

THE COMMON QUALITY
AGENDA 2017

Measuring Up 2017

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

Health Quality
Ontario

Let's make our health system healthier



Ontario

Health Quality Ontario

Health Quality Ontario
is the provincial advisor
on the quality of health care.
We are motivated by this
single-minded purpose:
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On the cover: Elgin, sitting on a park bench in Toronto. See page 37 for
his story. We thank Elgin and the other people who shared their
experiences in Ontario's health system. (Cover photo by Roger Yip)



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Foreword

Gordon, Lilac and Elgin know what it's like to go from one care setting to another and from treatment to treatment. In this year's *Measuring Up* report we share their stories and critical data to look at the big picture: Is our health system getting better at helping patients access the care they need? Is it providing care in a manner that makes transitions easier for them? Does it provide the care patients need, no matter where they live or who they are?

This year, Health Quality Ontario has measured those experiences in new ways to portray a more comprehensive picture of how patients use the health system, and what it's like for them. We've looked at specific parts of care for the first time – like how long patients like Gordon wait for a consultation with a surgeon to decide whether they need surgery, or whether patients like Lilac can see the same family doctor each time they need a visit. The answers to both those questions make a difference in how patients experience care, and to their health outcomes. We've also zeroed in on specific regions of the province to look at whether patients can see a doctor or nurse practitioner when they are sick, or if they are being screened for cancer.

Many aspects of health care in Ontario are good. People in the province are living longer, more of us are getting the cancer screening we need, and more people are seeing the same family doctor regularly. People in Ontario are also receiving better care in long-term care homes, where fewer residents have daily pain, receive unnecessary antipsychotic medication or are physically restrained.

At the same time, the health system is struggling to keep up with some ongoing challenges, especially with timely access to care, and patient transitions from one care setting to another. Gaps also persist in care for people with mental illness and addictions, like Elgin, who had a hard time getting the right care for bipolar mood disorder. As well, some troubling trends have emerged over the last year. There has been an increase in the number of days the province's hospital beds are occupied by patients waiting for care elsewhere, and wait times for hip and knee replacements are on the rise.

Compared to other provinces and countries, Ontario's performance is mixed. On a positive note, in all of Canada, Ontario had the lowest rate of premature mortality. And Ontario's performance in long-term care is among the best for provinces with comparable data. However, compared to 10 socioeconomically similar countries, Ontario ranks last in access to primary care appointments on the same day or next day when patients are sick, and in the middle of the pack when it comes to patients' ability to pay their medical bills.

Looking ahead, Health Quality Ontario's province-wide framework - *Quality Matters* - will keep the system focused on helping patients get the care they need that's safe, effective, patient-centred, efficient, timely and equitable. As we enter our second decade of reporting to Ontarians on the performance of their health care system, we now have better tools to improve and measure health care in the province. With *Quality Matters* and our *Measuring Up 2017* findings as guides, we look forward to better care for all patients in Ontario.




Dr. Joshua Tepper
 President and CEO




Dr. Andreas Laupacis
 Board Chair



Executive Summary

Excellent Care for Many, But Not All. Entering its second decade, *Measuring Up 2017* marks the 11th year of Health Quality Ontario reporting to Ontarians on the performance of their health care system. This year's report focuses on a set of highlights of importance to Ontarians, drawn from a review of a set of about 50 health system indicators called the Common Quality Agenda. *Measuring Up 2017* combines a broad range of data with the stories of people at the front lines of the system, including patients, families and health care professionals. From this combination of data and personal narratives, we learn what's working well and what needs improvement in our health care system.

Where we're doing well

Premature mortality

The big picture of health in Ontario looks good: people are living longer, and losing fewer years of their lives to premature death. Ontario has the lowest premature mortality rate in Canada, and it improved to 4,221 potential years of life lost per 100,000 population in 2013 from 5,120 per 100,000 people in 2003.

Continuity of care

A majority of Ontarians who saw a primary care doctor three or more times over the previous two years had at least three-quarters of their visits with the same doctor. High continuity – being able to see a regular primary care provider at least three-quarters of the time – improves patients' health outcomes and reduces unnecessary emergency department or hospital use.

Prevention and screening

Improvements in illness prevention and screening have kept more people in Ontario healthier. The rate of people being overdue for colorectal cancer screening has improved to 38.7% in 2015 from 43.6% in 2011.

Wait times to see a surgeon

Measuring Up 2017 marks the first time we are able to include wait times to see a surgeon. The proportion of cancer patients seen by a surgeon within the target wait time ranges from 83% to 87% depending on the priority level.

Cancer surgeries within target time

There has been some improvement in the wait time from the decision to have cancer surgery to the time of surgery, with the proportion of cancer surgeries that met the target increasing

year-over-year between 2008/09 and 2015/16 for all priority levels.

Long-term care

Among long-term care home residents, the percentage who experience pain has improved over time, to 6.1% in 2015/16 from 11.9% in 2010/11, the use of daily physical restraints has been reduced to 6% in 2015/16 from 16.1% in 2010/11, and the use of antipsychotic medications among residents without dementia has been reduced to 22.9% in 2015/16 from 35.0% in 2010/11.

Where we need to improve

Access

Timely access to care is an ongoing issue for patients in Ontario's health system. Fewer patients have surgery within the target time for hip and knee replacements – both increasingly common procedures. For example, 80% of patients who had Priority 4 knee replacement surgery (the category of knee replacement with the greatest number of surgeries) had them completed within the target time in 2016/17, compared to 85% in 2014/15. Little progress has been made in reducing the proportion of people – 33.1% in 2015 – going to the emergency department for a mental illness or addiction, who had not seen a doctor or psychiatrist previously.

Caregiver distress

Distress is on the rise among informal caregivers (usually family or friends). Continued distress among informal caregivers of patients who needed home care for at least a few months increased to 24.3% from 21.2% between the first half of 2012/13 and the first half of 2016/17.

Transitions

The system fails many patients as they transition from one care setting to another. The time patients spend in the emergency department before being admitted to hospital is not improving (15.2 hours, on average, in 2016/17), while many patients are in hospital beds who could be receiving care elsewhere, such as a long-term care home or home

care (13.9% of inpatient days in 2015/16). When patients are able to transition to receiving care at home, only 56.7% strongly agree that they felt involved in the development of their own care plan.

Palliative care

For those patients who are at the end of life, too few are able to receive timely palliative care in their home, even though this is what patients want (only 27.5% of people received a palliative-specific home care visit in 2015/16, in their last 30 days of life). More than half (54.8%) of people who died in 2015/16 had an unplanned visit to the emergency department in their last 30 days of life, which could indicate that they did not receive the care they needed in the community.

Equity

Some people in Ontario are much less likely than others to receive quality care. Ontario's overall premature mortality rate has improved, but there is striking variation by region. The rate of potential years of life lost was nearly 2.5 times higher in the North West LHIN region, at 7,647 years per 100,000 people, than in the Central LHIN region, at 3,026 years per 100,000 population, during the period between 2010 and 2012. Same-day or next-day access to primary care providers remains a challenge, particularly in rural and remote areas, ranging from a low of 22% in the North East LHIN region to a high of 60.3% in the Central West LHIN region.

There are inequities by income for colorectal cancer screening. Among urban residents, those in the lowest-income neighbourhoods had the highest rate of being overdue for colorectal cancer screening in 2015, at 46.5%, compared to 32.7% of those in the highest-income neighbourhoods.

Beyond our provincial borders: How Ontario compares

Average to good

Compared to other provinces and countries (where data are available), the results of Ontario's health system are mixed. Ontario had the lowest rate of potential years of life lost due to premature death in Canada. Ontario is also doing comparatively well in terms of quality of care in long-term care homes – best or second-best among the five provinces with comparable data when it comes to a reduction in residents experiencing pain, antipsychotic medication use and restraint use. Ontario is in the middle of the pack in terms of access to primary care outside of normal hours.

At or near the bottom

Compared to 10 socioeconomically similar countries, Ontario is the worst in terms of patient-reported ability to get a primary care appointment the same or next day when sick. And compared to nine socioeconomically similar countries, Ontario is a costly system for drug spending – fourth in the amount per person spent on drugs. About 1 in 12 people in Ontario reported having serious problems paying their medical bills.

How is Health Quality Ontario helping to improve care?

Measuring Up 2017 reflects Health Quality Ontario's role in reporting on the quality of the health care system. But our mandate is much broader, including a commitment to support active improvement in care. Here are some of the ways that Health Quality Ontario works with others at each level of the health care system to ensure better care for all:

Health Quality Ontario developed a provincial framework, *Quality Matters*, as a common guide for the health system to improve care for patients and their families and caregivers, and to support health care providers. *Quality Matters* defines the culture of a high-quality health system according to six dimensions: safe, effective, patient-centred, efficient, timely, and equitable.

More than 1,000 organizations in Ontario involved in hospital care, home care, primary care and long-term care have created annual Quality Improvement Plans – documented sets of commitments to improve the quality of the care they provide, through focused targets and actions. Regional Quality Tables across Ontario, each chaired by a Clinical Quality Lead, share local experiences and initiatives aimed at improving quality of care, and work to align and connect regional and provincial quality programs.

ARTIC (Adopting Research to Improve Care) initiatives are supporting the implementation of proven service delivery models. These include central intake and assessment centres for patients

with common musculoskeletal conditions, including back, neck and shoulder pain, and those who may need hip and knee replacements; and Patient Oriented Discharge Summary (PODS), a tool to ensure patients have the information they need before going home from the hospital.

Health care and services in Ontario often involve sophisticated technologies. Health Quality Ontario performs regular Health Technology Assessments of new and existing health care services and medical devices. A group of experts, leaders and patients that form the Ontario Health Technology Advisory Committee makes scientific evidence-based recommendations to the Ontario Ministry of Health and Long-Term Care on whether these health technologies should be publicly funded.

The Ontario Surgical Quality Improvement Network, supported by Health Quality Ontario, provides resources to surgical teams across the province to improve quality in surgery, as well as improved patient experience and outcomes. Health Quality Ontario is also working with patients, caregivers and doctors to develop quality standards that identify the care patients should be offered for specific health conditions such as depression or chronic obstructive pulmonary disease, based on the best available evidence.

Health system performance in Ontario — 2017 highlights

Quality Element*	Bright Spots	Room for Improvement	No Change
Effective	<ul style="list-style-type: none"> Obesity, cigarette smoking and physical inactivity Premature mortality (potential years of life lost) Overdue for colorectal cancer screening 	<ul style="list-style-type: none"> Follow-up with a doctor after hospitalization for chronic obstructive pulmonary disease or heart failure 	<ul style="list-style-type: none"> Follow-up with a doctor after hospitalization for mental illness or addiction Hospital readmission within 30 days for mental illness or addiction
Timely	<ul style="list-style-type: none"> Length of stay (for patients not admitted to hospital) and time to physician initial assessment in the emergency department Wait times for MRI and CT scans Wait times for cancer patients to see a surgeon and to have surgery performed 	<ul style="list-style-type: none"> After-hours access to a primary care provider Emergency department length of stay for patients admitted to hospital Wait times for hip replacement and knee replacement First contact in the emergency department for mental illness or addiction 	<ul style="list-style-type: none"> Same-day or next-day access to a primary care provider
Patient-centred	<ul style="list-style-type: none"> Pain experienced by residents in long-term care homes 	<ul style="list-style-type: none"> Home visits by a doctor in the patient's last 30 days of life Home care services in the patient's last 30 days of life Distress among informal caregivers of home care patients Home care patients with daily severe pain Home care patients involvement in their care plan 	
Safe	<ul style="list-style-type: none"> Use of antipsychotic medications in long-term care homes Use of physical restraints in long-term care homes 		
Efficient	<ul style="list-style-type: none"> Continuity of primary care 	<ul style="list-style-type: none"> Total health spending per person Health spending on drugs per person Unplanned emergency department visits Hospital beds occupied by patients who could be receiving care elsewhere Visits to emergency for conditions people thought could have been treated by their primary care provider 	
Equitable		<ul style="list-style-type: none"> Having serious problems paying or being unable to pay medical bills Premature mortality (potential years of life lost) variation by region Same-day or next-day access to a primary care provider variation by region Overdue for colorectal cancer screening variation by neighbourhood income 	

* Quality elements identified in Health Quality Ontario's *Quality Matters*, which was developed to guide the health system in Ontario to improve care for patients and their families and caregivers, and to support health care providers.

LEGEND

- Our Health
- Primary Care
- Mental Illness and Addictions
- Hospital Care
- System Integration
- Home Care
- Long-Term Care
- Palliative Care
- Health Spending

Introduction

Photo of Gordon
taken by Roger Yip.



Improving health system monitoring

With *Measuring Up 2017*, Health Quality Ontario enters its second decade of reporting to Ontarians on the performance of their health care system. As the changes made to the report over the years illustrate, doing this for the 11th time does not mean settling into a tried-and-true formula. As always, the goal is improvement, to make each year's report more informative and accessible than the previous one.

Measuring Up is therefore shorter this year and focuses on a smaller group of key indicators. As well, the report has been redesigned to make the information it contains easier to understand.

What hasn't changed is the overall purpose of *Measuring Up*, which is to provide an overview of the quality of Ontario's health system, and to identify the areas where the system is functioning well and those where improvement is needed. That includes examination of how well the health system is working in different regions and for different groups of people – such as those with lower incomes or less education – to assess whether health care is being provided equitably to all.

For the overview, *Measuring Up* uses a set of health system performance indicators developed by Health Quality Ontario in association with health care experts and health system partners such as doctors, nurses, hospitals, local health

integration networks and home care providers, as well as patients and their families and caregivers.

While *Measuring Up 2017* highlights only key findings, the full set of results can be found in the Technical Data Table available on the Health Quality Ontario website. Also available on the website is a technical appendix to this report, with details on the methodology and indicators used.

Looking beyond the facts and figures

Even though *Measuring Up* is shorter this year, the report still includes several stories detailing the personal experiences of patients, caregivers and health care providers. These real-life accounts add a human perspective to all the facts and figures, and in many ways convey why something might need to change better than any column of numbers or line of points on a graph.

What's new in 2017?

Three indicators are in *Measuring Up* for the first time this year.

The Continuity of Care indicator in the Primary Care chapter shows whether people are receiving ongoing, consistent care over time from a single primary care physician such as their family doctor. High continuity of care has been associated with better outcomes for patients, including greater patient satisfaction.

In the Hospital Care chapter, the new Time to Physician Initial Assessment indicator provides information on how long Ontarians have to wait to see a doctor when they go to an emergency department for care. That wait is measured from the time the patient is assessed (“triaged”) or registered – whichever comes first – to when they are first seen by the doctor.

The third new indicator, also found in the Hospital Chapter, is designed to present a more

complete picture of how long people who need cancer surgery have to wait for care. In previous years, *Measuring Up* reported on the amount of time patients wait to have their surgery performed, after making the decision together with their surgeon to have the surgery. This year, an indicator has been added that measures how long patients who need cancer surgery wait for their first appointment with a surgeon. Together, the two indicators help show how long people in Ontario wait to have surgery after they are diagnosed with cancer.

Putting it all together

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

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

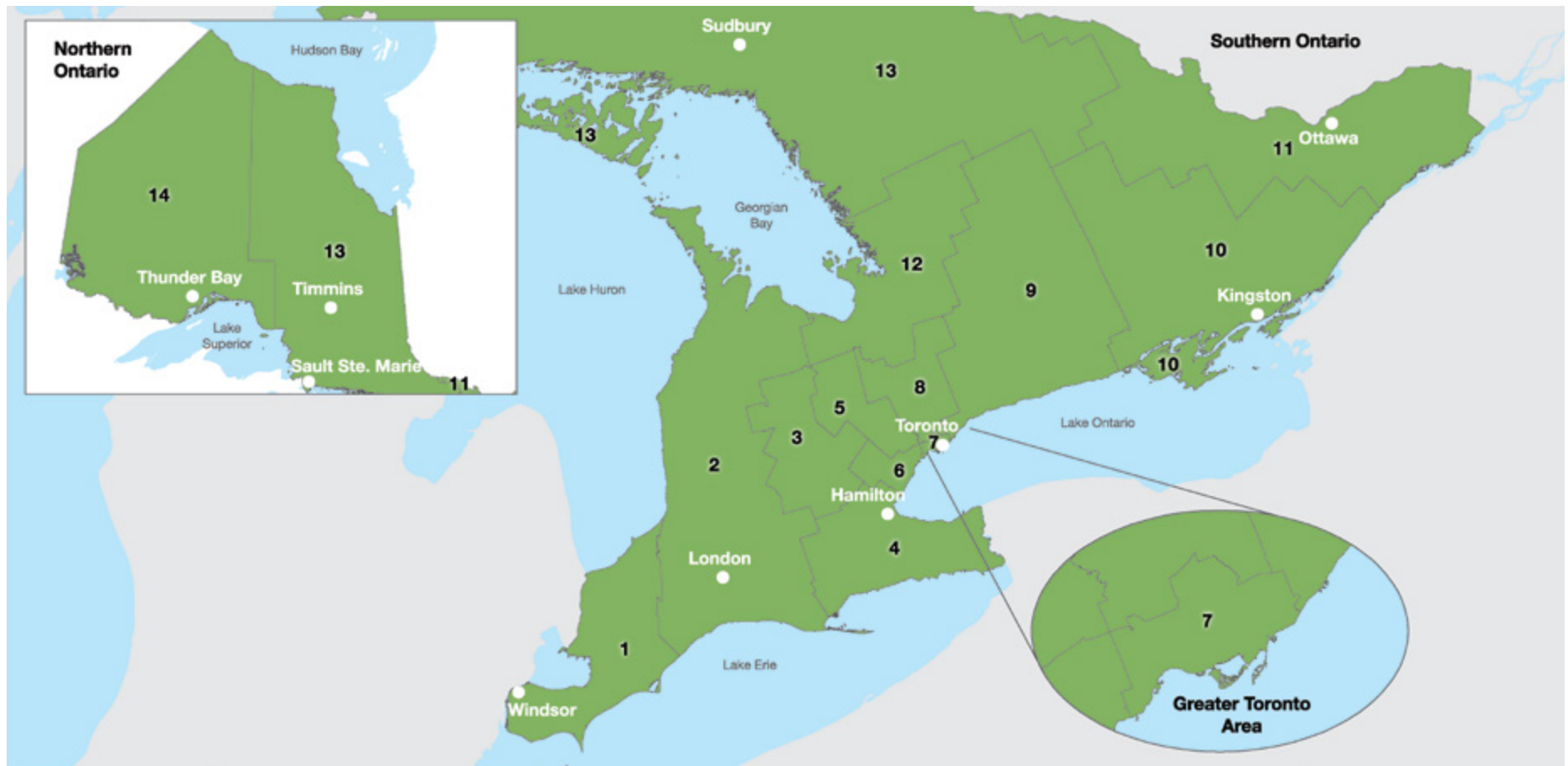
For some indicators, for the first time in *Measuring Up* this year, results are also provided for LHIN sub-regions. The sub-region data cover smaller geographic planning areas, and so provide a better understanding of health system performance and patient needs at a local level.

To provide additional perspective on overall health system performance in this province, for some indicators, *Measuring Up* compares Ontario to other provinces and Canada as a whole, as well as weighing Ontario’s results against health system performance in socioeconomically similar countries.

Some of the international comparisons are facilitated by the ongoing collaboration between Health Quality Ontario and The Commonwealth Fund that is expanding Ontario’s participation in The Commonwealth Fund’s annual international health policy surveys. The surveys usually include Canada, Australia, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. These countries are in many ways economically and demographically similar to Ontario, and therefore provide useful points of comparison for health system indicators.

The report also uses health data from the Organisation for Economic Cooperation and Development, which includes the same 11 countries.

Figure 1.1 Map of Local Health Integration Networks in Ontario



Ontario LHINs

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

CHAPTER 2

Our Health

This chapter highlights results for the following Common Quality Agenda indicators related to the health of Ontarians:

- Premature mortality
- Obesity, cigarette smoking and physical inactivity

Additional results for indicators related to the health of Ontarians can be found in the Technical Data Table.



Photo of Andy taken by Roger Yip.

● ● ● REAL-WORLD EXPERIENCES

Homeward Bound: Andy's story – “Believe in yourself”

“I owe Homeward Bound my life. I was about ready to give up when I met them,” says Andy, 42, a transgender Indigenous man who struggles with mental illness and now – after living on the street, in shelters and on friends' couches – has his first real home in 10 years thanks to De dwa da dehs nye>s Aboriginal Health Centre's Homeward Bound program, that focuses on Indigenous people.

Andy's friend, herself a Homeward Bound client, convinced him to try the program, despite his bad experiences with other places. “Some shelters have kicked me out. One men's housing program put me on a wait list, but they would only use my birth name, Amanda... To me that's lying about who I am. I can't do that anymore.”

Homeward Bound was different right from the first visit, says Andy. “Tyson [his case manager] brought me paperwork that all said ‘Andy.’ He told me about a native tradition that says trans people are ‘born with two spirits and have extra wisdom to give’... No one calls me an ‘it’ here. No one says ‘born a girl, stay a girl’ like at other places.”

Within a month, Tyson had helped Andy find a bachelor apartment; Homeward Bound provided some funds to buy furniture. Andy's

income is through the Ontario Works program, and he gets \$250 monthly rent subsidy from the City of Hamilton for five years.

Andy works hard to overcome crippling agoraphobia (fear of leaving home and of strangers) to ride his bicycle around town to see his nurse-practitioner, Michelle (part of Homeward Bound), meet with his therapist, and participate in art classes, hiking trips and Indigenous cultural events.

Andy was surprised to learn he was adopted – and of Indigenous heritage – when a family member blurted it out last year. “My native culture is becoming more important to me... I'm on my healing journey,” says Andy. “Before, it was just meds and psychiatrists... not the greatest, I never got better.” He's been diagnosed with post-traumatic stress disorder, depression, anxiety and attention deficit hyperactivity disorder as well as agoraphobia.

Homeward Bound has connected Andy with mental health services at the De dwa da dehs nye>s Aboriginal Health Centre in Hamilton, and introduced him to Selby Harris, a counsellor with the Hamilton Regional Indian Centre who sees Andy weekly, sometimes out in nature, or at Andy's home on the days Andy can't face the world.

Homeward Bound also helped Andy find a new family doctor who specializes in providing care to individuals who are transgender. “It's amazing,” says Andy. “The doctor is really respectful, everything is under ‘Andy’ even though my health card still has to say ‘Amanda.’” (He's learned that can change if he gets the sex designation on his birth certificate changed, which he's begun working on.)

Tyson visits Andy at home every week. “He always asks me what I need. One time I said, ‘I need to paint.’ He went out and came back with a bag of canvases, paints and brushes.” Andy's eyes light up. “I've made art since I was little. I paint my feelings.” His apartment walls are covered with his abstract artwork.

Andy is proud to be 16 years sober from drugs, and three months clean from cutting and other forms of self-harm. “I'm getting out, I'm talking more. I'm smudging [cleansing by burning traditional medicines]. I'm learning as I go.” He shows off his new left wrist tattoo: a small dark tree with roots, directly below the bold capped words BELIEVE IN YOURSELF. He plans to have more roots inked, going up his arm.

“I'm growing roots, I have a home. I have a community now.”

Addressing regional and socioeconomic barriers to wellbeing



There are many ways to examine the health of a population. Premature mortality rates show whether people's lives are being cut short by illness or injury. Cigarette smoking, obesity and physical inactivity rates represent some of the risks that threaten people's health. These indicators do not offer a complete picture of the health of the population, but examining them does provide opportunities to identify health trends and risks, and to take action on them through policy initiatives and preventive care.

Premature death rates have declined substantially over time in Ontario, but not everybody has benefitted equally, as rates vary substantially between regions of the province. Regional inequities in the health care people receive need to be recognized and addressed, as do inequities in socioeconomic determinants of health such as income, education, and employment status.

Data on cigarette smoking, obesity and physical inactivity show wide variations in the prevalence of these risk factors among different groups of Ontarians. Rates of cigarette smoking, obesity and physical inactivity are often higher among groups with lower levels of education or lower income, and also vary by sex and region of residence.

Key Finding 1

Premature mortality rates vary widely across Ontario

There are substantial differences between Ontario's regions in potential years of life lost among their residents. Potential years of life lost, and potential years of life lost due to suicide, are highest in northern regions of the province.

Key Finding 2

Health risks vary by education, income and area of residence

Cigarette smoking, obesity and physical inactivity – some of the known risk factors that affect health – vary in Ontario by people's education level, income level and area of residence. Rates are often higher among those with less education or lower income.

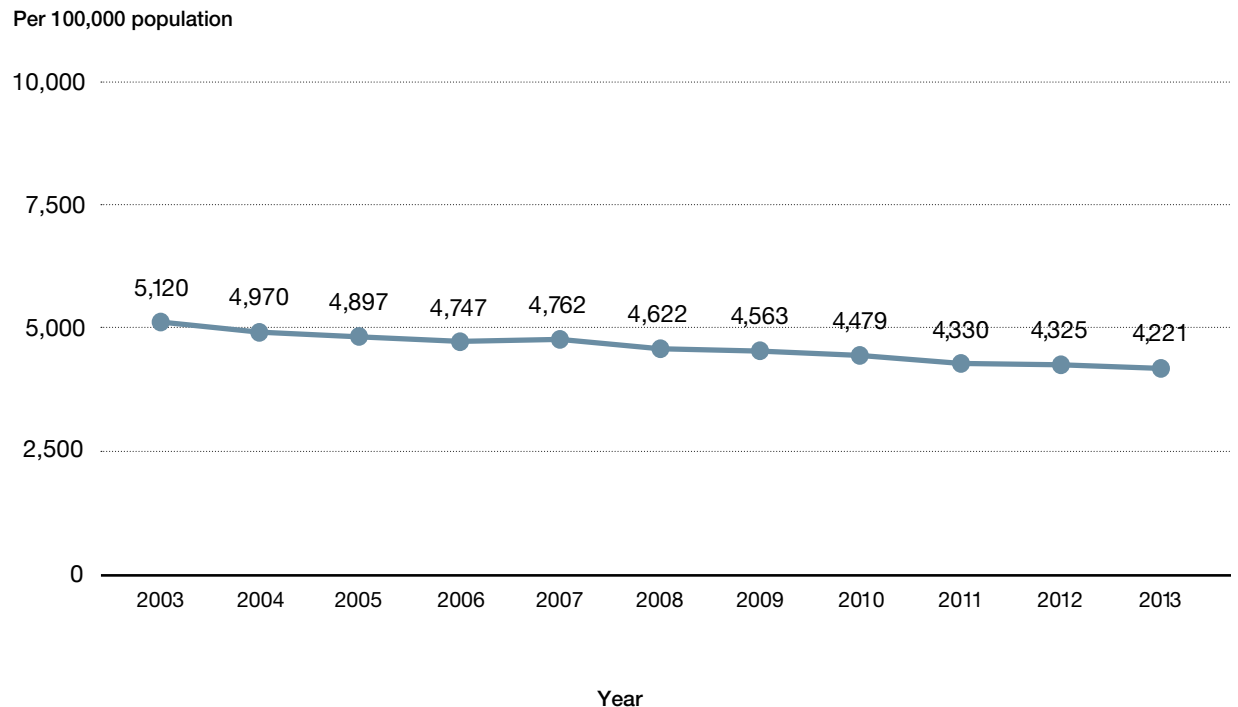
Potential years of life lost due to premature mortality

People in Ontario are living longer. A person born in 2011-2013 – the most recent years for which data are available – has a life expectancy of 82.2 years, compared to 80.8 years for someone born in 2005-2007. This chapter provides another perspective on mortality trends in the province by examining potential years of life lost due to premature death. Currently in Canada, a death before the age of 75 is considered to be premature, so someone who died at 60 would be considered to have lost 15 potential years of life, and someone who died at 73 would be counted as having lost two potential years of life.

Potential years of life lost collectively by all individuals in a population, such as Ontario as a whole, are added together to calculate the rate of potential years of life lost per 100,000 population. So, the greater the number of people in Ontario who die before the age of 75, and the earlier they die before the age of 75, the higher the rate of potential years of life lost will be for the province.

