Findings and variations

In 2014/15, 18% of the people who entered a long-term care home in Ontario had low to moderate care needs. This indicator result varied substantially across Ontario, with 27% of people who entered a long-term care home in the North West LHIN region

FIGURE 5.5

**Home care patients as a percentage of people who entered a long-term care home, with low to moderate care needs who entered a long-term care home, in Ontario, by LHIN region, 2014/15**



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

### **i** Indicator: Placement in long-term care homes

This indicator measures how many people with low to moderate care needs entered a long-term care home, as a percentage of all people who entered a long-term care home.

having low to moderate care needs, more than double the 12.1% in the South West LHIN region (Figure 5.5). The provincial result for this indicator was unchanged from 2013/14, when it was also 18%.

## Did you know?

Nearly 27,000 home care patients in Ontario moved into long-term care homes in 2014/15. This number has remained relatively consistent since 2009/10.[53]

### In summary

While the home care system in Ontario continues to evolve to meet the growing complexity and number of patients it serves, the results for indicators measuring its performance are stable. Wait times for in-home nursing service and personal support service for complex patients in 2014/15 were similar to those in the previous year, as was the percentage of people admitted to long-term care homes who had low to moderate care needs. Patient experience ratings show consistently positive results across LHIN regions.

While the home care sector as a whole is the focus of current health system improvements, caregiver distress is becoming an increasing concern, with rates of distress rising every year since 2010/11. Some specific initiatives are under way to improve the support provided to caregivers in Ontario.

# Hospital Care

In this chapter, we report on the following Common Quality Agenda indicators related to hospital care:

- Patient experience
- Time spent in the emergency department
- Wait times for some procedures performed in hospital (joint replacements, cardiac procedures, cancer surgeries)
- *C. difficile* infections acquired in hospital
- Caesarean section deliveries

Photo of Dale taken by Roger Yip.  
Please see his story on the next page.

## Real-World Experiences

### Straight from the heart: Dale's story

When Dale got the news he needed heart bypass surgery, he felt a strange mix of emotions. “In some regards, I was happy they finally found out what was wrong,” says the 56-year-old from Cambridge. “But I also felt like I was abnormal – less of a person in some ways, because there was something major wrong with me.”

The contrast in Dale's feelings reflects a full year of trying to get to the root of the problem. Initially, Dale, who works as a pipe fitter and welder, experienced pain and tightness in his throat. After speaking with Telehealth Ontario, an ambulance arrived to take Dale to the hospital.

“They asked me if I was having pain in my chest and I said it was in my throat,” Dale says about his hospital visit. “So they did an electrocardiogram, blood test and checked my lungs, and it all showed I was healthy as a horse.”

Dale went home, but the symptoms persisted in his throat. He thought it might be an issue with his esophagus or stomach. At one point, his doctor treated him for sinus congestion. Still no improvement. “Finally, my family doctor said, ‘Maybe it's your heart.’”

Dale was sent for a series of tests. At one point, results were inconclusive. “The waiting is stressful – it causes me anxiety,” Dale says. Eventually, he had a diagnostic cardiac catheterization, a test that involves taking images of the coronary arteries so doctors can see how blood flows into the heart. Results showed there were blockages that required bypass surgery.

“I was shocked,” says Dale's sister, Juanita, about the diagnosis. “I couldn't believe something so serious had taken so long to diagnose – almost a year.” While the news was tough for Dale and his family to hear, they feel well-informed and prepared for the next steps, thanks to the doctor and hospital team looking after Dale.

“I've been extremely impressed with the patient assistance,” says Juanita, who will stay with Dale for a few weeks following surgery. “The heart surgery information book they gave us is great and I have seen a high level of compassion. And once the cardiologist got involved, she has made herself much more available.”

Dale is doing his best to follow doctor's orders and take it easy, before and after the surgery. “I'm the kind of person who is very active and I'm having a hard time doing things at a level 1 or 2 when I want to be at a level 10,” he says, adding the post-surgery recovery will take about three months.

For the main types of cardiac surgery, patients in Ontario get surgery dates based on the urgency of their needs. The vast majority of patients have their procedures performed within the wait time target. In Dale's case, his surgery date has been pushed back because there are other patients with more urgent needs. Dale is upset his surgery has been delayed, but remains grateful that he'll get the treatment he needs.

“Finally, my family doctor said, ‘**Maybe it's your heart.**’”

# Emergency and inpatient care

People come to the hospital with different needs, such as to be diagnosed and treated for illnesses, or to have surgery and receive recovery care. Sometimes, all their needs can be met in the emergency department, but at other times, going to the hospital may mean staying in the hospital as an inpatient. At all times, the goal is to provide quality care and then discharge patients as soon as it is appropriate for them to return home or transfer to another level of care, such as rehabilitation or long-term care.

This section looks at indicators that measure the quality of services provided in the emergency department and in other parts of the hospital, as well as measuring patients' evaluations of their hospital experience.

**Hospitals play an integral role in our health system.**

From surgeries to life-saving emergency care, hospitals provide a high level of care to patients when they require it.

## Findings and variations

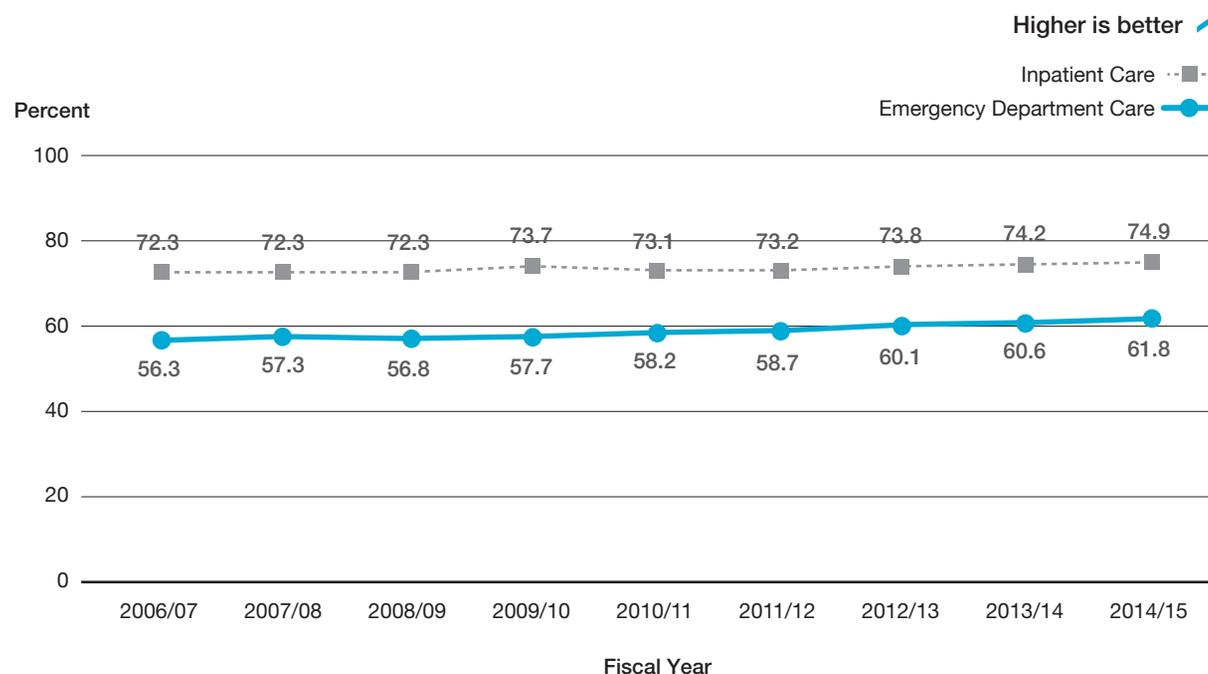
The percentage of people who visited a hospital emergency department in Ontario and said they would definitely recommend it to family and friends has improved since 2006/07, rising to 61.8% in 2014/15 from 56.3% in 2006/07 (Figure 6.1). The percentage who would recommend the hospital to family and friends was slightly higher for people discharged from inpatient care, at 74.9%, but has remained relatively stable since 2006/07, when it was 72.3% (Figure 6.1).

## Did you know?

Patients have identified the following factors as contributing most to their satisfaction with health care: Empathy/attitude; timeliness of care; competence of care providers; pain management; and sharing of information.[59]

FIGURE 6.1

### Percentage of survey respondents who would definitely recommend hospital/emergency department to friends and family, in Ontario, 2006/07 to 2014/15



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

**i** Indicators: Patient experience during A) a hospital stay and B) an emergency department visit.

These indicators measure the percentage of survey respondents who, after a hospital stay or an emergency department visit, answered “Yes, definitely” when asked:

- “Would you recommend this hospital to family and friends?”
- “Would you recommend this emergency department to family and friends?”

## Emergency department length of stay

People go to hospital emergency departments for a wide spectrum of reasons ranging from critical medical conditions, such as cardiac arrest, to less urgent health issues, such as a muscle sprain. It is important for hospitals to keep track of the amount of time it takes to respond to these patients' various needs, to make sure they are getting the care they need in a timely way.

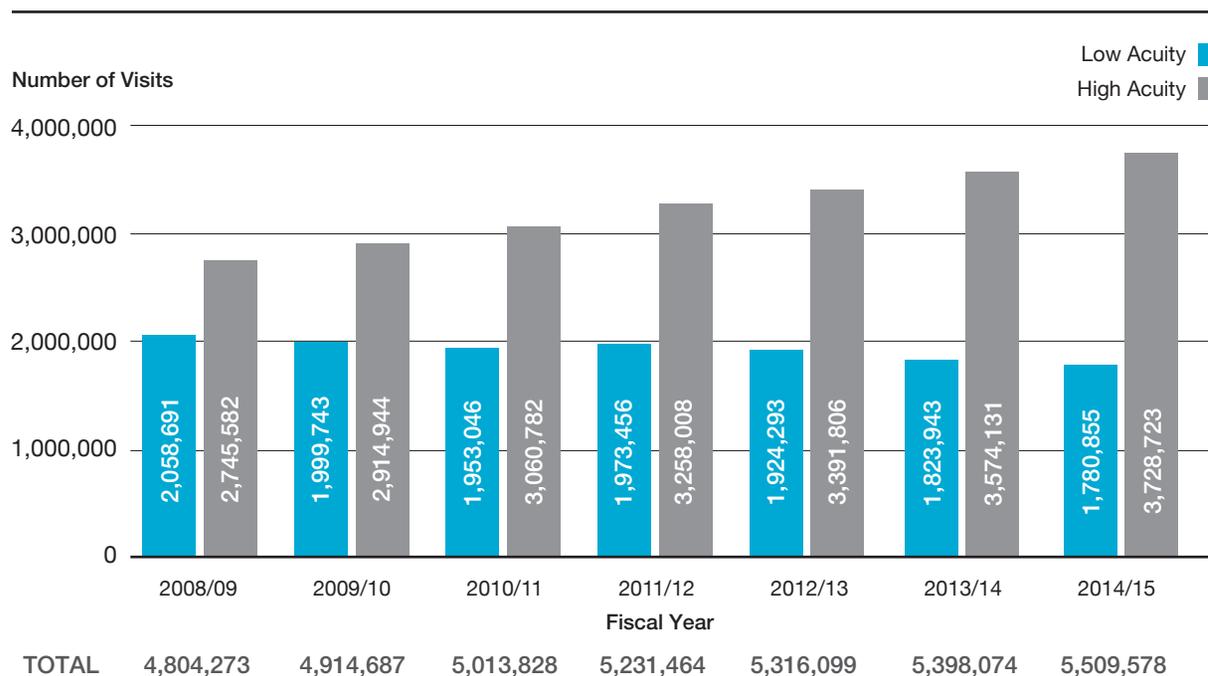
The time a patient spends in the emergency department depends on the nature of their illness or injury.[60] For this reason, the indicator results in this section split patients into two groups according to urgency level or 'acuity,' based on the Canadian Triage and Acuity Scale that hospitals use to evaluate the urgency of a patient's need for medical care, and also based on whether patients were admitted to hospital.

High-acuity patients have conditions that may threaten their lives and require immediate aggressive intervention; that are a potential threat to life or limb function and require rapid medical intervention; that could potentially progress to a serious problem requiring aggressive or rapid intervention; or that result in admission to hospital.

Low-acuity patients have conditions that would benefit from medical intervention or reassurance within two hours; or for which investigation and treatment could be delayed or referred to other areas of the hospital or health system.

People in Ontario made nearly 5.5 million visits to emergency departments in 2014/15, an increase of nearly 700,000 visits, or 14.4%, since 2008/09 (Figure 6.2). The annual number of emergency

FIGURE 6.2  
Number of visits to the emergency department, in Ontario, 2008/09 to 2014/15



Data source: Emergency Department Reporting System (EDRS) (April 2008 to October 2009) & National Ambulatory Care Reporting System (NACRS) Level 1 (November 2009 to March 2015), provided by Access to Care, Cancer Care Ontario

department visits by patients with high-acuity needs rose 35.8% between 2008/09 and 2014/15, to 3.73 million from 2.75 million (Figure 6.2). Conversely, there was a decline over the same period in the number of annual visits by low-acuity patients, to 1.78 million from 2.05 million.

Nearly 70% of emergency department visits in 2014/15 were made by high-acuity patients (Figure 6.2), compared to just under 57% in 2008/09.

### **i** Indicators: Time spent in the emergency department for A) low-acuity patients and B) high-acuity patients

These indicators measure the maximum amount of time, from triage or registration to discharge, within which half of patients completed their emergency department visit, and within which nine out of ten patients completed their visit, separately for high-acuity and low-acuity patients.

## Did you know?

The top three reasons for visiting an emergency department are abdominal/pelvic pain, pain in the throat and chest, and acute upper respiratory infection. Most of these patients are not admitted.[61]

Length of stay measure	Description
90th Percentile	The maximum amount of time nine out of 10 patients (90%) spent in the emergency department before they were discharged to go home or be admitted to an inpatient bed.
Median	The maximum amount of time half of patients (50%) spent in the emergency department before being discharged. This is a mid-point that provides a picture of a typical length of stay.

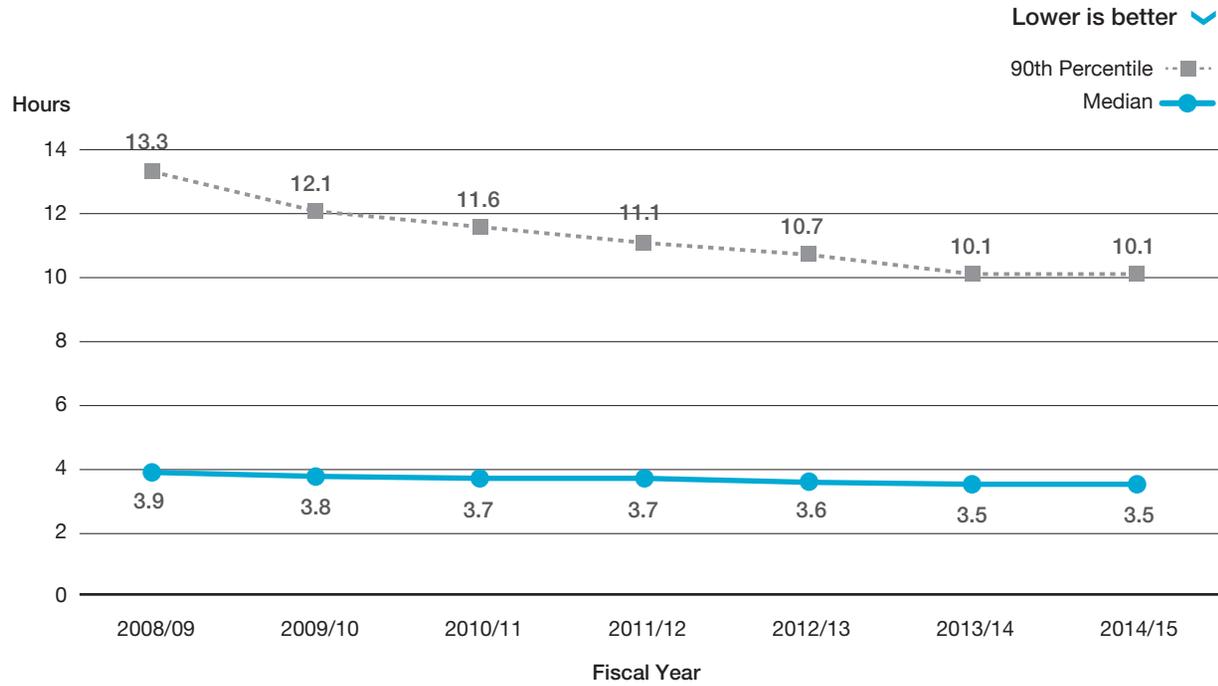
### Findings and variations

The length of time spent in the emergency department, often described as the length of stay, is measured from the time of registration or triage (whichever is earlier), to the time the patient is discharged from the emergency department to go home, transfer to another facility or be admitted to hospital as an inpatient. It includes the amount of time it takes for all parts of the patient’s emergency department visit to be completed – such as the wait for a doctor to see the patient, for tests results to be received, for treatment to be provided, and for a doctor to make a decision about discharge, as well as the wait for an inpatient hospital bed, if the patient is admitted.

The Ministry of Health and Long-Term Care sets targets for the amount of time high-acuity and low-acuity patients should spend in a hospital emergency department in Ontario. These targets are provided and explained in the table below, along with data findings related to them.[62]

Acuity level	Targets	Findings
<p><b>High</b> – The patient must be seen immediately or very soon, or needs to be admitted to an inpatient bed.</p> <p>The target wait time is longer for high-acuity patients because they typically need tests and care that takes more time.</p>	<p>The target is to have nine out of 10 high-acuity patients spend no longer than <b>eight hours</b> in the emergency department before discharge or admission to an inpatient bed.</p>	<p>In 2014/15, <b>85.7%</b> of emergency department visits by high-acuity patients were completed within the eight-hour target (Figure 6.5).</p> <p>Nine out of 10 high-acuity patients spent <b>10.1 hours or less</b> in the emergency department before discharge or admission to an inpatient bed, in 2014/15. While the target of eight hours was not met, this was an improvement (decrease) from 2008/09, when the 90th percentile length of stay was 13.3 hours or less (Figure 6.3).</p> <p>The median length of stay, or the maximum amount of time half of high-acuity patients spent in the emergency department, decreased slightly from 3.9 hours in 2008/09, to 3.5 hours in 2014/15 (Figure 6.3).</p>
<p><b>Low</b> – The patient has a less urgent medical condition that does not need to be assessed immediately, and the patient does not need to be admitted to an inpatient bed.</p>	<p>The target is to have nine out of ten low-acuity patients spend no longer than <b>four hours</b> in the emergency department before being discharged.</p>	<p>In 2014/15, <b>89.9%</b> of emergency department visits by low-acuity patients were completed within the four-hour target (Figure 6.5)</p> <p>The <b>target was met</b> in 2014/15, as nine out of 10 low-acuity patients completed their emergency room visit <b>within four hours</b>. This was an improvement from 2008/09, when the 90th percentile length of stay was 4.8 hours (Figure 6.4).</p> <p>The median length of stay, or the maximum amount of time half of low-acuity patients spent in the emergency department, has remained stable since 2008/09, at 1.9 hours (Figure 6.4).</p>

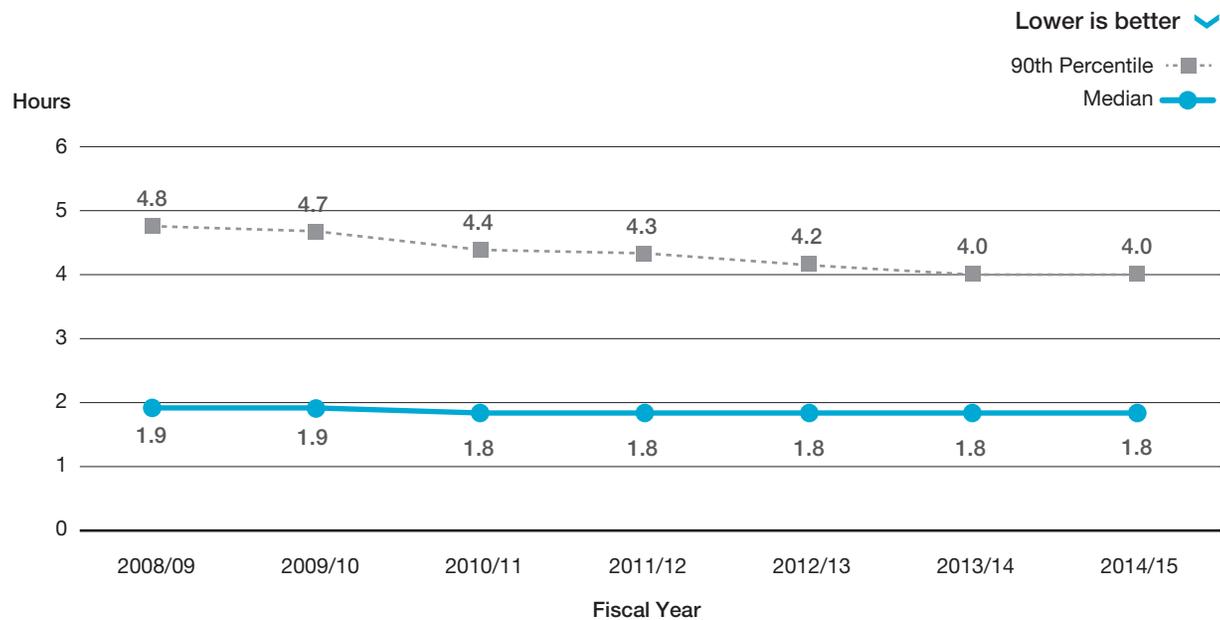
**FIGURE 6.3**  
**Maximum amount of time nine of 10 patients (90th percentile) and five of 10 patients (median) spent in the emergency department for high-acuity cases, in Ontario, 2008/09/ to 2014/15**



Data source: Emergency Department Reporting System (EDRS) (April 2008 to October 2009) & National Ambulatory Care Reporting System (NACRS) Level 1 (November 2009 to March 2015), provided by Access to Care, Cancer Care Ontario

FIGURE 6.4

**Maximum amount of time nine of 10 patients (90th percentile) and five of 10 patients (median) spent in the emergency department for low-acuity cases, in Ontario, 2008/09/ to 2014/15**



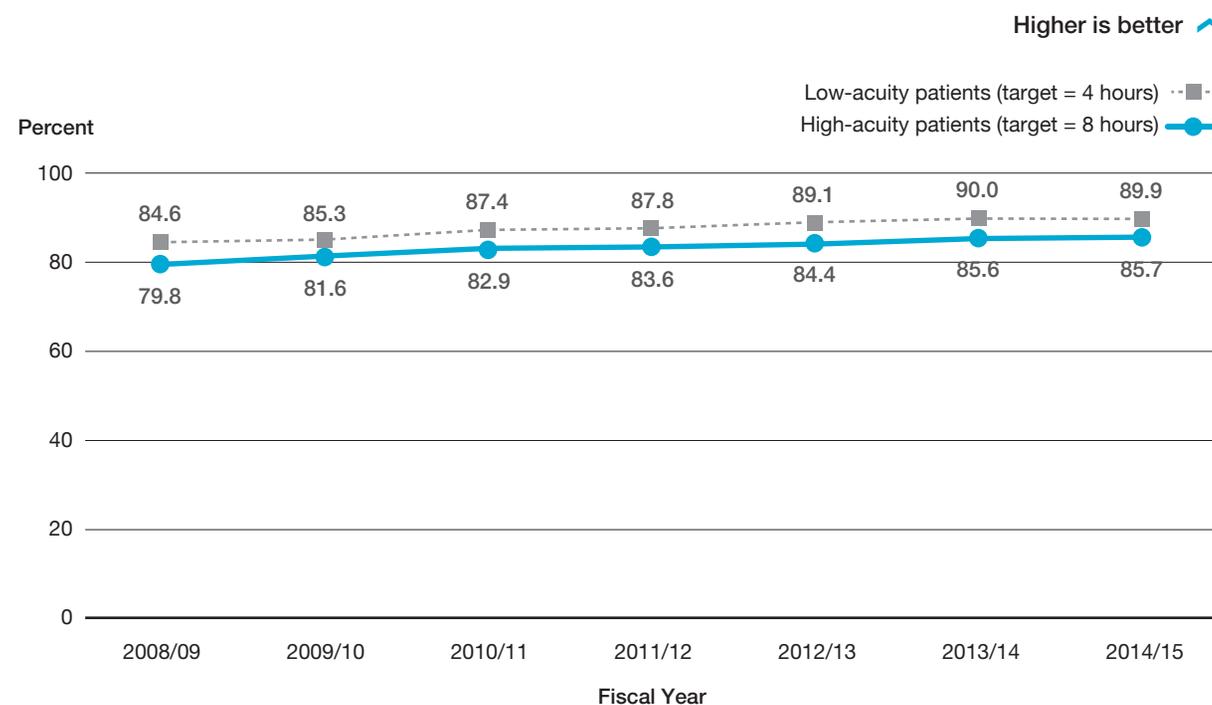
Data source: Emergency Department Reporting System (EDRS) (April 2008 to October 2009) & National Ambulatory Care Reporting System (NACRS) Level 1 (November 2009 to March 2015), provided by Access to Care, Cancer Care Ontario

Another way to report on the time people spend in the emergency department and on the performance of emergency departments in Ontario, is to look at how many of the patients visiting them complete their visit within the target period of time set for each level of patient acuity.

Since 2008/09, more and more visits to the emergency department have been completed within the target time. For high-acuity patients, the percentage of visits completed within the 8-hour target increased to 85.7% from 79.8% between 2008/09 and 2014/15. This increase represents just over 200,000 more visits being completed within target in 2014/15, compared to 2008/09 (Figure 6.5).

For low-acuity patients, the percentage of visits completed within the target time increased to 89.9% from 84.6% between 2008/09 and 2014/15. This increase represents about 100,000 more visits being completed within target in 2014/15, compared to 2008/09 (Figure 6.5).

**FIGURE 6.5**  
Percentage of emergency department visits completed within target time, by acuity level, in Ontario, 2008/09/ to 2014/15



Data source: Emergency Department Reporting System (EDRS) (April 2008 to October 2009) & National Ambulatory Care Reporting System (NACRS) Level 1 (November 2009 to March 2015), provided by Access to Care, Cancer Care Ontario

## Wait times for procedures

In Ontario, wait time targets have been established by the Ministry of Health and Long-Term Care for selected procedures such as hip replacement, cancer surgery, and diagnostic cardiac catheterization to take images of the coronary artery of the heart. The targets were developed with the help of clinical experts, and set out the optimal length of time within which patients should have the procedures, depending on the priority or urgency of their condition.

For the indicators in this section, the wait time was measured from the day the patient and surgeon decided to go ahead with a hip replacement, for example, to the day it was completed.[63]The calculation did not include the period of time between the referral by the patient's family doctor to the surgeon, and the patient's first visit with the surgeon.

## Hip and knee replacements completed within target wait times

More than 15,000 people had hip replacements in Ontario in 2015/16, an increase of 36% since 2008/09, and more than 26,000 had knee replacements, an increase of 25% since 2008/09.[64]

Target wait times for these surgeries are set according to priority levels that are based on the severity of the patient's condition. Priority 1 is the most urgent and Priority 4 is least urgent. The indicators in this section examine wait times for three priority levels of hip and knee replacements: Priority 2, for which the target wait time is 42 days; Priority 3, for which it is 84 days; and Priority 4, for which the target wait is 182 days. Wait times for Priority 1 patients are not included as they are emergency patients who have their surgery done immediately.

## Findings and variations

### Hip replacements

The largest proportion of hip replacements – about 70% – are Priority 4.[64] Although there was significant growth in the number of people having Priority 4 hip replacements, the proportion of patients who still had their surgery completed within the target wait time of 182 days was stable at 85% between 2011/12 and 2015/16 (Figure 6.6).

The proportion of patients who had Priority 3 hip replacements within the target wait time of 84 days was stable from 2008/09 to 2015/16, at around 67%. This means one-third of patients waited more than 84 days for a Priority 3 hip replacement in 2015/16 (Figure 6.6).

