

# 1.1 Executive summary

Ontarians are fortunate to have a publicly funded healthcare system that provides a comprehensive range of services for all. To make sure the system is working properly, the provincial government set up the Ontario Health Quality Council (OHQC) as an independent agency in 2005 to monitor all aspects of the system, to report to the people of Ontario on its quality and to encourage continuous improvement.

Our fifth annual report — Quality Monitor — examines Ontario's healthcare system with our most critical eye. We note changes for the better or for the worse and report them to you. More importantly, we compare how we are doing to the best results elsewhere and provide an opinion about whether quality is good or needs improvement.

### How we completed this report:

The OHQC routinely monitors indicators and data sources used throughout Ontario, Canada and internationally, and works with its Performance Measurement Advisory Board to select indicators for this report. Data is drawn from sources that include Ministry of Health and Long-term Care (MOHLTC) databases, Census Canada, international surveys from the Commonwealth Fund and many others. The Institute for Clinical Evaluative Sciences (ICES) helped us conduct many of the data analyses. Researchers, clinical experts and healthcare executives reviewed our findings for accuracy and validity.

### Key features of this year's report:

#### *Broader coverage of the nine attributes of quality*

The nine attributes that Ontarians tell us reflect a high performing health system include: accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated and focused on population health. This year, we have added new indicators to increase our insight into these nine attributes across all sectors of healthcare. They include:

- Expanded analysis of alternate level of care (ALC) bed days in hospital
- More information on safety and staying healthy in long-term care (LTC) and home care
- Expanded analysis of hospital infections and adverse events
- Addition of maternal and child health, sexual health and injuries
- Expanded coverage of mental health, including suicide, intentional harm and depression in LTC and home care

#### *Compact format*

We describe the entire healthcare system in 35 themes, with two pages per theme. Most indicators have a mini-graph to indicate progress or lack of improvement over time and a one- to three-sentence description of our interpretation of the data. Information on how indicators were defined and calculated and more detailed tables of actual data points can be found in the technical appendix to this report.

#### *Mini-summaries for leaders and staff in different sectors and people with different conditions.*

There are one to three-page summaries of key findings for hospitals, LTC, home care and primary care, as well as brief summaries for cardiovascular disease, diabetes, mental health and cancer. Each summary includes questions to ask of leaders or caregivers for self-reflection. Summaries of key differences for each local health integration network (LHIN) have also been included.

#### *Root cause analyses and change ideas*

Traditional public reporting simply gives indicator results and whether they are above or below average. Readers, however, are left wondering why these problems exist and what can be done about them. To counter this, we have included a root cause analysis with each theme, as well as ideas for improvement related to the root causes, as identified in the literature.

#### *Best practice stories*

We have identified local stories of improvement, selecting those that had a clear aim, measures, change ideas and run charts showing substantial improvement over a short period of time. These success stories are closely linked to the key findings of the report, demonstrating that improvement is possible.

### Our key findings:

**There are serious problems with how patients move through the healthcare system, from the emergency department to hospital to LTC. Patients wait too long and the system is wasting resources.**

Wait times for an LTC bed are too long — an average of 105 days, or more than three months. For people waiting while at home, the wait time is 173 days (almost half a year). Wait times have tripled since the spring of 2005.

Wait times for LTC affect hospitals, since frail individuals who cannot go home typically spend 53 days in hospital waiting for placement. As a result, currently 16% of all hospital beds in Ontario are occupied by patients designated as ALC, who do not need to be in hospital. Indeed, every increase of 3.3 days of average time spent waiting in hospital for LTC placement is associated with a 1% increase in the proportion of beds that are ALC. Not only is this a waste of hospital resources, but it puts patients at risk because they are being cared for by staff who are not trained to deal with their needs. This problem has gotten much worse in the last three years.

The backlog of ALC patients in hospital is one of the key factors affecting emergency department wait times. Patients admitted to hospital from the emergency department spend far too much time waiting for a hospital bed after the decision to admit — typically, 3.4 hours. They occupy a bed in the emergency department while waiting, which in turn slows the flow of less acute patients through the emergency department. In 2009, 25% of patients spent more time in the ED receiving care than the recommended target. The majority of patients did not get to see a doctor within the timeframe recommended by national experts. About 6% of them left the emergency department before being seen, likely because


**HOSPITAL**
**LONG-TERM CARE**
**HOME CARE**
**PRIMARY CARE**

they were tired of waiting. This indicator is at its worst level in the past five years. Overall, our emergency department wait times are among the worst in the world.

We are concerned that the problems with patient flow may have some indirect impact on surgical wait times. On the positive side, wait times have decreased for cataract surgery and hip and knee replacements and are generally good for cardiovascular procedures. However, for overall surgeries, our healthcare system struggles to meet wait time targets for urgent (priority 2) cases. For example, only 53% of urgent cancer cases are completed within the two-week target. We do not know all of the reasons for these waits, and recognize that there are likely multiple, complex causes. However, one issue to consider is that priority 2 cases are generally more complicated and may require timely access to an ICU bed after surgery. If hospital bed capacity is very tight because of the ALC bed situation, that could make it more difficult to schedule these urgent cases. Last year, we reported that one hospital (North York General Hospital) ensured that all patients got their urgent surgery on time by implementing improvements in the scheduling process, as well as ideas to reduce ALC beds. In this example, addressing these flow issues made a huge difference.

Numerous activities are currently taking place to improve patient flow. Within the emergency department, there is a Process Improvement Program to help hospitals improve their internal processes, as well as public reporting of wait times, a pay-for-results initiative and a nurse practitioner program to reduce emergency department visits from LTC homes. These are all strategies that have promise and we look forward to reporting on their impact in future years. However, they do not address one of the key root causes: the backlog of people waiting for LTC placement.

If this backlog is the origin of the problem, then what are the ideas for improvement? Last year, we described a case study from the health region around Lethbridge, Alberta, which kept its wait times to 28 days and used one-third fewer LTC beds compared to Ontario. That region had different publicly funded options for assisted living or supportive housing, where people could live in a home-like environment with 24-hour assistance when needed, if they required less care than that provided by LTC but more than that offered by home care. There may be important lessons for Ontario from this and other similar examples. Such a strategy would also require that safeguards and monitoring be in place to ensure that best standards for quality of care are maintained in these settings.

