Towards a Common Quality Agenda 2014

Measuring Up

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

Ontario
Health Quality Ontario

About Us

Health Quality Ontario is the provincial voice on the quality of Ontario's health system. We play a unique role reporting on the system's performance, sharing the best scientific evidence to guide change, and supporting quality improvement. Health Quality Ontario is the operational name for the Ontario Health Quality Council, an agency of the Ministry of Health and Long-Term Care.

On the cover: Ilona, 70, getting ready to go for a bike ride, not long after her second hip replacement. See page 56 for her story. We thank Ilona and the other people who shared with us their experiences in Ontario's health system. (Cover photo by Joel Esposito)

ISBN 978-1-4606-4679-3 (Print)

ISSN 2292-2067 (Print)

ISBN 978-1-4606-4680-9 (PDF)

ISSN 2292-2075 (Online)

Table of Contents

Foreword

Dr. Joshua Tepper

Dr. Andreas Laupacis

On behalf of Health Quality Ontario, we are pleased to share *Measuring Up*, our yearly report on the health of Ontarians and on how our health system is performing.

This report is our first based on the Common Quality Agenda. Created in partnership with many in the health system, the Common Quality Agenda currently includes 40 indicators.

Whenever possible in *Measuring Up*, we have compared Ontario with the rest of Canada and other countries. We have also compared Ontario's different regions with each other.

The report presents a mixed message. Overall, we are healthier than we have ever been and in some areas our health care system is steadily improving. Ontario performs as well as or better than the Canadian average in all measures for which we could make comparisons. However, compared with many other countries we do quite poorly on some measures.

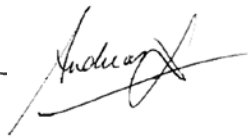
Ontarians wait too long to see their family doctor, to access certain hospital services and to get into a long-term care home. Our health system is not seamless, and this causes unnecessary complications for many people. The health of Ontarians – and the performance of their health care system – depends on where they live. Most strikingly, those who live in the north are much less healthy than people who live in other regions of Ontario.

This report is ultimately about people. We are appreciative that several patients were willing to share their personal experiences within the system. These are real stories. Some elements of these stories instil pride and satisfaction while others raise important concerns.

We included these stories because we need to reflect on Ontarians' experiences with the health system in words and not just numbers. The Common Quality Agenda is still evolving and there are important gaps. Through working with our partners, we will continuously improve the Common Quality Agenda and our yearly report.

This report is part of Health Quality Ontario's responsibility to monitor performance in the system. Our other mandates include reviewing evidence, setting standards for improved practice and care and supporting health care professionals and health systems in making changes to improve the quality of care. More information about our work in these areas can be found at **www.hqontario.ca**.

We look forward to using the results of *Measuring Up* to help guide the organization and our partners in improving care for the people of Ontario.



Dr. Joshua Tepper
President and CEO

Dr. Andreas Laupacis
Board Chair

Executive Summary

Every day in Ontario, millions of us deal with health issues of one kind or another, from the trivial to the serious.

A woman in Sarnia will butt out a cigarette that she hopes will be her last, a father in Toronto will start biking to work in an effort to get fit, and kids in a classroom in Chatham will roll up their sleeves to get immunization shots. In Thunder Bay, a new mother will cry with joy after giving birth to a baby daughter she hopes will lead a long and healthy life, a grandfather in Timmins will sit in a room waiting for a colonoscopy and a great-grandmother in Midland with a heart condition will laugh in delight as she celebrates her 90th birthday at home with her family after leaving the hospital.

Health plays a central role in our lives. When a nurse checks our vital signs after surgery, when a doctor prescribes us medication that relieves our symptoms, and when a physiotherapist helps get us back on our feet after a hip replacement, we feel grateful that we have such a robust health system in Ontario. But when we wait weeks to get an appointment to see our family doctor, months to see a specialist and years to get into our preferred long-term care home, we know things could be better. In this report, our goal is to highlight the areas of the health system that are performing well, as well as the parts that could be better.

The story of our health system's performance begins with our health. How are we doing? Overall, very well. We are healthier than we have ever been and healthier than the people of most other provinces and countries. Life expectancy in Ontario is the longest it has ever been at 81.5 years — more than 20 years longer than it was a century ago. We have the second-best avoidable mortality rate among the provinces and our infant mortality rate continues to improve. Although nearly one out of five of us still smoke and almost half of us report being physically inactive, fewer of us smoke or are inactive compared to previous years and we rank second-best among the provinces on both indicators.

Our health system is performing better than it was five and 10 years ago across many of the indicators that we report. However, access to care continues to be a problem in many areas of our health system.

Behind every statistic in this report, there are **patients, families, caregivers and providers.**

Our health system is performing better than it was five and 10 years ago across many of the indicators that we report. For example, the proportion of heart surgeries and cancer surgeries completed within the target wait time has improved. In long-term care homes, the use of physical restraints has dropped without an increase in the number of falls among residents. The number of hospital admissions for conditions that can be effectively prevented or treated outside the hospital has also decreased.

However, access to care continues to be a problem in many areas of our health system. Although nine out of 10 Ontarians have a family doctor or nurse practitioner, more than half of us cannot get in to see our primary care provider on the same day we get sick, or even the next day — the worst performance of the 11 countries in an international survey on primary care access. We also have trouble seeing our primary care providers in off-hours. More than half of us report not being able to access our primary care provider on evenings or weekends, the second-worst performance in the 11-country survey.

If one of our family members needs a bed in a long-term care home, we should be prepared to wait. Although the wait times for long-term care homes have improved in the last four years, most people still wait several months.

In addition, for several of the indicators highlighted in the report — including premature avoidable deaths, obesity, smoking, access to care and readmissions to hospital — performance is substantially worse in some parts of Ontario than others. In some regions, rates of premature avoidable deaths, smoking and readmissions for ambulatory care sensitive conditions are almost double those of other regions. And wait times for long-term care in some regions are more than twice as long as those in others.

Despite the wait times and the difficulties with access, patient satisfaction surveys tell us we are generally happy with the care we receive. For example, surveys show that more than nine out of 10 home care patients surveyed are pleased with their care, about three-quarters of hospital patients surveyed would definitely recommend the hospital where they received care to their friends and family, and more than eight out of 10 patients surveyed after seeing their family doctor or nurse practitioner say their primary care provider spends enough time with them.

These patient satisfaction surveys also give us an indication about how much we care about our health system when we need it, and how much we appreciate high-quality care. And now, for the first time, Health Quality Ontario is using a concise set of indicators, known as the Common Quality Agenda, to provide a window into how the diverse aspects of our health system are performing. There are so many indicators being used to monitor health system performance that we can become overwhelmed with information and have difficulty making sense of all the data. By using a focused set to regularly report on performance, we hope to ease some of the burden of this so-called “indicator chaos.” Through consultations with our partners and system leaders, Health Quality Ontario established the Common Quality Agenda set of indicators, which will continue to evolve over the coming years.

However, numbers do not tell us everything. Behind every statistic in this report, there are patients, families, caregivers and providers, some of whom share their experiences with Ontario’s health system in the stories throughout the report. Health Quality Ontario is dedicated to engaging the people of Ontario in its journey. This report marks further progress on the road toward continually improving our health system and helping to create a healthier Ontario.

Introduction

Why health system performance reporting matters to Ontarians

How healthy are Ontarians? Is our health system improving? How well does our health system perform compared to those in other provinces and countries? This report aims to answer these questions.

Health Quality Ontario and our role

Health Quality Ontario (HQO) is an arms-length government agency whose mandate was outlined in the *Excellent Care for All Act*.[1] Serving as the province's advisor on quality, HQO is responsible for monitoring and reporting to the people of Ontario about their health status and the performance of the health system, supporting continuous quality improvement, and promoting health care that is supported by the best available scientific evidence. One of our responsibilities is to report to the public each year on the performance of the health system and the health status of Ontarians, which is where this report comes in.

The journey towards a Common Quality Agenda

As the foundation for *Measuring Up*, we use the Common Quality Agenda, a set of key performance indicators selected in collaboration with health system partners. HQO led the development of this set of indicators to reflect the key priorities of patients and health care providers. The evolving Common Quality Agenda indicator set is intended to focus efforts and mobilize system leadership towards the delivery of the highest quality of care for Ontarians.[2]

The Common Quality Agenda indicators are being used to track long-term progress in meeting Ontario's health goals to help make the health system more transparent and accountable. The indicators are also being used to promote an integrated, patient-focused system.

Each chapter of *Measuring Up* represents a sector of the health system that aligns with the Common Quality Agenda indicators: Health Status, Public Health, Primary Care, Hospital Care, Home Care, Long-Term Care, System Integration and Health Workforce (Figure 1.1).

A technical appendix with detailed methodology and indicator specifications is available on HQO's website.

Performance within Ontario

In addition to examining changes in performance for the province as a whole, for some indicators we also report the data at the regional level. There are 14 Local Health Integration Networks (LHINs) in Ontario, based on geographical regions (Figure 1.2). Each LHIN is responsible for planning, integrating and funding some of the health care services within its area, with funding provided by the Ministry of Health and Long-Term Care.[3] For regional comparisons in Ontario, we report the data for each LHIN region along with the Ontario data for context.

FIGURE 1.1
Common Quality Agenda 2014

Health Status
- Life expectancy at birth
- Infant mortality
- Self-reported health status
- Premature avoidable deaths

Public Health
- Smoking
- Physical inactivity
- Obesity
- Measles immunization
- Meningococcal immunization
- Influenza immunization in older adults

Primary Care
- Having a primary care provider
- Access to a primary care provider on the same day or next day when sick
- Access to primary medical care in the evening, weekend or on a public holiday
- Patient experience
- Screening for colorectal cancer
- Diabetes eye exams

Hospital Care
- Patient satisfaction
- Emergency department length of stay
- Hip or knee replacement wait time
- Cardiac procedure wait time
- Cancer surgery wait time
- *Clostridium difficile* infections acquired in hospital
- Falls among complex continuing care patients
- Pressure ulcers among complex continuing care patients
- Use of physical restraints in acute mental health care

Home Care
- Patient satisfaction
- Wait time for nursing services
- Wait time for personal support services

Long-Term Care
- Long-term care home placement wait time
- Use of physical restraints in long-term care home residents
- Falls among long-term care home residents
- Pressure ulcers among long-term care home residents

System Integration
- Hospitalizations for ambulatory-care sensitive conditions
- Physician visit within seven days of hospital discharge
- Readmissions for mental illnesses
- Readmissions for medical or surgical patients
- Alternate level of care days

Health Workforce
- Number of registered nurses, registered practical nurses or nurse practitioners
- Number of family doctors or specialists
- Lost-time injury in health workers

How Ontario performs compared to others

To provide context on how Ontario's health system performs, we also provide comparisons with other provinces in Canada, as well as other countries. For comparisons across Canada, we report data for other provinces. We do not include data for the territories as their geographic locations and population sizes are quite different from Ontario and they may not be appropriate comparators.

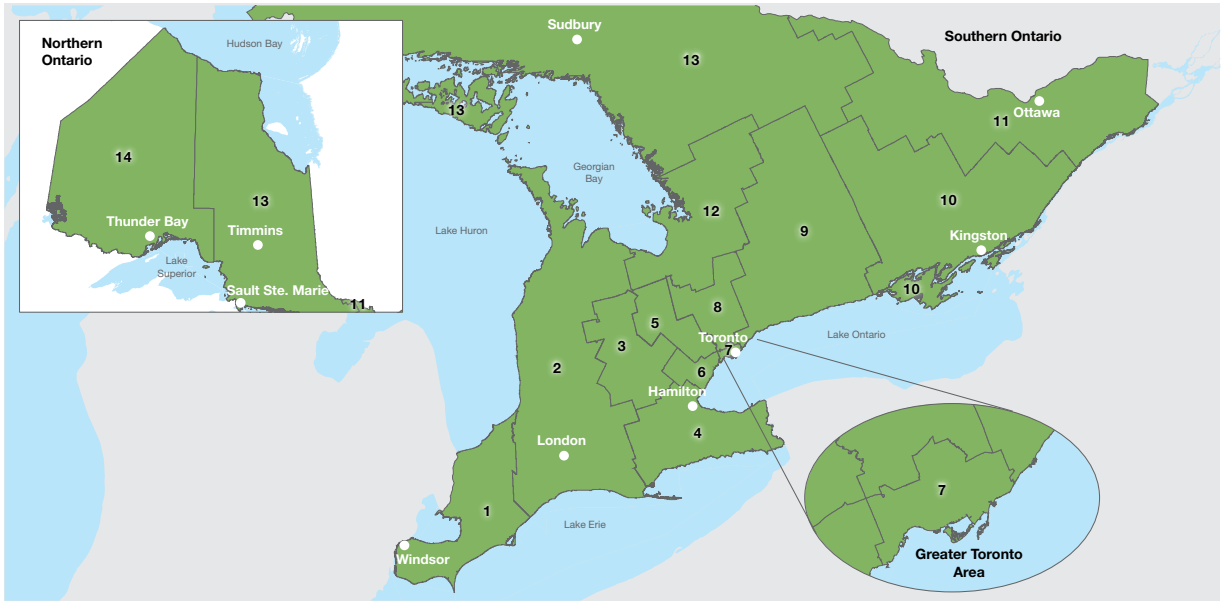
For international comparisons, we typically compare Ontario's performance to the 10 other countries that participate in the Commonwealth Fund's widely cited international survey. In addition to Canada, the countries included in the survey are: Australia, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and the United States. These countries have many economic and demographic similarities to Canada and therefore are generally considered to be appropriate comparators. HQO partners with the Commonwealth Fund to support the survey.

The stories behind the statistics

Measuring Up features a series of vignettes, based on interviews we conducted with patients and caregivers who told us their stories about health and health care in Ontario. We have also included the perspective of a nurse practitioner to show a provider's point of view. These stories are individual viewpoints and are not necessarily representative of everyone's experiences. The stories give us a snapshot of how some people experience the health system. They illustrate some of the successes, but also the challenges and complexities, that our health system faces in providing excellent care for all Ontarians. The stories tell us what the charts and figures in this report cannot: What does it feel like to wait for a hip replacement, to be the family caregiver for a husband with brain cancer, or to be a nurse practitioner? We are grateful to the patients, caregivers and health care professionals for sharing the personal details of their lives to give us a more complete picture of how the indicators in this report affect Ontarians.

FIGURE 1.2
Map of Local Health Integration Network regions in Ontario

In this report, we present regional-level data according to the geographical areas defined by the province's 14 Local Health Integration Networks, illustrated below.



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		

Health Status

In this chapter, we report on Common Quality Agenda indicators for life expectancy, infant mortality, self-reported health status and avoidable deaths.

The big picture

As its primary goal, any health system aims to maintain and restore health. Although it takes more than just a good health system for people to be healthy, reporting on measures of health status can help shine some light on how well our health system performs. We can also use these measures to make comparisons over time and with other provinces and countries.

Key Findings

Life expectancy in Ontario has improved by one year in the past seven years

Nearly 63% of Ontarians report their overall health as excellent or very good

Ontario has the second-best premature avoidable death rate among all 10 provinces

Reporting on measures of health status can help shine some light on **how well our health system performs**.

Life expectancy at birth

Life expectancy in Ontario improved by one year between 2003/2005 and 2007/2009 to 81.5 years

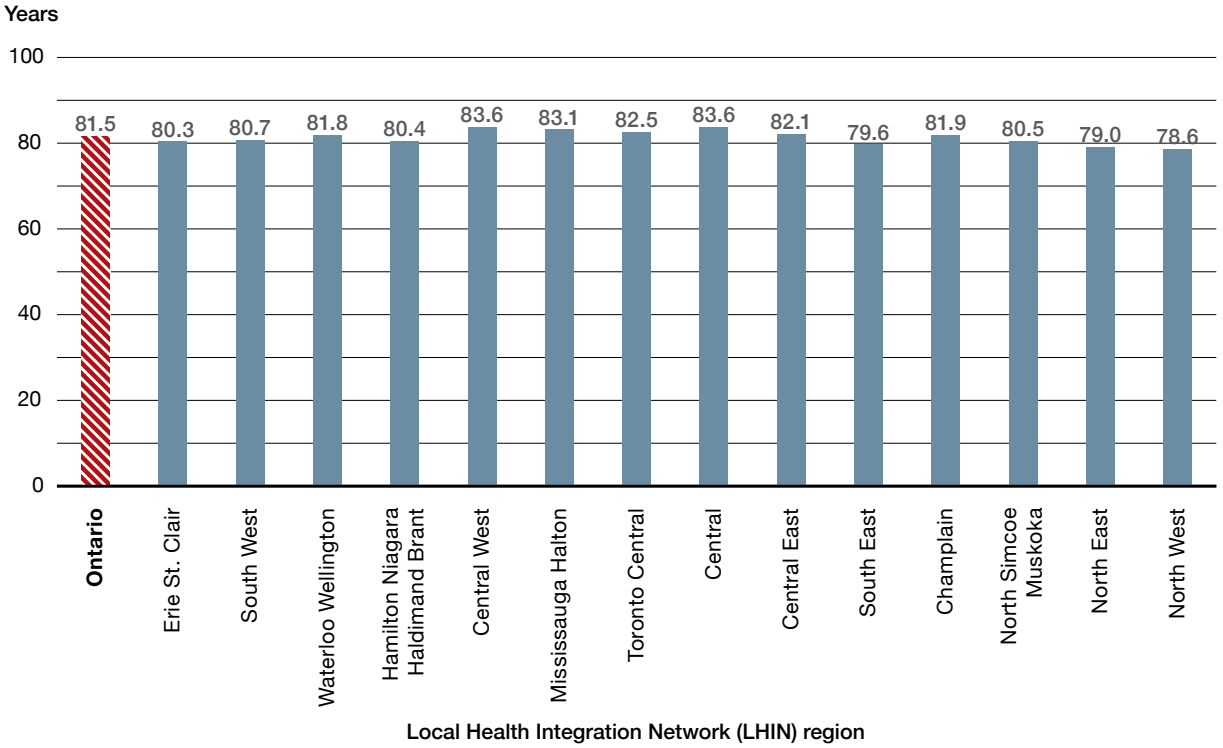
Over the last century, average life expectancy for Canadians has improved by 20 years, rising from about 60 years in the early 1920s to more than 80 years today.[4] In 2010, life expectancy in Canada ranked 10th of 34 countries in the Organization for Economic Co-operation and Development.[5]

The life expectancy of people in Ontario continues to improve. Between 2003/2005 and 2007/2009, life expectancy improved by one year to 81.5 years.[4]

People in some areas of Ontario live longer, on average, than in others. People in the North West Local Health Integration Network (LHIN) region have the shortest life expectancy at 78.6 years. In contrast, people in the Central and Central West LHIN regions have a life expectancy of 83.6 years (Figure 2.1).

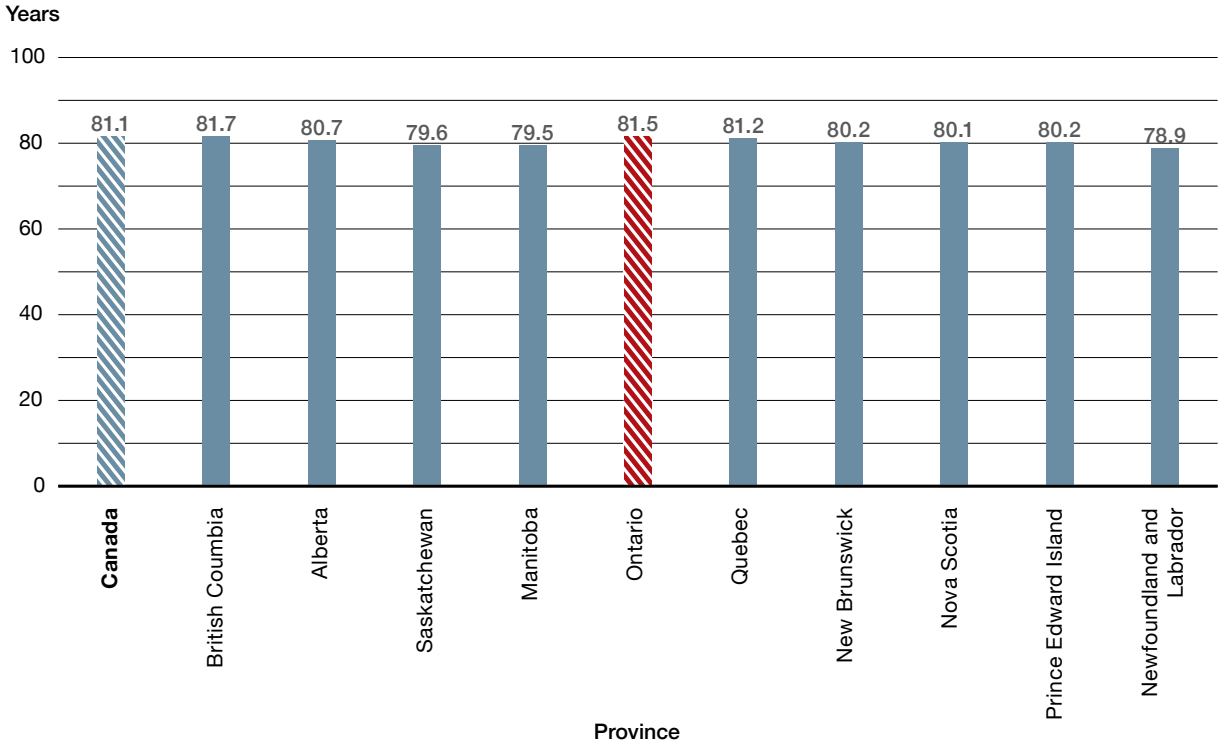
20 years
Improvement in life expectancy in Canada since 1920

FIGURE 2.1
Life expectancy at birth, in Ontario, by LHIN region, 2007/2009



Data source: Statistics Canada.[6]

FIGURE 2.2
Life expectancy at birth, in Canada, by province, 2007/2009



Data source: Statistics Canada.[6]

How Ontario compares: **within Canada**

At 81.5 years, life expectancy at birth in Ontario for the 2007/2009 period is similar to the Canadian average of 81.1 years. People in British Columbia have the highest life expectancy at 81.7 years (Figure 2.2).

Infant mortality

Ontario's infant mortality rate improved between 2007 and 2011

Infant mortality reflects how mothers and babies fare within their families, their communities and the health system.[7] Over the last century, the infant mortality rate has improved substantially in nearly every country in the Organization for Economic Co-operation and Development due to better sanitation, nutrition, infant feeding, and maternal and child health care.[8]

Between 2007 and 2011, the infant mortality rate in Ontario improved to 4.6 per 1,000 live births from 5.2 per 1,000 live births.[9]

Self-reported health status

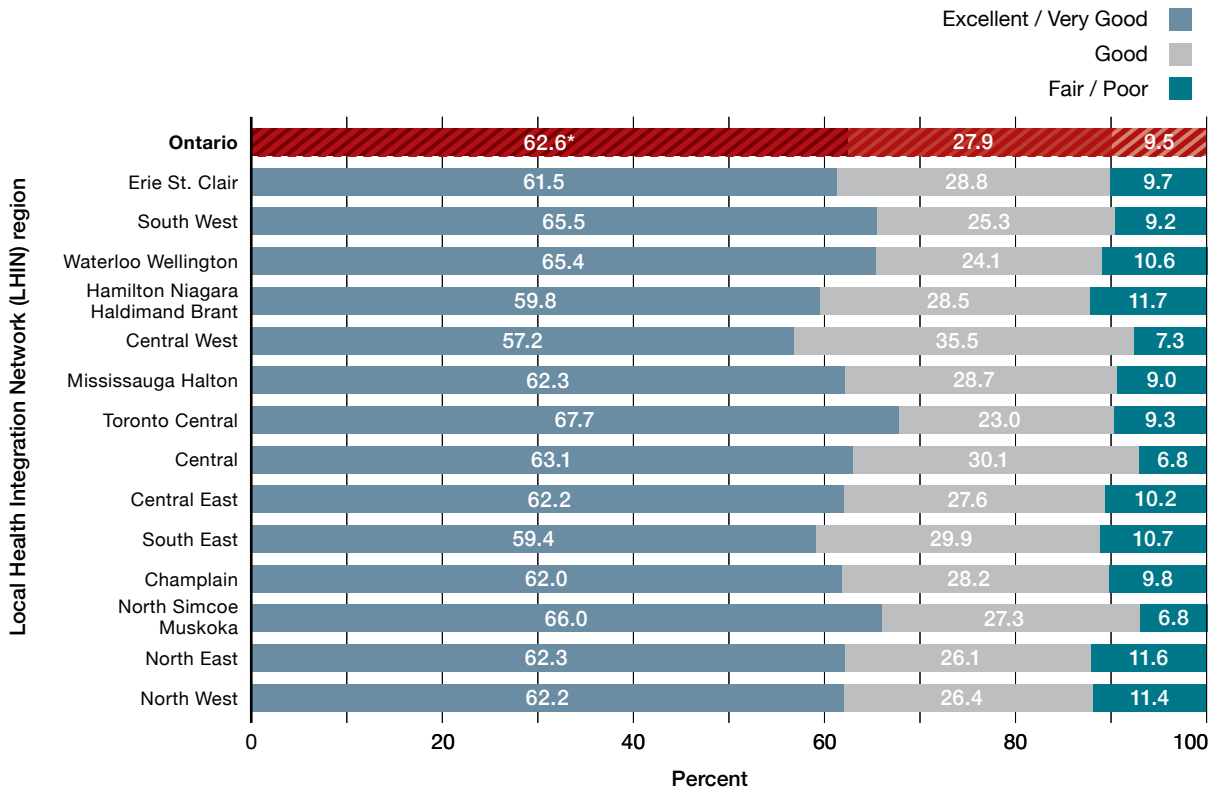
Nearly two-thirds of Ontarians rate their health as excellent or very good

Asking people what they think about their own health is an important way to monitor health status, in part because self-reported health status is a strong predictor of premature death and future disability.[10,11]

In 2012, 62.6% of Ontarians aged 12 and older report their overall health as excellent or very good, similar to 60.7% in 2008. Only 9.5% of respondents report that their health is fair or poor, similar to 11.2% in 2008.[12]

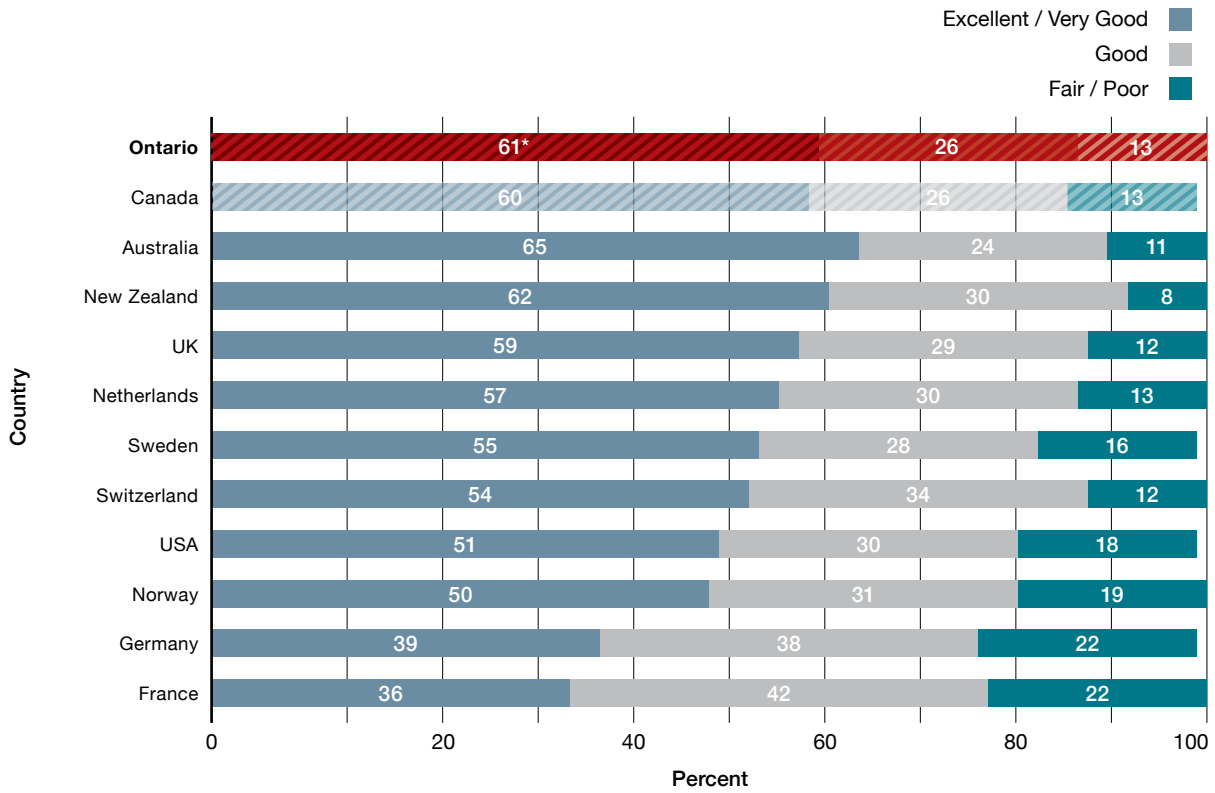
There are some modest differences in self-reported health status across Ontario. People in the Toronto Central LHIN region report the best health, with 67.7% of respondents rating their overall health as excellent or very good. People in the Central West LHIN region have the worst self-reported health, with 57.2% of respondents rating their health as excellent or very good (Figure 2.3).

FIGURE 2.3
Self-reported health status in Ontario, by LHIN region, 2012



Data source: Canadian Community Health Survey provided by the Institute for Clinical Evaluative Sciences. *The slightly different rates reported for Ontario across the provincial and international comparisons can be attributed to different survey samples used in the different data sources.

FIGURE 2.4
Self-reported health status, by country, 2013



Data source: 2013 Commonwealth Fund International Health Policy Survey. *The slightly different rates reported for Ontario across the provincial and international comparisons can be attributed to different survey samples used in the different data sources. Individual category percentages do not always add up to 100% because of rounding and other technical issues.

How Ontario compares: **around the world**

Based on data from the 2013 Commonwealth Fund survey, Ontarians and Canadians rank high among 11 other surveyed countries in terms of rating their health as excellent or very good. Some 61% of Ontarians rate their health as excellent or very good, just above the Canadian average of 60%. These percentages are similar to New Zealand (62% rate their health as excellent or very good) and the United Kingdom (59%) but substantially higher than France (36%) or Germany (39%) (Figure 2.4). Australians report the highest rate of excellent or very good health status among the surveyed countries (65%).

Premature avoidable deaths

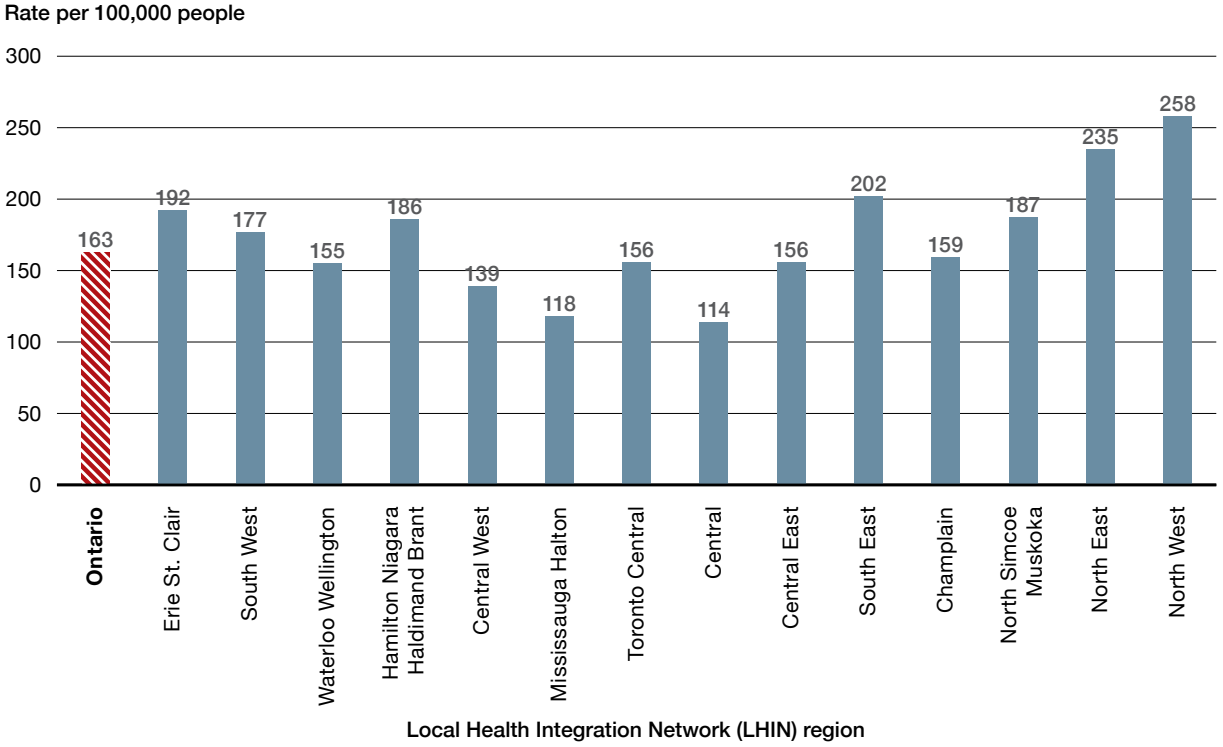
Premature avoidable deaths decreased to 163 per 100,000 people in 2009/2011 from 175 per 100,000 in 2006/2008

This indicator focuses on deaths occurring before the age of 75 that could potentially have been avoided. The measure includes deaths from diseases that can often be prevented (e.g., through healthier behaviours or immunizations) as well as deaths that could potentially have been avoided by effective treatment. For example, a death from a heart attack would be counted as a premature avoidable death, while a death from pancreatic cancer would not.

The rate of premature avoidable deaths in Ontario fell to 163 per 100,000 people in 2009/2011 from 175 per 100,000 in 2006/2008, mirroring the improvements in the national average, which fell to 171 premature avoidable deaths per 100,000 people from 185 per 100,000 in the same time period.[13]

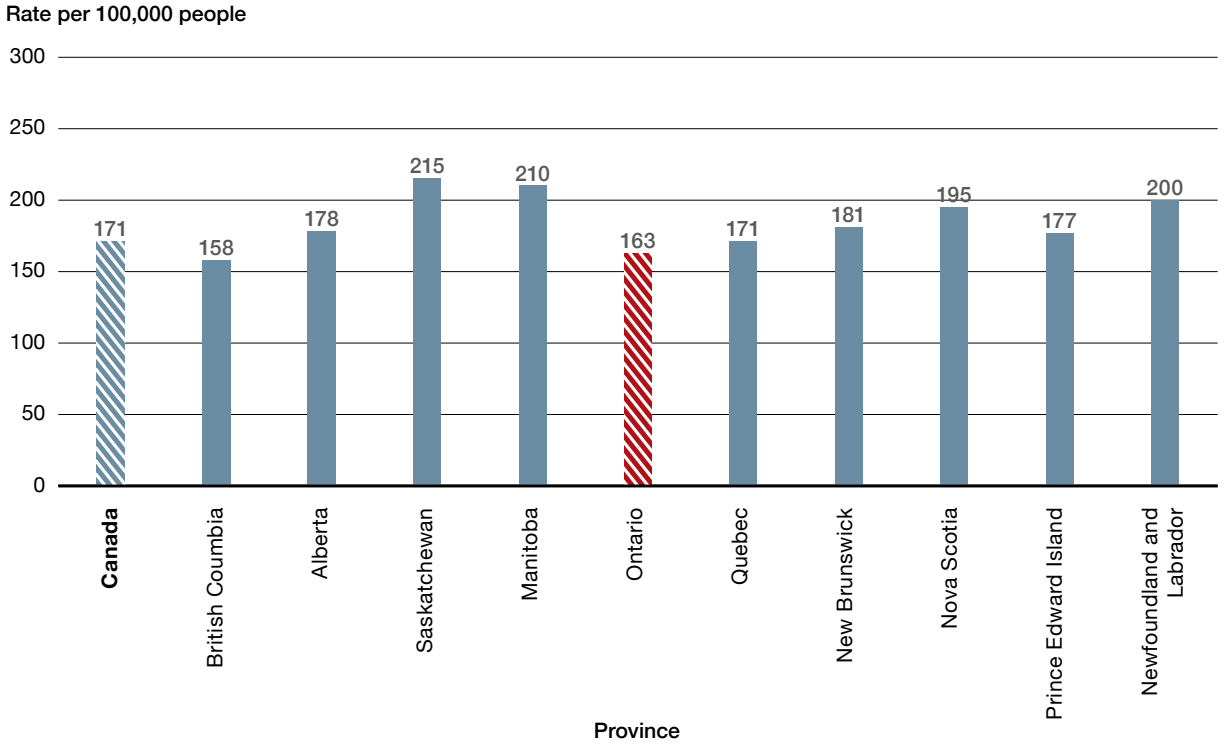
There is considerable regional variation in premature avoidable deaths in Ontario, with the lowest rate reported for the Central LHIN region of 114 per 100,000 people in 2009/2011 and the highest level reported for the North West LHIN region of 258 per 100,000 people (Figure 2.5).