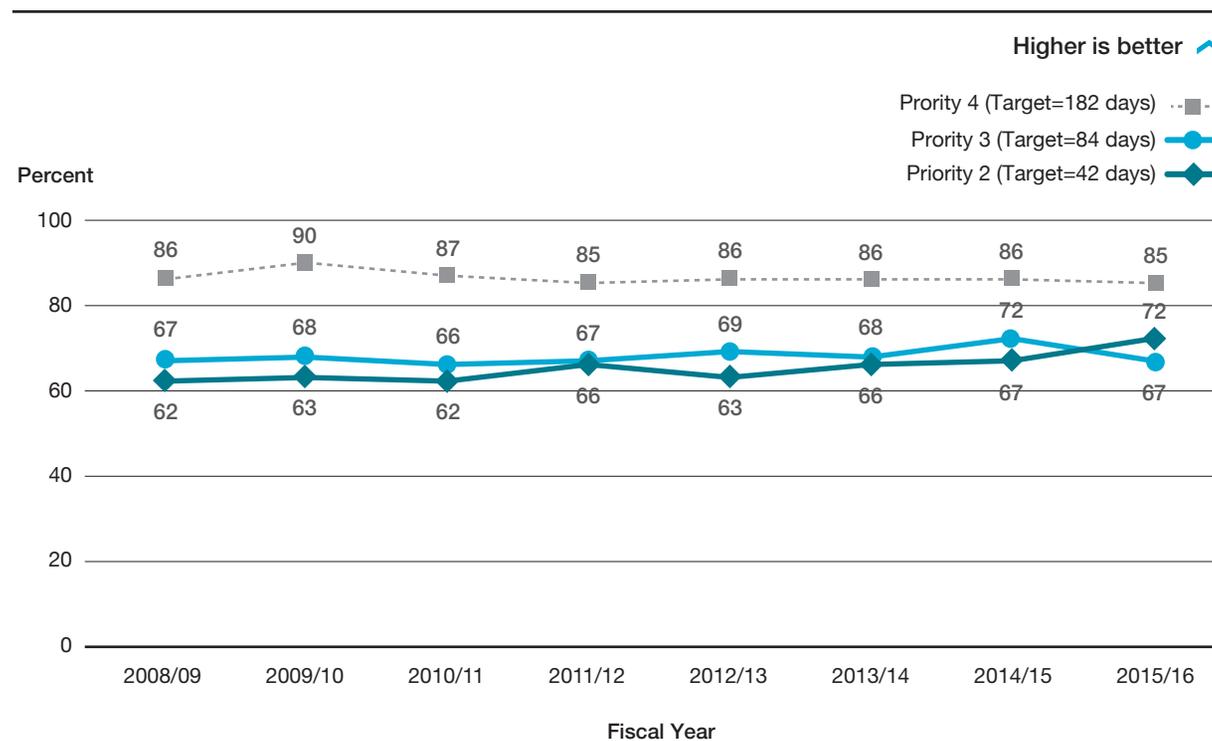
For patients having Priority 2 hip replacements, the proportion whose surgeries were performed within the 42-day target gradually increased from 62% in 2008/09 to 72% in 2015/16 (Figure 6.6). This means over one-quarter of patients were not operated on within the Priority 2 target of 42 days in 2015/16.

### **i** Indicators: Wait times for hip or knee replacement surgeries

These indicators measure the percentage of patients who had their hip or knee replacements completed within wait time targets based on priority level. Wait times were calculated from the day the patient and surgeon decided to proceed with the hip or knee replacement, to the day the surgery was performed.

FIGURE 6.6

### Percentage of hip replacements completed within target time, by priority level, in Ontario, 2008/09–2015/16



Data source: Wait Times Information System (WTIS), provided by Access to Care, Cancer Care Ontario

## Knee replacements

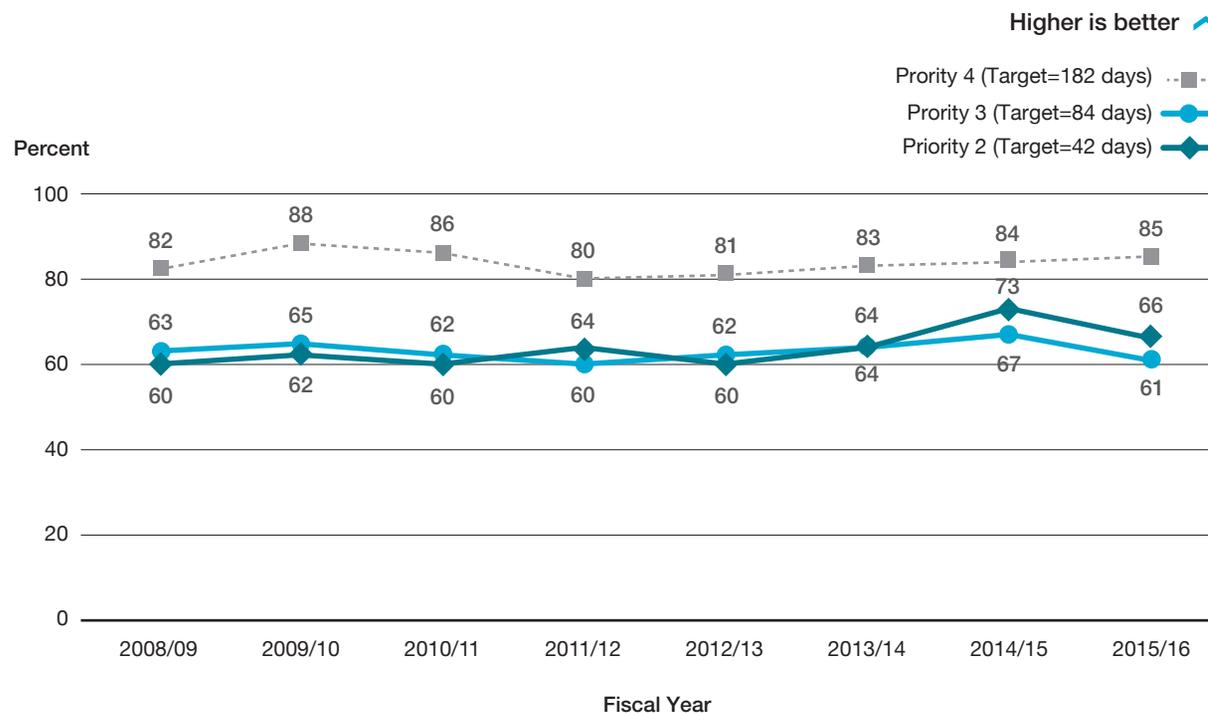
Even though more patients were receiving knee replacements each year, the proportion who had their Priority 4 knee replacements performed within the wait time target of 182 days grew to 85% in 2015/16, from 80% in 2011/12 (Figure 6.7). The large majority of knee replacements – about 75% – are Priority 4.[64]

The proportion of patients who had Priority 3 knee replacements done within the wait time target of 84 days decreased to 61% in 2015/16, from 67% in 2014/15 (Figure 6.7).

The proportion who had Priority 2 knee replacements performed within the wait time target of 42 days fell to 66% in 2015/16, from 73% in 2014/15, after having fluctuated narrowly between 60% and 64% from 2008/09 to 2013/14 (Figure 6.7).

FIGURE 6.7

### Percentage of knee replacements completed within target time, in Ontario, 2008/09–2015/16



Data source: Wait Times Information System (WTIS), provided by Access to Care, Cancer Care Ontario

## Did you know?

Between 2008/09 and 2015/16 in Ontario, the number of patients who had Priority 4 hip replacements each year more than tripled, and the number who had Priority 4 knee replacements more than doubled. Still, the percentage of surgeries completed within wait time targets has remained stable over the past four years for hip replacements, and has increased every year for knee replacements since 2011/12.[64]

## Cardiac procedure wait times

Commonly performed cardiac procedures to treat coronary artery disease include:

- **Diagnostic Cardiac Catheterization:** A test that produces images of the coronary arteries so doctors can see how blood flows into the heart.[65]
- **Percutaneous Coronary Intervention:** A procedure that involves using a catheter to insert a stent that opens blocked blood vessels in the coronary arteries.[66]
- **Coronary Artery Bypass Graft:** A surgery that involves creating a detour around a blocked part of a coronary artery, using a section of blood vessel from elsewhere in the body, such as the legs or chest wall, to allow blood to flow past the diseased part of the artery.[67]

Across Ontario, there are 19 cardiac centres that perform diagnostic cardiac catheterization, 18 that perform percutaneous coronary intervention and 11 that perform coronary artery bypass graft surgery. Each patient waiting for one of these procedures is assigned one of three urgency levels — urgent, semi-urgent or elective. The Cardiac Care Network of Ontario sets wait time targets for each level of urgency for each procedure. The indicators in this section look at the percentage of patients who had cardiac procedures performed within the wait time targets.

## Did you know?

Up to 80% of premature heart disease and stroke is preventable through the adoption of healthy behaviours, such as not smoking, maintaining a healthy weight, engaging in regular physical activity, eating a healthy diet and controlling high blood pressure, diabetes and high cholesterol.[68]

## Findings and variations

Among patients in Ontario waiting for each type of urgent cardiac procedure, 94% to 99% had it performed within the target wait time over the past 6 years (Figure 6.8). In 2015/16:

- Nine out of 10 patients designated as urgent had their diagnostic cardiac catheterization completed within two days. The target is seven days.
- Nine out of 10 patients designated as urgent had their percutaneous coronary intervention completed within four days. The target is seven days.
- Nine out of 10 patients designated as urgent had their coronary artery bypass graft surgery completed within 11 days. The target is 14 days.

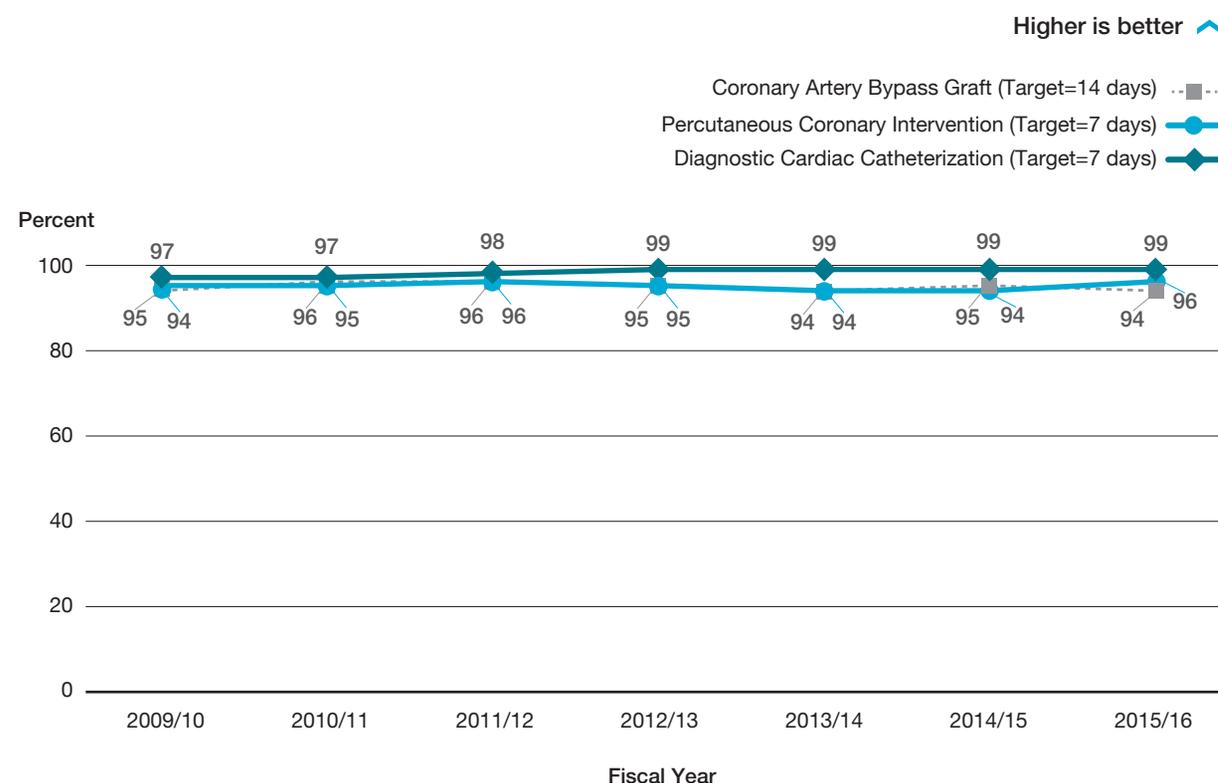
The results were similar for semi-urgent and elective procedures; at least 90% were completed within wait time targets in 2015/16.[69]

### **i** Indicators: Wait times for urgent cardiac procedures

These indicators measure the percentage of patients who had their urgent diagnostic cardiac catheterization, percutaneous coronary intervention or coronary artery bypass graft completed within the wait time target for the procedure. Wait times were calculated from the day the patient and doctor decided to go ahead with the procedure, to the day it was performed.

FIGURE 6.8

### Percentage of urgent cardiac procedures completed within access target, in Ontario, 2009/10 to 2015/16



Data source: Cardiac Care Network of Ontario Cardiac Registry, provided by Cardiac Care Network

## Cancer surgery wait times

Surgery is often a part of a patient's cancer treatment program. Because cancer may grow and spread to other parts of the body over time, having surgery in a timely fashion is important for cancer patients. In Ontario, there are established wait time targets for cancer surgery based on priority levels. Priority 1 is the most urgent and Priority 4 is least urgent.

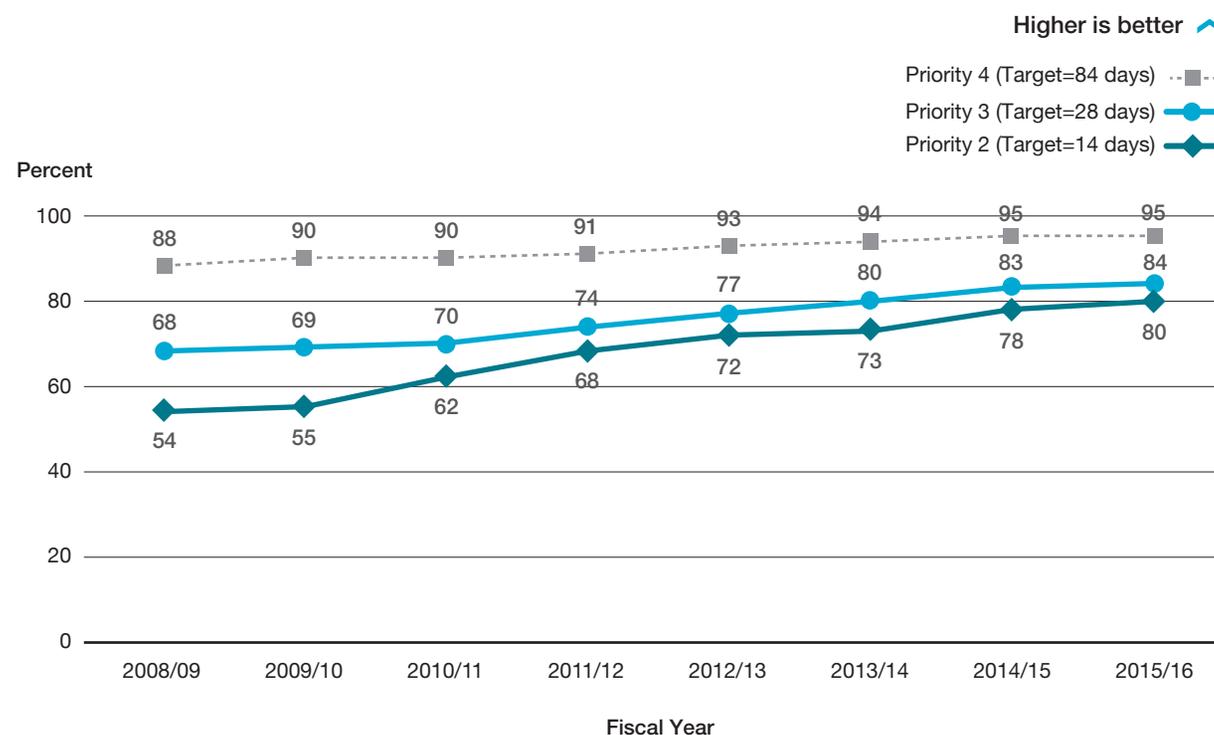
The indicators in this section look at what proportion of patients had their cancer surgery within the wait time target for three priority levels: Priority 2, for which the maximum recommended wait is 14 days, Priority 3, for which it is 28 days, and Priority 4, for which the wait target is 84 days.[63] Wait times for Priority 1 patients are not included as they are emergency patients who have their surgery done immediately.

## Findings and variations

For priority levels 2 and 3, the proportion of cancer surgeries completed within the target wait time improved every year between 2008/09 and 2015/16: from 54% to 80% for Priority 2 surgeries, and from 68% to 84% for Priority 3 surgeries (Figure 6.9). The proportion of Priority 4 surgeries performed within target has been stable at 95% over the last two years, having climbed from 88% in 2008/09 (Figure 6.9).

FIGURE 6.9

Percentage of cancer surgeries completed within target time, by priority level, in Ontario, 2008/09–2015/16



Data source: Wait Times Information System (WTIS), provided by Access to Care, Cancer Care Ontario

## Did you know?

There are more than 200 types of cancer. In Ontario, the most common types of cancer among men are prostate, lung and colorectal cancers. Among women, breast, lung and colorectal cancers are the most common.[70]

### Indicators: Wait times for cancer surgery

These indicators measure the percentage of patients who had cancer surgery within wait time targets based on priority level. The wait time was calculated from the day the patient and surgeon decided to proceed with the surgery to the day it was performed.

## C. difficile infections acquired in hospital

Hospital-acquired infections are serious and potentially deadly illnesses caused by bacteria that are present in the hospital environment and transmitted from one patient to another, directly or indirectly. Health care providers, hospital staff or visitors can spread the bacteria to patients if their hands are contaminated.

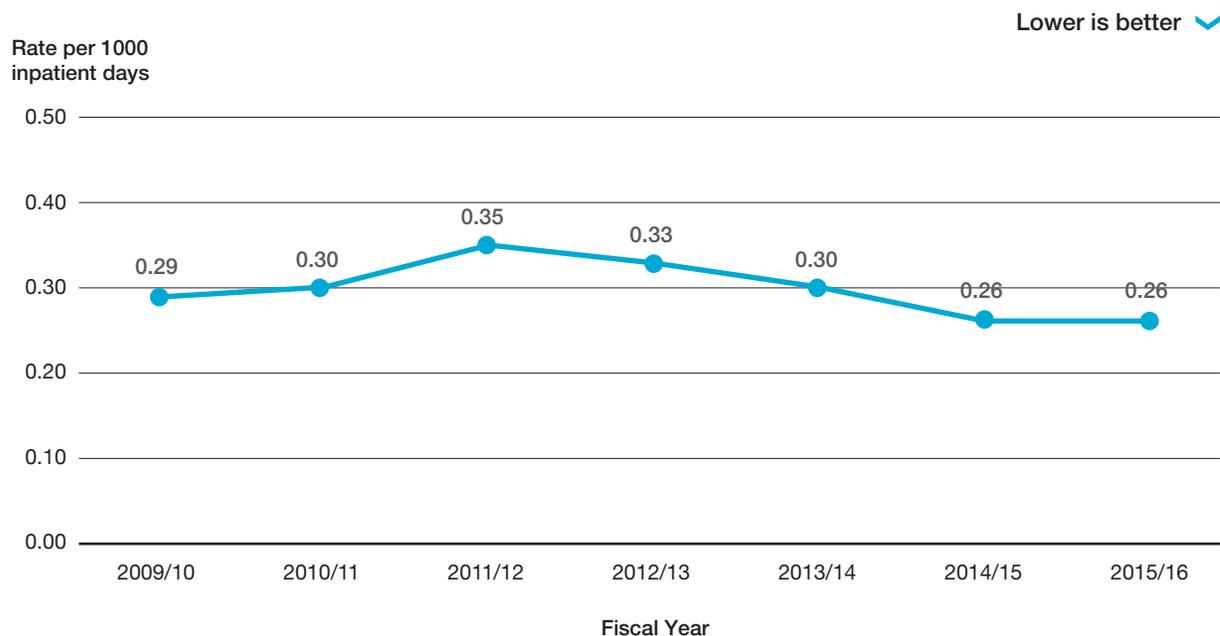
*C. difficile* is one of these bacteria. It can cause severe diarrhea, fever, abdominal pain and even death.[71] While it is not possible to eliminate *C. difficile* infections, hospitals can reduce their spread by following recommended protocols in areas such as hand washing.[72] Hospitals regularly monitor and publicly report the number of infections among their patients.

The *C. difficile* infection rate is measured as the number of new *C. difficile* infection cases that occurred per 1,000 inpatient days. One hundred patients each staying in hospital for 10 days would add up to 1,000 inpatient days.

### Findings and variations

In 2015/16, the *C. difficile* infection rate for Ontario hospitals was 0.26 per 1,000 inpatient days, meaning that if 100,000 patients each stayed in hospital for one day, 26 would have acquired the infection. The rate was the same in 2014/15, having decreased from 0.35 per 1,000 inpatient days in 2011/12, and from 0.29 in 2009/10 (Figure 6.10).

FIGURE 6.10  
Rate of hospital-acquired *C. difficile* infection, in Ontario, 2009/10 to 2015/16



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

## Did you know?

*C. difficile* is the most frequent cause of infectious diarrhea in hospitals and long-term care homes in Canada.[73]

### Indicator: *C. difficile* infections acquired in hospital

This indicator measures the number of hospital-acquired *C. difficile* infection cases that occurred per 1,000 inpatient days. Inpatient days count all the days each individual hospital bed was occupied by a patient.

### Caesarean section deliveries

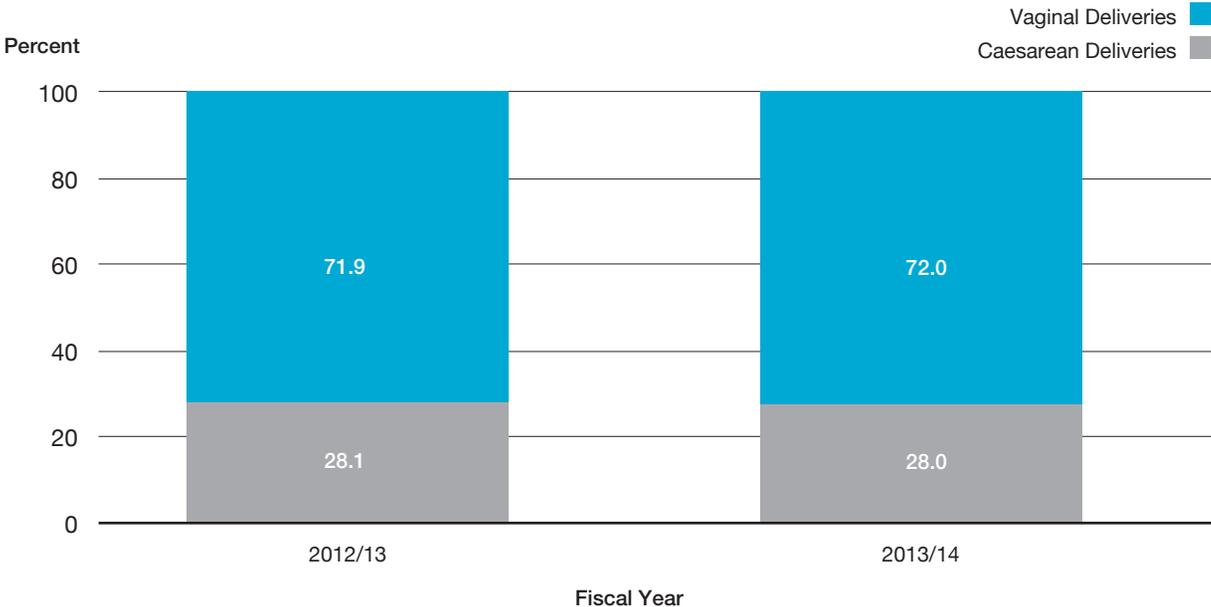
Delivering babies by Caesarean section is the most common inpatient surgical procedure in Canada.[74] Caesarean sections are most often performed when vaginal delivery is considered risky for the mother or baby.[75] In some cases, this type of delivery can be life-saving. However, the mother or baby can experience complications as a result of the procedure, so a Caesarean section should only be performed when there is a clear reason for doing so.[75]

### Findings and variations

Across Canada over the last 20 years, the rate at which women have been having Caesarean section deliveries has increased significantly, to more than 27% of all deliveries in 2013, from 17% in 1995.[76,77] This ongoing rise may be linked to several factors, including women being older the first time they deliver and the increasing body weight of pregnant women.

The data show the proportion of deliveries in Ontario that were Caesarean deliveries remained stable, at around 28%, between 2012/13 and 2013/14 (Figure 6.11).

FIGURE 6.11  
**Percentage of deliveries by delivery type, in Ontario, by fiscal year, 2012/13 to 2013/14**



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

**i** **Indicator: Caesarean section deliveries**

This indicator measures deliveries by Caesarean section, as a percentage of all deliveries.

The proportion of low-risk deliveries that were Caesarean deliveries also remained stable, at around 21%, between 2012/13 and 2013/14 (Figure 6.12). A delivery is considered to be low-risk when a woman who has not had a previous Caesarean section is giving birth to a single, full-term baby who presents head down, without maternal or fetal conditions or complications.

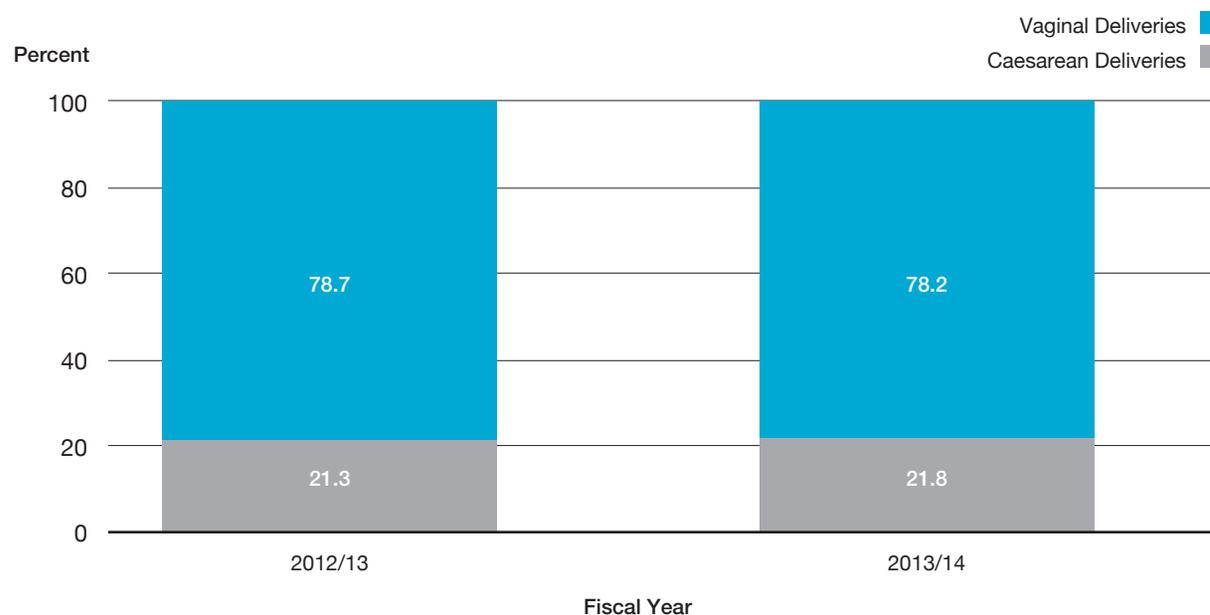
The rate of Caesarean sections among low-risk deliveries did not vary significantly in relation to the neighbourhood income level of the mother, in 2013/14.[78]

## Did you know?

Some of the common reasons women have a Caesarean delivery include abnormal fetal position, size or heart rate, previous Caesarean delivery, problems with the placenta, and the age of the mother.[75]

FIGURE 6.12

### Percentage of low-risk deliveries by delivery type, in Ontario, by fiscal year, 2012/13 to 2013/14



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

## In summary

People in Ontario continue to have somewhat favourable views of their experiences in emergency departments and inpatient wards. There has been improvement in emergency department lengths of stay, which continue to decrease and get closer to targets despite an increase in the number of people visiting emergency departments. The percentage of visits to emergency departments completed within target times has increased for both high-acuity and low-acuity patients.

As with emergency department lengths of stay, the impact of provincially-supported and concerted efforts to reduce wait times have made a significant difference for patients undergoing targeted procedures. The vast majority of cardiac procedures are completed within wait time targets, and the percentages of Priority 2, 3 and 4 cancer surgeries performed within wait targets are increasing. Among Priority 4 patients who need a hip or a knee replacement, 85% had their surgery completed within target times. However, the percentages of patients who had their Priority 2 and 3 knee replacements completed within target wait times decreased from 2014/15 to 2015/16.

While progress in reducing lengths of stay and wait times have been made in targeted areas, more work remains to be done in other areas and for procedures not included in this report. Also, the wait times measured do not cover all wait times that may occur in the process of receiving care. For example, a patient may have to wait to see a specialist before a decision to undergo a procedure is made.