Greater availability of timely, high-quality health care, as well as a reduction in cigarette smoking, obesity and other risks to health among the population, would decrease potential years of life lost. So would improvements in socioeconomic determinants of health such as education and income, which studies have shown can affect both access to care and risks to health.[1,2] Targeted efforts aimed at specific health issues such as the high number of opioid overdose deaths in Ontario would also have an impact on potential years of life lost.

FIGURE 2.1 Potential years of life lost due to premature death per 100,000 people,* in Ontario, 2003–2013



Data source: Statistics Canada. Table 102-4316 –Premature and potentially avoidable mortality, Canada, provinces and territories, annual *age-adjusted



Indicator: Potential years of life lost

This indicator measures potential years of life lost due to premature death, per 100,000 people. Premature death is defined as death before the age of 75.

Findings and variations

This indicator measures potential years of life lost due to premature death – before the age of 75 – per 100,000 population.

- The rate of potential years of life lost per 100,000 people decreased steadily in Ontario between 2003 and 2013, to 4,221 years per 100,000, from 5,120. (**Figure 2.1**)
- The rate of potential years of life lost was nearly 2.5 times higher in the LHIN region with the highest rate – the North West LHIN region – at 7,647 years per 100,000 people, than in the region with the lowest rate – the Central LHIN region – at 3,026 years per 100,000 population, during the period between 2011 and 2013. There was also wide variation among the rest of the LHIN regions.
- Deaths by suicide account for a substantial number of potential years of life lost, since it is a major cause of death for people aged 15 to 44 years.[3] Suicides among teenagers have been particularly high within some of Ontario's communities.[4] The rate of potential years of life lost due to suicide was five times higher in the North West LHIN region at 776 years per 100,000 population than in the Mississauga Halton LHIN region at 155 years per 100,000 population, during the period between 2010 and 2012. There was also wide variation in this rate among the rest of the LHIN regions.

- In 2013, Ontario had the lowest rate of potential years of life lost prematurely in Canada, at 4,221 per 100,000 population. Quebec was next at 4,327, followed by British Columbia at 4,355. The highest rate among the provinces was in Saskatchewan, at 6,062.

An Emerging Public Health Crisis

Opioid drug overdoses are claiming the lives of thousands of Canadians of all ages, from all walks of life, in what the Public Health Agency of Canada has described as an opioid crisis.[5] In the first six months of 2016, 412 people in Ontario died as a result of opioid overdose, compared with 371 during the same time period in 2015, representing an 11% increase.[6] Emergency department visits in Ontario for opioid poisoning increased 24% between 2010/11 and 2014/15, to 24.9 per 100,000 people from 20.1 per 100,000.[7]

While opioid-related deaths have increased significantly over the years in all age groups in Ontario, they are most common among young people. In 2010, nearly one in eight deaths among people 24 to 35 years old was opioid-related.[8]

Opioids are prescribed to relieve pain, including relieving pain for people receiving palliative care at the end of life. Opioids include a broad range of medications that are related to morphine. They work by changing the brain's perception of pain and may cause those who take them to feel elated and relaxed.[9]

In 2015/16, 9.2 million prescriptions for opioids were filled in Ontario, 5% more than in 2013/14.[10] Ontario has the highest rates of opioid prescribing in Canada, and Canada has the second-highest prescribing rates in the world.[11]

However, opioids can be addictive and some people who initially take them for pain may eventually start to experience negative physical or psychological effects. Some research suggests that as many as 1 out of every 8 people prescribed opioids for chronic pain will develop an addiction to opioids.[12] There is also a risk that people who develop an addiction will try to get opioids illegally if they are unable to get a prescription. This increases the risk of fatal overdose since opioids obtained illegally may be laced with fentanyl, which can be fatal even in very small amounts.[13]

Despite growing concerns about the potential harms of opioids and increasing rates of opioid addiction and overdose deaths,[14] people in Ontario filled more than 9 million prescriptions for opioids in 2015/16, up by nearly 450,000 prescriptions from three years earlier.

Risk factors that affect health

Research suggests that non-communicable diseases such as heart disease, cancer and diabetes cause about two-thirds of all deaths, and that these diseases can mostly be prevented by modifying risk factors such as cigarette smoking, obesity, physical inactivity, alcohol abuse and unhealthy diet.[15,16]

Cancer, heart disease and stroke are the three leading causes of death in Canada.[17]

One Canadian study found that risk factors such as cigarette smoking, poor diet and physical inactivity reduced overall life expectancy in Ontario by 7.5 years, and another concluded they reduced life expectancy in Canada by six years.[18,19] Chronic diseases such as chronic obstructive pulmonary disease and diabetes, which are associated with risk factors such as cigarette smoking and physical inactivity, were responsible for 79% of deaths in Ontario in 2007.[20]

Reducing these kinds of risk factors is considered to be an important component of health policy worldwide. However, cigarette smoking, obesity and physical inactivity are generally more common among people who have little income, limited education, live in remote regions, or are burdened with other social disadvantages.[21,22,23] So addressing inequities that result from socioeconomic determinants of health such as income, education and area of residence can have a key role to play in reducing risk factors and thereby providing everyone with the same opportunity for good health.

Findings and variations

These indicators measure the percentage of people aged 12 and older who reported daily or occasional cigarette smoking, and the percentage of people aged 18 and older who were obese or inactive.

Data related to education cover only people aged 25 and older.

Cigarette smoking

- In 2015, 17.2% of Ontarians aged 12 and older reported daily or occasional cigarette smoking. Smoking rates in other Canadian provinces ranged from 13.6% in British Columbia to 24.5% in Newfoundland and Labrador.
- Cigarette smoking rates varied widely among Ontario's LHIN regions in 2015, ranging from 12.1% in the Mississauga Halton LHIN region to 23.7% in the North East LHIN region.
- Cigarette smoking rates were higher among men (20.3%) than women (14.4%); among people with less than secondary school education (26.0%) compared to post-secondary graduates (13.9%); and among people who belonged to the fifth of the population with the lowest household incomes (23.4%) compared to those who belonged to the fifth of the population with the highest household incomes (14.3%). (**Figure 2.2**)

Obesity

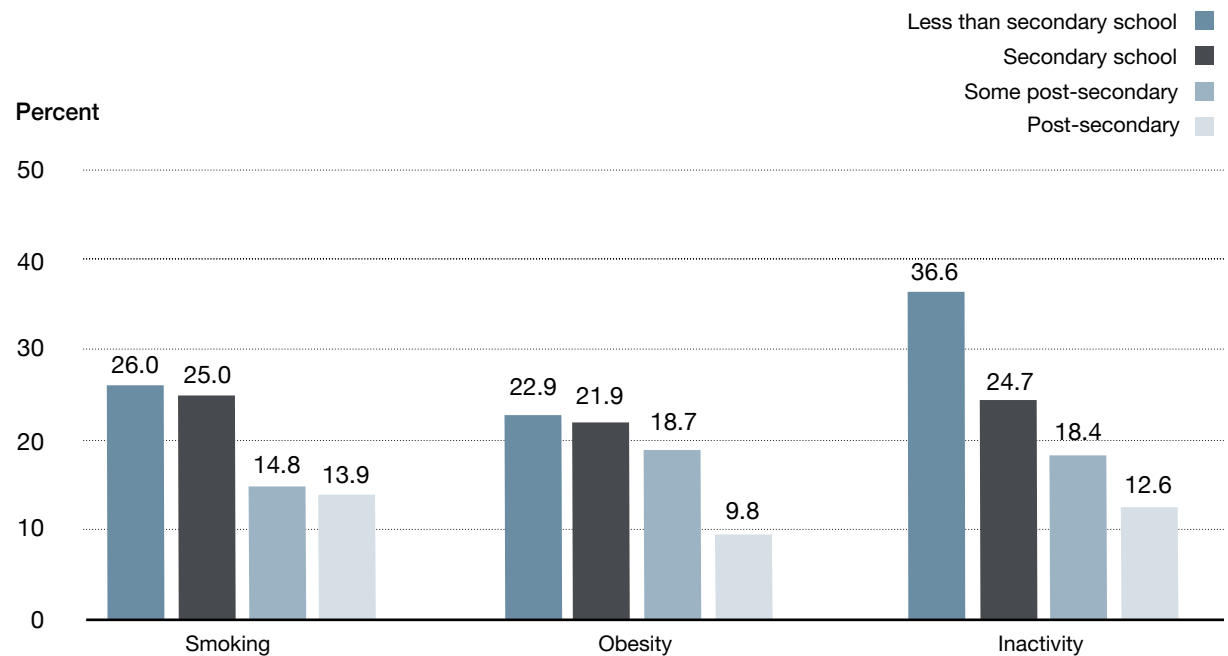
- In 2015, 18.4% of Ontarians aged 18 and older were obese. Ontario's obesity rate was third-lowest among Canadian provinces, after British Columbia, at 13.7%, and Quebec, at 16.4%. Newfoundland and Labrador had the highest rate, at 32.1%.
- There was wide variation in obesity rates among Ontario's LHIN regions in 2015. The rate was 13.7% in the Mississauga Halton LHIN region, compared to 27.7% in the Erie St. Clair LHIN region.
- Obesity rates were higher among men (20.0%) than women (17.0%); among people with less than secondary school education (22.9%) compared to post-secondary graduates (9.8%); and among people who lived in rural areas (22.4%) compared to those who lived in urban areas (17.9%). (**Figure 2.2**)

Physical inactivity

- In 2015, 20.5% of Ontarians aged 18 and older reported being physically inactive. Ontario's inactivity rate was in the middle of the pack among Canadian provinces, with British Columbia performing best at 15.4% and Newfoundland and Labrador worst at 28.0%.
- Physical inactivity rates were higher in 2015 among women (21.7%) than men (19.2%); among people with less than secondary school education (36.6%) compared to post-secondary

graduates (12.6%); among people who belonged to the fifth of the population with the lowest household incomes (27.2%) compared to those who belonged to the fifth of the population with the highest household incomes (13.3%); and among people who lived in rural areas (23.7%) compared to those who lived in urban areas (20%). (**Figure 2.2**)

FIGURE 2.2 Percentage* of people aged 25 and older who reported smoking cigarettes daily or occasionally; who were obese based on self-reported weight and height; who reported being physically inactive; in Ontario, by education level, 2015



Data source: Canadian Community Health Survey, 2015 provided by Statistics Canada. Results are based on new Canadian Community Health Survey data, for which changes have been made in definitions and methodology. *Age adjusted



Indicators: Cigarette smoking, obesity and physical inactivity

These indicators measure the percentage of people aged 12 and older who self-reported daily or occasional cigarette smoking, and the percentage of people aged 18 and older who were obese (with a body mass index greater than 30) based on self-reported height and weight, and who reported that they didn't engage in any moderate or vigorous physical activity that lasted a minimum of 10 continuous minutes in a week.

CHAPTER 3

Primary Care

This chapter highlights results for the following Common Quality Agenda indicators related to primary care:

- Continuity of primary care
- Same-day or next-day access to a primary care provider
- After-hours access to a primary care provider
- Overdue for colorectal cancer screening

Additional results for indicators related to the health of Ontarians can be found in the Technical Data Table.



Photo of Lilac
taken by Roger Yip.

 REAL-WORLD EXPERIENCES

Lilac: A doctor to trust with her life

Lilac, 51, says she's survived, and thrived, in her long experience with kidney disease in large part because of continuous care by the same family doctor. “I trust her with my life,” she says of her family doctor, and she's had to do just that.

After six years with no family doctor (she grew up with her family doctor, who retired), Lilac noticed “my ankles started swelling, and elevated hypertension caused me to feel my blood coursing through me,” so she took a doctor referral from a friend. At her first and only visit to that primary care provider, Lilac says she was told to wait for the doctor with no appropriate coverage and when the doctor came in, she didn't do anything to address it, recalls Lilac, still embarrassed about the incident. She didn't return to this primary care provider and continued her search for a new family doctor. “I need to feel they care, and not treat me like a number.”

Through a referral from a trusted co-worker, she found her current family doctor with whom she felt comfortable and who, after tests, immediately referred Lilac to a kidney specialist. “Heavy fluid retention bloated me to the point of imprinting the chair on my skin,” she recalls. The specialist ordered a biopsy and put her on medications, checking on her progress a few days later.

Diagnosed at age 36 with first one, then two, kidney diseases, Lilac says she was fearful of what the future held. As a young adult, she'd lost her father to cardiac arrest during his dialysis when he was 57. She had been very close to him, and

Lilac says memories of his hospitalizations resurfaced when she started dialysis.

Once diagnosed, she struggled to process her diagnosis. “It was my choice to keep this to myself. I associated it with a personal failure ... [and] my mom requested for me not to share my disease with members of her circle. It's a cultural thing,” says Lilac, who is first-generation Chinese-Canadian. “There is a stigma about losing face, not for the family, but for others not to judge me.”

That changed in 2012 at age 46 when Lilac began dialysis, a process where she had to spend up to 18 hours a week in the hospital with machines carrying waste and water out of her blood. She met a fellow dialysis patient who was also keeping his disease secret from the world. “His self-imposed isolation made him a very lonely man,” recalls Lilac, who decided to begin blogging updates, about how her disease doesn't have to stop her from living, to good friends in her life.

Lilac had pneumothorax (collapsed lung) due to complications from peritoneal dialysis. In 2013, while she continued on dialysis, the hospital spent a year running transplant workup tests to ensure her body would survive the surgery. In 2014, once officially approved to be on the transplant list, Lilac was extremely grateful to receive a kidney within months (she was told it would be a four-to-six-year wait). She's glad her mom, 83, lived to see Lilac transplanted and healthy; she died eight weeks later.

Lilac now gives back by helping others: she is a volunteer in the Patient Partnerships program to help general hospital planning and decision-making at the Toronto hospital where she was treated; an external stakeholder on the University of Toronto Bloomberg Institute's Faculty Council; and a peer support volunteer with the Kidney Foundation of Ontario.

Through it all, Lilac's family doctor has been a pillar of support. “I feel grateful I've had my current family doctor throughout my journey; we have history together,” Lilac says. “She is a mentally strong woman who used to run marathons. She leads by example and has remained caring, trustworthy, knowledgeable and transparently honest throughout my health journey. Although I see her every two years for general physical or for other non-transplant medical concerns, my transplant team sends her regular updates on my overall health.”

Lilac emphasizes that her doctor is much more than just a clinician. Upon one visit to ensure all vaccinations were compatible for a transplant patient, “she realized that I was about to celebrate a milestone birthday. She turned off her laptop, faced me and said, ‘You've looked your mortality not once, but twice, in its face and survived to tell the story. Not very many people have had that happen before the age of 50. This calls for a celebration.’ When I replied ‘How would you celebrate?’ my doctor said, ‘this is about you, this is your journey. It all depends on where your head space is and where your heart is.’ Her medical skills plus spiritual side makes her unique as a primary care provider.”

A key point of access to health care



Family doctors or nurse practitioners are usually people's first and main ongoing point of contact with the health system. They deliver a wide range of primary care – from diagnosing patients' illnesses and assessing their health problems, through managing acute and chronic conditions, to providing preventive care and counselling.

Collectively, primary care providers play a critical role in the health system as a key point of access to medical specialists such as surgeons, psychiatrists, cardiologists and oncologists. As well, they play an important role in coordinating patient care and connecting patients to other health professionals and services such as home care, dieticians, and addiction counselling, as well as in encouraging patients to be screened for diseases such as colorectal and cervical cancer.

Access to primary care is associated with lower rates of illness and death, more equity in the health status of a population, and a reduction in overall health system costs.[24,25]

In surveys, Canadians have identified accessibility, comprehensiveness, coordination and continuity to be among the most important features of the primary care they receive.[26,27]

In Ontario, 94.3% of people say they have access to a primary care provider for regular care.[28] And, data included in *Measuring Up* for the first time this year show the majority of

Ontarians, among those who see a primary care doctor at least three times over two years, receive high-continuity primary care from the same doctor.

However, people in Ontario often do not have timely access to primary care when they need it. More than half of Ontarians surveyed reported not being able to access their primary care doctor or other provider on the same or next day when they were sick. As well, more than half reported having difficulty accessing medical care without going to an emergency department when they needed care outside normal office hours. And, many Ontarians do not get screening tests for colorectal cancer, one of the most commonly diagnosed cancers in Ontario.

Key Finding 1

Most Ontarians receive high-continuity care

More than half of Ontarians who saw a primary care doctor three or more times over the previous two years had at least three-quarters of their visits with the same doctor. High continuity of care with the same doctor has been shown to result in better quality of care and patient outcomes.

Key Finding 2

Most Ontarians can't see their doctor quickly when they are sick

Less than half of Ontarians surveyed reported being able to see their doctor, nurse practitioner or another primary care provider in their office, on the same or next day when they were sick, and there has been no improvement in this finding in recent years. As well, more than half of Ontarians surveyed reported having difficulty accessing medical care without going to an emergency department when they needed care outside normal office hours, and this has not improved either in recent years.

Key Finding 3

Where you live affects access to care

The proportion of Ontarians surveyed who reported they could see their primary care provider the same or next day when they were sick did not vary by income. However, same-day or next-day access reported by respondents did vary widely by region of residence and according to whether people lived in an urban or rural area. There was also variation by region and urban or rural residence in reported access to after-hours care, and in continuity of care with the same physician.

Key Finding 4

Colorectal cancer screening rate improving

A growing proportion of Ontarians aged 50 to 74 are getting the recommended colorectal cancer screenings, but nearly 4 out of 10 were overdue for a screening test in 2015.

Continuity of primary care

Research suggests that when patients are seen consistently by the same primary care provider and are able to develop a relationship with that provider, it can improve their health outcomes and reduce the number of times they have to go to an emergency department or be hospitalized.[29,30,31,32]

Studies also associate this type of continuity of care with better preventive care for patients, better adherence to treatment by patients and higher patient satisfaction, as well as decreased health care costs and fewer medical errors.[33,34,35,36,37]

However, for various reasons, people may not always be able to see the same health care professional for primary care. They might not have a health care professional who is their regular primary care provider, or their provider may not be available on short notice or after regular office hours. Lack of a provider, long wait times for appointments and lack of after-hours care have all been linked to low continuity of care.[38,39]

Findings and variations

This indicator measures the continuity of the care received by people who saw a primary care doctor at least three times over the previous two years. For this indicator, high continuity is defined as patients having 75% or more of their visits with the same primary care physician, medium continuity is 50% to 74%, and low continuity is less than 50%.

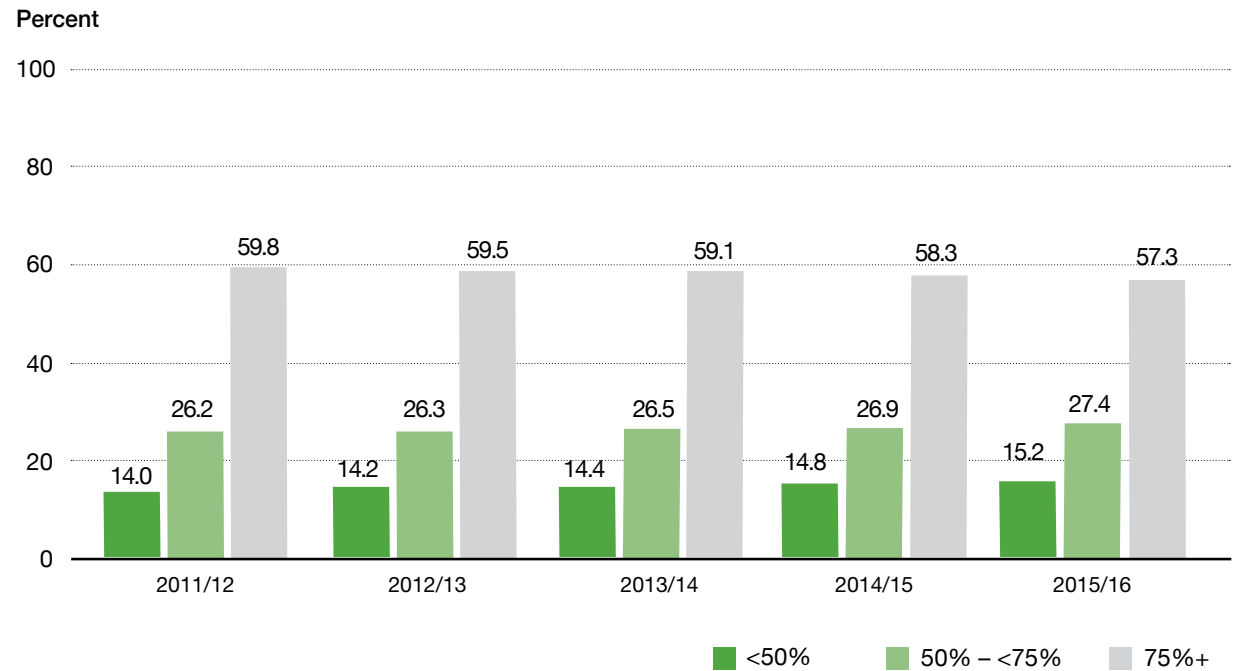
- In 2015/16, among Ontarians who had at least three primary care visits to a physician within the previous two years, 57.3% had high continuity of care and 15.2% had low continuity. **(Figure 3.1)**
- The proportion of people who had high continuity of care varied between Ontario's LHIN regions, from 66.5% in the South East LHIN region to 49.8% in the Central West LHIN region.
- Continuity of care was better among rural residents, with 68.2% having high continuity of care, compared to 64.9% of residents of medium-sized urban areas, and 54.8% of residents of large urban areas.
- Continuity of care was poorer for younger people, with about 45% of those up to 44 years old having high continuity of care, compared to 65.1% of people 45 to 64 years old, 74% of people aged 65 to 79, and 75.3% of those 80 and above.



Indicator: Continuity of primary care

This indicator measures the percentages of people who had high, medium or low continuity of primary care, among people who saw a primary care doctor at least three times over the previous two years. High continuity is defined as patients having 75% or more of their visits with the same primary care doctor, medium continuity is 50% to 74%, and low continuity is less than 50%.

FIGURE 3.1 Percentage of people who had less than 50%, 50% to 74%, or 75% or more of their primary care doctor visits with the same doctor, Ontario, 2011/12–2015/16



Data source: OHIP, CAPE, RPDB, CPDB provided by the Institute for Clinical Evaluative Sciences.

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

Although 94.3% of Ontarians report having a regular primary health care provider, that doesn't always mean they have access to primary care when they need it. About 20% of people in Ontario who have a regular doctor make use of walk-in clinics, suggesting they are sometimes not able to go to their provider when they require care.[40]

People who can't get appointments with their own doctors may also go to an emergency department. An estimated one in five visits to emergency departments in Canada, by patients who are not admitted to hospital, are made for conditions that can be treated at a doctor's office or clinic, such as sore throats and ear infections.[41]

However, some research suggests people are not necessarily using emergency departments or walk-in clinics because their primary care provider is not available, but rather due to factors such as convenience.[42]

If people are able to see their primary care provider in a timely manner when they are sick, that may help prevent them from getting sicker, and possibly from requiring emergency department or hospital care.[43] Or, if they have a chronic condition, timely access to care can avert visits to emergency for that condition.[44,45]

Findings and variations

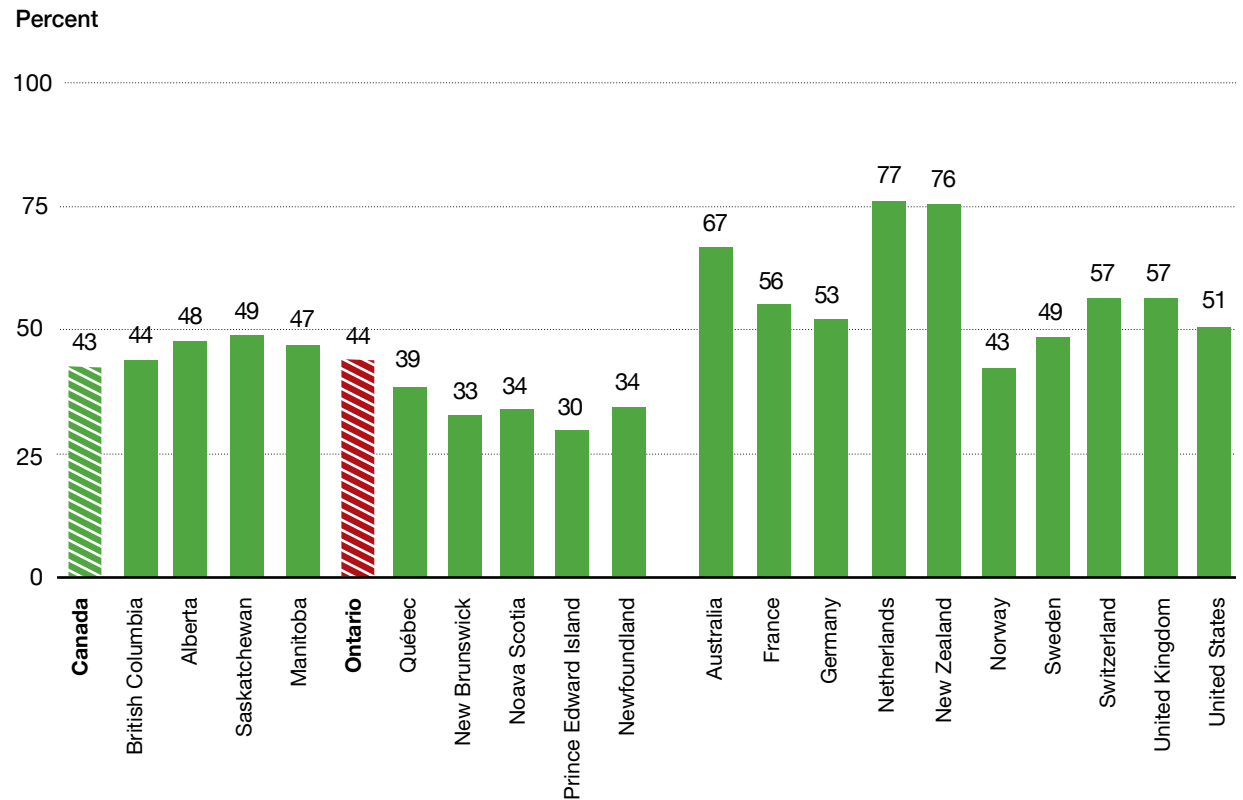
This indicator measures the proportion of people surveyed who reported being able to see their primary care provider or someone else in their office on the same day or next day when they were sick or had a health concern.

- In the 2016 Health Care Experience Survey, 43.1% of Ontarians aged 16 and over reported being able to get an appointment with their primary care provider, or another primary care provider in their office, the same day or next day when they were sick or had a health concern. This indicator has remained stable over three years.
- In the 2016 Commonwealth Fund International Health Policy Survey, 44% of Ontarians aged 18 and older reported being able to get an appointment with their primary care provider or someone else in their office the same or next day when they were sick or needed medical attention, putting Ontario in a tie for the worst performance among 10 socioeconomically similar countries. New Zealand placed first with 76% being able to get a timely appointment. **(Figure 3.2)**
- The Health Care Experience Survey shows wide variation between the province's LHIN regions in the proportion of patients who reported same-day or next-day access to primary care when they were sick, ranging from 22% in the North East LHIN region to 60.3% in the Central West LHIN region.
- In the Health Care Experience Survey, 45% of urban residents reported being able to get a same-day or next-day appointment with their primary care provider in 2016, compared to 31.2% of rural residents.

Indicator: Same-day or next-day appointment with a primary care provider

This indicator measures the percentage of people surveyed who reported being able to see their family doctor, nurse practitioner or another primary care provider in their office, on the same day or next day when they were sick or had a health concern.

FIGURE 3.2 Percentage of people 18 years and older who were able to see their primary care provider on the same day or next day when they were sick, in Canada and internationally, 2016



Data source: 2016 Commonwealth Fund International Health Policy Survey

After-hours access to a primary care provider

For high continuity of care, patients would see their own regular doctor or nurse practitioner whenever they needed primary care. Of course all providers cannot be available 24 hours a day, seven days a week, so the next-best alternative is usually considered to be another primary care provider in the same office, or in the community.