FIGURE 2.5
Age-standardized premature avoidable death rate in Ontario, by LHIN region, 2009/2011



Data source: Statistics Canada.[13]

FIGURE 2.6
Age-standardized premature avoidable death rate in Canada, by province, 2009/2011



Data source: Statistics Canada.[13]

How Ontario compares: **within Canada**

Ontario's premature avoidable death rate of 163 per 100,000 people in the 2009/2011 period is lower than the Canadian rate of 171 per 100,000 people and ranks as the second-lowest in Canada, just behind British Columbia's rate of 158 per 100,000 people (Figure 2.6).

In summary

The indicators we present in this chapter reveal a broad picture of Ontarians' health. In many respects, we are healthier than we have ever been before, and the most recent data suggest that life expectancy and infant mortality rates continue to improve. With some variation across the province, the majority of Ontarians rate their health as excellent or very good. This self-rating of health is similar to the overall rate across Canada, but higher than the rate in most other countries surveyed. Premature avoidable death rates have improved, and Ontario has one of the lowest rates in Canada for this indicator. However, there is regional variation for avoidable deaths in the province, with some regions having more than double the rate of others.

We are healthier than we have ever been before. However, there is regional variation for avoidable deaths in the province, with some regions having more than double the rate of others.

Meet Moe

Age: 92, Ottawa

Moe didn't think much about retirement when he was young. "Up to the age of 14, I was playing for my town baseball team. I was hoping I would play for the Detroit Tigers and that they would retire me as their best player. That was my only thought about retirement back then." Moe, who lives in Ottawa, went on to work for a large mining company and retired in 1983, when he was 61. He is now 92, and has been retired for almost as long as he worked.

While he was working, Moe made a point of setting aside time to play sports like golf, curling and downhill skiing. After he retired, Moe kept up with the curling and golf, and also took up cross-country skiing with his wife. Now he keeps in shape by walking, working out on a treadmill and riding his bicycle. He played tennis up until a couple of years ago.

At the age of 92, Moe has now been retired for almost as long as he worked...

he keeps in shape by walking, working out on a treadmill and riding his bicycle.

To stay healthy, Moe followed his wife's advice. "She was smarter than I was and always knew the right foods to eat and not to be foolish," he says of his wife, who died earlier this year at 93. "I had a happy marriage for 65 years."

Public Health

In this chapter, we report on the Common Quality Agenda indicators for the rates of smoking, physical inactivity, obesity and immunizations for measles, meningococcal disease and influenza.

Promoting better health

Promoting good health can keep people from getting sick and needing health care. Smoking, physical inactivity, alcohol consumption, stress and diet have a big influence on overall health. If everyone in Ontario were a non-smoker, physically active, consumed alcohol in moderation or not at all, and had low stress levels and a healthy diet, we could expect to live 7.5 years longer, on average.[15]

Key Findings

Ontario's smoking rate is second-lowest among the provinces

Ontarians are more physically active compared to five years ago

Influenza immunization rates for Ontarians aged 65 years and older worsened to 70.7% in 2012 from 75.2% five years earlier

Smoking is the leading cause of preventable disease and premature death in Ontario, and is responsible for about 13,000 deaths in the province each year.[14]

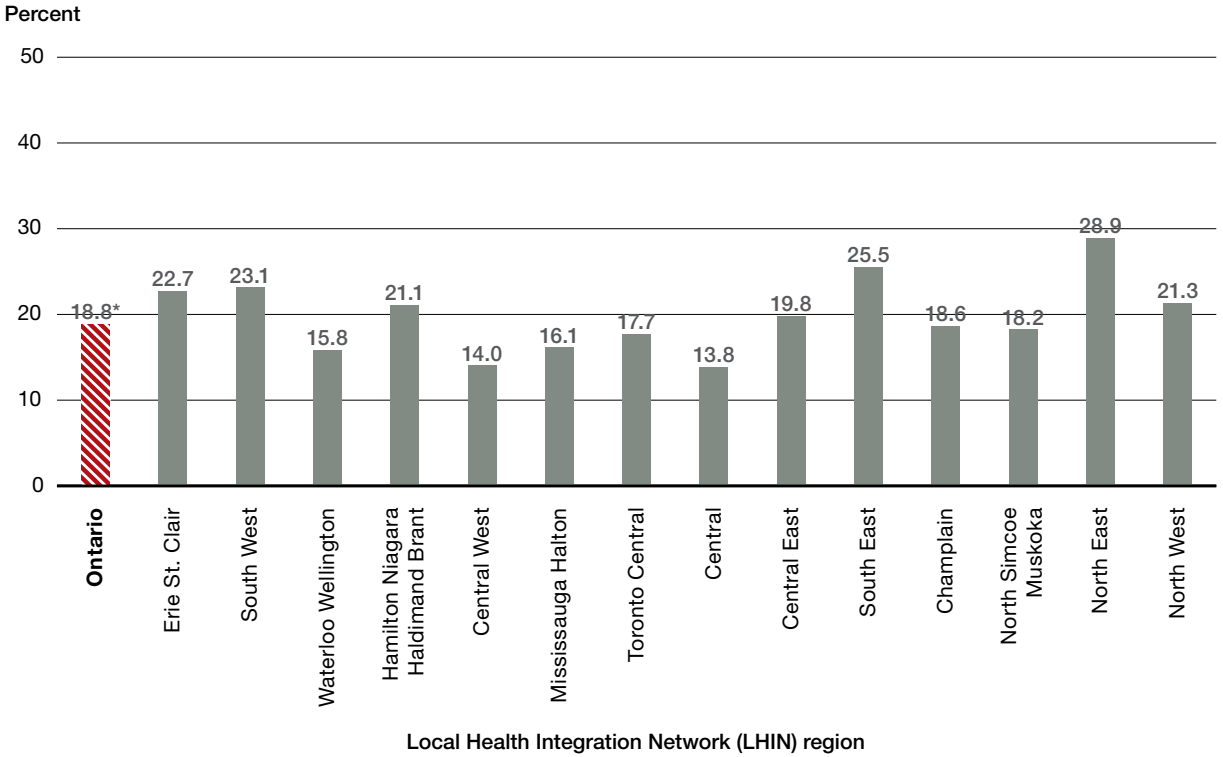
Smoking

Ontario's smoking rate improved to 18.8% from 21.2% over five years

Smoking is the leading cause of preventable disease and premature death in Ontario, and is responsible for about 13,000 deaths in the province each year.[14]

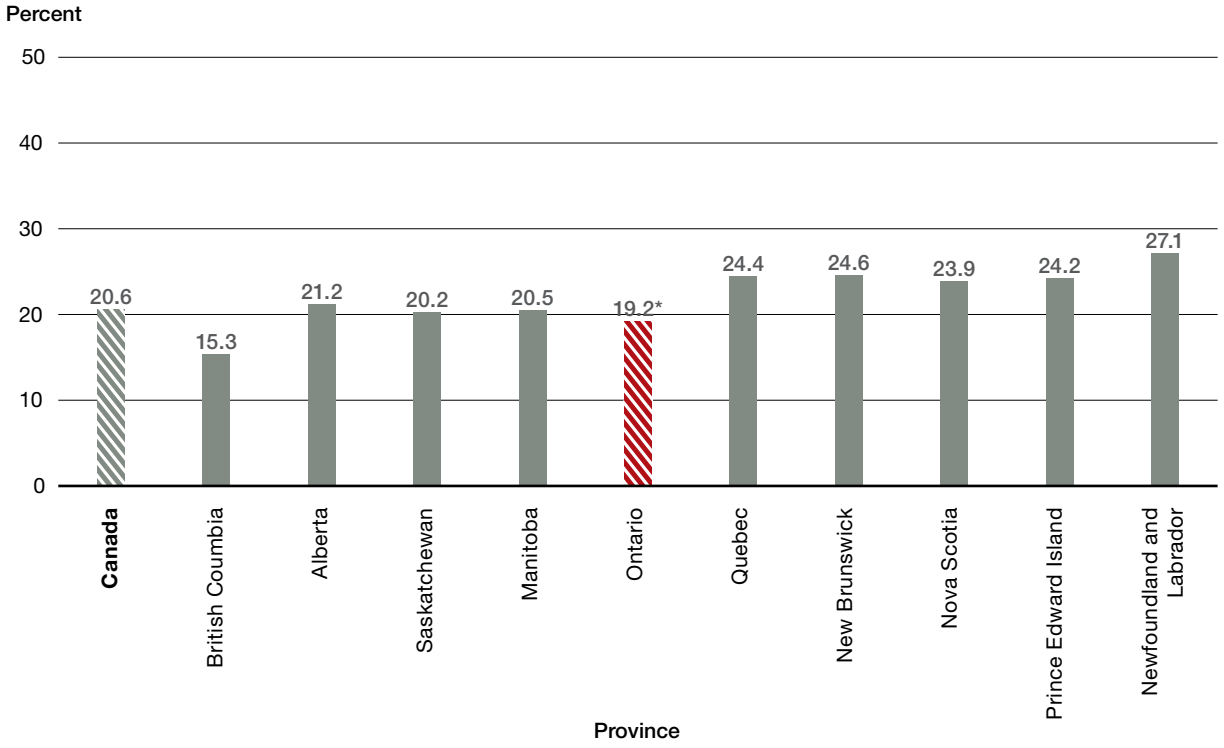
Between 2007 and 2012, the smoking rate in Ontario improved to 18.8% from 21.2%.[16] Smoking rates vary substantially across the province, with the rate of 13.8% in the Central LHIN region being less than half that of the rate of 28.9% in the North East LHIN region (Figure 3.1).

FIGURE 3.1
Age- and sex-adjusted smoking rates in Ontario, by LHIN region, 2012



Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Sciences. *Ontario rates vary because of different data methods.

FIGURE 3.2
Age-adjusted smoking rates in Canada, by province, 2012



Data source: Canadian Community Health Survey, Statistics Canada.[17] *Ontario rates vary because of different data methods.

How Ontario compares: **within Canada**

Using data from a Statistics Canada survey conducted in 2012, Ontario's smoking rate of 19.2% is below the Canadian average of 20.6% and ranks second-lowest in Canada, trailing only British Columbia's rate of 15.3% (Figure 3.2).

Physical inactivity

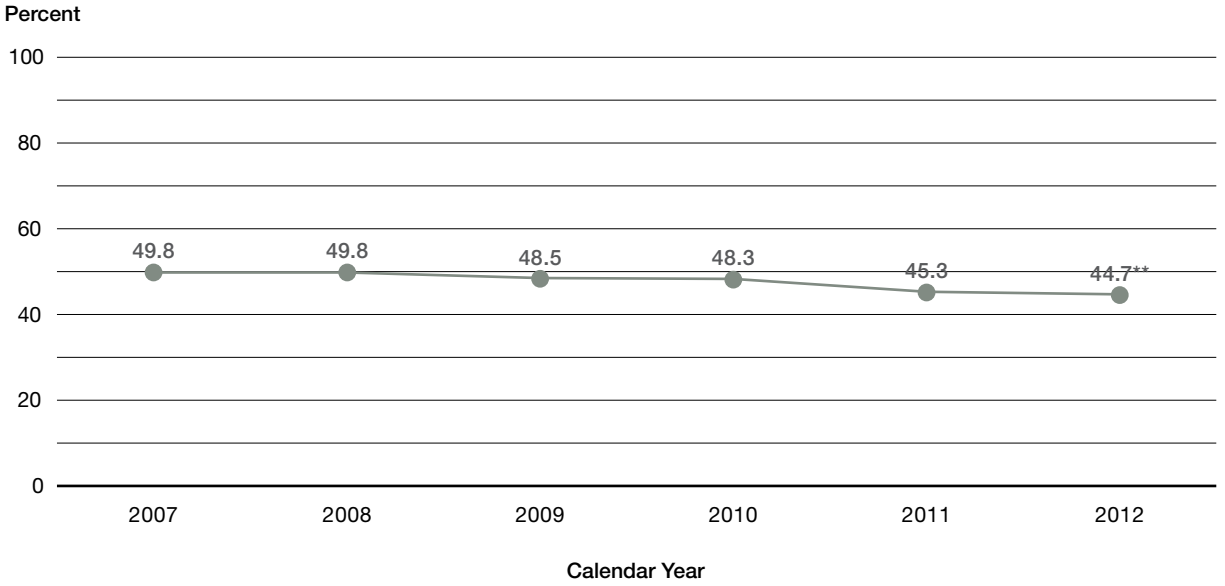
Ontarians are more active now compared to five years ago

Physical inactivity is associated with an increased risk of major chronic diseases, including heart disease, stroke, cancer, diabetes and osteoporosis.[18] Some researchers estimate that the burden of physical inactivity on population health is approximately equivalent to that of smoking.[15] Inactivity levels are estimated by examining survey respondents' answers to questions about daily leisure time physical activity. Those who are classified as active report physical activity equivalent to an hour of walking per day or 20 minutes of jogging per day, while those who are classified as inactive report activity equivalent to less than 30 minutes of walking per day. Those in between are classified as being moderately active.[19]

In 2012, 44.7% of Ontarians aged 12 and older report being physically inactive, a modest improvement over the 49.8% rate in 2007 (Figure 3.3).

Across Ontario, there is substantial variation in physical inactivity rates. The most favourable rate of inactivity in 2012 is in the North Simcoe Muskoka LHIN region at 31.6%, while people in the Central West LHIN region report being the least active, with an inactivity rate of 55.7% (Figure 3.4).

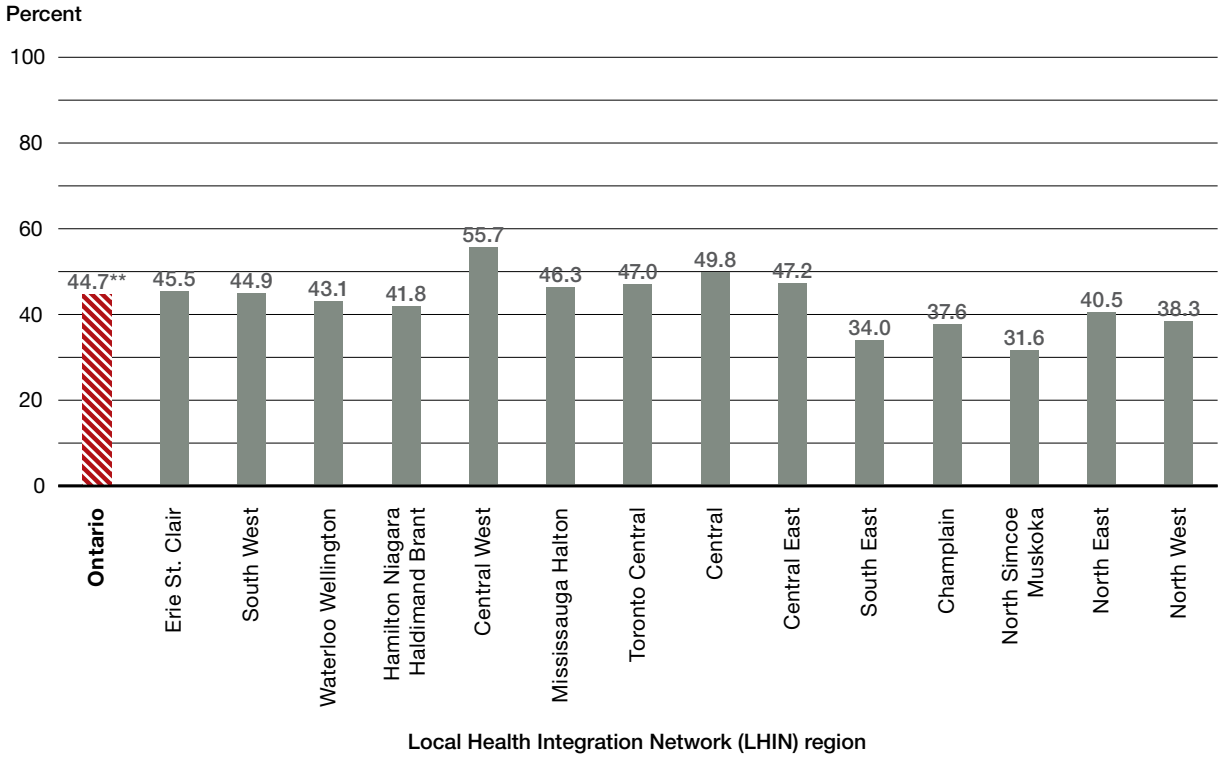
FIGURE 3.3
Age- and sex-adjusted rates of physical inactivity in Ontario, 2007 to 2012



Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Sciences **Ontario rates vary because of different data methods.

FIGURE 3.4

Age- and sex-adjusted rates of physical inactivity in Ontario, by LHIN region, 2012

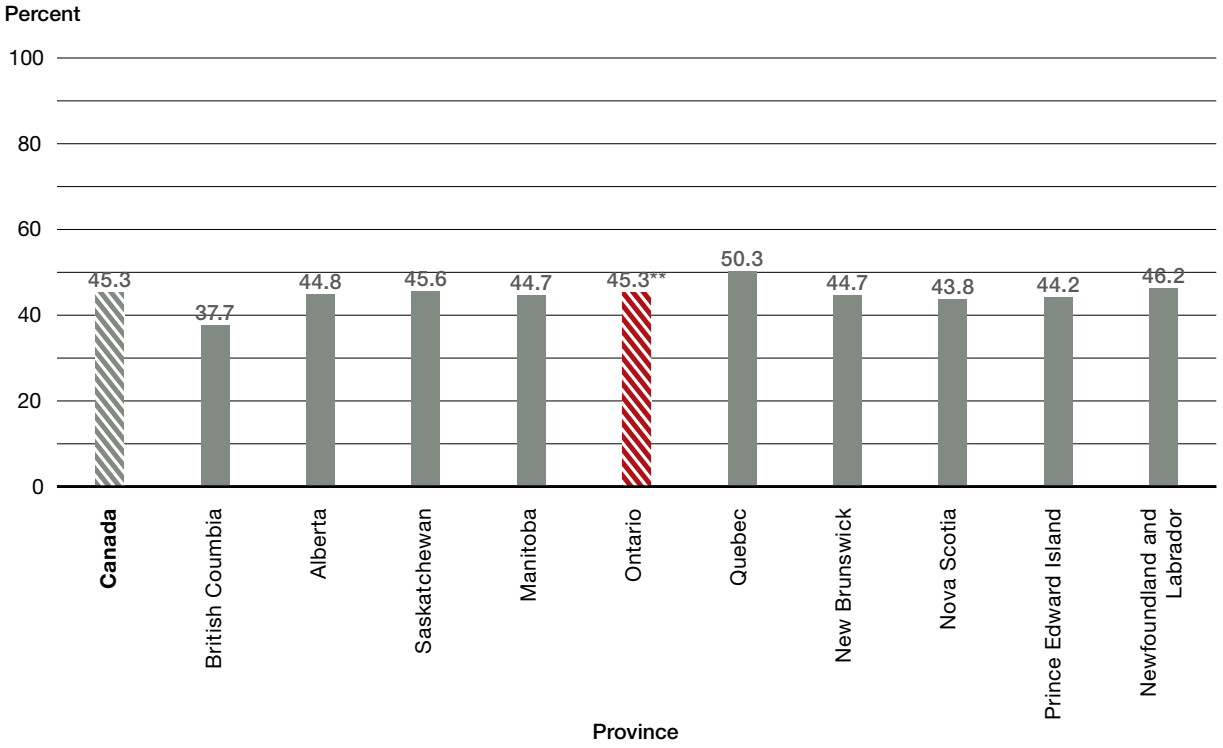


Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Sciences. **Ontario rates vary because of different data methods.

How Ontario compares: **within Canada**

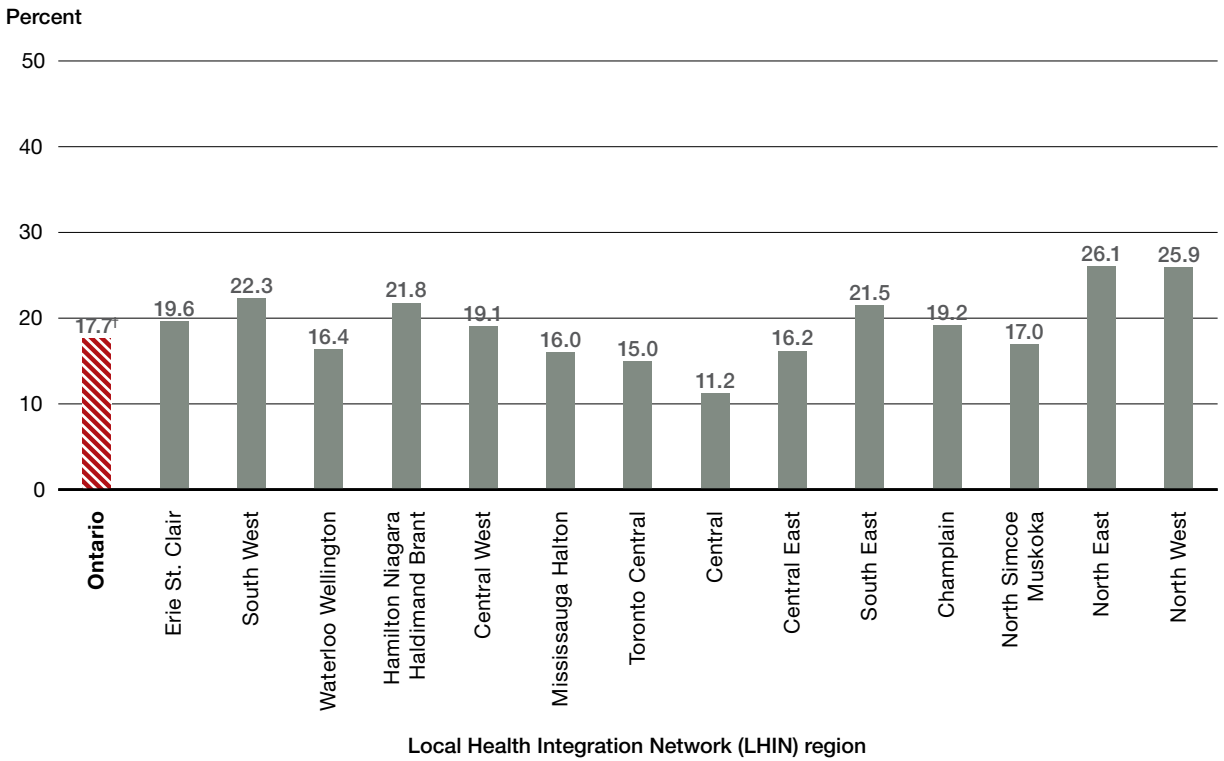
Data from Statistics Canada demonstrate that Ontario's inactivity rate is about the same as the Canadian average (45.3% report being inactive) in 2012. British Columbia reports the lowest (most favourable) inactivity rate in 2012 (37.7%) (Figure 3.5).

FIGURE 3.5
Age-adjusted rate of physical inactivity in Canada, by province, 2012



Data source: Canadian Community Health Survey, Statistics Canada.[17] **Ontario rates vary because of different data methods.

FIGURE 3.6
Age- and sex-adjusted prevalence of obesity in Ontario, by LHIN region, 2012



Data source: Canadian Community Health Survey, provided by the Institute for Clinical Evaluative Sciences †Ontario rates vary because of different data methods.

Obesity

The prevalence of obesity in Ontario remained stable over five years

People who are obese are more likely to develop a range of chronic diseases, including heart disease, stroke, high blood pressure, diabetes and arthritis.[20]

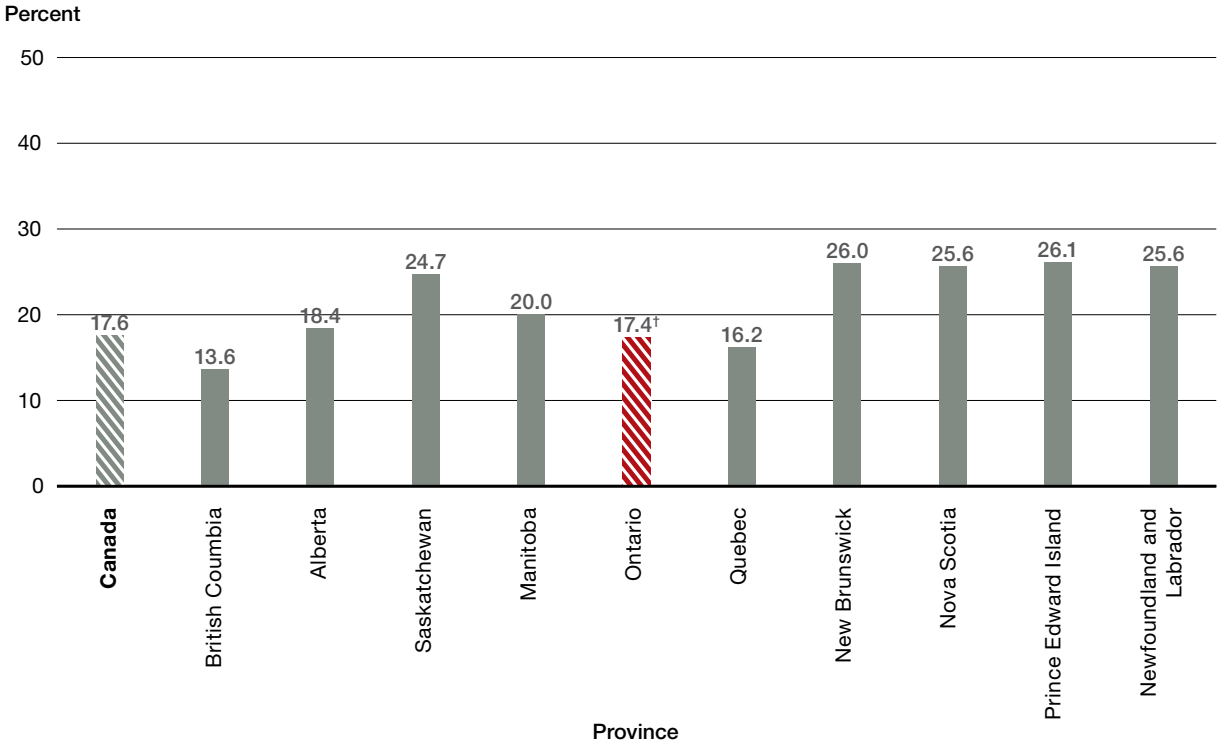
The prevalence of obesity in adults aged 18 and older in Ontario went from 16.5% in 2007 to 17.7% in 2012.[21]

The obesity prevalence is higher in the North East LHIN region (26.1%) and North West LHIN region (25.9%) than in the province as a whole (17.7%), and is lowest in the Central LHIN region (11.2%) (Figure 3.6).

How Ontario compares: **within Canada**

Statistics Canada's data suggest that the prevalence of obesity in Ontario (17.4%) is similar to the Canadian prevalence (17.6%) in 2012. Obesity prevalence is lowest in British Columbia (13.6%) (Figure 3.7).

FIGURE 3.7
Age-adjusted rate of obesity in Canada, by province, 2012



Data source: Canadian Community Health Survey, Statistics Canada.[17] †Ontario rates vary because of different data methods.

Measles immunization

Nearly 90% of Ontario school children were up-to-date on measles immunization in the 2012/13 school year

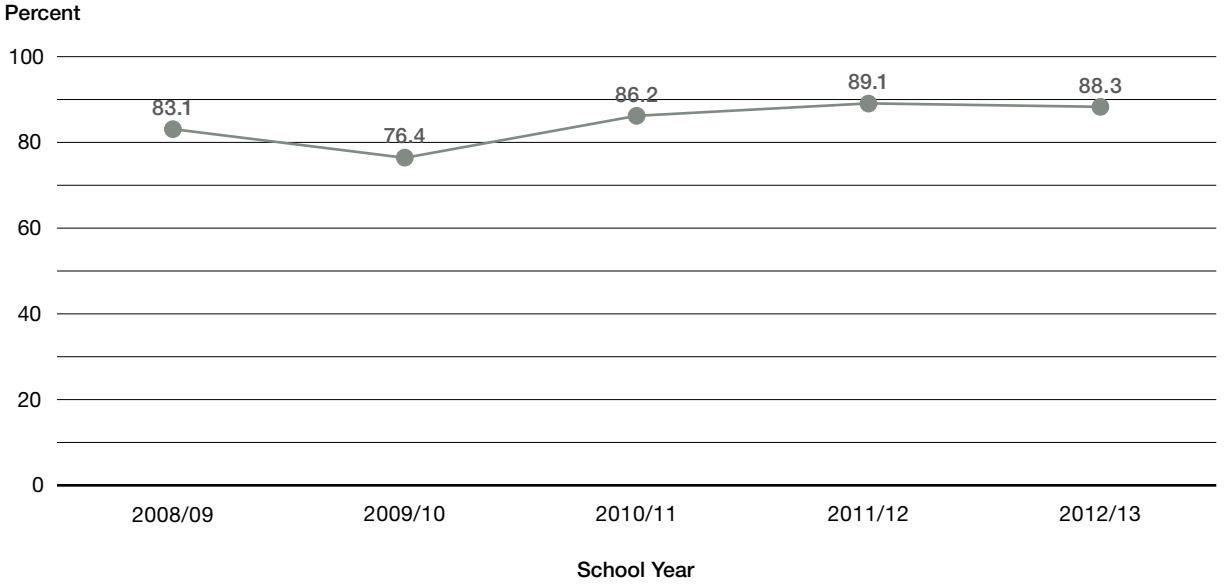
Measles is a contagious illness that can cause disability and death. Fortunately it can be prevented through immunization.

Over the last four years for which we have data, two-dose measles immunization coverage among seven-year-olds climbed to 88.3% in the 2012/13 school year, a slight improvement from 83.1% in 2008/09 (Figure 3.8).

Ontario is divided into seven Public Health Regions, and in the 2012/13 school year, the regions had substantially different results for measles immunization, ranging from a low of 80.4% in the Toronto Public Health Region to a high of 97.1% in the North West Public Health Region (Figure 3.9).

FIGURE 3.8

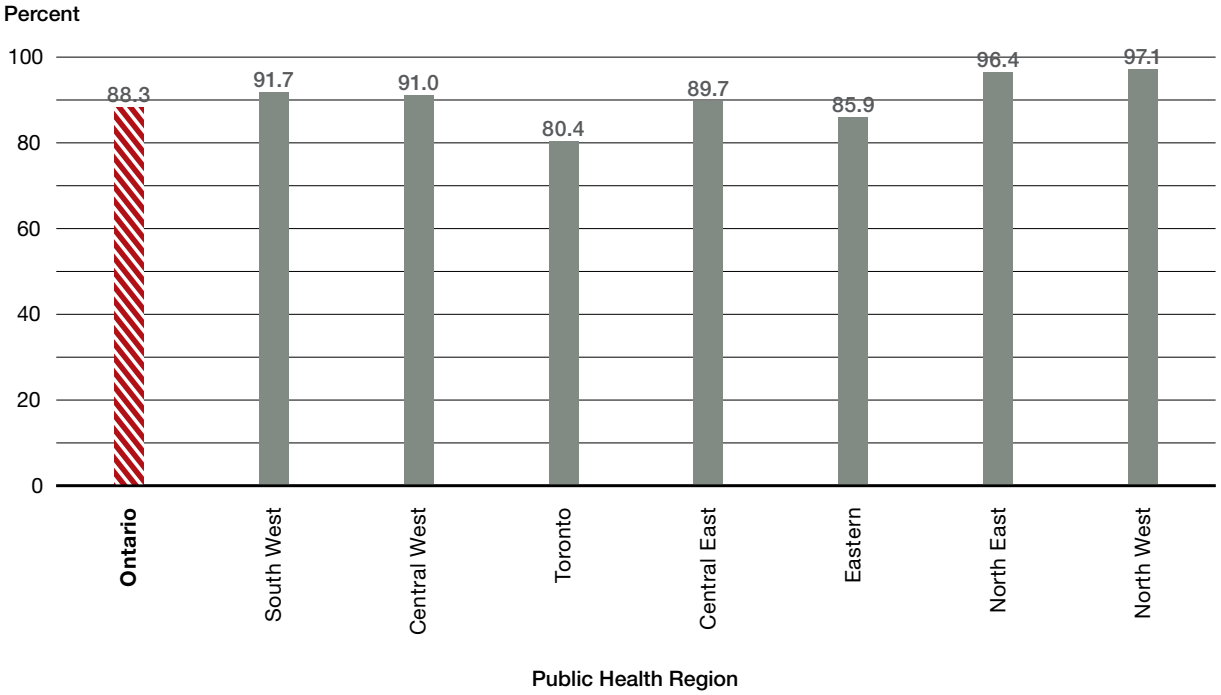
Two-dose measles immunization coverage for seven-year-olds, 2008/09 to 2012/13 school years



Data source: Immunization Records Information System provided by Public Health Ontario.

FIGURE 3.9

Two-dose measles immunization coverage for seven-year-olds, by Public Health Region, for the 2012/13 school year



Data source: Immunization Records Information System provided by Public Health Ontario.

Meningococcal immunization

Nine out of 10 Ontario school children were up-to-date on 1-dose meningococcal immunization in the 2012/13 school year

Meningococcal disease is contagious and can cause disability and death.[22] Ontario has two routine meningococcal immunization programs: an infant program and a school-based program. Here, we report the data for the school-based program.

The meningococcal immunization rate among 12-year-olds in Ontario improved slightly to 89.4% in the 2012/13 school year from 84.4% in the 2011/12 school year.[23]

Immunization rates across Ontario range from a low of 86.8% in the Toronto Public Health Region and a high of 92.0% in the North West Public Health Region.[23]

Influenza immunization for people 65 and older

Influenza immunization of Ontarians 65 and older decreased to 70.7% in 2012 from 75.2% in 2007

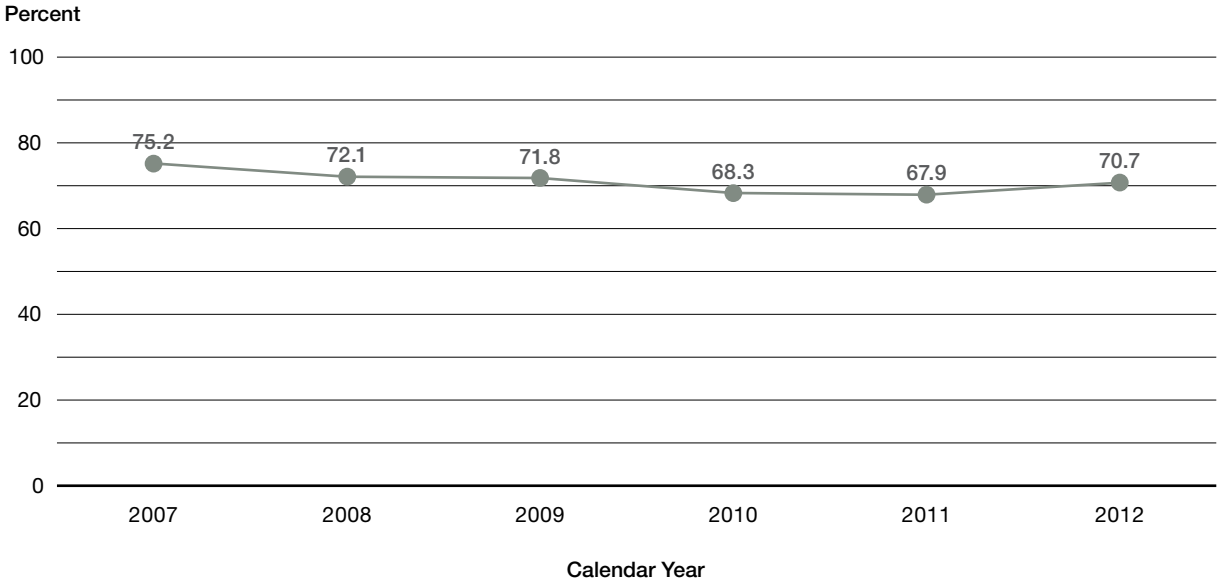
Influenza is a contagious disease that causes significant illness[24], workplace absenteeism[25], hospitalizations[26,27] and death.[28] People over the age of 65 are among those who are at the greater risk of dying from influenza[29], and research shows that Ontarians in this age group who were immunized against influenza have a lower death rate[30], which is why we monitor immunization rates in this age group.