Rates of *C. difficile* infections acquired in hospital have declined gradually and at their lowest rate since 2009/10. This suggests hospitals are getting better at preventing inpatients from contracting dangerous infections, as a result of quality improvement initiatives launched under the Quality Improvement Plans hospitals submit each year to Health Quality Ontario.

Work needs to be done regarding Caesarean deliveries, as they are being performed for one in five women who are considered at low risk of having a complicated delivery.

# Long-Term Care

In this chapter, we report on Common Quality Agenda indicators related to long-term care:

- Waiting to be admitted to a long-term care home
- Use of antipsychotic medications
- Pain experienced by residents
- Use of physical restraints
- Falls among residents

Photo of Malvina provided by her family. Please see her story on the next page.

## Real-World Experiences

### In search of a new home: Malvina and Lina's story

Sitting alone on her bed, Malvina cast a long, vacant stare at the mirror before her. "What are you doing?" asked Lina, Malvina's daughter, who had just arrived at her mom's apartment. "I'm keeping her company," Malvina replied, unaware the face in the mirror was her own. Lina turned away, not wanting her mother to see her eyes swell with tears.

Once a vibrant homemaker, Malvina, 91, now has dementia, which has caused her to experience intense mood swings, loss of memory and paranoid thoughts. For a year and a half, Lina, a social worker by training, cared for her mother on her own, while juggling career demands. Groceries, banking, cleaning, bathing, she did it all. "My mom worked very hard for me and I am her only child," Lina says. "I was her only source of support."

One day, Malvina fell and fractured her right hip. The injury changed everything. Malvina had successful emergency surgery at a local hospital, and spent two months in the orthopedic ward. Lina visited often, acting as a translator for her mom, who had reverted to speaking exclusively in her native Italian tongue as her dementia accelerated.

Lina says she had to do a lot of the care for her mother. "The staff would often call me because they

couldn't get my mother to eat or do things or understand what she was saying," Lina says. "I'd have to take time off of work to bring her food or I would get a call at midnight to help get her to bed. It took a real toll on me."

Lina says the social workers focused on discharge and were "pushing" long-term care. But Lina wanted to ensure her mom got the best home, not the first one that became available. "I had certain criteria," she says. "It needed to be an Italian long-term care home and close to my home or office. I needed to visit the home first. I resisted the pressure. I wanted it to be the right place for my mom."

The search for a long-term care home was emotionally and physically draining for Lina. "Here I was, still caring for my mom, looking after her apartment, all while being off work to look at long-term care homes," Lina says. It was really depressing. It's hard to see your parent deteriorate. I felt helpless because I wanted so much for my mom to have the best facility possible, and I felt the choices I had before me weren't possibilities. I didn't feel listened to."

The experience prompted Lina to make a number of suggestions to improve the system. "I think staff who deal with patients like my mom with dementia need to have specialized training, particularly

for communicating with patients from different backgrounds and being more culturally sensitive," she says. "There should be a checklist of all the things that need to help transition a patient from a hospital to a long-term care home." Another big recommendation is for more beds in long-term care homes, and social workers not having very large caseloads."

While Malvina is still on a waiting list for two Italian homes, Lina did find a long-term care home for her that is working out well. "From the moment we stepped in, they made us feel comfortable," she says of the home's staff. Still, there is no one there who speaks Italian, which sometimes causes misunderstandings and disruptive behaviour.

Lina still has doubt, guilt and uncertainty about her mom being in a long-term care home. "I can't find peace inside," she says. To come to grips with it all, Lina wonders what her late father would think of her decision. "My father loved my mom so much and I know he wouldn't want her to have to live outside of her own home," Lina said. "But if he were here, he would understand that I can't take care of her at home. He would want me to take care of my mother, but he would also want me to continue living my life."

# Caring for our frail and vulnerable

For people who need 24-hour nursing care and supervision, a long-term care home is often the right place to live. Long-term care homes work to provide their residents with safe and supportive care, to help them live with dignity and the best quality of life possible.

This work is challenging. An increasing number of residents are living with chronic conditions, such as heart disease, diabetes, arthritis, mood disorders and hypertension. More than half of residents – 64.5% in Q4 2015/16 – have some form of dementia such as Alzheimer’s disease.[79]

## Did you know?

There are more than 625 long-term care homes in Ontario, caring for about 78,000 residents at any given time.[79]

## Waiting to be cared for in a long-term care home

People who are waiting for a place in a long-term care home can receive other helpful services such as home care, supportive housing and day programs. However, most people who are waiting likely want to move into the home of their choice as quickly as possible. When they have to wait for a long time, their health may get worse over the waiting period, and it may be stressful because it may not be the most appropriate place to deal with their care needs.

While most people live in their homes while they are waiting for admission to a long-term care home, some wait while they are in hospital, potentially putting them at a higher risk for additional health problems like infections, loss of strength or loss of functional abilities due to the limitations of a hospital environment. Because they are occupying a hospital bed that could otherwise be used for a patient who needs the level of care only a hospital can provide, people waiting in a hospital can also affect the ability of the hospital to provide services to other patients. This includes patients waiting to be transferred from the emergency department to an in-patient hospital bed, or patients waiting for elective surgeries.[80,81]

## What can affect wait times?

There are a number of factors that can affect the amount of time people wait for admission to long-term care. They include:

Wait time factors can include	Description
Bed availability	A long-term care bed may not be available when a person applies for it. The availability of a bed is determined in part by a combination of how many beds exist in the region where it is needed, how frequently a discharge occurs, and how many others are waiting for a bed in that region.
Choice	Wait times are also affected by whether a bed is available in the home a person wants to move into. In Ontario, people can apply to up to five different long-term care homes. The wait time varies between homes, but generally, people applying to multiple homes may have a shorter wait than people applying to only one. Some homes that serve specific cultural, ethnic or religious groups draw applicants from all over Ontario and may therefore have longer wait times.
Priority	For some people, waiting to move into a long-term care home could put their health and safety at significant risk. They would therefore be prioritized and moved more quickly into long-term care because they require immediate admission to a long-term care home as a result of a crisis arising from their conditions or circumstances. High priority would also apply to people waiting in a long-term care home or hospital that was closing within 12 weeks or to people waiting in a hospital that is dealing with a severe demand for its beds.

## Findings and variations

The median wait time in Ontario for people who moved from their home into a long-term care home was 94 days in 2014/15 – meaning half of those people waited a shorter time and half waited longer. The wait period has been stable over the past five years, remaining significantly improved over the median wait in 2008/09, which was 150 days. For people waiting to move from a hospital to a long-term care home, the median wait time increased slowly but steadily from 2005/06 to 2010/11, but stayed between 60 and 70 days from 2010/11 to 2014/15 (Figure 7.1).

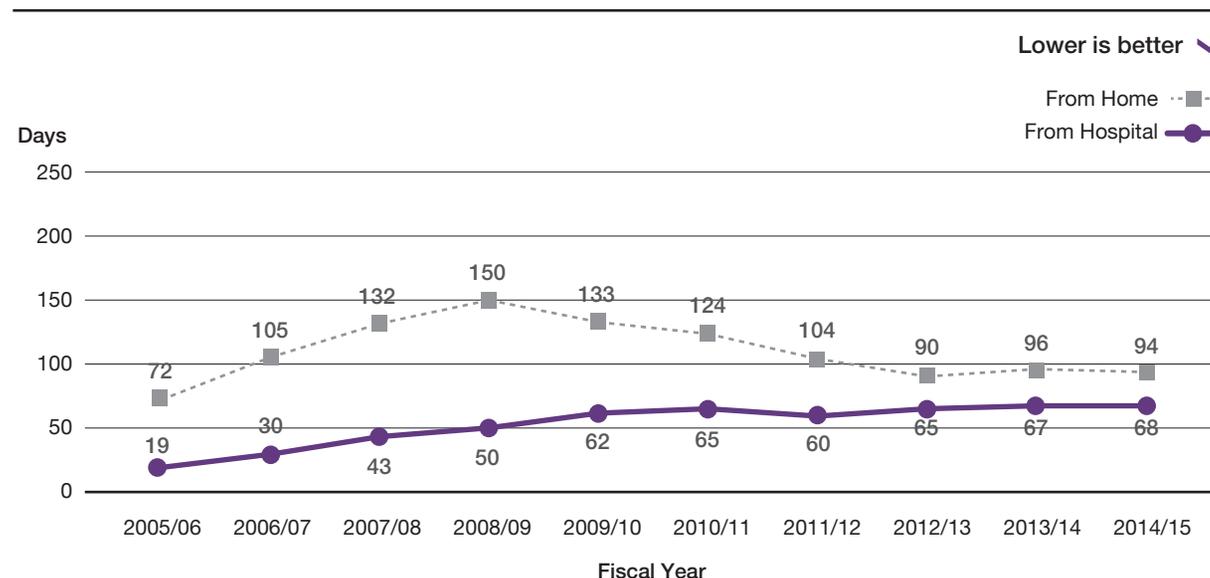
**i** Indicators: A) Wait time for admission from home to a long-term care home; B) Wait time for admission from hospital to a long-term care home

These wait time indicators measure:

- The median number of days a person living at home or in the community – in a retirement home, for example – waits to be admitted to a long-term care home, from the day they apply to the day they move in (The median is the mid-point at which half of people wait less time and half wait longer)
- The median number days a person staying in hospital waits to be admitted to a long-term care home, from the day they apply to the day they move in

FIGURE 7.1

Median number of days waited to move into a long-term care home from either home\* or hospital, in Ontario, 2005/06 to 2014/15



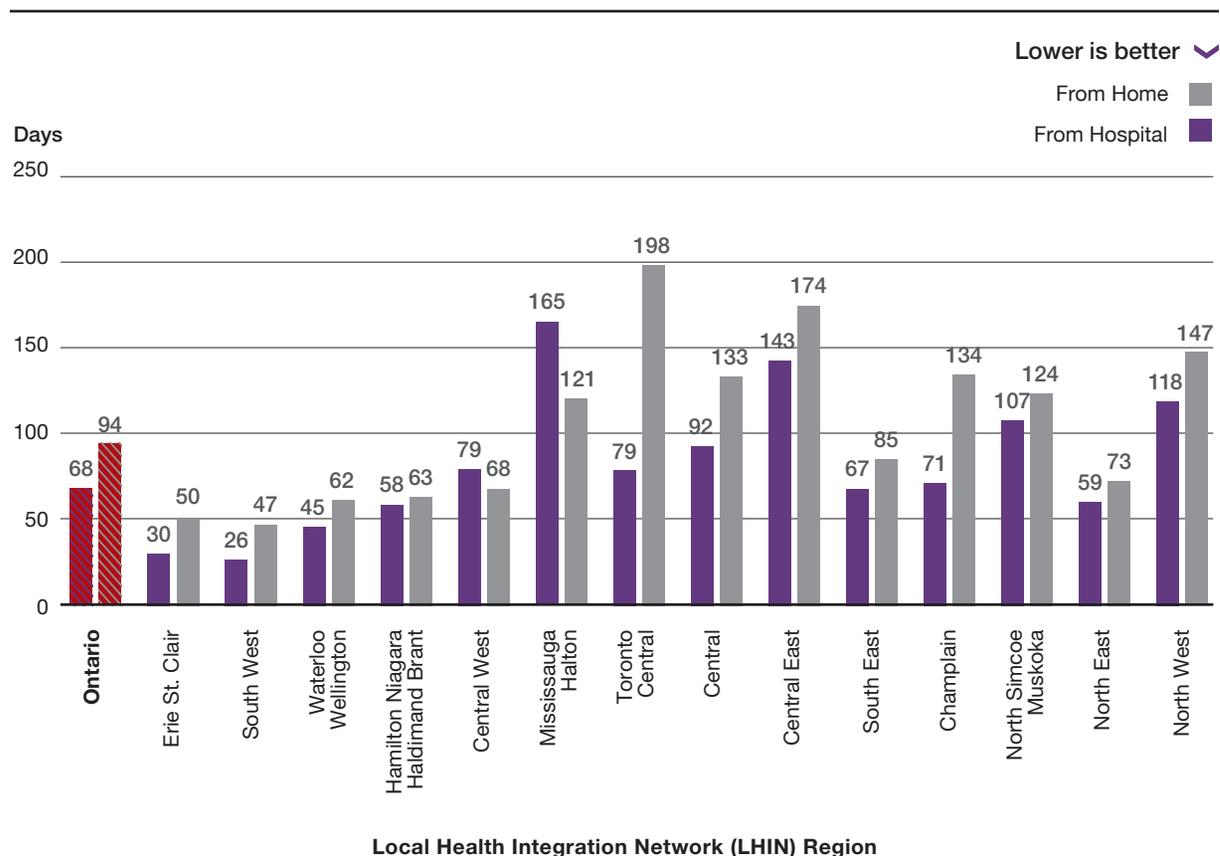
Data source: Client Profile Database, provided by the Ministry of Health and Long-Term Care

\*Home is used here to capture any place of residence in the community (such as the applicant's home, a retirement home or supportive housing), for applicants who were not waiting in hospital.

Note: The indicators measure wait times for all the people who waited to move into a long-term care home, except for those who waited to move from one long-term care home to another one. They include people with high priority who needed to move immediately into a long-term care home, as well as people with less urgent needs.

The wait time for long-term care placement in a LHIN region reflects how long a person had to wait to move to a long-term care home located in that LHIN region, regardless of whether the person lived in the region. For example, the median wait time for moving from a hospital to a long-term care home ranged from 26 days in the South West LHIN region to 165 days in the Mississauga Halton LHIN region, in 2014/15. For people moving from their home to long-term care, the median wait time ranged from 47 days in the South West LHIN region to 198 days in the Toronto Central LHIN region. With the exceptions of the Central West and Mississauga Halton LHIN regions, the wait from hospital was shorter than the wait from home (Figure 7.2).

**FIGURE 7.2**  
**Median number of days waited to move into a long-term care home from either home\* or hospital, in Ontario, by LHIN region\*\*, 2014/15**



Data source: Client Profile Database, provided by the Ministry of Health and Long-term Care  
 \*Home is used here to capture any place of residence in the community (such as resident's home, a retirement home or supportive housing), for applicants who were not waiting in hospital. \*\* The LHIN region refers to the location of the long-term care home the patient was applying to enter, not the location they live at prior to being admitted.

## Use of antipsychotic medications

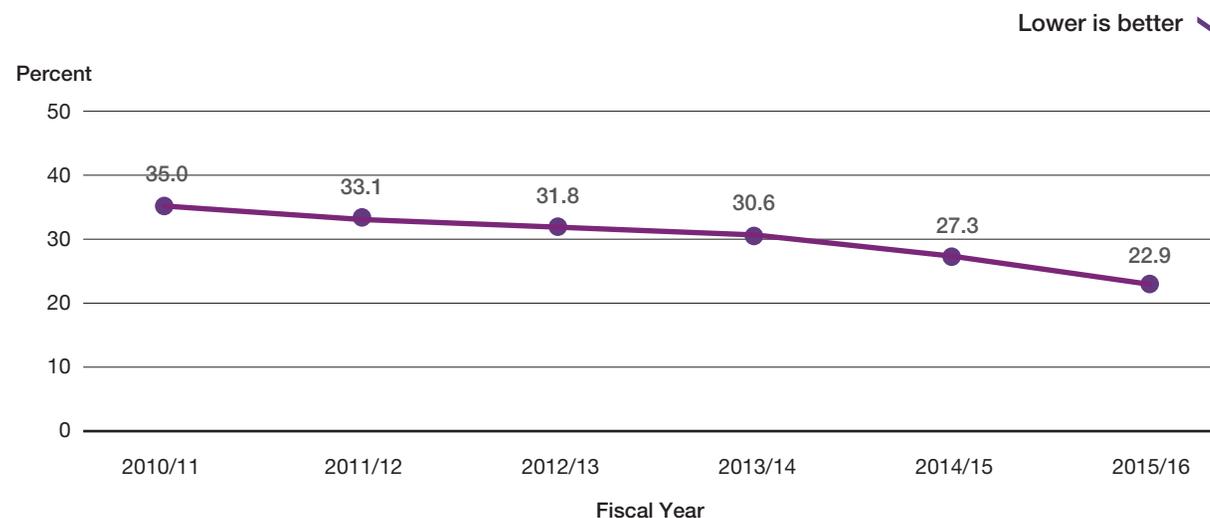
Antipsychotic medications are often used to manage psychosis, a term used to describe the hallucinations, delusions and other symptoms that can occur in people with dementia, Huntington's disease or mental health conditions such as schizophrenia. For some long-term care home residents who exhibit serious behavioural symptoms such as aggression or severe agitation, the prescription of antipsychotic medications may be appropriate even if the resident does not experience psychosis. For them, these medications may reduce behavioural symptoms, improve quality of life and reduce suffering.

The benefits of antipsychotic medications must be weighed against their possible side effects, which include sedation, confusion, higher risk of falls and slightly increased risk of death. While the use of these medications in long-term care homes may sometimes be appropriate, other courses of treatment should be used first.[82]

## Findings and variations

There has been steady improvement in this indicator over recent years in Ontario, as the percentage of long-term care residents without psychosis being given an antipsychotic medication decreased to 22.9% in 2015/16 from 35% in 2010/11. In the most recent year alone, the decrease was just over four percentage points, representing approximately 3,000 fewer long-term care residents without psychosis getting antipsychotic medications (Figure 7.3).

FIGURE 7.3  
Percentage\* of long-term care home residents without psychosis using antipsychotic medications, in Ontario, 2010/11 to 2015/16



Data source: Continuing Care Reporting System, provided by the Canadian Institute for Health Information  
\*Risk adjusted

### **i** Indicator: Antipsychotic medication use

This indicator measures the percentage of long-term care home residents without psychosis who were given antipsychotic medication in the seven days preceding their resident assessment.

In 2015/16 in Ontario, 22.9% of long-term care residents without psychosis were given an antipsychotic medication, which is down from 27.3% in 2014/15. There was some variation between LHIN regions in the proportion of patients without psychosis receiving antipsychotic medications, which ranged from a low of 19.1% to a high of 27%. However, there was wide variation between homes, from a low of 0.7% to a high of 57.1%.[79] These findings suggest there are opportunities to examine and compare the use of antipsychotic medications in long-term care homes, and to re-evaluate prescribing decisions.

## Pain experienced by residents

It is essential to assess the pain experienced by people living in long-term care homes because of the impact pain can have on them. In addition to lowering overall quality of life, pain can prevent residents from staying active or engaging in social activities, leading to worsening health problems. When pain is poorly managed, it also can contribute to depression, anorexia, anxiety, agitation, poor sleep, delayed healing, and falls.[83,84,85]

## Findings and variations

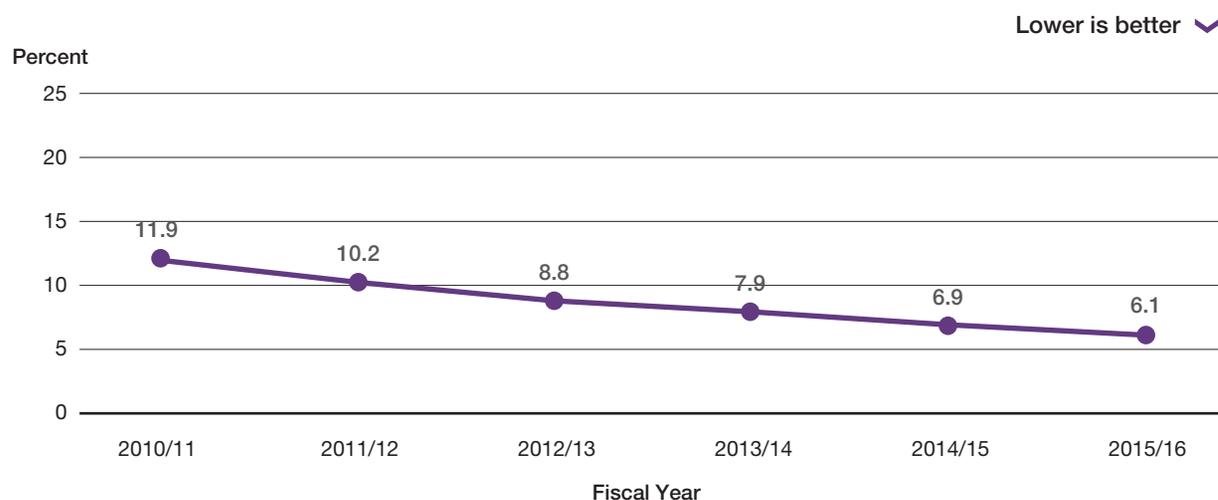
Overall in Ontario, there was a decrease in the proportion of residents who experienced pain, to 6.1% in 2015/16, from 11.9% in 2010/11 (Figure 7.4).

## Did you know?

Ontario Regulation 79/10 under the *Long-Term Care Homes Act, 2007* requires all long-term care homes in Ontario to have a pain management program for identification and management of residents' pain.

FIGURE 7.4

Percentage\* of long-term care home residents who experienced moderate pain daily or any severe pain, in Ontario, 2010/11 to 2015/16



Data source: Continuing Care Reporting System, provided by the Canadian Institute for Health Information  
\*Risk adjusted

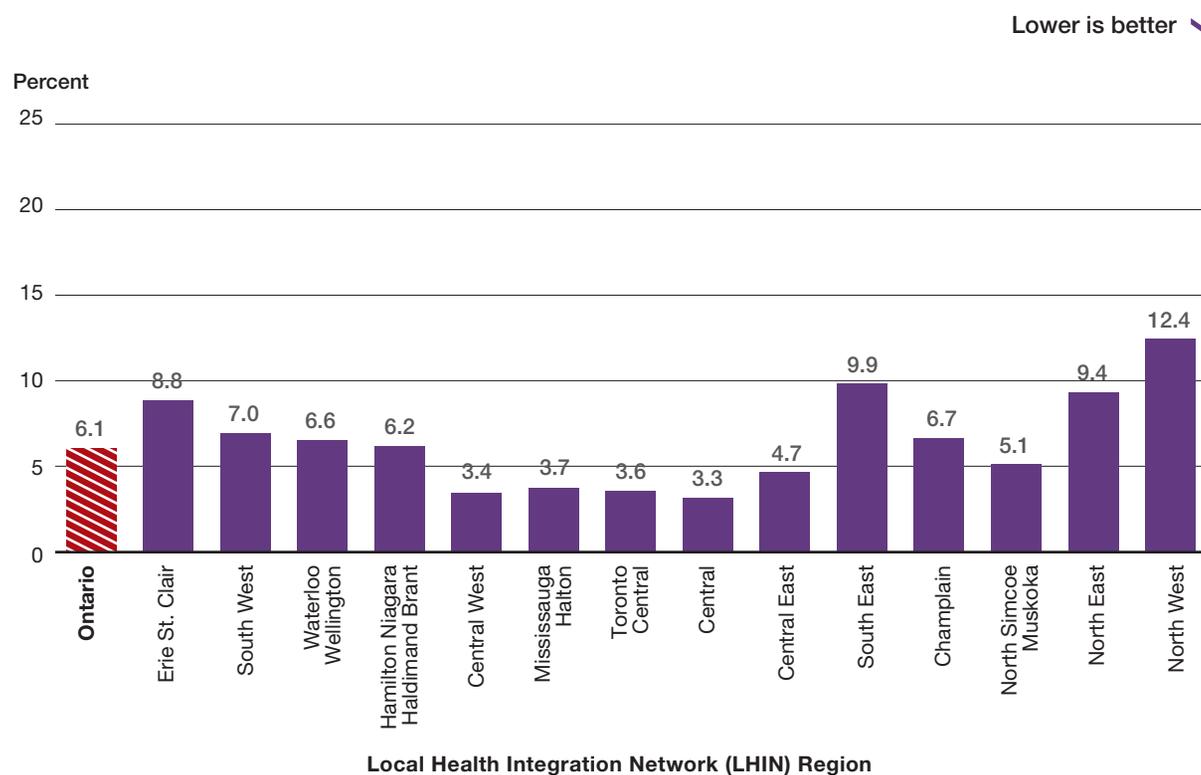
### **i** Indicator: Pain

This indicator measures the percentage of residents who experienced moderate pain daily or severe pain at any time during the seven days prior to their most recent clinical assessment. Pain was assessed on the basis of what the resident said, as well as observation by the assessor of the resident's behaviour such as moaning, wincing, frowning or adjusting posture to protect a part of the body.

There was variation by region, however, with the proportion of residents who experienced pain ranging from a low of 3.3% in the Central LHIN region to a high of 12.4% in the North West LHIN region, in 2015/16 (Figure 7.5).

FIGURE 7.5

**Percentage\* of long-term care home residents who experienced moderate pain daily or any severe pain, in Ontario, by LHIN region, 2015/16**



Data source: Continuing Care Reporting System, provided by the Canadian Institute for Health Information  
\*Risk adjusted

## Use of physical restraints

In certain instances, physical restraints such as lap belts, trunk or limb restraints and table trays may be used to prevent residents from falling or to reduce the risk they will harm themselves or others. They can also be used to prevent residents from rising, to ensure a treatment is completed or to manage some behaviours.[86] When it is determined that a restraint is necessary, there are very specific guidelines that must be followed.

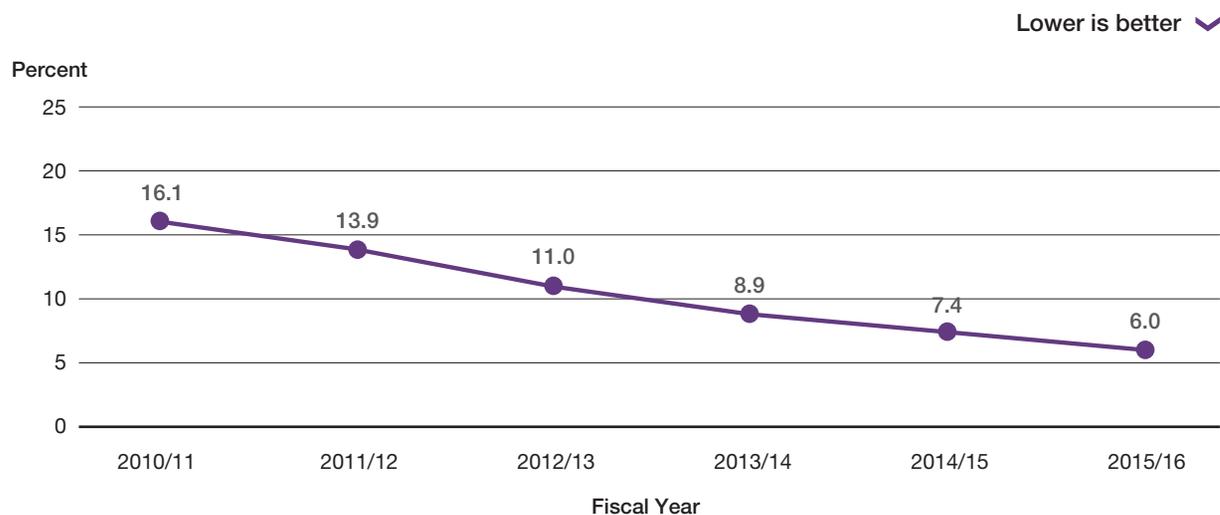
However, restraints can be problematic. They are associated with a loss of autonomy and dignity, can limit a resident's mobility, cause agitation and confusion, increase the risk of pressure ulcers, and in rare cases, can cause injury or death.[87,88] There is also evidence indicating the use of restraints actually increases rather than decreases the risk of negative health outcomes.[89]

## Findings and variations

In Ontario as a whole, the percentage of residents in daily physical restraints declined substantially to 6% in 2015/16 from 16.1% in 2010/11 (Figure 7.6).

FIGURE 7.6

**Percentage\* of long-term care home residents who were physically restrained on a daily basis, in Ontario, 2010/11 to 2015/16**



Data source: Continuing Care Reporting System, provided by the Canadian Institute for Health Information  
\*Risk adjusted

### **i** Indicator: Use of daily physical restraints

This indicator measures the percentage of residents who were physically restrained on a daily basis during the seven days prior to their most recent assessment.

