Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

March 2016

2015 Health Equity Summit: Feedback and Reflections

Let's make our health system healthier

Ontario
Health Quality Ontario

Introduction

A health system with a culture of quality is one that is safe, effective, patient-centred, efficient, timely and equitable. These six dimensions of quality form the overarching framework for achieving health quality that is described in a Health Quality Ontario report entitled *Quality Matters*.

The system has done considerable work to advance the first five dimensions, but equity has received less attention, at least partly because it is complex and not well understood. However, it is increasingly clear that this dimension of quality requires significantly more attention.

You cannot have a high-quality health care system without equity. Health equity allows people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are.

We know that certain populations in Ontario do not have the same access, experience or outcomes when interacting with the health system as others. For example, in Ontario the average life expectancy is increasing. However, for certain populations life expectancy remains stagnant and could even be decreasing.

People not getting access to the health care they need can result in poor health and a poor quality of life. It also can impact family, friends and caregivers who support those who are unwell, often with little recognition or support. In addition, it can cost the system through the misuse of services and the persistence of avoidable illness.

A quality health system is one that reflects all the dimensions of quality, including equity. It is a system that provides good access, experience and outcomes for *all* Ontarians.

To support this, Health Quality Ontario is developing a Health Equity Plan to embed equity into our own work and to encourage providers, system leaders and planners to make it prominent in their thinking, discussions and planning as they build a system that is safe, effective, patient-centred, efficient and timely.

To inform our thinking, we held a Health Equity Summit on December 3, 2015. This one-day event brought together various people from underserved communities and with lived experience, health system leaders, health and health care organizations, and providers from across the province to share stories, expertise, and thoughts about how to move forward. This report summarizes key discussion points and lessons from the summit.

For me, equitable care means …

Natrice:
“Equitable care means it should be available for all, for everyone; it doesn’t matter if you live on a reserve, if you’re a senior, [if] you’re poverty stricken, or if you’re rich. We should have all the same thing available to us.”

Rana:
“For me equitable care is having a sense of ownership with the health care system and also recognizing that . . . all of us are affected [when] some of us misuse it, but it also affects all of us in a very positive manner when we can access it.”

Kim:
“Equitable care for me is care that is really reflective of the community and also care that is informed by that diversity; that we are learning about each other, from each other. Not second-hand and third-hand sources and really deconstructing those barriers that exist between us. You know, we are more prejudiced than we think we are.”

Claude:
“Equitable care for me is partnership and collaboration. I’m living proof that it works. That partnership [is] with our caregivers – our brothers, and our sisters, our mothers and our fathers, and our sons and our daughters. . . .
[I send] a plea out there to our health care providers in this audience . . . to respect our privacy, but please take the time to listen to what our loved ones have to say about our care because they know us better than anyone else.”

What Does “Health Equity” Mean?

There are many definitions of “health equity. However the idea of “fairness” is a common theme across definitions. Health Quality Ontario developed its own working definition based on input from people who have experienced barriers to receiving high-quality care or who work in the health care system:

> **Health equity allows people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are.**

“Health equity” should not be confused with “health equality.” Health equality is the dividing of resources so that everyone gets the same. In contrast, health equity involves everyone getting the resources they need. Where more are needed, more are made available. Although this definition creates an ambitious goal we believe it is a good working definition to ground our work.

Overview of the Health Equity Summit

What follows below is a brief summary of the events of the summit, followed by the main themes that emerged from group discussions. We have also included particularly salient quotations from summit participants. (For further details about the day, please see Appendix: Health Equity Summit Agenda).

Session 1: Setting the context

To open the day, we had a number of system leaders[1] speak at the summit; they collectively asserted that improving health equity is a fundamental priority for the future of the health system, and that the time is right for change.

Below are some of the important messages that were conveyed:

- Health inequity, and broader social inequity, have a major impact on the lives of individuals and groups, health care providers and the system at large.
- Health equity cannot be meaningfully addressed without addressing the social determinants of health (housing, education, income, etc.).
- Health equity requires a profound change in the way our health system is organized and delivered.
- To be equitable, cultures and behaviours must change.
- Shared accountability measures must be put in place to ensure health equity is thought about and practised across the health system.
- Equitable health care means that **all** people in Ontario are being served properly.