However, in the 2016 Health Care Experience Survey of Ontarians aged 16 and older who had a primary care provider and who had visited the emergency department in the previous 12 months, 41.6% of respondents reported that their most recent visit to emergency was for a condition they thought could have been treated by their primary care provider if that provider had been available.^[46] This suggests some Ontarians go to the emergency department for primary care because they are not able to find alternative primary care such as an after-hours clinic in their community, or are not aware that it exists.

Differences in health care practices between urban and rural areas complicate regional comparisons for this indicator. Research suggests that in rural areas, a greater proportion of primary care is delivered through emergency departments, particularly in areas where few after-hours services are available.^[47,48]

Findings and variations

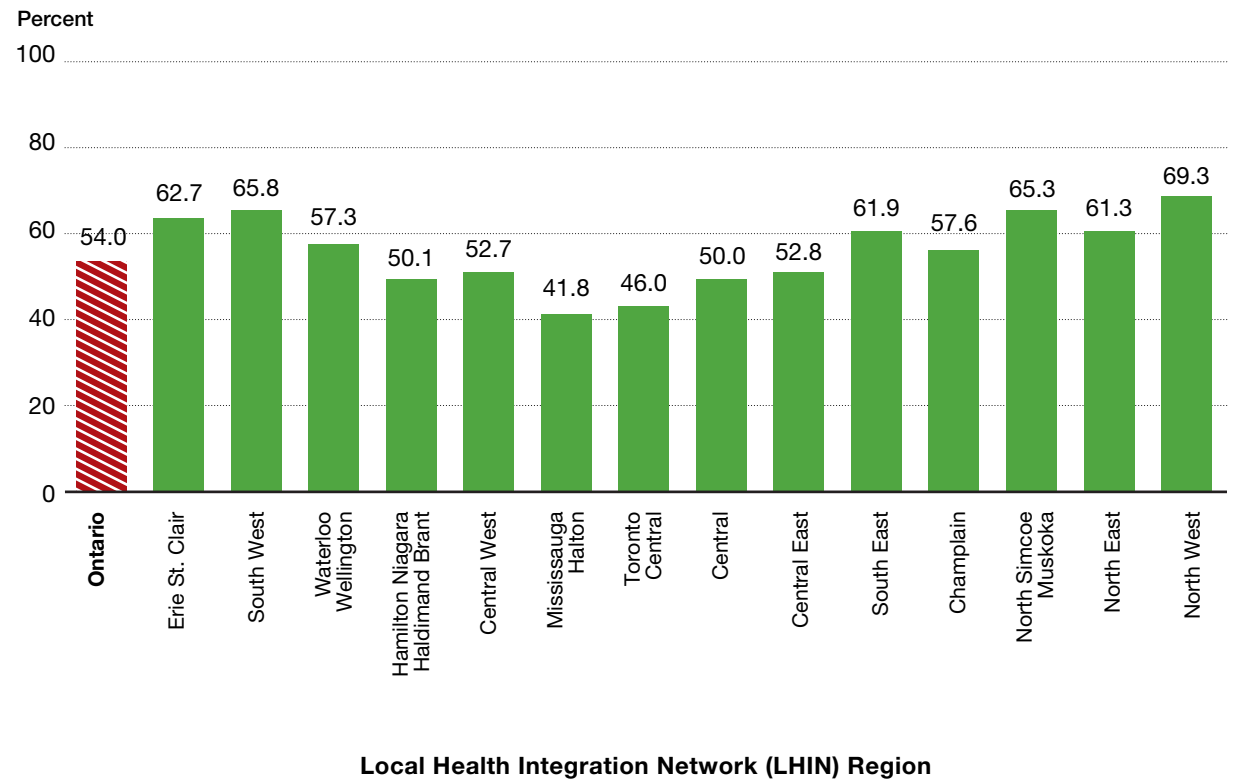
This indicator measures the proportion of people surveyed who reported having difficulty accessing medical care without going to an emergency department when they needed care outside normal office hours. A lower percentage is better in this indicator.

- In 2016 in the Health Care Experience Survey, 54% of Ontarians aged 16 and older reported difficulty accessing primary care without going to an emergency department when they needed care outside normal office hours.
- In the 2016 Commonwealth Fund International Health Policy Survey, 56% of Ontarians aged 18 and older reported difficulty accessing care outside normal office hours, placing the province in the middle of the pack among 10 socioeconomically similar countries such as Switzerland and the United States, while the Netherlands performed best at 25%.
- Results for the Health Care Experience Survey varied significantly between the province's LHIN regions in 2016, from 41.8% in the Mississauga Halton LHIN region to 69.3% in the North West LHIN region. (**Figure 3.3**)
- In the Health Care Experience Survey, 71.6% of rural residents reported difficulty accessing medical care outside normal office hours in 2016, while the rate for urban residents was 51.1%.

Indicator: After-hours access to a primary care provider

This indicator measures the percentage of people surveyed who reported having difficulty accessing medical care without going to an emergency department when they needed care outside normal office hours.


FIGURE 3.3 Percentage of people aged 16 and older who reported that getting access to care on an evening or weekend, without going to the emergency department, was very difficult or somewhat difficult, in Ontario, by LHIN region, 2016



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



Photo of Shawn
taken by Jason Spun.

 REAL-WORLD EXPERIENCES

Shawn Dookie: Building relationships with patients

One of the main reasons Shawn Dookie became a nurse practitioner was to be able to provide his patients with ongoing, continuous care that would help them when they were sick, but also benefit their overall health in the longer term. “I like building a relationship with people,” says Dookie. “I like not having to rush through a conversation with a patient. I can take my time and provide health teaching and really explain things to people so they can own their own health.”

That approach to caring for patients proved invaluable when Dookie started to work as a nurse practitioner in Thunder Bay. He had previously been a registered nurse, but returned to university to complete the nurse practitioner program that would allow him to take on additional responsibilities such as diagnosing and treating common illnesses, performing physical check-ups and prescribing certain medications.

At the nurse practitioner-led clinic where he first worked a nurse practitioner, Dookie found he needed ongoing connections with his patients just to learn enough about their lives to be able to care for them in the way he wanted. Many came from Indigenous, francophone, or socioeconomically disadvantaged communities that he had little

experience with when he was a registered nurse working in Toronto hospitals.

“The culture is much different up here, where you (patients) don’t believe what the health care providers tell you until you’ve had the chance to really build up some trust with them,” says Dookie.

Cultural differences meant not only that Dookie had to take the time to get to know his patients, but also that he sometimes had to treat their health issues differently than he might have for patients in the south. For example, he learned that with some patients he had to take a slower, more conservative approach at first to treat chronic conditions such as diabetes, until he gained their confidence.

“You really have to take that time to build a relationship with people,” he says. Dookie also found himself serving a group of patients with complex needs, who had chronic conditions that required continuous care. Many had had difficulty obtaining primary care elsewhere.

“So you get someone who’s applied to three different clinics and been declined because of their past medical history,” explains Dookie. “If you’re a healthy young person it’s easy to get care – but if you’re a 40-something-year-old person with

schizophrenia, diabetes and a head injury, nobody’s going to want to take you on as a patient, so that tended to be a lot of the patients we were taking on at the nurse practitioner-led clinic.”

Dookie believes nurse practitioners, while they can’t replace doctors, can play a positive role in improving access to health care in the province.

“I think that we can manage a lot of things like chronic disease, like preventative care, like public health. We can manage a lot of that stuff very safely and effectively, if we are given the right resources.”

Dookie has recently moved on to work at another health centre in Thunder Bay, but takes the same approach to building trust, understanding and relationships with patients that he established at his previous job, so that he can provide them with the best care possible.

Thinking about what would make for a perfect day as a nurse practitioner, Dookie says: “I’d feel like I made an impact on their lives, I’d feel like their chronic disease is getting better, I’d feel like their knowledge of their illness is getting better, and I can directly attribute that to the impact that I am having on their care and the time that I’ve taken to take care of them. So that’s an awesome day.”

Colorectal cancer screening

Ontario's rate of colorectal cancer is one of the highest in the world, and the disease is the second-leading cause of cancer in the province.[49] An estimated 9,200 Ontarians were diagnosed with colorectal cancer in 2015, and about 3,350 people in the province died from it that year.[50] However, colorectal cancer is highly treatable if caught early. When it is caught early, it's less likely to spread, patients usually have more treatment options, and about 90% recover fully after treatment.[51]

Ontario's screening program for colorectal cancer, ColonCancerCheck, recommends that people between 50 and 74 years of age with an average risk of colon cancer (those who have no symptoms and no family history of colorectal cancer) have a fecal occult blood test every two years that checks for blood in the stool.[52] The test is a simple one that can be done at home with a kit provided by a family doctor or nurse practitioner and sent by mail to obtain the result. Test kits can also be obtained by contacting Telehealth Ontario.

Primary care providers play an important role in informing their patients about screening for colorectal cancer and other cancers, and in encouraging patients to get tested.

Findings and variations

This indicator measures the percentage of people aged 50 to 74 who were overdue for colorectal cancer screening, meaning they did not have either a fecal occult blood test within the previous two years, a colonoscopy in the previous 10 years, or a flexible sigmoidoscopy in the previous 10 years. The indicator is slightly different from past years, when the time frame for the flexible sigmoidoscopy was the previous five years. It has been changed to align with ColonCancerCheck screening recommendations.

- The proportion of Ontarians overdue for colorectal cancer screening decreased in recent years, to 38.7% in 2015 from 43.6% in 2011.
- Results for this indicator - for which a lower result is better - varied among Ontario's LHIN regions in 2015, from a low of 34.9% in the North Simcoe Muskoka LHIN region to a high of 42.8% in the North West LHIN region.
- Men were more likely to be overdue for colorectal cancer screening, at 41.5% in 2015, compared to women, at 36.1%. **(Figure 3.4)**
- Among urban residents, those who lived in the lowest-income neighbourhoods had the highest rate of being overdue for colorectal cancer screening in 2015, at 46.5%, while those who lived in the highest-income neighbourhoods had the lowest rate of being overdue, at 32.7%. **(Figure 3.4)**

- People aged 50 to 54 – the youngest among the recommended age group for screening - had the highest rate of being overdue for screening, at 48.4%. **(Figure 3.4)**

DID YOU KNOW?

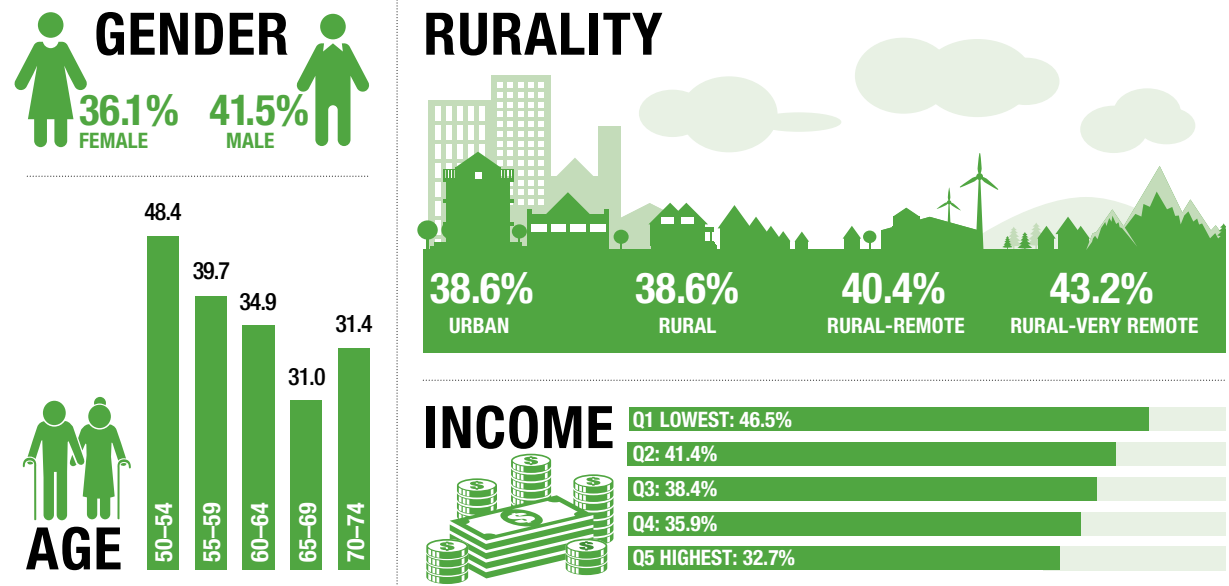


Ontario's ColonCancerCheck screening program appears to have helped reduce inequity in colorectal cancer screening among different population groups in the province. Historically, screening rates have been lower among people with lower incomes. Before the screening program, the difference between screening rates among the lowest- and highest-income groups in the population was widening. After the program was implemented in 2008, the gap started to narrow slightly.[53]

Indicator: Overdue for colorectal cancer screening

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

FIGURE 3.4 Percentage of people aged 50–74 overdue for colorectal cancer screening, by sex*, rural or urban setting*, urban neighbourhood income quintile*, age group, in Ontario, 2015



Data source: Colonoscopy Interim Reporting Tool, Laboratory Reporting Tool, Ontario Health Insurance Plan, Ontario Cancer Registry, Registered Persons Databae, provided by Cancer Care Ontario. *Age-adjusted.

CHAPTER 4

Mental Illness and Addictions


This chapter highlights results for the following Common Quality Agenda indicators related to mental illness and addictions:

- First contact in the emergency department for mental illness or addiction
- Seven-day follow-up after hospitalization for mental illness or addiction
- Hospital readmission within 30 days for mental illness or addiction

Additional results for mental illness and addictions indicators can be found in the Technical Data Table.



Photo of Elgin
taken by Roger Yip.

 REAL-WORLD EXPERIENCES

Elgin: Trust and empathy

Elgin's parents knew their son was in a bad state. He had just graduated from law enforcement training and was looking to get a job with the police force. But long hours working in a hospital kitchen, plus a second job doing business promotions in Toronto's entertainment district left Elgin stressed out, exhausted, and barely getting any sleep. He was suffering from insomnia and started having delusions during the day. "I was talking nonsense, saying all kinds of strange things," Elgin recalls.

His parents rushed him to the emergency department at the hospital in Scarborough where he worked. When the doctors came to see Elgin, he took off running, convinced they were out to get him. He eventually returned to see the doctors.

He was admitted to the hospital's psychiatry department, put in physical restraints, and injected with medication. Doctors diagnosed him with schizophrenia, although he says they didn't do a thorough assessment. Elgin stayed in hospital for six months, watching out the window as the seasons changed. This emergency department visit and hospitalization was Elgin's first experience receiving mental health care.

When he left the hospital, Elgin returned to work and was doing a little better, but he found the medication he had been prescribed made him very tired. "I didn't like how it made me feel, so I

stopped taking it. I had various relapses. It became like a revolving door with me in and out of hospital."

He also experienced stigma around his illness, which affected his relationship with his partner at the time. When they broke up, Elgin became homeless. He stayed at a shelter for a few days and then went back to the hospital for help. "You're not a danger to yourself or anyone else, they told me – we can't admit you," Elgin says.

Two days later, Elgin, experiencing delusions and hearing voices in his head, decided he had to leave the country. He took a taxi from downtown Toronto to Pearson Airport, convinced that he had to fly to Chicago because Michael Jordan wanted him to try out for the Chicago Bulls basketball team. Elgin bolted through the security checkpoint, punching and shoving people who were trying to stop him. He ran down the gangway entrance onto the airplane and into the cockpit with the pilot and co-pilot. After a few minutes, Elgin opened the cockpit door and was immediately pepper-sprayed and tackled to the floor.

After the plane incident, Elgin was taken to two different correctional facilities and says he didn't receive any treatment for his mental illness for three months. "I spent a lot of time banging on the door (of his cell) and yelling, and going back and forth to court," he says. Eventually, he saw a

psychiatrist who reassessed his condition and told him he had bipolar mood disorder, not schizophrenia. He started a new medication and responded well to it. For his court case, he received an absolute discharge on charges of hijacking and assault. "I didn't realize the charges until I was stable," Elgin says. "I started feeling really depressed about what had happened and the people that I had hurt."

Elgin is now married, and he and his wife have a 14-year-old daughter. He tried applying to become a police officer but wasn't successful. At another job he applied to he noticed a sticky note on his application that said: "We can't hire this person because he's schizophrenic and has mental illness." He persisted and became a licenced financial advisor who helps people who have a hard time qualifying for life insurance.

Every four months, Elgin, now 46, visits his long-time psychiatrist. "I'm very fortunate to have a good psychiatrist," he says. "We have a trusting relationship. Now I'm stable." Reflecting on the past 25 years of mental health care, Elgin wishes there was more care, and that people with mental illness had more resources available to them. "People need to really listen to the patient and how they're feeling," he says, "and then follow up with them afterwards."

Reducing the burden of mental illness and addictions



Every year, about two million Ontarians visit their doctor for a mental illness or addiction.^[54] Mental health conditions such as depression, anxiety, schizophrenia, and substance use disorder are collectively among the top causes of disability in Canada,^[55] and can decrease life expectancy by 10 to 20 years.^[56]

People in Ontario living with mental illness or addiction, who include a substantial segment of people living with both,^[57] need better access to both initial and follow-up care. The quality indicator data detailed in this chapter show that many people first receive care from a doctor or psychiatrist for an episode of mental illness or addiction in an emergency department. As well, a substantial proportion of people hospitalized for a mental health condition do not see a primary care doctor or psychiatrist within seven days of discharge, or are readmitted to hospital.

There has been little or no improvement in these indicator results over recent years. However, people may be receiving more mental health care than the indicators show, since the data only cover care provided by either doctors or hospitals, and don't include care provided by others such as nurse practitioners, psychologists, counsellors, social workers and other health care professionals.

Some indicator results vary between regions, and in relation to whether patients live in poorer or richer neighbourhoods. Regional variations may be related to factors such as local need for mental health care, local physician or hospital practices, availability of physicians or community resources, or local socioeconomic conditions, culture or demographics.

These indicators are aligned with the Mental Health and Addictions System Scorecard of indicators being developed to measure the performance of mental health care services in Ontario, in a project led and endorsed by the province's Mental Health and Addictions Leadership Advisory Council. A similar scorecard examining mental health care for children and youth has already been developed.^[58]

Key Finding 1

Access to physician care and care transitions for mental health conditions remain poor

Among people going to the emergency department for a mental illness or addiction, the proportion who did not receive mental health care from a primary care doctor or psychiatrist over the preceding two years remained slightly above 30% between 2006 and 2015. Over the same nine years, for people who were hospitalized for a mental illness or addiction, there was no reduction in hospital readmissions for a mental health condition, and no increase in timely follow-up visits with a primary care doctor or psychiatrist after discharge from hospital.

Key Finding 2

Where people live affects the care they receive

In 2015, there was wide variation between Ontario's LHIN regions in hospital readmissions and follow-up visits with a primary care doctor or psychiatrist for people who were hospitalized for a mental illness or addiction. There was also wide variation between LHIN regions in the proportion of people going to emergency for a mental illness or addiction who did not receive mental health care from a primary care doctor or psychiatrist over the preceding two years.

Key Finding 3

People from poorer neighbourhoods get less follow-up care from a doctor

Among people hospitalized for a mental illness or addiction, the proportion who saw a primary care doctor or psychiatrist within seven days of discharge was lowest for those who lived in the poorest neighbourhoods, and highest for those who lived in the richest ones.

First contact in emergency for a mental illness or addiction

In Ontario as a whole, about one-third of people who visited an emergency department for a mental health condition in 2015 had not received care for a mental illness or addiction, from a primary care doctor or psychiatrist, over the preceding two years.

Among Ontario children and youth aged 10 to 24 who visited emergency for a new mental health condition between 2010/11 and 2013/14, a study found more than half had not received mental health care from a primary care doctor or psychiatrist for that condition over the preceding two years.[59] Another study looked at postpartum visits to the emergency department for a mental health condition, which is one of the most common reasons for postpartum emergency visits. Among Ontario women who made a psychiatric visit to emergency between 2006 and 2012 after giving birth within the previous year, 60.4% had not received mental health care from a doctor since delivery.[60]

A mental health condition can sometimes emerge and become serious very quickly, so that there might not be time for the patient to obtain care from a doctor in the community before the patient reaches a crisis state that requires a visit to emergency.

However, the fact that a substantial segment of patients have their “first contact” for treatment of a mental health issue in an emergency department suggests some people are not receiving care from

a doctor in the community that might prevent a visit to emergency. It's possible some of these patients have accessed resources other than doctors or hospitals – such as nurse practitioners, psychologists, counsellors or social workers – but there are no data available that might show how many have done so.

There are many possible reasons – other than a rapid-onset mental illness – for a first-contact visit to emergency for a mental health- or addictions-related issue. They include not knowing where or how to access services and the stigma and discrimination associated with mental health conditions, which may discourage individuals from seeking support from their own doctor. Another might be lack of access to care or poor coordination of care. In the 2012 Canadian Community Health Survey, among Ontarians aged 15 and older who reported needing mental health care within the preceding year, more than one-third said that their need was either unmet or only partially met.[61]

Findings and variations

This indicator examines first-contact visits to the emergency department for mental health conditions, by measuring the proportion of people aged 15 and older visiting emergency for a mental illness or addiction who did not receive mental health care from a primary care doctor or psychiatrist over the preceding two years.

- Ontario-wide, there has been no improvement in this indicator for nine years. The proportion of people making a first-contact mental health visit to emergency actually increased slightly between 2006 and 2015, to 33.1% from 31.6%. (**Figure 4.1**)

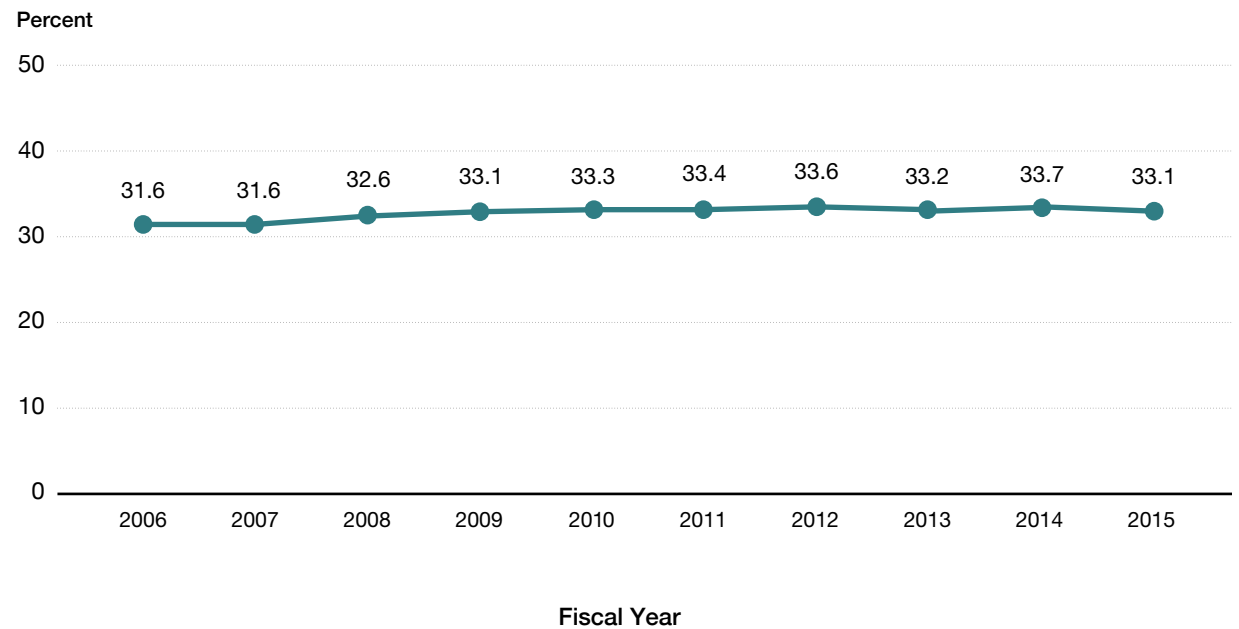
- In 2015, there was wide variation between Ontario LHIN regions in the proportion of people making a first-contact visit to emergency for a mental illness or addiction, ranging from 27.1% in the Toronto Central LHIN region to 40.7% in the North West LHIN region.
- The proportion of people making a first-contact mental health visit to emergency was higher in 2015 in rural areas of Ontario, at 41.3%, than in urban areas, where it was 31.8%.



Indicator: First contact in emergency for a mental illness

This indicator measures the percentage of people, among all those aged 15 and older who visited an emergency department for a mental illness or addiction, who did not receive mental health care from a primary care doctor or psychiatrist during the preceding two years.

FIGURE 4.1 Percentage of people who did not receive mental health care from a doctor or psychiatrist over two years, among people aged 15 and older who visited the emergency department for a mental illness or addiction, in Ontario, 2006–2015



Data source: DAD, OMHRS, OHIP, NACRS, RPDB; provided by the Institute for Clinical Evaluative Sciences.
Note: The standardized rate is adjusted by age and sex using the 2011 Canadian census population.

Follow-up with a doctor after a mental health hospitalization

Every year, about 5 of every 1,000 Ontarians are hospitalized for a mental illness or addiction.[62] For those people, going home or elsewhere in the community after being discharged from hospital can be a difficult transition. They are going from receiving round-the-clock care to having to manage their medications and other aspects of their condition themselves.

Timely follow-up with a family doctor or psychiatrist after discharge from hospital can help smooth this transition, and help ensure whatever treatment, medication adjustment, or assistance is needed gets provided. It may also help prevent a return to hospital.[63]

This indicator does not track post-hospitalization visits to non-physician providers such as psychologists, nurse practitioners, or community mental health and addictions programs. So, the results reported here underestimate the extent of follow-up care mental health patients receive after discharge from hospital.

Findings and variations

This indicator measures the proportion of patients aged 15 and older hospitalized for a mental illness or addiction who were seen by a primary care doctor or psychiatrist within seven days after being discharged from hospital.

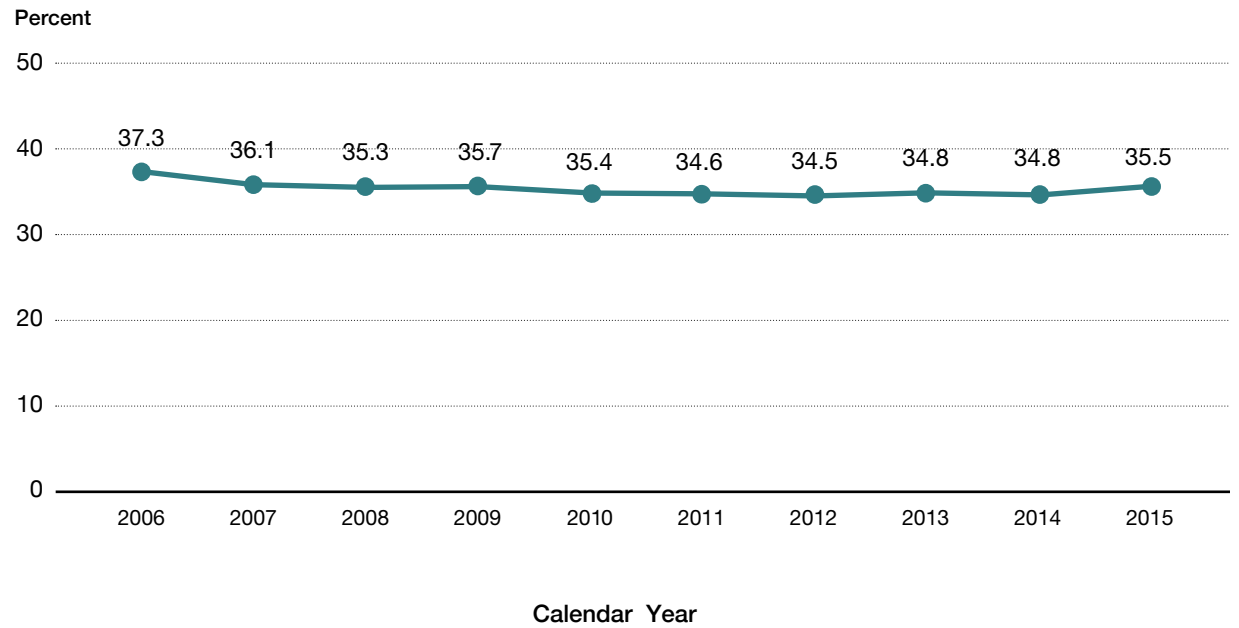
- The proportion of people hospitalized for a mental health condition who were seen by a primary care doctor or psychiatrist within seven days after discharge decreased slightly to 35.5% in 2015, from 37.3% in 2006. There has been no significant change in this indicator since 2011. **(Figure 4.2)**
- Results for this indicator varied substantially between Ontario's LHIN regions in 2015, from 44.8% in the Toronto central LHIN region to 24.3% in the North West LHIN region. This regional variation has persisted over recent years.[64,65]
- Among patients hospitalized for a mental health condition, 33% of those who lived in the poorest neighbourhoods saw a primary care doctor or psychiatrist within seven days of discharge in 2015, compared to 39.6% of patients from the richest neighbourhoods.
- Patients hospitalized for a mental health condition who lived in urban areas had a significantly higher rate of seven-day follow-up with a primary care doctor or psychiatrist, at 36.5%, compared to those who lived in rural locations, for whom the rate was 28.4%.