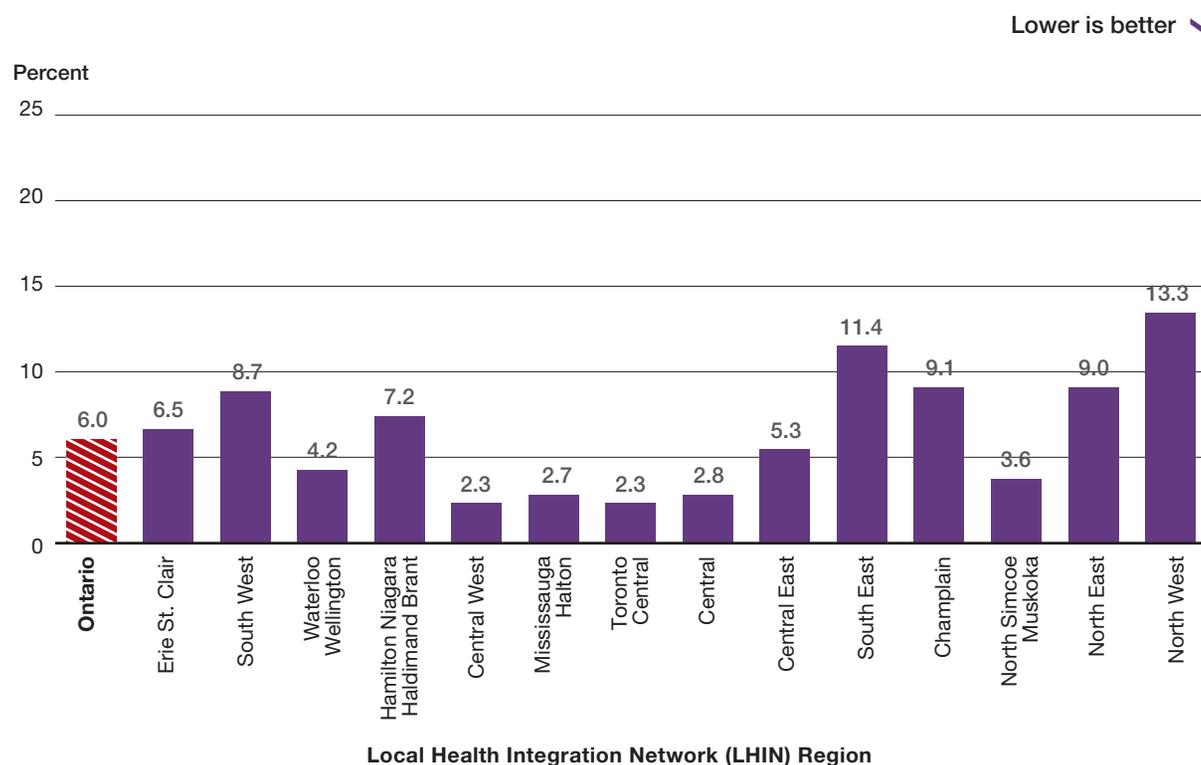
Rates varied substantially across Ontario in 2015/16, from 2.3% in the Central West and Toronto Central LHIN regions to 13.3% in the North West LHIN region (Figure 7.7).

## Did you know?

The regulation under the *Long-Term Care Homes Act, 2007* requires all homes in Ontario to have a written policy that aims to minimize the use of restraints and contains detailed requirements for the use of restraints.

FIGURE 7.7

Percentage\* of long-term care home residents who were physically restrained on a daily basis, in Ontario, by LHIN Region, 2015/16



Data source: Continuing Care Reporting System, provided by the Canadian Institute for Health Information  
\*Risk adjusted

## Falls among residents

When people living in long-term care homes fall, the consequences can be serious. Falls among frail residents can cause injuries that limit their independence and increase their care needs, or even result in death.[90] Falls can also lead to more emergency department visits, hospitalizations, and surgeries such as hip replacements.[91]

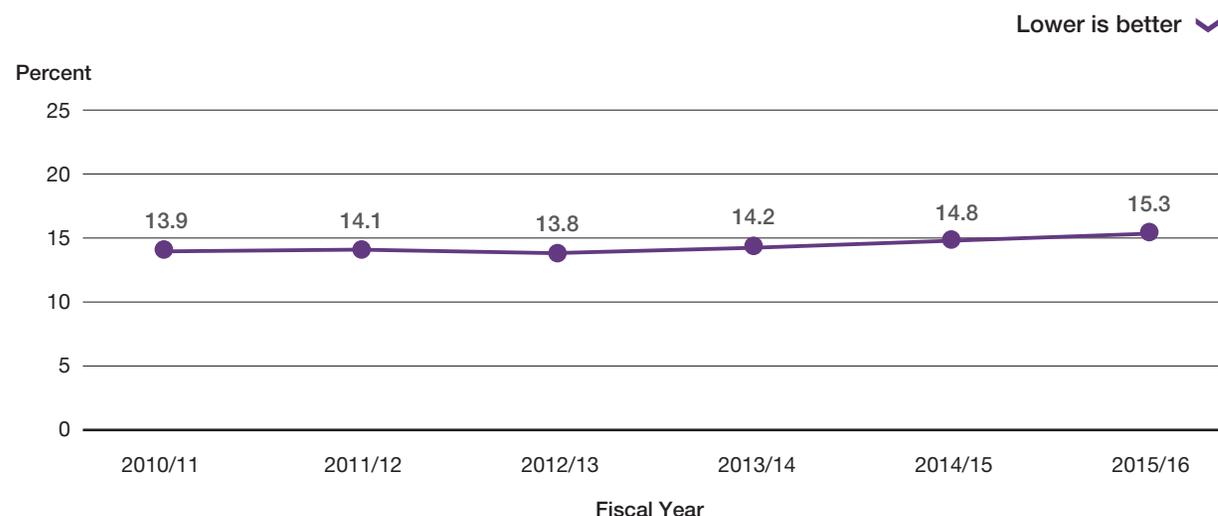
Even if a fall does not result in an injury, it can have psychological effects such as triggering a fear of falling, which can reduce a resident's mobility and social interactions, and thereby negatively affect their quality of life.[92] Health care providers work to strike a balance between trying to maximize residents' mobility and independence, and minimize the use of restraints, while at the same time following strategies to prevent falls from happening and mitigating any injury that might occur.

## Findings and variations across Ontario

The percentage of long-term care home residents who fell during the 30 days prior to receiving a clinical assessment has shown signs of slight increase in recent years but has remained around 14-15% each year over the last five years, which amounted to approximately 10,000 residents falling each year in Ontario (Figure 7.8). In view of the sharp decrease in the use of antipsychotic medications and the use of restraints and increased frailness of the residents, the small increase is a positive performance.

FIGURE 7.8

### Percentage\* of long-term care home residents who fell, in Ontario, 2010/11 to 2015/16



Data source: Continuing Care Reporting System, provided by the Canadian Institute for Health Information  
\*Risk adjusted

The data showed some variation across Ontario, ranging from a low of 12.5% of long-term care home residents falling in the Toronto Central LHIN region, to a high of 18.1% falling in North Simcoe Muskoka LHIN region, in 2015/16.[79]

### **i** Indicator: Falls

This indicator measures the percentage of long-term care home residents who fell during the 30 days prior to their most recent assessment, regardless of whether the fall resulted in injury.

## Did you know?

A regulation under the *Long-Term Care Homes Act, 2007* requires all long-term care homes in Ontario to have a falls prevention and management program to reduce the incidence of falls and the risk of injury.

## How Ontario measures up to the rest of Canada

In assessing the quality of care, services and treatment residents receive in Ontario's long-term care homes, it can be helpful to see how well the province performs in comparison with other provinces that have sufficient data to allow for comparisons. As illustrated in Table 7.1, in 2015/16:

- Ontario performed better than all other provinces in the use of restraints and in pain management
- Ontario performed better than some provinces and worse than others in falls and the use of antipsychotic medications.

TABLE 7.1  
How Ontario compares within Canada, 2015/16

Province	Antipsychotic medications use	Pain	Falls	Lower is better 
				Use of physical restraints
Ontario	22.9%	6.1%	15.3%	6.0%
Alberta	18.1%*	7.3%*	15.6%	6.9%*
British Columbia	27.9%*	14.1%*	16.2%*	9.6%*
Newfoundland and Labrador	37.5%*	14.7%*	11.2%*	12.1%*
Saskatchewan	29.1%*	12.5%*	13.2%*	11.7%*

Data source: Continuing Care Reporting System, provided by the Canadian Institute for Health Information  
\*Results are statistically different from Ontario

## In summary

Residents who live in long-term care homes have more complex health issues and are more physically frail than ever before. This is due in part to the advanced age of residents, with the number of people over the age of 85 in long-term care homes continuing to grow.[79] More residents are living with chronic conditions, which increases their care needs and, in turn, affects the demands on the long-term care system.

In spite of challenging circumstances, concerted efforts including changes in regulations and system oversight, targeted programs, such as pain management initiatives and other quality improvement initiatives have led to significant successes. For example, there have been some successes in managing wait times for admission to a long-term care home, with the median wait time to enter a long-term care home while at home lower than it was five years ago. Meanwhile, the median wait time from hospital has increased slightly, but is still much shorter than the wait time from home.

There have also been successes in reducing the use of antipsychotic medications and use of restraints while keeping the rate of falls stable. Ontario's indicator results for pain management and the use of restraints are the best in Canada and have both decreased over the past five years. While the use of antipsychotic medications in Ontario steadily decreased over the past five years, it remains average compared to the rest of Canada.

Residents who live in long-term care homes have more complex health issues and are more physically frail than ever before. In spite of challenging circumstances, concerted efforts have led to significant successes.

# Palliative Care



In this chapter, we report on the following Common Quality Agenda indicators for palliative care at the end of life:

- Home care services
- Home visits by a doctor
- Unplanned visits to the emergency department
- Location of death

Photo of Janet taken by Roger Yip.  
Please see her story on the next page.

## Real-World Experiences

### Dying with comfort and dignity: John's story

The travel plans were all set. John and Elizabeth were headed from Toronto to their native Scotland to celebrate 50 years of marriage. Their kids were secretly planning to surprise them overseas. But just days before take-off, John found out he had advanced colorectal cancer. The trip of a lifetime had to be postponed. "It was devastating for all of us," says John's daughter, Janet.

Some people would be overwhelmed by this turn of events, but John, a welder in his working days, wasn't the type to cave in. He took the news and the changes that would follow in his health in stride. "My dad was very independent and used to call himself 'hearty Scottish stock,'" recalls Janet.

The cancer would spread to John's liver and lungs. John had surgeries and for the next six years, he was treated with chemotherapy as an outpatient. "His oncologist told us years later that he was in palliative care the whole time," notes Janet. "It was very hard for us to hear that." (Janet's initial reaction to hearing "palliative care" isn't unusual as there is a common misconception that it means death is imminent. In fact, palliative care is the broad philosophy to provide comfort and dignity for patients and families facing any life-threatening illness.)

In the midst of his illness, for a few years John also acted as the primary caregiver for Elizabeth, who had developed dementia, "He kept my mom at home as long as he could and when she went to live in a long-term care home, he visited her every day," Janet says.

After first undergoing chemotherapy at a hospital clinic in Toronto, John then began to receive his treatments at home from nurses. "He had a really good relationship with one nurse in particular," says Janet. "She became part of his life – somebody he knew would come to take care of him. I think it made a huge difference for him. When my dad died, she came to the funeral."

Over time, the chemo took its toll on John, who was in his 80s. The family decided he should go and live with Janet in Orillia. "He could feel comfortable here living with his family," Janet says. A special mattress and walker were set up for John in Janet's home. She connected with home care providers and John received treatment and care from nurses, a nutritionist, a physiotherapist, a case manager, and a palliative care doctor.

"We had a palliative care doctor who came into our home that was really excellent," Janet says. "She had met my dad in the hospital and ... was very helpful in terms of explaining the process. He

was concerned about not being able to control pain and she reassured him that's what she was there for."

Janet's brother and sister, and their kids, live in Toronto, so they were concerned about being disconnected from their ailing dad and grandfather. "In palliative care, it's a journey for everyone, not just the person dying," Janet reflects. To help put their minds at ease, the palliative care doctor came to the house to meet with the whole family. "That was so helpful," Janet says. "Everybody could ask their questions and get answers."

As the cancer progressed, John's quality of life really started to deteriorate. "Eventually, he just felt miserable," Janet says. John ended up in hospital and when he came out, John and the family decided together it would be best for him to go into a long-term care home. "When my dad was in the long-term care home we were still able to spend time with him every day."

The palliative care doctor continued to follow John while he was in the long-term care home. He died a month later. "My dad and our family were extremely grateful and felt very well-supported by the palliative care we received," Janet says.

# Palliative care at the end of life

Patients can begin to receive palliative care, also known as hospice palliative care, any time after a diagnosis with a potentially life-limiting illness. The palliative care approach aims to provide comfort and dignity for patients and their families by addressing their physical, psychological, social, spiritual and practical needs, including their expectations, fears and hopes for the future. When patients receive palliative care earlier, they may have a better quality of life throughout their illness, which can span months or years even if it ends their life.[93]

Of the approximately 95,000 people who died in Ontario between April 2014 and March 2015, more than 54,000 received some form of palliative care in their last year of life. For the purposes of the data presented in this chapter, patients were considered to have received palliative care if they received any care that was identified in their medical records as palliative, or if they were designated in their records as being at the “end of life.”

These patients form the group referred to in this chapter as “palliative care patients.” The palliative care they received could have been provided, on just one occasion or more, by any health care provider such as a doctor, hospital, long-term care home or provincially funded home care agency. The group does not include patients who received palliative care that was not captured in medical records as being palliative or end-of-life care.

Nearly half of the 54,000 people who received palliative care first began receiving it during their last month of life. Palliative care is particularly complex at the end of life. Patients at this stage and their families face immense physical and emotional challenges, and count on the health system to be there for them to support all of their needs.

**Note:** This chapter focuses on palliative care services received in the last month of life by Ontario patients who died between April 1, 2014 and the end of March 2015. It includes patients who, on at least one occasion during their last year of life, received care identified as palliative in their medical records, or received end-of-life designation. Throughout the rest of this chapter, we refer to this group of people as “palliative care patients.”

One limitation of this analysis is that it does not include patients who received palliative care that was not captured in medical records as being palliative or end-of-life care. For more information on the analysis, see the online Technical Appendix.

## Home care services

Palliative care patients in Ontario can receive government-funded home care services, which include nursing care, personal support services, therapies, dietetics, social work and access to specialized equipment, such as hospital-style beds. They can also receive palliative-specific home care services designed for the special needs of patients, such as more hours of care per week or psychological counselling.

Studies have shown that patients who received palliative-specific home care were 50% less likely to die in hospital,[94] less likely to visit the emergency department, less likely to be admitted to hospital, and more satisfied with their care.[95]

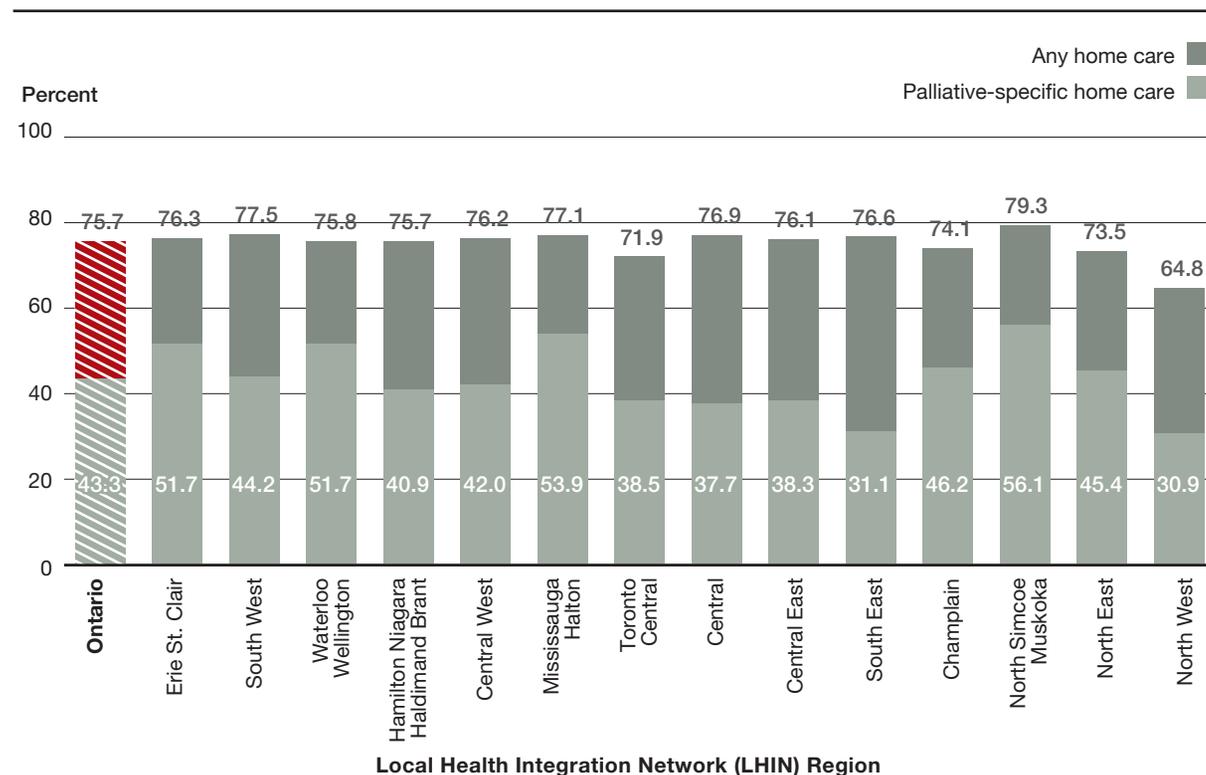
## Findings and variations across Ontario

About three-quarters, or 75.7%, of palliative care patients in Ontario who were residing in the community during their last month of life received at least one home care service in that period (Figure 8.1). Less than half, or 43.3%, of palliative care patients received one or more palliative-specific home care services in the last 30 days of life (Figure 8.1).

The proportion of patients who received palliative-specific home care services varied by region in Ontario, from 30.9% in the North West LHIN region to 56.1% in the North Simcoe Muskoka LHIN region (Figure 8.1). Some of the regional variation may be linked to differences in available resources or difficulties in providing services to patients spread out over a wide geographic area.

FIGURE 8.1

**Percentage of palliative care patients who received home care (any or palliative-specific) in their last 30 days of life, in Ontario, by LHIN region, 2014/15**



Data source: Continuing Care Reporting System, Discharge Abstract Database, Home Care Database, National Ambulatory Care Reporting System, National Rehabilitation Reporting System, Ontario Health Insurance Plan, Registered Persons Data Base, provided by the Institute for Clinical Evaluative Sciences  
 Note: For the sake of clarity throughout the chapter, we refer to the group of 54,000 patients who received palliative care as "palliative care patients." Palliative describes the type of care, not the patient.

### **i** Indicator: Home care

This indicator measures the number of palliative care patients living in the community during their last 30 days of life who received at least one home care service or palliative-specific home care service during that time.

## Did you know?

The proportion of palliative care patients who received at least one palliative-specific home care service during their last month of life was lowest among patients who lived in the poorest neighbourhoods, at 39.0% in 2014/15, and highest among patients who lived in the richest neighbourhoods, at 46.3%.[96]

### Home visits by a doctor

Under Ontario's publicly funded health system, patients can receive visits from doctors in their homes, where the doctors can provide palliative care services such as monitoring the progression of the patient's illness, exploring treatment options, and managing pain. Home visits by doctors may improve the quality of life for patients nearing the end of life and have been shown to reduce the number of unplanned visits to the emergency department.[97]

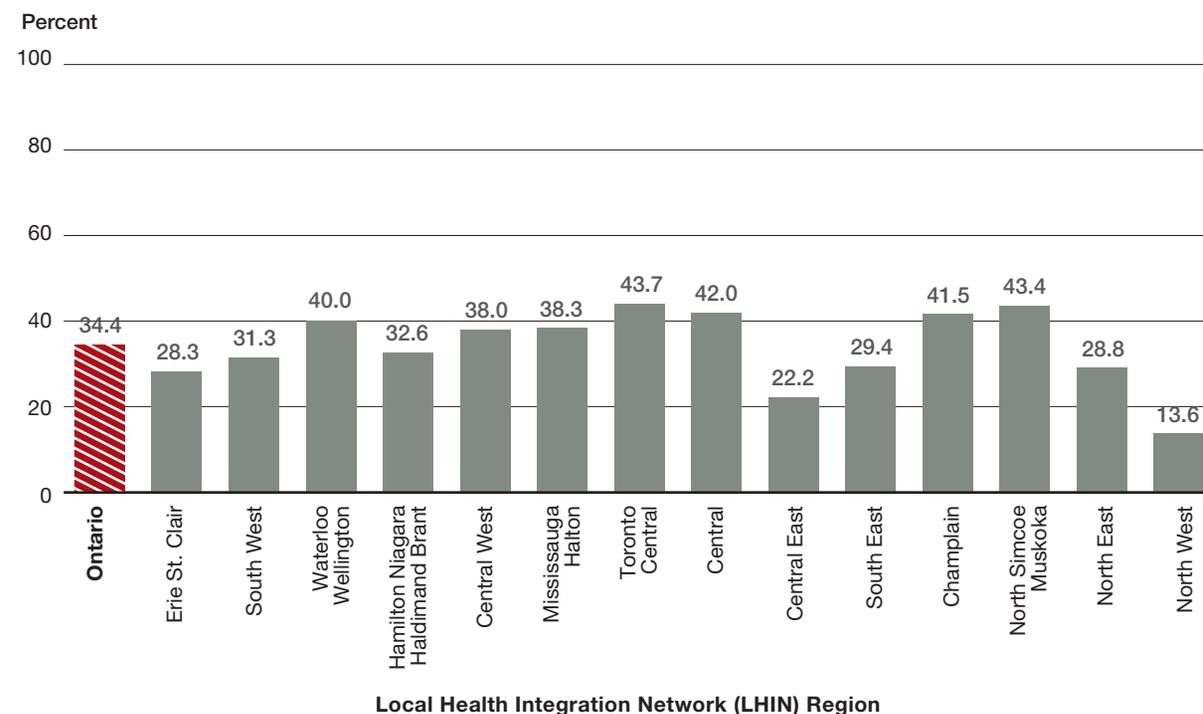
### Findings and variations

Just over one-third, or 34.4%, of palliative care patients in Ontario received a doctor home visit in the last month of life (Figure 8.2).

The proportion of palliative care patients who received such a doctor visit varied by region, ranging from 13.6% in the North West LHIN region

FIGURE 8.2

Percentage of palliative care patients who had at least one home visit by a doctor in their last 30 days of life, in Ontario, by LHIN region, 2014/15



Data source: Continuing Care Reporting System, Discharge Abstract Database, Home Care Database, National Ambulatory Care Reporting System, National Rehabilitation Reporting System, Ontario Health Insurance Plan, Registered Persons Data Base, provided by the Institute for Clinical Evaluative Sciences  
 Note: For the sake of clarity throughout the chapter, we refer to the group of 54,000 patients who received palliative care as "palliative care patients." Palliative describes the type of care, not the patient.

to 43.7% in the Toronto Central LHIN region (Figure 8.2). Some of the regional variation may be related to the difficulty involved for doctors in getting to patients spread over wide geographic areas. There are no data available on home visits for palliative care by nurses, nurse practitioners or other types of providers, which may be common in some areas.

### **i** Indicator: Home visits by a doctor

This indicator measures the percentage of palliative care patients who received at least one home visit from a doctor in the last 30 days of life.

## Did you know?

Palliative care patients who live in the poorest neighbourhoods are less likely than those who live in the richest neighbourhoods to receive a home visit by a doctor during their last month of life. In 2014/15, 29.4% of palliative care patients in the poorest neighbourhoods had such a visit, compared to 40.2% of palliative care patients living in the richest neighbourhoods.[96]

### Unplanned visits to the emergency department

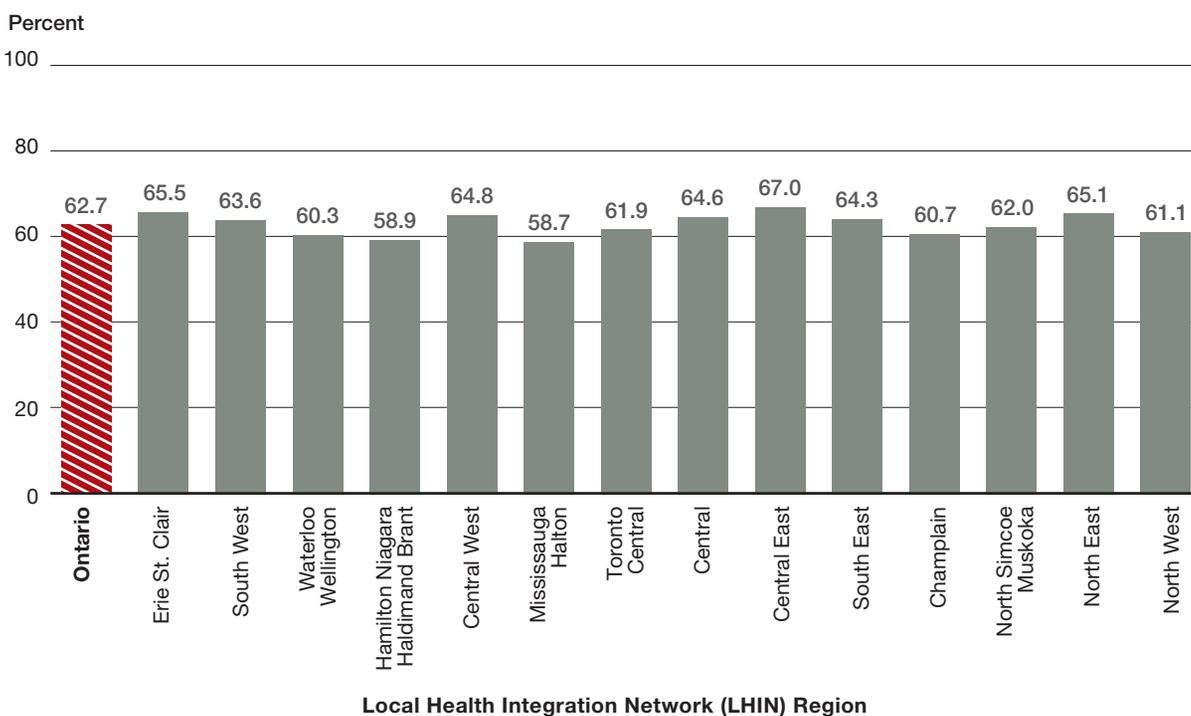
When patients receiving palliative care make unplanned visits to a hospital emergency department, it can be an indication they did not receive proper care in the community. There are times when these visits are appropriate or unavoidable, but transitions between care settings — for example, from home to hospital — can be very upsetting and disruptive for patients at the end of life and their caregivers.[98]

### Findings and variations

In 2014/15, nearly two-thirds, or 62.7%, of palliative care patients in Ontario had at least one unplanned visit to a hospital emergency department in their last month of life (Figure 8.3).

FIGURE 8.3

Percentage of palliative care patients who had at least one unplanned emergency department visit in their last 30 days of life, in Ontario, by LHIN region, 2014/15



Data source: Continuing Care Reporting System, Discharge Abstract Database, Home Care Database, National Ambulatory Care Reporting System, Ontario Health Insurance Plan, Registered Persons Data Base, provided by the Institute for Clinical Evaluative Sciences

Note: For the sake of clarity throughout the chapter, we refer to the group of 54,000 patients who received palliative care as "palliative care patients." Palliative describes the type of care, not the patient.

The proportion of palliative care patients who had an unplanned emergency department visit varied regionally from 58.7% in the Mississauga Halton LHIN region to 67.0% in the Central East LHIN region (Figure 8.3).

### **i** Indicator: Unplanned emergency department visits

This indicator measures the percentage of palliative care patients who had at least one unplanned visit to a hospital emergency department in the last 30 days of life.

## Location of death

In surveys, most people in Ontario and across Canada say they would prefer to die at home,[99,100] but these preferences do not match the reality, which is that most palliative care patients in the province die in hospital. Many factors affect where someone dies, including caregiver availability, availability of palliative care services, the amount of support available from family and the community, patient preferences (which can change over time), the nature of the illness, and the level of the patient's incapacity at the end of life.[101]

## Findings and variations

Close to two-thirds, or 64.9%, of palliative care patients died in hospital in 2014/15. About a quarter, or 23.5%, died in the community — at home or in a residential hospice, assisted living facility or retirement home — and 11.7% died in a long-term care home.