**We have seen solid improvements in cardiovascular disease care and cautious signs of improvement in care for diabetes and other chronic diseases. There is still, however, major room for improvement.**

The good news is that for heart attacks, there has been a steady decrease over the past few years in the incidence (rate of new heart attacks in the population), mortality rate and hospital readmission rate. For angina, the hospitalization rate has decreased sharply, by more than half in the past six years. For elective cardiovascular procedures (bypass surgery, angiography and percutaneous coronary intervention (balloons or stents to open the artery), about 95% of cases are done within the target

timeframe, which is excellent. (As noted previously, there is still room to improve with more urgent cases.) Although we can still do better, more patients with heart attacks are filling prescriptions for the right medications, including cholesterol-lowering drugs, beta-blockers and angiotensin-converting enzyme inhibitors (ACEIs) or angiotensin-receptor blockers (ARBs). For congestive heart failure (CHF), hospital admission rates are declining, which is good news, but readmissions are still very common, mortality remains high and we can increase the use of evidence-based medications further.

For diabetes, we are encouraged that the rates of serious complications, such as heart attacks, strokes and amputations, are now starting to decline. Many more people with diabetes are on life-saving medications, including cholesterol-lowering drugs and ACEIs. However, there is still vast room to do better. The use of the right medications should be higher still, and many people with diabetes are not getting the right monitoring (e.g., regular eye and foot checks).

We are also pleased with the decline in admissions for asthma in Ontario. However, admissions and readmissions for chronic obstructive pulmonary disorder (COPD), including emphysema, are still high.

While improvements in care are encouraging, we note that progress has been stalled for the past three years in addressing unhealthy behaviours that could lead to chronic diseases. These lifestyle activities include smoking, heavy drinking, obesity, physical inactivity and low consumption of fruits and vegetables. Although there are people of all socioeconomic groups who engage in these unhealthy behaviours, those with low incomes, less than high school education or who live in rural areas are at higher risk of doing so. People in these groups face many barriers to adopting healthy behaviours, including lack of access to or knowledge of opportunities for affordable physical activity and healthy food options. It will be important to tailor strategies for the most vulnerable populations in order to accelerate progress on chronic diseases.

Further improvements to chronic disease management will also depend on better engagement of patients in their own care and better coordination and communication among providers or institutions. For example, only one-quarter of patients who leave hospital receive all the information they need, such as what danger signs to watch for, when to resume usual activities, and an explanation of the purpose of medications to take at home that they can understand. Many physicians report delays in getting information from hospitals or specialists. Addressing these issues could help to reduce readmissions or other complications.

**Ontario has made significant improvements in the use of information technology, particularly in the use of electronic medical records (EMRs) by doctors in the province. However, we still lag far behind other countries in the adoption of these tools, and we still do a poor job of sharing information among doctors, hospitals and other settings to create a true electronic health record (EHR).**

The proportion of family doctors who have an EMR system has risen from 26% in 2007 to 43% in 2009 due to funding and support from the OntarioMD program. This represents important progress in a short period of time. However, we still lag behind countries such as the UK, Australia and the Netherlands, where 95 to 99% of family doctors have an EMR

## 1.1 Executive summary

system. We are also concerned that not all doctors are using all the functions of the EMR to improve quality, such as flagging for possible drug errors or sending reminders about tests.

Spending in information technology across all health sectors has steadily increased, which is also encouraging. Hospitals have made big investments, particularly associated with the ability to store, retrieve and share digital files of diagnostic images (e.g., X-rays). However, only 9% of our hospitals send information electronically outside the hospital — for example, to other hospitals, doctors or home care agencies.

The term EMR generally refers to information systems within one location (e.g., a doctor's office or hospital), while EHR refers to a system where information from multiple sources can be pooled and/or shared. It is important to recognize that most of the benefits of information technology will not be realized until we create the EHR. When that happens, Ontarians should see fewer unnecessary tests because the old results could not be accessed, fewer drug errors because no one was quite sure of all the medications being taken, and fewer mistakes or delays in care when someone is seen by a new doctor or healthcare provider because all the information about their medical history was not available.

### **Problems with access to primary care persist, despite major investments in recent years.**

About 7.1% of Ontarians continue not to have a family doctor; that's roughly 730,000 people. About half of these individuals do not have a family doctor and are actively looking but can't find one. For people who already have a family doctor, only half can see their doctor the same or next day when sick. Compared to 10 other countries, Ontario and Canada have the worst record on timely access to primary care. Almost nine in 10 Ontarians say they are waiting too long to see their doctor, and this indicator has gotten worse in the last three years.

The lack of improvement on access is perplexing, given that, at the same time, the supply of health professionals has been steadily increasing. In the last six years, the per capita supply of family doctors has increased by 6.2%, and that of nurse practitioners by 82%. There have also been

major investments in training positions for other health personnel, such as pharmacists, midwives and registered practical nurses. Since 2005, Ontario has created 150 family health teams (FHTs), which provide interdisciplinary care and extended hours of service to improve access.

Why, then, has there been no improvement in access? We will not know the exact answer until more information comes in, such as an upcoming external evaluation of the FHT initiative. One possibility is that while adding more personnel and creating team structures is important, those two ingredients do not necessarily mean that the actual teamwork is as good as it could be, or that health professionals are working to their full scope of practice. It will be important to ensure that all primary care practices design scheduling, work flow and assignment of tasks to different team members in a way that maximizes efficiency, reduces wasted time and provides better quality of care. We report two case studies of primary care practices in Ontario that achieved near-zero wait times and major improvements in chronic disease management using the resources they had. There is no reason why these examples could not be repeated throughout the province.

### **While there has been some progress in reducing hospital-acquired infections, there are still huge opportunities to do better.**

On the positive side, Ontario has led other provinces in public reporting of hospital infection rates. *C. difficile* infection rates have been decreasing gradually over the past year. However, handwashing rates are still far too low — only 53% at the moment just before a health professional sees a patient. Infections such as ventilator-associated pneumonia and central line infections continue to occur in our hospitals. These infections are associated with high mortality rates, and yet many leading institutions in North America and even here in Ontario have eliminated them through adherence to infection control practices. There is no reason why all hospitals in Ontario could not do the same. Achieving this will require strong leadership among hospital executives, boards and LHINs to drive a profound shift towards a culture of safety within their organizations.

# 1.2 Attributes framework

The attributes of a high-performing health system.

HOSPITAL

LONG-TERM CARE

HOME CARE

PRIMARY CARE

## ONTARIANS WANT THEIR HEALTH SYSTEM TO BE:

### ACCESSIBLE

**People should be able to get timely and appropriate healthcare services to achieve the best possible health outcomes.** For example, when a special test is needed, you should receive it when needed and without causing you extra strain and upset. If you have a chronic illness such as diabetes and asthma, you should be able to find help to manage your disease and avoid more serious problems.