Session 2: Taking direction from those with lived experience

The second panel in the morning provided further context about health equity but from a different perspective. Panelists were individuals from underserved communities with lived experience, who each brought a variety of perspectives grounded by personal experience. Here are a few key points from the panelists in the session:

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[1] Please see the appendix for a full list of speakers and panellists.

- Patients and caregivers need to be recognized as partners and ongoing contributors.
- Health care team members should include the broader communities that assist and support patients (e.g., community support agencies)
- Available services are not necessarily *accessible* services — fears, distance and even a lack of awareness can get in the way of their use.
- Equitable care is care that is available for all, involves a sense of ownership and is informed by the diversity of the community (the right care, right time, right place and right provider)
- The health system should treat people as *they* want to be treated — this means health care professionals should *ask* questions to determine this

> ***"I often talk about . . . the embodied experience of intersectionality. As someone who is a mixed-race person, [many people] ask me to quantify . . . the percentage of how mixed I am. 'So you're like a quarter-white, right? Or you're . . . a third this.' And for me intersectionality is a recognition that I'm not fractions, I'm layers.“***
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> *– Kim Katrin Milan is of Venezuelan Arawak, Afro-Caribbean, Indian and Scottish ancestry, born in Trinidad and Toronto and New York. She describes herself "as a queer woman of colour, and as someone who is married to a transgendered man."*

Key Learnings from Participants

The rest of the summit included a combination of individual presentations, including another panel and facilitated discussions on opportunities to improve health equity. Below are several prominent themes from these discussions; they represent changes participants feel are needed in the health care system at large.

1. Put patients and communities first

Building on the insights from the lived-experience panel in the morning many of the same themes were:

- We need to develop and tailor approaches that involve patients and communities in meaningful ways.
- Patients must be actively engaged at all stages of their health and health care.
- We need to provide care on patients' terms and be accountable to them.
- Patients put great trust in their care providers, and they expect and deserve to get it in return.
- For care to be patient-centred, it needs to be equitable. Legislation and policies must reflect a person's health and needs from a holistic perspective (e.g., physical, mental, social). Care should be provided not only for a person's "body parts" but for the whole person and all aspects of life (e.g., a person's health is partly determined by food security, housing and employment status).
- Patients are already telling us what they need – we need to listen.

Providing care on patients' terms

Natrice Rese:
I grew up in many different areas of Canada that were isolated, places like northern Manitoba, northern Ontario — no roads, high prices. . . . I was threatened with eviction this year, so . . . vulnerability is something I still feel, as a Canadian with all my rights and with all the privileges we're supposed to have."

Health care professionals can help patients feel less vulnerable when they take the time to listen and hear what patients are trying to convey. Natrice relates the story of one emergency room doctor who made a visible effort to understand her story.

"Patients need to be heard. . . . . When I was at the point where I couldn't walk any more with pain, . . . this doctor with flip flops and a bald head, six foot four, got down on his knee, and said, 'OK, tell me what's wrong.' And then [he] prescribed, not one, but two pain medication injections, and I'm like, 'hold on; one will do. That'll be great. I'll take that one and save the other one in case.' [My] question was answered [and my] needs were met, and that's what it's all about."

— Natrice Rese supports patients through social media.

2. Health is where you live, who you are and what you have

Health care is not the only factor that influences people’s health. There are other vitally important factors too. These circumstances have been referred to as social determinants of health.

The following points were raised by participants:

- Risk factors, including poverty, housing, education and geographic isolation, differ among people and can change over time. Strategies and approaches that are developed and implemented in a coordinated way across sectors can address these risk factors.
- Some unique populations experience one or more of these risk factors in ways that profoundly affect their health outcomes. For example, Indigenous peoples often experience increased poverty, geographic isolation and |a lack of education. When these factors are combined with poor access to health services, their health outcomes can be much worse than the Ontario average, such as a higher prevalence of diabetes and its complications.
- We need data on the nature and size of populations experiencing challenges like poverty and housing to tailor interventions that address their unique needs.
- To address the social determinants of health, new partnerships should include different communities and sectors, such as social and judicial services.