Indicator: Seven-day follow-up after hospitalization for mental illness or addiction

This indicator measures the percentage of patients aged 15 and older hospitalized for a mental illness or addiction who were seen by a primary care doctor or psychiatrist within seven days after being discharged from hospital.

FIGURE 4.2 Percentage of patients aged 15 and older who were seen by a primary care doctor or psychiatrist within seven days of discharge after being hospitalized with mental illness or addiction, in Ontario, 2006–2015



Data source: DAD, OMHRS, OHIP, RPDB; provided by the Institute for Clinical Evaluative Sciences.
Note: The standardized rate is adjusted by age and sex using the 2011 Canadian census population.

Readmission within 30 days after a mental health hospitalization

Approximately 9 out of every 100 patients admitted to hospital in Ontario for a mental illness or addiction are readmitted within 30 days of discharge. The readmission rate for these patients is slightly higher than for patients hospitalized for surgical treatment, among whom about 7 out of 100 are readmitted, and a bit lower than for patients hospitalized for medical treatment, among whom about 14 out of 100 are readmitted.[66]

Readmission to hospital typically occurs because the patient's condition has worsened after discharge. Looking at readmissions helps us understand whether or not people are getting the continued care they need after they leave hospital.

Patients discharged after hospitalization for mental illness or addiction may be readmitted because they did not have access outside the hospital to the mental health care and support they needed, or because their transition to care outside the hospital was not effectively managed.[67] Or, their condition may have worsened for a reason unrelated to the quality of care they received.

Findings and variations

This indicator measures the proportion of patients aged 15 and older hospitalized for a mental illness or addiction who were readmitted to hospital for a mental health condition within 30 days after being discharged.

- The proportion of patients readmitted to hospital within 30 days for a mental illness or addiction was unchanged in 2015, at 9.2%, compared to 2006, when it was 9.5%. It also remained stable between those years.
- Results for this indicator varied significantly between Ontario's LHIN regions in 2015, from 11.1% in the Toronto Central LHIN region, to 7.8% in the South East, Hamilton Niagara Haldimand Brant, and Erie St. Clair LHIN regions. (**Figure 4.3**)

DID YOU KNOW?



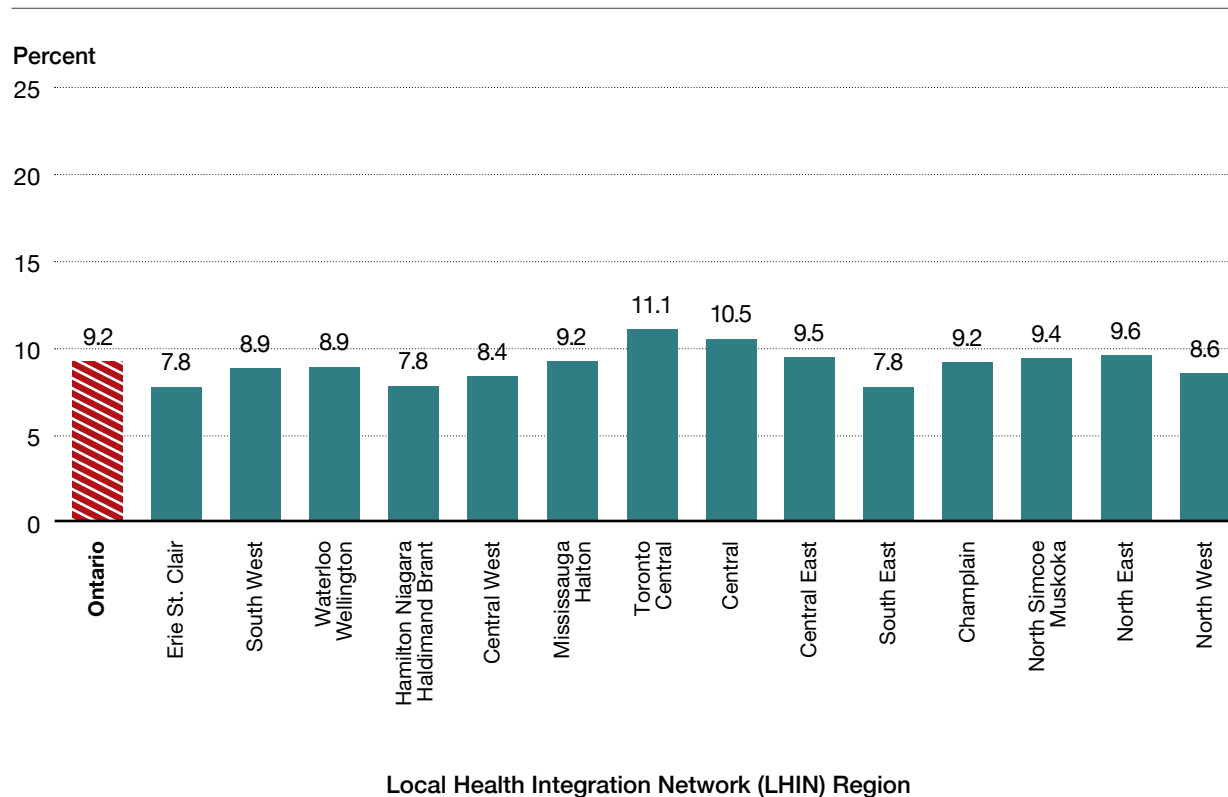
Quality standards that describe what high-quality care looks like, for people with conditions such as major depression, schizophrenia and opioid use disorder, have been and continue to be developed for Ontario by a partnership that includes patients, families and health care professionals.



Indicator: Readmission within 30 days after hospitalization for mental illness or addiction

This indicator measures the percentage of patients aged 15 and older hospitalized for a mental illness or addiction who were readmitted to either the same hospital or a different one for a mental illness or addiction within 30 days after being discharged.

FIGURE 4.3 Percentage of patients aged 15 and older hospitalized for a mental illness or addiction who were readmitted to hospital for a mental health condition within 30 days after being discharged, by LHIN region, 2015



Data source: DAD, OMHRS, RPDB; provided by the Institute for Clinical Evaluative Sciences.
Note: The standardized rate is adjusted by age and sex using the 2011 Canadian census population.

CHAPTER 5

Hospital Care


This chapter highlights results for the following Common Quality Agenda indicators related to timely access to hospital care:

- Wait times in the emergency department
- Wait times for hip replacement, knee replacement and general surgeries
- Wait times for cancer patients to see a surgeon and to have surgery
- Wait times for MRI and CT scans

Additional results for indicators related to hospital care can be found in the Technical Data Table.



Photo of Gordon
taken by Roger Yip.

 REAL-WORLD EXPERIENCES

Gordon: Any wait seems too long

Everything was a blur. Gordon was sitting in a nondescript consultation room in a London hospital. The general surgeon had just told the University of Toronto law and MBA graduate student that tests had come back positive for testicular cancer. From there, Gordon didn't remember much beyond walking in a daze down the hall to the urologist's office. Two weeks later, he had surgery.

"When you get your diagnosis, you're not thinking right," Gordon says. "I remember very little of all that was said. I don't remember much of anything."

Gordon had originally seen his family doctor about pain in his abdomen and was referred to a general surgeon with a suspected hernia. He waited about four weeks to see the surgeon, who, after some tests that same day, determined it was cancer. The first cancer surgery was urgent, Gordon says, so he didn't even think about having to wait. That all changed when the surgeon recommended a second, more complicated surgery that involved removing abdominal lymph nodes.

First, Gordon had to wait for pathology results, which took five weeks, followed by another four-week wait for his first meeting with the surgeon who would remove the lymph nodes. After

he met with the surgeon, Gordon's second surgery was scheduled for four weeks later, which brought his total wait time to about 13 weeks from the time he first found out he would need the second surgery.

"The waiting is frustrating because you know what needs to happen, but it's hard not knowing when it's going to happen, when you're going to get a call," Gordon says. "It's hard to live a life between when you find out what needs to happen and when it actually happens. It's a psychological barrier that I didn't have enough help with, or know to reach out for help to manage the anxiety from waiting."

During the wait for the second surgery, Gordon started skipping some of his university classes, and began to retreat from his normal life. He eventually stopped going to class altogether and didn't see any friends. "The last week before my surgery I don't think I left the house," Gordon says. "I didn't have the mental energy to go on acting as if things were normal."

As hard as it was to wait for the surgery, Gordon is realistic about wait times. "When you're a patient, any wait time seems like it's too long," he says. "But I also understand that it's not as easy

as adding more surgeons and more operating rooms to shorten the wait times. I wouldn't want the wait times to come at the expense of anything else."

The surgery was successful, and Gordon began chemotherapy a few months later. Over the summer, he was able to make up for the classes he had missed. Looking back on his care, Gordon says the providers were all individually very good, but communication could have been better with him and between themselves. Gordon spent a lot of time wondering when the surgeon's office would call, not knowing what was going on. Doctors and nurses sometimes relied on him to convey his medical history and didn't appear to have his complete files. When Gordon received home care after his second surgery, the nurses had "virtually no information" about him when they arrived the first time. "It was frustrating and very tiring to keep summarizing my story, especially as my medical history got longer and longer," Gordon says. "It's tiring at any time, and when you're already mentally and emotionally drained, it was the last thing I needed."

Gordon is slated to complete his JD/MBA (law and business) degree in 2019.

Timely access to inpatient and outpatient care



This chapter of *Measuring Up* focuses on wait times for hospital care, and this year for the first time reports on the average amount of time patients waited to see a doctor in the emergency department, and on the amount of time patients who underwent cancer surgery waited to see a surgeon.

The average wait time to see a doctor in the emergency department, which was up slightly in 2016/17, has remained relatively stable in recent years, even as the number of patient visits to emergency has increased. The average time spent by patients in the emergency department grew to more than 15 hours for those who were admitted to hospital in 2016/17.

For patients who need cancer surgery, the wait to see a surgeon is measured from the date the referral is received by the surgeon's office or a central intake office to the date of the patient's first consultation with the surgeon. The data are available only for cancer patients who ultimately had surgery.

The chapter also includes indicator results measuring the amount of time patients waited to have cancer, hip replacement, knee replacement or general surgery, after making the decision together with their surgeon to have the surgery.

For both kinds of wait times, delays related to a patient's availability and/or condition are not included in the wait time calculation.

In Ontario, maximum recommended wait times have been established for waits to see a surgeon and waits to have surgery performed. The recommended waits vary by priority levels that are based on the patient's condition, with Priority 1 being the most urgent and Priority 2, 3 and 4 surgeries being progressively less urgent. Wait time indicator results for Priority 2, 3 and 4 surgeries are detailed in this chapter. Priority 1 surgeries are not included as they involve patients who are seen and have their surgery done immediately.

Indicator results show shrinking percentages of patients had their Priority 2, 3 or 4 hip or knee replacement surgery within wait targets.

More than 9 out of 10 patients had their Priority 3 or 4 general surgery performed within wait targets, and just over 8 out of 10 had their Priority 2 general surgery performed within the wait target.

About 6 out of 7 Ontario patients who had cancer surgery had their first surgical appointment within target wait times in 2016/17 – but that left 1 in 7 waiting longer than they should. A greater

proportion of cancer surgeries were completed within the wait target for each in 2016/17, but 22% of Priority 2 cancer surgeries were not completed within the maximum recommended wait time.

Indicator results measuring how long patients waited for MRI and CT scans are presented as well in this chapter for Priority 2, 3 and 4 cases. (In Priority 1 cases the patients have their scans done immediately.) The proportion of MRI and CT scans completed within wait time targets increased in some instances, but substantial percentages of Priority 3 and 4 MRI and CT scans were not completed within target.

Key Finding 1

Waits increase for emergency department patients admitted to hospital

The average time spent in the emergency department increased by 10.9% over the past year for patients admitted to hospital, and remained the same for patients who were not admitted. The average time all patients waited in emergency to be seen by a doctor has remained relatively stable over the most recent four years, though it increased slightly over the past year.

Key Finding 2

Fewer hip, knee surgeries meet wait targets

The percentage of Priority 2, 3 and 4 hip and knee replacement surgeries completed within target wait times all decreased over the past year, after fluctuating over the previous seven years. The proportion of surgeries not performed within target continues to be substantially greater for Priority 2 and 3 surgeries than for Priority 4.

Key Finding 3

Wait targets to see a surgeon met for most cancer patients

The majority of patients who had Priority 2, 3 or 4 cancer surgery had their first surgical appointment within target wait times in 2016/17, but about 1 in 7 did not. The proportion of cancer surgeries completed within target increased overall between 2008/09 and 2016/17, but room for improvement remains.

Key Finding 4

More patients getting MRIs within wait targets

The proportions of Priority 2, 3 and 4 MRI scans completed within target wait times increased over the past year, though almost 7 out of 10 patients did not get their Priority 4 MRI scans completed within target. For CT scans, the proportion of Priority 2 scans completed within target increased over the past two years, while the proportions of Priority 3 and 4 scans completed within target decreased.

Wait times in the emergency department

There were about 5.7 million visits to Ontario emergency departments in 2016/17, an increase of about 480,000 visits, or 9%, since 2011/12. Despite this growth in patient visits, the average amount of time patients spend in the emergency department has changed little, and the average amount of time they wait to see a doctor has not changed much either.

The amount of time a patient waits to see a doctor in emergency, or “time to physician initial assessment,” is measured from the time the patient is assessed (“triaged”) or registered, whichever comes first, to when they are first seen by the doctor.

The total amount of time a patient spends in the emergency department, or their length of stay, is measured from the time the patient is triaged or registered to when they are discharged from emergency to go home, or are admitted to an inpatient bed, or are transferred to another acute care facility. For the purpose of measuring length of stay, patients not admitted to hospital are divided into acuity categories according to the urgency of their condition, based on the Canadian Triage and Acuity Scale hospitals use to triage emergency patients. Length of stay in emergency is measured in a separate category for patients who are admitted to hospital.

High-acuity patients have conditions that may threaten their lives and require immediate aggressive intervention; or that are a potential threat to life or limb function and require rapid medical intervention; or that could potentially progress to a serious problem requiring aggressive or rapid intervention. Low-acuity patients have conditions that would benefit from medical intervention or reassurance within two hours; or for which investigation and treatment could be delayed or referred to other areas of the hospital or health system.[68]

Findings and variations

These indicators measure the average amount of time patients waited in emergency before they saw a doctor, and patients’ average length of stay in the emergency department.

Wait time to see a doctor

- The average amount of time patients waited in emergency to see a doctor increased slightly over the past year, to 1.5 hours from 1.4 hours.
- Between 2011/12 and 2016/17, patients’ average wait in emergency to see a doctor decreased slightly to 1.5 hours from 1.6 hours.
- The average time patients waited in emergency to see a doctor varied among Ontario’s LHIN regions from 1.8 hours in the Erie St. Clair LHIN region to 1.2 hours in the South West, Central and North West LHIN regions, in 2016/17.

Length of stay

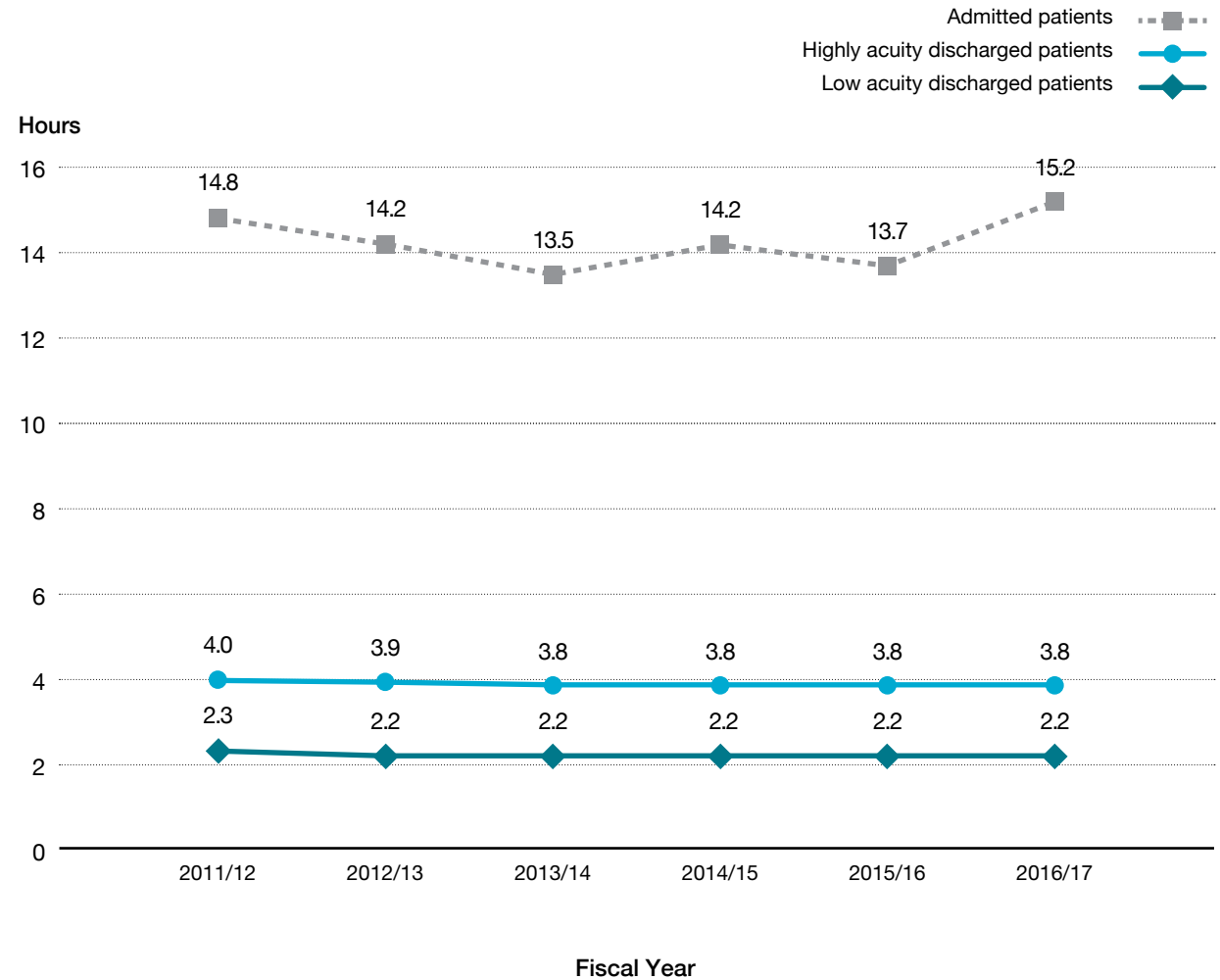
- For patients who were admitted to hospital, the average length of stay in emergency increased 10.9% to 15.2 hours in 2016/17 from 13.7 hours in 2015/16, and was higher than the 14.8-hour average length of stay in 2011/12. (**Figure 5.1**)
- For high-acuity patients who were not admitted to hospital, the average length of stay in emergency was the same in 2016/17 as in 2015/16, at 3.8 hours, which was lower than the 4-hour average length of stay in 2011/12. (**Figure 5.1**)
- For low-acuity patients who were not admitted to hospital, the average length of stay in emergency was 2.2 hours in 2016/17 and has been stable since 2011/12, when it was 2.3 hours. (**Figure 5.1**)
- The average stay in emergency for patients who were admitted to hospital was more than twice as long in the Central West LHIN region, at 19.6 hours, as in the Waterloo Wellington LHIN region, at 8.7 hours, in 2016/17.



Indicators: Time spent in the emergency department

These indicators measure the average amount of time patients spent in emergency before they saw a doctor – or time to physician initial assessment, and patients’ average length of stay in the emergency department.

FIGURE 5.1 Average time spent in the emergency department, by patient acuity, in Ontario, 2011/12 to 2016/17



Data source: National Ambulatory Care Reporting System (NACRS), Canadian Institute of Health Information (CIHI) provided by Cancer Care Ontario (CCO)

Wait times for hip replacement, knee replacement and general surgery

Along with cancer surgeries, hip and knee replacement surgeries were among the key health services that were the initial focus of the Wait Time Strategy launched in Ontario in 2005. That strategy has since been expanded to include all surgeries and time spent in emergency departments.[69]

The number of Priority 2, 3 and 4 hip replacement surgeries performed in total annually in Ontario increased by 45% over the past eight years, to 16,355 from 11,292, while the total number of Priority 2, 3, and 4 knee replacement surgeries rose by 35%, to 27,773 from 20,550. For both hip and knee replacements, the number of Priority 4 surgeries increased substantially, while Priority 2 and 3 surgeries decreased substantially.

Priority 2, 3 and 4 cancer surgeries, by comparison, increased 15.6% over the past eight years, to 48,896 from 42,285. Over the past four years, Priority 2, 3 and 4 general surgeries increased 5.7%, to 82,005 from 77,579.

The maximum recommended wait time to have hip or knee replacement surgery performed in Ontario is 42 days (6 weeks) for Priority 2, 84 days (12 weeks) for Priority 3, and 182 days (26 weeks) for Priority 4. For general surgeries, the maximum recommended wait is 28 days (4 weeks) for Priority 2, 84 days (12 weeks) for Priority 3, and 182 days (26 weeks) for Priority 4.

General surgeries include procedures such as gallbladder surgery, hernia surgery or acid reflux surgery, and do not include orthopedic, cancer, cardiac, eye or pediatric surgeries.

Findings and variations

These indicators measure the percentage of patients who had their hip replacements, knee replacements or general surgeries performed within wait targets.

Knee replacement

- 51% of patients who had Priority 2 knee replacement surgeries had them completed within the target wait time in 2016/17, while the proportion was 59% for Priority 3 surgeries and 80% for Priority 4 surgeries, which are the most common.
- There has been fluctuation in knee replacement surgeries performed within the target wait for all priority levels over the past eight years. The proportions of Priority 2, 3 and 4 knee replacements performed within target were all slightly lower in 2016/17 than in 2008/09. As well, there was a decline in performance for all priorities over the past year, with Priority 2 surgeries within target falling to 51% from 66%. (**Figure 5.2**)
- The proportion of patients whose Priority 4 knee replacement surgery was completed within the wait target varied widely between Ontario's LHIN regions, from 96% in the Central LHIN region to 48% in the South West LHIN region.

Hip replacement

- 58% of patients who had Priority 2 hip replacement surgeries had them completed within the target wait time in 2016/17, while the rate was 63% for Priority 3 surgeries and 84% for Priority 4 surgeries.
- The proportion of patients whose Priority 2, 3 or 4 hip replacement surgery was performed within target wait times fluctuated narrowly between 2008/09 and 2015/16. There was a decline for all priority levels in 2016/17, particularly for Priority 2 surgeries, for which the proportion within target decreased to 58% from 72%.
- The proportion of patients whose Priority 4 hip replacement surgery was completed within the wait target varied widely between Ontario's LHIN regions in 2016/17, from 98% in the Central LHIN region to 50% in the South West LHIN region.

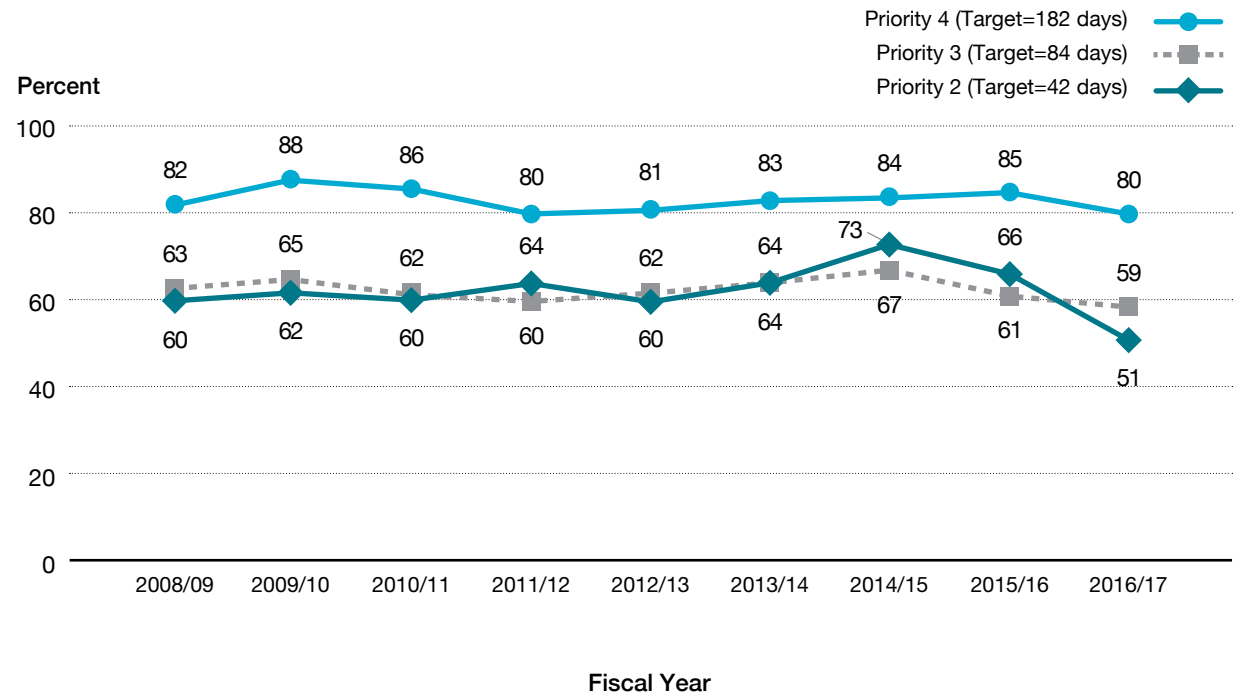
General surgery

- In 2016/17, 82% of patients who had Priority 2 general surgeries had them completed within the target wait time, while the rate was 92% for Priority 3 surgeries and 97% for Priority 4 surgeries.
- The proportion of patients whose Priority 2, 3 or 4 general surgery was performed within wait targets remained fairly consistent for all priority levels between 2012/13 and 2016/17.

Indicators: Waits for hip replacement, knee replacement and general surgeries

These indicators measure the percentages of patients who had their Priority 2, 3 or 4 hip replacements, knee replacements or general surgeries performed within the target wait times for each, by priority level.

FIGURE 5.2 Percentage of knee replacement surgeries completed within target wait time, by priority level, in Ontario, 2008/09–2016/17



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

Wait times for cancer patients to see a surgeon and to have surgery

Seeing a surgeon and having surgery performed quickly are important for cancer patients, whose cancers may grow or spread to other parts of their body if they wait too long.

Measuring Up is presenting data for the first time this year on cancer surgery patients' wait to see a surgeon, in addition to the data on their wait to have surgery performed that was provided in previous years' reports. Having information on both these wait times will provide a more complete view of whether patients are receiving the care they need in a timely manner. Both wait times exclude delays related to a patient's availability and/or condition. Cancer surgery is the only surgery for which a full year of data on the wait to see a surgeon was available to report.

Recommended targets for both waits vary by the priority level assigned by the surgeon to the patient's surgery. The maximum recommended wait target for a first surgical appointment is 10 days for Priority 2 cancer surgery, 21 days (3 weeks) for Priority 3, and 35 days (5 weeks) for Priority 4. The maximum recommended wait target to have cancer surgery performed is 14 days (2 weeks) for Priority 2, 28 days (4 weeks) for Priority 3, and 84 days (12 weeks) for Priority 4.

