

Measuring Up

2019

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



Ontario Health
Quality



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On the cover: Dr. Paul Gill, a Digital Coalition member.
See page 22 for his story. We thank Dr. Gill and the
other people who have shared their experiences with
us.

Foreword

Transforming Ontario's health system

The findings in Measuring Up 2019 show that parts of the system are working well or improving.

Ontarians should be able to feel secure that they are receiving the best possible health care, in a timely way. They should also be able to have the peace of mind that comes with knowing they are being supported in navigating the health system, no matter how much or little they know about health care or how the system works. That's what it means to have a quality health system.

This year's Measuring Up report on the performance of the province's health system focuses on a set of 10 key indicators and is based on the Quadruple Aim of health care improvement: better health outcomes, better patient experience, better provider experience, and better value and efficiency.

The findings show that parts of the system are working well or improving. The proportion of cancer surgeries completed within the recommended maximum wait time increased substantially in the last decade. More Ontarians say they are able to email their primary care provider when they have a medical question, compared to five years ago. Most people who were hospitalized say they received enough information about what to do if they had problems after leaving hospital. And provincially, we are keeping tabs on workplace violence and working to create more supportive workplaces for our health care professionals.

Many patients fall through the cracks as they move between different areas of care.

But the report also reveals key areas where improvement is needed. Many patients must navigate the health system on their own, with limited information, and face barriers or fall through the cracks as they move between different areas of care. For example, patients often have difficulty accessing their own health records. Or, they wait for hours in the emergency department to get admitted to a hospital bed. Once admitted, they may get stuck in the hospital for months as they wait for care elsewhere.

This kind of overcrowding in hospitals often results in patients being treated in hallways. But hallway health care doesn't happen in a vacuum. Problems elsewhere in the health system often contribute to hospital overcrowding. Wait times for long-term care homes continue to be an issue. Many patients are struggling to access home care to meet their needs. People often have trouble seeing their family doctor or other primary care provider when they're sick or have a health problem. Plus, many patients with mental health and addiction issues make frequent visits to emergency departments.

Measuring Up shows where there are opportunities to do better.

This report also highlights the need for many changes, including better use of technology for patients to have control over their own care through easy access to their health information, and for patients to be able to choose whether they interact with health care providers face-to-face or digitally. When implemented correctly, these digital tools will enable health care professionals, who are facing increasing levels of stress and burnout, to share information more easily.

The Premier's Council on Improving Healthcare and Ending Hallway Medicine, and others, have called for transformative change in how care is provided. The newly formed Ontario Health will play a key role in that transformation by bringing together under one roof the combined knowledge, strengths and experience of many health agencies. That collective expertise will tackle pressing issues like mental health and digital access to information and care, and will also be applied for the benefit of all Ontarians, in all areas of care, through one strategy and one set of priorities.

Our goals at Ontario Health are to improve patient care and supports to health care professionals, ensure patients can move smoothly between health care providers, improve patient experience, and obtain better value for our health dollars.

Measuring Up can guide Ontario Health toward these goals, for the benefit of patients, their family and friend caregivers, and the health care professionals who keep the system working each day.

1

Some patients in Ontario are getting stuck in a health system under strain.

Key Results

- Some 15.5% of all the days patients spent in Ontario hospitals in 2018/19 were spent waiting to receive care elsewhere.
- The median wait for patients who moved into a long-term care home directly from hospital was about three months, or 90 days, in 2018/19.
- The average amount of time Ontario patients waited in emergency departments for an inpatient bed was 9.7 hours in 2018/19.
- Among Ontarians who visited the emergency department in 2017/18 for a mental illness or addiction, 9.5% – or nearly 18,300 people – visited four or more times in one year.
- Public spending on health care in Ontario - \$4,125 per person in 2016 – was the lowest among all provinces, and lower than the Canadian average of \$4,487 per person.

Additional results for these indicators, as well as results for all of the indicators analyzed for Measuring Up 2019, can be found in the online digital report and accompanying Technical Supplement tables.

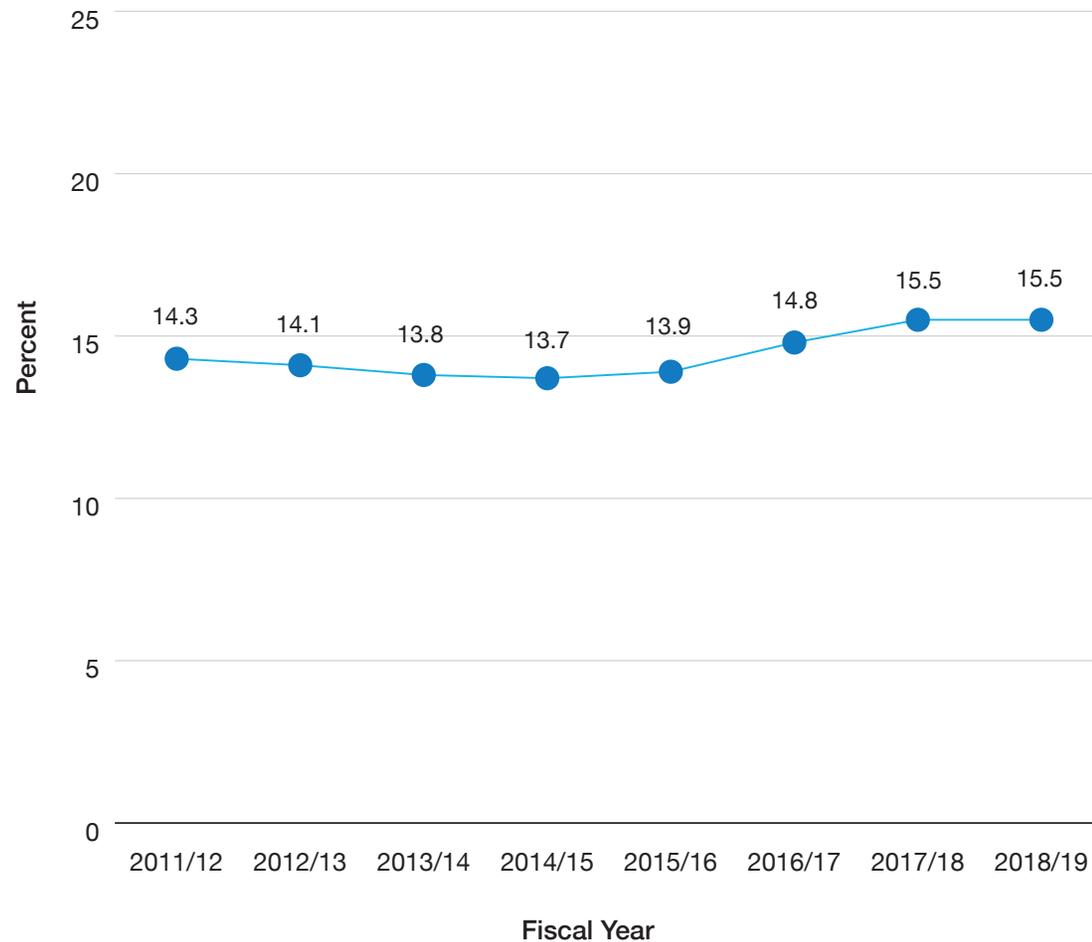
Some 15.5% of all the days patients spent in Ontario hospitals in 2018/19 were spent waiting to receive care elsewhere.

Patients who don't need to be in hospital are occupying an increasing proportion of Ontario hospital beds as they wait to receive care elsewhere, such as in a long-term care home or assisted living. On any given day in the province in 2018/19, about 4,500 hospital beds were occupied by patients waiting to go elsewhere. That's the equivalent of 11 large, 400-bed hospitals filled to capacity by patients who don't need the high level of care their hospital bed provides, and was up from about 4,000 beds per day on average in 2012/13.