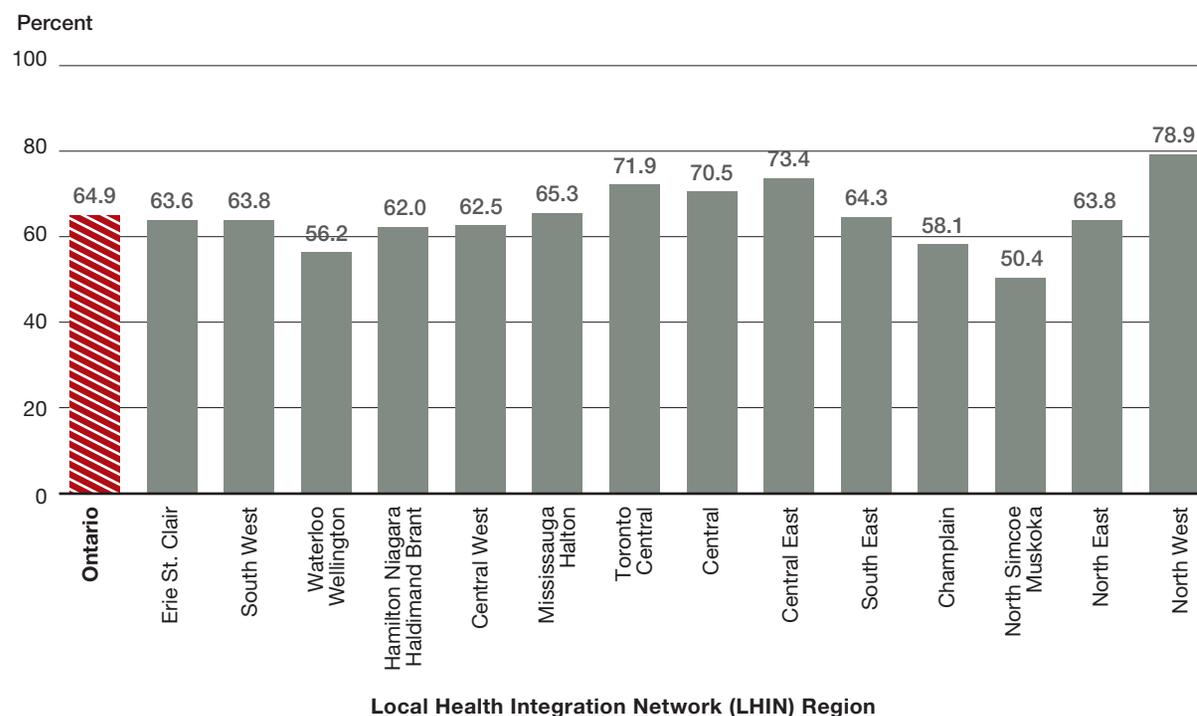
Regional variation in the proportion of palliative care patients who died in hospital ranged from 50.4% in the North Simcoe Muskoka LHIN region to 78.9% in the North West LHIN region (Figure 8.4).

### **i** Indicator: Location of death

This indicator measures the percentage of palliative care patients who died in hospital.

FIGURE 8.4

### Percentage of palliative care patients who died in hospital, in Ontario, by LHIN region, 2014/15



Data source: Continuing Care Reporting System, Discharge Abstract Database, Home Care Database, National Ambulatory Care Reporting System, National Rehabilitation Reporting System, Ontario Health Insurance Plan, Registered Persons Data Base, provided by the Institute for Clinical Evaluative Sciences

Note: For the sake of clarity throughout the report, we refer to the group of 54,000 patients who received palliative care as "palliative care patients." Palliative describes the type of care, not the patient.

## In summary

There is no province-wide data available to precisely evaluate the quality of palliative care in Ontario for patients at the end of their life. It's important to fill this gap in data regarding palliative care in the last 30 days of life, as well as earlier. This data will become even more important as Ontario's population ages, people live longer with chronic disease, and lifespans increase over the next quarter-century, which significantly increases the need for palliative care services.[102] The indicators in this chapter and in Health Quality Ontario's specialized report, *Palliative Care at the End of Life*, lay the foundation for public reporting on this key area of health care and the existing data can be used to draw some conclusions.

Although about two-thirds to three-quarters of people in Ontario and across Canada indicate in surveys that they would prefer to die at home, in reality, nearly two-thirds of palliative care patients in Ontario die in hospital. The majority of palliative care patients also make unplanned visits to the hospital emergency department, possibly indicating a lack of adequate supports in the community. To that end, about one-third of palliative care patients receive one or more home visits from a doctor, three-quarters receive at least one home care service and less than half receive one or more palliative-specific home care services.

The Ministry of Health and Long-Term Care prioritized palliative care in its *Patients First* strategy and an investment in palliative care is part of the Ontario government's 2016 budget. The ministry recently announced that the Ontario Palliative Care Network, a partnership of community stakeholders that includes health service providers, health system planners, patients and their families, is working to advance patient-centred palliative care and develop provincial standards to strengthen services. In addition to being a partner in the Ontario Palliative Care Network, Health Quality Ontario highlights palliative care as a priority in its strategic plan.

# System Integration



In this chapter, we report on the following Common Quality Agenda indicators that provide information about how well the various parts of the health system are working together:

- Follow-up with a doctor after hospitalization for chronic obstructive pulmonary disease or heart failure
- Readmission within 30 days of discharge following hospitalization for medical or surgical treatment
- Hospitalization for conditions that could be managed outside hospital
- Patients in hospital who could be receiving care elsewhere

**Lina, from Toronto, describes her experience looking for a long-term care home for her mother, Malvina, who was in the hospital at the time:**

“Here I was, still caring for my mom, looking after her apartment, all while being off work to look at long-term care homes. It was really depressing. It’s hard to see your parent deteriorate ... There should be a checklist of all the things that need to help transition a patient from a hospital to a long-term care home.”

**Bill, from Chatham, says he sometimes visits the small town’s only emergency department when he can’t get a timely appointment with his family doctor:**

“[The emergency department] gets pretty clogged up. There are about 20 beds back there. You put in a couple of heart patients, a couple of broken limbs, doctors get preoccupied and everything grinds to a halt.”

**Emilie, from Ottawa, says she received a follow-up with her doctor within seven days of being discharged from hospital for a mental health condition, but wishes the hospital and doctor could better coordinate her health information:**

“When you try and connect all of your mental health professionals with your family doctor, it doesn’t work well ... Whenever I see my family doctor, I have to give an update on changes in medications, changes in services and generally what’s going on. I think they should be communicating on their own.”

# Integrating care to benefit patients

The Ontario health system is complex and patients often need to cross over between the various organizations and individuals that provide care. Whether that transition is smooth or not, especially at key points in the patient's care journey, can affect a patient's health. Beyond the standard of treatment provided by individual hospitals or medical professionals, quality of care also depends upon the ability of the system as a whole to work well together. There must be links between the system's parts to support patients appropriately as they move, for example, from their family doctor to a specialist or from a rehabilitation facility to home.

Some of those key points of transition involve hospital care. While the indicators we report on in this chapter may appear hospital-focused, they speak as well to the care provided outside hospital doors. For example, readmissions to hospital within 30 days are counted at the hospital level, but they are also an indicator of the quality of care patients receive after discharge. While in some cases a readmission may simply reflect the worsening of the patient's condition, in others it may reflect on how well the patient and family were prepared for discharge, on the level of follow-up care and support received in the community, or on the effectiveness of communication between the hospital and other care providers in the community.

Indicators that speak to system integration are not only presented in this chapter. Other indicators in *Measuring Up*, such as home care patients with low to moderate care needs who entered a long-term care home or the palliative care indicators, also reflect integration in the health system. This is an area where more work is needed both in terms of measurement and capacity, to have truly integrated care.

## Follow-up after hospitalization for chronic obstructive pulmonary disease or heart failure

For patients admitted to the hospital for chronic obstructive pulmonary disease (a lung disorder) or heart failure, seeing a family doctor or a specialist shortly after being discharged from hospital can help prevent readmissions.[103] These patients benefit from having the opportunity after being discharged to meet with a doctor to ask questions and discuss any problems they might be having.

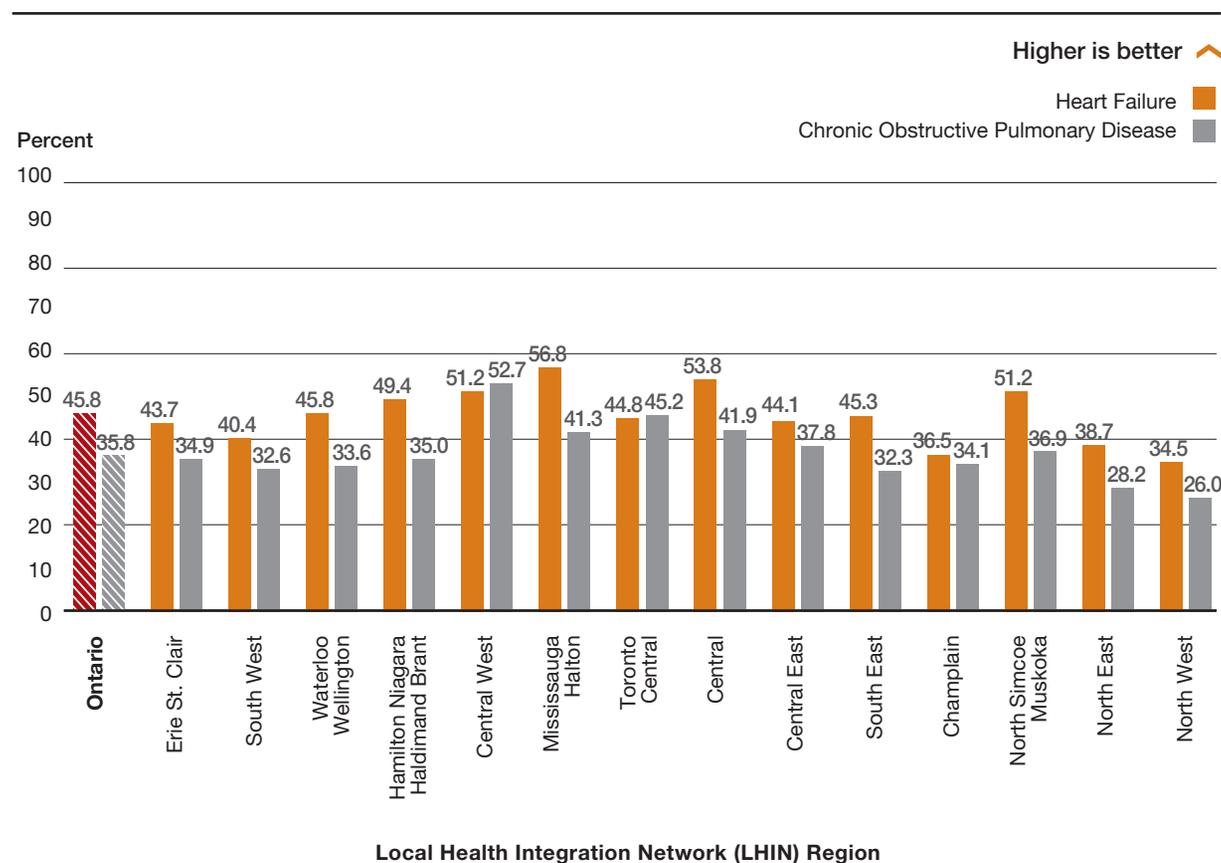
Without a follow-up with a doctor within seven days, patients may be more likely to suffer complications[103] that could result in a return to hospital – which would be not only a stressful situation for the patient and family, but also possibly an unnecessary use of hospital resources. In 2012, the patients most likely to be readmitted to hospital in Canada were those discharged from hospital after treatment for heart failure, 21% of whom were back within 30 days of discharge, or treatment for chronic obstructive pulmonary disease, of whom 19% returned within 30 days.[104]

### **i** Indicator: Follow-up after hospitalization for chronic obstructive pulmonary disease or heart failure

This indicator measures the percentage of patients who were seen by a family doctor or specialist within seven days of discharge after being hospitalized for chronic obstructive pulmonary disease or heart failure.

FIGURE 9.1

Percentage\* of patients who saw a family doctor or specialist within seven days of discharge after hospitalization for chronic obstructive pulmonary disease or heart failure, in Ontario, by LHIN region, 2014/15



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

## Findings and variations

In 2014/15, less than half of patients hospitalized for chronic obstructive pulmonary disease or heart failure saw a doctor within seven days of discharge. This proportion has been stable in recent years.[105]

Among the patients who saw a doctor within seven days after discharge, a small proportion saw a specialist related to their condition — 5.9% of chronic obstructive pulmonary disease patients who saw a doctor within seven days saw a respiratory specialist, and 12.6% of heart failure patients who saw a doctor within seven days saw a cardiologist. Among the rest, 75.7% of the heart failure patients and 81.1% of the chronic obstructive pulmonary disease patients who saw a doctor within seven days saw a family doctor. The remaining saw another type of doctor.[105]

Across the province, there was significant variation in the rate of follow-up with a doctor. In some places the rate was as much as twice that in other regions.

Some of the more remote regions had lower rates of follow-up with a doctor, both for patients with chronic obstructive pulmonary disease and for those with heart failure. For example, 26% of patients discharged after being hospitalized with chronic obstructive pulmonary disease were seen by a doctor within seven days in the North West LHIN region, compared to 52.7% in the Central West LHIN region (Figure 9.1).

Gaps between follow-up rates in different regions of the province were slightly narrower for patients leaving the hospital after a stay to treat heart failure. The North West and Champlain LHIN regions had the lowest rates in Ontario for follow-up with a doctor — 34.5% and 36.5% respectively. These were approximately 20 percentage points lower than in the Mississauga Halton LHIN region, where 56.8% of patients visited a doctor within seven days of discharge after hospitalization for heart failure (Figure 9.1).

## Did you know?

Among family doctors surveyed in Ontario:

- 71% say they always, or often, receive notification when their patient is discharged from hospital.
- 54% say that, on average, it takes up to four days to receive patient information for follow-up after hospital discharge.[106]

## Hospital readmission of medical or surgical patients

Sometimes patients have to be hospitalized again shortly after being discharged from a previous hospitalization. Such an event is referred to as a readmission and is not always avoidable. A readmission may be needed if the patient's condition is getting worse. Readmission may also indicate the quality of care the patient received in the hospital or in the community after leaving the hospital was inadequate in some way.

### Did you know?

Unplanned hospital readmissions cost the health system \$1.8 billion in Canada in 2010/11.[107]

## Findings and variations

Medical patients (patients who receive medical treatment but do not undergo surgery) consistently had higher readmission rates than surgical patients across all of Ontario.

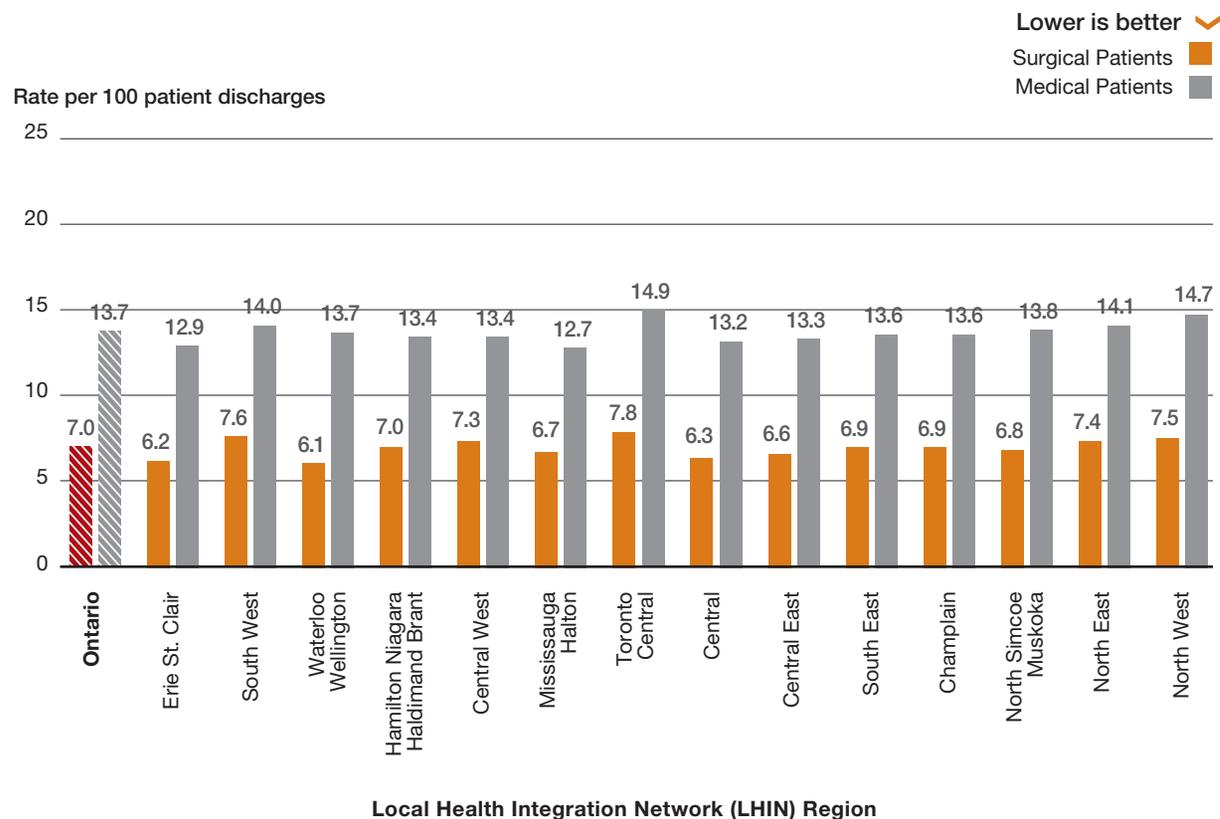
In 2014/15, the provincial hospital readmission rate for medical patients was 13.7 per 100 patient discharges, while the rate for surgical patients was 7 per 100. The rate is expressed as a number per 100 patient discharges because a single patient can have multiple readmissions and discharges from hospital within any given year.

The readmission rates for chronic obstructive pulmonary disease, at 18.5 per 100 patient discharges, and heart failure, at 21.4 per 100, were higher than the rates for medical patients in general. These two conditions represented the two highest volumes of readmissions compared to any other disease group.[108]

In 2014/15, there was slight variation across Ontario in readmission rates for both medical and surgical patients. The Mississauga Halton LHIN region had the lowest readmission rate for medical patients, at 12.7 per 100 patient discharges, followed closely by the Erie St. Clair LHIN region, at 12.9 per 100, while the Toronto Central LHIN region had the highest at 14.9 per 100. For surgical patients, the Waterloo Wellington LHIN region had the lowest readmission rate, at 6.1 per 100 patient discharges, followed closely by the Erie St. Clair LHIN region, at 6.2 per 100, and the Toronto Central LHIN region had the highest at 7.8 per 100 (Figure 9.2).

FIGURE 9.2

### Hospital readmission rates\* within 30 days of leaving hospital for medical or surgical treatment, in Ontario, by LHIN region, 2014/15



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

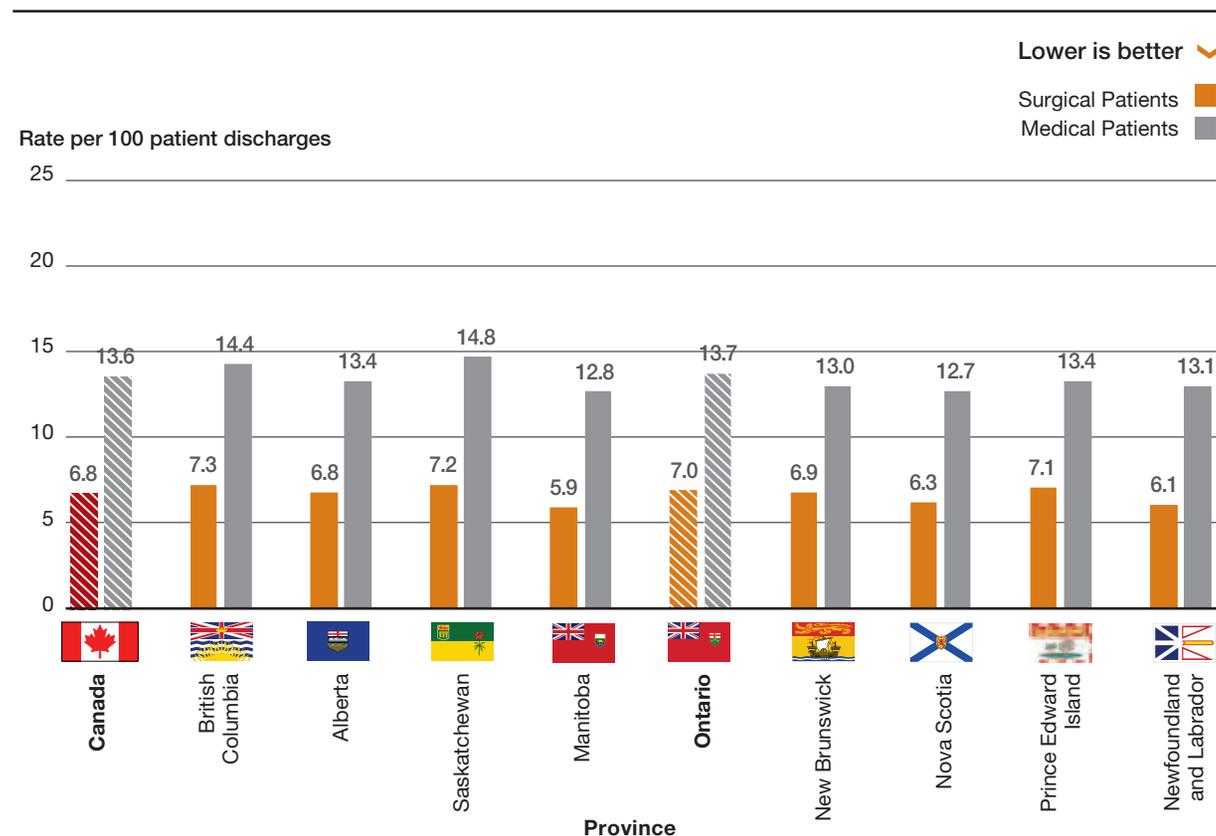
#### **i** Indicator: Hospital readmission within 30 days of discharge after medical or surgical treatment

This indicator measures the rate, per 100 patient discharges, of unplanned returns to the hospital within 30 days of discharge. It includes medical patients who were hospitalized for non-surgical treatment, and patients who had surgery while in hospital.

Nearly 10% of patients who were discharged from hospital were readmitted to hospital within 30 days of their previous admission for any health condition in 2014/15; this represents nearly 75,000 hospitalizations. The readmission rate for medical patients in Ontario, at 13.7 per 100 patient discharges, was very close to the national average of 13.6 per 100. For surgical patients, the Ontario readmission rate of 7 per 100 patient discharges was slightly higher than the national average of 6.8 per 100 (Figure 9.3).

FIGURE 9.3

### Hospital readmission rates\* within 30 days of leaving hospital for either medical or surgical care, by province\*\*, 2014/15



Data sources: Discharge Abstract Database and National Ambulatory Care Reporting System, provided by the Canadian Institute for Health Information.

\*Risk-adjusted. Readmissions are attributed to a region based on where the initial hospitalization occurred, not on where the patient lives.

\*\*Excluding Quebec

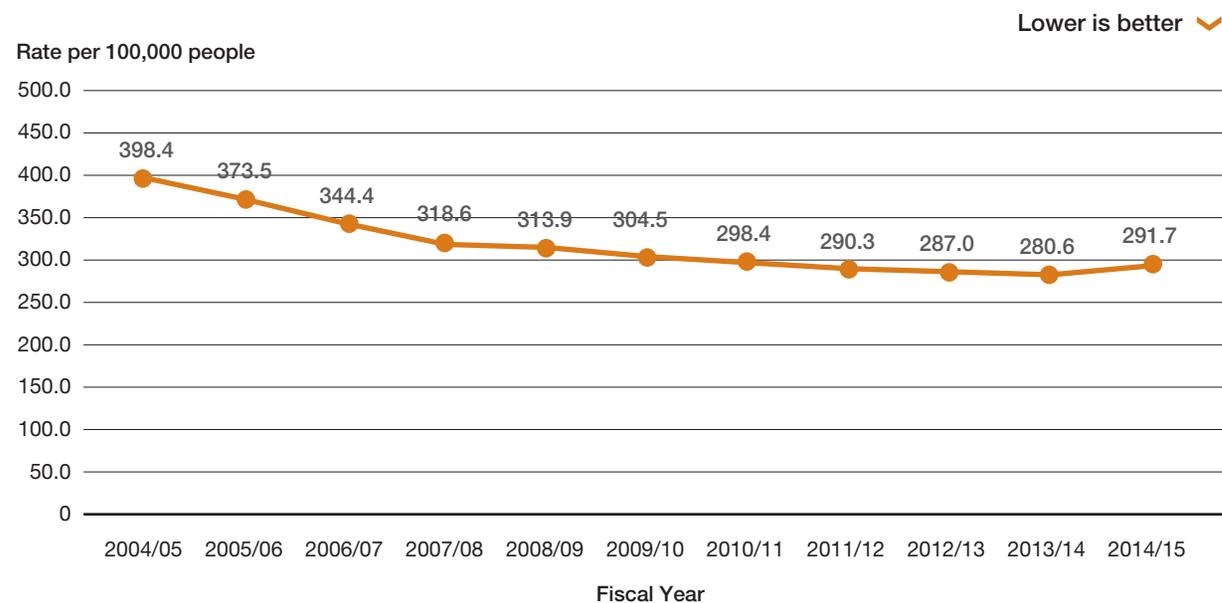
## Hospitalization for conditions that could be managed outside hospital

For some conditions, hospitalization can be avoided if patients receive appropriate care in the community. Those conditions are often referred to as ambulatory care sensitive conditions or conditions that could be managed outside the hospital. Managing health conditions before they become serious enough for someone to need to be hospitalized is better for the patient but also for the system in terms of efficient use of resources.[109] This indicator is affected by the health status of the population since a healthier population will have fewer hospitalizations overall. For example, a population with fewer smokers is likely to have fewer people with lung disease that may require hospitalization.

### Findings and variations

Over the past decade, there has been substantial improvement in the rate of hospitalization for conditions that can be managed outside of hospital, resulting in almost 4,000 fewer unnecessary hospitalizations per year on average. However, 2014/15 marks the first time in a decade that there has been an increase, although small at 4%, in hospitalization for conditions that can be managed outside of hospital (Figure 9.4).

FIGURE 9.4  
Hospitalization rate\* for conditions that can be managed outside the hospital, in Ontario, 2004/05 to 2014/15



Data sources: Discharge Abstract Database, provided by the Institute for Clinical Evaluative Sciences.  
\*Age- and sex-adjusted

### Indicator: Patients hospitalized for conditions that can be managed outside hospital

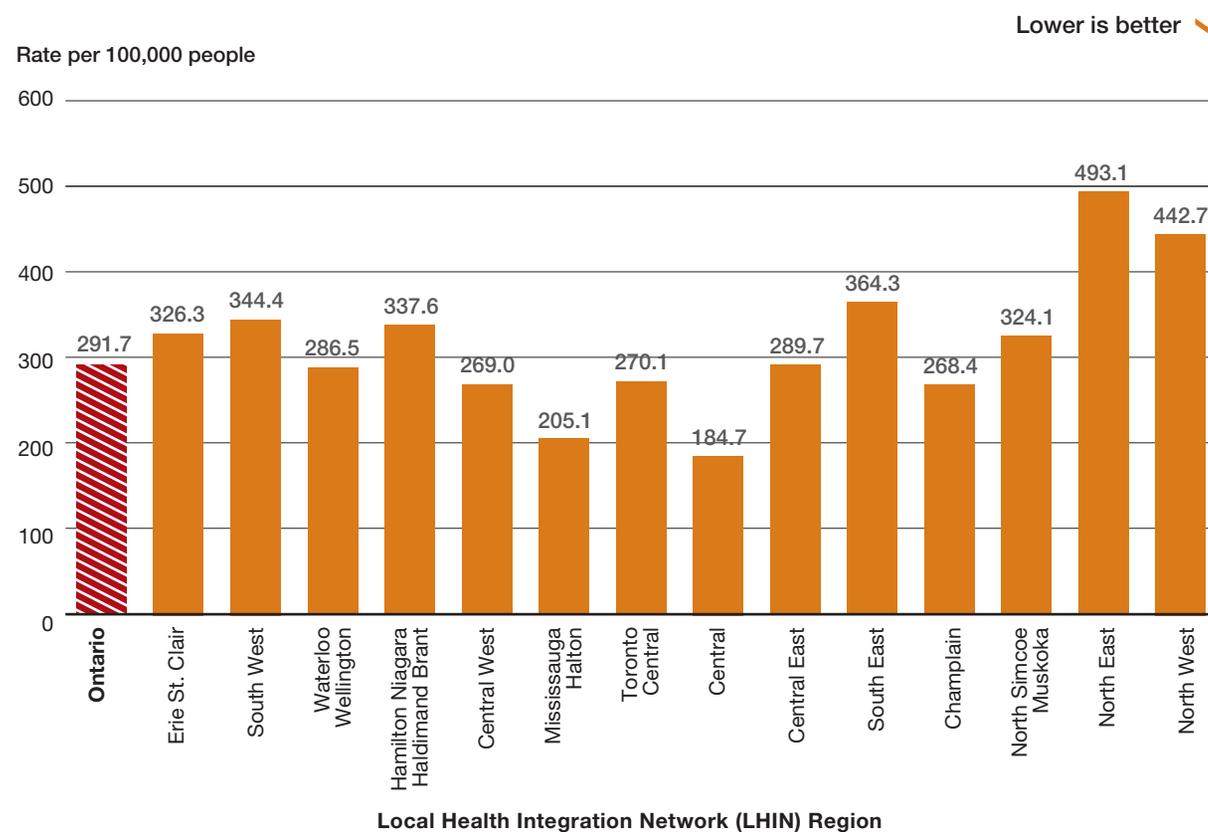
This indicator measures the rate of hospitalization, per 100,000 people under 75, for one of the following conditions that if effectively managed or treated earlier may not have resulted in admission to hospital: asthma, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, angina and epilepsy.