In Priority 1 cases (not included in these data) there is high suspicion of cancer or a biopsy is

positive, and a life- or limb-threatening condition is involved. For Priority 2 there is high suspicion of cancer or a positive biopsy; for Priority 3 there is a high suspicion of cancer that does not meet the criteria for Priority 2 or 4; and for Priority 4 there is intermediate suspicion of cancer or a positive biopsy. The majority of cases are Priority 3.

Findings and variations

These indicators measure, among patients who had cancer surgery, the percentage who had their first surgical appointment within the target wait time to see a surgeon, and the percentage who had their surgery performed within the target wait time to have the surgery performed.

Wait to see a surgeon

- In 2016/17, the proportion of patients seen by a surgeon within the target wait time was 86% for Priority 2 cancer surgeries, 87% for Priority 3 surgeries, and 83% for Priority 4 surgeries.
- The proportion of patients seen by a surgeon within the target wait time for Priority 3 cancer cases varied among Ontario's LHIN regions, from 96% in the Central West LHIN region to 79% in the North East LHIN region. **(Figure 5.3)**

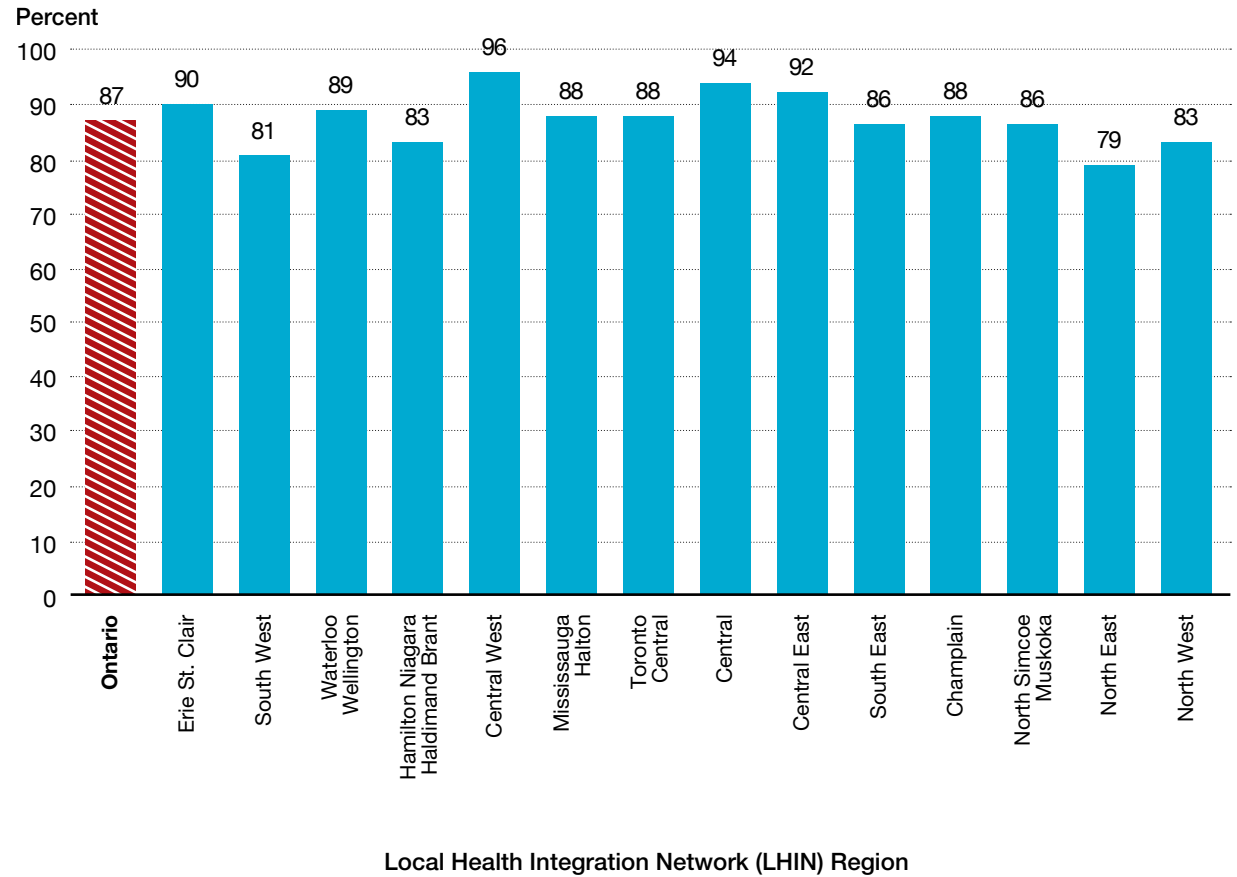
Wait to have surgery performed

- 78% of patients who had Priority 2 cancer surgeries had them performed within the target wait time in 2016/17, while the rate was 85% for Priority 3 surgeries and 93% for Priority 4 surgeries.
- The proportion of cancer surgeries that met the target wait generally increased year-over-year between 2008/09 and 2015/16 for all priority levels, and increased substantially over that period for Priority 2 and 3 surgeries. The proportion of Priority 2 and 4 surgeries performed within target decreased slightly in 2016/17, while the proportion of Priority 3 surgeries completed within target increased slightly.

Indicators: Wait times for cancer patients to see a surgeon and to have surgery

These indicators measure, among patients who underwent cancer surgery, the percentage who had their first surgical appointment within the target wait time, and the percentage who had their surgery performed within the target wait time, by priority level.

FIGURE 5.3 Percentage of Priority 3 cancer patients who had their first surgical appointment within the target wait time of 21 days, by LHIN, 2016/17



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

Wait times for MRI and CT scans

Having a patient undergo a CT (computerized tomography) or MRI (magnetic resonance imaging) scan is often a key step in medical diagnosis and decision-making, and the use of both is rising quickly in Ontario. The number of Ontarians who had a Priority 2, 3 or 4 CT scan increased 37.2% between 2012/13 and 2016/17, to 932,996 from 680,167. Over the same period, the number who had a Priority 2, 3 or 4 MRI scan rose 32.3%, to 719,637 from 543,785.

For CT scans, the greatest increase over the four-year period – 72% – was in the number of people who underwent Priority 2 scans. For MRI scans, the greatest increase was 44%, also in the number of people who had Priority 2 scans.

Wait time targets for both types of scans are the same and are measured from the date the diagnostic imaging facility receives the order for the scan, to the date the patient has the scan, minus any periods of time when the patient is unavailable for the procedure due to patient-related reasons. The maximum wait time targets for MRI and CT scans are 48 hours for Priority 2 scans, 10 days for Priority 3, and 4 weeks for Priority 4.

Findings and variations

These indicators measure the percentage of patients who had their CT or MRI scans performed within the target wait times, by priority level.

CT scans

- The proportion of patients who had their Priority 2 CT scan completed within the provincial target wait time increased to 96% from 92% between 2012/13 and 2016/17. Over the same period, the proportion of patients who had their Priority 3 scan done within target fell to 60% from 65%, and to 67% from 80% for Priority 4 scans.
- In 2016/17, there was wide variation between Ontario's LHIN regions in the proportion of people whose Priority 4 CT scan was completed within the target wait time, from a high of 91% in the Central East LHIN Region to a low of 48% in the Hamilton Niagara Haldimand Brant LHIN region.

MRI scans

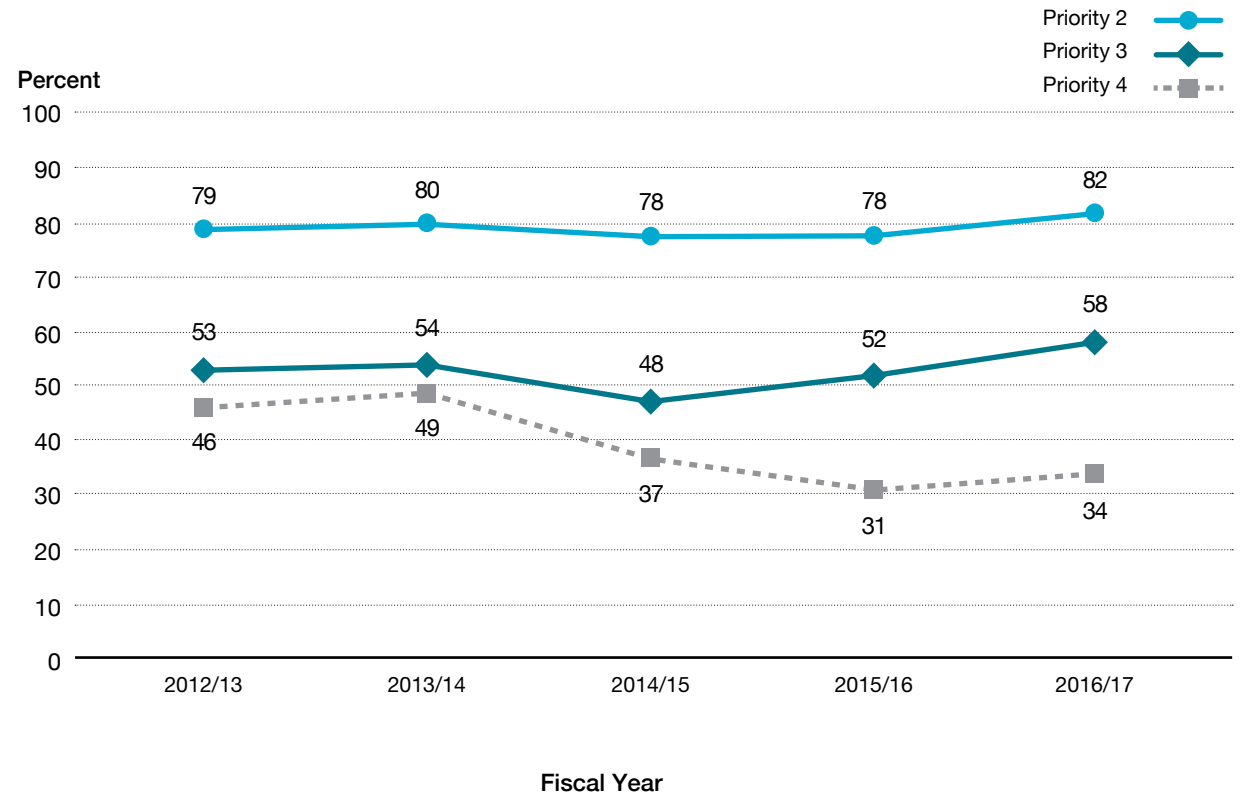
- Between 2012/13 and 2016/17, the proportion of patients who had their MRI scan completed within the target wait time increased to 82% from 79% for Priority 2 scans, and to 58% from 53% for Priority 3, while falling to 34% from 46% for Priority 4. (**Figure 5.4**)
- In 2016/17, there was wide variation between Ontario's LHIN regions in the proportion of people whose Priority 4 MRI scan was completed within target, from a high of 54% in the Central East LHIN Region to a low of 20% in the Mississauga Halton LHIN region.



Indicators: Wait times for MRI and CT scans

These indicators measure the percentages of patients who had their Priority 2, 3 or 4 CT or MRI scan performed within target wait times, by priority level.

FIGURE 5.4 Percentage of MRI scans completed within target wait time, by priority level, in Ontario, 2012/13 to 2016/17



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

CHAPTER 6

System Integration

This chapter highlights results for the following Common Quality Agenda indicators related to health system integration:

- Follow-up after hospitalization for chronic obstructive pulmonary disease or heart failure
- Patients in hospital waiting for care elsewhere
- Visits to emergency for conditions people thought could have been treated by their primary care provider

Results for additional system integration indicators can be found in the Technical Data Table.

Care in the right place at the right time



A patient is considered to be receiving high-quality care when they receive the right medical treatment at the right time in the right place – from health professionals who are able to work seamlessly together in the best interest of that patient.[70] For high-quality care to be achieved, the health system providing it needs to be well-integrated, with all its parts interacting efficiently.

But in Ontario, patients are sometimes not getting the care they need at the right time in the right place. For example, follow-up visits with a physician within seven days after discharge from hospital are declining among patients hospitalized for chronic obstructive pulmonary disease or heart failure, even though having those visits is considered to help those patients better manage their conditions.

As well, patients well enough to leave hospital often have to wait there for home care or a place in a long-term care home to become available, while they occupy a hospital bed that may be needed by other patients who require hospital care. And, many Ontarians report going to the emergency department for a health issue they believe could have been dealt with by their regular primary care provider, if that provider had been available.

Quality indicator results detailed in this chapter show some aspects of integration in

Ontario's health system are deteriorating rather than improving. Follow-up with a physician after hospitalization for chronic obstructive pulmonary disease or heart failure is not as frequent as it should be and is declining. The proportion of days hospital beds are occupied by people waiting for care elsewhere increased last year after three years of decline. The percentage of visits to the emergency department that were made for conditions perceived by patients as treatable by a regular primary care provider varies widely across the province, and shows a correlation to access to after-hours care as reported by patients.

Key Finding 1

Fewer patients with heart failure or chronic obstructive pulmonary disease see a doctor after leaving hospital

The percentage of patients who saw a family doctor or specialist within seven days of discharge after hospitalization for heart failure declined to 45.3% from 50.2% between 2005/06 and 2015/16. Similarly, the percentage of patients who saw a family doctor or specialist within seven days of discharge after hospitalization for chronic obstructive pulmonary disease declined to 35.2% from 39.2% over the same period. Both these findings mirror a similar lack of improvement in follow-up visits after hospitalization for mental illness or addiction, which is detailed in Chapter 4.

Key Finding 2

More hospital beds are occupied by patients waiting for care elsewhere

In 2015/16, on average, 13.9% of inpatient days – meaning 13.9% of the total of all the days each of every individual hospital bed in Ontario was occupied by a patient – were used for patients waiting to receive care elsewhere. These “alternate level of care” patients would have been more appropriately cared for in a long-term care home, in a rehabilitation hospital, at home, or in another setting, depending on their condition. The percentage of inpatient days used by alternate level of care patients rose in 2015/16 for the first time since 2011/12.

Key Finding 3

Visits to emergency for conditions people thought could have been treated by their primary care provider vary by region

There was wide variation across the province’s LHIN regions and sub-regions in the percentage of people who reported that their emergency department visit was for a condition that could have been treated by their primary care provider. The variation in sub-regions was highly correlated with reported difficulty accessing after-hours care.

Follow-up with a physician after hospitalization

The transition from hospital to home may be a difficult period for patients during which their condition can deteriorate if it is not managed properly. People who were hospitalized for heart failure or chronic obstructive pulmonary disease (COPD) are at particularly high risk of needing to return to hospital within 30 days of leaving.[71]

A follow-up visit with a health care professional like a physician soon after discharge from hospital may be helpful to improve the patient's ability to manage their condition and reduce the need for rehospitalization.[72]

The indicator reported here includes only follow-up visits with a family doctor or a specialist, and it is possible that people who were hospitalized with chronic obstructive pulmonary disease or heart failure saw another health professional after discharge.

The readmission rate in Ontario for patients hospitalized for heart failure was 20.1% in 2015/16, and 19.0% for those hospitalized for chronic obstructive pulmonary disease. These rates have not changed substantially since 2013/14.[73]

Findings and variations

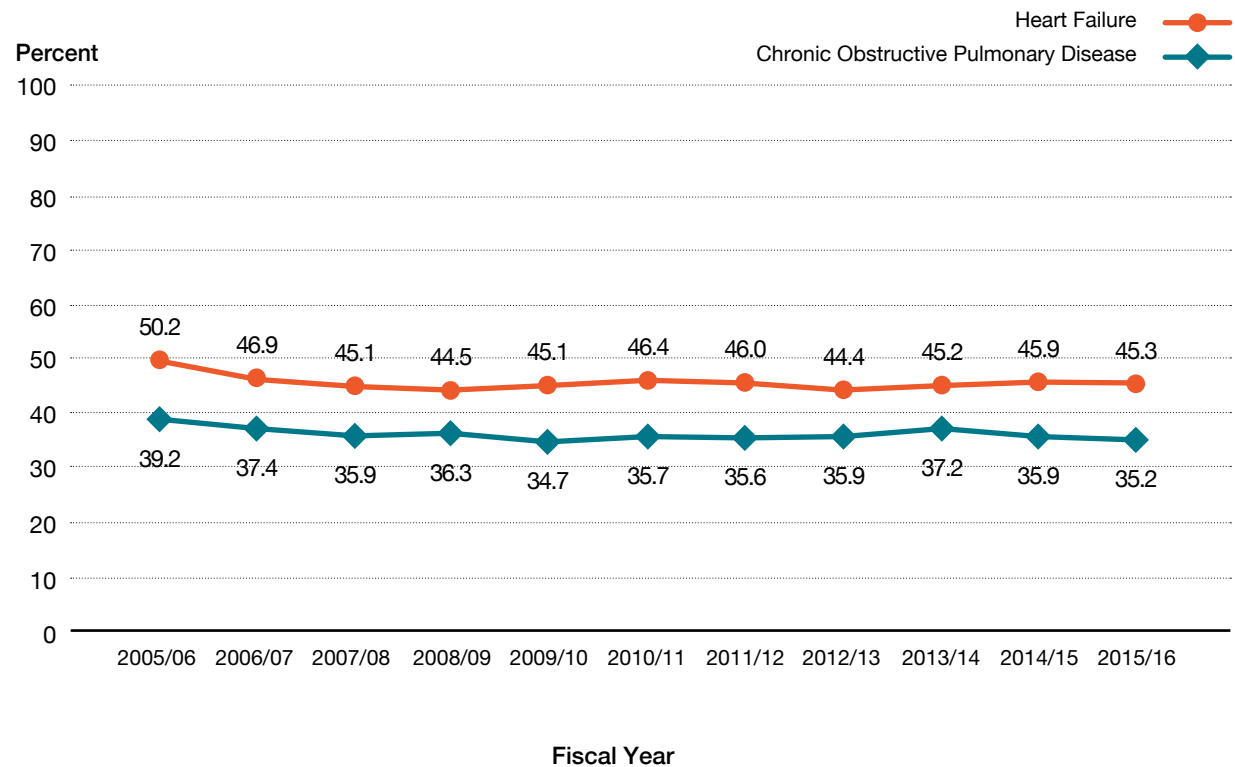
This indicator measures the percentage of patients who saw a family doctor or specialist within seven days of discharge after being hospitalized for heart failure or chronic obstructive pulmonary disease.

- The proportion of patients who saw a family doctor or specialist within seven days of discharge after hospitalization for heart failure declined to 45.3% from 50.2% between 2005/06 and 2015/16. (**Figure 6.1**)
- The proportion of patients who saw a family doctor or specialist within seven days of discharge after hospitalization for chronic obstructive pulmonary disease declined to 35.2% from 39.2% between 2005/06 and 2015/16. (**Figure 6.1**)
- In 2015/16, there was wide variation among Ontario's LHIN regions in the proportion of patients who saw a family doctor or specialist within seven days of discharge after hospitalization for heart failure, ranging from a high of 54.9% in the Mississauga Halton LHIN region to a low of 25.3% in the North West LHIN region.
- There was also wide variation in 2015/16 among LHIN regions in the proportion of patients who saw a family doctor or specialist within seven days of discharge after hospitalization for chronic obstructive pulmonary disease, ranging from 46.7% in the Central West LHIN region to a low of 26.2% in the North East LHIN region.

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

These indicators measure the percentages of patients who were seen by a family doctor or specialist within seven days of discharge after being hospitalized for chronic obstructive pulmonary disease or heart failure.

FIGURE 6.1 Percentage* of patients who saw a family doctor or specialist within seven days of discharge after hospitalization for chronic obstructive pulmonary disease or heart failure, in Ontario, 2005/06 to 2015/16



Data source: Discharge Abstract Database, Ontario Health Insurance Plan Database and Institute for Clinical Evaluative Sciences Physician Database, provided by the Institute for Clinical Evaluative Sciences. *Age- and sex-adjusted.

Patients in hospital waiting for care elsewhere

There are times when hospital patients are not able to leave even though they don't need to be in the hospital any more. These patients may no longer require the care only a hospital can provide, but do need an “alternate level of care” such as that which can be provided by a long-term care home, a rehabilitation centre, or home care services.

However, hospital patients sometimes have to wait for the alternate level of care they need, and while they wait, must occupy hospital beds that may be needed by other people who require hospital care. In 2015/16, an average of 3,961 Ontario hospital beds per day were occupied by patients waiting to receive care elsewhere. Those 3,961 beds were the equivalent of 10 large hospitals.

The use of hospital beds for patients who could be elsewhere negatively affects people waiting for hospital beds. It also affects patients waiting to leave who have to remain in hospital, where they face greater risk of exposure to infections, may lose some ability to perform daily activities, and may be socially isolated.

Findings and variations

This indicator counts “inpatient days” – the total of all the days each of every individual hospital bed in the province was occupied by a patient – to measure the percentage of days beds were occupied by patients identified as requiring an alternate level of care.

- The proportion of inpatient days on which Ontario hospital beds were occupied by patients waiting for an alternate level of care rose to 13.9% in 2015/16, from 13.7% the previous year, which equated to an increase of 25,000 in the days beds were occupied by patients requiring an alternate level of care. The increase came after a modest but steady decline to 13.7% from 14.3% between 2011/12 and 2014/15. (**Figure 6.2**)
- Among all patients designated alternate level of care in 2015/16, 45.2% of the days they spent in hospital were spent waiting for placement in a long-term care home, and 13.7% were spent waiting to go home with home care support from a Community Care Access Centre.

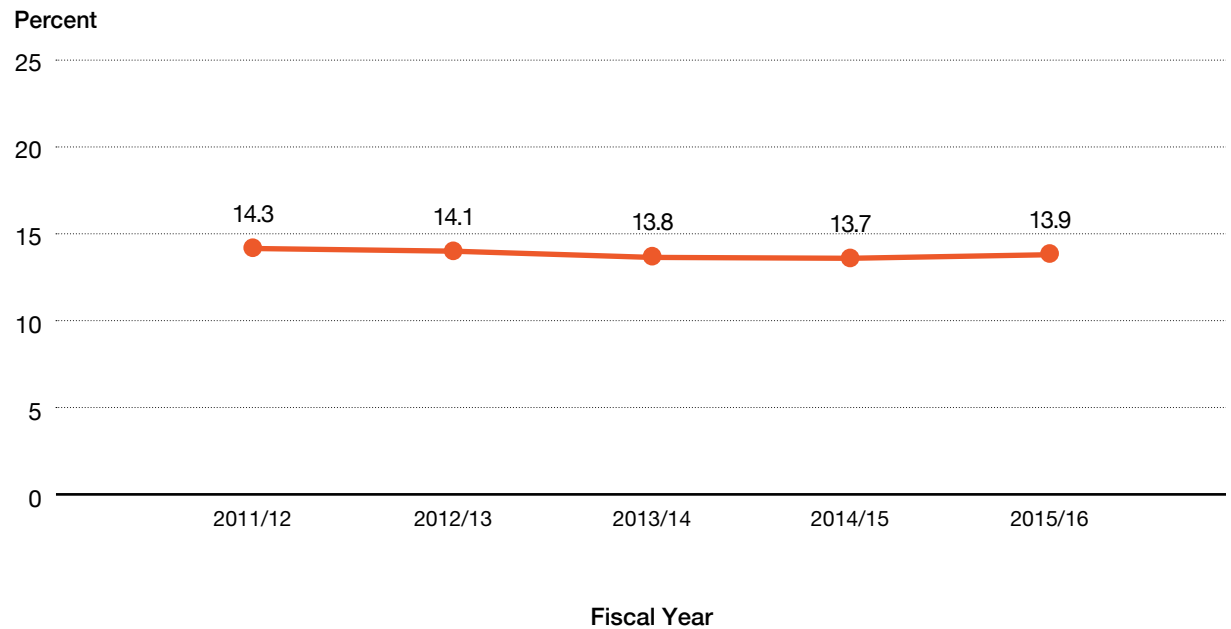
- In 2015/16, there was wide variation between the province's LHIN regions in the proportion of inpatient days used for patients waiting for care elsewhere, from a high of 27.1% in the North West LHIN region to a low of 5.5% in the Central West LHIN region. These variations were possibly related to differences in the availability of long-term care home spaces and other types of care people may need after discharge from hospital, or lack of integration with long-term care and other providers, or inadequate discharge planning.[74,75]



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

This indicator looks at “inpatient days” – the total of all the days each of every individual hospital bed was occupied by a patient – to measure the percentage of inpatient days hospital beds were occupied by patients identified as requiring an alternate level of care. Acute care, complex continuing care, mental health, and rehabilitation hospital beds are all included in the indicator.

FIGURE 6.2 Percentage of inpatient days that beds were occupied by patients who could have been receiving care elsewhere, in Ontario, 2011/12 to 2015/16



Data source: Wait Time Information System (WTIS-ALC), provided by Cancer Care Ontario.

Visits to emergency for conditions people thought could have been treated by their primary care provider

Visits to Ontario emergency departments have increased at more than double the rate of population growth in recent years.[76] As emergency departments strive to deal with this increased pressure on their resources, it becomes increasingly important to minimize unnecessary emergency department visits, in order to ensure those resources are available to the most seriously ill patients when they need them.

As well, when patients go to the emergency department for conditions that could be dealt with by a primary care doctor, it can result in less continuity of care for the patients and duplication of costly tests and diagnostic procedures.

Considerable efforts have been made in Ontario to reduce unnecessary visits to emergency.[77] Yet in 2016, more than 4 out of 10 Ontarians who visited the emergency department – among those who had a regular primary care provider – reported in a survey that their most recent visit to emergency was for a condition that could have been treated by their primary care provider, if that provider had been available.

In 2016/17, there were 6,098,551 emergency department visits in Ontario.[78] About 1 of every 27 emergency department visits made by people 1 to 74 years old was for a condition that administrative data show could potentially have

been treated in a primary care setting such as a doctor's office or community health clinic — including colds, sore throats, ear infections, migraines/headaches and prescription renewals.[79]

Comparing regional results for possibly unnecessary visits to emergency may be complicated by regional differences in health care practices.

For example, a greater proportion of primary care in rural areas may be delivered through emergency departments, particularly in areas where few after-hours services or walk-in clinics are available.[80,81]

Findings and variations

This indicator measures the percentage of people who reported in a survey that their emergency department visit was for a condition that could have been managed by their primary care provider, if that doctor, nurse practitioner or other provider had been available. It includes only people who had a regular primary care provider and who visited the emergency department at any time of the day or night in the previous 12 months.