The provincial rate of self-reported influenza immunization for people 65 and older is 70.7% in 2012. This is slightly worse than the rate of 75.2% in 2007, but better than the rate of 68.3% in 2010 (Figure 3.10).

Across Ontario, the lowest percentage of self-reported immunizations (57.8%) is in the Central West LHIN region and the highest (77.2%) in the South East LHIN region (Figure 3.11).

FIGURE 3.10

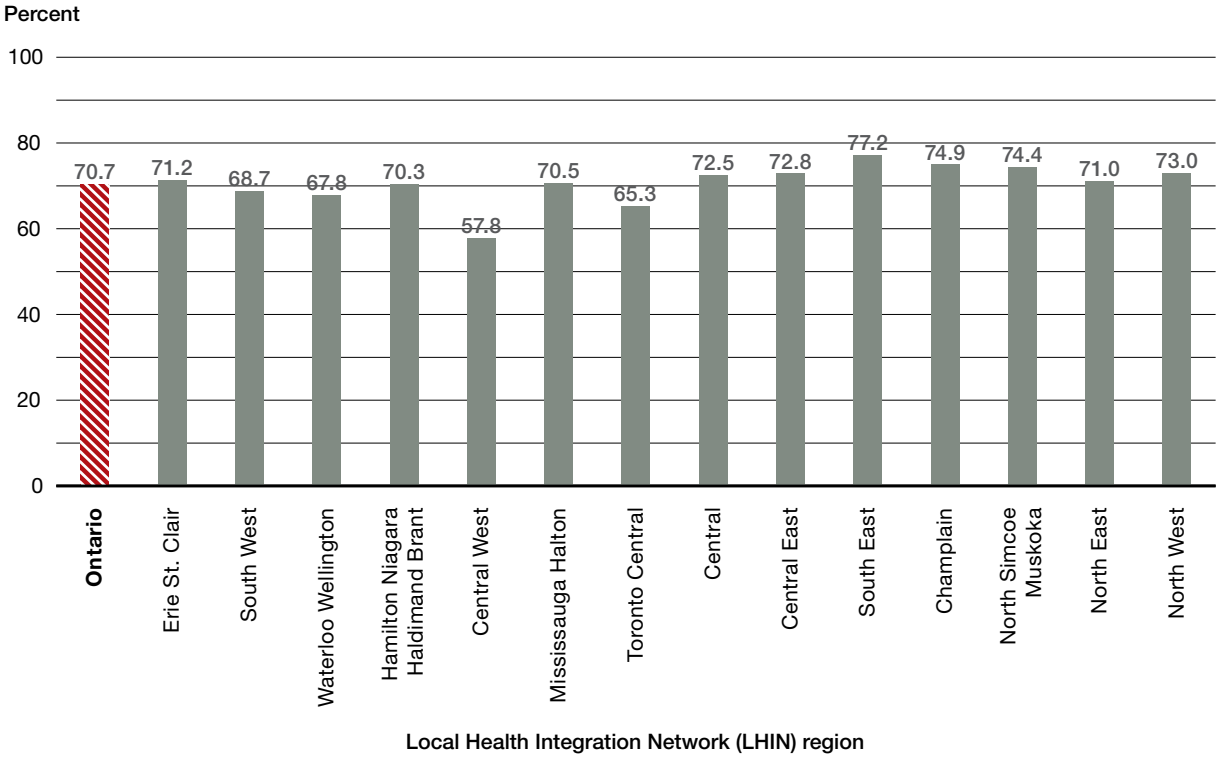
Percentage of influenza immunization among survey respondents aged 65 and older, in Ontario, 2007 to 2012



Data source: Canadian Community Health Survey provided by the Institute for Clinical Evaluative Sciences.

FIGURE 3.11

Percentage of influenza immunization among survey respondents aged 65 and older, in Ontario, by LHIN region, 2012



Data source: Canadian Community Health Survey provided by the Institute for Clinical Evaluative Sciences.

In summary

When it comes to lifestyle behaviours that affect our health, the story is mixed. Fewer Ontarians are smoking, and compared to other provinces, Ontario has one of the lowest smoking rates (but we still have 13,000 preventable deaths per year from smoking[14]). Fewer Ontarians report being inactive compared to five years ago, but almost half of us still report being inactive. The obesity rate in Ontario is not improving, but the province nevertheless has one of the lowest rates of obesity in Canada. For all of these indicators, there is wide variation across Ontario. In regards to preventing contagious diseases, immunization rates for childhood measles and meningococcal disease have improved over the last five years, but influenza immunization rates in older adults have not.

When it comes to lifestyle behaviours that affect our health, there is **wide variation across Ontario**.

Primary Care

In this chapter, we report on the Common Quality Agenda indicators that focus on access to primary care when it is needed, the experience patients have with their primary care providers, and whether patients receive recommended screening tests for some diseases.

Primary care in Ontario

Primary care providers — including family doctors, general practitioners and nurse practitioners — are viewed by many as the backbone of the health system. They assess and diagnose patients, provide counselling, give vaccinations, perform minor procedures, and provide continuity of care.[32,33]

Key Findings

More than 90% of Ontarians have a primary care provider they can see regularly

More than half of Ontarians (54.7%) report not being able to see their primary care provider on the same day or next day when sick

Over 40% of eligible Ontarians do not undergo colorectal cancer screening

Patients who have access to **coordinated, comprehensive and continuous primary care** tend to have better health than those who do not.[31]

Having a primary care provider

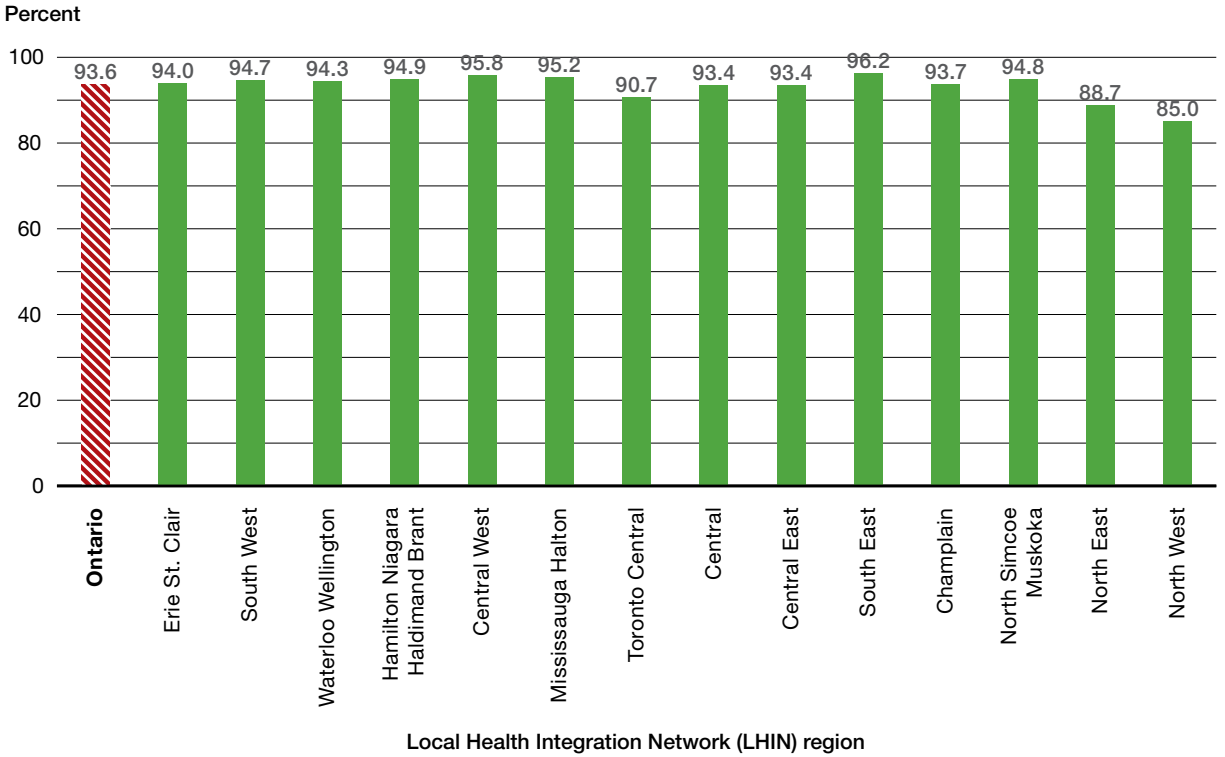
Except in northern regions, over 90% of those surveyed across Ontario report having a primary care provider

Patients who have access to coordinated, comprehensive and continuous primary care tend to have better health than those who do not.[31] Less access to primary care may lead to crowded emergency departments and inefficient use of health care resources.[34]

In 2013, 93.6% of Ontarians surveyed report having a primary care provider. There is moderate variation across Ontario, ranging from a low of 85.0% in the North West LHIN region to a high of 96.2% in the South East LHIN region (Figure 4.1).

FIGURE 4.1

Percentage of survey respondents who report having a primary care provider, in Ontario, by LHIN region, 2013



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

Timely access to primary care

More than half of Ontarians surveyed are not able to see their primary care provider on the same day or next day when they are sick

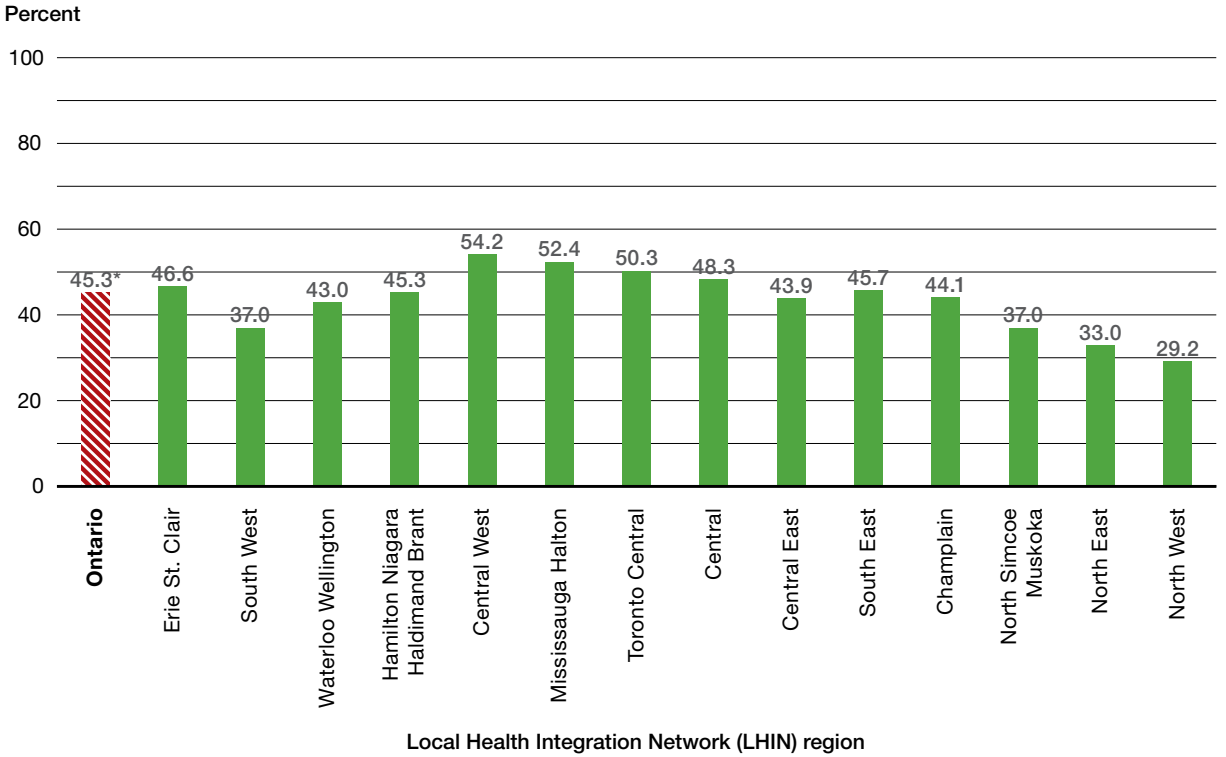
Having a primary care provider does not mean a patient will be able to get care when they urgently need it.

In Ontario, only 45.3% of those surveyed report that they are able to see their primary care provider on the same day or next day if they are sick (Figure 4.2).

Across Ontario, the proportion of people who report being able to see their primary care provider on the same day or next day when they are sick varies substantially, from a low (less favourable) of 29.2% in the North West LHIN region to a high (more favourable) of 54.2% in the Central West LHIN region (Figure 4.2).

FIGURE 4.2

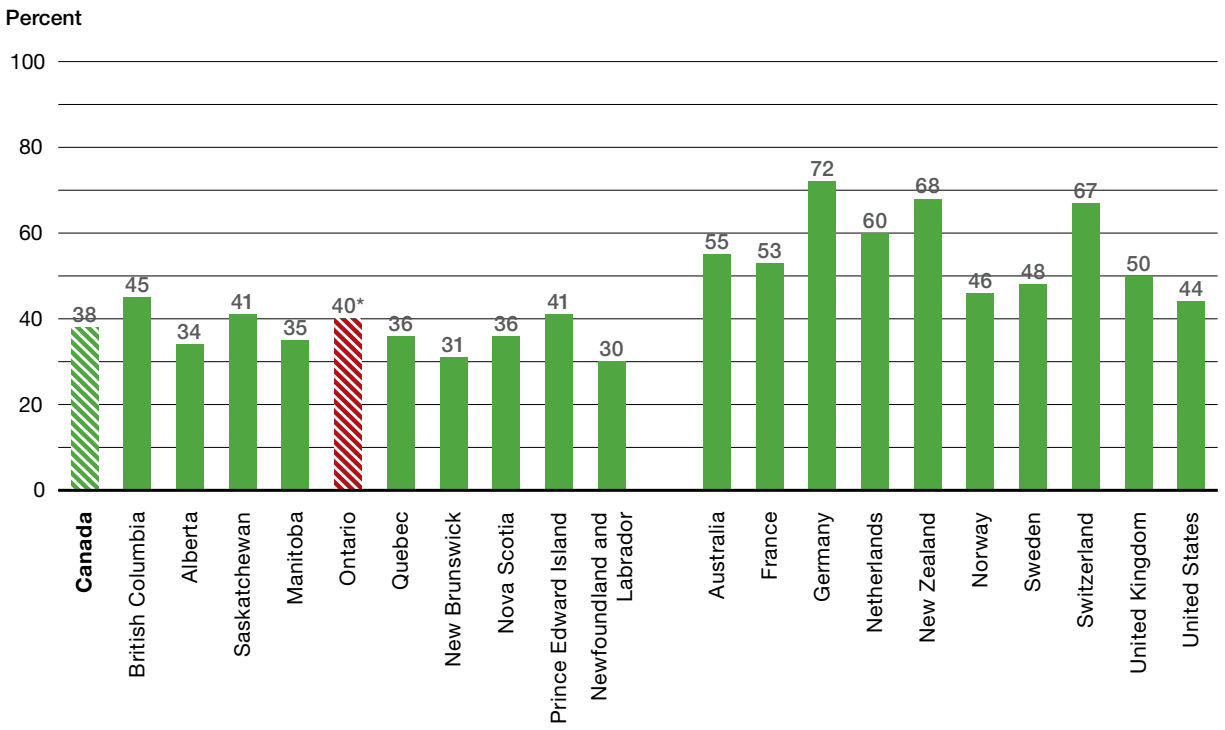
Percentage of survey respondents who were able to see their primary care provider on the same day or next day when they were sick, in Ontario, by LHIN region, 2013



Data source: Health Care Experience Survey, provided by Ministry of Health and Long-Term Care. *Ontario rates vary because of different data sources.

FIGURE 4.3

Percentage of survey respondents who were able to see their primary care provider on the same day or next day when they were sick, in Canada and internationally, 2013



Data source: 2013 Commonwealth Fund International Health Policy Survey. *Ontario rates vary due to different data sources.

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

Using the 2013 Commonwealth Fund survey, we can compare Ontario's performance with other provinces in Canada and internationally. In Canada, 40% of Ontarians surveyed report having access to same day or next day appointments with their primary care provider (Figure 4.3), higher than the 38% average for Canadians surveyed. People surveyed in British Columbia report the most favourable rate of timely access in Canada, with 45% reporting access to same day or next day appointments.

Compared internationally, however, Canadians and Ontarians surveyed report the worst access to same day and next day appointments with their primary care provider among the 11 countries in the survey (Figure 4.3). Germany has the most favourable percentage of people surveyed reporting same day or next day access at 72%.

Canada and Ontario have the **worst rates of same day/next day appointments** vs other countries

38% Canada

40% Ontario

72% Germany

44% United States

Meet Theresa

Age: 74, Caledonia

When Theresa tells her friends that she can get in to see her family doctor within a couple of hours of booking an appointment, they think she's making things up. "Some people just downright don't believe me," says Theresa, a 74-year-old retiree in Caledonia, south of Hamilton. "They think I'm exaggerating, but I'm not."

Theresa and her husband have the same family physician in nearby Dundas, where they used to live, for more than 25 years. She says it has always been fairly easy to get an appointment with her doctor if she said it was urgent, but things got even better about six years ago when the clinic became part of a family health team and switched to a new system for scheduling appointments.

"This is unbelievable," Theresa says. "If we call in the morning, we get in in the morning. If we call late in the day, we get in the next morning. You can plan your visits. If you know you are going down there for a 1 p.m. appointment and the longest you're going to wait is about 10 minutes, you're going to be out of there in an hour. The team is intent of making your experience a positive one. From a patient's point of view, it's a great system."

Although many Ontarians have trouble accessing primary care when they need it, some patients have timely access.

"The team is intent on making your experience a positive one. From a patient's point of view, it's a great system."

Accessing after-hours primary care

More than half of Ontario patients surveyed have difficulty accessing primary care on an evening or weekend

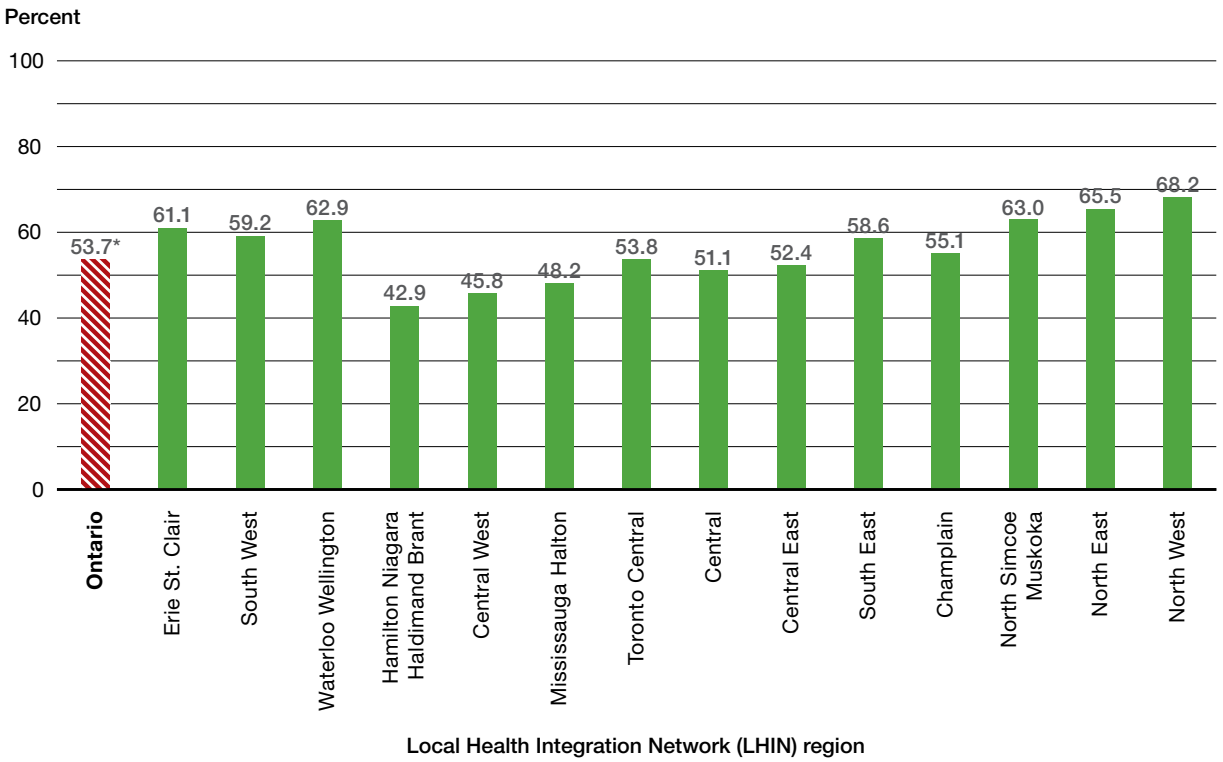
Having access to after-hours primary care is important to improve care for patients and reduces strain on other parts of the health system.[35]

More than half of people surveyed in Ontario (53.7%) report that getting evening or weekend access to primary care (without going to the emergency department) is very difficult or somewhat difficult.[36]

There is substantial variation across Ontario with 42.9% (more favourable) in the Hamilton Niagara Haldimand Brant LHIN region reporting difficulty in accessing primary care on evenings and weekends, compared to 68.2% in the North West LHIN region (Figure 4.4).

FIGURE 4.4

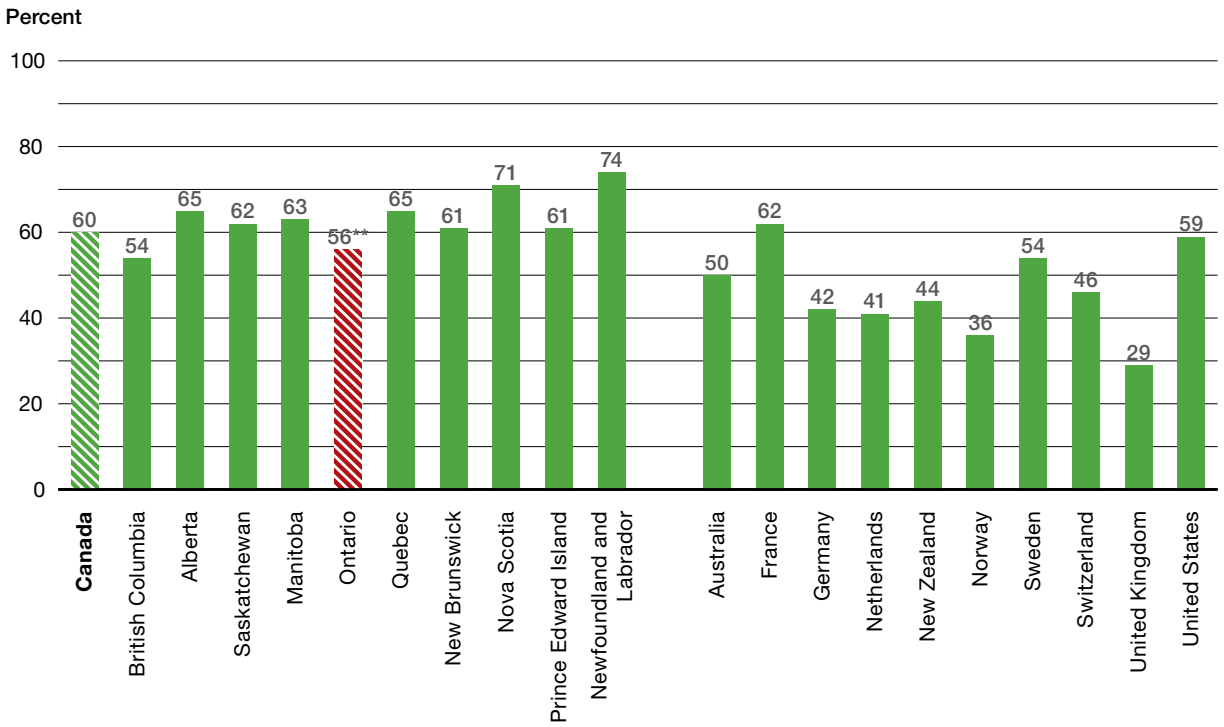
Percentage of survey respondents who report that getting access to care on an evening or weekend, without going to the emergency department, was very difficult or somewhat difficult, in Ontario, by LHIN region, 2013



Data source: Health Care Experience Survey, provided by Ministry of Health and Long-Term Care. **Ontario rates vary due to different data sources.

FIGURE 4.5

Percentage of survey respondents who report that getting access to care on an evening or weekend, without going to the emergency department, was very difficult or somewhat difficult, in Canada and internationally, 2013



Data source: 2013 Commonwealth Fund International Health Policy Survey. **Ontario rates vary due to different data sources.

More than half of Ontarians surveyed report that getting **evening or weekend access to primary care is very difficult** or somewhat difficult

56% Ontario

29% UK

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

The 2013 Commonwealth Fund survey provides context as to how well Ontario is performing compared to other provinces in Canada and internationally. In Canada, 56% of Ontarians surveyed say getting access to primary care on evenings or weekends is very or somewhat difficult (Figure 4.5). This is lower (more favourable) than the Canadian average of 60%.

Compared to the other countries in the Commonwealth Fund survey, however, people surveyed in Ontario and Canada overall have substantially more difficulty accessing primary care in the evening or on a weekend. People surveyed in the United Kingdom have the best rates of after-hours access, with only 29% reporting somewhat or very difficult experiences in accessing primary care during the evening or weekend, compared to Ontario at 56% and Canada at 60% (Figure 4.5).

Patient experience in primary care

Ontario patients give high marks to their primary care providers

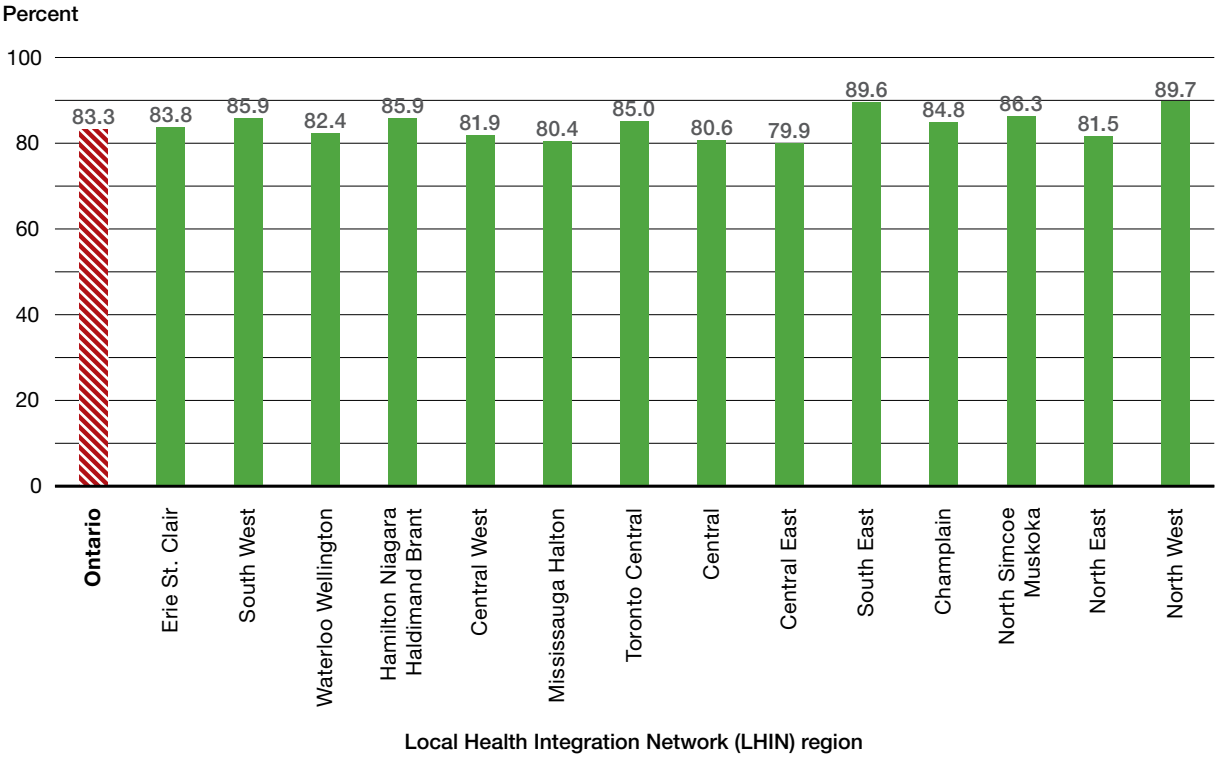
Measuring patient experience gives us an indication of the responsiveness of the health system to patients' expectations.[37]

Good communication between health care professionals and patients supports patient-centred care.[38] We report three communication indicators to assess patient experience in Ontario, asking whether patients believe their provider gives them the opportunity to ask questions, spends enough time with them and involves them in decisions regarding their care.

There is modest variation across Ontario for all three of the provider-patient communication indicators in 2013 (Figures 4.6a–c). The South East LHIN region consistently has the best ratings across the three indicators.

FIGURE 4.6A

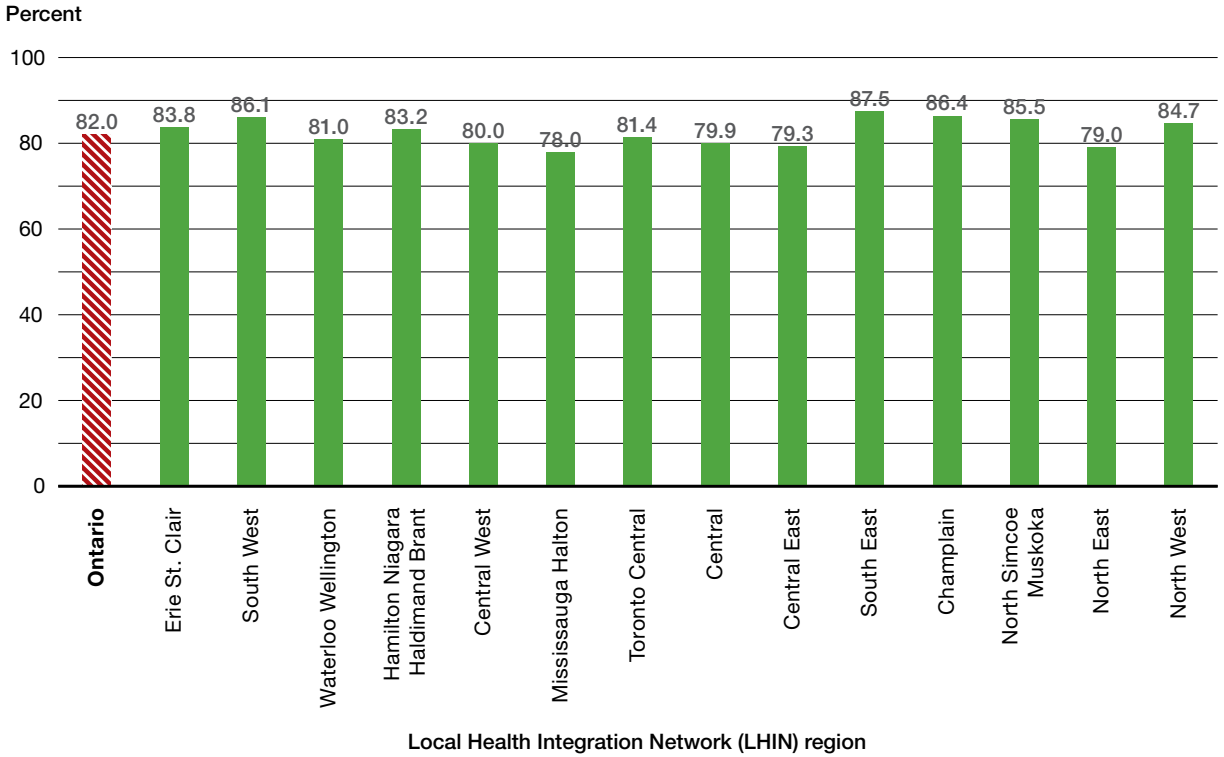
Percentage of survey respondents who report that their provider always or often gives them the opportunity to ask questions, in Ontario, by LHIN region, 2013



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

FIGURE 4.6B

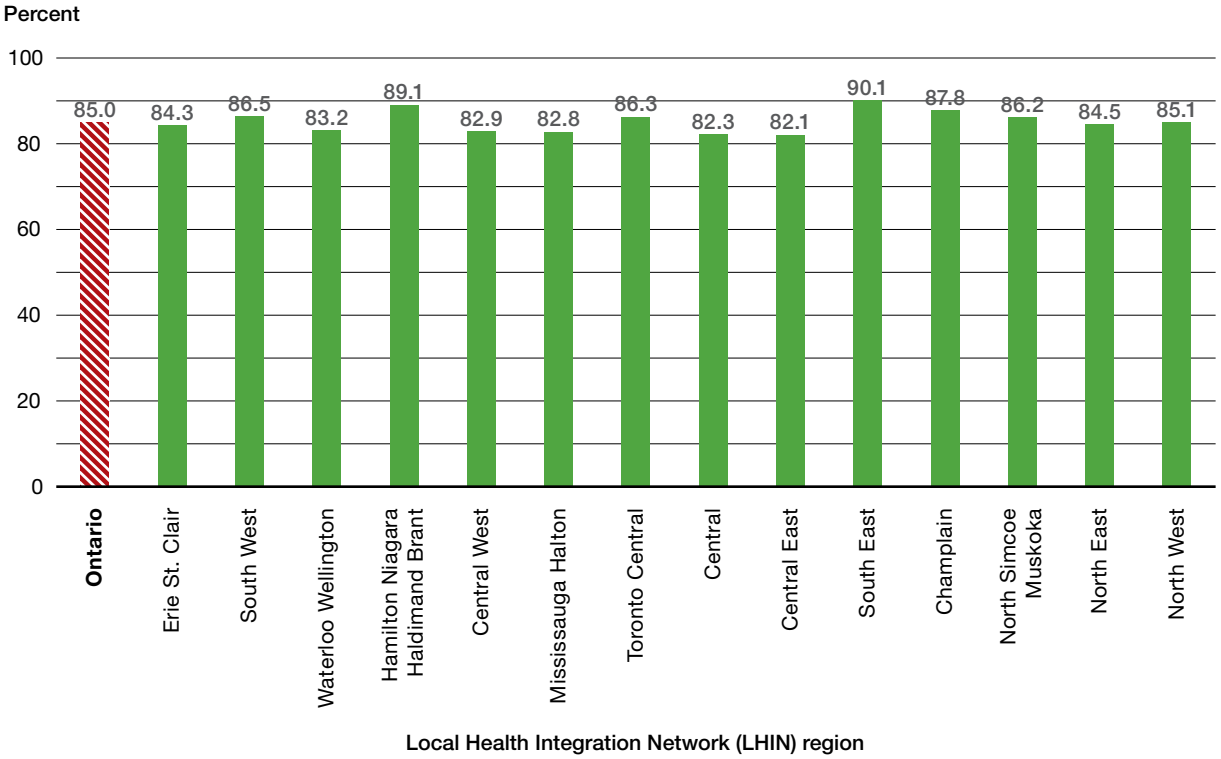
Percentage of survey respondents who report that their provider always or often spends enough time with them, in Ontario, by LHIN region, 2013



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

FIGURE 4.6C

Percentage of survey respondents who report that their provider always or often involves them in decisions regarding their care, in Ontario, by LHIN region, 2013



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

Meet Sara

Age: 32, Toronto

When the nurse called Sara and her husband into another room, she knew it would be bad news. Sara's husband, a PhD student in mechanical engineering who was living in Toronto, had just suffered a seizure and was in the hospital undergoing tests to find out what was wrong. Sara, then living in Ottawa pursuing a PhD in economics, had rushed to Toronto to be by his side.