In terms of overall hospital capacity, 15.5% of all the days patients spent in Ontario hospitals in 2018/19 were spent waiting to receive care elsewhere.¹ (Figure 1) Having patients in hospital waiting for care elsewhere is a symptom of broader issues across the health system, and leads to stress and uncertainty among patients and caregivers.²

Among health systems around the world, the U.K.'s National Health Service (NHS) reports the percentage of days hospital beds were occupied by patients waiting for care elsewhere in a similar way to Ontario.³ In comparison, the NHS reported a rate of just over 5% for 2017/18, more than its target of 3.5%, but still substantially lower than Ontario's rate of 15.5%.

FIGURE 1 Percentage of inpatient days that beds were occupied by patients who were waiting to receive care elsewhere, in Ontario, 2011/12 to 2018/19



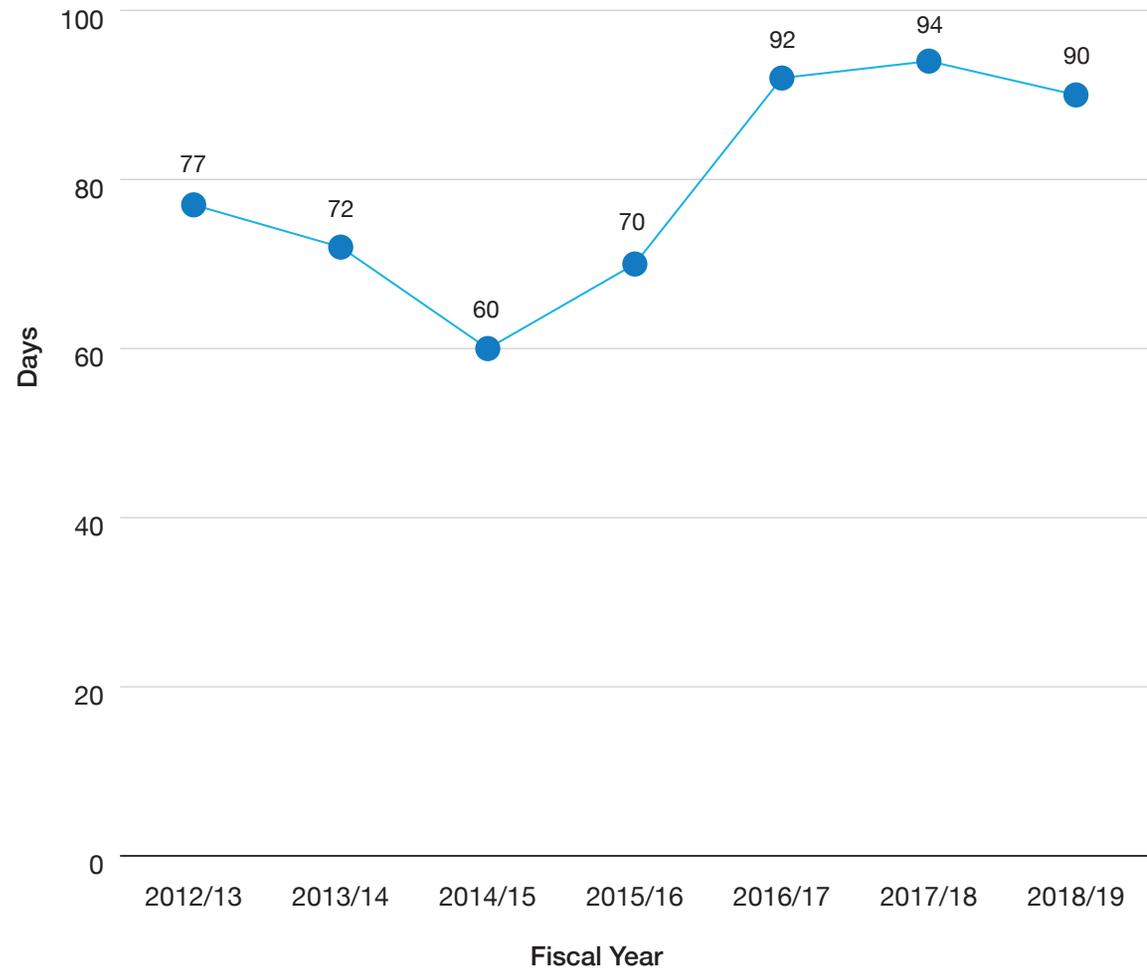
Data source: Bed Census Summary, Wait Time Information System, provided by Cancer Care Ontario
 Note: The data do not include patients designated Alternate Level of Care at Reactivation Care Centre sites

The median wait for patients who moved into a long-term care home directly from hospital was about three months, or 90 days, in 2018/19.

In Ontario, many of the patients in hospital beds waiting for care elsewhere are waiting for a place in a long-term care home. In 2018/19, the median wait for patients who moved into a long-term care home directly from hospital was about three months, or 90 days. (Figure 2)

If you count all the days Ontario patients waited in hospital beds for care elsewhere in 2018/19, 44% were days patients spent waiting to go to a long-term care home, while 13% were days patients spent waiting for supervised or assisted living, and 11% were days patients spent waiting for home care.⁴

FIGURE 2 Median number of days waited to move into a long-term care home by people admitted from hospital, in Ontario, 2012/13 to 2018/19



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

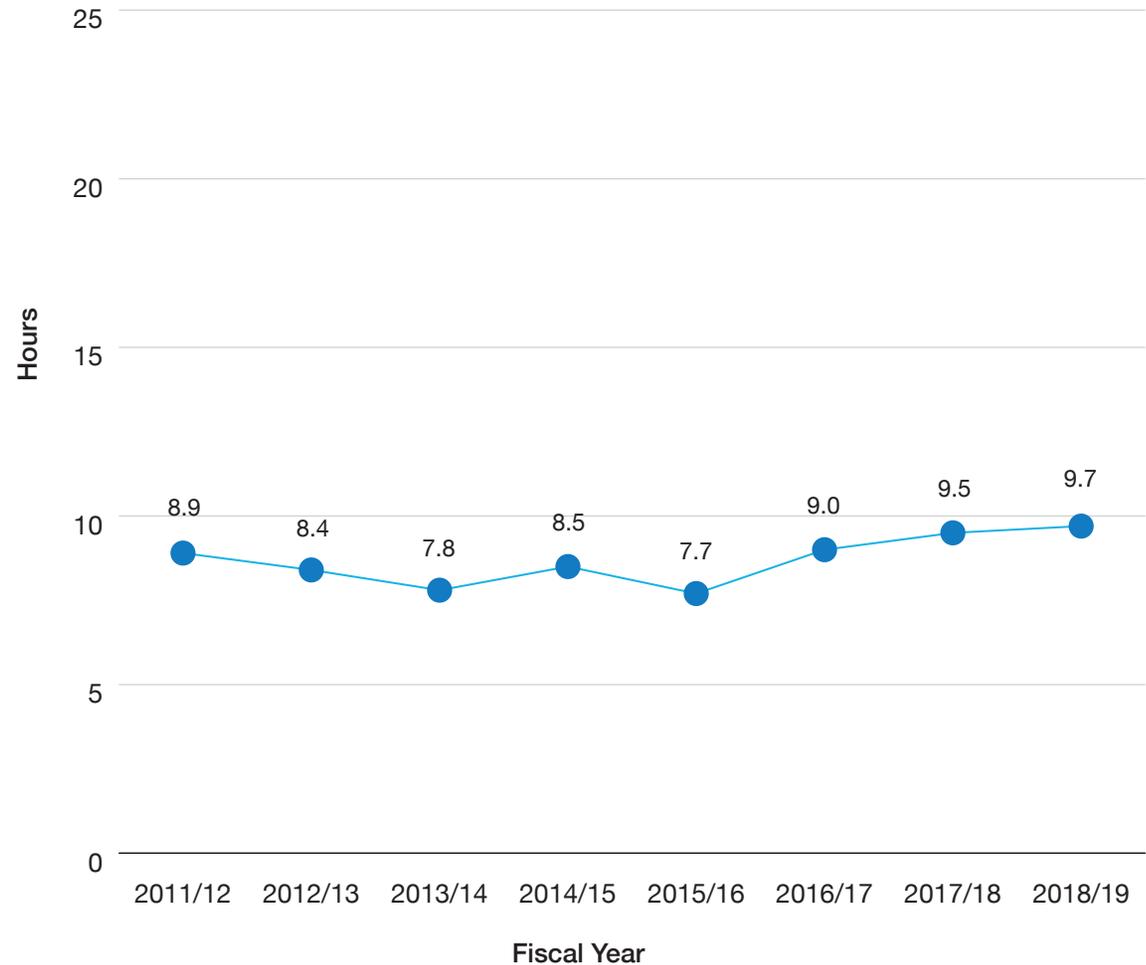
The average amount of time Ontario patients waited in emergency departments for an inpatient bed was 9.7 hours in 2018/19.