- In 2016, 41.6% of survey respondents reported that their most recent emergency department visit was for a condition that could have been treated by their primary care provider.
- 55.2% of people living in rural areas reported that their most recent emergency department visit was for a condition that could have been

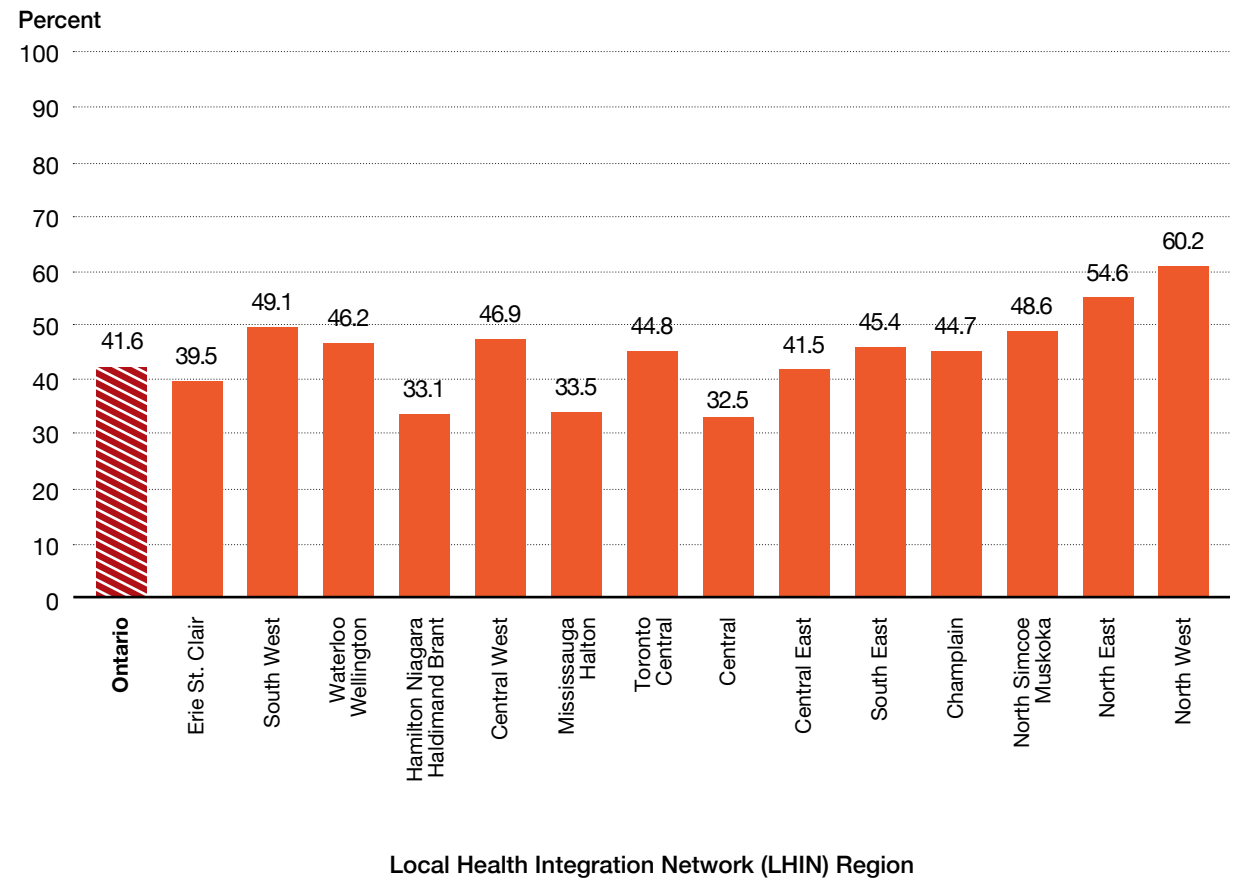
treated by their primary care provider, compared to 39.0% of people living in urban areas.

- There was wide variation in this indicator result among Ontario's LHIN regions in 2016, ranging from a low of 32.5% of respondents in the Central LHIN region reporting that their most recent emergency department visit was for a condition that could have been treated by their primary care provider, to a high of 60.2% of respondents in the North West LHIN region reporting the same. **(Figure 6.3)**
- Looking at information collected between January 2013 and September 2016, there was wider variation in this indicator result among LHIN sub-regions, with 16.4% of respondents in the sub-region of Oakville reporting that their most recent visit to the emergency department was for a condition that could have been treated by their primary care provider, compared to 75.3% in the District of Kenora sub-region.
- Among LHIN sub-regions, as the percentage of patients who reported difficulty accessing after-hours care increased, so did the percentage of patients who reported going to emergency for a condition they thought could have been handled by their primary care provider. This shows a strong correlation between the two indicators.[82]

Indicator: Visits to emergency for conditions people thought could have been treated by their primary care provider

This indicator measures the percentage of people with a regular primary care provider who reported in a survey that the last time they went to the emergency department, it was for a condition that they thought could have been treated by their provider if that provider had been available. It includes only patients aged 16 and older who visited the emergency department in the previous 12 months.

FIGURE 6.3 Percentage of patients aged 16 and older who reported their emergency department visit was for a condition that could have been managed by their primary care provider, if that provider had been available, by LHIN, 2016



Data source: Health Care Experience Survey, Ministry of Health and Long-Term Care, 2016

CHAPTER 7

Home Care

This chapter highlights results for the following Common Quality Agenda indicators related to home care:

- Patient involvement in the development of their care plan
- Home care patients with daily severe pain
- Distress among informal caregivers of home care patients

Additional results for home care indicators can be found in the Technical Data Table.



Photo of Kyra and Brenda provided by the family.

 REAL-WORLD EXPERIENCES

Kyra: Determined to choose her own path

In September 2014 at age 22, Kyra went to the emergency department with what was first thought to be a bowel obstruction. That afternoon, she received the terrible news that she had ovarian cancer, and had surgery within a week to remove several tumours and all her reproductive organs. Months of chemotherapy followed, then the cancer returned, and there was more treatment and more chemotherapy.

Kyra was accompanied from nearly the beginning of her cancer treatment by a home care nurse, Karen Bowers, who visited her Windsor home to change her bandages and monitor her condition. Bowers' visits made a "huge difference," according to Kyra, particularly in helping her stay out of hospital, and in attending to her needs in a much more personal way.

"It's more of a one-on-one thing with the home care."

Kyra's mother, Brenda, describes how Bowers has always kept Kyra and her family involved in the decisions about her care. "All I have to do is pick up the phone and call and she's there answering questions," says Brenda. "And when we have a rough patch, she takes the extra time with us, explains what's happening."

While Bowers was a nurse regularly making home visits when she first started caring for Kyra, she's now manager of clinical practice at the health care organization in Windsor that has been providing Kyra's home care services. But she still visits Kyra regularly, acting as a support to her, her family, and the current primary care nurse who visits three times a week.

"I continue to see Kyra because I told her in the beginning that I would be a part of her care team until she beat cancer or until it beat her," explains Bowers. "Obviously, we were both hoping for the former."

For her part, Kyra has never wanted to throw herself a "pity party," as she told the Windsor Star newspaper in 2015, when it published an article about her efforts to spread awareness of ovarian cancer. Rather, she said, "I'm just going to live each day as if I'm on this side of the dirt and that's great."

And so she has. But the cancer was not cured, and in March of 2017, Kyra decided it was time to stop seeking a cure and change her care plan to focus on palliative care, to keep her as comfortable as possible and allow her to remain at home instead of in hospital.

To learn about Kyra and her family's experience with palliative care, see "Brenda" in the Palliative Care chapter on page 93.

Bringing care to patients' homes



In Ontario, publicly funded home care allows people to remain in the comfort and familiarity of their own residences when they are ill, injured or disabled, instead of needing to stay in a hospital, long-term care home or other care facility. In 2015, the province paid for about 6.9 million nursing visits and 28.7 million hours of personal support and homemaking services for approximately 650,000 home care patients – 60% of whom were aged 65 or older.[83]

The need for these services is likely to increase in the next 25 years as the number of people in Ontario aged 65 and older is expected to more than double.[84] As well, home care patients are requiring more care. Between 2012/13 and 2015/16, the proportion of home care recipients with high to very high care needs increased to 53% from 48%.[85] Many of these patients depend on informal, unpaid caregivers such as family members, friends and neighbours to also provide care.

Home care indicator results show the majority of patients felt “strongly” that they were involved in the development of the plan for the care they received, while about 4 out of 10 reported feeling “somewhat” or less strongly involved.

Pain management can be a crucial component of home care, as pain can affect a patient’s quality of life and lead to increased disability and other

problems. Almost one-quarter of patients who received care for more than 60 days experienced daily severe pain, which suggests their pain wasn’t being managed as effectively as it might be.

Indicator results also show a growing segment of informal caregivers of home care patients experience continued distress as the result of the significant caregiving burden that some need to take on. Nearly 1 in 4 Ontario long-stay home care patients had caregivers who experience continued distress, anger or depression in relation to their caregiving role.

Key Finding 1

Most patients feel involved in their care plan

The majority of patients agreed “strongly” that they felt involved in the development of the plan for the care they would receive. However, there is room for improvement as about 4 out of 10 patients reported feeling less or no involvement.

Key Finding 2

More patients are experiencing daily severe pain

The proportion of home care patients who experienced daily severe pain, among those who received care for more than 60 days, increased by 16.8% between 2012/13 and 2016/17. More than 1 out of 5 experienced daily severe pain in 2016/17. The increase was most dramatic among high- to very-high-needs patients, a population that is growing in home care.

Key Finding 3

Caregiver distress is high and continues to rise

A growing segment of long-stay home care patients had informal caregivers who experienced continued distress, anger or depression in relation to their caregiving role, as reported in at least two consecutive patient assessments. The proportion of patients with caregivers who experienced these difficulties increased by 14.6% between 2012/13 and 2016/17, among long-stay patients who had at least one informal caregiver and received home care for more than six months.



Home care is changing

Home care in Ontario is currently undergoing a number of major changes in response to issues raised by the provincial auditor general and as a result of improvement initiatives undertaken by the provincial government. The changes include a reorganization of how home care is administered and delivered, and the creation of a Levels of Care Framework of home and community care standards to help ensure consistency and transparency of home care services across the province.^[86] Concurrently, Health Quality Ontario is updating the way it monitors home care performance by refreshing the indicators used to track performance.

Patient involvement in the development of their care plan

Agencies that provide home care in Ontario, under the Home Care and Community Services Act, must develop a “plan of service” that sets out the amount of service that will be provided to a patient. They are also required to provide patients with an opportunity to participate fully in the development of that plan, as well as in evaluations of the plan and revisions to it.[87]

If the home care patient has cognitive or other issues that make them incapable of participating in the development of their care plan, people legally authorized to make decisions on their behalf must be given the opportunity to participate in the development of the plan.

Involving patients and caregivers in decisions about patients’ care supports the patient-centred care dimension of quality, and may encourage adherence to the care plan, improve patients’ own management of their conditions and increase patient satisfaction.[88]

Findings and variations

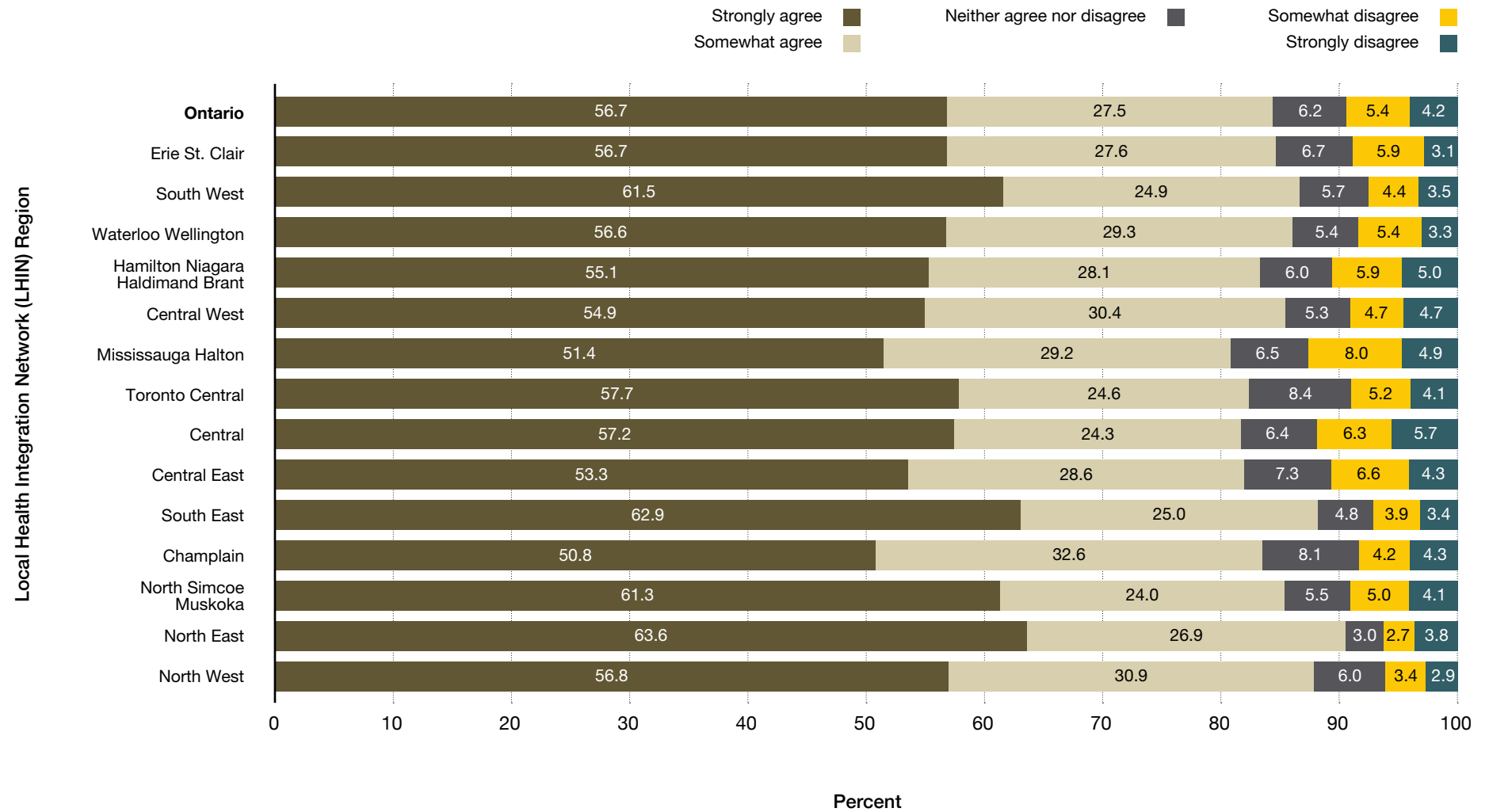
This indicator measures the proportions of home care patients who chose “Strongly agree,” “Somewhat agree,” “Neither agree nor disagree,” “Somewhat disagree” or “Disagree” in response to being asked whether they felt involved in the development of their care plan.

- In 2015/16, 56.7% of home care patients in Ontario strongly agreed that they felt involved in the development of their care plan, while 27.5% somewhat agreed, 6.2% neither agreed nor disagreed, 5.4% somewhat disagreed and 4.2% strongly disagreed. (**Figure 7.1**)
- There had been no significant change in this result since 2013/14, when 54.9% strongly agreed that they felt involved in the development of their care plan, 29.0% somewhat agreed, 7.0% neither agreed nor disagreed, 5.1% somewhat disagreed and 4.0% strongly disagreed.
- There was some variation between Ontario’s LHIN regions in the proportion of home care patients who strongly agreed that they felt involved in the development of their care plan, from a high of 63.6% in the North East LHIN region to a low of 50.8% in the Champlain LHIN region, in 2015/16. (**Figure 7.1**)

Indicator: Patient involvement in care plan

This indicator measures the percentages of patients who responded with “Strongly agree,” “Somewhat agree,” “Neither agree nor disagree,” “Somewhat disagree” or “Strongly disagree” when asked about the following statement regarding the planning of their care: “I felt involved in developing my plan.”

FIGURE 7.1 Percentage of home care patients who chose “Strongly agree,” “Somewhat agree,” “Neither agree nor disagree,” “Somewhat disagree” or “Disagree” when asked if they felt involved in the development of their care plan, in Ontario, by LHIN region, 2015/16



Data source: Client and Caregiver Experience Evaluation Survey, provided by Health Shared Services Ontario (HSSO)

Home care patients with daily severe pain

Pain management is an important component of home care. Home care nurses and personal support workers may help patients with medications or provide direct care, assessments or care plans that can have an impact on pain. Physiotherapists may provide treatment that will help reduce musculoskeletal pain, help patients deal with mobility problems that can cause pain, and teach patients relaxation techniques that can help to alleviate pain. Occupational therapists might help patients handle day-to-day activities and movement in ways that are less painful.

Health care supplies provided through home care, such as walking aids, braces and cushions, may also have a role in relieving pain. As well, assistance with personal care and homemaking might help spare patients from activities that trigger pain.

Pain can affect quality of life for patients and decrease their level of activity, which can in turn lead to loss of strength and stamina, increased disability and additional medical problems.[89,90] Pain among home care patients can be under-reported if a patient has difficulty communicating, and so may be undertreated as well.

Research shows pain can be reduced among home care patients through measures such as education of home care staff about pain and evidence-based practices for the management of pain, and provision of reminders and tools to help staff implement pain management practices.[91,92]

Findings and variations

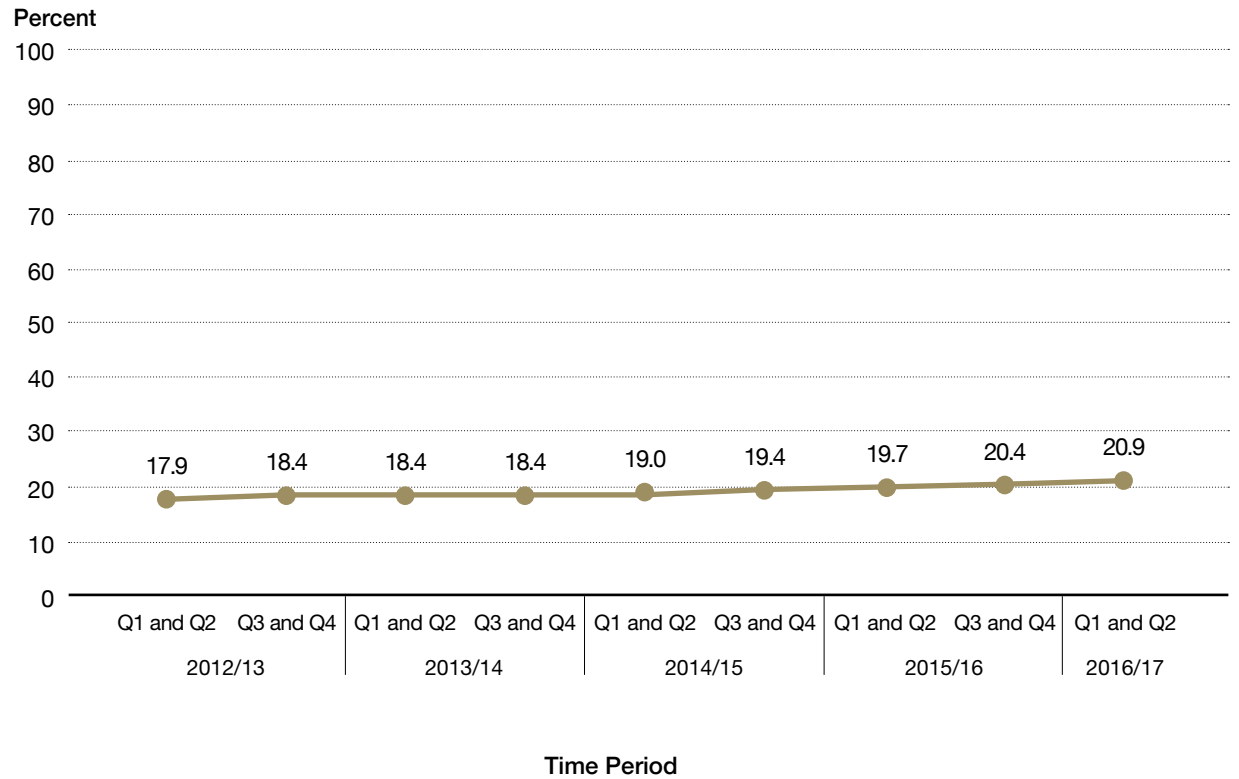
This indicator measures the proportion of home care patients who reported or were observed to be experiencing daily severe pain, among patients who received home care for more than 60 days.

- There was a 17% increase over four years in the proportion of home care patients who experienced daily severe pain, among patients who received care for more than 60 days. In the first half of 2016/17, 20.9% experienced pain, compared to 17.9% in the first half of 2012/13. **(Figure 7.2)**
- Results for this indicator varied widely between Ontario's LHIN regions in the period from July through December of 2016/17, from 16.1% in the Waterloo Wellington LHIN region to 24.0% in the North West LHIN region.

Indicator: Home care patients with daily severe pain

This indicator measures the percentage of home care patients who reported or were observed to be experiencing daily severe pain, among patients who received home care services for more than 60 days.

FIGURE 7.2 Percentage of long-stay home care patients with daily severe pain, in Ontario, 2012/13 to 2016/17



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

Distress among informal caregivers of home care patients

The opportunity for a patient to go home from a hospital often depends on the availability of an informal, unpaid caregiver to help them out at home. Among the approximately one-third of home care patients who receive services over a long or indefinite period of time,[93] about 97% have at least one informal caregiver.[94]

Informal caregivers are usually family members, friends or neighbours who help the patient with important activities ranging from shopping, cooking and housekeeping to managing medications, bathing, dressing, eating and toileting.

However, informal caregivers may experience distress, anger, depression and other physical and psychological consequences as a result of the work, time and emotional strain involved in caregiving. These stressors can have negative effects on the caregiver's health, ranging from back problems, migraines, stomach ulcers, hormonal changes, and anxiety, to early death. [95,96,97,98]

Research shows informal caregivers tend to be more distressed the older, more cognitively impaired, functionally disabled and frail the people they care for are. As well, patients whose caregivers are distressed receive more hours of care from them than patients whose caregivers are not distressed.[99]

Distress among caregivers is likely to become an increasingly important issue for Ontario's health system, as the province's population ages and the growing number of home care recipients with increasingly complex conditions require an increasing amount of help from informal caregivers.[100]

This year's *Measuring Up* report uses a new caregiver distress indicator that measures continued distress. The new indicator looks at distress, anger or depression among informal caregivers that was reported in at least two assessments over a period of at least six months.

The indicator used in last year's *Measuring Up* report examined episodes of distress among caregivers that may have lasted for a relatively short period of time and may have only been reported in a single assessment. That indicator included anger, depression and inability to continue caring activities. Inability to continue caring activities was not included in this year's indicator because results over previous years showed only a very small proportion of patients – less than 1% – had caregivers who were unable to continue.

According to the indicator used last year, 37.3% of long-stay home care patients had an informal primary caregiver who experienced at least short-term distress, anger, depression or inability to continue caring activities in 2015/16, as reported in the patient's most recent assessment, compared to 35% in 2014/15.

Findings and variations

This indicator measures continued distress, anger or depression experienced by the primary or main informal caregivers of home care patients, as reported in at least two consecutive patient assessments. It includes only patients who received home care for more than six months.

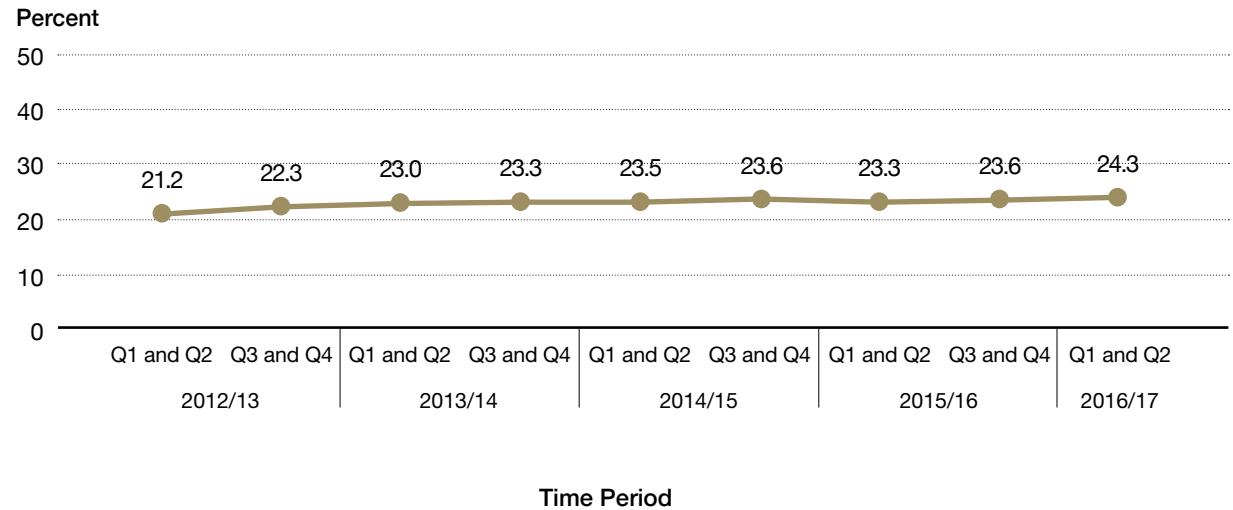
- In the first half of 2016/17, among long-stay home care patients with at least one informal caregiver, 24.3% had caregivers who experienced continued distress, compared to 21.2% in the first half of 2012/13. That was a 14.6% increase over a four-year period. (**Figure 7.3**)
- There was wide variation between Ontario LHIN regions in the proportion of long-stay patients whose caregivers experienced continued distress in the period from July through December of 2016/17, ranging from 16.6% in the South West LHIN region to 43.5% in the North Simcoe Muskoka LHIN region.

DID YOU KNOW?



There was new funding in 2017 in Ontario for respite services for informal caregivers, as well as increases in education and training programs to help informal caregivers learn how to look after loved ones at home, and, a new Ontario Caregiver Tax Credit to replace the caregiver and infirm dependent tax credits.

FIGURE 7.3 Percentage of long-stay home care patients whose primary informal caregiver experienced continued distress, anger or depression, in Ontario, 2012/13 to 2016/17



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



Indicator: Caregiver distress

This indicator measures the percentage of long-stay home care patients whose primary informal caregiver experienced distress, anger or depression in relation to their caregiving role, as reported in at least two consecutive patient assessments approximately six months apart. It includes only patients who had at least one unpaid informal caregiver and received home care for at least six months.

CHAPTER 8

Long-Term Care

This chapter highlights results for the following Common Quality Agenda indicators related to long-term care:

- Use of antipsychotic medications
- Use of physical restraints
- Pain experienced by residents

Results for additional long-term care indicators can be found in the Technical Data Table. Indicator results for individual homes are available at the [Health Quality Ontario website](#).

24-hour care for complex needs



A long-term care home is often the best option for people who need access to around-the-clock nursing care and supervision to keep them as safe, healthy and comfortable as possible. Ontario's approximately 625 long-term care homes, with a total of about 78,700 beds, provided that type of care to about 110,000 residents over the course of the year in 2015/16.

Many residents had multiple serious health conditions – 79.7% had been diagnosed with neurological disease, including 63.1% with dementia; 76.2% with heart or circulatory disease; 40.4% with a psychiatric or mood disorder; and 27.9% with diabetes.[101]

Despite the challenges experienced by such a complex group, quality indicators that measure the use of antipsychotic medications and physical restraints in long-term care homes, and the pain experienced by long-term care home residents, all showed improvement province-wide in 2015/16. For residents, antipsychotics can cause side effects such as confusion, drowsiness and a higher risk of falls. The use of physical restraints can lead to agitation, confusion, and increased risk of injury and pressure ulcers, as well as limiting activities. Pain can result in agitation and depression, and negatively affect quality of life.

Indicator results measuring antipsychotic use, restraint use and pain also improved in 2015/16 for all the 14 LHIN regions in Ontario, except in one instance for the pain indicator in one LHIN region.

Key Finding 1

Antipsychotic use, restraint use and pain decline across Ontario

There was a province-wide decrease in 2015/16 in the use of antipsychotic medications and physical restraints in long-term care homes, as well as in daily moderate pain or any severe pain experienced by long-term care home residents. This continued a pattern of steady improvement in these indicators over the previous five years. For example, the use of physical restraints fell to 6% in 2015/16 from 16.1% in 2010/11.

Key Finding 2

Performance improves in all LHIN regions

The use of physical restraints and antipsychotic medications in long-term care homes decreased in 2015/16 in each of Ontario's 14 LHIN regions. As well, the proportion of residents who experienced moderate pain daily or any severe pain declined in all but one LHIN region. Performance in all three of these indicators improved in all LHIN regions between 2010/11 and 2015/16, though there continued to be variation between regions.

Key Finding 3

Ontario compares well to the rest of Canada

In 2015/16, the proportion of long-term care home residents who experienced moderate pain daily or any severe pain was smaller in Ontario than in all the other Canadian provinces where comparable data are available (British Columbia, Alberta, Saskatchewan and Newfoundland). As well, a smaller percentage of residents were physically restrained on a daily basis in Ontario. Only Alberta had a smaller proportion than Ontario of long-term care home residents without psychosis receiving antipsychotic medications, at 18.1% compared to Ontario's 22.9%.

Quality indicators that measure the pain experienced by long-term care home residents, and the use of antipsychotic medications and physical restraints in long-term care homes, all showed improvement province-wide in 2015/16.