### EFFECTIVE

**People should receive care that works and is based on the best available scientific information.** For example, your doctor (or healthcare provider) should know what the proven treatments are for your particular needs including best ways of coordinating care, preventing disease or using technology.

### SAFE

**People should not be harmed by an accident or mistakes when they receive care.** For example, steps should be taken so that elderly people are less likely to fall in nursing homes. There should be systems in place so you are not given the wrong drug, or the wrong dose of a drug.

### PATIENT-CENTRED

**Healthcare providers should offer services in a way that is sensitive to an individual's needs and preferences.** For example, you should receive care that respects your dignity and privacy. You should be able to find care that respects your religious, cultural and language needs and your life's circumstances.

### EQUITABLE

**People should get the same quality of care regardless of who they are and where they live.** For example, if you don't speak English or French it can be hard to find out about the health services you need and to get to those services. The same can be true for people who are poor or less educated, or for those who live in small or far-off communities. Extra help is sometimes needed to make sure everyone gets the care they need.

### EFFICIENT

**The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas and information.** For example, to avoid the need to repeat tests or wait for reports to be sent from one doctor to another, your health information should be available to all of your doctors through a secure computer system.

### APPROPRIATELY RESOURCED

**The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs.** For example, as people age they develop more health problems. This means there will be more need for specialized machines, doctors, nurses and others to provide good care. A high-performing health system will plan and prepare for this.

### INTEGRATED

**All parts of the health system should be organized, connected and work with one another to provide high quality care.** For example, if you need major surgery, your care should be managed so that you move smoothly from hospital to rehabilitation and into the care you need after you go home.

### FOCUSED on POPULATION HEALTH

**The health system should work to prevent sickness and improve the health of the people of Ontario.**

# 1.3 Hospital sector summary

Summary for boards, CEOs, senior management and clinical leaders.

Topic area	Key facts	Questions to ask at the board, senior management table or quality committee
1. ALC (section 7.2)	<ul style="list-style-type: none"> <li>• 16% of beds are designated as ALC and the problem has grown worse in the last three years.</li> </ul>	<ul style="list-style-type: none"> <li>• How quickly are we getting discharge planning involved?</li> <li>• Are we identifying people at high risk for becoming an ALC patient?</li> <li>• Are we identifying people at high risk for being ALC early enough (e.g., when they come to the emergency department for the first time)?</li> <li>• Are we labelling people as needing LTC too early, before they have had a chance to recover?</li> <li>• Are we using utilization management tools to objectively measure when someone does not need to stay in a hospital anymore?</li> <li>• Do our ALC patients really need an LTC bed or supportive housing? If the latter, are we working with others to make sure these resources are available in our community?</li> <li>• Are there frail or elderly patients in our practice whose needs have not yet been assessed by a community care access centre (CCAC)?</li> </ul>
2. Emergency department wait times (section 2.1)	<ul style="list-style-type: none"> <li>• Although there are many efforts to reduce wait times, there has been no improvement yet and we are still not meeting targets.</li> <li>• Approximately 25% of people spend more time in the emergency department than is desirable.</li> <li>• Six out of every 100 Ontarians who visit the emergency department leave without being seen by a physician.</li> </ul>	<ul style="list-style-type: none"> <li>• Have we considered all the different ideas for improving patient flow within the emergency department (e.g., fast-track area, improved layout, chairs for acute patients, flexible human resources scheduling, spreading elective, non-urgent and surgical cases more evenly throughout the week, information systems to track patients and results, etc.)?</li> <li>• Are we moving patients who do not need to be receiving care in the hospital to the right place as quickly as possible (see 1 above)?</li> <li>• Are we redirecting/connecting people who are using the emergency department as the first place to get healthcare to appropriate services that will reduce their chances of coming back (e.g., mental health patients and people without a family physician)?</li> </ul>
3. Surgical and CT/MRI scan wait times (section 2.3)	<ul style="list-style-type: none"> <li>• Wait times are good for cataract and cardiovascular surgeries and have improved for hip and knee replacements; however, there is still room to do better.</li> <li>• The largest area for improvement is urgent (priority 2) cases for all surgeries and CT/MRI scans (e.g., 50% of urgent cancer surgeries are not done within the recommended timeframe).</li> <li>• CT/MRI scan waits are still too long — only one-third of MRI scans are done on time despite having doubled the number of scans in the last six years.</li> </ul>	<ul style="list-style-type: none"> <li>• What are we doing to make sure all the hand-offs in arranging scheduling are made consistently and without delay?</li> <li>• Do we measure demand and supply and do we know if we are in balance? Have we ever done queue-clearing blitzes?</li> <li>• For urgent cases, what is the root cause of delays — poor hand-offs and organization, lack of standardized processes and/or lack of an intensive care unit or other bed to admit to? (If the latter, see strategies under ALC.)</li> <li>• For CT/MRI scans, are we taking a hard look at the appropriateness of tests being done? Are we using new tools to help us do that (e.g., appropriateness scales)?</li> </ul>