In many Ontario hospitals, having many patients waiting for care elsewhere can lead to overcrowding, with patients receiving care in hallways because no regular beds are available. This overcrowding is often most visible in hospital emergency departments. Here, patients who need to be admitted to the hospital can get stuck waiting for a bed to become free. The average amount of time Ontario patients waited in emergency departments for an inpatient bed – calculated from the time the decision was made to admit them – increased to 9.7 hours in 2018/19, from 7.7 hours in 2015/16. (Figure 3) The average time admitted patients spent in total in emergency departments increased over the same period to 16.2 hours from 13.8 hours.

For people not admitted to hospital, Ontario hospitals have managed to hold the line on the amount of time spent in emergency departments. Despite a 12.2% increase in visits to emergency between 2011/12 and 2018/19, time spent in emergency by patients who were not admitted remained essentially unchanged. In 2018/19, among patients who were not admitted, the provincial 8-hour target for maximum length of stay in emergency was met for 93.3% of those with more serious conditions, while the provincial 4-hour target was met for 85.3% of those with less serious conditions.

Like Ontario, New Zealand has had to deal with overcrowding in its hospital emergency departments – with patients often spending a long time in emergency receiving care and waiting for an inpatient hospital bed. Target-setting and increases in hospital capacity resulted in improved patient flow within hospitals and led in the short term to decreases in time spent in emergency. However, little was done to improve capacity in other parts of the health system to better enable the flow of patients out of hospitals, and improvements in emergency wait times have slowed.⁵

FIGURE 3 Average wait time for an inpatient bed in the emergency department, in Ontario, 2011/12 to 2018/19



Data source: National Ambulatory Care Reporting System, provided by Access to Care, Cancer Care Ontario (CCO)

Among Ontarians who visited the emergency department in 2017/18 for a mental illness or addiction, 9.5% – or nearly 18,300 people – visited four or more times in one year.

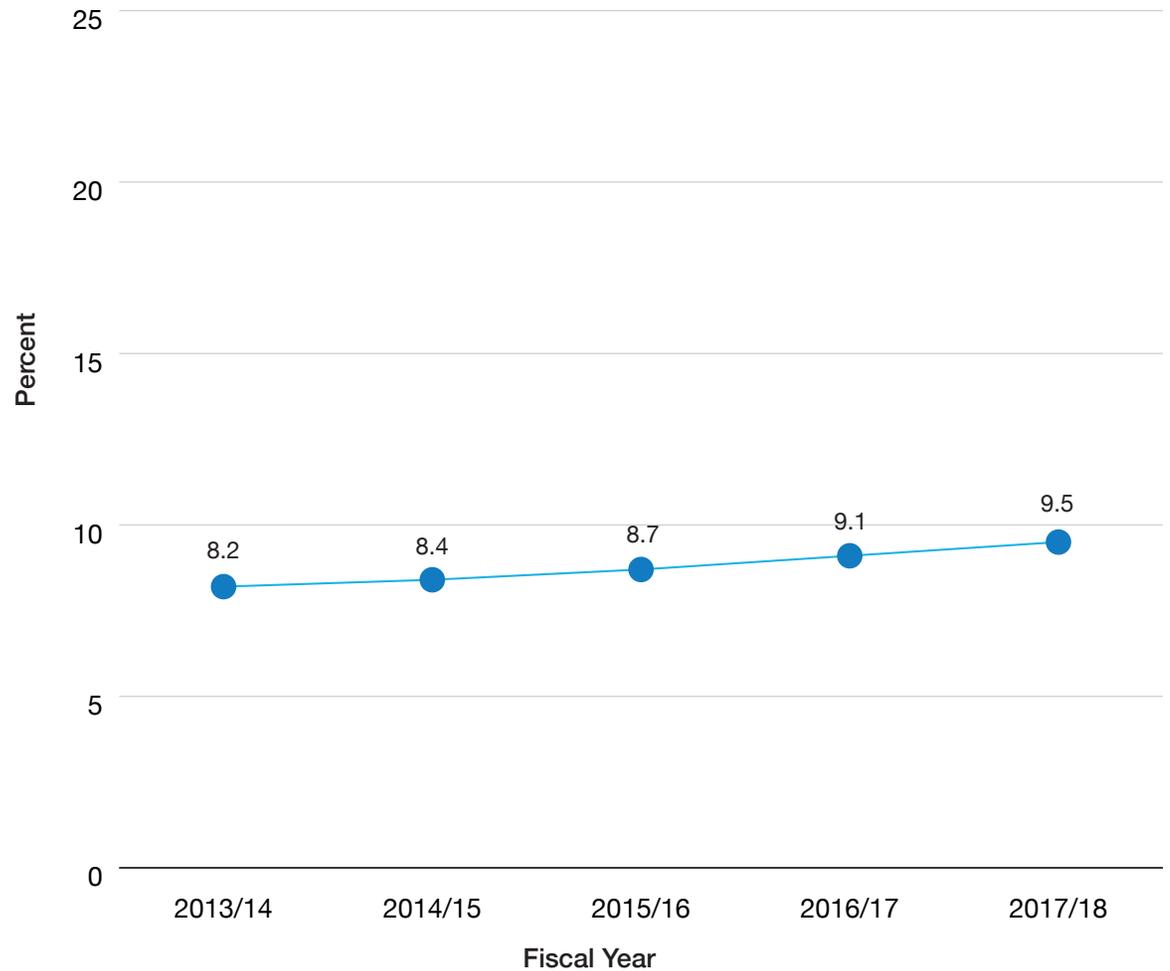
Also contributing to crowding in Ontario’s hospital emergency departments are patients whose primary care provider is not available, or who don’t get the health care or supports they need outside the hospital.

Four out of 10 Ontarians (41.7%) who had visited the emergency department said in 2018 that their most recent visit was for a condition they thought their primary care provider could have managed, if that provider had been available.

Among adults who visited emergency for a mental illness or addiction in 2017, about a third (31.9%) had not received mental health care from a family doctor or psychiatrist during the preceding two years. However, there has been improvement in this indicator for children and youths up to 24 years old. In 2017, 40.4% had not received mental health care from a family doctor, pediatrician or psychiatrist during the two years preceding their visit to emergency, compared to 49.9% in 2006.

Among Ontarians who visited the emergency department in 2017/18 for a mental illness or addiction, 9.5% – or nearly 18,300 people – visited four or more times in one year. That was up from 8.2% – or about 13,200 people – in 2013/14. (Figure 4) Frequent visits to emergency for mental health care may indicate a lack of services or support in the community to meet people’s level of need.

FIGURE 4 Percentage of people with four or more visits over 12 months, among people who visited the emergency department for a mental illness or addiction, in Ontario, 2013/14 to 2017/18



Data source: National Ambulatory Care Reporting System, provided by Ontario Ministry of Health and Long-Term Care
Note: Adjusted for age and sex

Public spending on health care in Ontario - \$4,125 per person in 2016 – was the lowest among all provinces, and lower than the Canadian average of \$4,487 per person.