3. Technology can help

Participants identified technology as one of many ways to address barriers such as a lack of transportation, a lack of or untimely access to health care providers and services, and unaffordable costs. Suggestions included:

- E-consultations and telemedicine to address issues of geography, transportation and timeliness
- Mobile technology to enhance communication and collaboration between patients and caregivers and their providers
- Remote monitoring to provide care closer to home
- Tools to educate and empower those receiving care and to promote healthier lifestyles.
- Easy access to translation services to reduce language barriers
- Remote access to information systems to promote standardized care

Change the way we provide care

Kim Katrin Milan:
“Often the golden rule is to ‘treat people the way you want to be treated,’ but that assumes you’re the standard for others’ experience, and you’re not. So I think it’s important to treat other people the way *they* want to be treated. Which means we have to ask. We can’t apply this standardized model of care, knowing that inherently the standard is based on usually able-bodied, white, … straight, a very particular kind of individual. [You] must recognize that, especially if you haven’t worked with a lot of folks who are very very different, you want to engage them in that process of participating in their care.

“When I was about 17 [years old], I burnt myself with a pot of boiling water and [had] second [degree, almost] third-degree burns. I called 911. [When] the EMTs looked at my arm, they said, ‘you look fine.’

“[I answered], ‘I’m brown, so I want you to know that I don’t get pink the way you do and my skin doesn’t look the same way that yours does, but I’m telling you this is a very serious burn and I really need you to take this seriously.’

”He was like, ‘it doesn’t look bad; I’m sure you’re going to be fine. Just call us back if you need anything.’

“I’m literally crying hysterically in so, so much pain. They leave, and within a few minutes . . . the skin on my arm turns to black ash and completely crumbles off. . . . I’m in even more pain than I was in before, and have to again call the ambulance. [The dispatcher asked], ‘Didn’t you just call? I thought they were just there.’

“‘I know! But they told me to call back because they didn’t believe me that I was really hurt!’ [This is] because they’re using a Eurocentric model of what pain looks like. . . . I think . . . a lot of research has come up very recently that suggests a lot of doctors believe that black folks don’t feel as much pain as white patients and then don’t prescribe pain-killers as easily. . . . It may not come up explicitly as someone telling you that I’m not intelligent, but when someone tells me that I don’t know about the pain that I’m feeling, or they’re not willing to believe the stories that I’m telling them, I can tell inherently that that’s because of the person that I am. . . . I do think there is a lot of really important dialogue and discourse that needs to happen in engaging communities and breaking down those internal barriers . . . in health care providers and [in the] medical-industrial complex].”

– Kim Katrin Milan is of Venezuelan Arawak, Afro-Caribbean, Indian and Scottish ancestry, born in Trinidad and Toronto and New York. She describes herself “as a queer woman of colour, and as someone who is married to a transgendered man.”

4. Work together

No one individual or organization can advance health equity on its own. We need a focused, coordinated effort. Summit participants described this process as a "movement," and stated that we will be able to sustain this movement only if sufficient time, effort and resources are allocated to it: Here are some additional messages from summit participants:

- To improve health equity in Ontario, collaboration is needed across the health system. Provincial agencies, organizations and leaders must be engaged and work together to promote effective approaches. All areas in the system should make equity a long-term priority (e.g., hospitals, primary care providers, home and community care, long-term care).
- Ministries and all levels of government need to coordinate approaches. Equity must be considered in resource allotment and the development and evolution of policies.
- Health care providers need to reach out to sectors beyond the health sector to improve outcomes for patients.
- Patients and caregivers must be supported as partners in their care, actively involving them in the planning and delivery of services and care. The health system as a whole will not be equitable unless people are considered partners in their care, no matter who they are or where they come from.

5. Change the way we provide care

Funding models, education and the way we deliver care might need to be changed to promote health equity. Some comments we heard were:

- The system is funded to treat sickness, not to promote health.
- New funding models should be considered, with a move away from fee-for-service payments.
- Primary care providers should be sensitive and trained to address the social circumstances of patients.
- Models of care should reflect the situations of patients and their communities. They might need care delivered closer to home to address access issues.
- Health care providers must take an interest in and listen to their patients to incorporate any unique circumstances and challenges. This is needed to ensure that the delivery of care actually improves health outcomes. For example, consider whether patients can afford their prescribed medication.

"Patients are already telling us what they need — we need to listen"

Claude Lurette:
"We talk about who I am; you know, I spent most of my life trying to figure that out for myself as well. It took 25 years of recovery [from] a serious mental illness — a bipolar disorder and addictions — to really find out who I am. . . . I'm a husband, I'm a step-father, I'm a son, I'm a brother, I'm a caregiver and I'm an advocate, but I'm also a cancer survivor. Going through cancer treatment three times, while living with a serious mental illness was really a big challenge for me.