## HOSPITAL

## LONG-TERM CARE

## HOME CARE

## PRIMARY CARE

Topic area	Key facts	Questions to ask at the board, senior management table or quality committee
4. Safety — hospital infections and other areas (sections 4.1, 4.2 and 4.3)	<ul style="list-style-type: none"> <li>Hospital standardized mortality ratio (HSMR) rates have fallen for the second year in a row, with 71% of hospitals reporting a decrease in their HSMR score over the past year.</li> <li>In-hospital mortality for heart attacks and strokes has also decreased.</li> <li><i>C. difficile</i> infection rates have decreased in the last year; however, we can still do better.</li> <li>Hand hygiene remains an area of concern — only half of healthcare providers correctly wash their hands.</li> <li>Incidents of ventilator-associated pneumonia and central line infections continue to occur in intensive care units. We can do better, as many hospitals have eliminated these incidents completely.</li> <li>In one out of every 200 surgeries, patients continue to get potentially life-threatening blood clots. There has been no improvement and we can do better.</li> </ul>	<ul style="list-style-type: none"> <li>Do we have proper surveillance and incident reporting systems in place?</li> <li>Are we regularly using checklists, standardized order sets or protocols to minimize reliance on memory?</li> <li>Are we following best practices in relation to environmental cleaning, hand hygiene and other infection control best practice documents?</li> <li>What are we doing to ensure that all staff and physicians are using proper handwashing techniques (e.g., education materials, convenient location of hand-washing stations and sanitizers with lotion, audit and feedback to staff on compliance)?</li> <li>Do we have a physician champion to gain buy-in for infection control practices?</li> <li>Are we promoting and measuring a culture of safety in our hospital? Do people feel comfortable speaking up if they see a safety issue?</li> <li>Are we encouraging patients to ask questions about safety?</li> <li>Are we educating patients on their role in safety?</li> <li>Have we considered the use of automated order sets and protocols, along with ensuring compliance through hospital physician credentialing processes?</li> <li>If we use contractors for maintenance and cleaning, are safety standards part of the agreement and how are they enforced?</li> </ul>
5. Effectiveness/evidence-based practices (section 3.1)	<ul style="list-style-type: none"> <li>There has been some increase in the number of patients filling prescriptions upon discharge — most notably, 86% of acute myocardial infarction (AMI) patients are prescribed a statin upon discharge.</li> <li>Making sure patients leave hospitals on the right medication will help reduce readmission rates.</li> </ul>	<ul style="list-style-type: none"> <li>Do we have information technology systems in place to remind doctors of standard protocols and treatment plans or to track compliance with guidelines?</li> <li>Are we educating our patients and their families about the importance of filling and taking their prescriptions?</li> <li>Are we using checklists or standardized order sets at admission and discharge?</li> </ul>
6. Patient-centred/discharge hand-offs (sections 5.1 and 9.1)	<ul style="list-style-type: none"> <li>One in three patients is sent home from the hospital and emergency department without all the information needed — there is room for improvement.</li> <li>Ontario does a poorer job than most countries in making sure discharge summaries are sent quickly to family doctors.</li> </ul>	<ul style="list-style-type: none"> <li>How quickly are we transferring discharge summaries to family physicians?</li> <li>Are written discharge instructions routine for all of our patients (including warning signs, whom to call, etc.)?</li> <li>Are we ensuring that our patients understand their course of treatment after discharge?</li> <li>Do we make sure all patients being sent home have follow-up care arranged?</li> </ul>
7. Readmissions (section 3.3)	<ul style="list-style-type: none"> <li>Readmission rates have decreased for heart attacks, CHF and asthma over the past few years, but there is still room to improve.</li> <li>Conditions with the highest rates are CHF and COPD.</li> </ul>	<ul style="list-style-type: none"> <li>To reduce deterioration and the risk of readmission, are we making sure patients have all the information needed when they are sent home? (see 5 and 6 above)</li> <li>Are we making sure patients have the right medication and treatment when sent home? (see 5 above)</li> </ul>

## 1.3 Hospital sector summary

Topic area	Key facts	Questions to ask at the board, senior management table or quality committee
8. EHR adoption (section 8.2)	<ul style="list-style-type: none"> <li>We have made progress in implementing information technology in hospitals, but improvements are still needed.</li> <li>Hospitals have made major improvements in the ability to store and retrieve digital diagnostic images such as X-rays.</li> <li>Ontario lags behind the US for EMR adoption; only 50% of hospitals have electronic patient records and fewer than one in 10 send information electronically to doctors and home care services in the community.</li> </ul>	<ul style="list-style-type: none"> <li>Do we have the support of our physicians in the adoption of information technology? Who are our physician champions?</li> <li>What percentage of our annual budget are we dedicating to the adoption of information technology?</li> <li>What are we doing to improve our hospital's ability to share information with other hospitals, doctors and home care?</li> <li>What proportion of our hospital medical record is populated through computerized data entry versus paper records?</li> </ul>
9. Worker health and safety (section 8.3)	<ul style="list-style-type: none"> <li>There has been no major improvement in injury rates in the past six years. There is much room for improvement in this area.</li> <li>Although hospitals have lower injury rates than other sectors, such as LTC, overall healthcare has higher injury rates than other industries, such as construction and mining.</li> </ul>	<ul style="list-style-type: none"> <li>Do we have mandatory safety training for all new staff? Have all staff and physicians received this training?</li> <li>Have we done the proper risk assessments to ensure a safe environment?</li> <li>Do we promote and support healthy lifestyles in our organization?</li> <li>Do we recognize jobs well done and high performers?</li> <li>Have we purchased safety equipment to reduce the number of injuries? If not, have we budgeted for the purchase of these systems?</li> </ul>
10. Hospitalization for ambulatory care sensitive conditions (section 3.2)	<ul style="list-style-type: none"> <li>There has been a steady drop in admission rates for angina, asthma and CHF; however, we believe there is still an opportunity to reduce these rates further.</li> </ul>	<ul style="list-style-type: none"> <li>Are we educating patients about their own role in treating their chronic diseases? Have we simplified care plans, making them easier to follow?</li> <li>Do we need a strategy to help engage primary care providers and/or the community to improve chronic disease management so their patients do not end up in our hospital?</li> </ul>
11. Hospital finances (section 7.1)	<ul style="list-style-type: none"> <li>More than 40% of hospitals were in a deficit position this year, with one in every two community hospitals having a deficit.</li> <li>Hospitals continue to struggle to manage their current ability to pay bills without having to borrow.</li> </ul>	<ul style="list-style-type: none"> <li>While the first instinct when facing a deficit is to cut services, has our hospital management carefully thought of all the different sources of waste in the system and made aggressive plans to eliminate them (e.g., unnecessary tests or services and waste of staffing, space, inventory and supplies)?</li> </ul>

# 1.4 Home care summary

Summary for home and community care leaders, staff and clients.