Total health spending in Ontario – which includes both public spending by government and private spending by insurers and individuals – increased to \$6,239 per person in 2016, the most recent year for which final spending estimates are available, and was up 9.0% from 2006.⁶ Public spending on health care in Ontario - \$4,125 per person in 2016 – was the lowest among all provinces, with spending in Newfoundland and Labrador being highest at \$5,502 per person.

Public health spending in Ontario was also lower than the Canadian average of \$4,487 per person. Compared to countries with similar social and economic profiles in the Organisation for Economic Cooperation and Development (OECD), Canada was among the lowest-spending half when it came to public spending on health care per person in 2016. Forecasted health spending estimates suggest Canada will be in a similar position compared to its OECD peers in 2018.⁷



Photo of Mendal.
Please see Mendal's story on the
next page.

Lisa, Diane and Mendal's story: Stuck in the hospital

Mendal “presented well,” but his wife and seven kids knew something was very wrong.

The 85-year-old retired dentist from Kingston was diagnosed with Alzheimer's disease in 2015. “We as the kids were seeing problem after problem,” says his daughter Lisa. “We would kind of joke amongst ourselves that we have to defuse bombs each week.”

One night, the situation escalated when Mendal called his brother-in-law and left a message that caused him to believe that Mendal would harm his wife or himself. The family had to call the police, who escorted Mendal to the hospital in Kingston, where he was admitted to the psychiatric ward.

At the hospital, the family was told that Mendal did not qualify for long-term care and that he should go to a private retirement home or move back home with around-the-clock care. The family decided Mendal would stay in hospital.

After three months in hospital, Mendal was deemed eligible for long-term care, but there was only one long-term care home in the Kingston area that had a secure facility to accommodate his behavioural issues and flight risk. And once the Kingston long-term care home assessed Mendal, they determined that the home would not be an appropriate place for him.

The family decided to put Mendal's name on the wait list for a long-term care home near Toronto. They were told the wait would be six months to two years for long-term care.

After another four months waiting in the Kingston hospital's psychiatric ward – seven months in total – Mendal's health had deteriorated. He had to stay in the psychiatric ward because he needed to be in a locked unit, which was not available in the regular hospital wards. This proved very difficult for Mendal and the family, says Lisa. Mendal's wife, at home, was struggling with her own health issues, along with the stress of feeling like she had abandoned her husband. The seven siblings, who lived in different parts of the province, scrambled to help as well.

The family felt a lot of pressure for their dad to leave the hospital, and they finally decided to pay out of pocket for a private retirement home, spending more than \$40,000 over six months. Eventually, a spot opened up in the long-term care home near Toronto, in Markham.

At the long-term care home, Mendal tried to get out of a locked unit, and in the process knocked down one of the staff. He was admitted to a psychiatric unit of the hospital nearby, where the chief psychiatrist correctly diagnosed him with frontal lobe dementia, which can cause drastic personality changes and impair cognitive reasoning.

“Mom moved to Toronto once he had calmed down,” his daughter Diane says. “The long-term care home is phenomenal, and the staff is wonderful. He's very stabilized, his family is close by, and it's as optimal as it can be. But it was a long, hard journey getting here.”

2

Patients may face long waits for care, and often lack the information and digital tools they need.

Key Results

- About 69% of Ontarians say the timing to see their primary care provider when they were sick or had a health problem was “about right.” About 17% say their wait was “somewhat long” and about 13% say it was “much too long.”
- The percentage of Ontarians who said they emailed their primary care provider in the previous 12 months when they had a medical question increased to 4.7% in 2018 from 2.5% in 2013.
- More than 4 in 10 long-stay home care clients with caregivers had caregivers who experienced distress, anger or depression in relation to their caregiving role, or were unable to continue caregiving, in 2017/18.

Additional results for these indicators, as well as results for all of the indicators analyzed for Measuring Up 2019, can be found in the online digital report and accompanying Technical Supplement tables.

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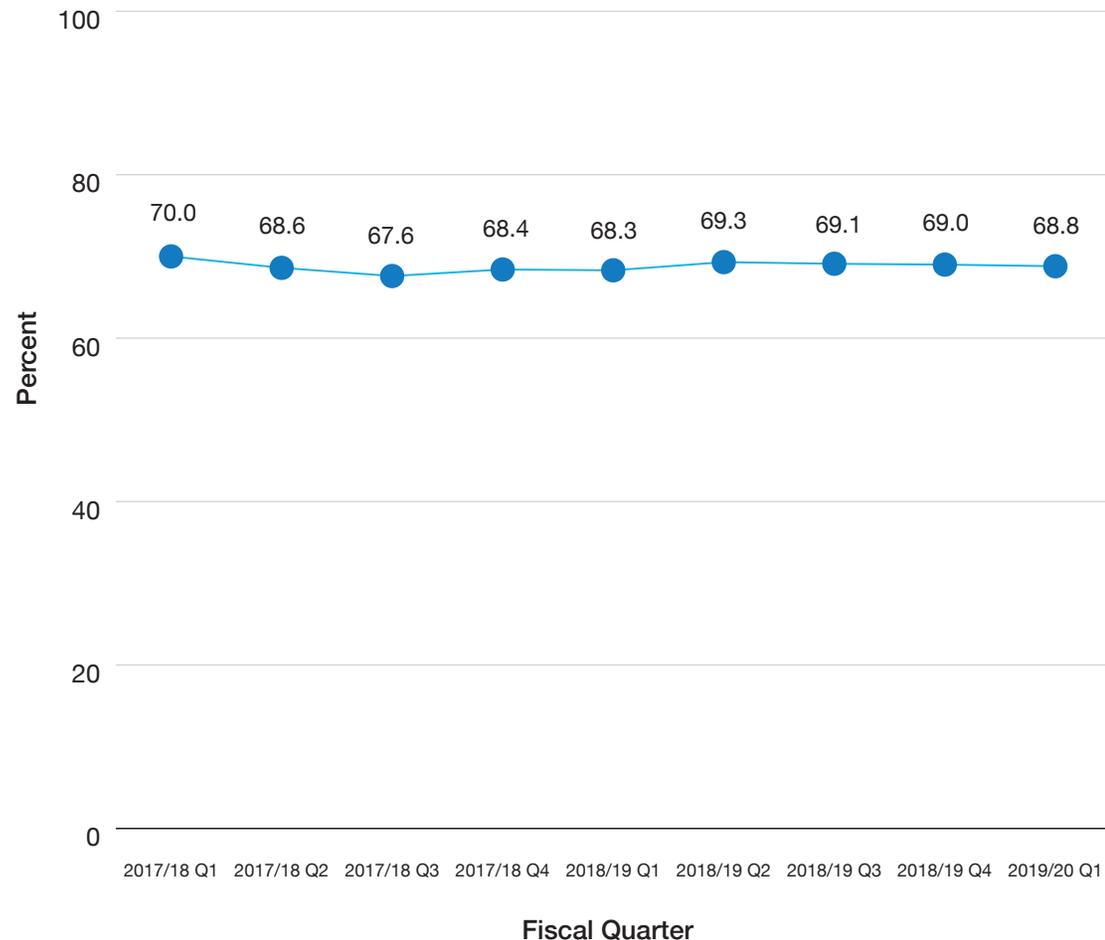
A high-performing health system has a strong foundation of primary care, which includes family doctors, general practitioners, and nurse practitioners. Through primary care, patients should be able to find and access specialty care when they need it for things like hip or knee replacement surgery.

Ontarians give mixed reviews on their wait time to see their family doctor or other primary care provider. About 69% said in 2018 that the timing to see their primary care provider when they were sick or had a health problem was “about right.” (Figure 5) About 17% said their wait was “somewhat long” and about 13% said it was “much too long.” As well, patients report waiting longer to see a specialist.

The percentage of cases completed within target for the most common category of hip and knee replacement surgeries has decreased compared to a decade ago. For example, 83% of the most common hip surgeries were completed within target in 2018/19, dropping slightly from 86% in 2008/09. However, the number of surgeries completed over this time more than quadrupled.