Use of antipsychotic medications

In the general population, antipsychotic medications may be prescribed to manage psychosis, a term often used to describe mental health conditions in which people have trouble distinguishing between what is real and what is not.[102]

For long-term care home residents, these medications are sometimes used to help control dementia symptoms such as hallucinations, agitation or aggression. But the side effects they can cause include confusion, a higher risk of falls and a slightly increased risk of death.[103]

Non-drug treatments are usually considered a better option for residents living with dementia who are experiencing troubling symptoms. Health Quality Ontario's quality standard for long-term care home residents living with dementia notes that antipsychotic medications should only be used when residents are at risk of harming themselves or others, or are in severe distress.[104]

Findings and variations

This indicator measures the proportion of long-term care home residents not living with psychosis who were given antipsychotic medication in the seven days preceding their most recent assessment.

- The proportion of Ontario long-term care home residents without psychosis who were given antipsychotic medication fell to 22.9% in 2015/16 from 35% in 2010/11 – a decline of 34.6%.

(Figure 8.1)

- Results improved in 2015/16 for all the 14 LHIN regions, but remained varied, from a high of 27.0% in the Erie St. Clair LHIN region to a low of 19.1% in the Waterloo Wellington LHIN region. Results for all LHIN regions were better than in 2010/11.
- Compared to other provinces in Canada where comparable data are collected, only Alberta, where 18.1% of long-term care home residents without psychosis were given antipsychotic medication, performed better than Ontario in 2015/16.

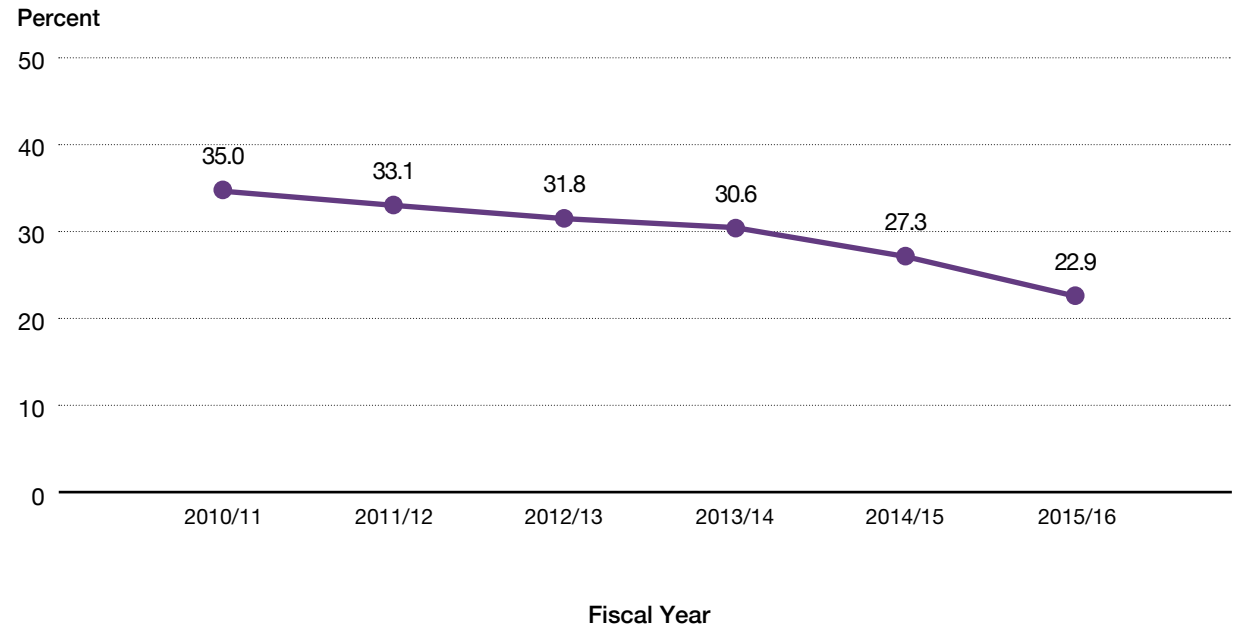
A provincial benchmark of 19%, representing high-quality care, has been set for this indicator by an expert panel assembled by Health Quality Ontario.



Indicator: Antipsychotic medication use

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

FIGURE 8.1 Percentage* of long-term care home residents without psychosis who were given antipsychotic medication, in Ontario, 2010/11 to 2015/16



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

Use of physical restraints

Long-term care homes may use physical restraints to protect residents from falling or from harming themselves or others. These could include lap belts or table trays that prevent them from rising from a chair, or restraints that limit the movement of parts of their bodies.

While the goal of restraints is resident safety, there are problems associated with their use. They limit the mobility of residents, may cause agitation or confusion and may increase the risk of injury and pressure ulcers.[105,106]

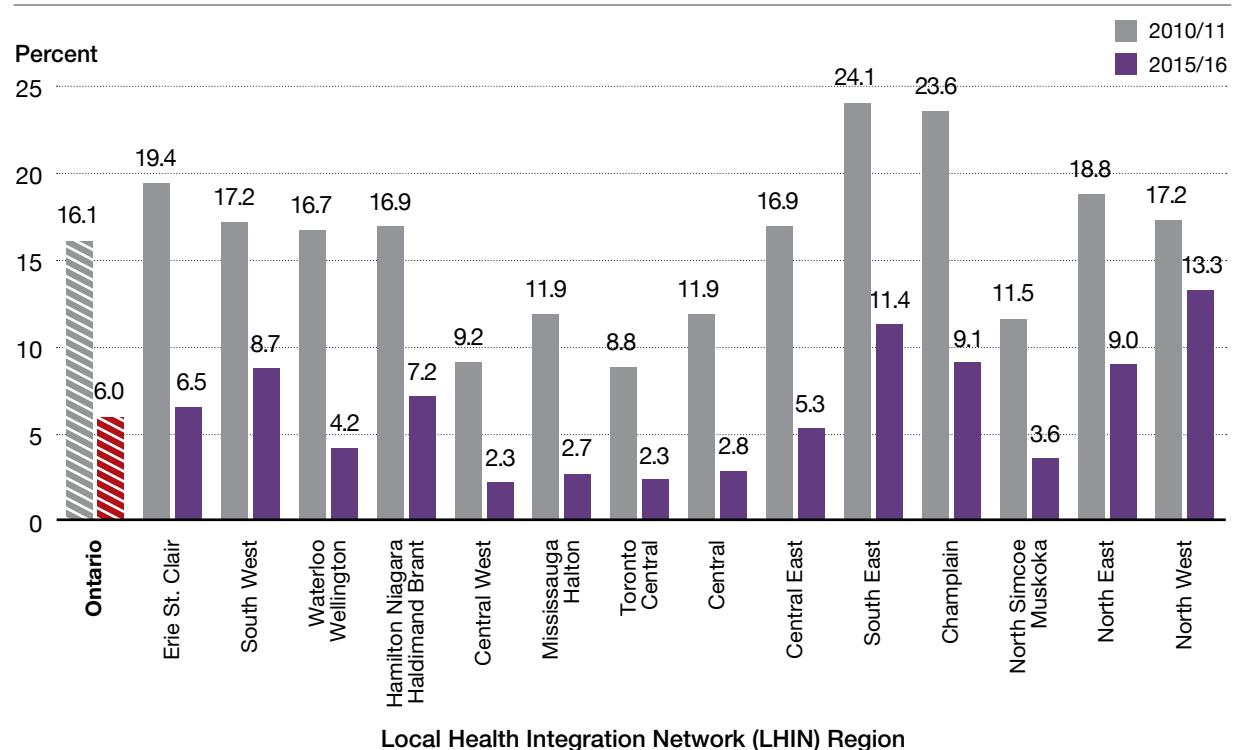
Under the *Long-Term Care Homes Act, 2007*, long-term care homes are required to have written policies aimed at minimizing the use of restraints on residents, and that policy must detail when, how and under whose authority they may be used.[107]

Findings and variations

This indicator measures the proportion of long-term care home residents who were physically restrained on a daily basis during the seven days preceding their most recent assessment. The use of bed rails is not included in the indicator.

- The proportion of Ontario long-term care home residents physically restrained on a daily basis fell to 6.0% in 2015/16 from 16.1% in 2010/11 – a decline of 62.7%.
- Results for this indicator improved in 2015/16 for all the 14 LHIN regions, but remained varied, from a high of 13.3% in the North West LHIN region to a low of 2.3% in the Toronto Central and Central West LHIN regions. Results for all LHIN regions were improved over 2010/11. (**Figure 8.2**)

FIGURE 8.2 Percentage* of long-term care home residents who were physically restrained on a daily basis, in Ontario, by LHIN region, 2010/11 and 2015/16



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

- Ontario performed better in this indicator than all the other provinces in Canada where comparable data are collected, just ahead of Alberta, where 6.9% of long-term care home residents were physically restrained on a daily basis in 2015/16.

A provincial benchmark of 3%, representing high-quality care, has been set for this indicator by an expert panel assembled by Health Quality Ontario.



Indicator: Use of physical restraints

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

Pain experienced by residents

Besides making long-term care home residents uncomfortable, pain can also cause sleep problems, mobility problems, depression and agitation. It may also discourage residents from being physically active and engaging in social activities, which can be detrimental to their overall health and well-being and decrease their quality of life.[108,109,110]

All long-term care homes in Ontario are required by law to have a pain management plan that includes strategies to manage residents' pain, methods to assess the pain of residents who are unable to communicate or who are cognitively impaired, and processes to monitor the effectiveness of their pain management activities.[111]

Findings and variations

This indicator measures the proportion of long-term care home residents who experienced moderate pain daily or any severe pain during the seven days preceding their most recent assessment.

- The proportion of Ontario long-term care home residents who experienced moderate pain daily or any severe pain fell to 6.1% in 2015/16 from 11.9% in 2010/11 – a decline of 48.7%.
- Results for this indicator improved in 2015/16 compared to the previous year for all but one of the 14 LHIN regions, but remained varied in 2015/16, from a high of 12.4% in the North West LHIN region to a low of 3.3% in the Central LHIN region. Results for all LHIN regions were better than in 2010/11.
- In 2015/16, Ontario performed better in this indicator than the other five provinces in Canada where comparable data are collected, placing just ahead of Alberta, where 7.3% of long-term care home residents experienced moderate pain daily or any severe pain. (**Figure 8.3**)

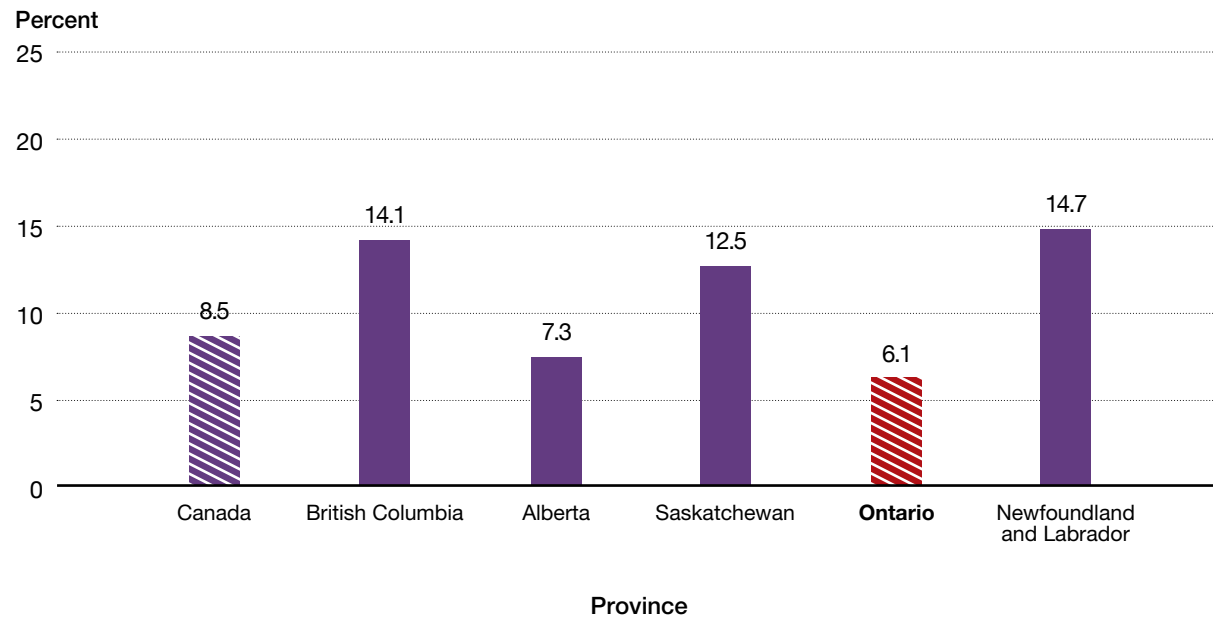
A provincial benchmark has not been set for this indicator.

DID YOU KNOW?



In 2015/16 in Ontario, 63.1% of long-term care home residents had a diagnosis of dementia, a chronic and progressive decline in cognitive ability that interferes with daily functioning, compared to 58.0% in 2010/11. [112]

FIGURE 8.3 Percentage* of long-term care home residents who experienced moderate pain daily or any severe pain, by province, 2015/16



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

Indicator: Pain experienced by residents

This indicator measures the percentage of long-term care home residents who experienced moderate pain daily or any severe pain during the seven days preceding their most recent assessment.

CHAPTER 9

Palliative Care

This chapter highlights results for the following Common Quality Agenda indicators related to palliative care:

- Unplanned emergency department visits
- Home care services
- Home visits by a doctor

Additional results for palliative care indicators can be found in the Technical Data Table.



Photo of Karen and Brenda
taken by Roger Yip.

●●● REAL-WORLD EXPERIENCES

Brenda: Providing comfort and calm for Kyra

Two-and-a-half years after being diagnosed with ovarian cancer and undergoing several rounds of chemotherapy that failed to stop its progression, 25-year-old Kyra chose to receive palliative care. It has helped to make her more comfortable and allowed her to live at home in Windsor with her family, but she needs a lot of support.

“Kyra is basically bedridden now,” says her mother, Brenda. “She can make small steps with full assistance. I sponge bathe her every day, as our home is an older one that is not accessible.” Kyra sleeps 20 to 22 hours a day. In addition to being very ill from cancer, she has lost her hearing on the right side and has suffered nerve damage to her hands and feet as a result of chemotherapy, explains Brenda.

Kyra’s long-time home care nurse, Karen Bowers, still visits regularly to support Kyra and her family even though she has moved into a new job supervising other home care nurses. Bowers, who has specialty training in palliative care, visits about every two weeks to answer questions and help keep things running smoothly. Kyra’s current primary home care nurse visits three times a week for symptom management and to

manage the intravenous line through which she receives all her medications.

As well, at the request of her family, Kyra’s care team has grown to include staff from a local hospice. A doctor and a nurse educator from there visit regularly, and a nurse practitioner has also visited. The hospice can be contacted 24 hours a day for additional help, and has also offered the family counselling and pastoral care.

Still, in order to make Kyra’s time with her family as calm and uninterrupted as possible, her mother has tried to minimize the number of care providers coming into their home.

“Brenda has been handling the majority of Kyra’s actual care needs, and uses the nurses for back-up and as a second set of eyes,” explains Bowers. “They are truly an amazing family.”

Brenda, however, credits the home care and hospice support Kyra has received with allowing the family to cope and to “come to terms with the outcome of this journey.” She notes all the options for her daughter’s care and the help available have been explained in detail to the family, and both home care and hospice staff have made sure Kyra’s wishes are a priority and that her care plan going forward is based on those wishes.

“We are very lucky to have the team we have,” says Brenda. “The open communication has been key to Kyra’s care and now her palliative care plan. This journey has not been without bumps, but communication has helped clear up things and we have learned to listen first and take time before making decisions. This has made it easier for Kyra to have a greater understanding of her options, and for us as a family to have more understanding.”

In memoriam: Kyra died peacefully at home in Windsor on August 30, 2017.

Improving palliative care services in Ontario



Palliative care – the approach to providing comfort and dignity for patients (and their families) who are living with a life-threatening illness – can make an enormous difference in what is often a very difficult time in people’s lives.

In surveys, most people in Ontario say they would prefer to die at home.[113,114] However, the majority of people die in hospital.[115] More people should have access to the supports they need, including palliative-specific home care services and physician home visits, to be able to die in the location of their choice.[116]

The data in this report show that the majority of people in Ontario who died visited the emergency department in their last month of life. Some of these visits could likely have been prevented with better access to palliative services and care outside the hospital.[117,118]

Palliative-specific home care services and home visits by a doctor – key components of palliative care services at the end of life – are not the norm in Ontario and vary depending on where people live in the province. Yet they are often essential to relieve pain and suffering and improve quality of life by addressing the immense physical,

psychological, spiritual and practical challenges faced by people nearing the end of life, and by their families.

The palliative-specific home care and doctor home visits that people receive also vary by sex, and by neighbourhood income quintile (calculated by ordering the population of adults by the income of their neighbourhood, from lowest to highest, and then dividing into five equal groups, or quintiles).

Key Finding 1

In their last 30 days of life, most people have an unplanned visit to the emergency department

More than half (54.8%) the people who died in 2015/16 had unplanned emergency department visits in their last 30 days of life. The rate of unplanned emergency department visits in the last 30 days of life varied across LHIN regions, ranging from 48.5% in North West LHIN region to 58.4% in Central East LHIN region.

Key Finding 2

Just over a quarter of people receive a palliative-specific home care service in their last month of life, but the percentage is increasing

In their last 30 days of life, 27.5% of people received a palliative-specific home care visit, in Ontario, in 2015/16, and the rate varied by LHIN region from 14.7% in the North West LHIN region to 36.0% in the North Simcoe Muskoka LHIN region. The percentage of people who received a palliative-specific home care visit in their last 30 days of life increased in the last four years, to 27.5% in 2015/16 from 24.1% in 2011/12.

Key Finding 3

Less than a quarter of people receive a home visit by a doctor in their last month of life, but the percentage is improving

In their last 30 days of life, 24.1% of people had at least one home visit by a doctor in 2015/16. People living in certain LHIN regions of the province, and those living in higher-income neighbourhoods are much more likely to have a home visit by a doctor in the patient's last 30 days of life. Women are more likely than men to have a home visit by a doctor in the patient's last 30 days of life. The percentage of people who received a home visit by a doctor in their last 30 days of life increased in the last four years, to 24.1% in 2015/16 from 20.0% in 2011/12.

Unplanned emergency department visits

Among people who died in Ontario in 2015/16, more than half (54.8%) had unplanned emergency department visits in their last 30 days of life. **(Figure 9.1)** The type of planned visit excluded from this indicator would be, for example, an appointment in the emergency department for scheduled treatment or consultation when clinic or day surgery areas are unavailable.

The rate of unplanned emergency department visits in the last 30 days of life varied across LHIN regions, ranging from 48.5% in the North West LHIN region and 51.7% in the Waterloo Wellington LHIN region to 58.4% in the Central East LHIN region. **(Figure 9.1)** Lower rates of unplanned emergency department visits may reflect difficulty in getting to the emergency department in areas with more rural and remote communities, rather than receiving better palliative care.

When people make unplanned visits to the emergency department in the last month of life, it could indicate that they did not receive the care they needed in the community.[119] There is currently no benchmark for what this rate should be, and these visits may be unavoidable, but a sudden and unexpected transition from the home or other place in the community to the hospital emergency department can be an extremely difficult experience for patients near the end of their life.

Findings and variations

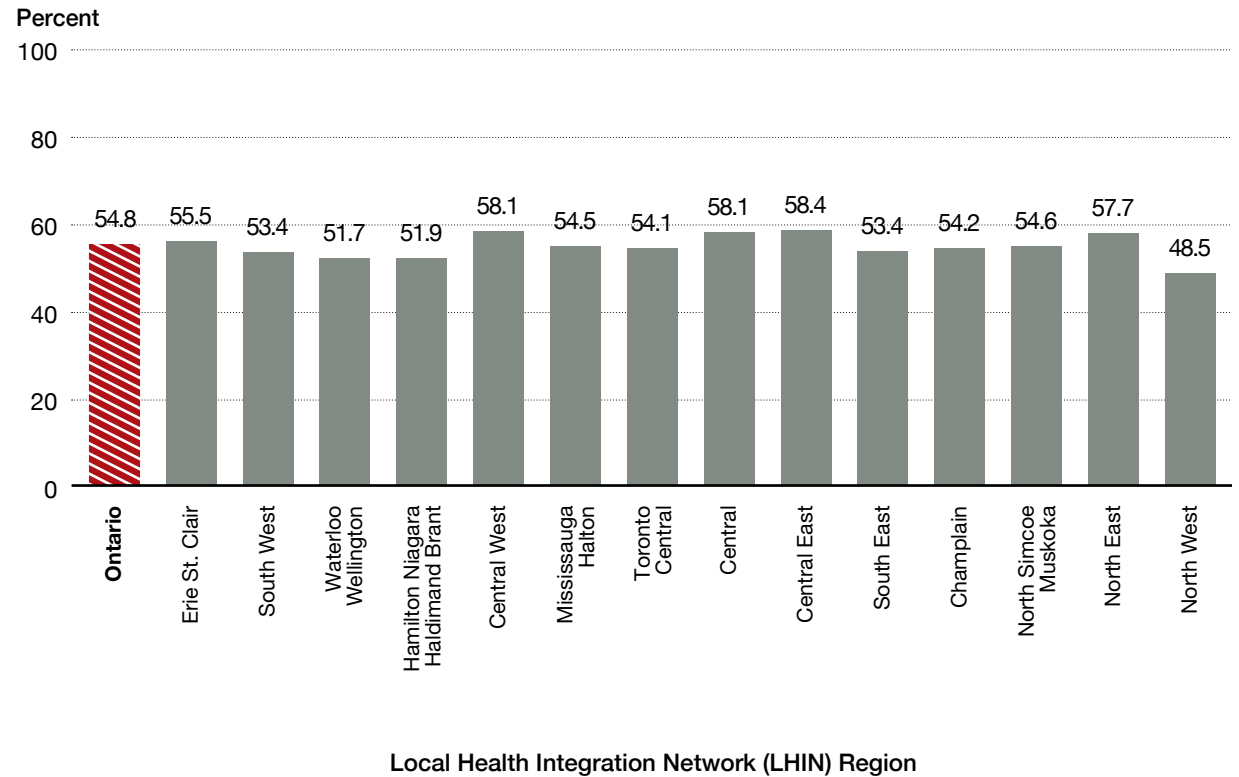
This indicator measures the percentage of people, among all those who died, who had at least one unplanned emergency department visit in their last 30 days of life.

- Men were more likely than women to have an unplanned emergency department visit in their last 30 days of life, with 57.4% of men making at least one unplanned visit to emergency during that period, compared to 52.2% of women, in 2015/16.
- People living in rural areas of the province were slightly more likely than those in urban areas to have an unplanned visit to the emergency department in their last 30 days of life, at 56.7% compared to 54.5% in 2015/16.

Indicator: Unplanned emergency department visits in the last 30 days of life

This indicator measures the percentage of people, among all those who died, who had at least one unplanned emergency department visit in their last 30 days of life. It excludes people who were in the hospital during the entire 30-day period before death.

FIGURE 9.1 Percentage of people, among all those who died, who had at least one unplanned emergency department visit in their last 30 days of life, in Ontario, by LHIN region, 2015/16



Data source: RPDB, NHCRC provided by the Institute for Clinical Evaluative Sciences.

Palliative-specific home care services

Just over a quarter (27.5%) of people who died in Ontario in 2015/16 received a palliative-specific home care service in their last 30 days of life, and another 28.8% received at least one home care service that was not designated palliative-specific. The proportion that received at least one palliative-specific service varied by LHIN region from 14.7% in the North West LHIN region to 36.0% in the North Simcoe Muskoka LHIN region. (**Figure 9.2**)

Home care services that are palliative-specific have been associated with a 50% reduction in the likelihood of dying in hospital.^[120] Palliative-specific home care usually involves more hours of care per week than home care not designated as palliative.

Findings and variations

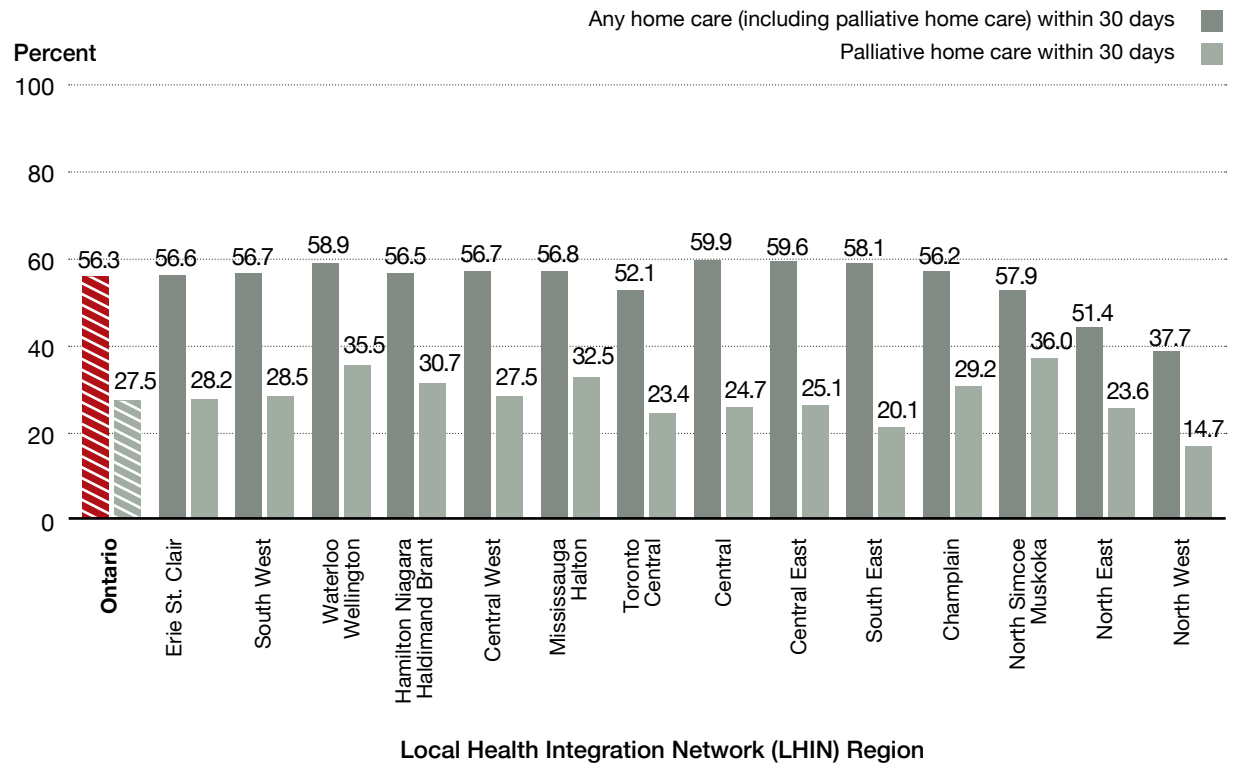
This indicator measures, among people who lived in the community during their last 30 days of life, the percentage who received at least one home care service – including palliative-specific home care – during that period.

- Women were more likely than men to receive a palliative-specific home care service in their last month of life (30.0% for women compared to 25.4% for men), across Ontario in 2015/16.
- People living in higher-income neighbourhoods were more likely to receive palliative-specific home care than those in lower-income areas (32.2% among those in the highest neighbourhood income quintile compared to 22.7% for the lowest), in 2015/16.
- The percentage of people who received a palliative-specific home care service in their last 30 days of life increased to 27.5% in 2015/16 from 24.1% in 2011/12.

Indicator: Home care services

This indicator measures, among people who died, the percentage who received at least one home care service – including palliative-specific home care – in their last 30 days of life. It excludes people who spent their last 30 days of life in a hospital, long-term care home, complex continuing care facility or rehabilitation facility.

FIGURE 9.2 Percentage of people, among all those who lived in the community during their last 30 days of life, who received at least one home care service during that period, in Ontario, by LHIN region, 2015/16



Data source: HCD, RPDB provided by the Institute for Clinical Evaluative Sciences.