**HOSPITAL**

**LONG-TERM CARE**

**HOME CARE**

**PRIMARY CARE**

Topic area	Key facts	Questions to ask
1. LTC wait times/ALC (sections 2.4 and 7.2)	<ul style="list-style-type: none"> <li>Despite a major increase in LTC beds several years ago, wait times for an LTC bed have tripled since the spring of 2005 and are now at 105 days (over three months). For those waiting in the community, the wait is 173 days; for those waiting in hospital, it is 53 days. The latter contributes to the serious and growing problem of ALC beds in hospitals — one-sixth of hospital beds are occupied by someone who does not need to be there.</li> <li>One in four people placed in LTC could potentially be cared for in alternative settings.</li> </ul>	<ul style="list-style-type: none"> <li>Is home care involved early during the hospital stay for vulnerable clients?</li> <li>What additional home care services are needed to keep people out of LTC?</li> <li>What alternatives to LTC are there for those who do not need the full range of LTC services? More home care? Assisted living or supportive housing options?</li> <li>Are decisions to apply for LTC being made prematurely for hospital patients, before they have had a chance to recover?</li> </ul>
2. Falls (section 4.6)	<ul style="list-style-type: none"> <li>Of people receiving care in the community, 25% have fallen within the last 90 days. There is likely room to improve.</li> </ul>	<ul style="list-style-type: none"> <li>Are we checking for clutter or poor lighting in the home? Are there safety bars?</li> <li>Are we encouraging the use of mobility aides (e.g., walkers) and checking for proper use?</li> <li>Do high-risk clients get rehabilitation to improve strength and balance?</li> <li>Are any clients on a drug with side effects that might cause a fall? If so, have we discussed safer alternatives with the doctor?</li> </ul>
3. Pressure ulcers (section 4.6)	<ul style="list-style-type: none"> <li>Of people receiving care at home and in the community, 1.4% have new stage 2 to 4 pressure ulcers every six months.</li> </ul>	<ul style="list-style-type: none"> <li>Do vulnerable clients get risk assessments for ulcers? Are they up to date? Are staff regularly monitoring for early signs of ulcers? Are high-risk clients getting special padding to avoid ulcers on pressure points?</li> </ul>
4. Injuries (section 4.6)	<ul style="list-style-type: none"> <li>12% of home care clients have had unexplained injuries, burns or fractures in the past six months. There is room to improve.</li> </ul>	<ul style="list-style-type: none"> <li>Are we checking for safety hazards in the home (e.g., hot water temperature, electrical outlets and clutter)?</li> </ul>
5. Bladder incontinence (section 3.6)	<ul style="list-style-type: none"> <li>46% of clients have had a decrease in bladder function, or no improvement of a past bladder control problem over the past six months.</li> </ul>	<ul style="list-style-type: none"> <li>Are home care staff teaching “prompted voiding” protocols or bladder strengthening exercises to clients to prevent deteriorating bladder control?</li> <li>Are clients advised to stop certain foods (e.g., caffeine)?</li> </ul>
6. Activities of daily living (section 3.6)	<ul style="list-style-type: none"> <li>44% of clients experience a new problem with normal everyday tasks (getting dressed, eating, personal hygiene) or have an old problem that is not getting better.</li> </ul>	<ul style="list-style-type: none"> <li>Are home care clients being offered physiotherapy or rehabilitation services to keep them mobile?</li> </ul>
7. Mental health (section 3.6)	<ul style="list-style-type: none"> <li>9% of clients show signs of serious depression (e.g., profound sadness and withdrawal from normal activities).</li> </ul>	<ul style="list-style-type: none"> <li>Is home care arranging for social activities or coordinating treatment of depression with the family doctor?</li> </ul>
8. Pain control (section 3.6)	<ul style="list-style-type: none"> <li>Of home care clients who have pain, 22% have pain that is not well controlled. There is likely room to improve.</li> </ul>	<ul style="list-style-type: none"> <li>Are home care clients getting frequent assessments of pain?</li> <li>Are home care workers communicating information about pain to the doctor so that treatment plans can be adjusted?</li> </ul>
9. Readmissions (section 3.3)	<ul style="list-style-type: none"> <li>Readmission rates for heart attacks, CHF and asthma have decreased in the past five years. However, they remain high for CHF and COPD (e.g., emphysema). There is still room to improve.</li> </ul>	<ul style="list-style-type: none"> <li>Are we making sure clients leave hospital on the right medications and know what warning signs to look out for and whom to call for help?</li> <li>Are we screening and monitoring high-risk clients who are at risk of readmission?</li> <li>Are clients getting the right monitoring at home (e.g., daily weight-taking for CHF clients)?</li> <li>Do we have a process to ensure medication reviews are done routinely (e.g., MedsCheck)?</li> </ul>

# 1.5 Primary care summary

Summary for primary care practitioners.

Topic area	Key facts	Questions for physicians, nurses and other primary care practitioners to ask themselves
1. Access to primary care (section 2.2)	<ul style="list-style-type: none"> <li>• There has been no change in the past three years in the percentage of Ontarians without a regular family doctor. Roughly 730,000 adults are without a doctor, with half of them actively looking.</li> <li>• Nine in 10 Ontarians think they wait too long for a family doctor appointment. Only 53% of Ontarians can see their doctor on the same day or next day when sick — this standing is the worst among 11 major countries surveyed.</li> </ul>	<ul style="list-style-type: none"> <li>• Are we tracking wait times in our clinic?</li> <li>• Are we using advanced access, the system of scheduling appointments and managing patient flow to reduce or eliminate wait times for appointments?</li> <li>• Could we reduce unnecessary repeat visits to free up more time to serve people better (e.g., by giving lab results over the phone instead of requiring a visit)?</li> <li>• Are our processes as efficient as they could be? For example, is each exam room set up exactly the same way? Can things be relocated to reduce walking around?</li> <li>• Are we working in a team? If yes, are we using each team member to his/her fullest capacity? What tasks could be shifted from one team member to another?</li> </ul>
2. Surgical and CT/MRI scan wait times (section 2.3)	<ul style="list-style-type: none"> <li>• Wait times for some surgeries are good or improving (e.g., cataract surgery, hip and knee replacements and cardiovascular procedures), but there is still room for improvement overall.</li> <li>• Wait times are still too high for CT/MRI scans.</li> </ul>	<ul style="list-style-type: none"> <li>• For CT/MRI scans, are all the tests we are ordering necessary? Do we find ourselves pressured into ordering tests that are not needed? What could we do about that?</li> <li>• Do we ever use the Ontario Wait Times website to find places that can do a surgery sooner if the patient wants this?</li> </ul>
3. ALC (section 7.2)	<ul style="list-style-type: none"> <li>• 16% of hospital beds are designated as ALC and the problem has gotten worse in the last three years.</li> </ul>	<ul style="list-style-type: none"> <li>• Are we identifying people at high risk for becoming an ALC patient?</li> <li>• Are there frail or elderly patients in our practice whose needs have not yet been assessed by a CCAC?</li> </ul>
4. Chronic disease management (section 3.2)	<ul style="list-style-type: none"> <li>• While complications from diabetes have decreased significantly over the past five years, patients are still not getting the regular monitoring of their condition and risk factors that they need.</li> <li>• Only half of diabetes patients have their eyes and feet examined and slightly fewer than half are getting the medication they need. While this is an improvement over the past six years, it is still far from the standard set by experts who say nearly all patients should receive medication.</li> <li>• The number of patients who die within one year of having a heart attack has improved slightly to one in 11, but we can still do better.</li> </ul>	<ul style="list-style-type: none"> <li>• Are we using methods such as flow sheets to remind us of all the best practices?</li> <li>• If we have an EMR, does it provide us with data on the percentage of our diabetes patients who are on the right drugs (e.g., a statin, ACEI/ARB and acetylsalicylic acid) and who have received a recent A1C or eye exam? Have we set the EMR up so that it reminds us when they need tests or follow-up?</li> <li>• Do all of our patients know what their targets are for good disease control (e.g., BP&lt;130/80 for diabetes or A1C&lt;7)? Have they identified their own goals for improving their health (e.g., personal targets for weight reduction)? Have they all been connected with a chronic disease self-management program?</li> <li>• Are we using all members of our health team to ensure that all recommended tests, education, etc. in the chronic disease management guidelines are completed?</li> <li>• Do we have a monofilament in the office to do proper diabetes foot exams?</li> </ul>