There was also significant variation in the rates across Ontario in 2014/15, with a three-fold difference between the Central LHIN region, 185 per 100,000 people under 75, and the North East LHIN region, at 493 per 100,000 (Figure 9.5).

## Did you know?

People hospitalized for conditions that could be treated outside the hospital make up less than 1% of all Canadians under age 75 but count for 6% of all hospitalized patients and for 11% of all hospital days.[109]

**FIGURE 9.5**  
**Hospitalization rate\* for conditions that can be managed outside hospital, by LHIN region, in Ontario, 2014/15**



Data sources: Discharge Abstract Database, provided by the Institute for Clinical Evaluative Sciences.  
\*Age- and sex-adjusted

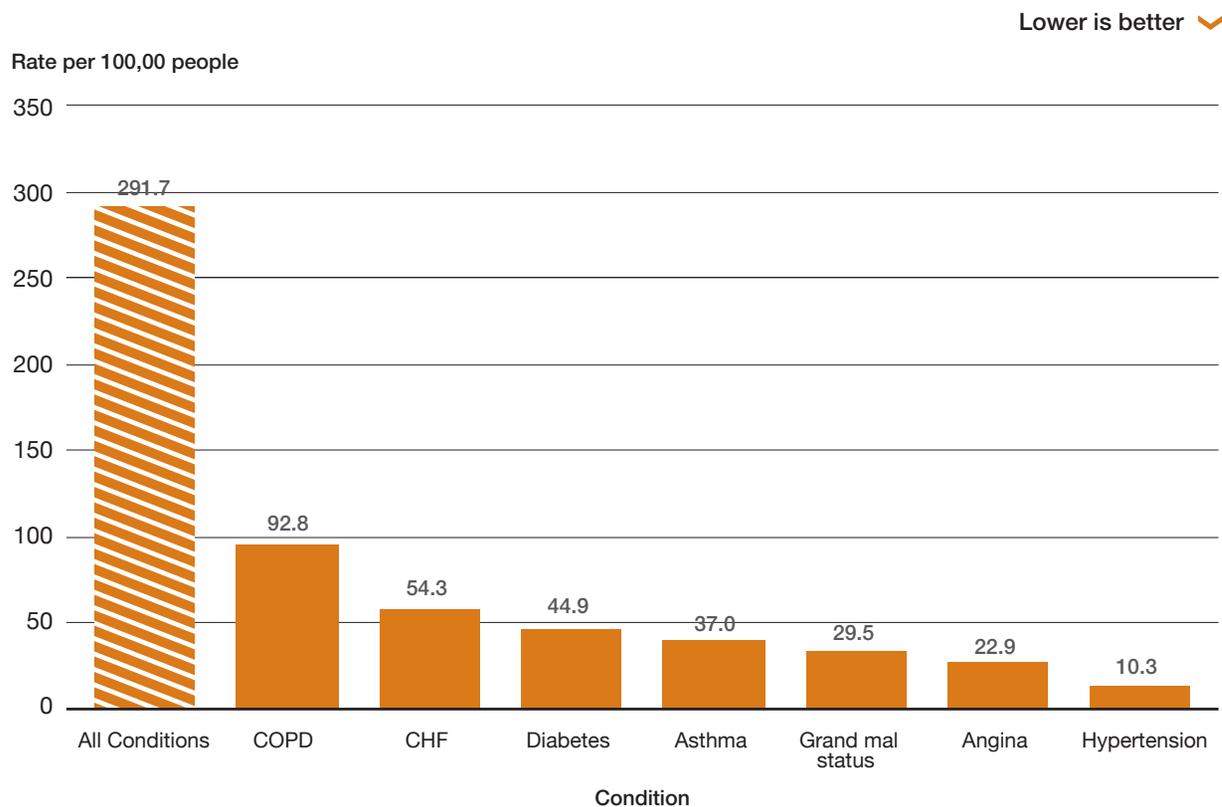
Among the conditions that can be managed outside hospital, chronic obstructive pulmonary disease contributed the highest percentage of admissions, at 31.8%, followed by heart failure at 18.6%, in 2014/15 (Figure 9.6). This equates to 12,457 admissions for chronic obstructive pulmonary disease and 7,278 admissions for heart failure within the year.

## Did you know?

The majority of patients in Ontario hospitals who could be receiving care elsewhere are waiting for long-term care or home care.

- 55% were waiting for long-term care and 32% for home care in 2014/15.
- Almost 20% of these patients designated “alternate level of care” waited 30 days or longer for care outside the hospital in 2014/15.[110]

**FIGURE 9.6**  
**Hospitalization rate\* for conditions that can be managed outside hospital, by type of condition, in Ontario, 2014/15**



Data sources: Discharge Abstract Database, provided by the Institute for Clinical Evaluative Sciences.  
 \*Age- and sex-adjusted

## Patients in hospital who could be receiving care elsewhere

For the majority of patients, their hospital stay ends when they no longer need the type of care that the bed they occupy is meant to provide. Some, however, may have to stay longer until a place or service that is more appropriate for them is available. In those cases, the patient is identified as requiring an “alternate level of care,” meaning that they could be receiving care elsewhere in a more appropriate setting.

For example, the patient could be waiting in hospital for home care services, a bed in a long-term care home or a bed in a rehabilitation unit. Waiting in a hospital bed when that is not the best place for them can affect the patient: they may lose some ability to perform daily activities, face greater risk of exposure to hospital-acquired infections, and may feel socially isolated.

For the patient, and to ensure a smooth flow of patients across the system, the ideal is to have everyone in the level of care that is most appropriate for them. Measuring what proportion of patients in hospital could be cared for elsewhere can help us see whether there is sufficient capacity and availability of long-term care and home care, as well as rehabilitation, mental health, community and other types of care.

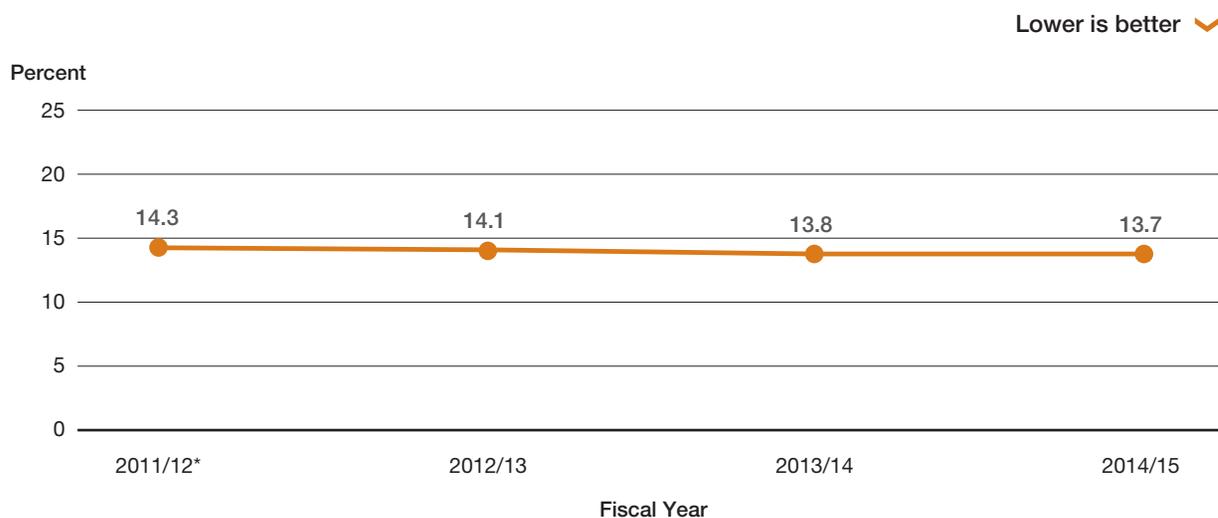
## Findings and variations

Inpatient days are a count of each day an individual hospital bed is occupied by a patient – so two patients each staying five days in the same hospital will add 10 inpatient days to the hospital's total. In the last three years, there has been a decrease in the percentage of inpatient days during which Ontario hospital beds were occupied by patients who could have been receiving care elsewhere, to 13.7% in 2014/15 from 14.3% in 2011/12 (Figure 9.7).

On any day in 2014/15 in Ontario, on average, almost 4,000 inpatient days were being used for patients waiting to receive care elsewhere. The improvement in this number over the past three years works out to about 214 fewer inpatient days being used across the province each day for such patients.

FIGURE 9.7

### Percentage of inpatient days that beds were occupied by patients who could have been receiving care elsewhere, in Ontario, 2011/12 to 2014/15



Data sources: Wait Time Information System and Bed Census Summary, provided by Cancer Care Ontario  
\*Incomplete Fiscal Year: July 2011 - March 2012

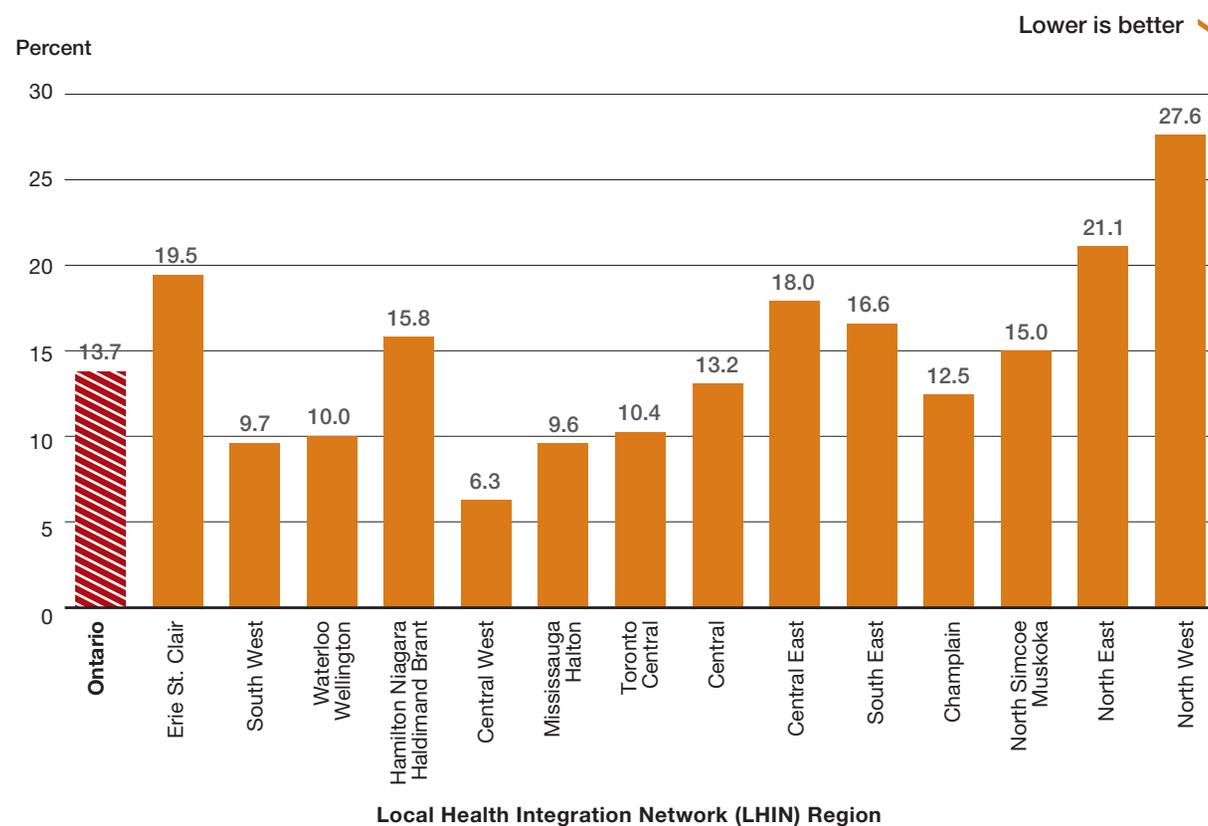
#### Indicator: Hospital beds occupied by patients who could be receiving care elsewhere

This indicator looks at “inpatient days” – a count of the days individual hospital beds were occupied by patients – to measure the percentage of days hospital beds were occupied by patients identified as requiring an alternate level of care, meaning they did not require the type of care for which the bed was designated. Patients designated as requiring alternate level of care are usually waiting for a place elsewhere in the health system that provides the type of care they need, such as a long-term care home or home care.

In 2014/15, there was a significant difference between regions across Ontario in the number of days hospital beds were occupied by patients waiting for a different level of care elsewhere in the health system. For example, only 6.3% of inpatient days in the Central West LHIN region were being used for such patients, compared to more than four times that percentage, or 27.6%, in the North West LHIN region (Figure 9.8).

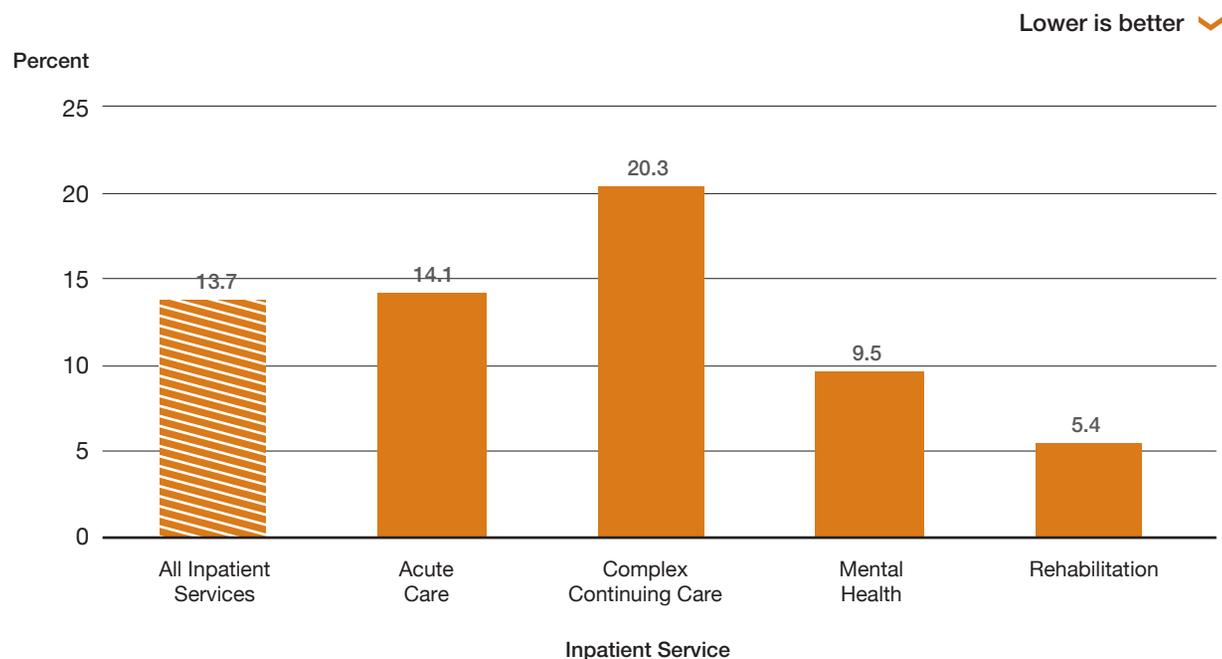
FIGURE 9.8

**Percentage of inpatient days that beds were occupied by patients who could have been receiving care elsewhere, in Ontario, by LHIN region, 2014/15**



Data sources: Wait Time Information System and Bed Census Summary, provided by Cancer Care Ontario

**FIGURE 9.9**  
**Percentage of inpatient days that beds were occupied by patients who could have been receiving care elsewhere, by inpatient service, in Ontario, 2014/15**



Data sources: Wait Time Information System and Bed Census Summary, provided by Cancer Care Ontario

The rate at which inpatient days are used for patients designated alternate level of care – the alternate level of care rate – may vary according to the care designations of the beds the patients are waiting in. These designations include:

- Acute care beds: Care for patients who are waiting for or have already undergone surgical procedures, or who are receiving acute medical care
- Complex continuing care beds: Specialized care for patients with medically complex conditions
- Mental health beds: Specialized services for patients with addictions or mental illness
- Rehabilitation beds: Specialized care to improve or maintain physical, psychological or cognitive functioning

In 2014/15 in Ontario, 5.4% of inpatient days in rehabilitation beds, 14.1% in acute care beds and 20.3% in complex continuing care beds were used for patients requiring an alternate level of care (Figure 9.9).

## In summary

There are signs of improvement in the health system as a result of focused efforts and system-wide strategies. For example, the percentage of inpatient days during which hospital beds were occupied by patients who could have been receiving care elsewhere decreased over the last three years. Still, every day in Ontario, there were on average almost 4,000 inpatient days used for patients waiting in hospital to receive care elsewhere. The hospitalization rate for conditions that could be managed outside of hospital was better in 2014/15 than it was 10 years earlier, but the last year of data indicated a slight increase over the previous.

The rates of hospital readmission after discharge for medical or surgical treatment, and of follow-up with a doctor after hospitalization for chronic obstructive pulmonary disease or heart failure, have remained stable, although they showed significant variation across the province. Both indicators point to the need to improve the transition to care in the community after leaving hospital. Less than 50% of patients hospitalized for chronic obstructive pulmonary disease or heart failure saw a family doctor or specialist within seven days of discharge.

While significant challenges remain, more health care providers focus on collaborative efforts to make system improvements as indicated in the Quality Improvement Plans they submit to Health Quality Ontario. Also, more Health Links have been established and are now working together to provide coordinated health care to patients with multiple complex conditions.

# Health Workforce

In this chapter, we report on the following Common Quality Agenda indicators for the health workforce:

- Nurse workforce
- Doctor workforce
- Lost-time injury rates

Photo of Sarah taken by Roger Yip. Please see her story on the next page.

## Real-World Experiences

### Outreach nurse on the go: Sarah's story

**“I don’t even know if I’d be alive if it wasn’t for you coming here,” a bedridden man told his nurse, Sarah Logan, after one of her visits to the room in a shared house he hadn’t left in a year.**

A typical day for Sarah, an outreach registered nurse within an integrated mental health and primary care clinic, sees her jumping in her car to visit clients at their homes in Durham Region. She might be reviewing medications and doing pain assessments at their bedside. She could be connecting clients, via the provincial telemedicine network, with a pain doctor, physiotherapist, pharmacist, psychiatrist, foot care provider or nutritional counsellor, or consulting with their primary care provider about her concerns.

Sarah often works alongside her partner, a case manager in the outreach program, who helps coordinate services, including improving financial situations, obtaining housing and navigating the health system. The partners always meet prospective clients together for the first time, at a home or a local coffee shop.

Many of Sarah’s clients have psychiatric disabilities as well as multiple chronic health conditions and “haven’t seen a health

professional in years,” she says. Mostly between 30 to 70 years in age, her clients are often socially isolated, too. “Many of them don’t have families, don’t want them involved, or they live far away,” says Sarah. There are some exceptions: “One client and his family I was really close with. I was at his home with them three times a week doing palliative care until he passed. I was emotional about that case, privately.” For their part, clients’ families appreciate working with Sarah and her colleagues because “they don’t have to tell their stories over and over” to health care professionals, she says.

Sarah, 24, was hired right out of nursing school by the nurse practitioner-led clinic. Having surveyed local community agencies for their need, the clinic asked Sarah to develop an outreach program. “I was absolutely terrified,” she laughs, “but then, as a new grad, I was nervous about any kind of nursing job. It was very cool to create my own job.” That involved researching outreach nursing in Canada and other places, then designing the program, and launching it in late 2015, under the guidance of the clinic leadership team.

Sarah says she loves that her job combines so many types of nursing work. “Sometimes with

mental health, it’s so intense that you have your other skills pushed aside,” Sarah notes, but she gets to do wound care, immunizations, screening for sexually transmitted infections and cancers, medication injections and chronic disease management, as well as supporting the work of mental health nurses. “I know I’m lucky that I get to work to my full scope of practice.”

Working at what she calls “a one-stop shop” for primary care, mental health, community and social services is “phenomenal,” says Sarah. Her colleagues at the clinic include two other registered nurses, two nurse practitioners, three registered practical nurses, as well as Sarah’s partner, the case manager.

The near future includes the clinic working with a housing agency to offer several units for clients in a new building. “The cool thing for me is that they plan on having a nursing office in the building,” Sarah says. “I will be able to be stationed there when assisting and caring for the clients who live there. To keep people out of a hospital, whenever we can, is so important – they are most comfortable in their homes. It’s so rewarding to see our clients in the community. They’re not all thriving - but they’re trying.”

# Working to keep Ontario healthy

Health care workers are the foundation of Ontario's health system. From treating and caring for patients to engaging in research and developing health policies, health care workers perform vital functions. While there are many types of health care providers, the data we focus on are two key categories of professionals — doctors and nurses.

Given the key contributions doctors and nurses make, it is important to have the right mix of these professionals to meet the health care needs of patients, when and where those needs arise.

In this chapter, we look at how many regulated nurses and doctors are practising in Ontario, and as a measure of workplace safety, we also report on health care workers who are injured or become ill on the job.

## Did you know?

Nurses represent the single largest group of health care professionals in Canada, making up almost half the health workforce.[111]

## Ontario's nurse workforce

Nurses provide care to patients both individually and as part of a health care team, with a wide array of services aimed at helping patients achieve optimal well-being. They often work directly with patients' families and caregivers, and can be responsible for coordinating the delivery of care and for supporting patients in their self-care. In addition, nurses work in administration, research, policy and education. Having a sufficient number of nurses available in Ontario communities is therefore integral to providing quality health care, keeping in mind that the right number of nurses 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.

Regulated nurses who are registered with the College of Nurses of Ontario include:

- Registered nurses
- Nurse practitioners
- Registered practical nurses

### **i** Indicator: Nurse workforce

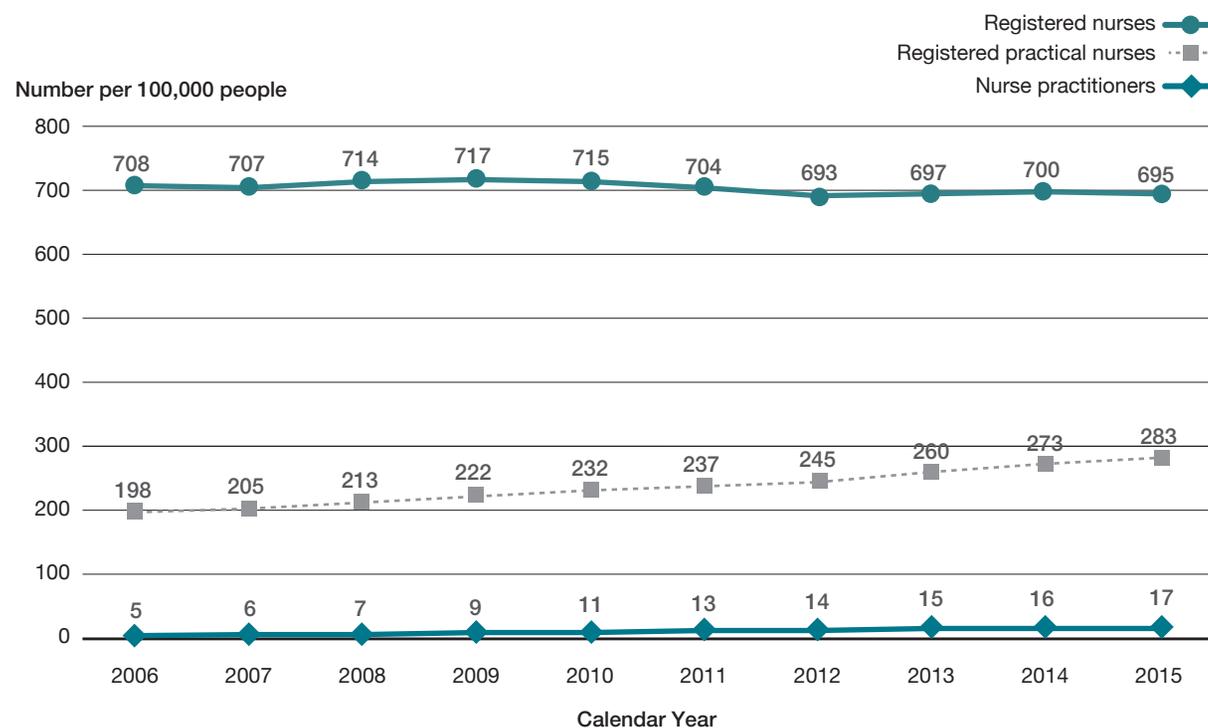
This indicator measures the number of nurses practising in Ontario per 100,000 people. It includes full-time, part-time and casual hours for:

- Registered nurses
- Nurse practitioners
- Registered practical nurses

Note: Full-time - 30 hours or more per week;  
part-time - less than 30 hours per week;  
casual - working on an as-needed basis

FIGURE 10.1

### Number of nurses practising in Ontario per 100,000 people, by nursing category, 2006 to 2015



Data sources: College of Nurses of Ontario Membership Statistics Report 2015; 2006-2014 population estimates, provided by Statistics Canada; 2015 population projection, provided by the Ontario Ministry of Finance

## Findings and variations

The number of registered nurses practising in Ontario per 100,000 people decreased between 2009 and 2012, to 693 from 717, but has remained stable over the last few years (Figure 10.1). The total number of registered nurses in 2015 was 96,007.[112] The total

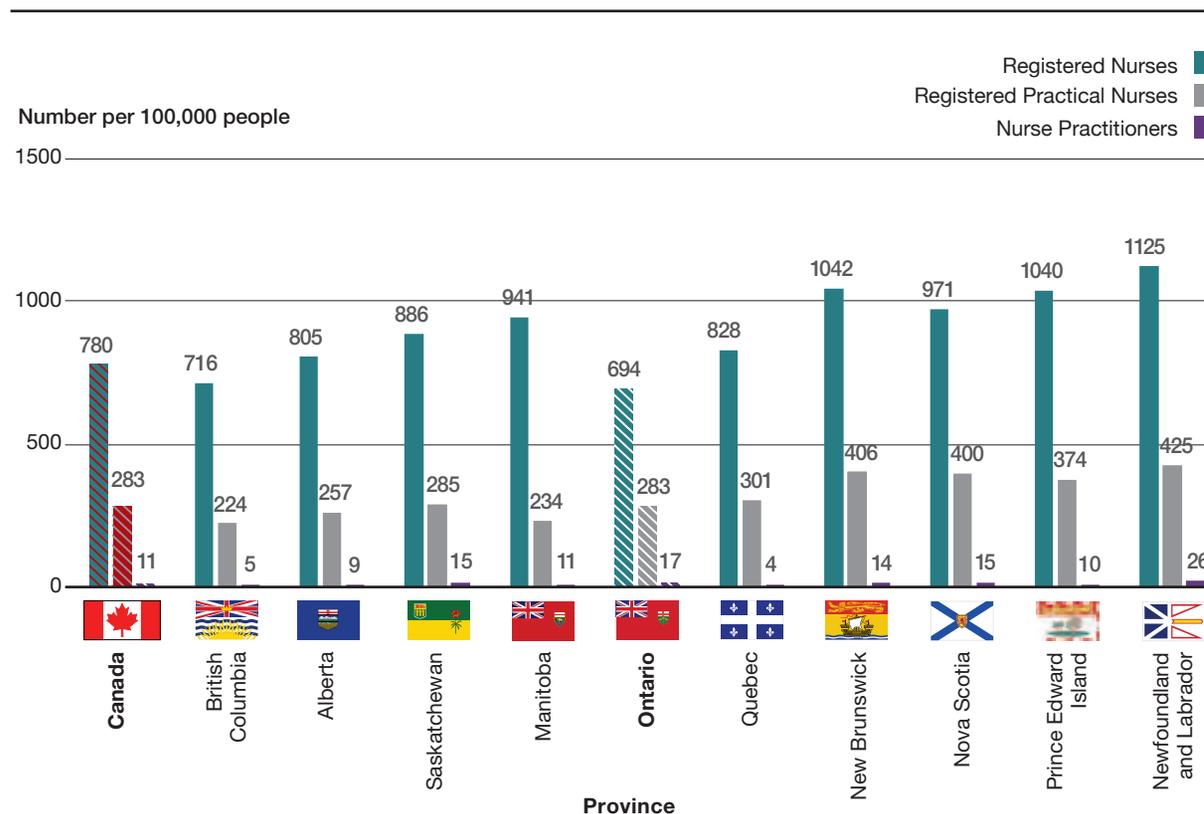
number of registered practical nurses in 2015 was 39,111.[112] The total number of nurse practitioners in 2015 was 2,407.[112] The number of nurse practitioners and registered practical nurses per 100,000 people continued to increase.