"When I was diagnosed with cancer 15 years ago, . . . I wanted my psychiatrist to be part of my health care team, my cancer team. And the resistance that I received from my cancer team, was unbelievable to me, because quite frankly this is my care, this is my body. I need him. He's part of my well-being. They said, 'No, no. We'll take care of your depression and mental health needs,' when they really didn't know what they were doing. They knew what medication I was on, but they didn't know what the reactions were and things like that.

"So I told my oncologist that, unless my psychiatrist becomes part of my care team, I would rather die of cancer than die of mental health. Because my depression and my [suicidal thoughts had lasted for years]; at least with cancer I would die quickly. . . . Given that choice, my oncologist said, 'Well, you know, we'll give him privileges.' And [my psychiatrist] did become part of my care team. And I'm proud to say that oncologist now makes it a point to ask his patients, 'Are you under psychiatric care? Or do you have a psychologist and would you like for them to be part of your circle of care?

– Claude Lurette is an experienced bilingual leader in patient engagement. Claude currently sits on the board of the Canadian Mental Health Association, Ottawa branch, is a co-chair of the Central Canada Depression Hub, and is Lived Experience Team Leader of the Canadian Depression Research and Innovation Network.

6. A lot of learning needs to happen

During the summit participants underscored the need to educate providers and patients pertaining to all aspects of health equity. Providers need to consider their own perspectives and values to improve patient experience. Patients have to be empowered with the knowledge to participate as partners in their health. Other points raised included:

- Time needs to be created in the system: time for people to talk, tell their stories and ask questions; time to build relationships between patients and care providers.
- Cultural competency, and even more general education around cultural humility and how to have effective personal conversations, is required.

Patients are often unaware of available services. The Ministry, health care providers and organizations need to work together to make this information easy to access and to teach patients how to navigate the health system.

7. The need for more and better data

Without meaningful data at policy and health care and provider levels, summit participants thought that health inequities will remain or worsen in Ontario. They also thought that the right information has to be available at the right time for policy makers, providers and patients to make the right decisions. Additional thoughts included:

- We lack data, and the data we have might not accurately reflect health outcomes of certain populations.
- Data are currently collected in silos and must be shared between sectors. This means developing new partnerships with health organizations across the province.
- What we measure must reflect what is important to patients. They must be engaged in planning what will be collected.
- An equity framework or lens needs to be used when collecting, analyzing and applying the data.
- Much of the social determinants data we need might not be within the health system.
- The best available evidence can come from narratives and practice-based evidence.
- We do not have enough discussion about the return on investment. Measuring the results of initiatives should also address cost-effectiveness.
- Effective action must follow data collection.
- Don’t wait for *all* the data. There are things you can do now.

A lot of learning has to happen

Rana Khan:
My diagnosis of breast cancer was a complete shock because it wasn’t in my immigration plans at all. . . . But I learned, or rather had to learn a lot along my cancer journey. I had to learn how to ask questions, how to be proactive, how to seek support. I also got to know about volunteers who would actually help me go to my medical appointments, but where I faced challenges was after the treatment was over. Because I suffered acute anxiety and depression, I was . . . falling to pieces. And here I have to say, I did not get [the] support I needed. I went to the doctor, and I was offered medication, whereas I think I needed more counselling and emotional support. I saw that the after-treatment follow-up wasn’t as good or comprehensive or time-specific as the treatment protocol that said that within six weeks I had to have surgery, et cetera. . . . Only now [have I learned] that with my Sunnybrook card I could actually access counselling services. I didn’t know that earlier. So I have to say that the barriers I faced was by way of knowledge gaps and accessing of those services.

– Rana Khan is a freelance writer and an ESL supply teacher.She is passionate about social justice issues and works part-time for Working for Change, an organization that is committed to providing economic and leadership opportunities to the psychiatric consumer/survivor community.

8. We need to share what we learn

Some communities and organizations have already reduced inequities at a local or community level. They have been doing this for a while. We also have examples of successful health equity initiatives from health systems around the world. We have many opportunities to share what's worked well and lessons learned:

- We need provincial coordination or a hub to share what we learn.
- Coordinating efforts and partnerships are key to building on each other's achievements instead of duplicating efforts.
- Community and grass-roots successes should be scaled and spread to other communities. We can learn a lot from how groups have taken an equitable or population-based approach to serving their communities.
- Part of learning is listening to patients about what they need from the system.
- The system is ready for change but needs suggestions for *how* to change. We must build capacity through knowledge, tools and partnerships.
- We have started to build awareness and understanding, but this needs to trickle down to health care providers, who also need knowledge and tools to be able to provide equitable care.