The doctor confirmed Sara's fears: Her husband had a brain tumour. Sara and her husband were in shock when they left the hospital. "The doctors never mentioned the word cancer," Sara says. "Only later when I researched brain tumours did I realize that he had cancer."

Sara abandoned her studies and moved from Ottawa to care for her husband. "He was in denial about the cancer and didn't tell his family about it," she says. Doctors did not recommended surgery right away, leaving the couple to just watch and wait. Sara dealt with her husband's seizures — at one point up to five per day. Just before one of the seizures, she remembered looking directly into his eyes. "It felt as if he was looking at something far, far away," Sara says. "I was crying very hard but not making any sound … I was so sad to see my intelligent, best friend going through this."

In her new role as full-time caregiver for her husband at home, Sara felt alienated from her friends, and from the health system. "When people saw me, they always asked how he was doing," Sara says. "No one ever asked me how I was doing."


Photo by Roger Yip

As her husband's cancer progressed and he underwent both surgery and chemotherapy, Sara says the doctors were often dismissive of her concerns and statements over her husband's health and treatments. Once, when she took her husband to the emergency department after he bit his tongue during a seizure, a doctor admonished her for overreacting.

Months later, after her husband's condition stabilized, Sara started doing research and found out there was a name to describe her: family caregiver. She eventually found some supports to help her sharpen her caregiving skills, and to learn how to take care of herself. "Family caregivers are the largest invisible population in the health system," Sara says.

She is continuing to pursue a PhD, but now in Toronto, with a focus on health policy.

Family caregivers are active participants in the health system, but many struggle for recognition of their role.

"Family caregivers are the largest invisible population in the health system."

Colorectal cancer screening

More than four out of 10 eligible Ontarians do not undergo recommended screening for colon cancer

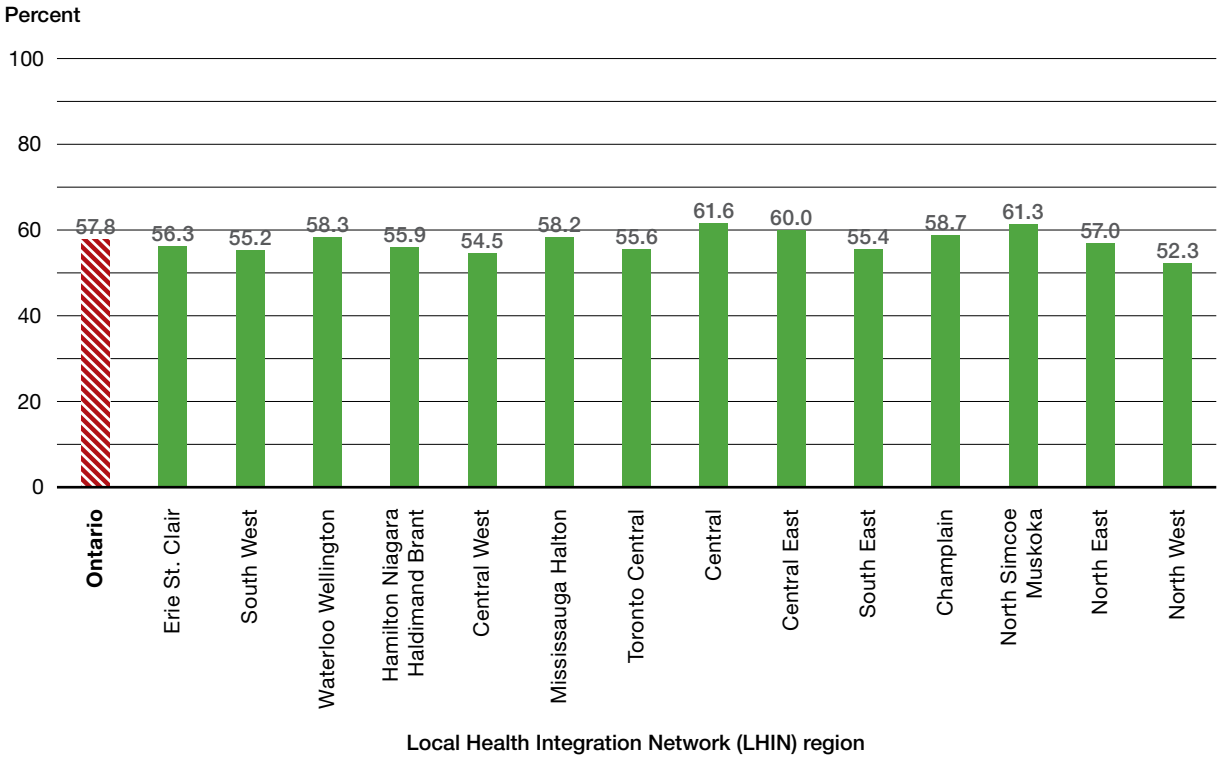
More than 7,800 Ontarians die of colorectal cancer each year, making it the fourth-leading cause of cancer deaths in the province.[39] Screening for colorectal cancer saves lives.[40] Ontario's colorectal cancer screening program, ColonCancerCheck, recommends that people with an average risk of colon cancer between the ages of 50 and 74 years have a test that checks for blood in the stool (often called "fecal occult blood testing") every two years.[41] Other screening test options for colon cancer include flexible sigmoidoscopy or colonoscopy.[40]

57.8%

Percentage of eligible Ontarians who had recommended colorectal cancer screening in the past year

FIGURE 4.7

Colorectal cancer screening rate among people aged 50–74, by LHIN region, 2012



Data sources: Ontario Health Insurance Plan, Laboratory Reporting Tool, Ontario Cancer Registry, Pathology Information Management System, Registered Persons Database, Postal code conversion file 5k, Colonoscopy Interim Reporting Tool, provided by Cancer Care Ontario.

Looking at all three of the main screening tests combined (checking for blood in the stool, flexible sigmoidoscopy and colonoscopy), the rate among 50–74-year-old Ontarians improved slightly from 2009 to 2012, rising to 57.8% from 53.2%.[42]

There is modest variation in the colorectal cancer screening rates across Ontario, with the Central LHIN region having the most favourable rate of 61.6% and the North West LHIN region the least favourable rate of 52.3% (Figure 4.7).

Diabetes eye exams

One-third of Ontarians with diabetes do not undergo regular screening for diabetic retinopathy, a life-changing complication

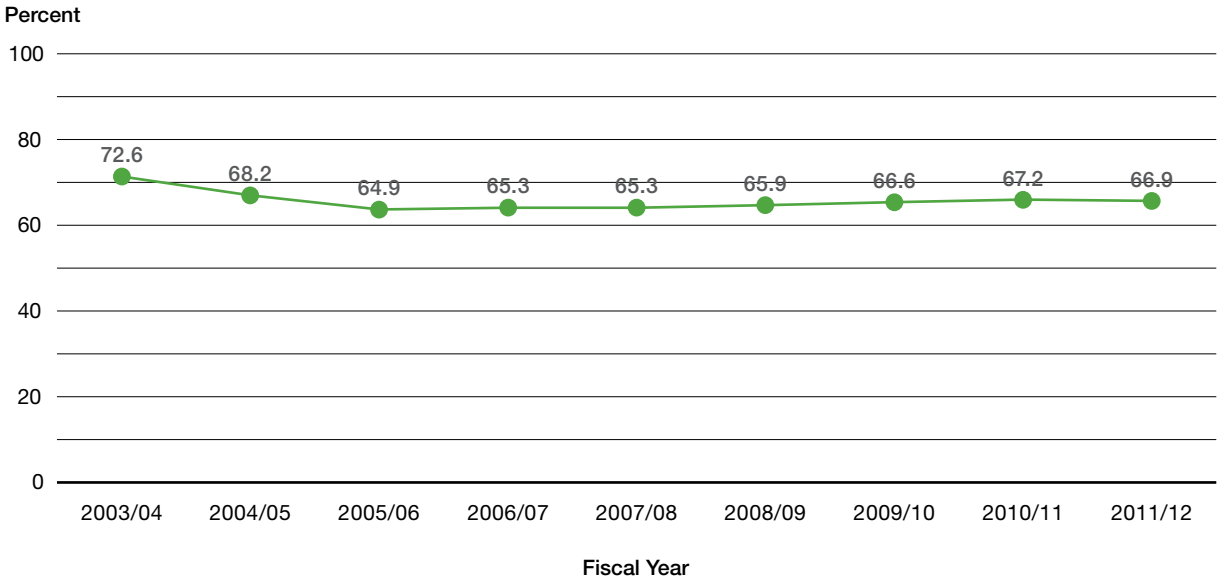
Primary care providers are in a prime position to counsel their patients with diabetes to have regular vision exams. The goal is to prevent vision loss from the eye disorder diabetic retinopathy, which is caused by changes in the blood vessels in the retina of the eye. This disorder is a common complication among the more than one million Ontarians currently living with diabetes[43], and is also the most common reason that young and middle-aged adults develop blindness in Canada.[44] Since treatment for retinopathy is much more successful when it is detected early, clinical practice guidelines recommend screening for retinopathy in patients with diabetes every one or two years.[45] Primary care physicians can educate diabetic patients to get regular eye exams.

About one-third of Ontarians with diabetes are not screened for diabetic retinopathy within a two-year cycle (Figure 4.8).

There was a notable decline in the screening rate from a high of 72.6% in 2003/04 to 64.9% in 2005/06. This decrease has been associated with discontinuation of public funding for routine eye exams for healthy adults in 2003/04.[46] Although patients with diabetes can still receive eye exams free of charge, the change may have confused some physicians and patients.[46]

FIGURE 4.8

Percentage of people with diabetes who received an eye exam within a two-year period, in Ontario, 2003/04 to 2011/12



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

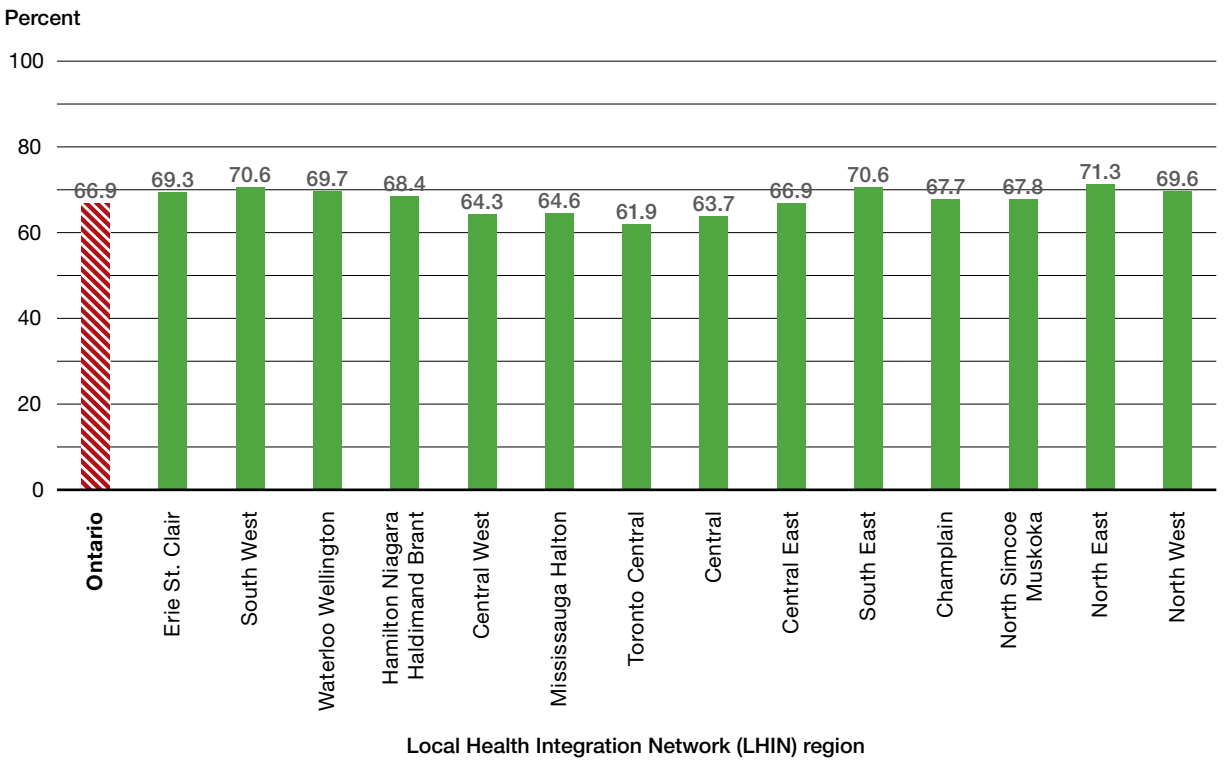
The screening rate for diabetic retinopathy varies moderately across Ontario. The percentage of patients with diabetes who had an eye exam within two years ranges from 61.9% in the Toronto Central LHIN region to 71.3% in the North East LHIN region (Figure 4.9).

1/3

About one third of **Ontarians with diabetes do not get eye exams** as frequently as recommended

FIGURE 4.9

Percentage of people with diabetes who received an eye exam within a two-year period, in Ontario, by LHIN region, 2011/12



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

In summary

Although nine out of 10 Ontarians report having a regular primary care provider, more than half of Ontarians report have difficulty accessing primary care on short notice and on evenings and weekends. This is similar to the Canadian average, but substantially worse than in other countries. However, when Ontarians do receive care, they report very positive experiences with their primary care providers.

There is room for improvement in the two screening rates we include in this report: colorectal cancer for people aged 50–75, and retinopathy screening for people with diabetes. Four out of 10 eligible Ontarians do not have recommended screening for colon cancer, and one-third of Ontarians with diabetes may not have eye exams within the recommended two-year period.

For all of the indicators reported in this chapter, we note moderate to substantial variation across the province, in particular with respect to access to primary care when needed and on evenings and weekends.

Nine out of 10 Ontarians report having a regular primary care provider, but **more than half report having difficulty accessing primary care on short notice and on evenings and weekends.**

Hospital Care

In this chapter, we report on Common Quality Agenda indicators related to patient satisfaction, the time people spend in the emergency department, wait times for some procedures performed in hospital (e.g., joint replacement, cardiac procedures, cancer treatment), rates of a hospital-acquired infection, as well as rates of pressure ulcers, falls and restraint use for select groups of patients.

A rich history of reporting on hospital care

Public reports about the performance of hospital care in Ontario have a two-decade-long history with the first of such reports produced by the Institute for Clinical Evaluative Sciences.[47] The Ontario Hospital Association through its *Hospital Reports* series[48], the Canadian Institute for Health Information[49] and Health Quality Ontario[50] have also produced reports offering information about the quality of care provided in Ontario hospitals.

Hospitals provide many forms of care and serve many different types of patients.

Key Findings

Nearly three out of four Ontario inpatients surveyed say they would definitely recommend to family and friends the hospital where they were treated

The percentage of urgent coronary artery bypass graft surgeries completed within the target wait time improved to 87% from 74% over six years

The percentage of urgent cancer surgeries completed within the target time in Ontario improved to 73% from 54% over five years

The use of physical restraints for patients with mental health conditions requiring inpatient treatment decreased to 5.3% from 8.5% over five years

Patient satisfaction

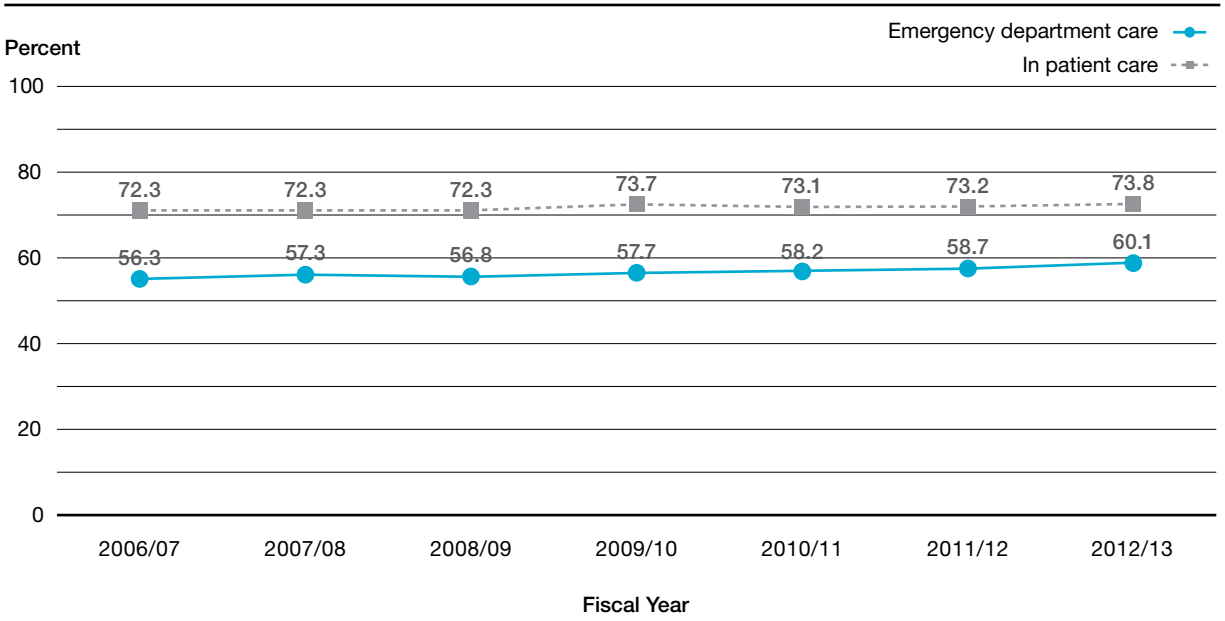
Nearly three-quarters of Ontario inpatients surveyed would 'definitely' recommend to family and friends the hospital where they received care

Many patients being discharged from hospital receive a survey asking them whether they would recommend to their family and friends the hospital where they received care. Answer options include: "Yes, definitely," "Yes, probably," and "No."

The percentage of patients who responded "Yes, definitely" to recommending to family and friends the hospital emergency department improved slightly over the last seven years rising to 60.1% in 2012/13 from 56.3% in 2006/07. Recommending hospital inpatient care was stable over the same period, with 73.8% in 2012/13 responding "Yes, definitely," compared to 72.3% in 2006/07 (Figure 5.1).

FIGURE 5.1

Hospital satisfaction: percentage of survey respondents who would "definitely" recommend hospital to family and friends, by inpatient and emergency department care, in Ontario, 2006/07 to 2012/13



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

Emergency department length of stay

For both low-acuity and high-acuity patients, the 90th percentile emergency department length of stay is higher than the target time

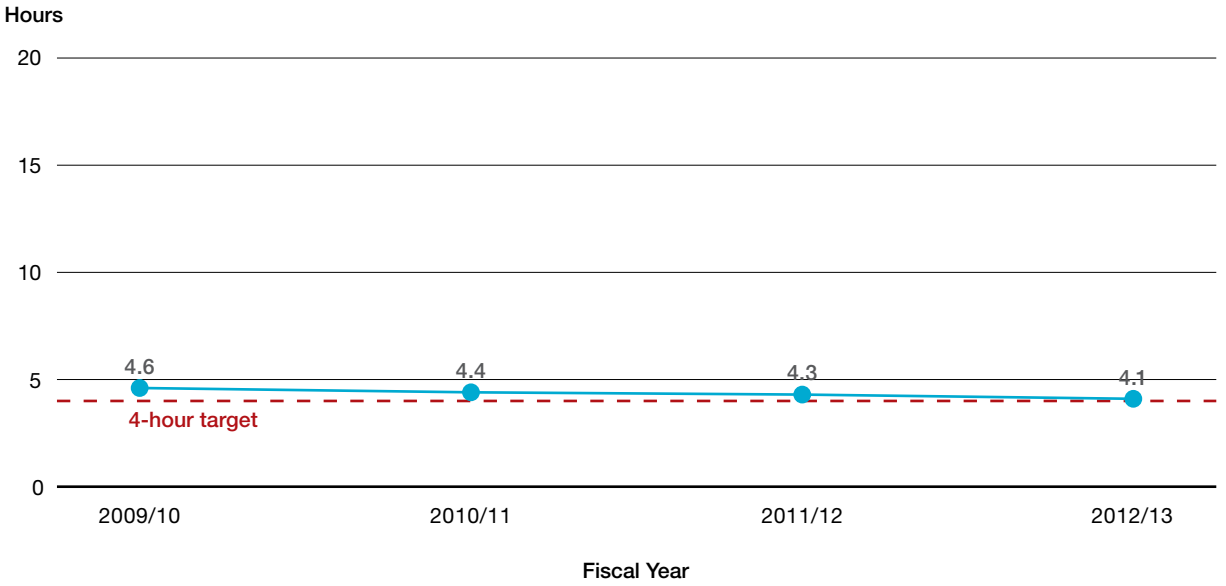
In the past year (2012/13), there were about 5.3 million visits to Ontario's emergency departments, compared to about 4.9 million visits in 2009/10.[61]

The Ministry of Health and Long Term Care set targets for the amount of time patients should spend in the emergency department. The targets are based on the 90th percentile length of stay, which is the amount of time within which nine out of 10 patients are discharged from the emergency department. There are separate targets of four hours for low-acuity patients (i.e., those whose medical condition does not generally require an immediate assessment) and eight hours for high-acuity patients (i.e., those who need to be seen immediately or very soon after arrival in the emergency department).[52] Acuity levels are determined upon arrival at the emergency department. In 2012/13, low-acuity patients accounted for about 40% of emergency department visits, and high-acuity patients accounted for about 60%.[51]

The emergency department length of stay measures the total time that someone who visits an emergency department spends there. The timing starts when a patient either registers or is triaged — whichever happens first — and ends when the patient is discharged from the emergency department or transferred to a hospital bed. We report the 90th percentile emergency department length of stay, which is the amount of time within which nine out of 10 patients are either discharged from the emergency department or admitted to hospital for further care.[52]

FIGURE 5.2

Maximum amount of time nine out of 10 patients (90th percentile) spent in the emergency department for low-acuity conditions, in Ontario, 2009/10 to 2012/13



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

Low-acuity patients

Low-acuity patients in Ontario had a 90th percentile emergency department length of stay of 4.1 hours in 2012/13, an improvement from 4.6 hours in 2009/10 (Figure 5.2) and very close to the ministry target of four hours for this group.[52]


Photo by Michelle Hill

Meet Mary

Age: 59, Dryden

Mary fidgeted restlessly in the waiting room, trying to ignore the waves of pain that pulsed through her shoulder. A few hours earlier, she had tripped and fallen at work, landing with a thud on her right arm. Despite the throbbing pain, Mary managed to finish up the last half hour of her shift before a co-worker drove her to the rural emergency department about 350 kilometres west of Thunder Bay.

Arriving at the emergency department at 5:30 p.m., a nurse assessed Mary's injury about half an hour later and told her she would have a one- or two-hour wait to see a doctor. Luckily, Mary had grabbed a quick dinner before heading to the hospital, because a few hours later, she was still waiting. Her mother had come by to see her, but at about 9 p.m. she told her mom to go home, as it didn't look like she'd be seeing a doctor anytime soon. The waiting room was busy that night — staff were dealing with at least two cases that were more urgent than hers — but as the hours dragged on, Mary wished someone could give her an update on how much longer she could expect to wait.

Mary began to get anxious, but **felt that she had no choice but to keep waiting**.

Knowing she had to get to work at 7:30 the next morning, Mary began to get anxious, but felt that she had no choice but to keep waiting. "What else are you going to do?" she says. "It was not pleasant. I was getting upset." She struck up conversations with some other people in the waiting room, including one woman who had been there since 11 a.m. and didn't see a doctor until 11 p.m.

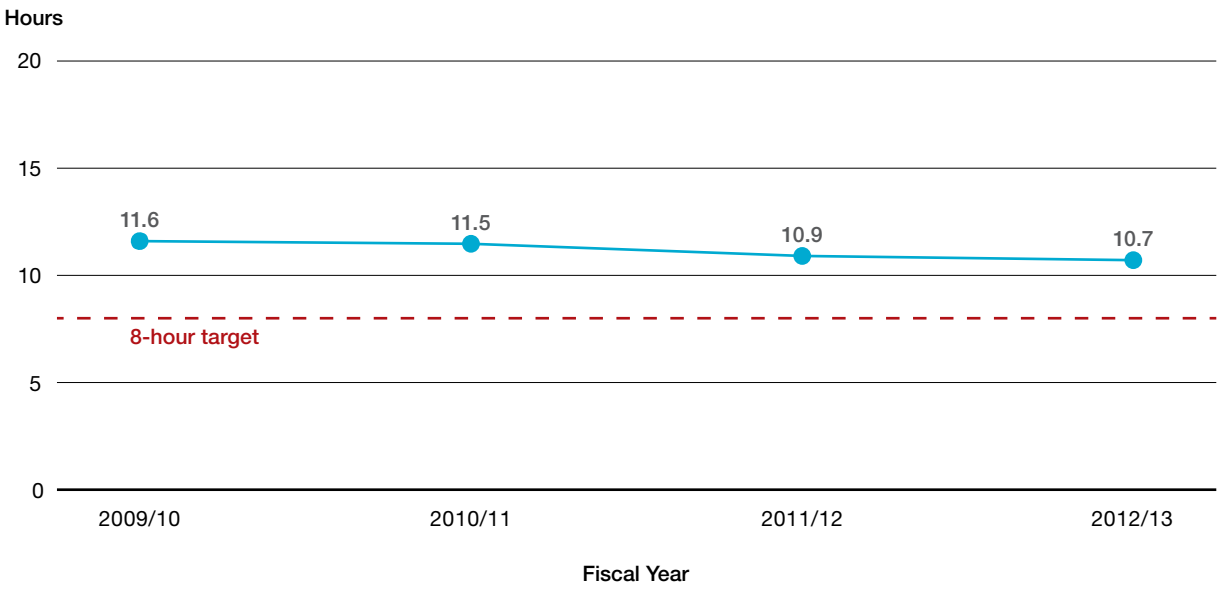
At about 1 a.m., more than seven hours after arriving at the emergency department, Mary finally made it in to see a doctor, who examined her arm. An X-ray was inconclusive, so the doctor told Mary she should keep moving her arm so it wouldn't seize up, and sent her home. She made it to work on time for her shift later that morning feeling physically and emotionally exhausted.

High-acuity patients

The 90th percentile emergency department length of stay of 10.7 hours for high-acuity patients in 2012/13 improved from 11.6 hours in 2009/10 (Figure 5.3), moving closer to the ministry target of eight hours for high-acuity patients.[52]

5.3 million
Number of emergency department visits Ontario hospitals handled in the past year

FIGURE 5.3
Maximum amount of time nine out of 10 patients (90th percentile) spent in the emergency department for high-acuity conditions, in Ontario, 2009/10 to 2012/13



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

Wait times for procedures

The Ministry of Health and Long-Term Care has set recommended maximum wait time targets for selected diagnostic tests, procedures and surgeries.[53] These recommended maximum wait times may differ depending on the urgency of the case. We report the percentage of patients who receive certain procedures within the target time frame.

Wait times meeting targets

This summary table shows the percentage of patients for whom the recommended maximum wait time targets are met, with the target time based on urgency level:

TABLE 5.1

Percentage of procedures completed within recommended maximum wait time, in Ontario, 2013/14

Procedure	Priority level	Recommended maximum wait time (days)	Percentage of procedures completed within recommended maximum wait time (%)
Hip replacement	Elective	182	86
Knee replacement	Elective	182	83
Diagnostic cardiac catheterization	Urgent	7	91
	Semi-Urgent	28	80
	Elective	84	97
Percutaneous coronary intervention	Urgent	7	91
	Semi-Urgent	14	87
	Elective	28	98
Coronary artery bypass grafts	Urgent	14	87
	Semi-Urgent	42	88
	Elective	90	96
Cancer surgery	Urgent	14	73
	Semi-Urgent	28	80
	Elective	84	94

Data source: Wait Times Information System, Cancer Care Ontario; Cardiac Care Network of Ontario Cardiac Registry.

Hip or knee replacements completed within target wait time

The percentage of hip or knee replacements completed within the target time frame has remained stable over the past five years

A hip or knee replacement can significantly improve a patient's mobility and quality of life.[54,55] The wait time for these procedures is measured from when a patient and surgeon decide to go ahead with the surgery to the time the actual procedure is completed. While this wait time frame is important, it does not include the entire time the patient spends waiting for care.

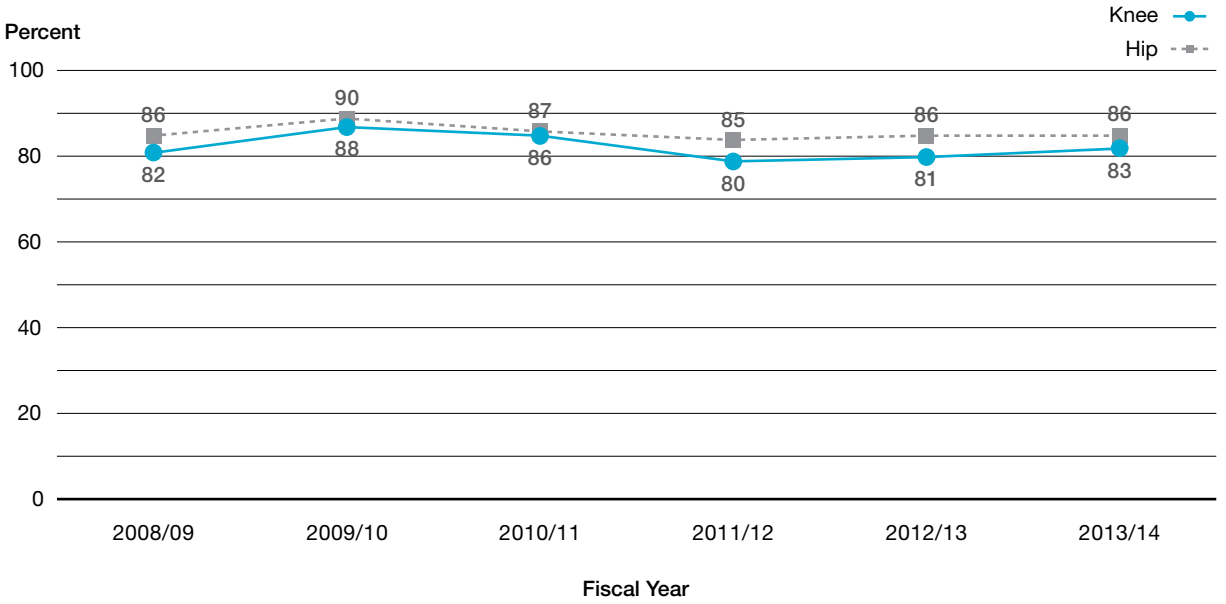
The percentage of elective (the most common category) hip replacements completed within the target time frame of 182 days (i.e., six months) remained stable around 86% in Ontario over five years (Figure 5.4).

For elective (the most common category) knee replacements, the percentage of surgeries completed within the 182-day target also stayed stable over five years at 83% in 2013/14 compared to 82% in 2008/09 (Figure 5.4).

For a complete summary of hip or knee replacement surgery completion rates within target time frames, see Table 5.1.

FIGURE 5.4

Percentage of elective hip or knee replacements completed within the recommended maximum wait time (182 days), in Ontario, 2008/09 to 2013/14



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

Photo by Joel Esposito

"Nothing makes me happier than chasing around my grandson, but the pain in my left hip made it impossible."

Meet Ilona

Age: 70, Toronto

Ilona knew something was wrong when a short walk to the park with her young grandson became a struggle. "Nothing makes me happier than chasing around my grandson, but the pain in my left hip made it impossible," says the 70-year-old from Toronto. "I was hobbling around just trying to do the most basic things."

Ilona's family doctor diagnosed her with osteoarthritis and referred her to a surgeon to see if she might benefit from a hip replacement. As a first-time patient, the doctor warned Ilona that it might take nine months or longer just to get assessed.

"My pain became unbearable," Ilona says, "so I called after six months to see when I might get an appointment, only to find out that they never received the referral from my family doctor." After another referral from her family physician, she saw a different surgeon within two months, and received a surgery date four months after that.

While she was waiting, her life became increasingly difficult. Despite the constant pain in her left hip, Ilona tried to maintain her active lifestyle, continuing to garden, go for walks and ride her bike. But as she favoured her painful hip, she added stress to her right hip, and to her knees.

The surgeon successfully performed Ilona's left hip replacement operation in August 2011. "I was very happy with the daily improvements during the recovery period," she says. "The surgeon was a true master of his craft." She followed instructions for regular exercise, walking, biking and doing yoga.

Two years later, ongoing pain in her right hip quickly worsened, and in February 2014, Ilona received an appointment with the same surgeon. X-rays showed the need for another hip replacement surgery on the right side.

"I thought as a repeat patient I would not have to wait as long for the second hip replacement surgery — I was wrong," Ilona says. The surgeon was fully booked for months. "I was desperate," Ilona says. "I knew I didn't have that much life left in my right hip." She asked to be put on a waiting list for any cancellation and told the receptionist that she was ready to go, anytime.

When Ilona heard nothing back from the surgeon's office, she spent days worrying, and eventually put herself on wait lists for four different surgeons. "I was so upset," she says. "Not knowing was the hardest aspect for me, while in constant pain and in need of surgery. Will I be lucky to get a call from any of the surgeons' offices? Why does my health care depend on luck?"

When a cancellation opened up a surgery date for June 2014, Ilona was thrilled. "I was excited and so happy when the assistant gave the date to me," Ilona says. The surgery went well, and although her recovery wasn't quite as smooth as the first operation, Ilona is back trying to keep up with her grandson as he runs down the sidewalk on the way to the park.

Cardiac procedures completed within target time frame

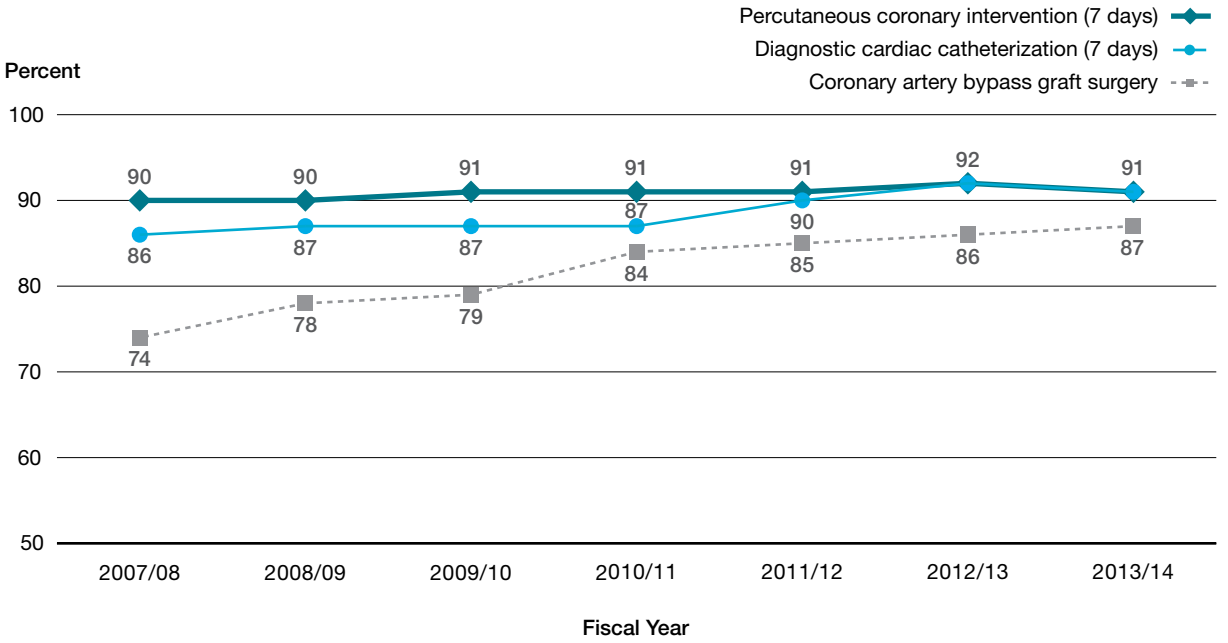
The percentage of urgent coronary artery bypass graft surgeries completed within the target wait time frame improved over six years to 87% from 74%

For each patient who is waiting for a cardiac procedure, the Cardiac Care Network of Ontario calculates a "recommended maximum wait time" based on the individual patient's clinical need. Each patient is also assigned one of three urgency levels – elective, semi-urgent or urgent. For monitoring purposes, the Cardiac Care Network of Ontario also sets access targets (maximum wait times) for each urgency level. We report on the percentage of patients who received care within their recommended wait time targets for these three main cardiac procedures:

- **diagnostic cardiac catheterization:** a test that involves taking images of the coronary arteries so doctors can see how blood flows into the heart[56]
- **percutaneous coronary intervention:** a procedure that involves using a catheter to insert a stent to widen the blood vessels in the heart[57]
- **coronary artery bypass graft:** often referred to as bypass surgery, this procedure involves creating a detour around a blocked part of the coronary artery by inserting a section of blood vessel from elsewhere in the body to the affected area of the heart[58]

FIGURE 5.5

Percentage of urgent cardiac procedures completed within target time, in Ontario, 2007/08 to 2013/14



Data source: Cardiac Care Network of Ontario Cardiac Registry.