**HOSPITAL****LONG-TERM CARE****HOME CARE****PRIMARY CARE**

Topic area	Key facts	Questions for physicians, nurses and other primary care practitioners to ask themselves
5. Drug safety (section 4.4)	<ul style="list-style-type: none"> <li>• Only 13% of Ontario doctors routinely provide patients with a list of medications taken, with 46% never providing a list.</li> <li>• About one in five seniors aged 65 and over are on a medication with potentially dangerous side effects.</li> </ul>	<ul style="list-style-type: none"> <li>• Can our EMRs easily generate an up-to-date list of all medications for our patients? Are we giving these updated lists regularly to our patients?</li> <li>• Are we encouraging patients to fill their prescriptions at the same pharmacy each time?</li> <li>• Are we considering safer alternatives for seniors who are currently taking a drug on the “Beers” list of drugs to avoid (e.g., using nortriptyline instead of amitriptyline; using other SSRIs instead of Prozac; avoiding long-acting benzodiazepines such as valium; either stopping short-acting benzodiazepines or keeping the dose to half the usual adult dose)?</li> <li>• Are we reviewing medications during transitions of care?</li> </ul>
6. EHR adoption (section 8.2)	<ul style="list-style-type: none"> <li>• The percentage of family doctors with EMRs rose from 26% in 2007 to 43% in 2009. We have made progress, but improvements are still needed. Ontario lags behind Australia, the UK and the Netherlands, which have 95 to 99% adoption rates.</li> <li>• Not all family doctors are using key features of EMRs such as flagging drug interactions or sending reminders for follow-up.</li> </ul>	<ul style="list-style-type: none"> <li>• If we are considering buying an EMR system, ask the potential vendors: <ul style="list-style-type: none"> <li>- Can it give me a list of all patients with certain chronic diseases?</li> <li>- Can it track key indicators such as percentage of diabetes patients with A1C under control (see 4 above)?</li> <li>- Will it send reminders when patients need follow-up or tests?</li> <li>- Can it connect to pharmacies, labs, hospitals and other providers?</li> </ul> </li> </ul>
7. Health human resources (section 8.4)	<ul style="list-style-type: none"> <li>• From 2002 to 2008, there has been an increase in the supply of family doctors and nurse practitioners. However, despite the greater rise in nurse practitioner positions, there is still only one nurse practitioner for every 10 family physicians in the province, and only half of Ontario’s family doctors routinely work with other healthcare providers in their practice. Improvement is still needed as we are far from being able to create teams where family doctors work routinely with nurse practitioners.</li> </ul>	<ul style="list-style-type: none"> <li>• Are we using a team approach in our practice? If not, what are the reasons for not using it?</li> <li>• Could our current practice be more efficient and/or effective (e.g., do we have good communication and are we using everyone’s role to its full potential)?</li> <li>• What are the roles and responsibilities of the various health professionals? How can using other professionals reduce the workload in our practice?</li> </ul>
8. Population-based health (chapter 10)	<ul style="list-style-type: none"> <li>• We saw some improvements in healthy behaviours from 2001 to 2004, but we have since lost ground from 2005 to 2008. Half of Ontarians are not getting enough exercise, one in six are smoking and one in five are heavy drinkers.</li> <li>• Breastfeeding rates are increasing and teen pregnancy rates are decreasing, but there is still room to improve.</li> <li>• One-quarter of the population does not get necessary health prevention services (e.g., pap tests, mammography and flu shots).</li> <li>• People with low incomes or poor education are at higher risk of unhealthy behaviours and not getting health prevention services.</li> </ul>	<ul style="list-style-type: none"> <li>• Do we ask our patients about their smoking cessation at each visit?</li> <li>• Do we have a list of all smoking cessation supports in our community for our patients?</li> <li>• Do we have outreach programs for people in high-risk groups?</li> <li>• Do we use flow sheets to remind us of all the health prevention interventions that need to be done during periodic health exams?</li> <li>• If we have an EMR, does it generate reminders when people are due for their next health prevention service?</li> </ul>

## 1.6 Long-term care summary

Summary for LTC leaders, staff, residents and family members.

Topic area	Key facts	Questions to ask
1. LTC wait times (sections 2.4 and 7.2)	<ul style="list-style-type: none"> <li>• Despite a major increase in LTC beds several years ago, wait times have tripled since the spring of 2005 and are now at 105 days (over three months). This is contributing to the worsening ALC problem in acute care hospitals.</li> <li>• Only 40% of those needing LTC care got their first choice of home when placed for the first time.</li> </ul>	<ul style="list-style-type: none"> <li>• Do we have enough housing and care options in the community for people who need more services than those provided by home care but not all those provided by an LTC home?</li> <li>• Are there bottlenecks that delay the admission of residents to a home? How can the admission intake process be redesigned to make it more efficient?</li> <li>• Have we considered the cultural, ethnic and linguistic needs of our region? Have we factored this into our capacity planning?</li> </ul>
2. Falls (section 4.5)	<ul style="list-style-type: none"> <li>• One in seven residents has fallen in the last month and there has been no change in the rate of serious falls resulting in emergency department visits in recent years. There is likely room for improvement.</li> </ul>	<ul style="list-style-type: none"> <li>• Are we evaluating the cause of each fall?</li> <li>• Are we doing risk assessments for falls consistently? Are they up to date? Are we checking for clutter, poor lighting or other hazards? Are we avoiding physical restraints, which can cause falls?</li> <li>• Are we offering and encouraging the use of assistive devices (e.g., walkers), hip protectors for those at high risk and exercise programs to maintain strength and balance?</li> <li>• Are we avoiding drugs that make residents dizzy or confused (see 6 below)?</li> <li>• Do we have enough staff to assist residents in getting to washrooms, etc.?</li> <li>• If a resident is on a drug with side effects that might cause a fall, have we discussed a safer alternative with the doctor?</li> </ul>
3. Pressure ulcers (section 4.5)	<ul style="list-style-type: none"> <li>• Approximately one in nine residents develops a new, serious pressure ulcer each year.</li> </ul>	<ul style="list-style-type: none"> <li>• Are we doing risk scoring for ulcers consistently for all residents?</li> <li>• Do we provide training for all staff in protocols for prevention (e.g., early detection, turning immobile residents regularly and proper technique to avoid tearing the skin when moving a resident)?</li> <li>• Do we have proper padding or special mattresses for high-risk residents?</li> <li>• Do we have standard protocols agreed to by all doctors for treating pressure ulcers?</li> </ul>
4. Bladder incontinence (section 3.5)	<ul style="list-style-type: none"> <li>• One in six residents finds that his/her bladder control has gotten worse over the past three months.</li> </ul>	<ul style="list-style-type: none"> <li>• Are residents getting help with either exercises to strengthen bladder muscles or learning “prompted voiding” protocols that can help avoid incontinence?</li> <li>• Are residents getting prompt assistance when they want to go to the washroom?</li> <li>• Do residents know that some food items (e.g., drinks with caffeine) can worsen incontinence?</li> </ul>