Over the same time frame, there has been substantial improvement in waits for the most common priority category of cancer surgeries. Ontario-wide, the proportion of these cancer surgeries completed within target increased to 85% from 68% between 2008/09 and 2018/19.

FIGURE 5 Percentage of people aged 16 and older who said that the amount of time they waited for an appointment with their primary care provider when sick was about right, in Ontario, 2017/18 Q1 to 2019/20 Q1



Data source: Health Care Experience Survey, provided by Ministry of Health and Long-Term Care
 Note: This indicator is calculated as a rolling four-quarter average

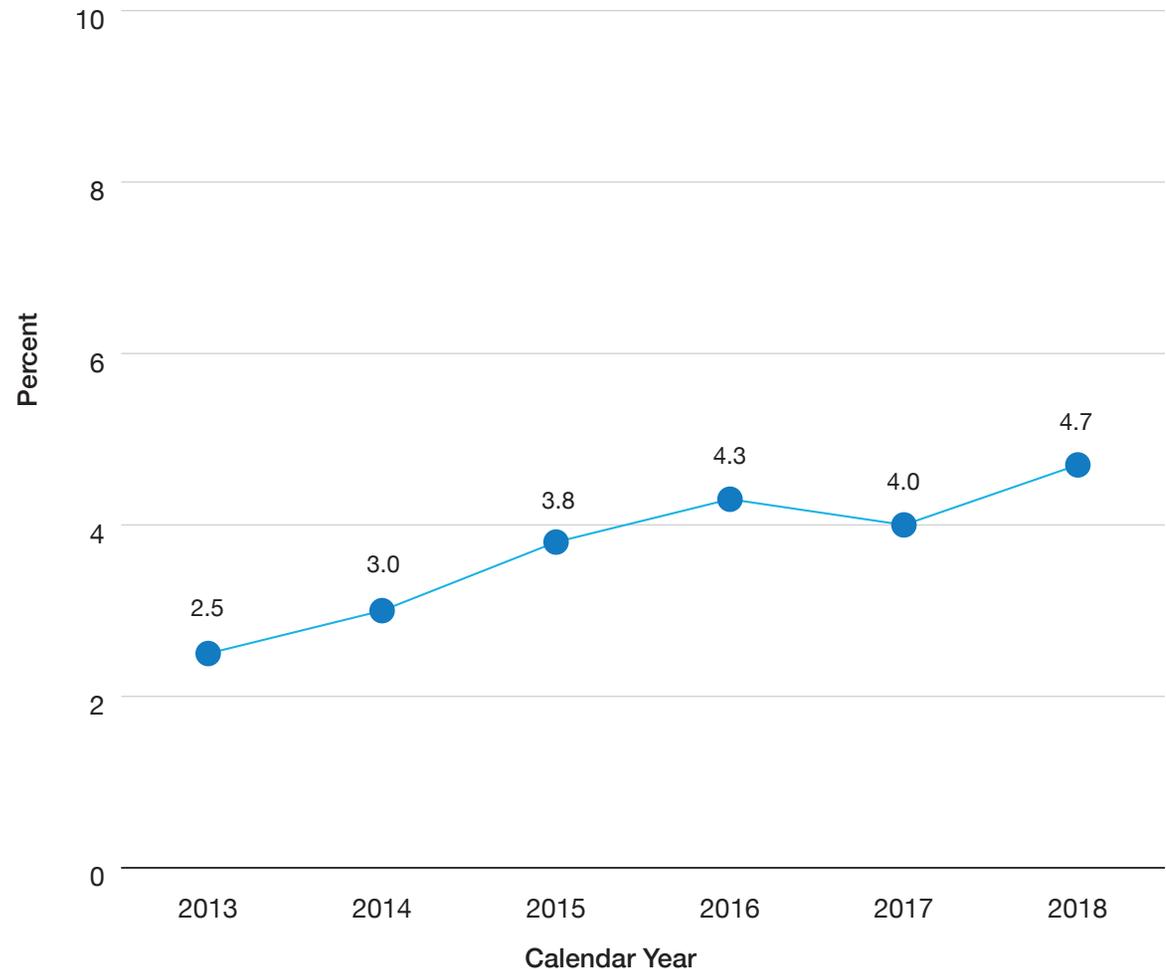
The percentage of Ontarians who said they emailed their primary care provider in the previous 12 months when they had a medical question increased to 4.7% in 2018 from 2.5% in 2013.

It's also often tough for patients and their family and friend caregivers to find the information they need – via digital access or other solutions – to navigate the health system and manage the patient's health.

The percentage of Ontarians who said they emailed their primary care provider in the previous 12 months when they had a medical question increased to 4.7% in 2018 from 2.5% in 2013. (Figure 6) But in a 2016 international survey, the percentage of Ontario adults who said they had emailed a question to their regular health care provider's practice in the previous two years was very low – at 4% – compared to countries such as France, at 24%, and the U.S., at 12%. The international survey also showed 6% of adults in Ontario had viewed online or downloaded their own health information in the previous two years, compared to 27% in France and 25% in the U.S.

Some patients in Ontario are accessing health care remotely through digital tools. In 2018, Ontarians made nearly 900,000 virtual visits with health care professionals, and more than 33,000 eConsults were conducted.⁸

FIGURE 6 Percentage of adults who had emailed their primary care provider with a medical question in the previous 12 months, in Ontario, 2013 to 2018



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

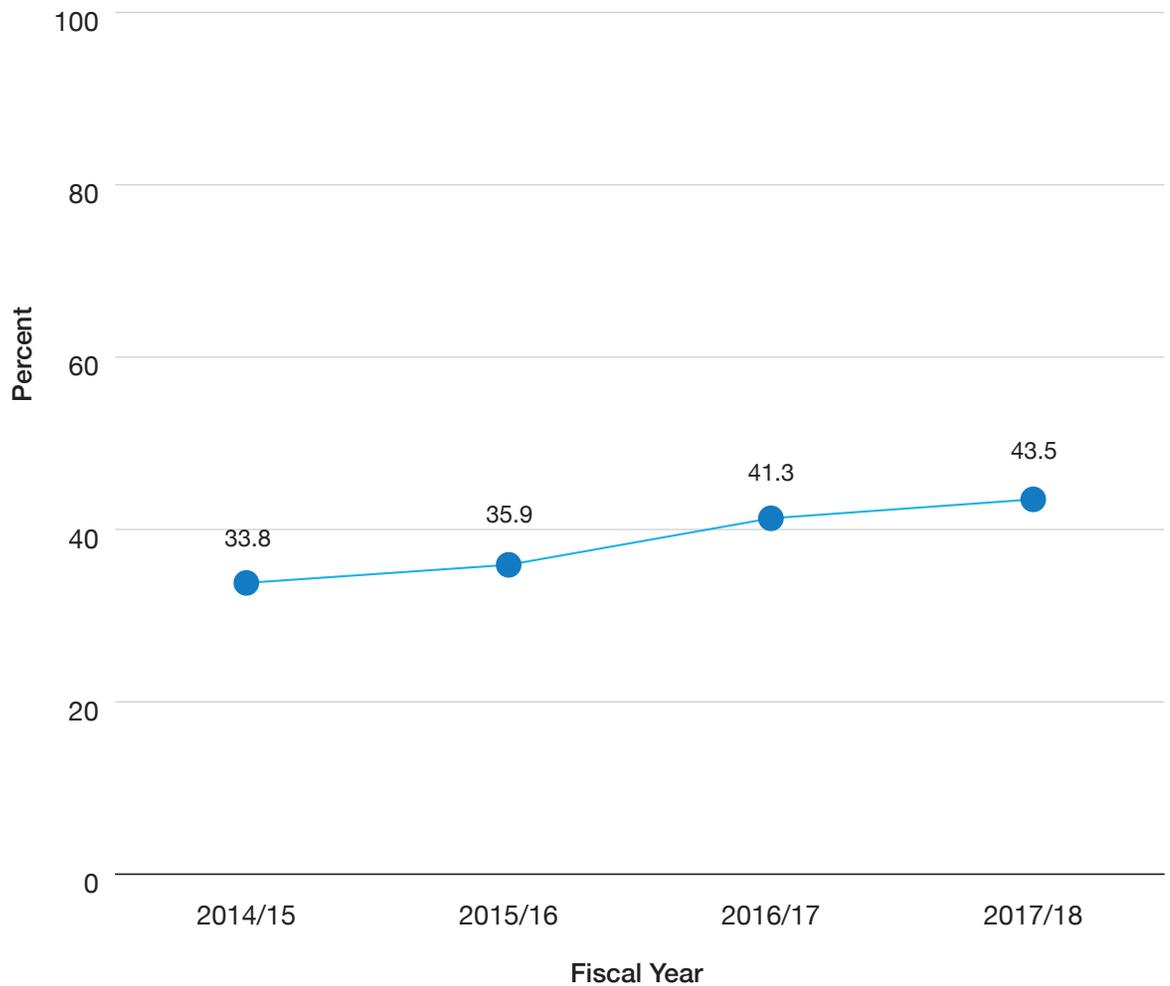
More than 4 in 10 long-stay home care clients with caregivers had caregivers who experienced distress, anger or depression in relation to their caregiving role, or were unable to continue caregiving, in 2017/18.