## Comparison to the nurse workforce across Canada

Each province has its own legislation and regulations governing nursing practice, as well as its own regulatory body that regulates and grants licenses or registration to nurses. The following table compares the average number of each type of regulated nurse professional in Ontario to their average number in Canada as a whole (Figure 10.2). The data for these comparisons are from the Canadian Institute for Health Information. Although the Institute’s methods are different from the College of Nurses of Ontario’s, its data are used here in order to compare Ontario with other provinces, keeping in mind that the right number of nurses 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.

Nurse Category	Comparison (Ontario & National Average, 2015)
Registered nurses	The number of registered nurses in Ontario per 100,000 people is lower than the national average (Figure 10.2)
Nurse practitioners	The number of nurse practitioners in Ontario per 100,000 people is higher than the national average (Figure 10.2)
Registered practical nurses	The number of registered practical nurses in Ontario per 100,000 people is the same as the national average (Figure 10.2)

FIGURE 10.2  
Number of nurses practising in Canada per 100,000 people, by nursing category and province, 2015



Data sources: Health Workforce Database, provided by the Canadian Institute for Health Information; 2015 population estimates, provided by Statistics Canada

## Ontario's doctor workforce

Doctors perform many important functions, such as evaluating symptoms, making diagnoses and determining with the patient appropriate tests and treatments.

In this chapter, we look at two groups of doctors — family doctors and specialists. Family doctors are typically a patient's first point of contact with the health system for any health issue, and they provide ongoing care to people and their families. Specialists focus on specific areas of care, such as cardiology, which deals with heart conditions, or ophthalmology, which deals with eye problems.

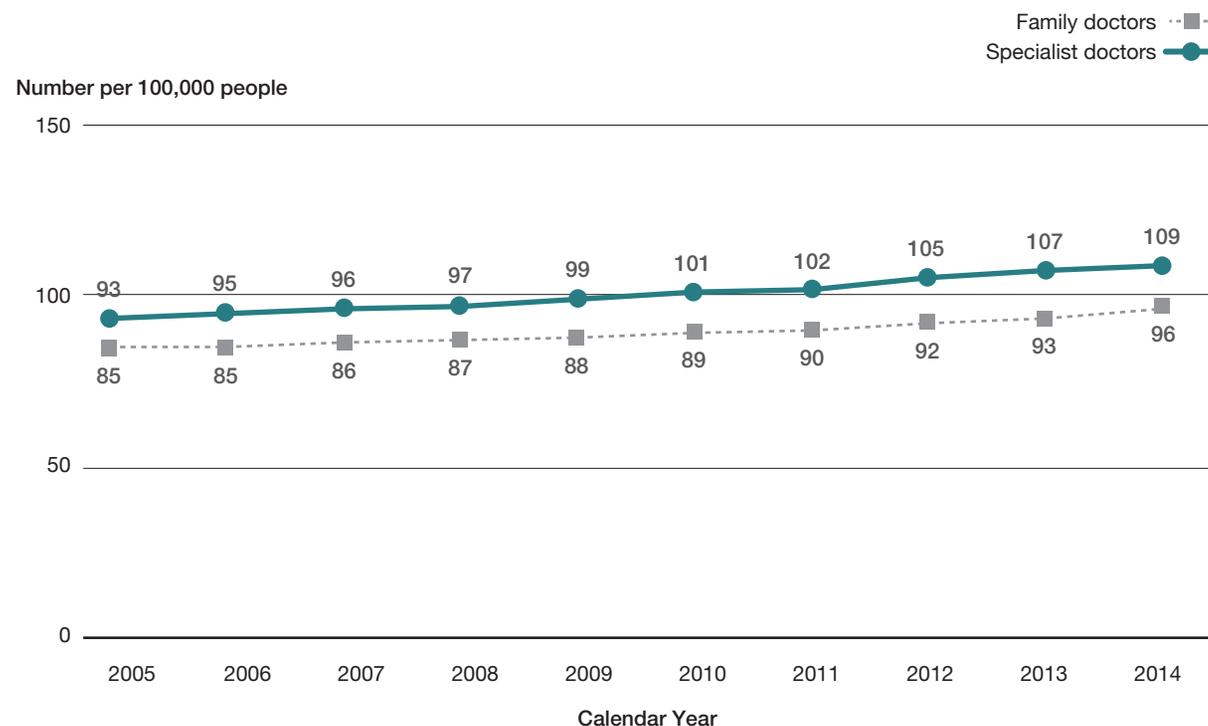
### Findings and variations

The ratio of family doctors and specialists to population in Ontario has continued to increase, with the number of family doctors rising to 96 per 100,000 people in 2014 from 85 in 2005, and the number of specialists climbing to 109 per 100,000 people in 2014 from 93 in 2005 (Figure 10.3).

#### **i** Indicator: Doctor workforce

This indicator measures the number of licensed physicians and specialists practising in Ontario, per 100,000 people. It includes family doctors and specialists practising full-time, part-time or on a casual basis.

FIGURE 10.3  
Number of family doctors and specialists per 100,000 people, in Ontario, 2005 to 2014



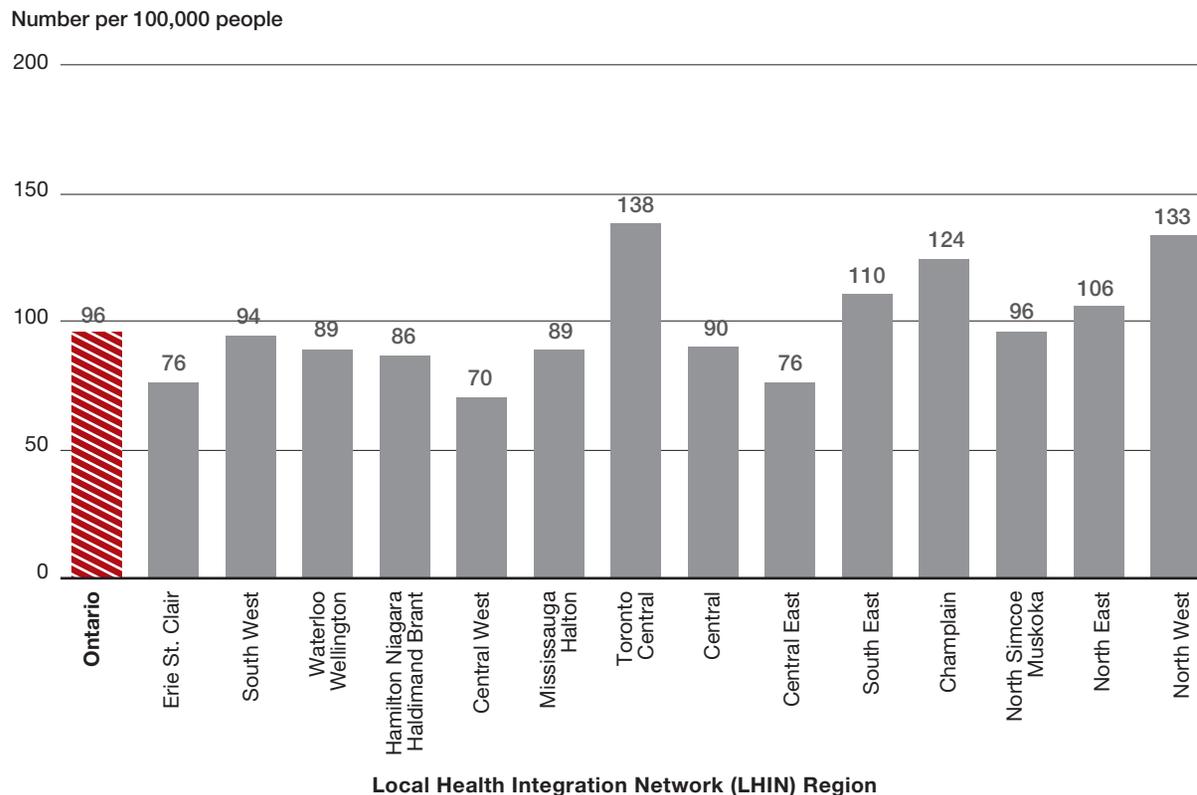
Data sources: Ontario Physician Human Resource Data Centre Physicians in Ontario 2014 report; 2005–2014 population estimates, provided by Statistics Canada

There was wide regional variation in the ratio of family doctors to population in 2014, from a low of 70 per 100,000 people in the Central West LHIN region, to a high of 138 per 100,000 people in Toronto Central LHIN region (Figure 10.4).

## Did you know?

Just over one-quarter of Ontario's doctors received their medical degree outside Canada.[114]

**FIGURE 10.4**  
**Number of family doctors per 100,000 people, in Ontario, by LHIN region, 2014**



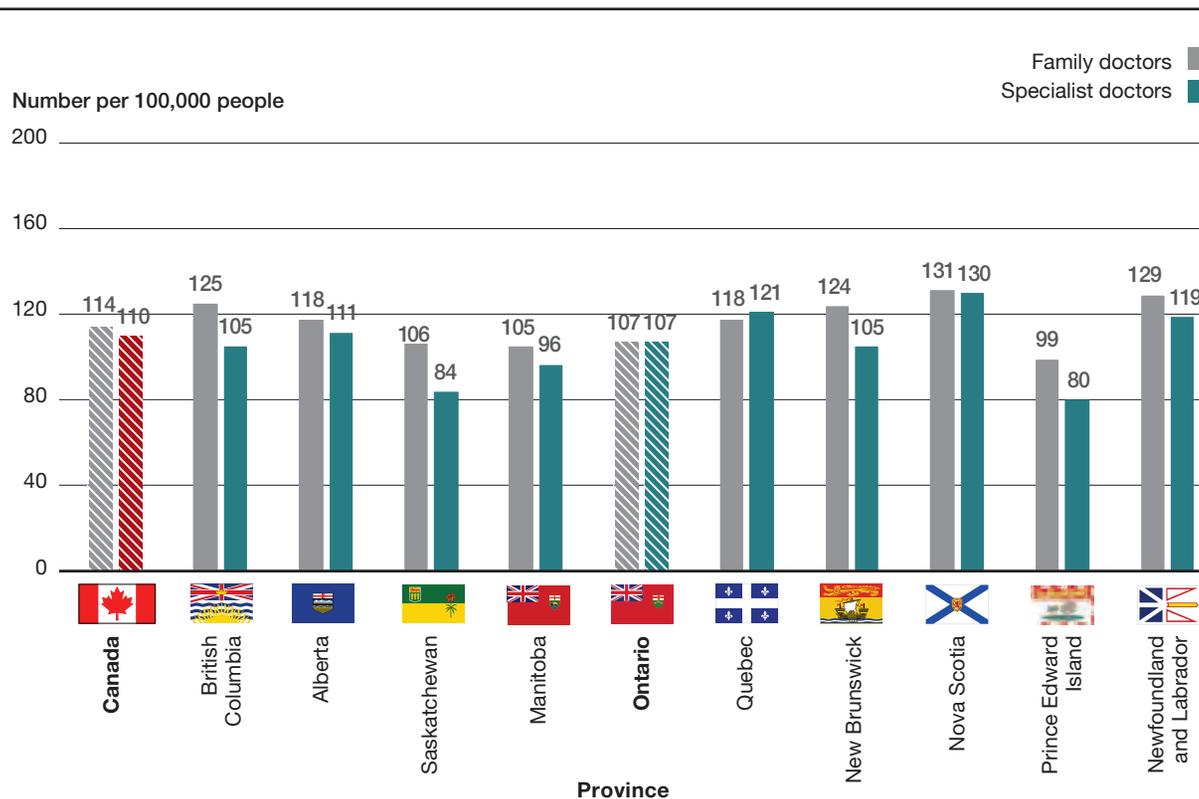
Data sources: Ontario Physician Human Resource Data Centre Physicians in Ontario 2014 report; 2005-2014 population estimates, provided by Statistics Canada

## Comparison to the doctor workforce across Canada

Each province has its own legislation governing the practice of medicine, as well as its own body that regulates and grants licences to doctors. The following table compares the numbers of family doctors and specialists in Ontario to their numbers in other provinces (Figure 10.5). The data for these comparisons are from the Canadian Institute for Health Information. Although the Institute’s methods are different from the Ontario Physician Human Resource Data Centre’s, its data are used here in order to compare Ontario with other provinces, keeping in mind that the right number of doctors or specialists 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.

Doctor Category	Comparison (Ontario & National Average, 2014)
Registered nurses	Ontario sits in the middle compared to the rest of Canada in terms of the number of family doctors per 100,000 people, with more than in three other provinces (Figure 10.5)
Specialists	The number of specialists in Ontario per 100,000 people is in line with the national average, as Ontario has more than in five other provinces (Figure 10.5)

FIGURE 10.5  
Number of family doctors and specialists per 100,000 people, in Canada, by province, 2014



Data sources: Scott's Medical Database, provided by the Canadian Institute for Health Information; 2014 population estimates, provided by Statistics Canada

## Lost time injury rates

Whether they're employed in a hospital, family practice or long-term care home, it is important for Ontario's health workers to be able to provide care in a safe work environment. When a health worker suffers a work-related injury or illness that results in time off work, lost wages or a permanent disability, their employer is required to file a "lost-time injury" claim and report it to the Workplace Safety and Insurance Board.

## Findings and variations

Overall in Ontario, the rate of lost-time injuries per 100 full-time equivalent (FTE) health care workers has decreased to 1.2 injuries per 100 FTE workers in 2015 from 2.0 per 100 in 2006 (Figure 10.6).

In the hospital sector, the rate of lost-time injury decreased to 0.9 injury per 100 FTE workers from 1.8 per 100 over the same period (Figure 10.6).

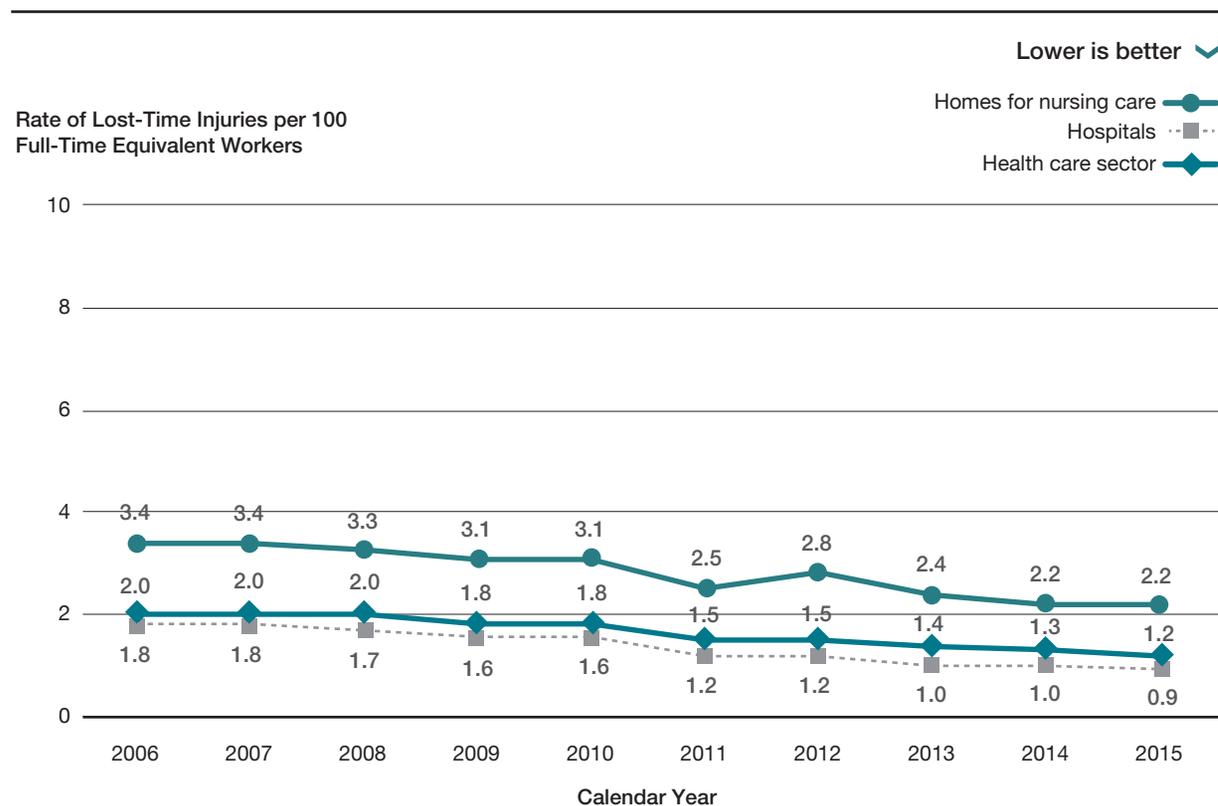
In homes for nursing care (long-term care homes), the rate of lost-time injury decreased to 2.2 injuries per 100 FTE workers from 3.4 per 100 over the same period (Figure 10.6).

## Did you know?

The most common types of work-related injuries in Ontario's health care sector are strains and sprains.[115]

FIGURE 10.6

### Lost-time injury rates for the health care sector overall, homes for nursing care and hospitals, in Ontario, 2006 to 2015



Data source: By the Numbers: 2015 WSIB Statistical Report (Schedule 1), provided by the Workplace Safety and Insurance Board

### **i** Indicator: Lost-time injury rate

This indicator measures the number of allowed lost-time injury and illness claims made by health care workers, per 100 full-time equivalent (FTE) workers, per year.

## In summary

As Ontario's population grows each year, health care planners work to ensure there are nurses and doctors in place to meet the health care needs of people and communities.

The data show that over the past decade in Ontario, the number of registered practical nurses per 100,000 people has increased by 43% and the number of nurse practitioners per 100,000 people has increased by 250%. The numbers of family doctors and specialists per 100,000 people have also increased over the last 10 years, by 13% and 17% respectively.

Overall lost-time injury rates for health care workers in Ontario have decreased to 1.2 injuries per 100 full-time equivalent workers in 2015 from 2.0 per 100 in 2006.

Among Canada's provinces, Ontario, British Columbia and Alberta had the lowest numbers of registered nurses per 100,000 people in 2015. However, Ontario had one of the highest ratios for nurse practitioners.

Ontario was in the middle of the pack compared to the rest of Canada in terms of the ratio of family doctors to population. Ontario had more family doctors per 100,000 people than three other provinces and more specialists per 100,000 people than five other provinces in 2014.

# Health Spending

In this chapter, we report on the following Common Quality Agenda indicators for health spending in Ontario:

- Total health spending per person
- Health spending on drugs per person
- Prescription medication insurance

Photo of Mary and Brian taken by Roger Yip. Please see their story on the next page.

## Real-World Experiences

### No magic wand: Brian and Mary's story

Brian has to take 12 prescription medications three times a day to be healthy. He struggles to keep track of them all. “Many days I see a batch I’ve missed in the pill case,” says Brian, who lost a third of his left brain with a stroke a decade ago that still affects his cognition. Keeping the pills down is hard, too, since he doesn’t eat much. Brian, 62, has no teeth, can’t afford dentures and most of the time doesn’t have money for groceries. The only way Brian can afford all those prescription drugs (which cost about \$900 a month) is because he’s on the Ontario Disability Support Program.

Brian’s medications were not always covered by the provincial disability program. At first, the maximum daily dose of an anticonvulsant prescribed to him was not covered, and Brian could not pay for it out-of-pocket. “Our amazing pharmacist scrambled to get us free samples for months,” says Mary, Brian’s common-law wife.

Soon after his stroke, Brian suffered a grand mal seizure at home that left him unconscious. It was the start of daily seizures that continue to this day. After three years of tinkering with medications, doctors managed to control the seizures enough for him to walk safely. “I should be dead at least like six times by now,” says Brian, counting them off on his fingers, including bouts with two types of cancer, and meningitis twice.

Brian’s wiry arms and legs shake even when he’s at rest. His bearded cheeks tremble in the lead-up to his daily seizures, and his head sometimes wobbles so violently he says strangers stare. On his feet, Brian’s 6-foot-1, 140-pound frame tilts dangerously. “I’m afraid of the stairs to our bedroom,” he says of the rental in downtown Hamilton that he shares with Mary. Anything further than a block, Brian has to be supported by someone or use his motorized scooter.

“I used to be so tough,” says Brian, his face twisting in an effort not to cry, but his large, brown eyes well up. “When I met Mary, I told her: ‘I’ll take care of you.’”

Mary, 53, and Brian have been together since 2001. They had a few months of dating while Brian was healthy and working full-time as an industrial technician, a job he’d loved for years. He suddenly started acting strangely, symptoms of then-undiagnosed hepatitis C, which he says cost him his dream job – the best one he’d had since dropping out of grade 11 – and leaving the workforce for good. He was 48. Four years later, Brian suffered the stroke. He had to relearn to walk before he could go home, and spent a year relearning to speak and swallow properly.

Mary, who is also severely underweight, has fibromyalgia, depression, and problems with her joints, requiring three of her own prescription medications for these conditions. As Brian’s dependent, her medications are covered. Since dropping out of Grade 9, Mary worked for decades

full-time at low-paying retail and call centre jobs (her best year she brought in \$20,000), while also taking care of her elderly mom who lived with them for years. Mary stopped working in late 2015 due to muscle pain and fatigue from the fibromyalgia.

“We can’t go on like this.” They don’t have enough money to pay for utilities or to buy enough groceries. The couple used to regularly enjoy the Hamilton waterfront a few blocks away – he on the scooter, she on bicycle – but pain and depression keep them from venturing out much these days. “We used to be very social,” Mary recalls. “After work, we’d go see our friends at the pub around the corner – you know, busy lives, fun lives.”

Mary and Brian both say the hardest part of their diminished lives is dealing with strangers’ assumptions about them. “They peg Brian’s shaking and weaving as being alcoholic or a drug user,” says Mary. “I’ve been called anorexic. One time I shot back, ‘No, I’m just hungry.’”

Brian admits that much of the time, he is angry and depressed. “I hate this, I hate it so much,” he says.

Mary takes Brian’s hand and holds it silently for a moment. “I know we’re blessed in many ways, that much of what we need is covered,” she says. “But we’re hungry, and scared we’ll lose power, and we’re exhausted from all the health issues all these years. I don’t know how many times I’ve wished I had a magic wand and could go poof – all better.”

# How Ontario spends its health care dollars

The amount of money spent on the health of people living in Ontario, and how it is allocated between health services, are important elements of health system performance. Expenditure decisions depend on many factors, such as the health status of the people living in Ontario, how health care delivery is structured and managed, and what other societal needs are competing for the dollars that could go to health care.

But expenditures alone do not tell us how well the health system is doing. Health spending should not be looked at in isolation, but rather together with services provided, health care quality, health outcomes and patient experience.

Possible financial barriers to obtaining health care — such as low income and lack of prescription medication insurance — are also an important aspect of health spending and health system performance.

This chapter examines how much is spent on health care in Ontario, how it is spent, how Ontario spends on health in comparison to other provinces and comparable countries, and what groups of people in Ontario are sometimes not able to spend as they need to on their own health.

## Did you know?

Health has the largest share of government spending in Ontario, accounting for almost 40% of the total budget.[116]

## Total health spending per person

Maintaining and improving the health of people living in Ontario is expensive; in fact, health accounts for almost 40% of the provincial budget, the largest share.[116] A standard way to measure health expenditures is by tracking the average amount of money spent per person in a year.

## Findings and variations

In recent years, total health spending in Ontario grew slowly and steadily — to \$4,089 per person in 2010 from \$3,624 in 2004, measured in constant 1997 Canadian dollars (Figure 11.1).

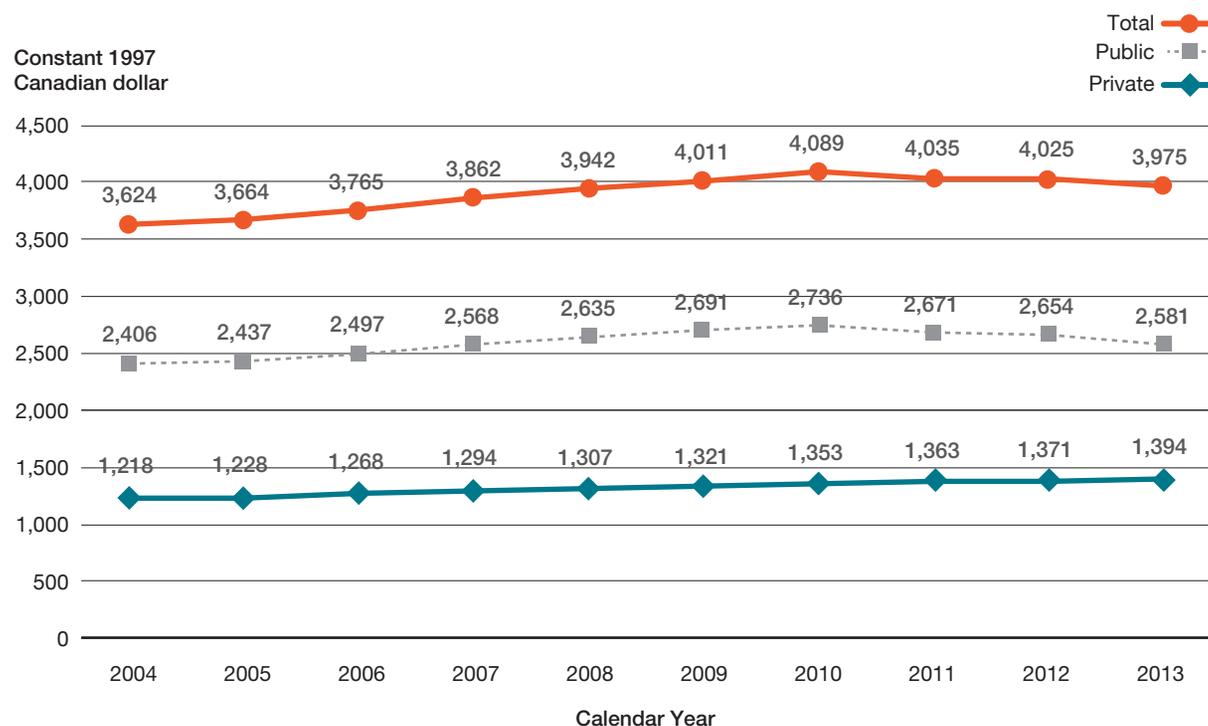
Spending decreased slightly by 2013 to \$3,975 per person, in constant 1997 Canadian dollars, in a trend that has been observed in many countries belonging to the Organisation for Economic Co-operation and Development.[117]

## Public-sector and private-sector spending in Ontario

The public sector in Ontario has consistently accounted for approximately 65% of total health spending per person.[118] Public-sector health spending includes expenditures by provincial, federal and municipal governments, as well as agencies such as the Ontario Workplace Safety and Insurance Board.

Accounting for 35% of total health spending per person, private-sector spending includes expenditures on drugs, devices and services that people pay for out of pocket or through private insurance coverage. Since 2004, private-sector health spending has been relatively stable (Figure 11.1).

FIGURE 11.1  
Total health spending per person, by sector (public or private), in Ontario, 2004 to 2013



Data source: Natinal Health Expenditure Database, Canadian Institute for Health Information

Note: Total health spending per person in Ontario, overtime is presented in constant 1997 Canadian dollars in order to standardize for both population growth and inflation, which varied during the last decade.

### **i** Indicator: Total health spending per person

This indicator measures how much money is spent, on average, on health care for each person living in Ontario. It looks at health spending within the public sector and within the private sector.