**HOSPITAL****LONG-TERM CARE****HOME CARE****PRIMARY CARE**

Topic area	Key facts	Questions to ask
5. Avoidable emergency department visits (section 3.7)	<ul style="list-style-type: none"> <li>Avoidable emergency department visits are common among LTC residents. There has been no change in the last six years. There is likely major room for improvement.</li> </ul>	<ul style="list-style-type: none"> <li>What training or support do staff need to increase their skills in handling minor emergencies without needing to transfer to the emergency department?</li> <li>Have we considered using nurse practitioners, telemedicine or better organized call schedules for physicians to improve the availability of people to assess minor emergencies within the home?</li> <li>Are family members aware of the potential risks of emergency department visits (e.g., confusion and hospital-acquired infections)?</li> </ul>
6. Drug safety (section 4.4)	<ul style="list-style-type: none"> <li>The use of drugs that should be avoided in the elderly (the “Beers” list) is decreasing but could be decreased further. Shortly after entering an LTC home, one in six residents receives a new antipsychotic drug that he or she was not taking before, and one in four receives a new drug for anxiety or sleep. These drugs have many risks.</li> </ul>	<ul style="list-style-type: none"> <li>Why are so many people started on sleeping pills once they enter an LTC home? What non-drug options are being tried to reduce insomnia (e.g., avoiding caffeine, reducing noise, adopting a regular sleep routine, avoiding long naps and managing underlying depression)?</li> <li>Are physicians and staff familiar with drugs to avoid in the elderly? Should some drugs be removed from the formulary?</li> <li>Does a pharmacist do regular, detailed reviews of medications, with the involvement of family and staff?</li> <li>Have we tried non-drug approaches for behavioural issues such as aggression (see 8 below)?</li> </ul>
7. Restraint use (section 4.5)	<ul style="list-style-type: none"> <li>17% of LTC residents are physically restrained. Ontario lags behind other countries with much lower rates. There is room to improve.</li> </ul>	<ul style="list-style-type: none"> <li>Are we educating staff and family members who ask for restraints about their hazards (e.g., falls, pressure ulcers and asphyxiation)?</li> <li>For people who wander, have we considered alternatives to restraints, such as bed and door alarms?</li> </ul>
8. Behavioural issues (section 4.5)	<ul style="list-style-type: none"> <li>11% of LTC residents’ behaviours have grown worse (e.g., aggression or wandering) over the past three months.</li> </ul>	<ul style="list-style-type: none"> <li>Are staff trained in communication and conflict de-escalation techniques to avoid making residents frustrated (e.g., good eye contact and one-sentence questions)?</li> <li>Can we communicate in the various languages of our residents?</li> <li>Do staff consider that behaviour may result from an existing or new health problem, discomfort or fear? When causes of disruptive behaviour can be identified, are solutions incorporated in care plans?</li> </ul>

## 1.7 Cardiovascular disease summary

### Cardiovascular disease

Overall, there has been a great improvement in the management of cardiovascular disease, but there are still areas where we can do better — particularly in congestive heart failure (CHF).

1. **Wait times for cardiovascular surgeries are within target for most patients, but there is still room to improve.** For coronary artery bypass, angiography and percutaneous coronary intervention, around 95% of patients have their surgery done within the recommended timeframe. There is some room to improve wait times for urgent cases for bypass (79% done within the target time) and semi-urgent percutaneous coronary interventions (65% done within the target time).
2. **More patients are on the right medications after a heart attack but, again, there is room to improve.** Use of a statin, beta-blocker and ACEI/ARB is at 86%, 79% and 80%, respectively, whereas experts suggest these rates should be closer to 90%.
3. **Heart attack incidence, mortality and readmissions are declining.** Hospitalizations for angina have also dropped by more than half over the past six years.
4. **High mortality and readmissions for CHF.** One-third of patients admitted with CHF for the first time die within the following year. This has not improved in the last six years. There were decreases in readmissions several years ago, but no improvement in the last three years. The 30-day readmission rate for CHF remains the highest of any diagnostic group, at 11%.
5. **For stroke, mortality has improved but there are opportunities to do better.** Mortality rates are declining and almost all patients are on acetylsalicylic acid or other anti-thrombotic drugs. However, only 12% of stroke patients arriving in an emergency department who could benefit from thrombolysis (clot-busting drug) get it within the recommended one-hour timeframe. Lives could be saved and disability avoided if we did a better job.
6. **Progress in reducing unhealthy behaviours (such as smoking, obesity and physical inactivity) that lead to heart disease has been stalled in the last three years.** At present, the rates of these behaviours in the population are 16%, 50% and 18%, respectively.
7. **Those with low incomes and poor education continue to be at greatest risk for both heart disease and unhealthy behaviours.** For example, smoking rates are 31% for those without a high school diploma and 13% for those with post-secondary education. Rates of physical inactivity are 58% for those in the lowest income brackets, compared to 37% for those in the highest income brackets. If we want progress in reducing these unhealthy lifestyle activities, we will need to focus on strategies that are tailored to the most vulnerable parts of our population.