Whether they have access to health information and care options may affect patients' and caregivers' ability to cope with the challenges they face.

Among Ontarians who were hospitalized, just over half (55.8%) said in 2017/18 that they received enough information about what to do if they had problems after leaving hospital. Among all Ontarians who received home care, just over half (53.9%) said in 2017/18 that they "strongly agree" that they felt involved in the development of their home care plan. Another 28.3% said they "somewhat agree."

For the family and friend caregivers of long-stay home care clients – those who have received home care for more than two months – the rate of distress is on the rise. More than 4 in 10 long-stay home care clients with caregivers (43.5%) had caregivers who experienced distress, anger or depression in relation to their caregiving role, or were unable to continue caregiving, in 2017/18. (Figure 7) That was up from 33.8% in 2014/15, and represented more than 26,000 additional distressed caregivers. Ontario's caregiver distress rate was highest among all the provinces for which comparable data were available, and more than double that of Alberta, a sign that caregivers here may not be receiving the supports they need.

FIGURE 7 Percentage of long-stay clients whose caregiver experienced distress, anger or depression in relation to their caregiving role, or was unable to continue caregiving, in Ontario, 2014/15 to 2017/18



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



Photo of Katherine.
Please see Katherine's story on
the next page.

Katherine's story:

Digital opportunities for care and communication

Katherine always believed that no news was good news, especially when medical tests were involved.

In 2014, she'd been having chest pains and difficulty swallowing, but after her tests, the phone didn't ring. "If you don't hear anything, you assume it's all good," she says. But during a regular visit with her doctor the following year, the Thunder Bay retiree found that both tests had identified problems. "A year and a half had gone by and I wasn't informed."

The delay meant a year of missed treatment for gastrointestinal reflux disease and for an esophagus disorder that causes difficulties swallowing and weakening of the muscle that moves food into the stomach. It wasn't the first time that Katherine – who was already managing several chronic health problems – felt left in the dark in a way that affected her care and even how she understood her conditions. "It would make a big difference for me to be able to access test results," she says.

During that year of waiting, troubled breathing had sent Katherine to the emergency department, where a CT scan revealed an aortic aneurysm. She got those results by phone, with instructions to see a vascular surgeon in Toronto. Before the appointment, she limited her activities, and didn't even drive. "I was petrified. I thought this thing could just burst inside my chest."

It wasn't until after she saw the surgeon, two months later, that she learned the condition wasn't as dangerous as she'd understood. "It was just a lot of miscommunication," she says. "I never saw what the original radiologist wrote down."

Along with the vascular surgeon, Katherine has seen a nephrologist, an endocrinologist, a cardiologist, and a gastroenterologist over the past four years. She sees the specialists once or twice a year and follows up with her family doctor. Some of her medications for one condition can interact with others in ways that can cause problems, and she's reached out for help in sorting everything out. "I've been going to the pharmacist and getting him to sit down and go over everything and make sure everything is in order."

Katherine retired five years ago, tries to stay active, and is even working part-time at her old job. "I have good days and bad days," she says of managing the different conditions. But co-ordinating all the information on them has been harder. For example, when she asked her family doctor about a thyroid disorder diagnosed by one specialist, her doctor hadn't been informed. "She didn't have any report, so she didn't know anything about it," she says.

Katherine takes notes at appointments and does research on her own to figure out what's going on, but the lack of information that's specific to her case is disheartening, she says. Without it, "I never feel that I'm getting the optimum care that I require." Getting to see some blood test results through lab portals has been helpful, but what she really wants is access to all of her own records, including the larger test results like X-rays or CT scans. "I'd have more information about what's been done and what the results are [and] what's completely normal, what's abnormal," she says. "I don't think I'd feel as frustrated ... I'd feel more in control of my own health."

3

Pressures in the health system affect the people working in health care as well, and may lead to stress or burnout.

Key Results

- In a 2019 survey, 54% of primary care doctors in Ontario reported that their job was “extremely” or “very” stressful, while 37% said it was “somewhat” stressful.
- All hospitals in Ontario have committed to reporting on workplace violence incidents and putting initiatives in place to reduce these events, with more than three-quarters of hospitals making this a strategic priority.

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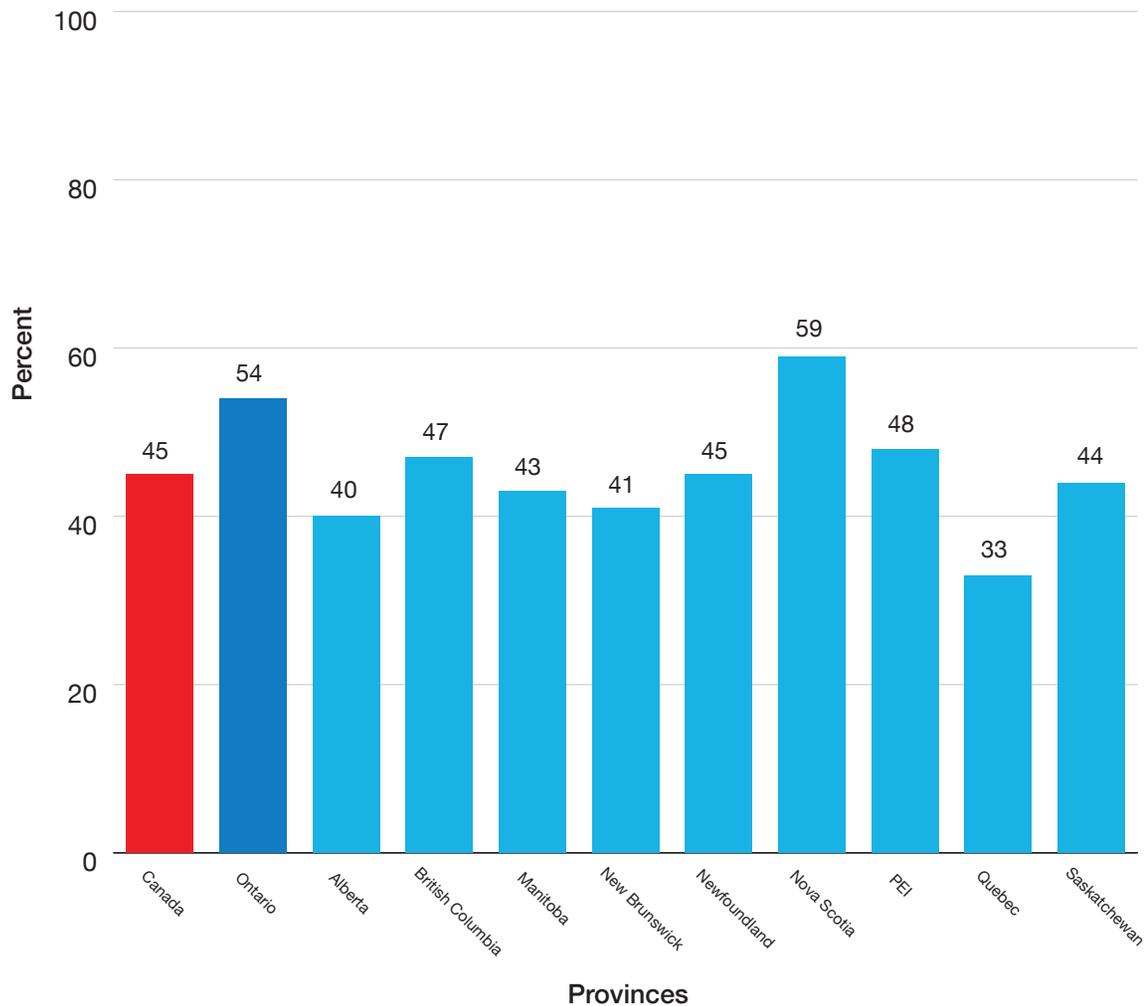
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The stresses within the health system are also having an effect on the mental health and wellness of doctors, nurses and the many other health professionals who provide care. In a 2019 survey, 54% of primary care doctors in Ontario reported that their job was “extremely” or “very” stressful, while 37% said it was “somewhat” stressful and 7% said it was “not too” or “not at all” stressful. The percentage who said it was extremely or very stressful was higher in Ontario than the Canadian average of 45%, and was among the highest reported in the provinces, with Nova Scotia at 59%, Prince Edward Island at 48% and British Columbia at 47%. The lowest rate - 33% - was in Quebec. (Figure 8)