### What health expenditures are used for

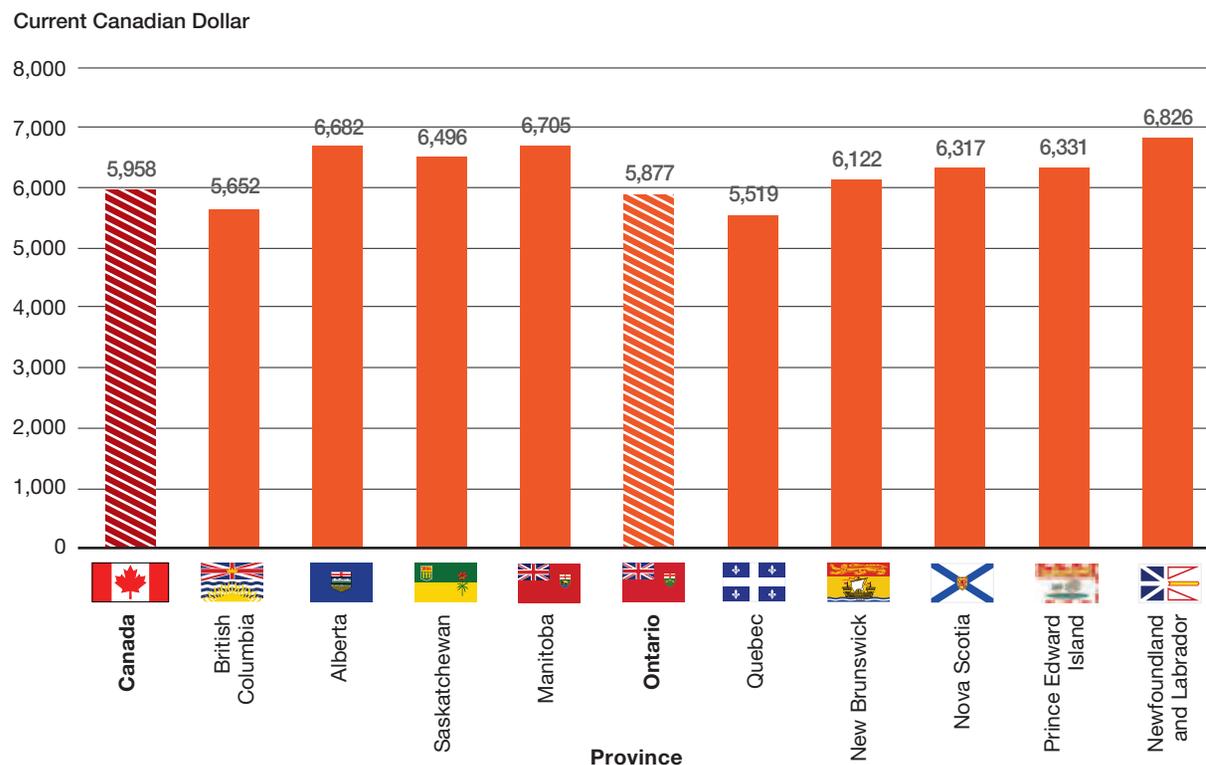
More than a quarter, or 28%, of all health expenditures (public and private) in Ontario are spent on hospital services, while 16.6% pay for drugs (both over-the-counter drugs and prescription medications purchased in drugstores or other retail stores) and 16.2% pay for doctors' services. These top three expenditure categories together make up more than 60% of all health spending in Ontario.[118]

### How Ontario compares within Canada

While Figure 11.1 presents total health spending per person in Ontario, in constant 1997 Canadian dollars to allow for meaningful comparison over time, Figure 11.2 presents it in current Canadian dollars so that the value is expressed in "today's" dollars as per the year reported. Total health spending per person - including both public and private spending - in Ontario was \$5,877 in 2013, very close to the Canadian average of \$5,958 (Figure 11.2).

Across Canada in 2013, health spending per person was highest in Newfoundland and Labrador at \$6,826, Manitoba at \$6,705 and Alberta, at \$6,682. At \$5,877 per person, Ontario's health spending rate sits in the middle group. British Columbia and Quebec lower, at \$5,652 and \$5,519 per person, respectively.

FIGURE 11.2  
Total health spending per person, current dollars, in Canada, 2013



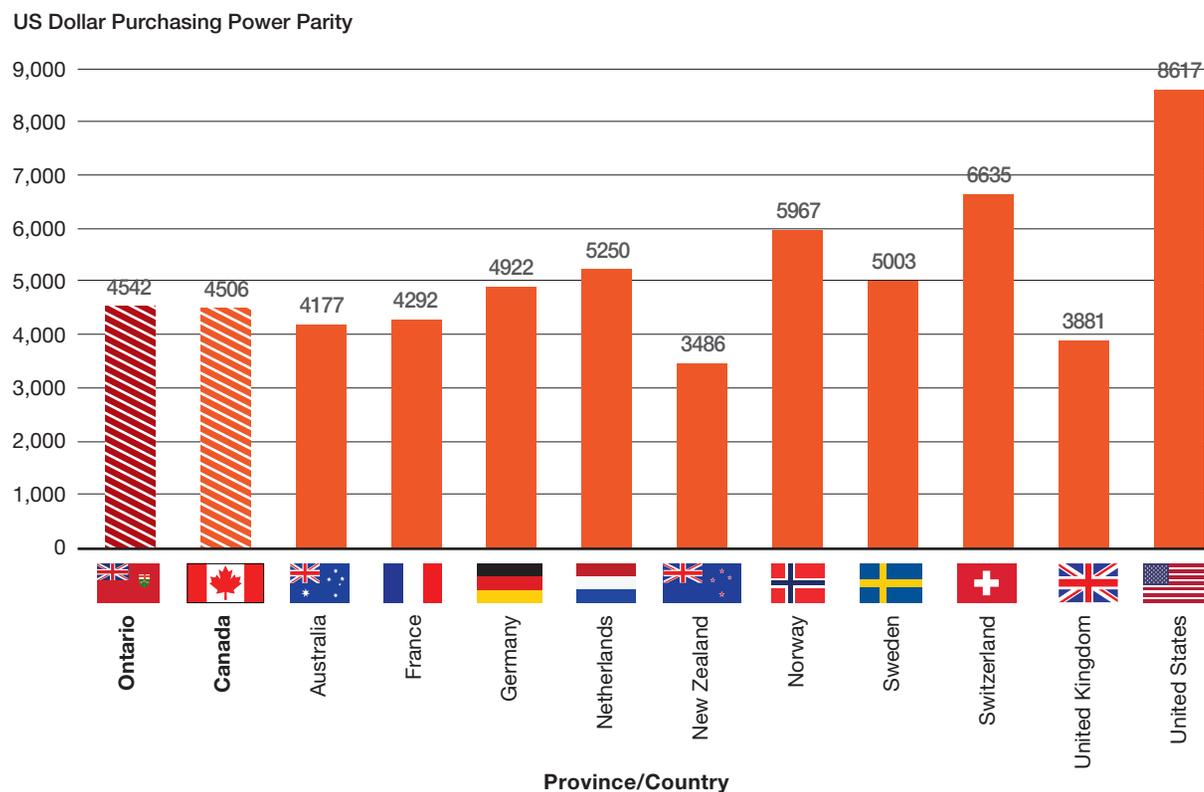
Data source: National Health Expenditure Database, Canadian Institute for Health Information  
 Note: The health spending per person (public and private) in Canada shown here is the sum of provincial/territorial total spending divided by the sum of provincial/territorial population based on the most recent revised population estimates.

### How Ontario compares internationally

To make international comparisons meaningful, each country's spending is given in US dollars and adjusted using a method called purchasing power parity that seeks to eliminate differences in price levels between countries. Ontario's health spending per person, at US\$4,542, falls in the middle range of spending among 11 countries in the Organisation for Economic Co-operation and Development, including Canada.

The United States is by far the top spender, at US\$8,617 per person. The second-highest is Switzerland, at US\$6,635 per person (Figure 11.3). However, the amount spent does not necessarily reflect overall health system performance. Some other countries that spend less are viewed as having higher-performing health systems. For example, in one survey with a heavy emphasis on primary care, the United Kingdom ranked first in terms of health system performance among the 11 countries, while placing tenth in total health spending per person.[19]

FIGURE 11.3  
Health spending per person in Ontario, Canada, and internationally, 2013



Data source: National Health Expenditure Database, Canadian Institute for Health Information; OECD health Statistics 2016, Organisation for Economic Co-operation and Development.

Note: Each country's spending is given in current US dollars and adjusted using a method called purchasing power parity to convert the different currencies.

## Health spending on drugs per person

Prescription drugs are an important component of health care for many people living in Ontario. Drugs were one of the fastest-growing categories of health spending between 2001 and 2013, and were among the top three health spending categories. The cost of drugs (both over-the-counter drugs and prescription medications purchased in drugstores or other retail stores) accounts for 16.6% of total health spending in Ontario.

### Findings and variations

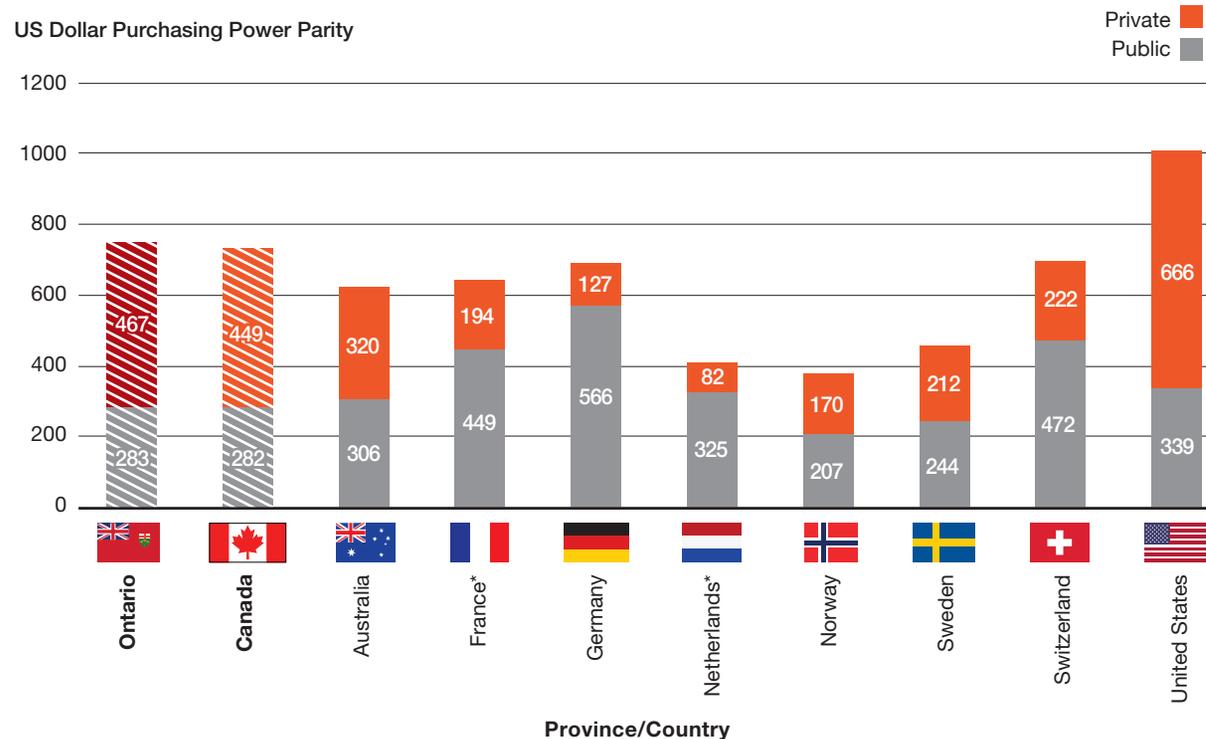
In 2013, Ontario was the second-highest among comparable countries in expenditures on drugs, at US\$750 per person, behind only the United States, which spent slightly more than US\$1,000 per person (Figure 11.4).

About 62% of drug expenditures in Ontario were made by the private sector which includes both out of pocket expenses and private health insurance expenses. While the private sector spent US\$467 per person on drugs, the public sector spent US\$283 per person on drugs (Figure 11.4). Public drug plans in Ontario, as in Canada generally, cover approximately 30% of the population. That raises the question of equitable access to prescription medications.

## Did you know?

More than one third, or 34%, of adults living in Ontario reported taking two or more prescription medications on a regular or ongoing basis in 2013.

FIGURE 11.4  
Health spending on drugs per person in Ontario, Canada, and internationally, 2013



Data source: National Health Expenditure Database, Canadian Institute for Health Information; OECD Health Statistics 2016, Organisation for Economic Co-operation and Development.  
Note: Each country's spending is given in US dollars and adjusted using a method called purchasing power parity to convert the different currencies. \*The data, in addition to pharmaceutical expenditure, also include other medical non-durable goods.

### **i** Indicator: Health spending on drugs per person

This indicator measures how much money is spent per person living in Ontario on prescription medications and over-the-counter drugs purchased in drugstores or other retail stores.

## Prescription medication insurance

The ability to afford medication is an important aspect of care, especially among people with multiple chronic conditions.[125] For people without insurance coverage, the cost of prescription medications can represent a significant out-of-pocket expense.

Recent immigrants, and people living in lower-income neighbourhoods often don't have prescription medication insurance. That means they sometimes can't afford the drugs needed to prevent or treat a health condition. Not taking a needed prescription medication can have serious consequences, which may include needing more health care from a family doctor or specialist, or even hospitalization.[126]

## Findings and variations

In 2014, three-quarters of people 12 to 64 years old living in Ontario, or 74.7%, reported having prescription medication insurance. That coverage rate had remained stable since 2008.[127]

The one-quarter of people who did not have prescription medication insurance most often fell into certain groups including: people with the lowest level of education, recent immigrants, and people living in the poorest neighbourhoods.

### **i** Indicator: Prescription medication insurance

This indicator measures the percentage of people living in Ontario, aged 12 to 64, who reported having prescription medication insurance.

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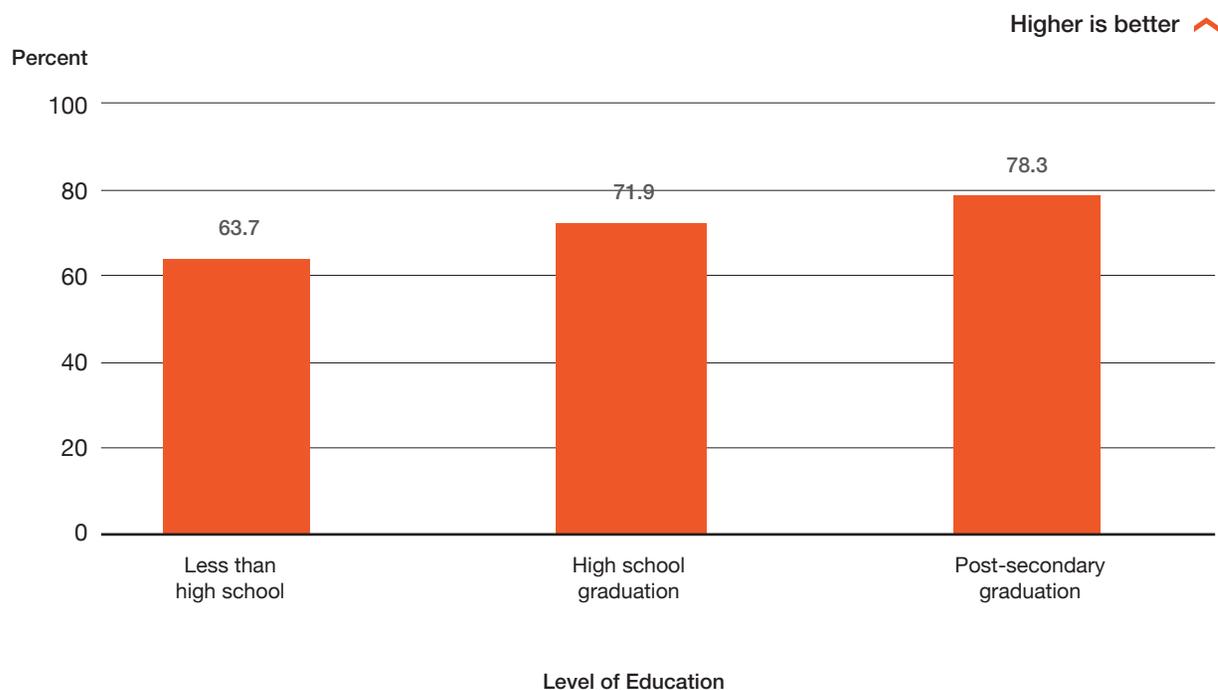
### People with less education

People with a lower level of education were less likely to have prescription medication insurance.

The biggest difference in 2014 was found between people who didn't graduate from high school and those who graduated from post-secondary education. For people aged 25 to 64, the proportion with prescription medication insurance was 23% greater among post-secondary graduates, at 78.3%, than among those who didn't graduate high school, at 63.7% (Figure 11.5).

FIGURE 11.5

**Percentage of survey respondents, aged 25 to 64, who report having prescription medication insurance, in Ontario, by level of education, 2014**



Data source: Canadian Community Health Survey, 2014 provided by the Institute for Clinical Evaluative Sciences

### People with lower incomes

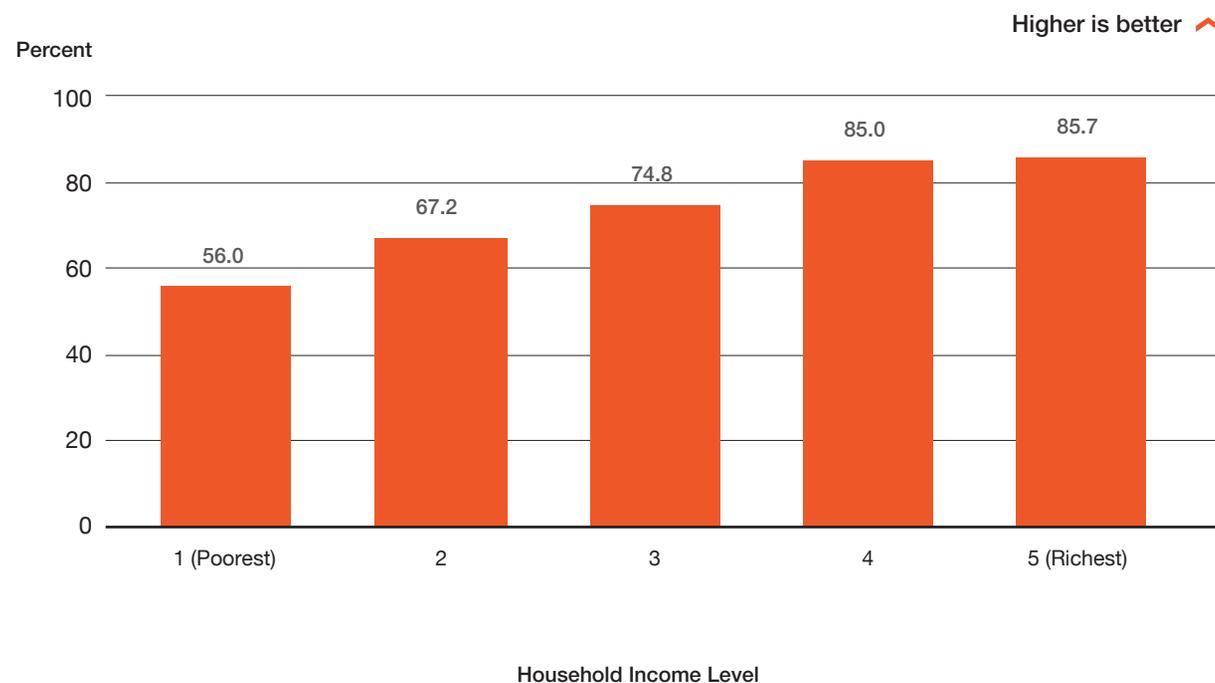
There was a significant gap in prescription medication insurance coverage between people with the lowest incomes and people with the highest incomes.

Among those aged 12 to 64 in Ontario, 53% more people living in the richest neighbourhoods had prescription medication insurance, at 85.7%, compared to people living in the poorest neighbourhoods, where 56% had it (Figure 11.6).

The data used for these calculations included those people under 65 years of age who were part of Ontario's Trillium Drug Program. Despite the availability of this program, which assists people with high prescription medication costs relative to their income, coverage was still much lower among people with the lowest incomes.

FIGURE 11.6

### Percentage of survey respondents, aged 12 to 64, who report having prescription medication insurance, in Ontario, by household income level, 2014



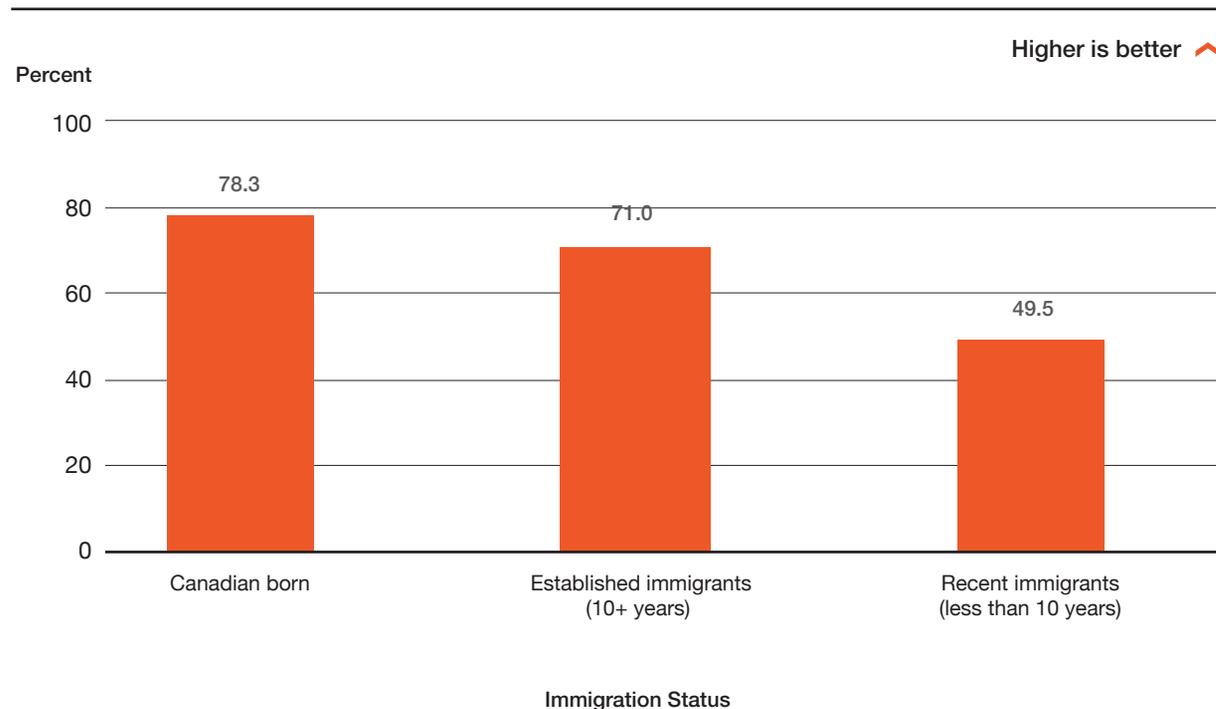
Data source: Canadian Community Health Survey, 2014 provided by the Institute for Clinical Evaluative Sciences

### Recent immigrants

In 2014 in Ontario, recent immigrants, defined as those who had lived in Canada less than a decade, were less likely to have prescription medication insurance than both established immigrants who had been in the country 10 years or longer, and Canadian-born citizens.

Among people aged 12 to 64 in Ontario, 58.2% more of those born in Canada had prescription medication insurance, at 78.3%, compared to recent immigrants, among whom 49.5% had it (Figure 11.7).

**FIGURE 11.7**  
**Percentage of survey respondents, aged 12 to 64, who report having prescription medication insurance, in Ontario, by immigration status, 2014**



Data source: Canadian Community Health Survey, 2014 provided by the Institute for Clinical Evaluative Sciences

## In summary

Targeted efforts to contain health spending have resulted in a slight decrease in total health spending per person in Ontario since 2010, a trend that has been observed in many comparable countries.[117] Still, Ontario's health spending per person sits in the middle in relation to other Canadian provinces and other comparable countries. However, spending on drugs per person in Ontario is second only to the United States.

People who live in Ontario are less likely to have prescription medication insurance if their income is low, if their education level is low, or if they are recent immigrants. These gaps in coverage suggest everyone in Ontario does not currently have the same opportunity for good health.

# The Road Ahead



Photo of Bill taken by Roger Yip.  
Please see his story on the page 28.

*Measuring Up 2016 shows how some Ontarians struggle to navigate between different parts of the system, may have trouble accessing the care they need, where and when they need it, and that inequities persist among particular groups of people depending on where they live in the province. But in areas where there have been focused efforts, we've seen that significant improvements can be achieved. We can learn from these successes, and the time is right to act in targeting needed improvements.*

## Time for change

The Ministry of Health and Long-Term Care's *Patients First* action plan in 2015 identified four key objectives that align with the main findings of this report: faster access to the right care; delivering better coordinated and integrated care in the community and closer to home; supporting people and patients with the information they need to make better decisions; and making evidence-based decisions for a sustainable

health system. In addition, the ministry's 2015 report *Bringing Care Home*, included recommendations to improve patient and family-centred home care.

As we move forward to transform the health system, we can learn by looking back at the comprehensive set of policies, legislation, quality improvements and reporting that have worked on areas that needed fixing. This includes public health interventions to reduce the smoking rate, the Wait Time Strategy to speed up access to key health services, and the *Long-Term Care Homes Act, 2007* to improve the quality of life for residents. These examples show when we apply a focused approach, improvement follows.

More local accountability and clinical leadership could result in more seamless transitions for patients, including follow-ups with a doctor after a hospitalization for the mental illness or addiction. Best use of resources in areas such as palliative care (where home visits by doctors could avoid unplanned visits to the emergency department) and palliative-specific home care visits, could ensure people are

able to die in the location of their choice. All of this would not only fit with patients' choices, but many of these improvements could also be more cost-effective and help the system in the long term.

Improvement will take concerted collaborations across the health system. Quality Improvement Plans developed by organizations in acute care, home care, long-term care and a portion of the primary care sector not only include improvements related to their own organization, but also how they'll collaborate to improve care at the points of transition. This offers hope that with continued focus, we'll be able to achieve gains in the future.

## Health Quality Ontario's commitments to quality

To complement the tremendous efforts in improvement across the system, Health Quality Ontario works every day, in partnership with system stakeholders, patients, families and members of the public, to help improve health care quality in Ontario. Below are just some of the many examples of our work with partners:

We recently announced three emerging areas of focus for our organization in our three-year strategic plan – mental health and addictions care, palliative and end-of-life care, and primary care. All of these focus areas tie into *Measuring Up*'s key findings and the ongoing work at the ministry and elsewhere in the province. In addition, to help narrow the inequity gaps, we have worked with partners across Ontario to establish an equity roadmap to support significant improvements in health equity.

To support evidence-based decisions in health care quality, we are collaborating with patients, caregivers and clinicians on a new initiative called Quality Standards - easy-to-understand statements outlining the care that patients with selected conditions should expect to be offered, and based on the best available evidence. They are designed to lay the foundation for evidence-based quality improvement and to support the delivery of equitable care across Ontario. Through the Ontario Health Technology Advisory Committee, we also make recommendations about whether health technologies should be publicly funded or not.

Large-scale quality improvement efforts with Health Quality Ontario, Local Health Integration Networks, the Ministry of Health and Long-Term Care, and with Health Links teams, come together to provide a population approach to improving coordination of care, such as care for patients with complex needs and circumstances.

To enable the adoption of best practices, we support the development of Quality Improvement Plans by health care organizations across the province to

address quality issues and to meet their goals for better care. Our quality improvement specialists work with Local Health Integration Networks to translate innovations into practices that can be implemented on a broader scale.

Health Quality Ontario and the Local Health Integration Networks have also recognized the need to connect efforts locally and provincially by establishing a clinical lead for quality and Regional Quality Tables. These cross-sector groups of health system leaders in each region of the province play an important role in developing a regional quality plan using the data from this report as an important input, ensuring response to local quality issues while also contributing to the larger provincial goals.

And while *Measuring Up 2016* provides an overview of how well the health system as a whole is performing, we also work to ensure that health care providers and organizations get the data they need for improvements at the local levels. This includes expanding the scope and amount of information available at the practice, organizational, sub-regional and regional levels. We're also looking at new ways of tailoring our reporting to different audiences.

As highlighted in Health Quality Ontario's quality framework *Quality Matters*, achieving better health outcomes and better patient experiences in a sustainable manner requires everyone to be involved, starting with patients, their families and the public. Throughout all of these efforts, we engage with patients, families and members of the public to guide us on making all of our activities relevant to their

needs and experiences, while working hand-in-hand with partners across the system.

Through *Measuring Up 2016* we see that significant improvements are possible when there is a will to make them happen. The system is keen to make improvements and change is already underway. The data presented in this report are designed to inform the efforts needed for better care and better health for the people of Ontario as we move forward.

## Better health for all Ontarians

As we continue to work with partners over the next year, Health Quality Ontario will blaze new trails toward our goal of achieving better health for everyone in Ontario. We'll review measures in home care and patient safety, and dive deeper into regional variation (focusing on the north, and on sub-regional reporting). We'll also evolve our work by exploring new interactive and timely ways of reporting to the people of Ontario on the performance of the health system, while increasing patient involvement in the development of our reporting and measurement.

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# Acknowledgments

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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 voices 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, there is much to be proud of, but also that it often falls short of being the best it can be. Plus, certain vulnerable segments of the population are not receiving

acceptable levels of attention. Our intent at Health Quality Ontario 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.

## System Performance 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, specialized 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  
130 Bloor Street West  
10th Floor  
Toronto, ON M5S 1N5

Telephone: 416-323-6868  
Toll-free: 1-866-623-6868  
Email: [info@hqontario.ca](mailto:info@hqontario.ca)  
[www.hqontario.ca](http://www.hqontario.ca)

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