In 2013/14, 91% of patients waiting for urgent diagnostic cardiac catheterization had their procedures completed within their individualized recommended wait time (a maximum of seven days), a slight improvement from 86% in 2007/08.

The percentage of urgent percutaneous coronary interventions completed within the recommended wait time (a maximum of seven days) remained stable over six years in Ontario, at 91% in 2013/14 from 90% in 2007/08.

For patients undergoing coronary artery bypass graft in the urgent category, 87% had their procedures completed within the recommended wait time (a maximum of 14 days) in 2013/14, a moderate improvement from 74% in 2007/08.

In Figure 5.5, we present the wait times for surgeries categorized as urgent for all three cardiac procedures, over six years. For a complete summary of all cardiac procedure completion rates within target time frames, see Table 5.1.

Cancer surgery wait times

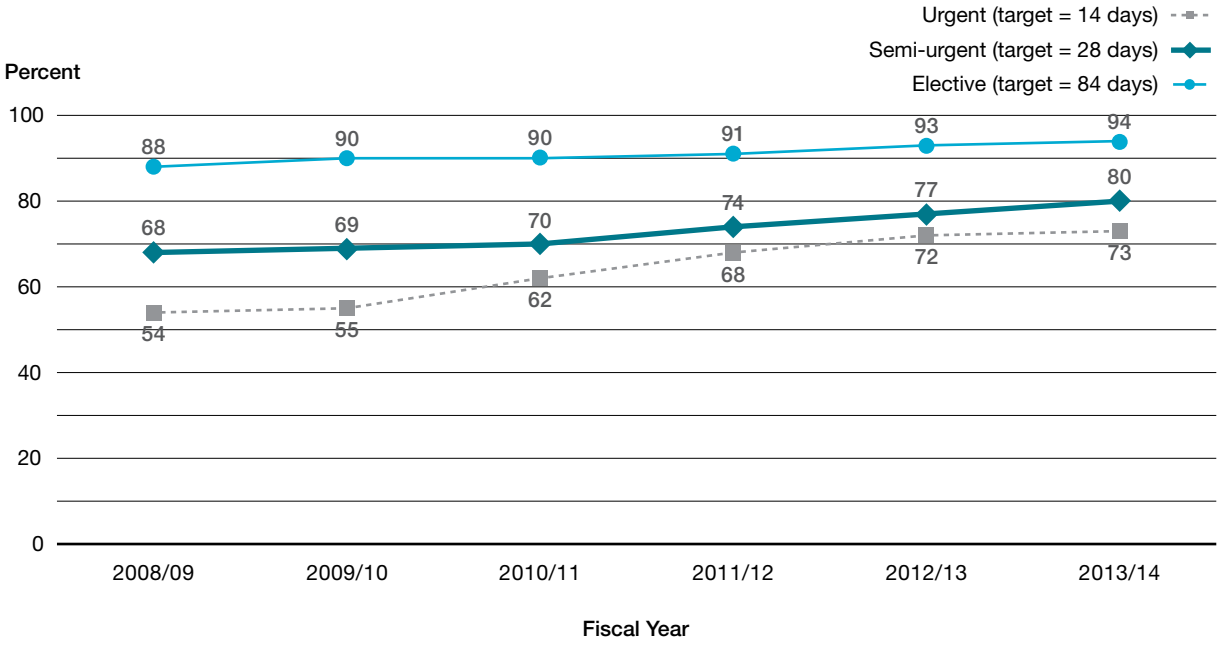
The percentage of urgent cancer surgeries completed within the target time improved to 73% from 54% over five years

To achieve the best possible outcomes, it is important that cancer patients receive timely treatment.[59,60] Wait times for cancer surgeries have generally improved, even as the number of cancer surgeries in Ontario has increased by 13% between 2008/09 and 2013/14.[61] Among Ontario patients whose cancer surgeries were categorized as urgent, 73% had their surgery completed within the target time of 14 days in 2013/14, up substantially from 54% in 2008/09 (Figure 5.6). Of the patients categorized as semi-urgent, 80% had their surgeries completed within the target time frame of 28 days in 2013/14, up moderately from 68% in 2008/09.

For a complete summary of all cancer surgery completion rates within target time frames, see Table 5.1.

FIGURE 5.6

Percentage of cancer surgeries completed within recommended maximum wait time, by urgency level, in Ontario, 2008/09 to 2013/14



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

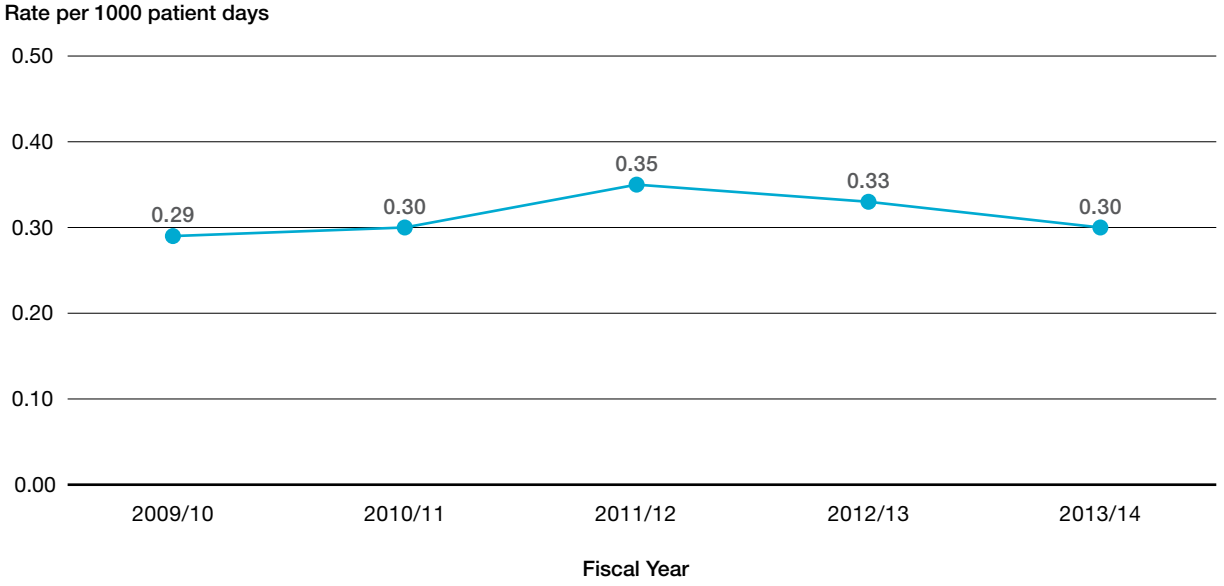
Clostridium difficile infections acquired in hospital

The rate of hospital-acquired *Clostridium difficile* infections has been stable over four years in Ontario

Beyond waiting for procedures, there are other ways to measure performance in hospital care. For example, when patients end up in hospital, they may not realize they are at risk of contracting the potentially deadly and difficult-to-treat *Clostridium difficile* (commonly known as *C. difficile*) infection. *C. difficile* infections, one of several hospital-acquired infections, can be transmitted from one patient to another inside a hospital. Patients who have a *C. difficile* infection can be very sick with diarrhea and fever, and in some cases the infection can cause death.[50] Hospitals can reduce the transmission of *C. difficile* infections by following recommended protocols.[62]

Over the past four years, the rate of *C. difficile* infections has remained stable at around 0.30 per 1000 patient days (Figure 5.7).

FIGURE 5.7
Rate of hospital-acquired *C. difficile* infection, in Ontario, 2009/10 to 2013/14



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

Falls among complex continuing care patients

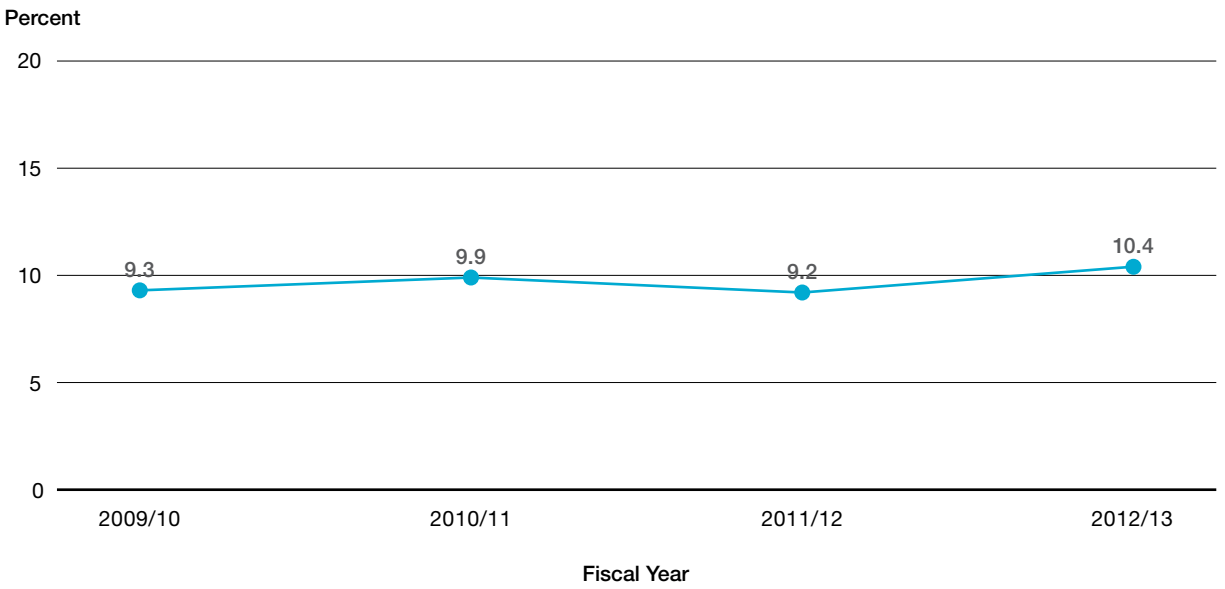
The percentage of complex continuing care patients who fell in the last 30 days remained stable at 10.4%

In Ontario, patients who have complex health care needs but do not need acute care or rehabilitation, can be cared for in "complex continuing care" beds. These beds may be housed in acute care hospitals, or separate facilities. Patients needing complex continuing care can include those recovering from a stroke, serious injuries such as car accidents or patients with conditions such as kidney or heart disease that are severe and require continuous care. As these patients may have trouble moving around, falls are one of the leading causes of serious injuries in complex continuing care patients.[63]

The proportion of complex continuing care patients in Ontario who fell in the 30 days prior to data collection was stable at 10.4% in 2012/13 from 9.3% in 2009/10 (Figure 5.8).

FIGURE 5.8

Percentage of complex continuing care patients who fell in the last 30 days, in Ontario, 2009/10 to 2012/13



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

Pressure ulcers in complex continuing care patients

The percentage of complex continuing care patients with pressure ulcers remained stable over three years

Pressure ulcers — commonly known as bedsores — are often painful and debilitating injuries to the skin and/or underlying tissue caused by friction or pressure, typically because a patient remains in one position for too long.

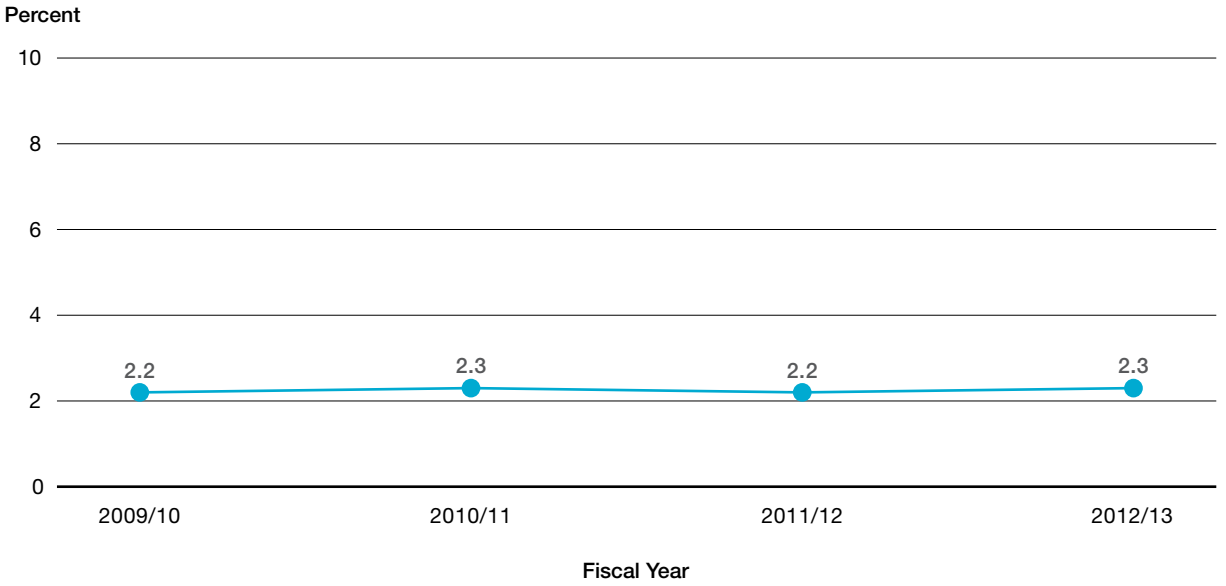
Many complex continuing care patients are at high risk for developing a pressure ulcer. Patients may need help moving from a bed to a chair, or be bedridden, which can lead to pressure ulcers.

Measuring the development of pressure ulcers is one way of monitoring the quality of care that complex continuing care patients receive. Pressure ulcers are classified into four stages, with stage 1 being the beginning of the sore, stage 2 when the skin breaks open or forms an ulcer, stage 3 when the sore expands into the tissue beneath the skin and stage 4 when there is exposed bone, tendon or muscle.[64] Studies show that pressure ulcers can be effectively prevented by frequently repositioning patients.[64,65]

The percentage of complex continuing care patients in Ontario who report having a new stage 2 or worse pressure ulcer in the three months prior to data collection remained stable over three years, at 2.3% in 2012/13 compared to 2.2% in 2009/10 (Figure 5.9).

FIGURE 5.9

Percentage of complex continuing care patients with a new stage 2 or worse pressure ulcer in the last three months, in Ontario, 2009/10 to 2012/13



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

Use of physical restraints in acute mental health care

The rate of physical restraints use in acute mental health care improved to 5.3% from 8.5% over five years

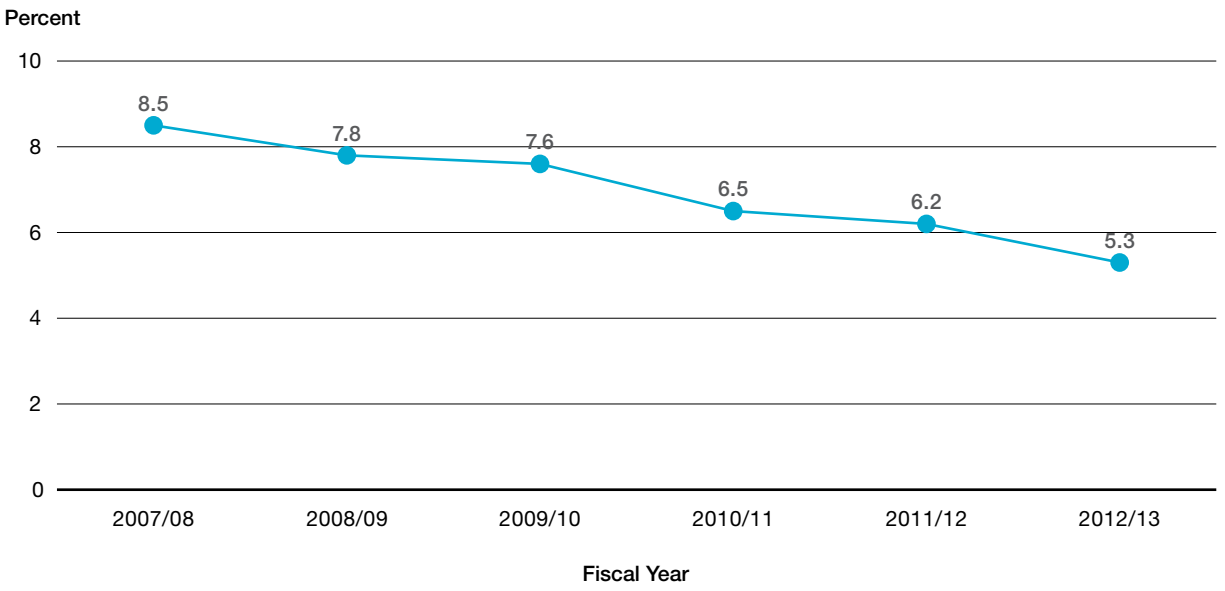
Mental illness is the second-leading cause of disability and premature death in Canada.[66] A small proportion of hospital patients with mental illness are at risk of harming themselves or others. "Control interventions" are physical restraints and other interventions (such as giving certain medications, sometimes called chemical restraints) that can protect patients from hurting themselves or others. The Canadian Institute for Health Information reported that nearly a quarter of patients admitted to a designated mental health bed in Ontario experienced at least one type of control intervention during their hospitalization.[67]

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*[68], the *Mental Health Act*[69] and the *Health Care Consent Act*[70] have all helped facilities develop best practices and guidelines for the use of these control interventions.

There was a slight decline in the use of physical restraints during acute mental health care over five years (Figure 5.10). The rates improved to 5.3% in 2012/13 from 8.5% in 2007/08.

FIGURE 5.10

Percentage of patients in mental health designated beds who were physically restrained, in Ontario, 2007/08 to 2012/13



Data source: Ontario Mental Health Reporting Systems, provided by the Institute for Clinical Evaluative Sciences.

In summary

Hospitals provide so many forms of care and serve so many different types of patients that it can be difficult to paint a comprehensive picture of the quality of hospital care. Nevertheless, some general themes emerge from the findings we report in this chapter. Wait times for care provided in hospital have generally improved. More patients are receiving urgent cancer surgeries and cardiac procedures within recommended time frames (targets), but there is still room for improvement. Also, these results don't capture the entire wait. For example, the time a patient spends waiting to see a specialist before the procedure. Patients requiring emergency department care are being discharged more quickly than they were several years ago. For those with low-acuity emergency needs, times spent in the emergency department are close to the ministry target of four hours, but for those with high-acuity needs, their time in the emergency department remains above the ministry target of eight hours. Also, there is a decrease in physical restraint use in patients who stayed in designated mental health beds.

Although many indicators show some improvement, performance is stable over time for other indicators. The percentage of patients who would definitely recommend the hospital in which they were treated continues to range between 72% and 74%. The percentage of patients receiving hip or knee replacements within the recommended time frame (target) is stable at 86% and 83%, respectively. The rate of *C. difficile* infections is unchanged as are the rates of falls and worsening pressure ulcers in complex continuing care patients.

Wait times for care provided in hospital have generally improved, but these results don't capture the entire wait.

Home Care

The Common Quality Agenda indicators presented in this chapter cover patient satisfaction with the home care services and coordination they receive and the percentage of new and existing adult home care patients who receive services within five days of authorization.

Ontario was the first jurisdiction in Canada to **introduce provincial public reporting on the home care sector**.

An increasing need for home and community care services

The 14 Community Care Access Centres (CCACs) in Ontario coordinate and provide a wide range of home care services, including nursing, case management, personal support, physiotherapy, occupational therapy, speech-language therapy, social work, nutritional counselling and medical supplies.[71]

Patients receive publicly funded home care services either directly from CCAC staff or by provider organizations contracted by the CCACs. To help home care patients navigate the health system and manage transitions from one care setting to another, CCACs also work with primary care providers, hospitals and community support services.[71] The 14 CCACs have the same geographical boundaries as the 14 LHINs in Ontario and share the same geographical names (Figure 1.2).

Home care patients today have greater needs, on average, than they did a few years ago. The need for home care services is affected by the overall age and level of illness of Ontarians, the number of long-term care home beds in the province, as well as the length of time people stay in hospital.

Ontario was the first jurisdiction in Canada to introduce provincial public reporting on the home care sector, and Health Quality Ontario has been publicly reporting on home care since 2009.

Key Findings

More than nine out of 10 home care patients in Ontario report being satisfied with the home care services they receive

More than 90% of Ontario home care patients requiring nursing care receive the service within five days of it being authorized

The percentage of home care patients with complex needs receiving personal support services within five days of authorization varies substantially across Ontario

Patient satisfaction

More than nine out of 10 Ontario patients surveyed say they are satisfied with their home care

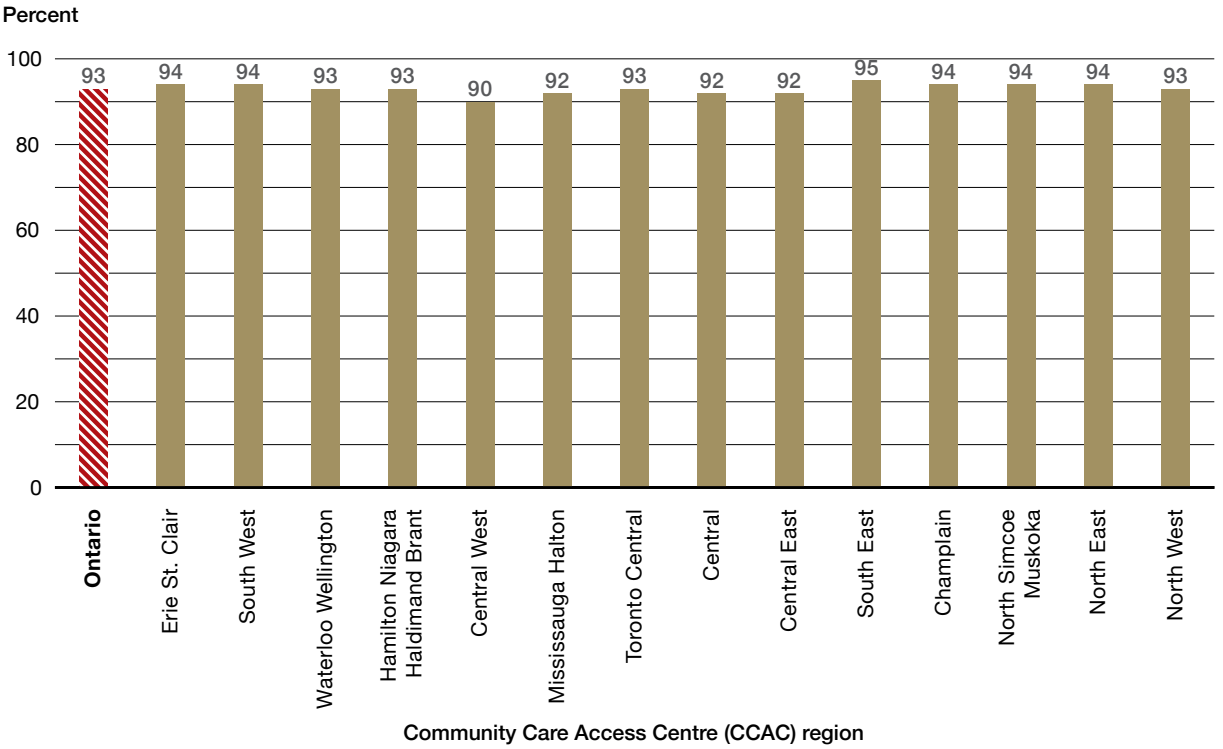
Higher patient satisfaction scores are usually associated with higher quality of care[72], and reflect how patients are engaged by providers in their health care.[73]

Home care patients are anonymously surveyed to determine their satisfaction with the services they receive. In 2012/13, 93% of home care patients surveyed in Ontario report being satisfied with the services they received from both care coordinators and service providers (Figure 6.1).

There is slight variation in home care services satisfaction across the province, ranging from 90% in the Central West CCAC region to 95% in the South East CCAC region.

FIGURE 6.1

Percentage of survey respondents who are satisfied with their home care from both care coordinators and service providers, in Ontario, by CCAC region 2012/13



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

Meet Muhammad

Age: 84, Mississauga

"When can I go home where I belong?" Muhammad begged his son Hameed, as he lay in the hospital bed that had been his temporary home for nearly two months.

A year earlier, Muhammad had been an active 81-year-old, despite having Parkinson's disease and an inoperable back condition. He was still able to walk, and spent part of the summer touring Venice with his family. But when he returned from Italy, Muhammad suffered several falls and ended up in hospital. Hameed says the physical care his father received in hospital was amazing, but there was no psychological or emotional link. "And if your mind and heart is not in there, you know you can do better," Hameed says. "So he wanted to go back home, where he can do little things, everyday things, in better ways."

Despite many unwanted weeks in hospital, thanks to a home care program from his local community care access centre, Muhammad was finally able to go back home, rather than stay in hospital or be admitted to a long-term care home. His care coordinator visited Muhammad at home to help arrange the services he needed, including nursing care, personal support workers to help with bathing and dressing, speech therapy, as well as medical equipment.

Muhammad, who is unable to speak, wrote a letter of thanks. "Now I am at home," he wrote. "Special thanks to my care coordinator … she is constantly following up with my family doctor, physiotherapist, occupational therapist and other medical professionals. She is trying her best to ensure that I can get the best possible medical treatment at my home and can get better quality of life for the remaining years of my life."

Hameed is also grateful to have his father at home. "It's a blessing," he says, "because whatever time I spend with him, I'm making good memories. My dad is safe and happy at home with his family."

Photo courtesy of Mississauga Halton CCAC

After more than a year of receiving care coordination and services, Muhammad **has not returned to hospital.**

After more than a year of receiving care coordination and services, Muhammad has not returned to hospital. He stays in the family's main bedroom, where he can enjoy the company of his son, daughter-in-law, two grandchildren and their beloved Yorkshire terrier, Ronni.

Source with permission: Mississauga Halton Community Care Access Centre

Wait times

The percentage of home care patients who received services within a five-day target

Many people who develop a need for home care require the services urgently. In early 2013, the Minister of Health and Long-Term Care announced a five-day target for wait times for home care nursing services and for home care personal support services for patients with complex needs.[74]

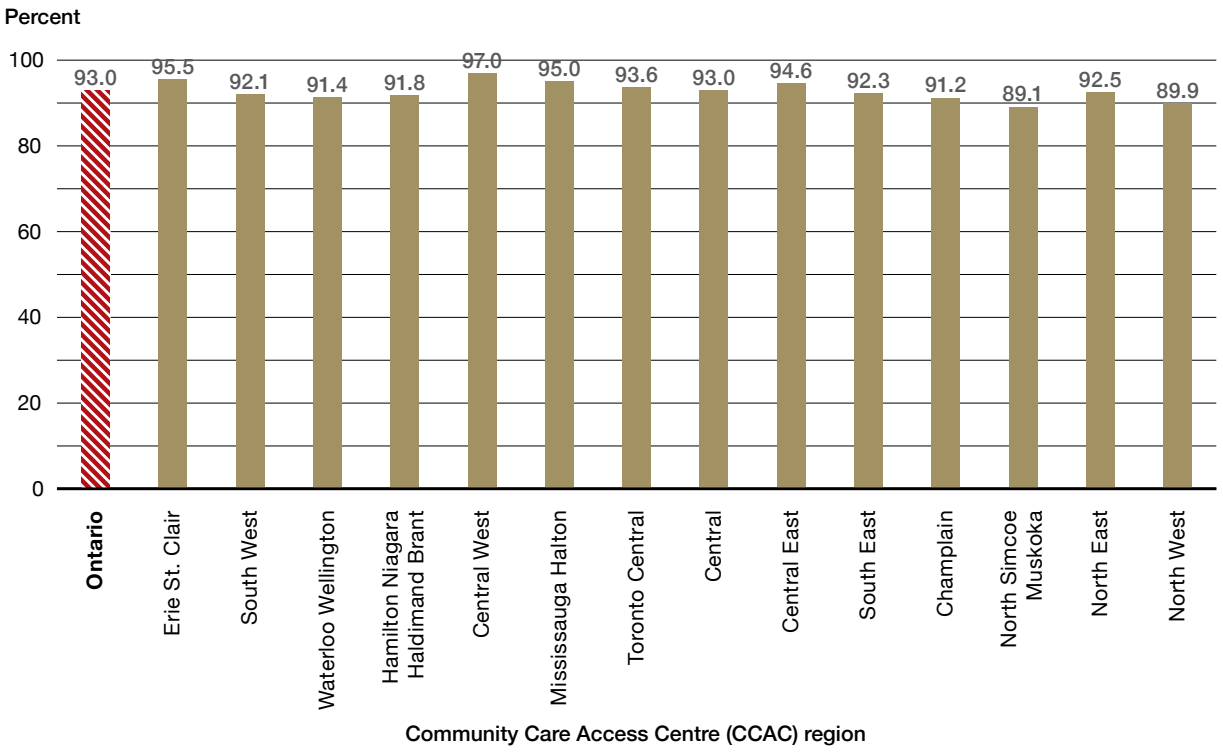
There are several steps that must occur before a patient receives home care in Ontario – typically there is a referral, an assessment performed by a care coordinator, an authorization for a service provider to deliver one or more services, and then services can start. The wait time we report here, and the ministry target of five days, covers only the time from authorization to the start of services for new and existing adult home care service patients. We look at two situations: all home care patients receiving nursing services, and complex home care patients receiving personal support services.

In 2013/14, among home care patients requiring nursing services, 93.0% received the service within five days.

There is moderate variation across the province in the percentage receiving services within five days, ranging from a low of 89.1% in North Simcoe Muskoka CCAC region to a high of 97.0% in the Central West CCAC region (Figure 6.2).

FIGURE 6.2

Percentage of home care patients who received their first nursing visit within five days of authorization to receive nursing services, in Ontario, by CCAC region, Q3 2013/14



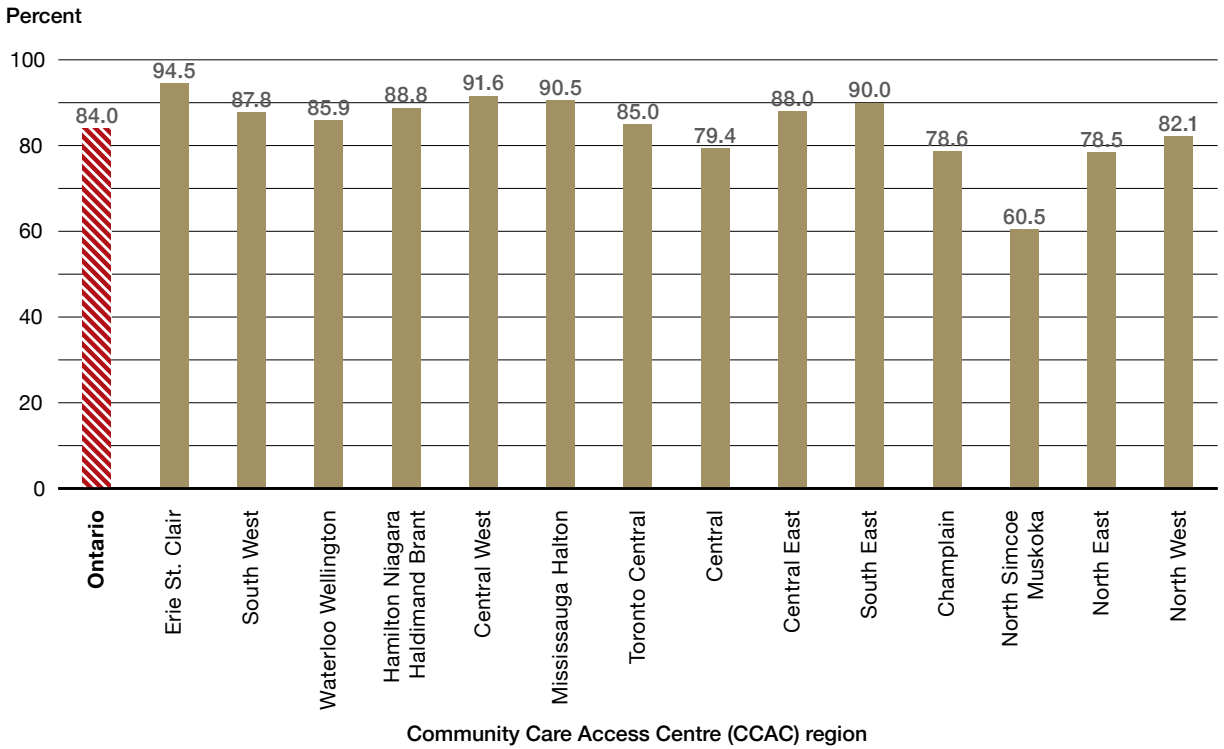
Data source: Home Care Database, provided by the Ministry of Health and Long-Term Care.

For patients with complex-needs who received personal support services, 84.0% received the services within five days of authorization.

There is substantial variation across Ontario, with percentages receiving services within five days ranging from a low of 60.5% in the North Simcoe Muskoka CCAC region to a high of 94.5% in the Erie St. Clair CCAC region (Figure 6.3).

FIGURE 6.3

Percentage of home care patients with complex needs who received their personal support visit within five days of authorization to receive personal support services, in Ontario, by CCAC region, Q3 2013/14



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

In summary

Most Ontario home care patients report a high rate of satisfaction with the care they receive. The majority of home-care recipients receive their nursing services within the five-day target set by the ministry, but there is variability across Ontario in the wait time for both nursing and personal support services. The wait times we report don't provide a comprehensive picture of the total wait time that patients experience for home care services. We report only the time patients wait for their home care service once the service has been authorized. We do not report on the time a patient waits to see a home care coordinator who assesses their needs and authorizes services.

The majority of home care recipients receive their services within **the five-day target**, but there is variability across Ontario.

Long-Term Care

In this chapter, we report on Common Quality Agenda indicators related to wait times for a bed in a long-term care home from the hospital and from the community, the use of daily physical restraints, falls in the last 30 days and new or worsening pressure ulcers.

Ontario's growing demand for long-term care

More than 600 long-term care homes in Ontario provide accommodation, services and specialized health care for more than 112,000 people with advanced illnesses or injuries.

Health Quality Ontario has been publicly reporting on long-term care performance since 2010, and recently developed and released benchmarks for some of the quality indicators that are publicly reported on our website. This made Ontario the first province to establish benchmarks for long-term care home quality indicators.[75] Long-term care homes can use benchmarks to compare their data to a standard to gauge their performance.

Ontario has the **largest and longest-running** long-term care data collection system in the country.