Internationally, when compared to its socioeconomic peers, Ontario had one of the highest proportions of primary care doctors reporting their job was extremely or very stressful. Sweden had the highest, at 65%, while Australia had the lowest, at 29%.

In the same survey, 49% of Ontario primary care doctors reported they were “slightly” or “not at all” satisfied with their daily workload, while 34% were “moderately” satisfied and 16% were “extremely” or “very” satisfied. The proportion who were only “slightly” or “not at all” satisfied was higher in Ontario than the Canadian average (42%), and compared to other provinces was only significantly lower than in Nova Scotia (61%). Alberta was the top performer at 31%. Compared internationally, the proportion of primary care doctors in Ontario who were only “slightly” or “not at all” satisfied was in the middle of the pack, while Switzerland was best at 23%.

FIGURE 8 Percentage of primary care doctors who reported that their job as a primary care doctor is extremely/very stressful, by province, 2019



Data source: Commonwealth Fund 2019 International Health Policy Survey of Primary Care Doctors
 Note: Ontario’s result is statistically different than those of Alberta, Manitoba, New Brunswick, Newfoundland, Quebec, and Saskatchewan

All hospitals in Ontario have committed to reporting on workplace violence incidents and putting initiatives in place to reduce these events, with more than three-quarters of hospitals making this a strategic priority.

When health professionals experience burnout, it affects not only their productivity, but also has an impact on patient safety, quality of care, and patient satisfaction. This burnout can also add costs to the system through staff turnover and absenteeism. Improving the wellness of health professionals requires recognizing the seriousness of the issue, moving from a focus on burnout to the concept of work-life balance, and having health care organizations taking an active role to improve the wellbeing of their staff and members.⁹

Health professionals also face risks to their personal safety while at work, which include physical actions against workers – such as punching – and threats of physical violence. To support their workers, all hospitals in Ontario have committed to reporting on workplace violence incidents and putting initiatives in place to reduce these events, with more than three-quarters of hospitals making this a strategic priority. These initiatives include training on violence prevention and appropriate interventions, staff and physician surveys on incidents and responses, and developing protocols to identify or respond to patients at high risk of becoming violent.



Photo of Dr. Paul Gill and Kimberly VanWyk. See their story on the next page.

Digital Coalition: Digital tools ease health care provider stress and burnout

Doctors and other health care professionals who are part of a new digital technology program in South West Ontario explain how it's helping to ease stress and burnout among health care providers.

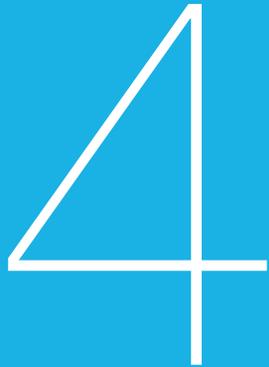
Many doctors and other health care professionals in Ontario are getting stressed and burned out because they spend too much time on computers filling out documents and forms, says Dr. Paul Gill, the Clinical Digital Lead for the province's South West region. Dr. Gill says a new program called the Digital Coalition is helping to ease that burden. The Digital Coalition – an extension of the Partnering for Quality, Practice Facilitation Program – is a partnership of information technology champions throughout South West Ontario working to embed digital tools into electronic medical records. The key is to do this in a way that works seamlessly into health care professionals' existing workflows, to save time and effort.

“Digital health tools often have clunky user interfaces, confusing and non-standardized terminology, leading to increased levels of provider stress and burnout,” Dr. Gill says. “Our teams of health care professionals in South West Ontario were each spending 3 to 5 hours per week building forms that had already been built somewhere else in the region, multiple times over. They were receiving a lot of forms requiring constant updates, and this ripple effect was a fast-moving treadmill that providers had to jump on every day. It was exhausting.”

Now with the momentum of the Digital Coalition, there is buy-in from the specialist and primary care doctor or other health professionals on the forms before they are built. The coalition has dramatically improved the health care provider experience by decreasing workload through automation, improving workflow, and reducing redirected and rejected referrals for patients, Dr. Gill says. In just over four months, the Digital Coalition's work with 28 clinics saved about 1,900 hours of administrative work.

“This is work that truly focuses on the quadruple aim increasing health care provider satisfaction, while simultaneously freeing up clinician and staff time to improve access to care for patients and reducing delays in care,” says Dr. Kellie Scott, lead physician at one of the participating clinics. “The Digital Coalition enables collaboration between siloed clinics which are able to share the administrative workload of forms management.”

Kimberly VanWyk, Executive Director of a participating Family Health Team, agrees. “The Coalition has allowed us to move our reception time from building forms to offering more direct time for patient care,” she says.



Ontarians' life expectancy is flattening, mainly due to a steep increase in opioid-related deaths.

Key Results

- Opioid-related deaths in Ontario have nearly doubled in three years and tripled over the last 12 years, rising to 10.2 per 100,000 population in 2018, from 5.3 in 2015 and 3.4 in 2006.
- More than 1 in 7 Ontarians aged 12 and older reported smoking cigarettes in 2017, while just over 1 in 4 aged 18 or older were obese, and about 1 in 6 aged 12 and older reported being heavy drinkers.

Additional results for these indicators, as well as results for all of the indicators analyzed for Measuring Up 2019, can be found in the online digital report and accompanying Technical Supplement tables.

Opioid-related deaths in Ontario have nearly doubled in three years and tripled over the last 12 years, rising to 10.2 per 100,000 population in 2018, from 5.3 in 2015 and 3.4 in 2006.