How Health Quality Ontario Can Help

At the summit we were very interested in hearing from participants about how Health Quality Ontario can help advance the equity agenda. Late in the day, we had a break out session where people discussed possible activities the organization could pursue to help the system improve health equity. Some examples of activities suggested by participants for Health Quality Ontario's consideration include

- Integrate a health equity focus with Quality Improvement Plans and the evolution of Health Links.
- Engage with patients and caregivers to learn about their perspectives, hear their stories, build ongoing relationships, and get feedback.
- Review the evidence (literature and experience) to understand where inequities exist and how big the problem is, and to share best practices based on the gaps that are identified.
- Advocate for better data in this area.
- Measure and report on health equity indicators that matter to individuals experiencing inequities.
- Measure and report on the link between social determinants of health and health outcomes Measure how health inequity affects the system (e.g., the cost of poverty to the health system). This can be a driver for change.
- Lead and partner with other organizations and systems to reduce health inequities in Ontario.
- Build on work that has already started.
- Provide knowledge, resources and tools to help the system build capacity to integrate health equity into culture and practice.
- Lead by example by integrating health equity into the culture and practice at Health Quality Ontario.
- Be the "central" place to go to learn more about health inequity in Ontario.
- Develop and execute a plan of action that embeds health equity in all that Health Quality Ontario does, and that helps to make it prominent in the thinking, discussions and planning of health care providers, system leaders and planners as they build a system that is safe, effective, patient-centred, efficient and timely. Keep "the movement" going.

- Continue to increase awareness and understanding of what health equity is and keep the conversation going (e.g., by organizing summits).
- Advise the government on health-equity issues that can improve health quality and that can affect policy decisions.

We appreciated all of the ideas shared. The above activities will be carefully considered by our Health Equity Advisory Committee as they develop a set of recommendations for Health Quality Ontario (and the broader health system), and by Health Quality Ontario as we develop our Health Equity Plan.

Conclusion

Equity is a one of six dimensions of quality adopted by Health Quality Ontario. We are committed to working with others to improve health care quality so that all can reach their full health potential and receive high quality care, no matter where they live or who they are.

The summit was the start of a conversation that needs to continue among all of us. We need to continue to listen and engage. Including people with lived experience at the summit was very valuable because patients' voices are often under-represented at both policy and planning tables. If we are going to increase health equity and build a system that represents all of us, this needs to change.

Key highlights and lessons from the summit are currently being considered as critical inputs to our forthcoming health equity plan. Although not all suggestions by participants are relevant to Health Quality Ontario's mandate, we are committed to sharing the feedback with those in the best position to act on individual suggestions.

Last, we acknowledge and thank summit participants for their thoughtful advice. Many groups and individuals have been working to improve health equity in Ontario for some time. We look forward to learning from each other and working together on this important quality goal.

Acknowledgements

We thank the members of the Health Equity Advisory Committee for their valuable contributions to planning this day. In addition, we thank the speakers and panellists, and indeed all of the summit participants, for their enthusiasm and commitment.

Health Equity Advisory Committee Member List

- Camille Orridge (Chair)
- Dr. Philip Berger
- Dr. Kwame McKenzie
- Joanne Plaxton
- Uzma Shakir
- Louise Paquette
- Dr. Eva Purkey
- Dr. Cheryl Forchuk
- Samina Talat
- Dr. Chandrakant P. Shah
- Gilles Marchildon
- Madonna Broderick
- Dr. Jeffrey Turnbull

Appendix. Health Equity Summit Agenda

Date: December 3, 2015
Time: 8 a.m. – 5 p.m.
Location: 123 Queen Street West, Sheraton Centre Toronto, **Room:** Willow Centre and Willow West