Key Findings

For people waiting in the community for a long-term care bed, the median wait time improved by 79 days over four years, but is still 111 days

The use of daily physical restraints in Ontario long-term care homes has decreased in the last three years

Rates of falls and worsening pressure ulcers in Ontario long-term care home residents have remained stable over four years

Waiting for a bed in a long-term care home

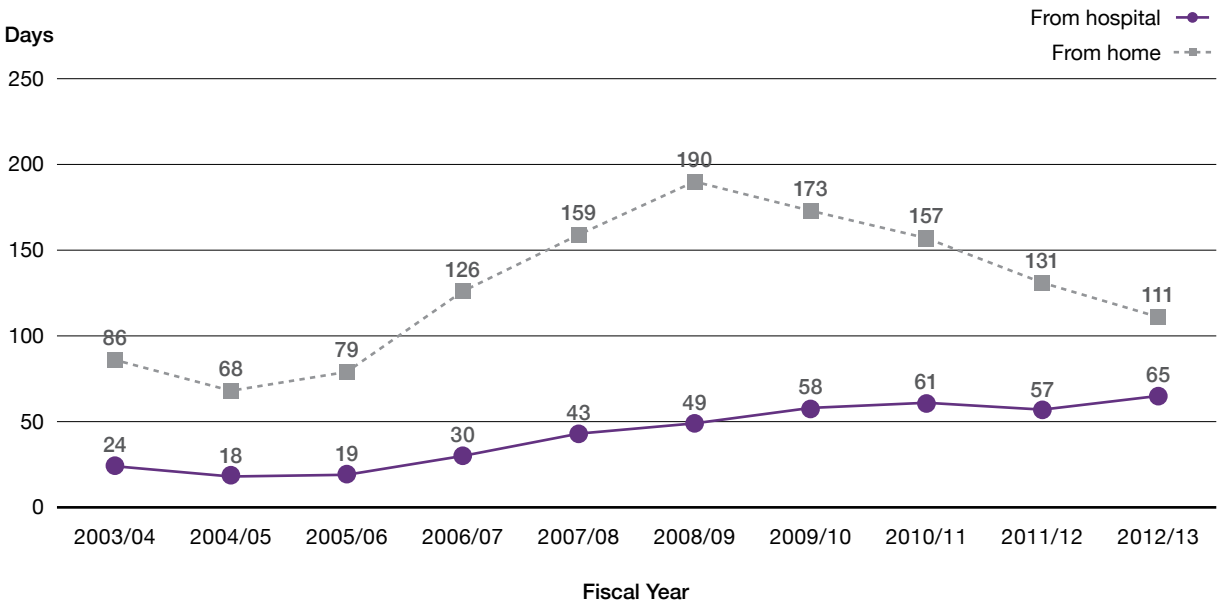
The median wait time for long-term care is 111 days for residents waiting at home, and 65 days for residents waiting in hospital

Delayed access to a long-term care home can result in health complications for the patient[76], stress on family members and other caregivers, and hospital resources being used to provide care to people whose needs would be best served by a long-term care home.[77] Wait times for admission to a long-term care home are divided into two groups: people waiting in a hospital and those waiting from their homes in the community. Since patients waiting in hospital are usually designated as having priority, wait times from the community are generally much longer.

This indicator measures the median number of days a person waited to be placed in a long-term care home from the date of long-term home application to the date of placement. It does not include residents designated as being in crisis or people prioritized for spousal/partner reunification, whose wait times tend to be much shorter. The measure also excludes transfers from another long-term care home.

Over four years (2008/09 to 2012/13), the median wait for people admitted to a long-term care home from their homes in the community dropped by 79 days, improving to 111 days from 190 days (Figure 7.1). Looking over 10 years of data, median wait times from home were at a low of 68 days in 2004/05 and have increased over the decade.

FIGURE 7.1
Median number of days to admission to a long-term care home from either hospital or home, in Ontario, 2003/04 to 2012/13



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

From hospital, median wait times for long-term care home beds rose by 16 days to 65 days from 49 days in the last four years of data, from 2008/09 to 2012/13 (Figure 7.1), and increased by 41 days over the full 10-year period of data.

Long-term care home wait times for residents who were admitted vary substantially across Ontario. The 219-day median wait time from home in the Toronto Central LHIN region is more than four times longer than the 53-day median wait in the South West LHIN region. Median wait times from hospital range from a high of 152 days in the Missisauga Halton LHIN region to a low of 33 days in the South West LHIN region (Figure 7.2).

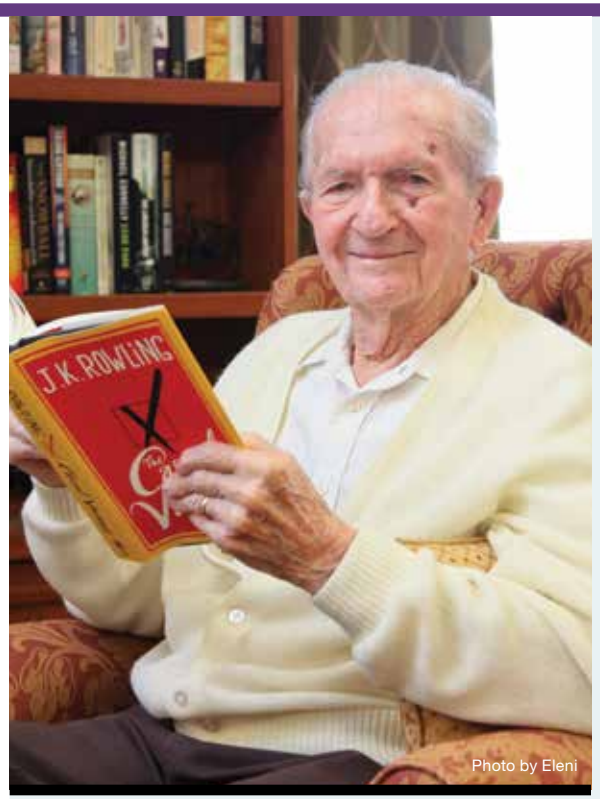


Photo by Eleni

Meet Steve

Age: 96, Windsor

After a four-year wait, Steve says he is relieved and grateful to be in a new long-term care home with his wife. “This is the best spot we have seen,” says Steve, a 96-year-old former automotive worker, of the new facility in the Windsor area. “We are fortunate to get in here.”

Steve chose to wait for the specific home that he and his wife wanted.

“This is the best spot we have seen. We are very fortunate to get in here.”

Steve’s 91-year-old wife has dementia and requires a lot of care. Home care services from the local Community Care Access Centre helped the couple stay at home for as long as possible, but eventually Steve decided that long-term care was the best option. “My wife was getting worse and worse, so we had to do something,” he says.

There were shorter wait lists for other long-term care homes, but Steve chose to wait for the specific home that he and his wife wanted. The couple also needed to be placed in the same home together, which added a further complication.

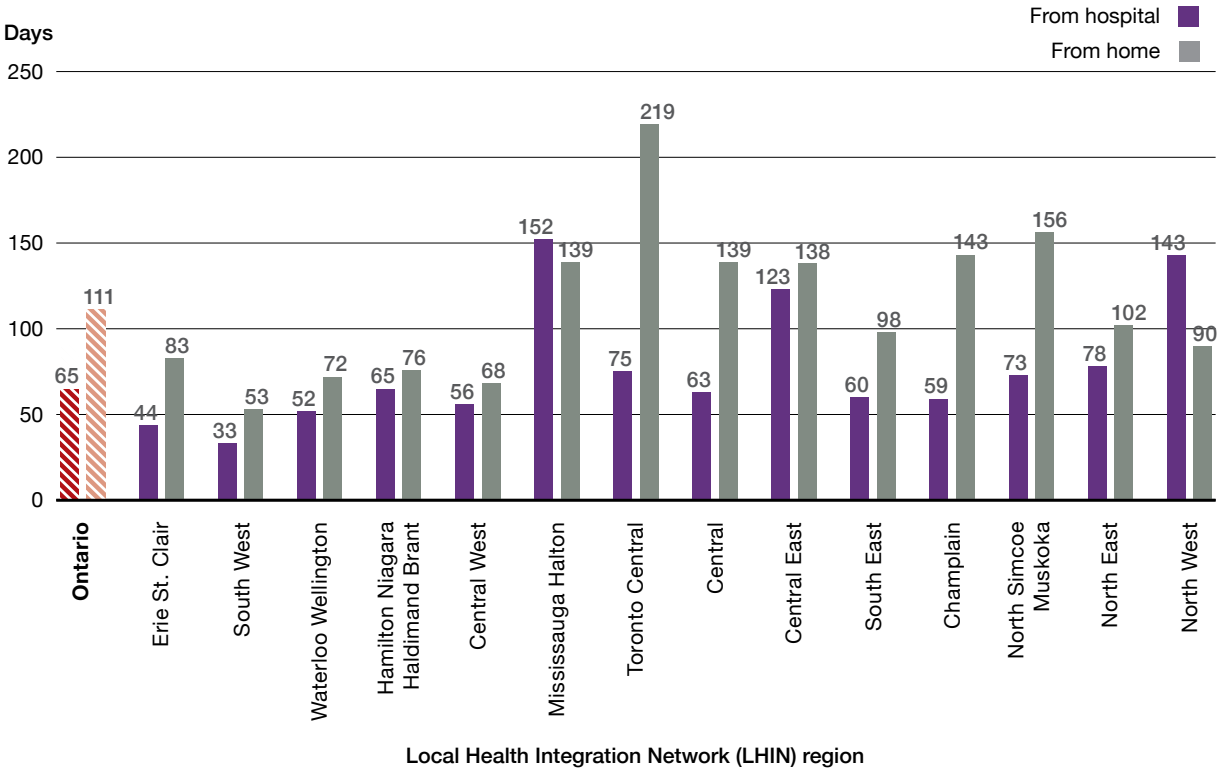
Now that he and his wife have moved in, Steve says he gets all the care he needs. “It’s clean, and the meals are good,” he says. Twice a day, he goes to the gym to do cardiovascular exercises with a hand-cycle machine and lifts weights. “I like it here,” he says.

111

Number of days for the median wait time for residents admitted to a long-term care home from their homes in the community in 2012/13, down from 190 days in 2008/09 but up from 68 days in 2004/05

FIGURE 7.2

Median number of days to admission to a long-term care home from either hospital or home, in Ontario, by LHIN region, 2012/13



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

Long-term care home wait times for residents vary substantially across Ontario.

Use of daily physical restraints in long-term care homes

The daily use of physical restraints on residents in Ontario long-term care homes has improved moderately over three years

The *Long-Term Care Homes Act* (2007) requires homes to have policies that minimize restraint use in their homes.[78] Long-term care homes sometimes use physical devices such as wheelchair safety belts and table tops to help residents perform their daily activities and to prevent residents from falling. In some cases, restraints are used to reduce the risk of residents harming themselves, or other residents.[79]

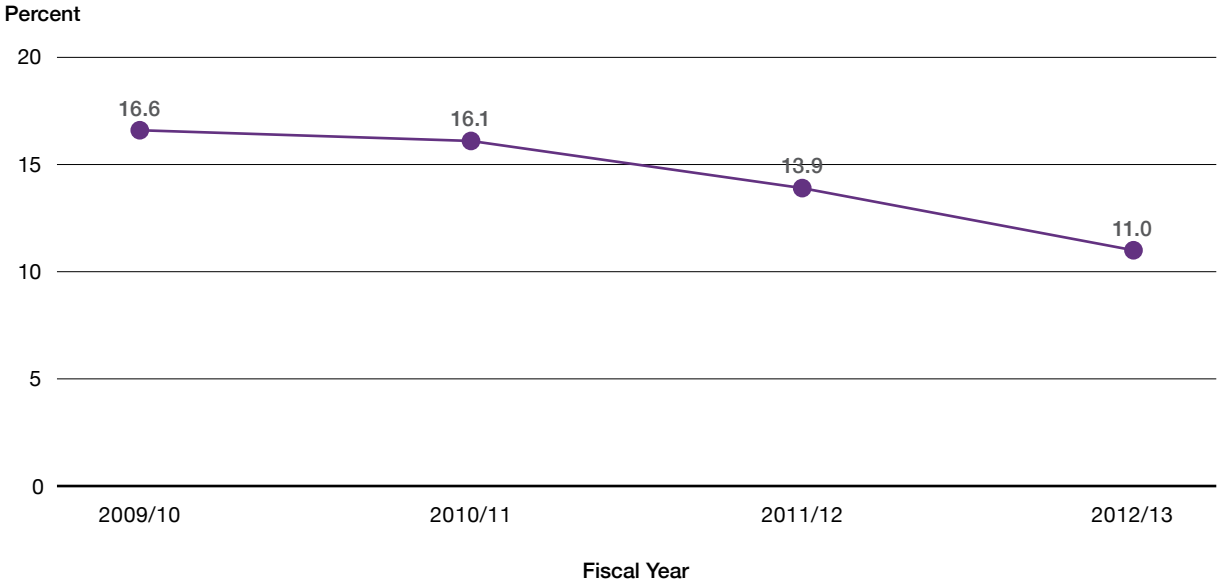
The use of restraints has substantial downsides. In addition to the fact that restraints are associated with a loss of autonomy and dignity, restraints limit a resident's mobility, increase the risk of pressure ulcers and can cause agitation and confusion. In rare cases, the use of restraints can indirectly lead to a resident's death.[79]

The percentage of residents in long-term care homes in Ontario in physical restraints on a daily basis decreased moderately to 11.0% in 2012/13 from 16.6% in 2009/10 (Figure 7.3).

Rates vary substantially across Ontario, from a low of 4.8% in the Central West LHIN region to a high of 16.6% in the Champlain and South East LHIN regions (Figure 7.4).

FIGURE 7.3

Percentage of long-term care home residents in physical restraints on a daily basis, in Ontario, 2009/10 to 2012/13



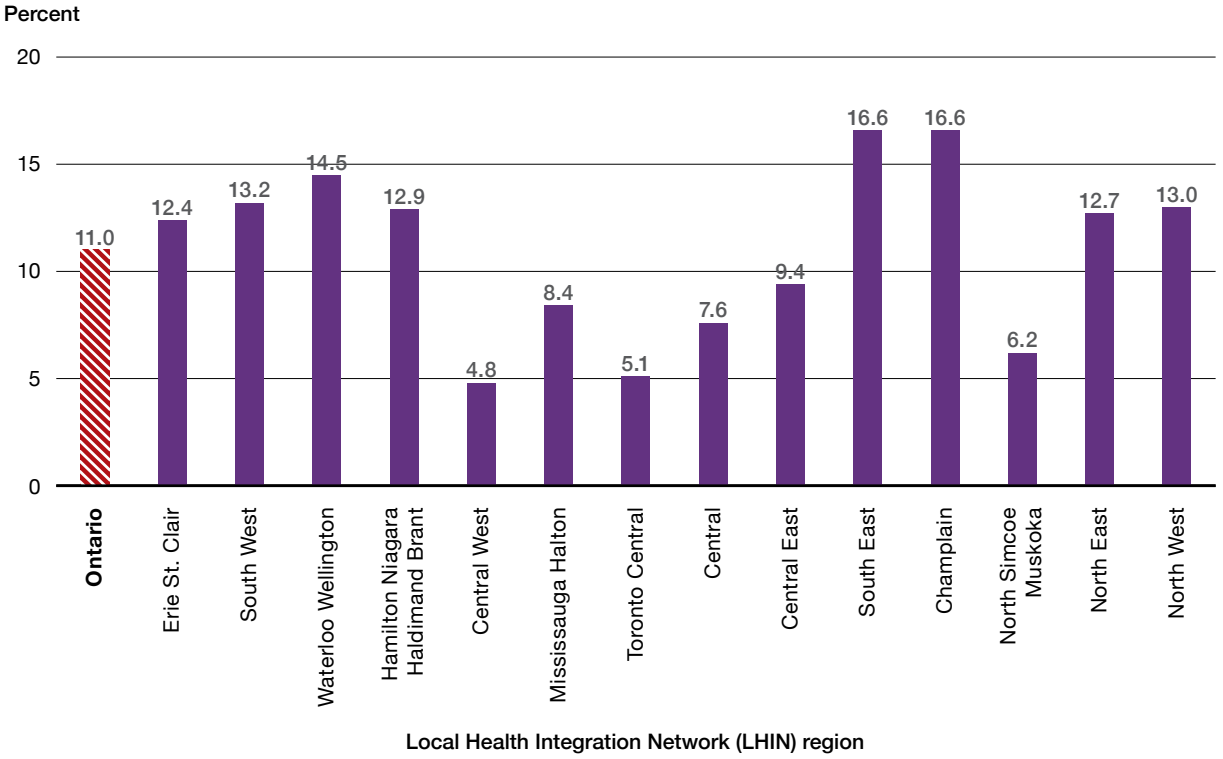
Data source: Continuing Care Reporting System eReports, provided by the Canadian Institute for Health Information.

11.0% (2012/13) | **16.6%** (2009/10)

The percentage of **residents in long-term care homes in Ontario in physical restraints on a daily basis decreased**

FIGURE 7.4

Percentage of long-term care home residents in physical restraints on a daily basis, in Ontario, by LHIN region, 2012/13



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

Although we see a **decrease in daily physical restraint use** at the provincial level in Ontario, there is substantial variation in use across Local Health Integration Network regions.

Falls in long-term care homes

The percentage of residents who fell within the last 30 days in Ontario long-term care homes remains stable at 14%

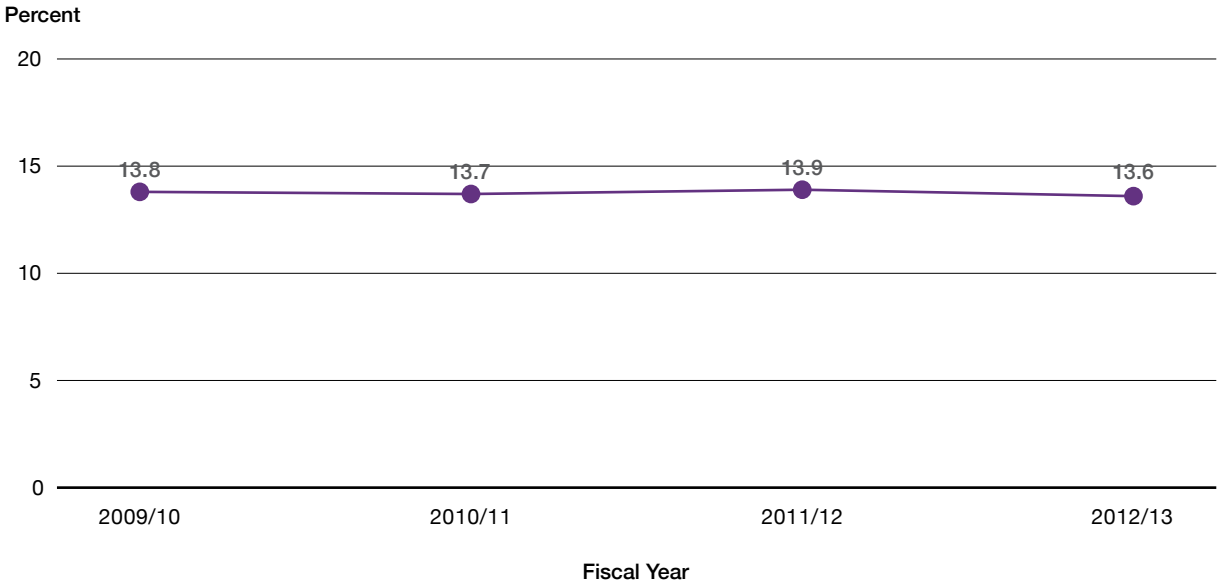
Falls are a common cause of injury and death among older residents[80] and often lead to emergency department visits, hospitalizations and hip fractures.[81] In an effort to cut down on the number of falls, the *Long-Term Care Homes Act* (2007) requires long-term care homes to implement a falls prevention and management program.[82] It should be noted that the goal of minimizing falls and the goals of maximizing independence, autonomy and mobility can sometimes conflict. It is therefore not possible to eliminate all falls.

The percentage of Ontario long-term care home residents who fell in the 30 days prior to data collection remained stable at approximately 14% between 2009/10 and 2012/13 (Figure 7.5).

The most recent results (2012/13) show little variation across Ontario.[83]

FIGURE 7.5

Percentage of long-term care home residents who fell in the last 30 days, in Ontario, 2009/10 to 2012/13



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

New or worsening pressure ulcers

The percentage of Ontario long-term care residents with new or worsening pressure ulcers is stable at 2.9%

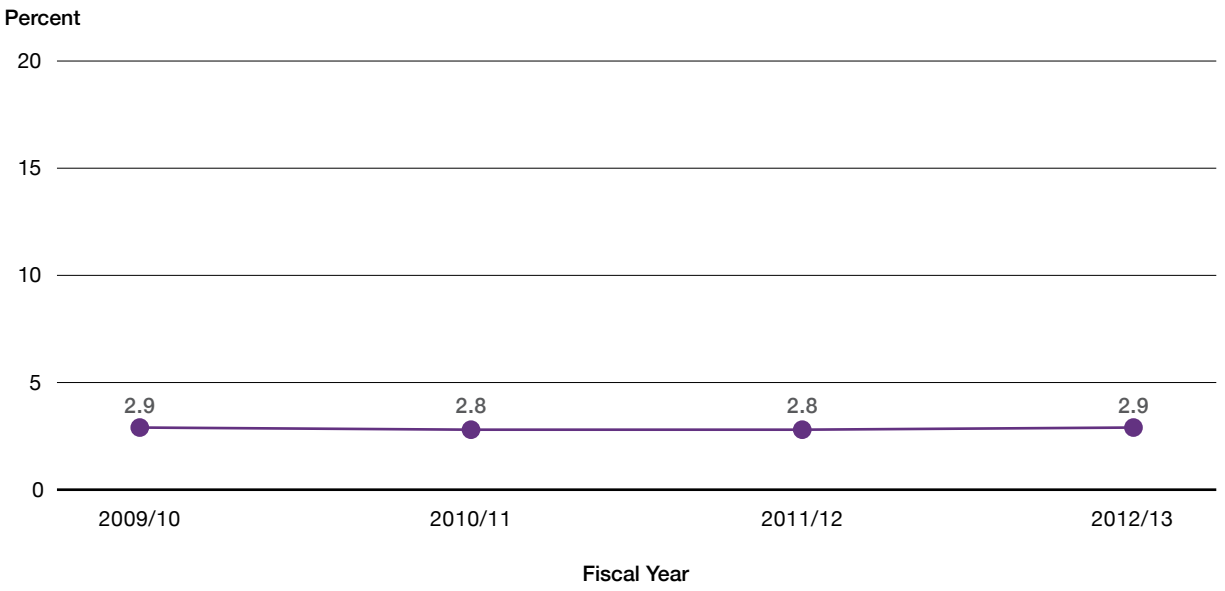
Pressure ulcers, often called bedsores, are injuries to the skin and/or underlying tissue. When a long-term care resident lies or sits in one place for too long, pressure or friction can damage the skin and result in a pressure ulcer, which can then worsen as it moves deeper into the underlying tissue or bone.[64] Pressure ulcers are painful and can become infected.[79] Research has shown that pressure ulcers can be effectively prevented by frequently repositioning residents who have restricted movement[84], using pressure redistribution devices and maintaining good nutrition and hydration.[85]

The percentage of long-term care residents with new or worsening pressure ulcers remained stable at 2.9% across the province from 2009/10 to 2012/13 (Figure 7.6).

The most recent data (2012/13) show little regional variation across Ontario.[86]

FIGURE 7.6

Percentage of long-term care home residents with new or worsening pressure ulcers, in Ontario, 2009/10 to 2012/13



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

How Ontario compares: **within Canada**

Ontario has the largest and longest-running long-term care home data collection system in the country. Some other provinces and territories are now reporting enough data to compare results for restraint use, falls and pressure ulcers indicators. British Columbia and Alberta have 270 and 167 long-term care homes reporting in 2012/13, respectively, offering the best comparison to Ontario (636 homes in 2012/13). Overall, Ontario's performance on these indicators is similar to these other provinces.

Daily physical restraint use: Ontario (11%) has similar results compared to Alberta (11%) and British Columbia (12%)

Falls: Ontario (14%) has similar rates compared to both Alberta (14%) and British Columbia (15%)

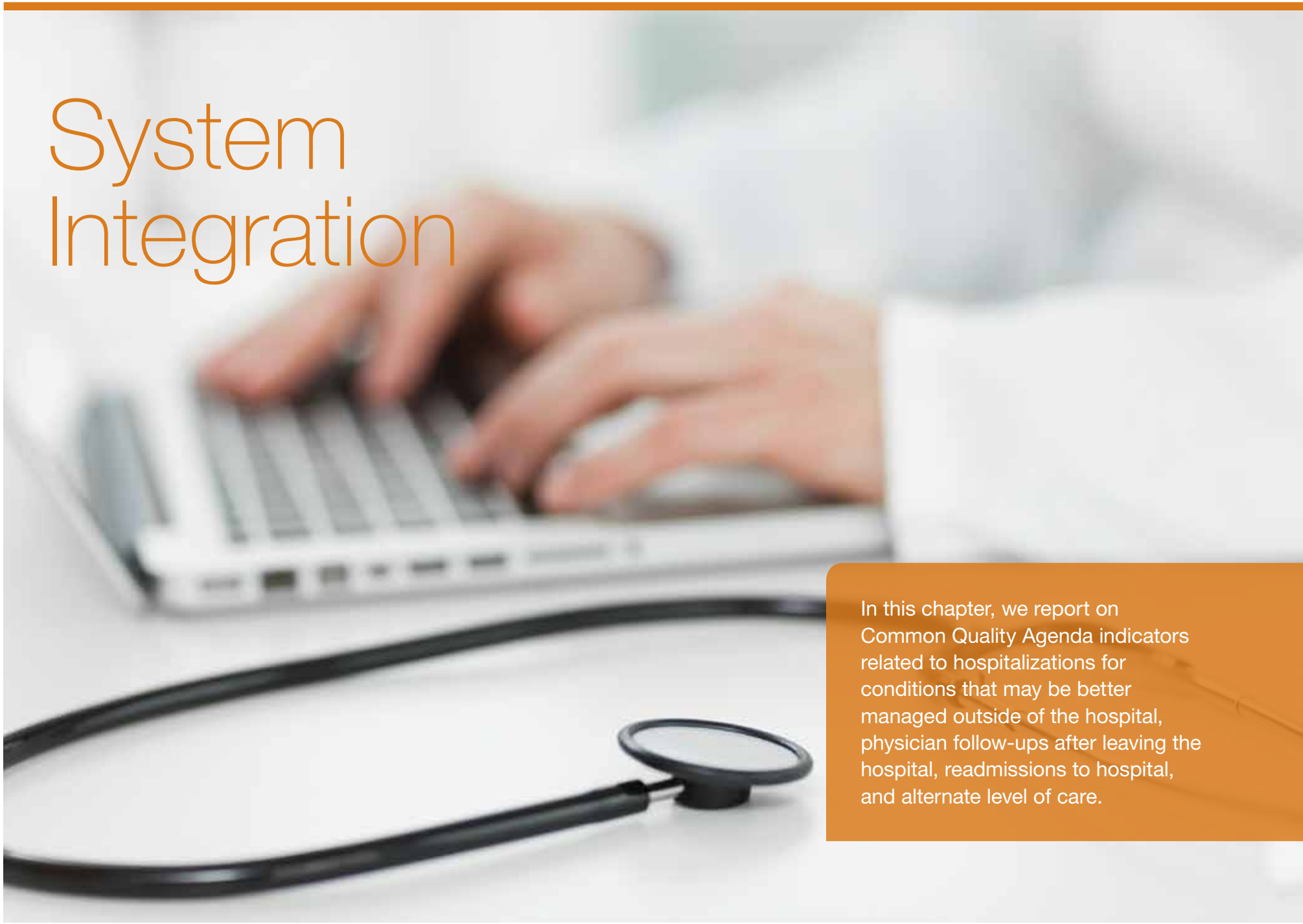
New or worsening pressure ulcers: Ontario (2.9%) has similar results compared to Alberta (3.1%) and British Columbia (2.9%)

In summary

There have been some improvements in long-term care in Ontario over the past four years. There has been a modest decrease in daily physical restraint use in long-term care residents, and the median wait for placement in long-term care homes is decreasing for residents coming from their own homes. However, for long-term care residents waiting in their homes, the median wait is longer today than it was eight years ago, and for residents coming from hospital, the waits have been increasing over the past decade. For both daily physical restraint use and median wait times, there is substantial variation across Ontario. The rates of falls and worsening pressure ulcers show no change in performance over time, and no variation across the province.

There have been **some improvements in long-term care** in Ontario, but there is substantial variation across the province.

System Integration



In this chapter, we report on Common Quality Agenda indicators related to hospitalizations for conditions that may be better managed outside of the hospital, physician follow-ups after leaving the hospital, readmissions to hospital, and alternate level of care.

Measuring how the individual parts of the health system work together

Some patients receive most or all of their health care within a single sector. People who have few health care needs, for example, might receive virtually all of their health care from a primary care provider.

But many people, particularly those who are chronically ill or have complex needs, depend on the different sectors of the health system to work well together. When a patient is discharged from hospital, for example, the primary care provider needs to know what happened in hospital so that she or he can follow up with the patient accordingly. All of the indicators in this chapter are a reflection of how well the individual parts of the health system work together.

Many people, particularly those who are chronically ill or have complex needs, **depend on the different sectors of the health system to work well together**.

Key Findings

The rate of hospitalizations in Ontario for people with conditions that can be managed in the community improved to 246 per 100,000 people in 2012/13 from 353 per 100,000 people in 2003/04

About two-thirds of patients with mental health conditions do not have a follow-up family physician or psychiatrist visit within seven days of their hospital discharge

A substantial proportion of hospital beds are occupied by patients who are waiting for care that can be provided elsewhere

Hospitalizations for ambulatory care sensitive conditions

The rate of hospitalizations for medical conditions that can potentially be managed outside the hospital improved substantially to 246 per 100,000 people in 2012/13 from 353 per 100,000 in 2003/04

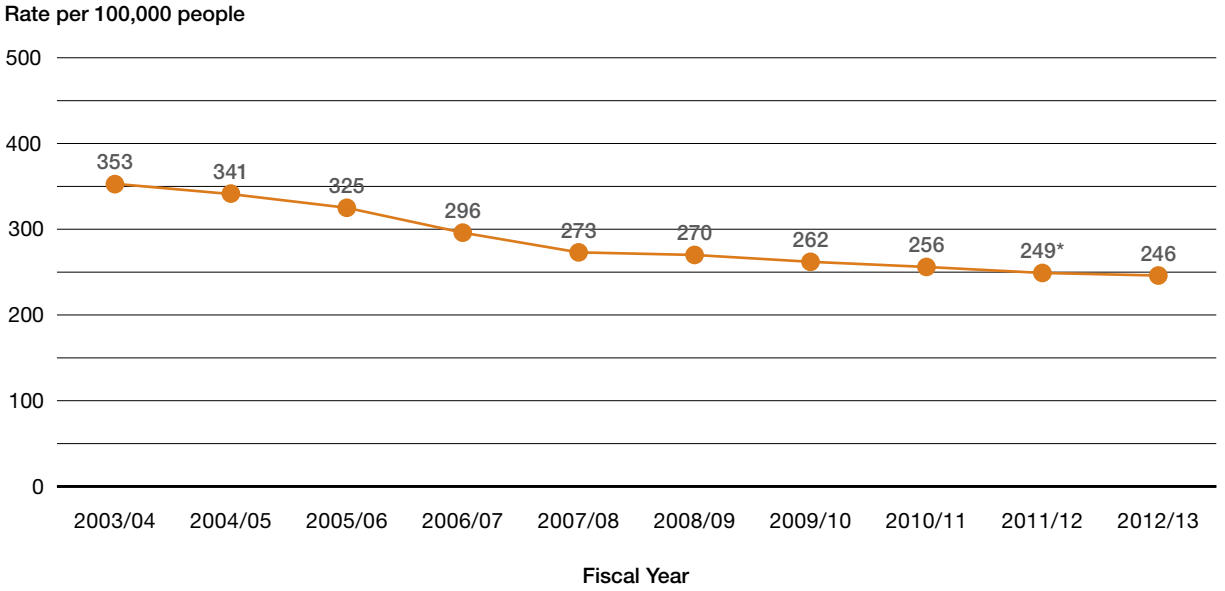
Hospitalization rates for asthma, heart failure, chronic obstructive pulmonary disease, epilepsy, hypertension, diabetes and angina, which can often be managed outside of hospitals, are often viewed as markers of how well primary care providers, pharmacists, home care providers and specialist physicians work together. The rates may also be affected by factors such as higher rates of smoking, obesity, diabetes or other diseases in a region.

The rate of hospitalizations for **ambulatory care sensitive conditions** improved substantially

246
per 100,000 people
2012/13

353
per 100,000 people
2003/04

FIGURE 8.1
Age- and sex-adjusted hospitalization rate for ambulatory care sensitive conditions, in Ontario, 2003/04 to 2012/13



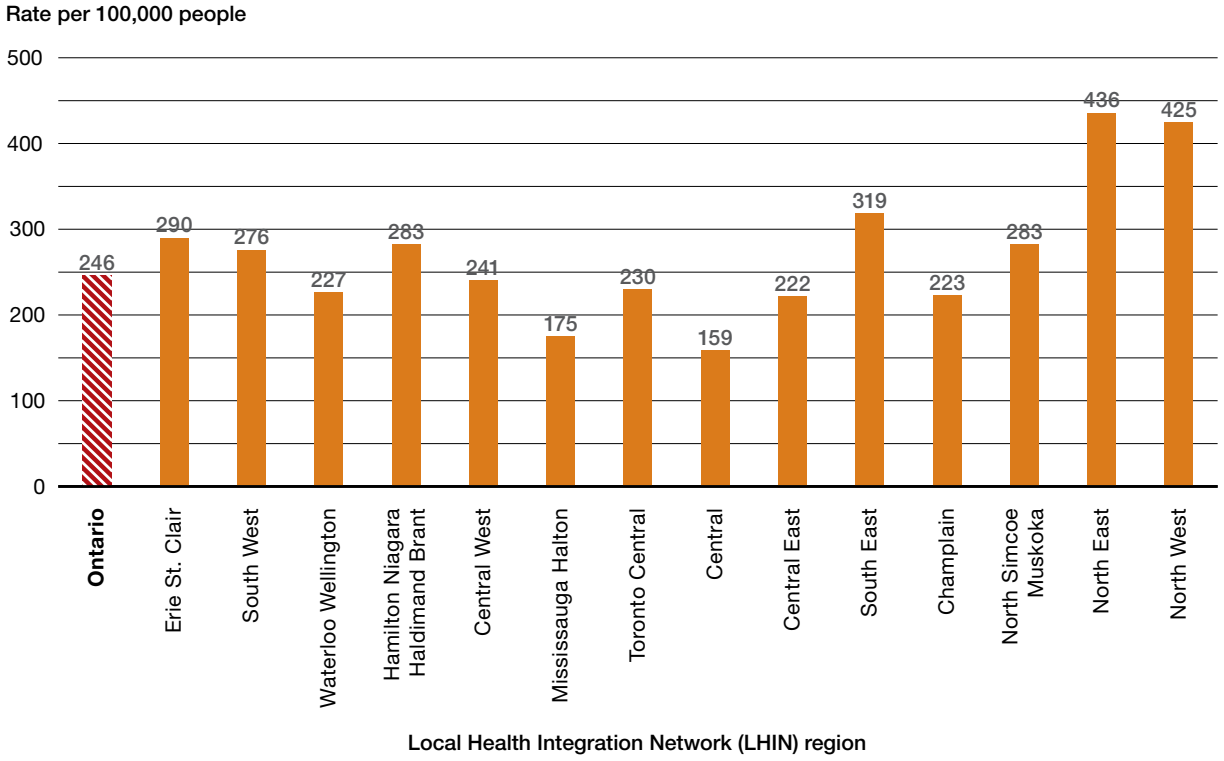
Data source: Discharge Abstract Database, provided by the Institute for Clinical Evaluative Sciences. *Variation in the Ontario rates reported for ambulatory care sensitive conditions for 2011/12 are due to methodological differences between the data sources.

Over 10 years of data, the rate of hospitalizations for these "ambulatory care sensitive conditions" improved substantially to 246 per 100,000 people in 2012/13 from 353 per 100,000 in 2003/04 (Figure 8.1).

There is substantial variation across Ontario, with a rate of 159 per 100,000 people in the Central LHIN region to a high of 436 per 100,000 in the North East LHIN region (Figure 8.2).

FIGURE 8.2

Age- and sex-adjusted hospitalization rate for ambulatory care sensitive conditions, in Ontario, by LHIN region, 2012/13



Data source: Discharge Abstract Database, provided by the Institute for Clinical Evaluative Sciences.