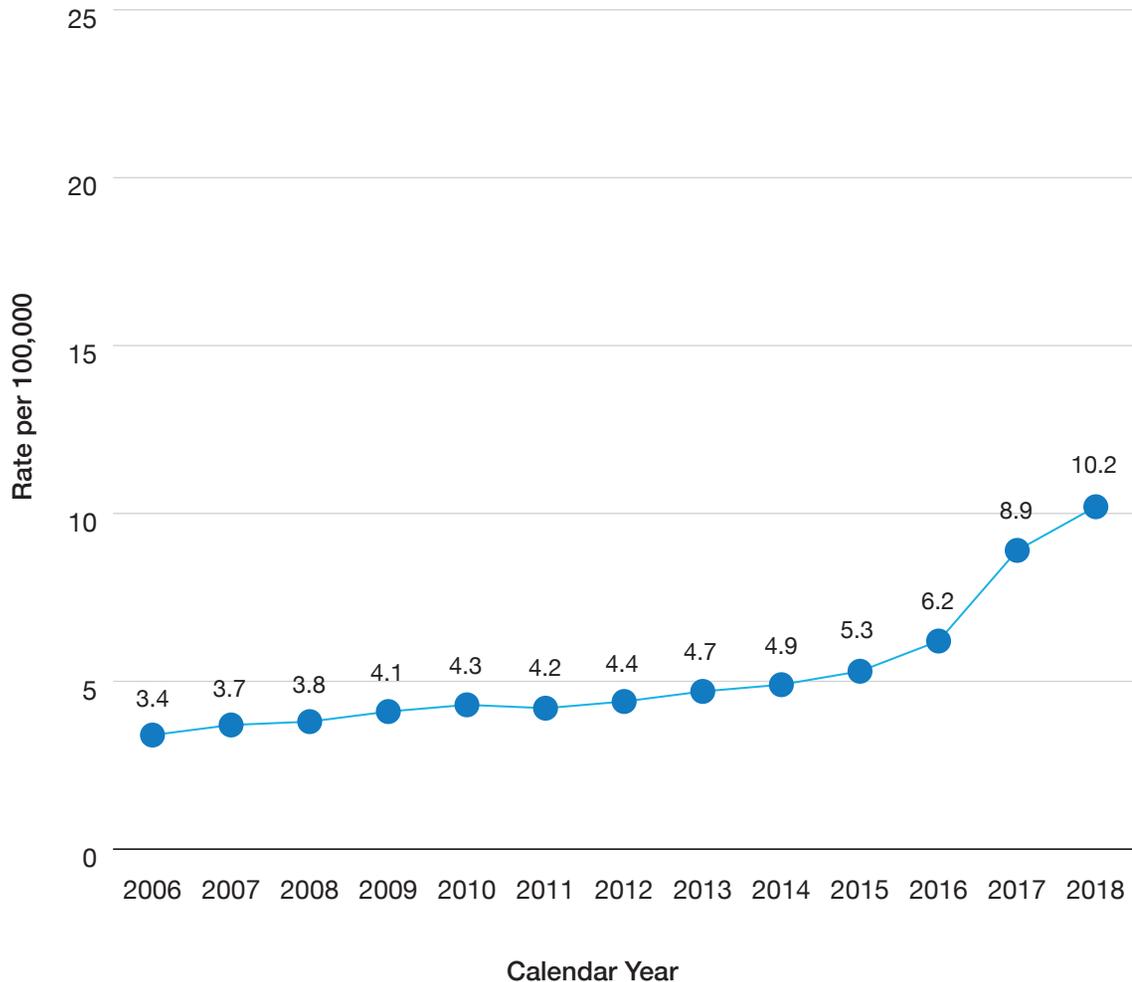
Life expectancy in Ontario is levelling off after years of steady improvement, a change that is largely attributed to a sharp increase in deaths from opioid poisoning. As well, population health risks such as smoking, obesity, and heavy drinking have the potential to shorten Ontarians' lifespans in the future.

Opioid-related deaths in Ontario have nearly doubled in three years and tripled over the last 12 years, rising to 10.2 per 100,000 population in 2018, from 5.3 in 2015 and 3.4 in 2006. (Figure 9) That's a total of 1,473 opioid poisoning deaths in 2018, up from 728 in 2015, and 436 in 2006.

When opioids are prescribed, it's usually for managing pain. However, their use carries risks that include addiction, overdose and death. While opioid-related deaths are often a consequence of using drugs obtained from illicit sources,¹⁰ health care professionals can help reduce people's exposure to the risks of opioids by starting patients on them less often, at lower doses and for shorter periods of time, if appropriate.

This is not just an Ontario issue – other provinces and some other countries are also seeing decreases in life expectancy and striking increases in opioid deaths. An Organisation for Economic Co-operation and Development (OECD) report on the opioid crisis found that the U.S. and Canada had the highest rates of opioid-related deaths among 25 OECD countries for which data are available.¹¹ A 2019 report found that increases in life expectancy have recently stalled, citing an increase in accidental opioid poisoning as one of the contributors.^{12,13}

FIGURE 9 Rate of opioid-related deaths per 100,000 population, in Ontario, 2006 to 2018



Data source: Ontario Opioid-Related Death Database, and Office of the Chief Coroner for Ontario, provided by Public Health Ontario
Note: The 2018 deaths data should be considered preliminary and is subject to change

More than 1 in 7 Ontarians aged 12 and older reported smoking cigarettes in 2017, while just over 1 in 4 aged 18 or older were obese, and about 1 in 6 aged 12 and older reported being heavy drinkers.

Suicide rates are rising among children and youths. In 2016, there were 6.6 deaths by suicide per 100,000 population aged 10 to 24, compared to 4.8 in 2013.

Ontarians' health is at risk from smoking, obesity, and heavy drinking. More than 1 in 7 Ontarians aged 12 and older (15.3%) reported smoking cigarettes in 2017, while just over 1 in 4 (25.5%) of those aged 18 or older were obese¹⁴, and about 1 in 6 (18.0%) aged 12 and older reported being heavy drinkers.



Photo of Deirdre.
See Deirdre's story on the next page.

Deirdre and Dr. Lisi's story: Minimizing opioids after surgery

Before she underwent colon surgery at Collingwood General and Marine Hospital, Deirdre decided she wanted to manage her post-surgery pain without any opioids.

The 68-year-old former teacher had been given opioids after two other surgeries in the past, didn't like the way they made her feel, and worried about becoming dependent on them.

Deirdre knew from her own research that some people who are prescribed opioids after surgery end up staying on them for many months or even years. She discussed the issue with her surgeon, Dr. Michael Lisi, who is also the hospital's chief of staff, and they came up with a plan to manage her post-surgical pain without a prescription for opioids.

Deirdre's colon surgery took a little longer than expected, but everything went well. She left the hospital the next day to return to her home in Creemore, with two non-opioid medications for pain. "That was all I had, and it was all I needed," Deirdre says.

Dr. Lisi says Deirdre's experience is an example of early success in the hospital's new program to reduce unnecessary opioid prescribing after common surgeries, which is part of a province-wide surgical quality improvement campaign among 47 hospitals in Ontario. Many post-operative patients leave Collingwood General and Marine Hospital with a prescription for a small amount of opioids, consistent with Health Quality Ontario's quality standard on opioid prescribing for acute pain, and some patients like Deirdre choose to avoid opioids altogether.

In some areas of the Simcoe Muskoka region, including Collingwood, emergency department visits for opioid poisoning are much higher than the Ontario average because people have become addicted to them. "Although not just a surgical issue, surgery does play a role in the opioids problem because it's how many patients are first exposed to them," Dr. Lisi says.

Collingwood General and Marine Hospital's opioids reduction strategy educates patients about their expectations for pain, reviews the risks of opioids, and develops strategies for taking fewer opioid pills post-surgery or managing pain without opioids by using other types of non-opioid medications and therapies. The program also provides health care providers with education on opioid prescribing practices.

Early results of the initiative showed a substantial reduction in the percentage of patients who were prescribed opioids after surgery. Dr. Lisi reports that the rates of opioid prescribing after day surgery dropped to 28% from 59% before the program started, and to 47% from 90% for patients admitted to the hospital.

Two months after her surgery, Deirdre says she'll soon be cleared to get back to the gym to work out. "I can't wait," she says.

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Data for the Health Care Experience Survey (HCES) were collected by the Institute for Social Research. All estimates are weighted to account for the design characteristics of the survey and are post-stratified to reflect the population of Ontario. All counts have been rounded to the nearest thousand. Urban/rural status is defined using Statistics Canada's Statistical Area Classification. Respondents who answered "don't know" or "refused" are excluded from analyses of those questions. Due to a temporary stop in the survey during the 2018 provincial elections, one quarter of data (from April 2018 to June 2018) is approximately two-thirds the size of a full quarter.



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