Home visits by a doctor

Less than a quarter (24.1%) of people in Ontario who died in fiscal year 2015/16, among those who lived in the community during their last 30 days of life, received a visit at home by a doctor during those 30 days. (**Figure 9.3**)

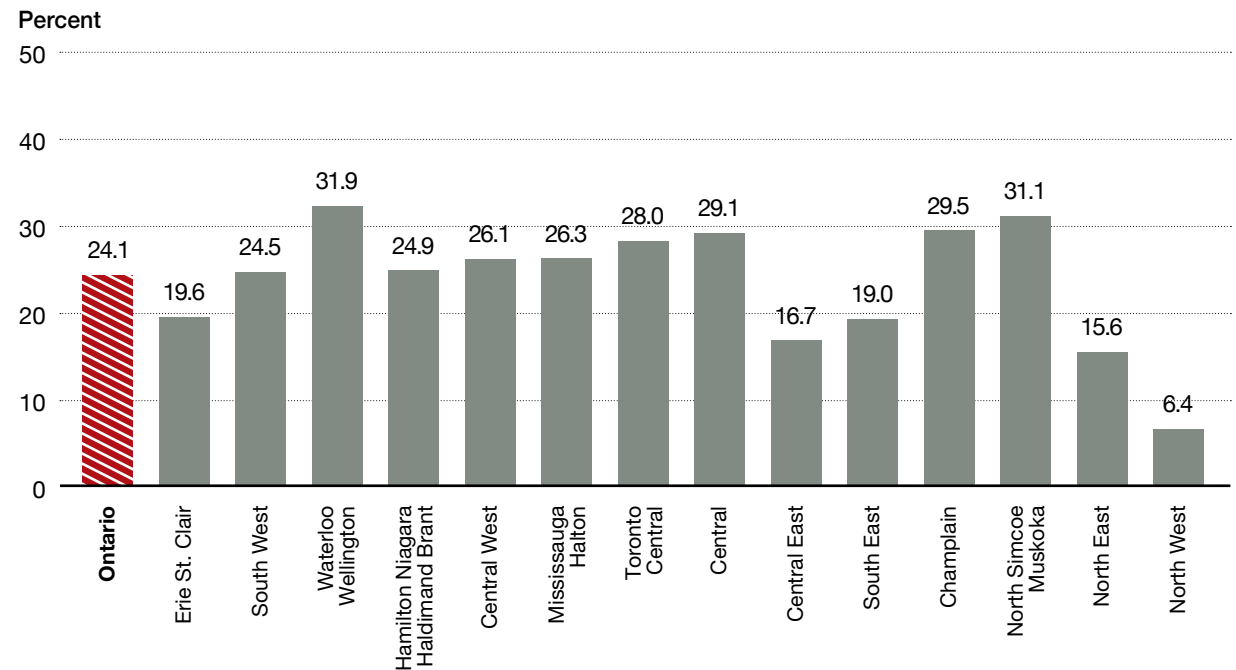
For people near the end of their life, visits to the home by a doctor can result in fewer unplanned trips to the hospital emergency department, and increase the likelihood they will be able to die at home rather than in hospital.[121]

Findings and variations

This indicator measures, among people who lived in the community during their last 30 days of life, the percentage who received at least one visit at home by a doctor during that period.

- Results for this indicator varied significantly between Ontario's LHIN regions in 2015/16, ranging from a high of 31.9% in the Waterloo Wellington LHIN region to a low of 6.4% in the North West LHIN region. (**Figure 9.3**)
- The percentage of people who received a home visit by a doctor in their last 30 days of life increased to 24.1% in 2015/16 from 20.0% in 2011/12.

FIGURE 9.3 Percentage of people, among all those who lived in the community during their last 30 days of life, who had at least one physician home visit during that period, in Ontario, by LHIN region, 2015/16



Data source: RPDB, OHIP, provided by the Institute for Clinical Evaluative Sciences.



Indicator: Home visit by a doctor in the last 30 days of life

This indicator measures, among people who died, the percentage who received at least one visit at home by a doctor in their last 30 days of life. It excludes people who spent their last 30 days of life in a hospital, long-term care home, complex continuing care facility or rehabilitation facility.

CHAPTER 10

Health Spending

This chapter highlights results for the following Common Quality Agenda indicators related to health spending:

- Having serious problems paying or being unable to pay medical bills
- Health spending on drugs per person
- Total health spending per person

Additional results for health spending indicators can be found in the Technical Data Table.

Health spending in Ontario



In Ontario, health spending by government covers many health care costs such as doctor visits, hospital care, diagnostic tests and scans, annual eye exams for people who have certain medical conditions such as diabetes or who are under 20 years old or over 64, and some travel expenses for those who must travel long distances for specialty medical care.^[122]

Medical costs not covered by government – such as prescription drugs dispensed outside a hospital, eye exams for people aged 20 to 64 years old, and some ambulance services – are paid for from private sources like health benefits provided by employers, or out-of-pocket payments by individuals.

About two-thirds of total health care expenditures in the province are paid for by public health spending, and the rest by private spending. But some people find it difficult to pay or are unable to pay medical costs not covered by government health spending.

Financial barriers to care need to be addressed in a health system that strives for equity and aims to provide access to quality care to everyone regardless of ability to pay.

Ontario's health spending on drugs per person is relatively high compared to some socioeconomically similar countries, while the province's total health spending per person falls in the middle when compared internationally.

Key Finding 1

Some Ontarians have serious problems paying their medical bills

In an international comparison, a relatively high percentage of Ontarians reported difficulty paying health care costs. More Ontarians reported having serious problems paying or being unable to pay their medical bills than people in the United Kingdom, Australia, Germany, New Zealand and Sweden, in a survey conducted by the Commonwealth Fund. Ontario's results were better than those of the United States, Switzerland and France.

Key Finding 2

Ontario spending on drugs is comparatively high

In 2014, Ontario was the fourth-highest spender on drugs in comparison to socioeconomically similar countries in the Organisation for Economic Co-operation and Development (OECD), after the United States, Switzerland and France, and ahead of countries such as Australia, Germany and Sweden.

Key Finding 3

Health spending is relatively stable in Ontario

Total health spending per person in Ontario, which includes both public and private spending, has remained relatively stable in recent years. Ontario spends a little bit under the average for all the provinces in Canada. Internationally, Ontario falls in the middle when it comes to health spending per person, in comparison to 10 socioeconomically similar OECD countries.

Difficulty paying private medical costs

Nearly 1 out of 12 Ontarians reported difficulty paying medical costs, in response to the Commonwealth Fund International Health Policy Survey. The ability to afford medication is an important aspect of access to medical care, especially among people with multiple chronic conditions.[123] For people without insurance coverage, the cost of prescription medication can represent a significant out-of-pocket expense.

In 2015, 71.1% of Ontarians 12 to 64 years old reported having prescription medication insurance. That left nearly 30% of Ontarians in that age group needing to have their prescriptions paid for out of pocket. The proportion who had insurance was much greater among those who lived in the richest neighbourhoods, at 85.9%, than among those who lived in the poorest neighbourhoods, at 50.1%.[124] People aged 65 or older have most of their medication costs paid by the Ontario Drug Benefit program. Among developed countries that have a public health insurance system, Canada's is the only system that does not include universal coverage of prescription drugs used outside hospitals.[125]

Findings and variations

This indicator measures the proportion of people 18 years old and older who reported in a survey that they had serious problems paying or were unable to pay their medical bills.

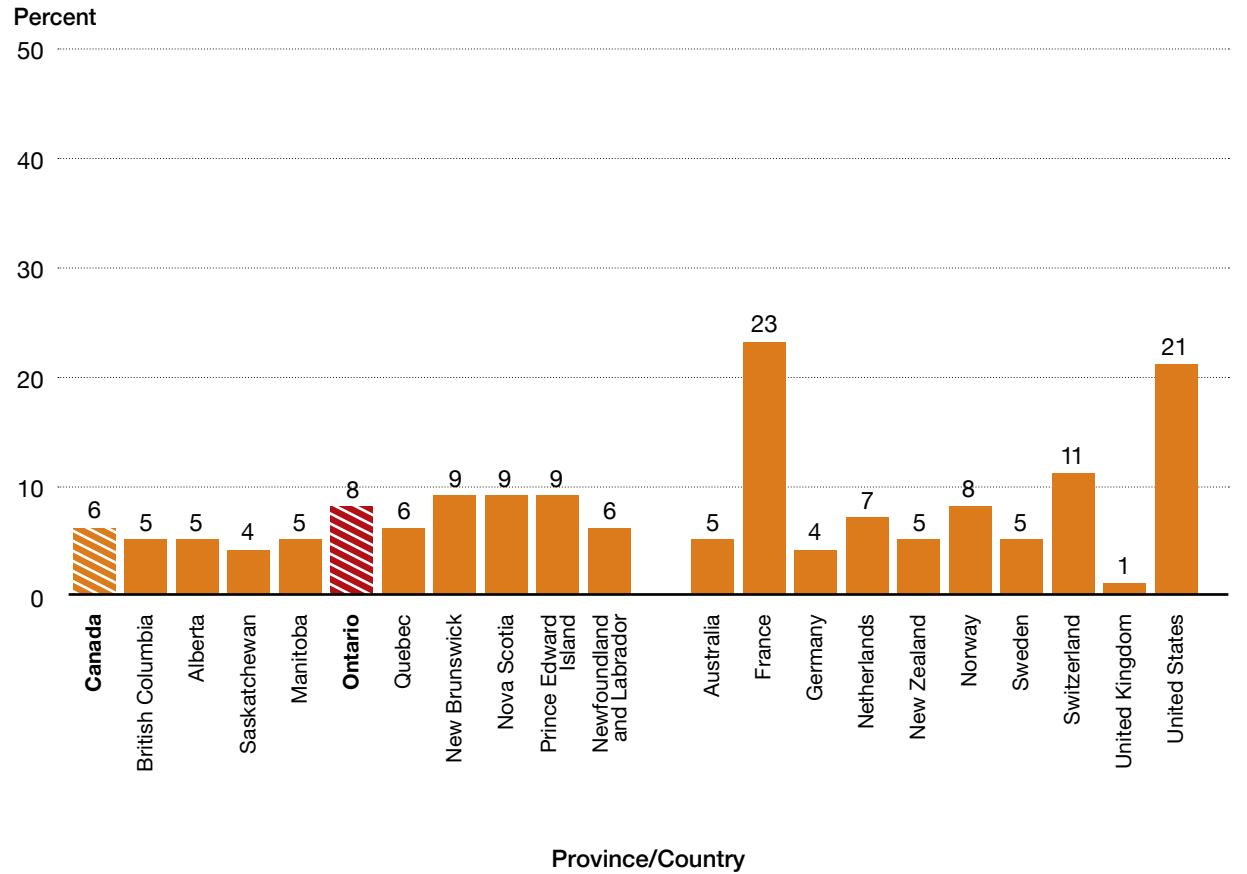
- In Ontario, 8% of survey respondents reported serious problems paying or were unable to pay their medical bills in 2016. (**Figure 10.1**)
- 10% of survey respondents in Ontario between 50 and 64 years old – an age group that often experiences chronic health conditions – reported serious problems paying their medical bills in 2016. The proportion with problems paying dropped to 4% among respondents aged 65 or older, whose prescription costs are covered by the Ontario Drug Benefit program. Among those 18 to 49 years old, 16% reported serious problems paying.
- In comparison to people in 10 socioeconomically similar countries that participated in the Commonwealth Fund survey, more Ontarians reported serious problems paying or not being able to pay their medical bills than people in the United Kingdom, Australia, Germany, New Zealand and Sweden. Ontario's results were better, however, than those of the United States, Switzerland and France, and similar to those of the Netherlands and Norway. (**Figure 10.1**)



Indicator: Serious problems paying or being unable to pay medical bills

This indicator measures the percentage of survey respondents aged 18 and over who reported having serious problems paying or being unable to pay their medical bills.

FIGURE 10.1 Percentage of survey respondents who had serious problems paying or were unable to pay their medical bills in Ontario, Canada and internationally, 2016



Data Source: 2016 Commonwealth Fund International Health Policy Survey

Health spending on drugs per person

Prescription drugs are an important component of health care for many people living in Ontario. [126,127] Drugs were one of the fastest-growing categories of health spending between 2001 and 2013,[128] and were among the top three health spending categories, along with hospital services and doctors' services. The cost of drugs – including both over-the-counter drugs and prescription medications purchased in drugstores or other retail stores – accounted for 17% of total health spending in Ontario in 2014.[129] Nearly 62% of the money spent on drugs per person in Ontario comes from private sources, including private health insurance and out-of-pocket payments by individuals.

Findings and variations

This indicator measures how much money is spent on average per person on prescription medication and over-the-counter medication in a given period of time. Spending is given in US dollars to facilitate international comparison. Dollar figures are adjusted using a method called Purchasing Power Parity (PPP) that seeks to eliminate differences in price levels between countries.

- In 2014, US\$767 was spent per person in Ontario on prescription and over-the-counter medication.
- Of that US\$767, US\$474 came from private funding such as drug benefits provided by employers or out-of-pocket payments by individuals, and US\$293 came from public funding, in 2014. Almost 62% of spending on drugs came from private funding.
- In comparison to nine socioeconomically similar OECD countries, Ontario spends the fourth-highest amount on drugs per person, spending US\$767 per person on prescription and over-the-counter medication (which includes patients' out-of-pocket expenses). (**Figure 10.2**)

DID YOU KNOW?



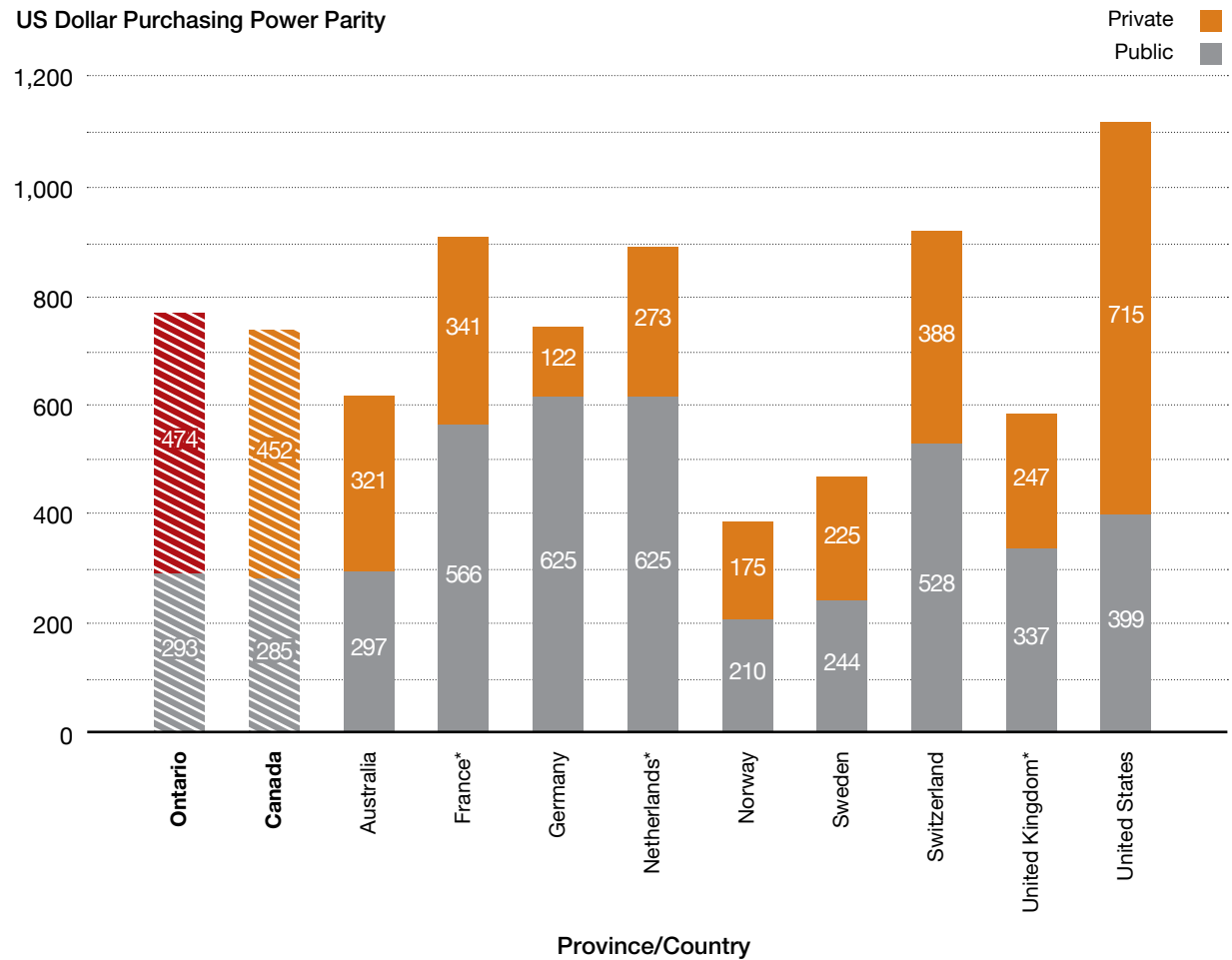
Beginning January 1, 2018, all children and youth 24 years of age or younger in Ontario who are covered by OHIP will have the cost of their eligible prescription medications fully covered, regardless of family income, under OHIP+: Children and Youth Pharmacare, announced in the 2017 provincial budget.



Indicator: Health spending on drugs per person

This indicator measures how much money is spent per person on prescription medications and over-the-counter drugs purchased in drugstores or other retail stores.

FIGURE 10.2 Health spending on drugs per person in Ontario, Canada and internationally, 2014



Data source: National Health Expenditure Database, Canadian Institute for Health Information; Organisation for Economic Cooperation and Development. OECD health Statistics 2017

Note: Each country's spending is given in US dollars and adjusted using a method called purchasing power parity to convert the different currencies. * The data, in addition to pharmaceutical expenditure, also include other medical non-durable goods.

Total health spending per person

In 2014, total health spending in Ontario – including both public and private expenditures – accounted for 11.3% of the provincial GDP, and in Canada as a whole, total health spending accounted for 10.9% of the national GDP. In 2017, spending on health care accounted for almost 40% of the provincial budget, the largest share among all budget expense categories.[130]

One way of measuring health expenditures is by tracking the average amount of money spent per person in a year.

Findings and variations

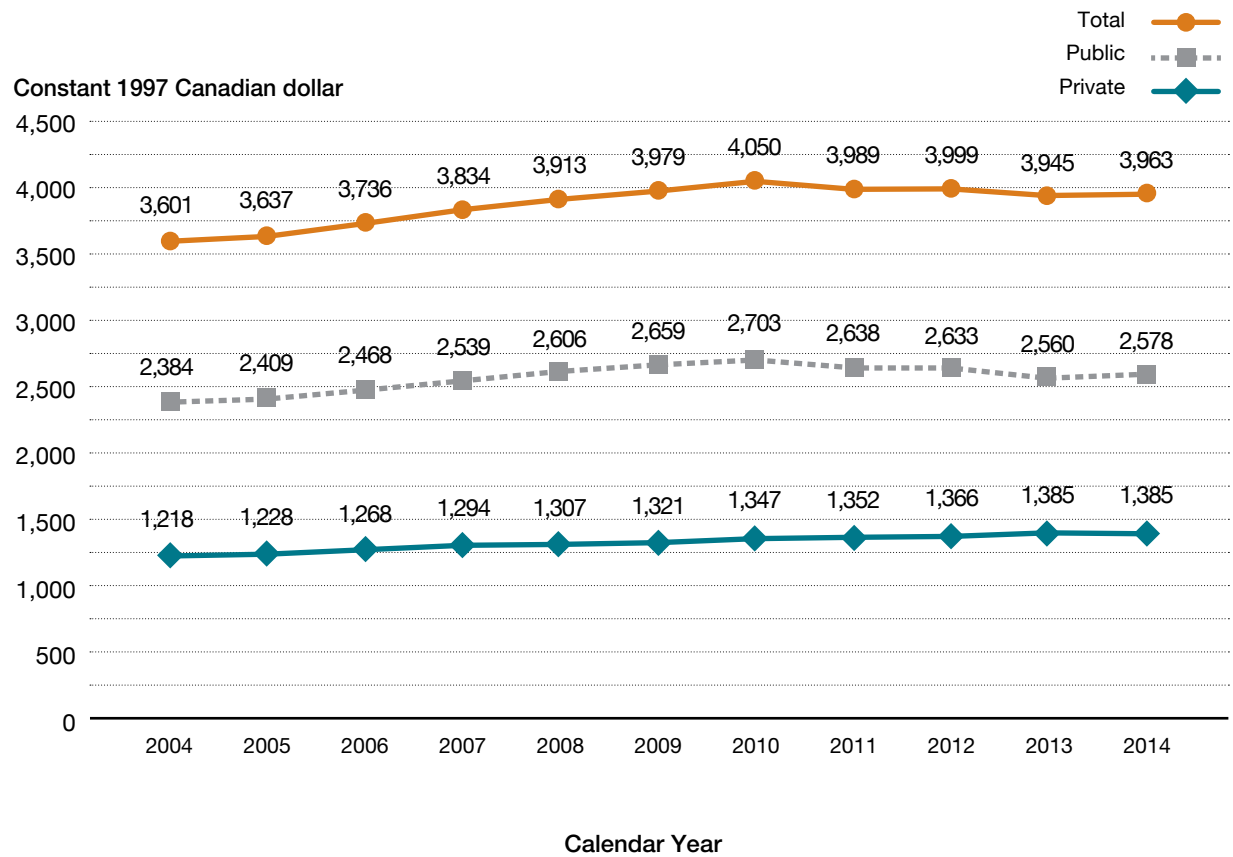
This indicator examines total health spending on average per person per year. It includes health spending by both public and private sources. The most recent year for which indicator data are available is 2014.

- Both public and total health spending per person in Ontario have decreased in recent years, with public expenditures decreasing 4.6% between 2010 and 2014, to \$2,578 from \$2,703 per year, and total expenditures decreasing 2.1%, to \$3,963 from \$4,050, measured in constant 1997 Canadian dollars to account for inflation and to allow for comparison over time. Over the same period, annual private expenditures increased 2.8%, to \$1,385 from \$1,347. (**Figure 10.3**)
- Over the longer term, between 2004 and 2014, total annual health spending per person in Ontario increased 10.0%, with public spending increasing 8.1%, and private spending climbing 13.7%. (**Figure 10.3**)
- Between 2004 and 2014, publicly funded health spending accounted for about 65% of total health spending in Ontario.
- Internationally in 2014, Ontario's health spending per person fell in the middle among socioeconomically similar OECD countries, at US\$4,415, with the United States spending the most, at US\$9,036, (dollar figures adjusted to Purchasing Power Parity).

Indicator: Total health spending per person

This indicator measures how much money is spent on health care, on average per person per year. The indicator includes health spending from both public and private sources.

FIGURE 10.3 Total, public, and private health spending per person, in Ontario, 2004–2014



Data source: National Health Expenditure Database, Canadian Institute for Health Information; population and price indices, Statistics Canada
Note: The figures in the graph present health expenditure per person at constant prices to standardize for both population growth and inflation which have varied during the last decade.



Photo of Lilac
taken by Roger Yip.



The Road Ahead

Ontario's health system is performing well in many respects. The overall care tends to be good once patients receive it. Many of the challenges the system faces relate to problems with access and transitions from one care setting to another. These strains create a ripple effect across sectors and care settings, and make it more difficult for patients to receive equitable care and services. Many patients in hospital are waiting to receive care elsewhere, which builds pressure in other areas, such as time spent in the emergency department for admitted patients, who often do not have a bed available to them for 15 hours or longer. Caregiver distress is growing among those caring for loved ones at home, and many people do not receive palliative-specific home care or a home visit from a physician in their last month of life. Many Ontarians report having problems paying their medical bills.

Ontario is not alone in facing challenges with care transitions, access and equity. National and international comparisons show mixed results. Our health system sometimes performs in the middle, sometimes slightly better and sometimes worse than many provinces and other countries. But of course we should not be content to stay in the middle of the pack relative to other health systems, but rather strive to be among the best. This report has identified areas that need improvement, and many efforts are underway to address these in specific sectors as well as across the health system.

System integration

Each of the 14 LHINs has developed Community Health Links which provide coordinated,

consistent and effective care for people with complex conditions. This model of care helps with transitions between care settings, as patients receive their own care plan tailored to them, and ensures they have the supports they need.

To improve patient transitions across care settings, steps are being taken provincially to reduce the number of patients needing an alternate level of care (ALC) who are occupying hospital beds, by developing supportive housing for homeless ALC-designated seniors who would be able to live independently with appropriate supports, and by developing additional short-term care and accommodation options outside hospital for ALC-designated patients. Lessons from these initiatives will be used to develop a province-wide approach to the issue.

Mental illness and addictions

Efforts are underway to improve access to supports through the development of a province-wide structured psychotherapy program, as well as by expanding existing services. Such efforts are supported by the Ontario Health Technology Advisory Committee recommendation that evidence-based, structured, individual and group psychotherapy provided by non-physicians be publicly funded for patients with major depressive disorder and/or generalized anxiety disorder.

Youth service hubs to provide integrated mental health and addictions services, primary care and other social services such as employment and housing are being developed, and additional supportive housing units are being added across

Ontario for people who are living with mental health and addictions issues who are homeless or at risk of becoming homeless.

Hospital care

For better access to specialist care and surgeries, a musculoskeletal care program being developed by the Ministry of Health and Long-Term Care aims to provide timelier, appropriate and transparent specialist care for patients with common musculoskeletal conditions such as back, neck and shoulder pain, and candidates for hip and knee replacement surgery. Under the program, which is coordinated through the Local Health Integration Networks, patients will be referred to central points of contact to receive a timely assessment and consultation, which should avoid unnecessary surgical or imaging consults and reduce unnecessary wait times.

The Ontario Surgical Quality Improvement Network, supported by Health Quality Ontario, provides resources to surgical teams across the province to help them work together to achieve surgical quality improvement goals, and to improve experiences and outcomes for patients.

The Emergency Department Return Visit Quality Program established by Health Quality Ontario monitors return visits to hospital emergency departments to identify adverse events and quality issues. The program is mandatory for many high-volume emergency departments in the province, but all Ontario hospitals are encouraged to participate.

Palliative care

The Ontario Palliative Care Network provides leadership to advance patient-centred care and recommend provincial standards for health care providers. Additional resources are being provided to increase residential hospice capacity to support patients with end-of-life care in the community. There are also initiatives to improve palliative care for underserved populations, and resources are being developed to help patients and caregivers understand their care needs and their options for meeting them.

System-wide quality of care

Quality Improvement Plans are documented sets of quality commitments made by health care organizations to their patients, clients, residents, staff and community, and are updated every year. The goal is to improve quality through focused targets and actions. Work on a Quality Improvement Plan takes place throughout the year, as teams in organizations across the province implement the change ideas in their plans and track their course to improvement. This process currently involves more than 1,000 organizations in the hospital, home care, primary care and long-term care sectors.

Regional Quality Tables have been established across Ontario to share regional learning and initiatives to improve the health outcomes and experiences of patients, and to align and connect regional and provincial programs aimed at providing high-quality health care. Each regional table is chaired by a Clinical Quality Lead

co-appointed by Health Quality Ontario and the region's Local Health Integration Network. Other table members include representatives from specific health disciplines such as primary, emergency and mental health care, and from area hospitals.

ARTIC (Adopting Research to Improve Care), a joint program developed by Health Quality Ontario and the Council of Academic Hospitals of Ontario, supports and fast-tracks the implementation of innovative and proven health care interventions and service delivery models. ARTIC's mandate is to accelerate the spread of proven care.

Quality standards, developed by Health Quality Ontario along with patients, caregivers and doctors, identify the care patients should be offered for specific health conditions, in specific care settings such as in hospital or a primary care clinic in the community, based on the best available evidence. The standards focus on health conditions for which there are large variations or gaps in the care patients across Ontario receive.

Quality Matters, a provincial framework for health care quality, has been developed by Health Quality Ontario to provide a common guide that health care providers can use to work toward improving care for patients and their families and caregivers. *Quality Matters* defines the culture of a high-quality health system according to six dimensions of quality care: safe, effective, patient-centred, efficient, timely, and equitable.

As we work together to fill in the gaps in Ontario's health system, the patient, caregiver and provider stories in this report remind us what's at stake. Excellent care means everything to those who need it.



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