159 vs. 436

per 100,000 people

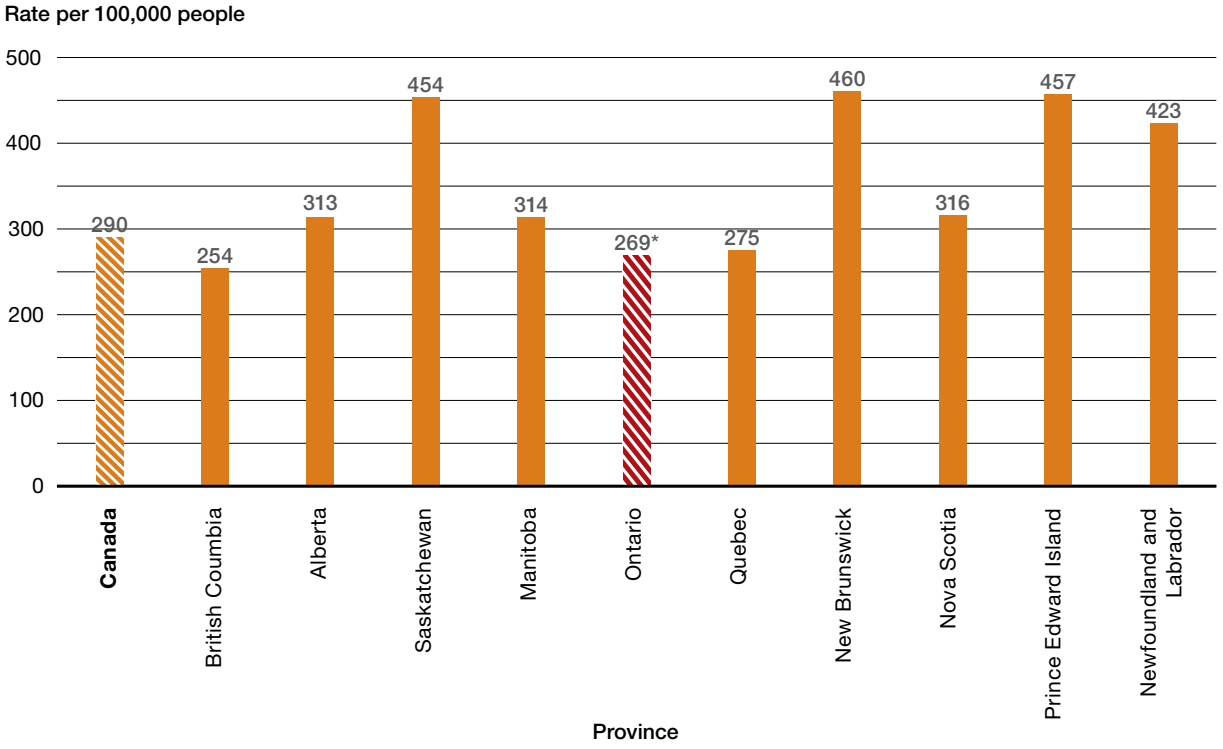
The rates of hospitalizations for ambulatory care sensitive conditions in the Central LHIN region and the North East LHIN region, respectively

How Ontario compares: **within Canada**

Ontario's hospitalization rate for ambulatory care sensitive conditions is the second-lowest among the Canadian provinces in 2011/12. At 269 per 100,000 people, the Ontario rate is below the national average of 290 per 100,000 and just behind British Columbia's level of 254 per 100,000 (Figure 8.3).

FIGURE 8.3

Age-adjusted hospitalization rate for ambulatory care sensitive conditions, in Canada, by province, 2011/12



Data source: Discharge Abstract Database eReports, provided by the Canadian Institute for Health Information. *Variation in the Ontario rates reported for ambulatory care sensitive conditions for 2011/12 are due to methodological differences between the data sources.

Physician visit within seven days of hospital discharge

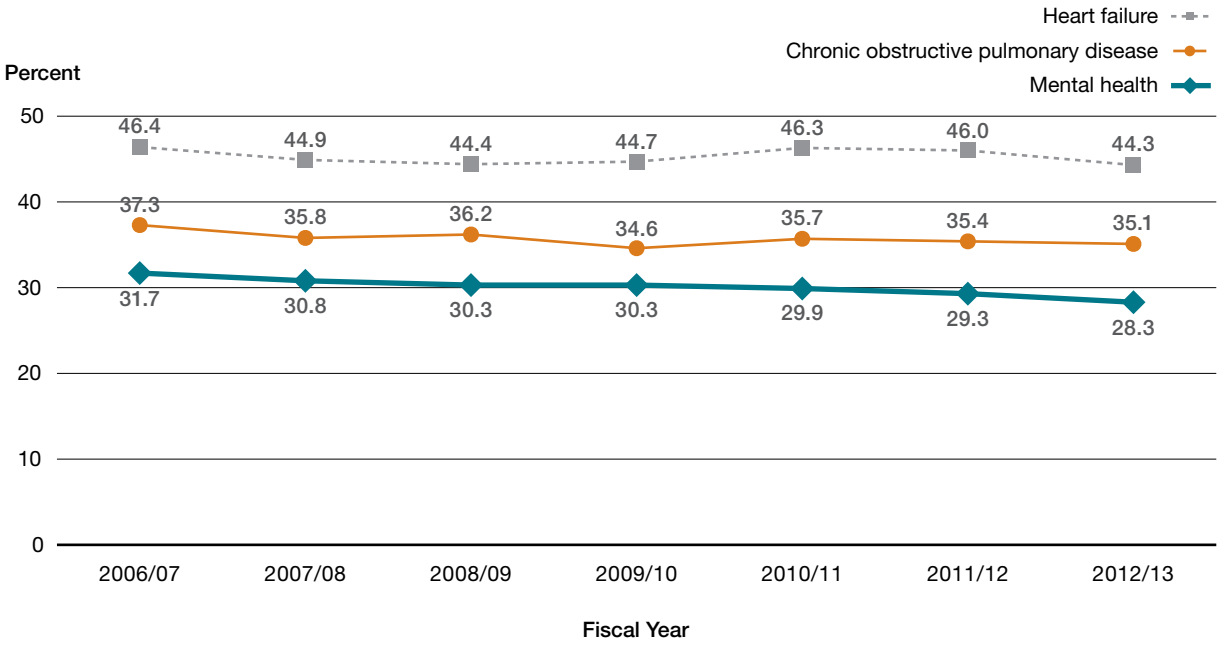
More than half of patients discharged from hospital for conditions requiring follow-up do not see a physician for follow-up within seven days of leaving the hospital

Many patients who are discharged from hospital should see a physician for a follow-up within a few days of discharge. This gives the patient an opportunity to ask questions and discuss any problems they might be having. Follow-up appointments also provide physicians with the opportunity to learn about what happened in hospital, and to see whether their patients are continuing to progress as expected.[87,88]

We provide information here about physician follow-up for patients hospitalized for heart failure, chronic obstructive pulmonary disease and mental health conditions. These are not the only conditions for which early follow-up is important, but they do provide measures that show whether hospitals and physicians who provide outpatient care – both primary care physicians and specialists – are working together effectively. The rates reported here are based on physician billing data and may not capture follow-up visits to care settings such as nurse practitioner-led clinics, community health centres or community mental health programs. This may result in underreporting the actual follow-up care a patient receives.

FIGURE 8.4

Percentage of patients discharged from hospital who had a physician visit within seven days, by condition, in Ontario, 2006/07 to 2012/13



Data sources: Discharge Abstracts Database, Ontario Mental Health Reporting System, Ontario Health Insurance Plan Database, Institute for Clinical Evaluative Sciences Physician Database, provided by the Institute for Clinical Evaluative Sciences.

Despite the importance of early follow-up, most patients in Ontario discharged from hospital after an admission for heart failure, chronic obstructive pulmonary disease or a mental health problem do not see a physician within seven days (Figure 8.4).

Only 28.3% of mental health patients, 35.1% of chronic obstructive pulmonary disease patients and 44.3% of heart failure patients see a physician within seven days after discharge from hospital. These rates are similar to the rates over the past six years for all conditions.

Readmission rates for mental illness

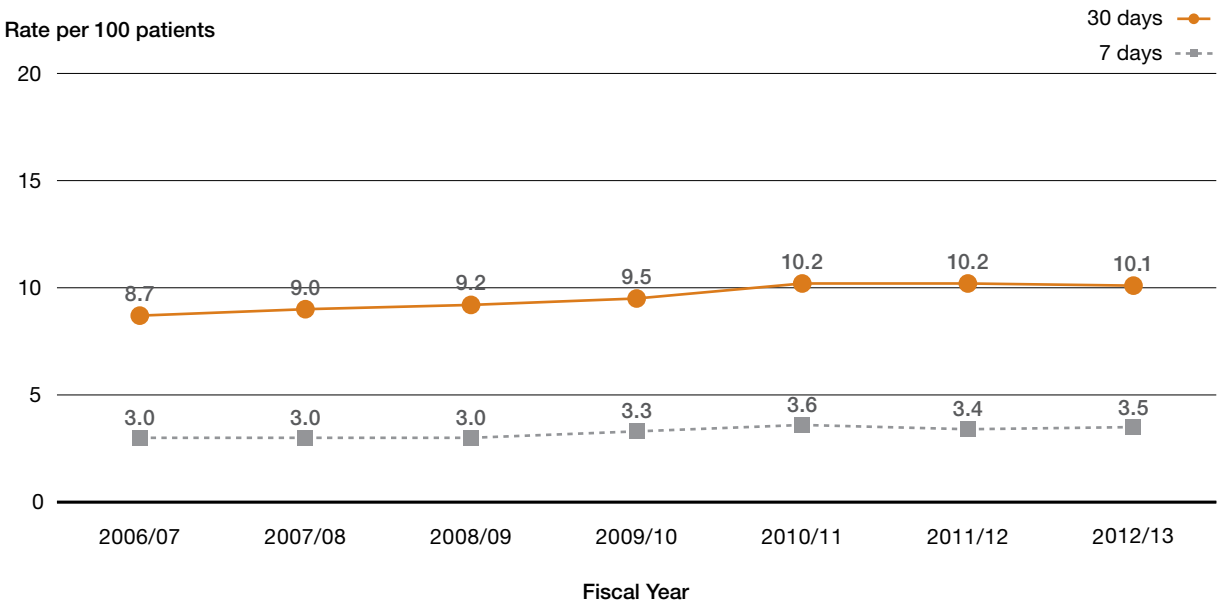
The 30-day readmission rates for mental illness has remained stable near 10 per 100 patients

When a person is admitted to hospital, discharged to their home or to the community but then needs to be re-hospitalized within a short period of time, this is deemed a readmission to hospital. Readmission to a hospital soon after discharge can occur for many reasons. Some patients become ill soon after being discharged from hospital and that readmission is unavoidable.[89] However, readmission rates are also considered to be a marker of how well the various parts of the health system work together.

The seven-day readmission rates for mental health and addiction conditions was stable over six years, ranging from 3.0% in 2006/07 to 3.5% in 2012/13. Thirty-day readmission rates also remained stable, from 8.7% in 2006/07 to 10.1% in 2012/13 (Figure 8.5).

FIGURE 8.5

Readmission rates (seven and 30 days) following hospitalization for a mental health and addiction condition, in Ontario, 2006/07 to 2012/13



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

30-day readmission rates for medical and surgical patients

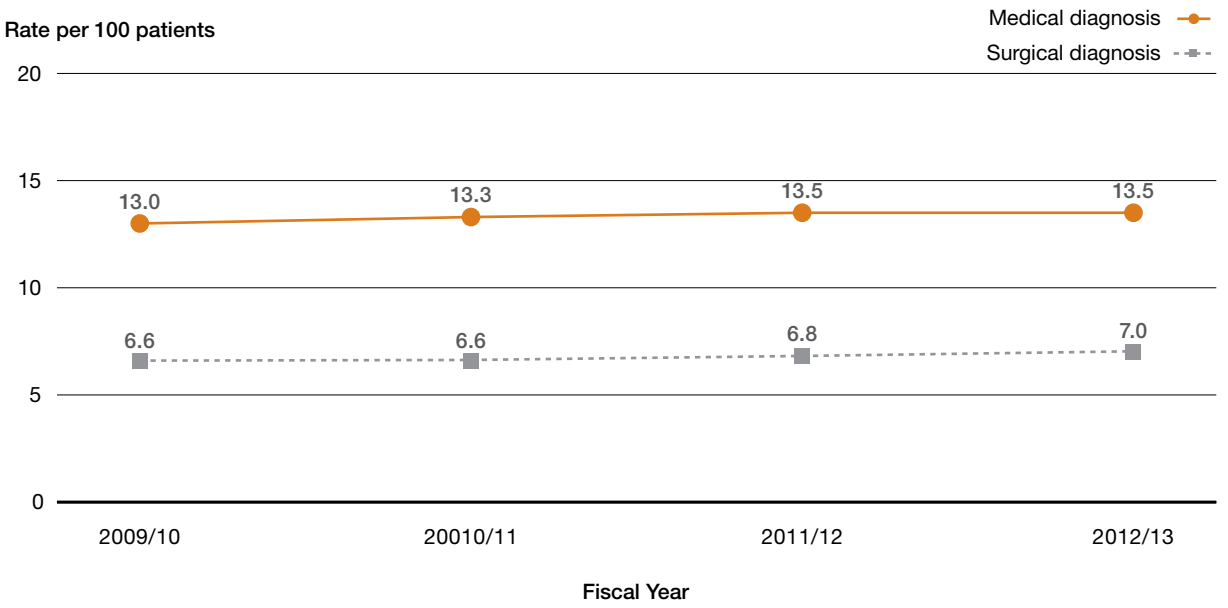
The 30-day readmission rates for medical patients remained stable over three years at 13.5% in 2012/13 from 13.0% in 2009/10

A readmission to hospital describes when a patient needs to be hospitalized again shortly after leaving the hospital. The indicator we report here measures readmissions for any reason within 30 days after being in hospital for a medical or surgical diagnosis. These readmissions account for 66% and 24% of all 30-day readmissions, respectively.[95]

The 30-day readmission rate for medical patients in Ontario was stable at 13.5% in 2012/13, compared to 13.0% in 2009/10 (Figure 8.6). The readmission rate for surgical patients was 7.0% in 2012/13, and also stayed stable over the previous three years.

There is slight variation across Ontario for medical and surgical readmissions (Figure 8.7). For medical patients, the lowest readmission rates are in the Waterloo Wellington and Mississauga Halton LHIN regions, both at 12.0%, while for surgical patients the lowest readmission rate is in the Central East LHIN region (5.8%). The highest readmission rates are in the northern LHIN regions, with medical readmissions at 14.6% in the North West LHIN region and surgical readmissions at 8.0% in the North East LHIN region.

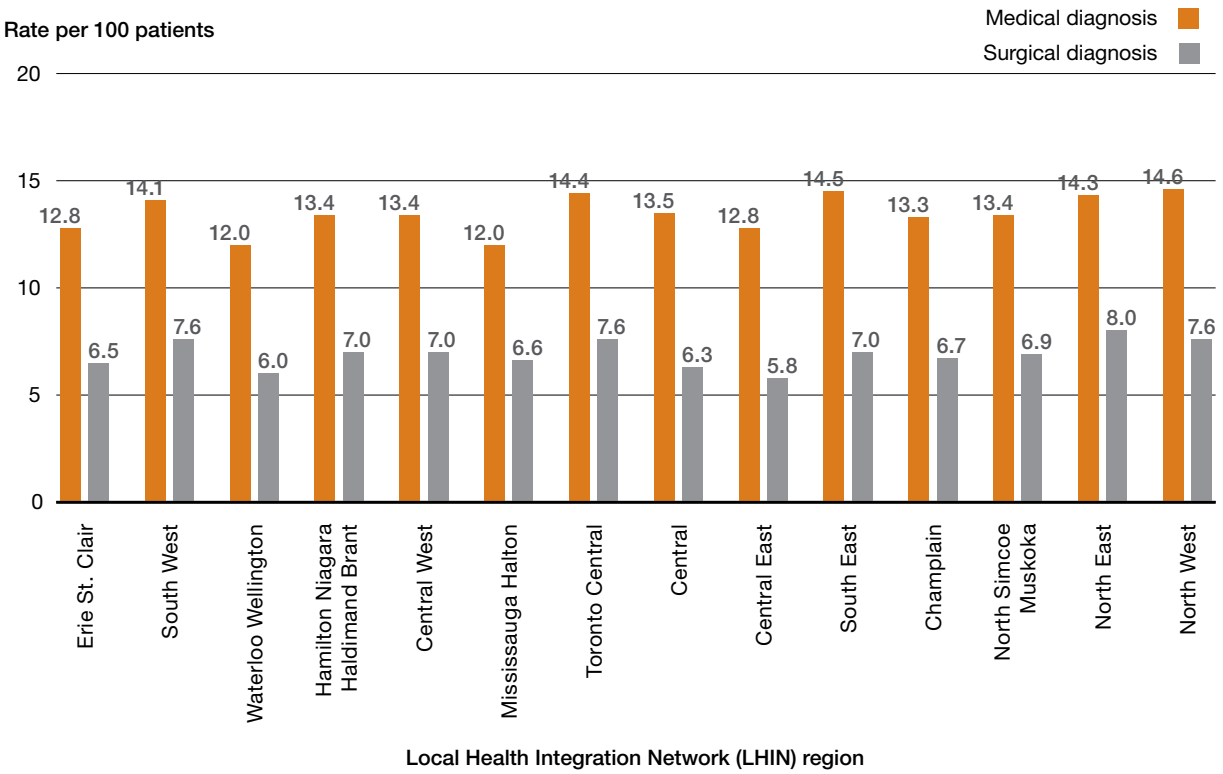
FIGURE 8.6
30-day readmission rates following hospitalization for either medical or surgical diagnoses, in Ontario, 2009/10 to 2012/13



Data source: Discharge Abstracts Database, provided by the Canadian Institute for Health Information upon request.

FIGURE 8.7

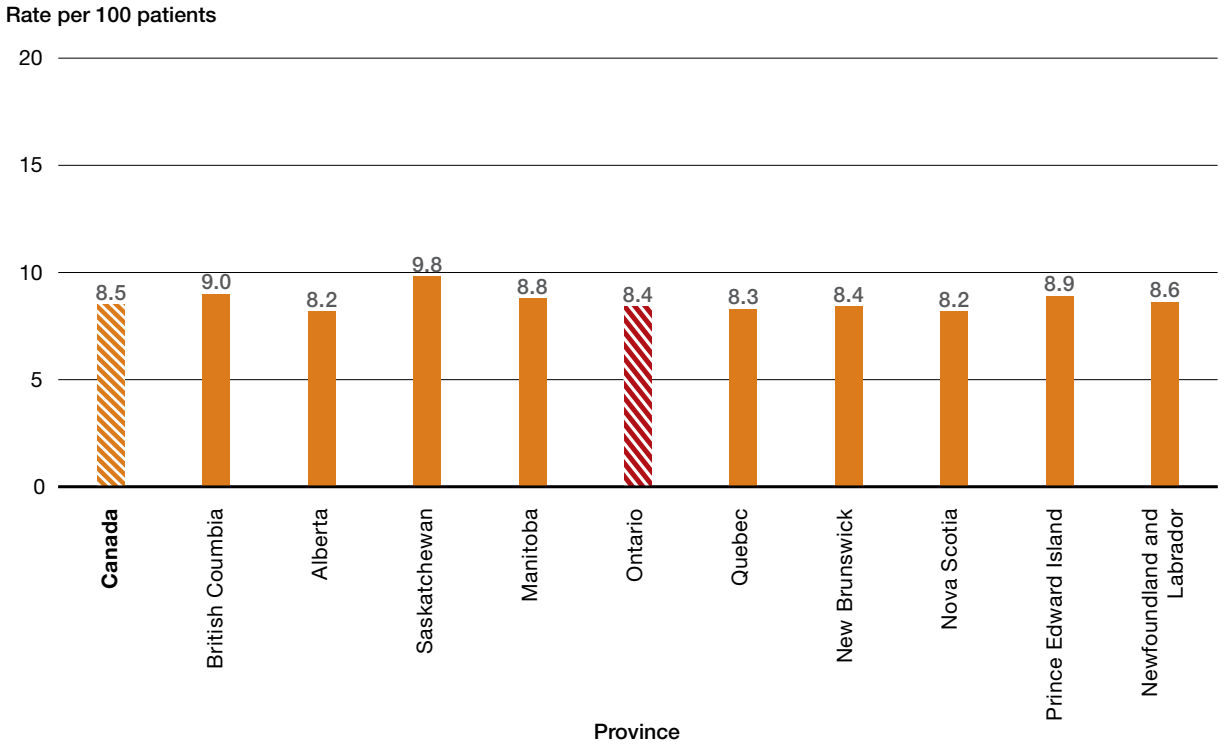
30-day readmission rates following hospitalization for either medical or surgical diagnoses, in Ontario, by LHIN region, 2012/13



Data source: Discharge Abstracts Database, provided by the Canadian Institute for Health Information upon request.

FIGURE 8.8

30-day readmission rates following hospitalization, in Canada, by province, 2010/11



Data source: Discharge Abstract Database, provided by the Canadian Institute for Health Information upon request.

How Ontario compares: **within Canada**

For comparisons with the other provinces in Canada, we can look at the overall readmission rate that combines patients readmitted after initial medical, surgical, obstetrical or pediatric diagnoses. Ontario's 30-day readmission rate of 8.4% for all patients is similar to the Canadian average of 8.5% for 2010/11, the last period for which pan-Canadian data are available. Alberta and Nova Scotia have the lowest rates of readmissions within 30 days, both at 8.2% (Figure 8.8).

Alternate level of care days

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

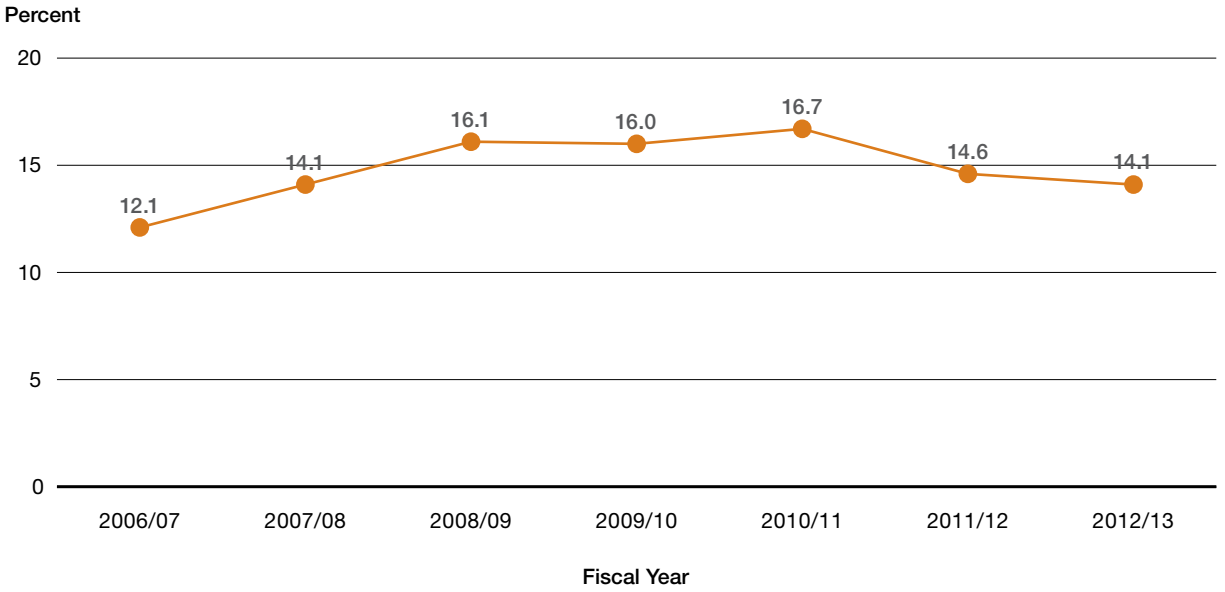
Most patients can leave the hospital when they no longer need acute care, but sometimes the type of care that a patient needs — such as rehabilitation or long-term care — is not immediately available. Alternate level of care refers to the situation that arises when a health care professional has indicated that a hospital patient no longer requires acute care services in hospital but cannot yet be sent home.[63] Many experts believe that a high percentage of alternate level of care days is a marker that the health system is not using its resources most appropriately.[90]

The percentage of hospital inpatient days designated as alternate level of care days improved slightly over the past two years of data, decreasing to 14.1% in 2012/13 from 16.7% in 2010/11 (Figure 8.9). However, since 2006/07 there has been a slight increase in the percentage of hospital inpatient days designated as alternate level of care.

Moderate variation in the percentage of acute care days designated as alternate level of care is evident across Ontario, with highs of 23.8% in the North East LHIN region and 23.2% in the North Simcoe Muskoka LHIN region and a low of 9.9% in the South West LHIN region (Figure 8.10).

FIGURE 8.9

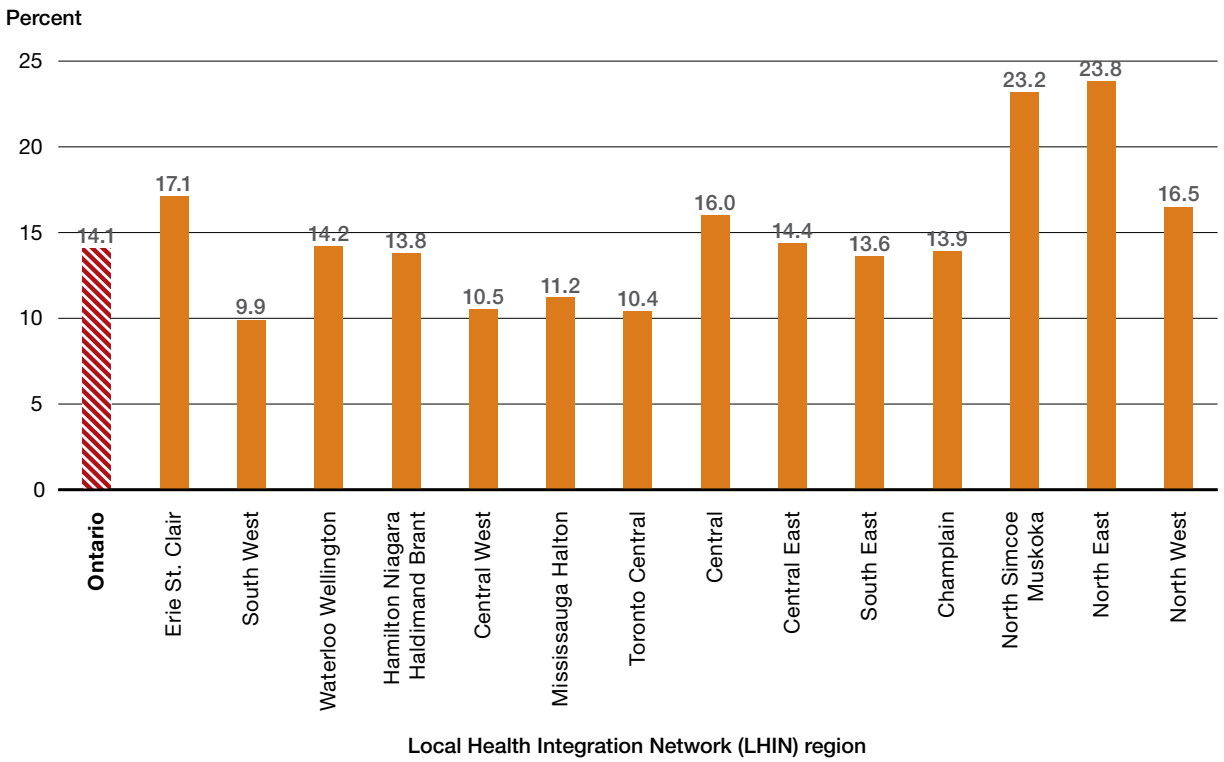
Percentage of acute care days designated as alternate level of care, in Ontario, 2006/07 to 2012/13



Data source: Discharge Abstracts Database, provided by Health Analytics Branch, Ministry of Health and Long-Term Care.

FIGURE 8.10

Percentage of acute care days designated as alternate level of care, in Ontario, by LHIN region, 2012/13



Data source: Discharge Abstracts Database, provided by Health Analytics Branch, Ministry of Health and Long-Term Care.

1 in 7

The number of hospital beds occupied by patients who are well enough to receive care outside the hospital


Photo by Roger Yip

Meet Douglas

Age: 68, Etobicoke

"Prostate cancer ... watchful waiting and surveillance ... aggressive." Douglas could not believe it when he heard the doctor say those words.

But not long after his diagnosis, things got even worse for Douglas. "I was getting ready to go to work one morning and had a lot of pain in my chest," he says. "I went to the emergency at a local hospital, where they did an ECG [electrocardiogram] and blood work and they found that I had suffered a minor heart attack." Douglas was given nitroglycerin to open up his blood vessels, and then taken in an ambulance to a hospital in Toronto for an angiogram. Doctors told Douglas that because of his heart attack, they would have to put off the cancer surgery for months.

After recovering from the heart attack, Douglas received a referral to a specialist at another Toronto hospital to assess his prostate cancer condition, but he had trouble connecting, as his calls kept going to voicemail. Finally, he decided to drop by the specialist's office in person and spoke with the receptionist. "They said, 'OK, we realize you're a priority and will schedule something,'" Douglas says. "[The specialists] get requests from other doctors, but they're just passed along as papers in an in-tray. It took me giving a human touch."

When the cancer surgery day arrived, doctors told Douglas he'd be in hospital for a few days. He ended up there for eight weeks. A post-surgery blockage, a bladder problem and an infection in his bowel caused serious complications. "They hooked tubes through my kidney and bladder," Douglas says. "I had about four or six different tubes to drain. It was not fun at all!"

Determined to leave the hospital in time to spend Christmas at home with his family, Douglas regained enough strength to be discharged just in time. The community care access centre arranged for a special fridge to keep his food at a particular temperature, and for home care to help him set up his feeding tube every night. Douglas experienced some stressful times when the nurses were unfamiliar with the equipment the hospital had sent.

The system could do better with transitions.

"They need to make it seamless so there are no roadblocks, and have a system in place so that people can navigate through more effectively."

Although he was generally happy with the care he received, Douglas says the system could do better with transitions. "They need to make it seamless so there are no roadblocks, and have a system in place so that people can navigate through more effectively," he says. "If there were simple guidelines for if the destination is D, you know that you need to go A, B and C."

Now, Douglas has no trace of cancer and sees a couple of specialists every six months. He takes medication for his heart condition.

"We have a great health system, there's no doubt about it," Douglas says, "but we can make it better."

In summary

It is not an easy task to determine how well the different parts of our health system work together. The data presented in this chapter reveal some improvements, but also areas where work needs to be done. Overall in Ontario, hospitalizations for ambulatory care sensitive conditions have decreased substantially over the last decade. More recently, alternate level of care has decreased slightly, while hospital readmission rates have remained stable over time.

However, regional rates for hospitalizations for ambulatory care sensitive conditions and alternate level of care vary substantially across Ontario. Also, over half of patients discharged for certain conditions do not have physician follow-up within seven days.

More than two-thirds of mental health patients, almost two out of three chronic obstructive pulmonary disease patients and more than one out of two heart failure patients **do not receive a follow-up physician visit within seven days of their discharge from hospital**.

Health Workforce

In this chapter, we report on the Common Quality Agenda indicators for the supply of nurses and doctors in Ontario, and the amount of time lost to injury for select health care providers.

Health workers: the backbone of the health system

A high-performing health system needs the right mix of healthy, knowledgeable and productive health workers who are committed to continually improving the care they provide.

The people who provide health care in Ontario form the **foundation of the province's health system.**

Key Findings

The number of nurse practitioners per 100,000 people has tripled in the last seven years

The number of family doctors and specialists per 100,000 people has increased in the last seven years

The number of workplace injuries resulting in lost time is decreasing

Nurses

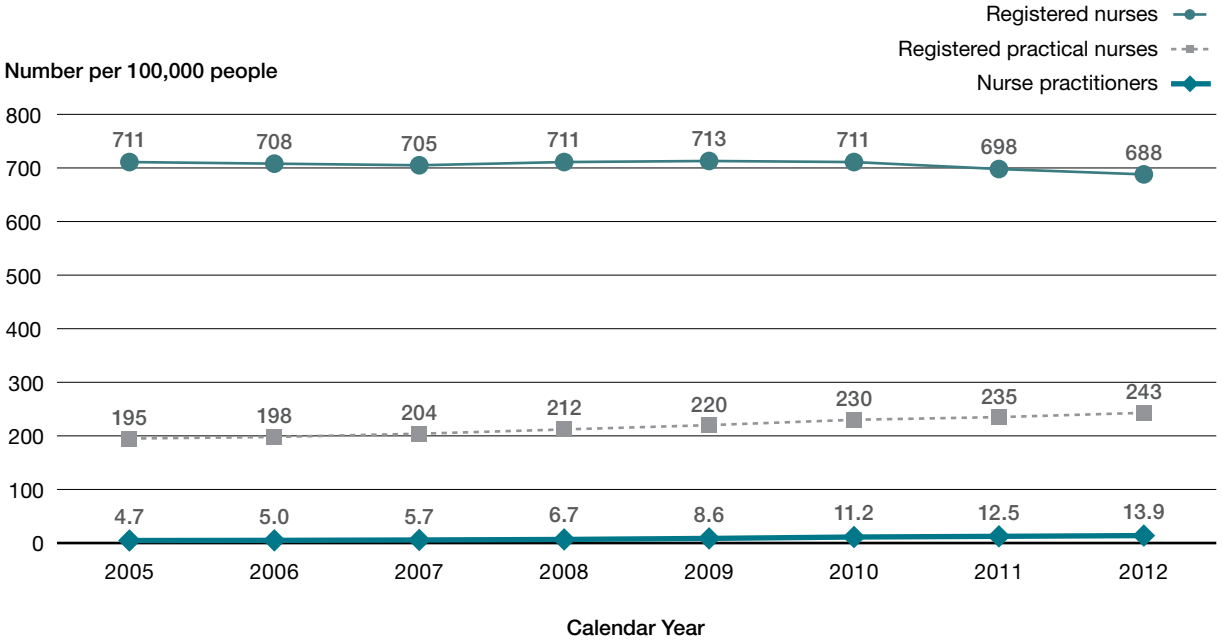
The number of registered practical nurses and nurse practitioners per 100,000 people has increased over seven years

Three classes of nurses in Ontario — registered nurses, nurse practitioners and registered practical nurses — offer different types of care, based on their training, education, and scopes of practice.[91,92]

The number of employed nurse practitioners per 100,000 people in Ontario nearly tripled over seven years to 13.9 per 100,000 people in 2012 from 4.7 per 100,000 in 2005 (Figure 9.1). The number of employed registered practical nurses grew to 243 per 100,000 people in 2012 from 195 per 100,000 in 2005, while the number of employed registered nurses per 100,000 people decreased slightly to 688 per 100,000 people from 711 per 100,000 over the same time period.

FIGURE 9.1

Number of employed nurses per 100,000 people, by nursing category, in Ontario, 2005 to 2012



Data source: College of Nurses of Ontario Membership Statistics Highlights 2013 Report; 2006 Census based Ministry of Finance Population Estimates.

Meet Heather

Nurse practitioner, Hamilton


Photo by Roger Yip

As a nurse practitioner, Heather sees her role as a unifying force to deliver better patient care. “I feel like a sort of glue that ties things together,” says Heather, who works on the general internal medicine team at a Hamilton hospital. “I find when you work in the collaborative environment with physicians and other health professionals, the nurse practitioner role can really flourish.”

A nurse for more than 21 years, Heather became interested in pursuing a nurse practitioner education in 2011 when provincial legislation expanded the roles and responsibilities of the profession, which included allowing nurse practitioners to prescribe most medications and diagnostic tests. Heather had been working as a clinical nurse specialist for 12 years before returning to school to become a nurse practitioner.

Heather says the staff at her workplace are strong advocates for nurse practitioners. “Everyone’s just very supportive,” she says. “The physicians rotate every week or two, so I’m the continuity for the patients and family. It’s very helpful to know the patient well.”