TIME	ACTIVITY	SPEAKERS
8:00 to 8:45 a.m.	Breakfast/Registration	
8:45 to 8:55 a.m.	Welcome by Master of Ceremonies	Camille Orridge, Chair, Health Quality Ontario Health Equity Advisory Committee
8:55 to 9:20 a.m.	Welcome from Health Quality Ontario	Dr. Joshua Tepper, President and Chief Executive Officer of Health Quality Ontario Dr. Jeffrey Turnbull, Chief of Clinical Quality at Health Quality Ontario
9:20 to 9:45 a.m.	Achieving health equity through action on social determinants: Dr. Andrew Pinto	Dr. Andrew Pinto, family physician, public health specialist and scientist at St. Michael's Hospital
9:45 to 10:25 a.m.	Remarks from the Minister of Health and Long-Term Care	Hon Eric Hoskins, Minister of Health and Long-Term Care
10:25 to 10:40 a.m.	Break	

TIME	ACTIVITY	SPEAKERS
10:40 to 11:40 a.m.	Panel Session #1: Understanding health equity through community engagement: A facilitated dialogue with individuals with lived experience	Laura Williams, Interim Director, Patient, Caregiver and Public Engagement at Health Quality Ontario Natrice Rese, Rana Khan, Kim Milan and Claude Lurette, who collectively represented perspectives of caregivers, seniors, residents of isolated communities in the North, women's health, the immigrant experience, youth, persons of colour, the LGBTQ (lesbian, gay, bisexual, transgender, queer) community and people with mental health and addictions
11:40 to 12 p.m.	Why Indigenous Cultural Safety is Essential for Health Quality and Equity for the Indigenous Population	Gertie Mai Muise, Associate Director at Southwest Ontario Aboriginal Health Access Centre
12 to 12:45 p.m.	Table Breakout Sessions #1: Facilitated discussions on the opportunities and transformational changes required to improve health equity in Ontario. 1. What are the key challenges we may encounter in the health care system in our efforts to advance health equity? 2. What promising opportunities can we collectively build on to advance equity in the health care system? 3. What actions can we as providers, patients, families/caregivers, clinicians, researchers and government take individually and collectively to advance health equity?	
12:45 to 1:45 p.m.	Networking Lunch	
1:45 to 2 p.m.	Creating a Culture of Health Equity Across the Health Sector	Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
2 to 2:30 p.m.	Overview of Health Quality Ontario's Health Equity Roadmap followed by a Q&A period	Dr. Jeffrey Turnbull
2:30 to 3:30 p.m.	Panel Session #2: Opportunities for Health Quality Ontario to work with the health care system to improve health equity from the following perspectives:	Dr. Cheryl Forchuk, Assistant Director at Lawson and Associate Director of Nursing Research, Health Sciences and Professor,

TIME	ACTIVITY	SPEAKERS
	• Measuring and reporting to the public on the quality of the health care system • Making evidence based recommendations about health care services, interventions and standards of care • Supporting continuous quality improvement	Dept. of Psychiatry at Schulich School of Medicine & Dentistry at The University of Western Ontario Dr. Walter Wodchis, Principal Investigator for the Health System Performance Research Network Dr. Vivian Welch, Director, Methods Centre at the Bruyère Research Institute; Assistant Professor at the School of Epidemiology, Public Health and Preventive Medicine, University of Ottawa and Co-convenor at the Campbell and Cochrane Equity Methods Group Dr. Gary Bloch, Family Physician, St. Michael's Hospital, Co-Chair of the Ontario College of Family Physician's Committee on Poverty and Health
3:30 to 3:45 p.m.	Break	
3:45 to 4:45 p.m.	Table Breakout Sessions # 2: Facilitated discussions about what Health Quality Ontario can do in step with patients and partners to support system transformation and achieve more equitable health care. 1. How can Health Quality Ontario advance health equity through its mandate and more broadly, in particular in the following areas • Monitoring and reporting on health system performance • Providing guidance on important quality issues and assessing evidence to determine what constitutes optimal care • Engaging with patients, caregivers and members of the public in shaping a quality health system • Promoting ongoing quality improvement 2. While we want to be ambitious in moving forward, we also realize that fundamental change does take time. Where should we start? What should be Health Quality Ontario's	

TIME	ACTIVITY	SPEAKERS
	focus in the next three years?	
4:45 to 5:00 p.m.	Wrap Up and Closing Remarks	Camille Orridge and Dr. Jeffrey Turnbull

About Health Quality Ontario

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

Who We Are.

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

What We Do.

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voice of patients, caregivers and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large scale quality improvements by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

Why It Matters.

We recognize that, as a system, we have much to be proud of, but also that it often falls short of being the best it can be. Plus certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent at Health Quality Ontario is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better has no limit.