Since she began work as a nurse practitioner, Heather’s role has changed a lot. “It used to be that I would assess someone and come up with an idea of what was going on, and then refer them to a physician,” she says. “Now, as a nurse practitioner, I work on a treatment plan and provide medical care for the patient. It’s definitely stimulating to me and challenges me. Being like a detective, there’s gratification when you help the patient.”

The Chief of Medicine at the hospital where Heather works says nurse practitioners play an important role in the health care team, especially in caring for the increasing number of older, frail patients with complex conditions. “Having personnel with different skills like nurse practitioners has really helped solidify the medical services and allowed us to maintain a higher level of care,” he says. “They have become an invaluable part of the infrastructure here at our hospital.”

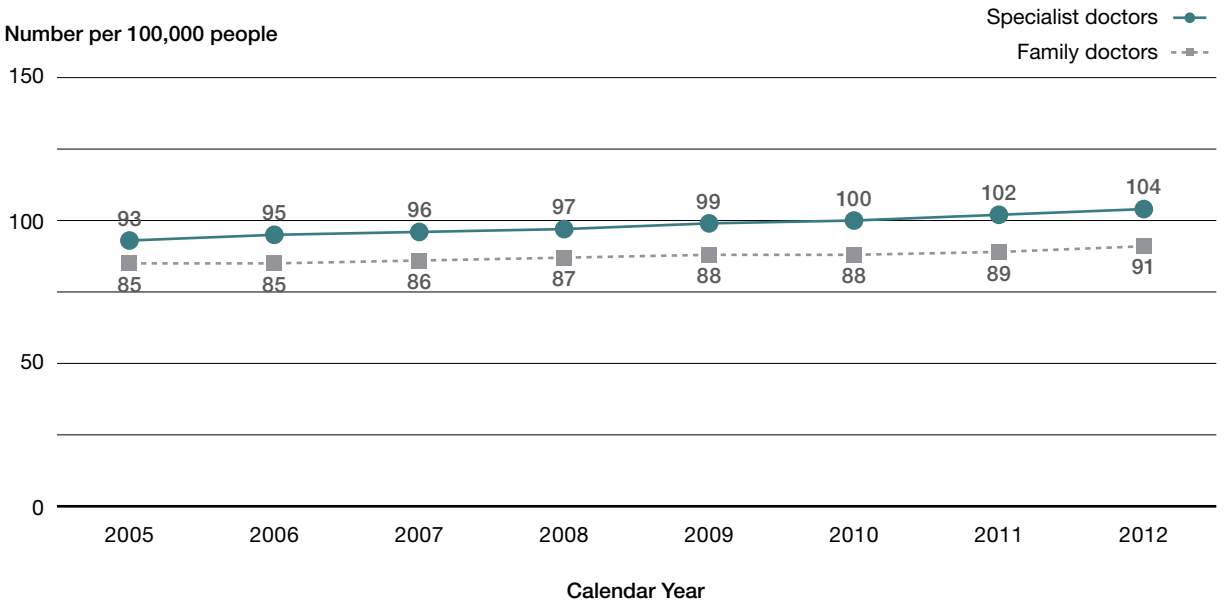
Family doctors and specialists

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

The number of family doctors and specialist doctors increased steadily over the last seven years. Between 2005 and 2012, the number of family doctors increased to 91 per 100,000 people from 85 per 100,000, and the number of specialist doctors increased to 104 per 100,000 from 93 per 100,000 (Figure 9.2).

FIGURE 9.2

Number of family doctors and specialist doctors per 100,000 people, in Ontario, 2005 to 2012



Data source: Ontario Physician Human Resources Data Centre.

How Ontario compares: **within Canada**

The Canadian Institute for Health Information (CIHI) also reports on physician supply, and while the methods differ from our report, we can still look to the CIHI report to compare Ontario to the other provinces in Canada. Ontario's supply of 100 family doctors per 100,000 people is below the national average of 109 per 100,000 in 2012. Prince Edward Island has the lowest provincial ratio of family doctors at 98 per 100,000 people, while Nova Scotia has the highest at 127 per 100,000 people.

The supply of specialist doctors in Ontario is 102 per 100,000 people, slightly lower than the Canadian rate of 106 specialist doctors per 100,000. Saskatchewan has the lowest provincial ratio of specialist doctors, at 80 per 100,000 people, while Nova Scotia has the highest with 123 specialist doctors per 100,000 people.[93]

The number of family doctors and specialist doctors **increased steadily over the last seven years**.

Lost time injury rates

The rates of lost time due to injury for health workers have declined across all sectors

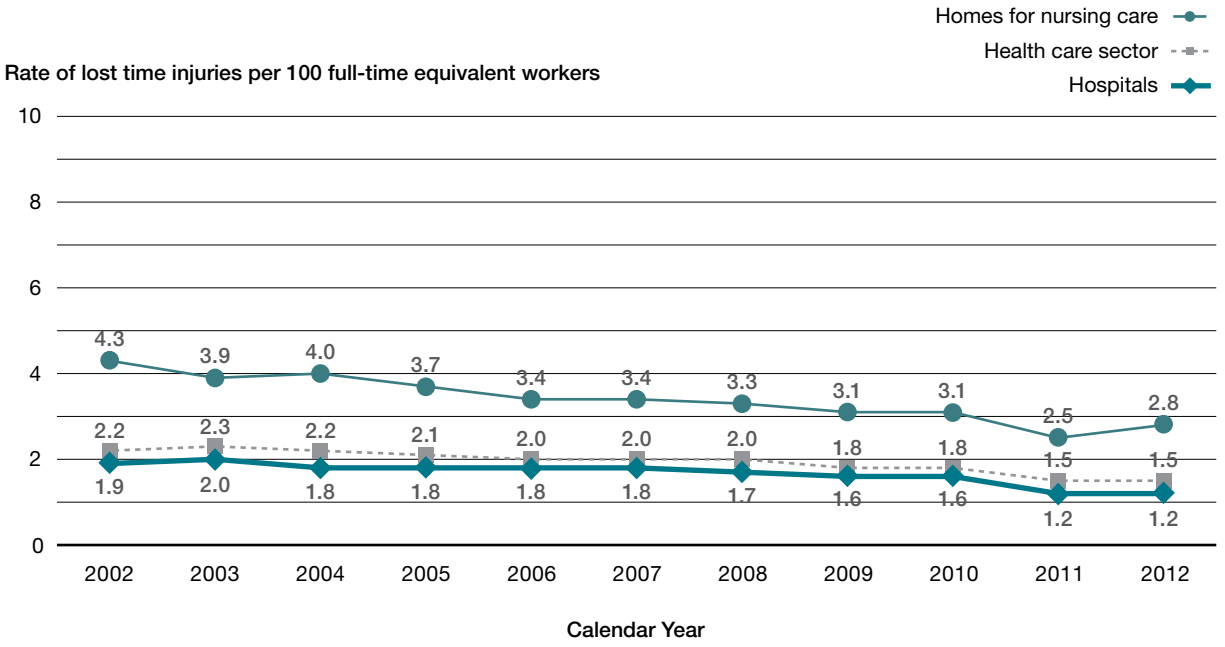
Ontario's health workers should work in environments that are as safe as possible.[94] When a health worker sustains a work-related injury that results in time off work, lost wages or a permanent disability, these often lead to a "lost time injury" claim. These claims are monitored by the Workplace Safety Insurance Board.

The rates for lost time injury claims for nursing care homes, hospitals and the health care sector as a whole all declined between 2002 and 2012 (Figure 9.3). The lost time injury rate in hospitals decreased to 1.2 injury claims per 100 full-time equivalent health workers in 2012 from 1.9 injury claims per 100 full-time equivalent health workers in 2002.

At homes for nursing care (e.g., long-term care homes), the lost time injury rate was higher than in hospitals, but also improved over the 10 years for which we have data, declining to 2.8 injury claims per 100 full-time equivalent health workers in 2012 from 4.3 injury claims per full-time equivalent health workers in 2002.

FIGURE 9.3

Lost time injury rates for select health worker groups and the overall lost time injury rate for the overall health sector, 2002 to 2012



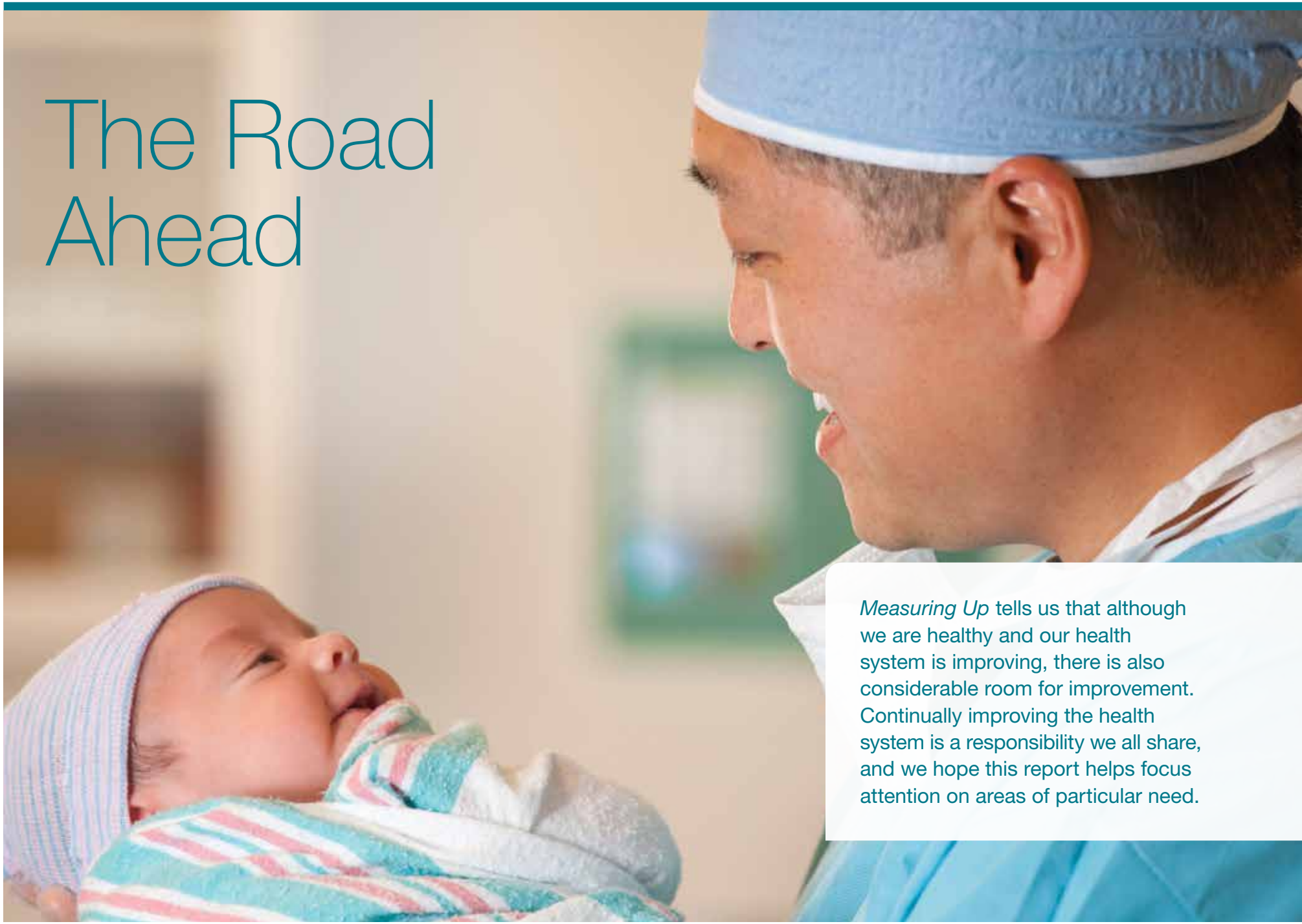
Data source: By the Numbers: 2012 WSIB Statistical Report in 2012 Schedule 1 Statistical Report (online).

In summary

The people who provide health care in Ontario form the foundation of the province's health system. The numbers of registered practical nurses, nurse practitioners and doctors per capita are increasing in Ontario and there are fewer injury claims being filed for health workers.

The numbers of registered practical nurses, nurse practitioners and doctors per capita are increasing in Ontario.

The Road Ahead



Measuring Up tells us that although we are healthy and our health system is improving, there is also considerable room for improvement. Continually improving the health system is a responsibility we all share, and we hope this report helps focus attention on areas of particular need.

Health Quality Ontario's role

At Health Quality Ontario, we are committed to being a trusted, independent resource for information about the quality of care in Ontario. As we assembled this report, we were encouraged by the overwhelming amount of support we received from Ontarians who share our vision to improve the province's health system. Patients, caregivers, health care providers, researchers and leaders within the system all played key roles in helping us fulfil our mandate to produce this yearly report on the health status of Ontarians and the performance of our health system. We are grateful for their help.

In addition to monitoring and reporting on Ontario's health system's performance, Health Quality Ontario also supports those who deliver care and promotes the delivery of evidence-based health care. More information about this part of our work can be found at **www.hqontario.ca**.

The Common Quality Agenda in the future

The framework for *Measuring Up* is the Common Quality Agenda, a set of key performance indicators for Ontario's health system. By using this set of indicators we hope to bring focus to measuring Ontario's health system performance by reigning in the overwhelming number of indicators currently being used. Nevertheless, we also recognize that important areas, such as mental health, are currently under-represented in the Common Quality Agenda. In partnership with patients, health care providers

Health Quality Ontario also supports those who **deliver care and promotes the delivery of evidence-based health care**.

and researchers, we will continue to refine this set of indicators. As part of our strategic renewal, we are also developing a transparent process that we will use to review all of the indicators we report. We will begin to implement this process to review the Common Quality Agenda set of indicators in 2015. We also provide more data on our website with analyses to support quality improvement.

Personalized reports and theme reports

It is not enough to produce a single report each year. A new series of theme reports will take a more in-depth look at important quality issues in our health system and show how performance can be improved. The first of these reports will be published in 2015. We will also provide more data directly to health care providers, in the form of personalized reports.

Health Quality Ontario **advocates for more comprehensive and timely data** to help us better understand the quality of health care in Ontario and the health of Ontarians.

Better information, greater impact

Health Quality Ontario advocates for more comprehensive and timely data to help us better understand the quality of health care in Ontario and the health of Ontarians.

Although we believe that *Measuring Up* provides a wealth of useful information, there are still major challenges in our ability to monitor the quality of health care provided in Ontario. In some areas, there are minimal or no data. In other areas, the data is unreliable. When it comes to wait times, for example, the available data often allow us to provide information only about one component of the time that any given patient waits. We provide information about the number of doctors and nurses working in Ontario, but not their distribution. We provide information about the length of time that people wait to get into a long-term care bed, but not about whether people's needs can be adequately met at home. We provide information about patient satisfaction and experience for some health sectors, but we do not have measures yet for patient experience in long-term care.

We need more data, and we also need to make sure we are interpreting the data we do have correctly.

We will work in partnership with patients, health care providers and others to make sure we are doing this, and also bring the data to life in ways that are meaningful and helpful.

Evidence-based decisions

Evidence plays an increasingly important role in Ontario health policy and decision-making. Health Quality Ontario's Evidence Development and Standards branch works with clinical experts, scientists, panels and field evaluation partners to provide evidence about the effectiveness and cost-effectiveness of health technologies and services in the province. Using the information, the Ontario Health Technology Advisory Committee (OHTAC) — a standing advisory subcommittee of Health Quality Ontario's board of directors — makes recommendations about the introduction, acceptance, distribution or removal of health interventions in the province. Using OHTAC's recommendations and advice, Health Quality Ontario's board offers final recommendations to the health care system and the Minister of Health and Long-Term Care. You can find the OHTAC recommendations and other related reports at **www.hqontario.ca/evidence/publications-and-ohtac-recommendations**.

Our mission: your health

Health Quality Ontario plays a unique role in the Ontario health system by bringing together into one organization the functions of reporting, promotion of scientific evidence and quality improvement. At Health Quality Ontario, we share the road ahead with all Ontarians. On this road, we will continue to work together to strive for a healthier Ontario.

References

1. Ministry of Health and Long-Term Care. *Excellent Care for All Act*. 2010; Available from: http://health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx.
2. Health Quality Ontario, *Partnering for a Common Quality Agenda* 2013: p. 5.
3. Local Health Integration Networks. *Ontario's Local Health Integration Networks*. 2014; Available from: http://www.torontocentrallhin.on.ca/aboutus.aspx.
4. Statistics Canada, *Table 102-0512 - Life expectancy, at birth and at age 65, by sex, Canada, provinces and territories, annual (years) Footnotes*. CANSIM database.
5. Organization for Economic Co-operation and Development (OECD). *OECD StatExtracts: Health Status*. [cited 2014 May 5]; Available from: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#.
6. Statistics Canada, *Table 102-4307 - Life expectancy, at birth and at age 65, by sex, three-year average, Canada, provinces, territories, health regions and peer groups, occasional* CANSIM database.
7. Organization for Economic Co-operation and Development (OECD), *Infant mortality, in OECD Factbook 2014: Economic, Environmental and Social Statistics*, Organization for Economic Co-operation and Development (OECD). 2014, OECD Publishing.
8. Public Health Agency of Canada, *Canadian Perinatal Health Report, 2008 Edition*.
9. Statistics Canada, T*able 102-0030 - Infant mortality, by sex and birth weight, Canada, provinces and territories, annual*. CANSIM database.
10. DeSalvo, K.B., et al., *Mortality Prediction with a Single General Self-Rated Health Question*. Journal of General Internal Medicine, 2006. 21: p. 267–275.
11. Idler, E.L. and S.V. Kasl, *Self-ratings of health: Do they also predict change in functional ability?* . The Journals of Gerontology Series B: Psychological Sciences and Social Sciences. 1995. **50B**(6): p. S344-53.
12. Canadian Community Health Survey provided by the Institute for Clinical Evaluative Sciences, *Self-reported overall health status*.
13. Statistics Canada, *Table 102-4311 - Premature and potentially avoidable mortality, three-year average, Canada, provinces, territories, health regions and peer groups, occasional*. CANSIM database.
14. Lung Association of Ontario. *Smoking and Tobacco: Smoking and Health Facts*. 2011 August 18, 2014.
15. Manuel DG, et al., *Seven more years: the impact of smoking, alcohol, diet, physical activity and stress on health and life expectancy in Ontario. An ICES/PHO Report* 2012: Institute for Clinical Evaluative Sciences and Public Health Ontario. p. 33.
16. Canadian Community Health Survey provided by the Institute for Clinical Evaluative Sciences, *Self-reported smoking status*.
17. Statistics Canada, *Table 105-0503 - Health indicator profile, age-standardized rate, annual estimates, by sex, Canada, provinces and territories, occasional*. CANSIM database.
18. Katzmarzyk P, *The Economic Costs Associated with Physical Inactivity and Obesity in Ontario*. Health and Fitness Journal of Canada, 2011. **4**(4): p. 31-40.

19. Gilmour H, *Physically active Canadians Physically active Canadians Physically active Canadians* Health Reports, 2007. **18**(3): p. 45.

20. Kopelman P, *Health risks associated with overweight and obesity*. Obesity Reviews, 2007. **8 Supplement** (1): p. 13-17.

21. Canadian Community Health Survey provided by the Institute for Clinical Evaluative Sciences, *Self-reported height and weight*.

22. Bettinger JA, et al., *The disease burden of invasive meningococcal serogroup B disease in Canada*. The Pediatric Infectious Disease Journal, 2013. **32**(1): p. e20-25.

23. Public Health Ontario, *Immunization Records Information System*. 2008-2013.

24. Schanzer DL, Langley JM, and Tam TWS, *Co-morbidities associated with influenza-attributed mortality, 1994–2000, Canada*. Vaccine 2008. **26**(36): p. 4697-4703.

25. Schanzer D, Zheng H, and Gilmore J, *Statistical estimates of absenteeism attributable to influenza from the Labour Force Survey*. BMC Infectious Diseases, 2011. **11**: p. 1-9.

26. Schanzer DL, Langley JM, and Tam TWS, *Role of influenza and other respiratory viruses in admissions of adults to Canadian hospitals*. Influenza and Other Respiratory Viruses, 2008. **2**: p. 1-8.

27. Schanzer DL, McGeer A, and Morris K, *Statistical estimates of respiratory admissions attributable to seasonal and pandemic influenza for Canada*. Influenza and Other Respiratory Viruses 2013. **7**(4): p. 799-808.

28. Kwong JC, et al., *The effect of universal influenza immunization on mortality and health care use*. PLOS Medicine 2008. **5**: p. e211.

29. National Advisory Committee on Immunization (NACI), *Statement on seasonal influenza vaccine for 2013-2014*. Canadian Communicable Disease Report, 2013. **39**(ACS 4): p. 1-37.

30. Rivetti D, et al., *Vaccines for preventing influenza in the elderly*. Cochrane Database Systematic Reviews, 2006. **Jul 19**(3): CD004876.

31. Starfield B, Shi L, and Macinko J, *Contribution of primary care to health systems and health*. Millbank Quarterly, 2005. **83**(3): p. 457-502.

32. Institute for Clinical Evaluative Sciences, *Primary Care in Ontario: ICES Atlas*, U.R. Jaakkimainen L, Klein-Geltink JE, Leong A, Maaten S, Schultz SE, Wang L. 2006: Toronto.

33. Manuel DG, et al., *Primary Care in the Health Care System*. Primary Care in Ontario: ICES Atlas 2006.

34. Grumbach K, Keane D, and Bindman A, *Primary Care and Public Emergency Department Overcrowding*. American Journal of Public Health 1993. **83**(3): p. 372-378.

35. Ministry of Health and Long-Term Care, *Ontario's Action Plan for Health Care*. 2012.

36. Ontario Ministry of Health and Long-Term Care. *The Health Care Experience Survey*. 2013 May 23, 2013; Available from: http://www.health.gov.on.ca/en/news/bulletin/2012/hb_20121001_1.aspx.

37. Organisation for Economic Co-operation and Development. *Health at a Glance 2013: OECD Indicators*. 2013; Available from: http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf.

38. Agency for Health Care Quality, *National Healthcare Disparities Report, 2010*.

39. Cancer Care Ontario. *Cancer Statistics*. August 18, 2014]; Available from: https://www.cancercare.on.ca/ocs/csurv/stats/.

40. Hewitson P, G.P., Watson E, Towler B, Irwig L, *Cochrane systematic review of colorectal cancer screening using the fecal occult blood test (hemoccult): an update*. American Journal of Gastroenterology, 2008. **103**(6): p. 1541–1549.

41. Cancer Care Ontario. *Colorectal Cancer Screening*. [cited 2013 July 24]; Available from: http://www.csqi.on.ca/cms/one.aspx?portalId=258922&pageId=273238#.

42. Ontario Health Insurance Plan, Laboratory Report Tool, Ontario Cancer Registry, Pathology Information Management System, Registered Persons Database,Colonoscopy Interim Reporting Tool provided by Cancer Care Ontario, *Colorectal cancer screening*. 2009-2013.

43. Booth GL, et al. *Regional Measures of Diabetes Burden in Ontario*. 2012 [cited 2014 July 22]; Available from: http://www.ices.on.ca/flip-publication/regional-measures-of-diabetes-burden/index.html#4.

44. Ontario Ministry of Health and Long Term Care, *Diabetes Task Force Report to Ministry of Health and Long-Term Care*. 2004. 1-78.

45. Canadian Diabetes Association. *Clinical Practice Guidelines* 2013; Available from: http://guidelines.diabetes.ca/Browse/Chapter30.

46. Kiran, et al., *Unintended consequences of delisting routine eye exams on retinopathy screening for people with diabetes in Ontario, Canada*. Canadian Medical Association Journal, 2013. **185**(3): p. E167-E173.

47. Institute for Clinical Evaluative Sciences. *Atlases and Reports*. 2014; Available from: http://www.ices.on.ca/Publications/Atlases-and-Reports.

48. Ontario Hospital Association. *Hospital Reports* 2014; Available from: http://www.oha.com/KnowledgeCentre/Library/HospitalReports/Pages/HospitalReports.aspx.

49. Canadian Institute for Health Information (CIHI). *Hospital Care*. 2014; Available from: http://www.cihi.ca/CIHI-ext-portal/internet/EN/subtheme/types+of+care/hospital+care/cihi016803.

50. Health Quality Ontario. *About Patient Safety Public Reporting*. 2013; Available from: http://www.hqontario.ca/public-reporting/patient-safety/about-patient-safety-public-reporting.

51. Canadian Institute for Health Information, *National Ambulatory Care Reporting System*. 2009-2013.

52. Ontario Ministry of Health and Long Term Care. *Ontario Wait Times: Provincial Summary.* 2010 April 20, 2010; Available from: http://www.ontariowaittimes.com/er/En/ProvincialSummary.aspx?view=0.

53. Ontario Ministry of Health and Long Term Care. *Ontario Wait Times: Wait Time Targets*. 2014; Available from: http://www.health.gov.on.ca/en/pro/programs/waittimes/surgery/target.aspx.

54. Sloan FA, George LK, and Hu L, *Productivity Improvements in Hip and Knee Surgery*. Arthritis, 2014. **2014**: p. 1-8.

55. Norman-Taylor FH, Palmer CR, and Villar RN, *Quality-of-life improvement compared after hip and knee replacement* The Journal of Bone and Joint Surgery, 1996. **78-B**: p. 74-77.

56. Heart and Stroke Foundation. *Angiography*. 2012 September 2006; Available from: http://www.heartandstroke.com/site/c.ikIQLcMWJtE/b.3484085/k.6FB8/Heart_disease__Angiography.htm.

57. Heart and Stroke Foundation. *Percutaneous coronary intervention (PCI or angioplasty with stent)*. 2007 June 2012; Available from: http://www.heartandstroke.com/site/c.ikIQLcMWJtE/b.3831925/k.4F32/Heart_disease__Percutaneous_coronary_intervention_PCI_or_angioplasty_with_stent.htm.

58. Heart and Stroke Foundation. *Coronary artery bypass surgery*. 2012 July 2012; Available from: http://www.heartandstroke.on.ca/site/c.pvl3IeNWJwE/b.4010277/k.3D0B/Heart_Disease__Coronary_artery_bypass_surgery.htm.

59. Lohrisch C, et al., *Impact on survival of time from definitive surgery to initiation of adjuvant chemotherapy for early-stage breast cancer.* Journal of Clinical Oncology, 2006. **24**(30): p. 4888-4894.

60. Des Guetz G, et al., *Does delaying adjuvant chemotherapy after curative surgery for colorectal cancer impair survival? A meta-analysis*. European Journal of Cancer, 2010. **46**(6): p. 1049-1055.

61. Cancer Care Ontario, *Wait Times Information System*.

62. Ontario Agency for Health Protection and Promotion Provincial Infectious Diseases Advisory Committee, *Annex C - Testing, Surveillance and Management of Clostridium difficile. Annexed to: Routine Practices and Additional Precautions in All Health Care Settings*. 2013, Public Health Ontario: Toronto Ontario: Queen's Printer for Ontario.

63. Canadian Institute for Health Information (CIHI), *Resident Safety: Characteristics Associated With Falling in Ontario Complex Continuing Care* 2007. p. 1-12.

64. Health Quality Ontario, Ontario Health Technology Assessment Series (OHTAS). *Publications and OHTAS Recommendations: Prevention of Chronic Pressure Ulcers*. [July 17, 2014]; Available from: http://www.hqontario.ca/evidence/publications-and-ohtac-recommendations/ontario-health-technology-assessment-series/prevention-of-chronic-pressure-ulcers.

65. Registered Nurse's Association of Ontario. *Best Practice Guideline: Risk Assessment and Prevention of Pressure Ulcers*, March 2005; Available from: http://healthsci.queensu.ca/assets/NSG_Simlab/Old_Assets/638_bpg_pressure_ulcers_v2__2.pdf.

66. Lim K, J.P., Dewa C, *How Much Should We Spend on Mental Health? in IHE Report*. 2008, Institute of Health Economics: Edmonton, Canada.

67. Canadian Institute for Health Information (CIHI), *Restraint Use and Other Control Interventions for Mental Health Inpatients in Ontario*. 2011. p. 1-18.

68. The Patient Restraint Minimization Act S.O. 2001, Chapter 16. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_01p16_e.htm.

69. Mental Health Act R.S.O. 1990, Chapter M.7. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm.

70. Health Care Consent Act S.O. 1996, Chapter 2; Schedule A. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm.

71. Community Care Access Centres, *How we care: 2012-2013 CCAC Quality Report*. 2012-13.

72. Jha, A.K., et al., *Patients' Perception of Hospital Care in the United States*. New England Journal of Medicine, 2008. **359**(18): p. 1921-1931.

73. McMillan, S.S., et al., *Patient-Centered Approaches to Health Care: A Systematic Review of Randomized Controlled Trials*. Medical Care Research and Review, 2013. **70**(6): p. 567-96.

74. Ontario Ministry of Finance. *2013 Ontario Budget, Chapter 1: A Prosperous and Fair Ontario, Section B: A Fair Society*. 2013 May 2 [cited 2014 July 7]; Available from: http://www.fin.gov.on.ca/en/budget/ontariobudgets/2013/ch1b.html.

75. Health Quality Ontario, *Long-Term Care Benchmarking Resource Guide*. 2013: Toronto, ON: Queen's Printer for Ontario.

76. Health Quality Ontario, *Long-Term Care Public Reporting; Accessible Care (Wait Times)*. 2013: Health Quality Ontario Public Reporting Website.

77. Institute for Clinical Evaluative Sciences (ICES), *Median and 90th percentile wait times to long-term care placement for seniors, in Ontario, 2002/03–2007/08*. September 2010: Aging in Ontario: An ICES Chartbook of Health Service Use by Older Adults.

78. Long-Term Care Homes Act S.O. 2007, Chapter 8. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_07l08_e.htm.

79. Canadian Institute for Health Information (CIHI), *Resident Assessment Instrument (RAI) MDS 2.0 © User's Manual Canadian Version Addendum-Original Resident Assessment Protocols (RAPs)*. Jan 9, 2012.

80. Canadian Institute for Health Information (CIHI), *Resident Assessment Instrument (RAI) RAI-MDS ©2.0 User's Manual - Canadian Version*. September 2010.

81. SMARTRISK, *The Economic Burden of Injury in Canada*. 2009: SMARTRISK: Toronto, ON.

82. Ontario Regulation 79/10 made under the Long-Term Care Homes Act S.O. 2007, Made: March 10, 2010; Filed: March 29, 2010; Published: March 31, 2010. Available from: http://www.e-laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10079_e.htm.

83. Continuing Care Report System provided by the Canadian Institute for Health Information, *Falls in the 30-days prior to assessment in long-term care home residents*.

84. Registered Nurses' Association of Ontario (RNAO), *Nursing Best Practice Guideline: Risk Assessment & Prevention of Pressure Ulcers*. 2005, revised 2011: Toronto, Canada: Registered Nurses' Association of Ontario.

85. Ontario Health Technology Advisory Committee (OHTAC), *OHTAC Recommendation: Prevention and Management of Pressure Ulcers* October 2009.

86. Continuing Care Report System provided by the Canadian Institute for Health Information, *New and worsening pressure ulcers in long-term care home residents*.

87. Heart Failure Society of America (HFSA), *HFSA 2010 Guideline Executive Summary*. Journal of Cardiac Failure, 2010. **16**(6).

88. Vigod S, et al., *Within-hospital readmission: An indicator of readmission after discharge from psychiatric hospitalization*. Canadian Journal of Psychiatry, 2013. **58**(8): p. 476-481.

89. Reuben DB and Tinetti ME, *The Hospital-Dependent Patient*. The New England Journal of Medicine 2014. **370**(8): p. 694-697.

90. Sutherland JM and Crump RT, *Exploring alternative level of care (ALC) and the role of funding policies: an evolving evidence base for Canada, in CHSRF Series of reports on cost drivers and health system efficiency: Paper 8*. 2011, Canadian Health Services Research Foundation. p. 1-43.

91. Registered Nurses' Association of Ontario (RNAO), *Registered Nurse Workforce Backgrounder*. January 2014. p. 14. Available from: http://rnao.ca/sites/rnao-ca/files/Nursing_HR_Backgrounder-Jan_31_2014.pdf.

92. Registered Nurses' Association of Ontario (RNAO). *Types of Nursing*. [cited 2014 July 7]; Available from: http://rnao.ca/about/types-nursing.

93. Canadian Institute of Health Information, *Supply, Distribution and Migration of Canadian Physicians 2012* September 25, 2013.

94. Health Force Ontario. *Healthy Work Environments: What are Healthy Work Environments?* 2013 May 7 [cited 2014 July 7]; Available from: http://www.healthforceontario.ca/en/Home/Policymakers_and_Researchers/Healthy_Work_Environments.

95. Discharge Abstracts Database, provided by the Canadian Institute for Health Information upon special request.

Acknowledgements

Health Quality Ontario

Board

Andreas Laupacis, Chair

Marie E. Fortier, Vice-Chair

Richard Alvarez

Tom Closson

Jeremy Grimshaw

Shelly Jamieson

Julie Maciura

James Morrisey

Tazim Virani

Biographies are posted at:
www.hqontario.ca/about-us/governance

Management

Joshua Tepper, President and Chief Executive Officer

Irfan Dhalla, Vice President, Health System Performance

Lee Fairclough, Vice President, Quality Improvement

Les Levin, Vice President, Evidence Development and Standards

Jennifer Schipper, Chief, Communications and Patient Engagement

Jeffrey Turnbull, Chief, Clinical Quality

John Yip, Vice President, Corporate Services

Biographies are posted at:
www.hqontario.ca/about-us/executive-leadership-team

Report development

This report was developed by a multi-disciplinary team from Health Quality Ontario including Symron Bansal, Susan Brien, Ann-Elise Chen, Shirley Chen, Naushaba Degani, Maaike de Vries, Gail Dobell, Ryan Emond, Galina Gheihman, Louise Grenier, Wissam Haj-Ali, Michal Kapral, Carey Levinton, Eseeri Mabira, Andrée Mitchell, Jennifer Modica, Ryan Monte, Aliya Pardhan, Morgan Slater, Angus Steele, and Naira Yeritsyan.

Health Quality Ontario acknowledges and thanks the many dedicated people who contributed to this report, including:

HQO's expert review panel, a group of research and measurement experts from around the province who provided advice on all quantitative research and analysis:

Daniel Bedard, Sarah Blakely, Nancy Cooper, Imtiaz Daniel, Lisa Droppo, Kevin Feng, Jason Garay, Rick Glazier, Andrea Gruneir, Jeremy Herring, Noah Ivers, Kim Jarvi, Boris Kralj, Paul Kurdyak, Helene Lacroix, Chris Lau, Cindy Lee, Monique Lloyd, Rod Millard, Garth Oakes, Connie Paris, Kristen Parise, Jeff Poss, Debbie Roberts, Paula Rochon, Ruth Sanderson, Claudia Sanmartin, Michael Schull, Doug Sider, Jane Simms, Ann Sprague, Linda Tracey, Sue Vanderbent, Eugene Wen, Sarah Wilson, Walter Wodchis, and Anne Wojtak.

The following organizations, which provided reviews or data for the report:

BORN Ontario, Cardiac Care Network of Ontario, Institute for Clinical Evaluative Sciences, Canadian Institute for Health Information, Cancer Care Ontario, College of Nurses of Ontario, Commonwealth Fund, Marianhill Inc., Ministry of Health and Long-Term Care, Ontario Association of Community Care Access Centres, Mississauga Halton Community Care Access Centre, Ontario Association of Community Care Access Centres, Ontario Hospital Association, Ontario Medical Association, Public Health Ontario, Registered Nurses' Association of Ontario, Saint Elizabeth, Statistics Canada, Workplace Safety and Insurance Board.

Staff at multiple divisions and branches of the Ministry of Health and Long-Term Care for supplying data and background information and verifying facts:

Community and Population Health Branch, Health Analytics Branch, Health Promotion Division, Health Quality Branch, Health System Labour Relations & Regulatory Policy Branch, Health Workforce Policy Branch, Implementation Branch, Nursing Policy and Innovation Branch, Primary Health Care Branch, Provincial Program Branch, Public Health Division, X-ray Safety and Long-Term Care Homes Branch.

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
www.hqontario.ca

FSC
www.fsc.org
FSC® C004129