Key questions for patients with heart disease to ask themselves or discuss with their healthcare provider:

- Am I on all the right medications? Ask about acetylsalicylic acid (aspirin), a cholesterol-lowering drug (e.g., a statin), ACEI/ARB and beta-blocker for past heart attacks, blocked arteries and CHF.
- Am I getting all the right monitoring? This includes blood pressure checks, periodic cholesterol tests and, for CHF patients, an echocardiogram and daily weight monitoring.
- Do I know the early signs of a stroke, so I know when to go to the hospital immediately?
- Do I know my targets for blood pressure and cholesterol? Typical blood pressure targets are 140/90 (or 130/80 for those who also have diabetes); the target for LDL (“bad cholesterol”) is two or less.
- What am I doing to eliminate smoking, improve my physical activity and achieve or maintain my ideal weight? What personal goals would I like to set for myself? What help do I need — nutrition counselling, exercise groups, smoking cessation aids, support from friends or family?

# 1.8 Diabetes summary

**HOSPITAL**
**LONG-TERM CARE**
**HOME CARE**
**PRIMARY CARE**

## Diabetes

Overall, we are cautiously optimistic that there are signs of improvement in managing diabetes, but there is still a lot of room to do better — particularly in monitoring and screening patients' conditions and risk factors and filling prescriptions. If we are to see further progress, it is also important for patients to be engaged in managing their own care and setting their own targets and plans for improving their lifestyle choices.

- 1. The incidence of serious complications from diabetes has decreased in the last five years, but there is still room for improvement.** About one in 20 diabetes patients will experience a major complication (death, heart attack, stroke, amputation or kidney failure) in a year.
- 2. More patients are on the right medications for diabetes, but we are still far from the best.** Only 58% regularly fill their prescriptions for a cholesterol-lowering drug (e.g., a statin), 67% for ACEI/ARB, and 46% for both. Experts suggest that nearly all diabetes patients should be on these drugs.
- 3. Monitoring diabetes conditions is poor.** Only half of diabetes patients get regular eye and foot exams. All should be receiving these exams.
- 4. Rates of unhealthy behaviours that lead to or worsen diabetes have either not improved or recently become worse.** Rates of obesity and physical inactivity improved from 2001 to 2005, but then deteriorated from 2005 to 2008. In 2008, half of Ontarians were physically inactive and 18% were obese.
- 5. People at low income levels are less likely to receive proper diabetes monitoring.** For example, in 2008, 49% of people in the lowest income bracket had eye exams, compared to 66% among the wealthiest income levels. Those with low incomes also have a greater risk of pursuing unhealthy behaviours related to diet, exercise and smoking.

Key questions for healthcare leaders and staff to ask:

- Are we using methods such as flow sheets to remind us of all the best practices?
- If we have an EMR, does it provide us with data on the percentage of our diabetes patients who are on the right drugs (e.g., a statin and ACEI/ARB) or who have had a recent A1C or eye exam? Have we set up the EMR so that it reminds us when diabetes patients need testing or follow-up?
- Have our patients identified goals for improving their health? Have they been connected with a chronic disease self-management program?
- Do we use a monofilament in the office to do proper diabetes foot exams?
- What are we doing to reach out to the most vulnerable populations to ensure they are getting services targeted to their education level, culture or language?

Key questions for patients with diabetes to ask themselves or discuss with their healthcare provider:

- Am I on all the right medications? Ask about a statin, ACEI/ARB and acetylsalicylic acid (aspirin), in addition to medications to control blood sugar.
- Am I getting all the right monitoring? This includes eye checks, foot exams and urine tests, as well as regular blood tests for cholesterol and A1C (a three-month average of your blood sugar).
- Am I doing my own monitoring of blood sugar and blood pressure? Do I keep a log of my measurements at home?
- Have I set targets for blood sugar, blood pressure (ideally 130/80) and weight with my doctor?
- Am I eating properly and staying physically active? What personal goals do I want to set for improving my health? What support do I need to achieve my goals — nutrition counselling, exercise groups, smoking cessation aids, support from friends or family?

## 1.9 Cancer summary

### Cancer

Overall, there have been some improvements in cancer treatment in Ontario. However, patients continue to wait too long for surgeries and systemic treatments, and more progress is needed in reducing unhealthy behaviours and improving cancer screening.

- 1. Wait times for cancer care can be improved. Our greatest concern is with urgent cancer surgeries and systemic treatments (e.g., chemotherapy).** Only 53% of urgent (priority 2) patients have their surgery within the recommended timeframe. Some hospitals, including North York General Hospital, have achieved 97% through well-designed and efficient scheduling processes. Other hospitals could do the same. Wait times for radiation therapy have improved and three out of four patients are treated within the target timeframe. But there is still room to do better. Wait times for systemic treatments continue to be longer than the recommended 14-day target for both referral to consult and consult to treatment.
- 2. Rates of lung cancer and mortality from breast cancer have improved over the last 10 years.** This is good news and may be due to reduced smoking in previous decades and better treatments over time.
- 3. Screening rates for breast and cervical cancer are not getting better.** Approximately one-quarter of the population still does not get mammography screening or pap tests. Screening rates for colon cancer are increasing but are still too low, at 31%.
- 4. Progress in reducing unhealthy behaviours, such as smoking, inadequate consumption of fruits and vegetables, obesity, physical inactivity and heavy drinking has stalled recently.** At present, the rates of these behaviours in the population are 16%, 59%, 18%, 50% and 21%, respectively. There was some improvement in these rates between 2001 and 2005, but either no progress or deteriorating trends occurred from 2005 to 2008. These unhealthy lifestyle activities have been linked to breast, colon, lung, liver, kidney and other cancers.
- 5. People with low incomes and poor education levels continue to be at greatest risk for unhealthy behaviours and for not receiving preventive screening.** For example, smoking rates are 31% for those without a high school diploma and 13% for those with post-secondary education. Rates for mammography screening are 64% among low-income women, compared to 75% for those with higher incomes. Future plans to battle cancer need to consider strategies that target the most vulnerable in our population.

Key questions for healthcare leaders and staff to ask:

- What targets are we setting for wait times? If some places have achieved major improvements (e.g., North York General Hospital), why can we not do the same thing?
- Have we mapped out the processes involved in arranging cancer surgery, radiation or chemotherapy? Where are the areas of waste, duplication, error or missed hand-offs? What are we doing to make our processes more timely and reliable?
- Do we have information systems to ensure that everyone due for cancer screening is reminded?
- What are we doing to reach out to the most vulnerable populations?

Key questions for people to ask themselves or discuss with their healthcare provider:

- Which screening tests do I need for my age and gender and how often? When am I due for each of these?
- What am I doing to eliminate smoking, become more physically active and achieve or maintain my ideal weight? What personal goals would I like to set for myself? What help do I need — nutrition counselling, exercise groups, smoking cessation aids, support from friends or family?

# 1.10 Mental health summary

**HOSPITAL**
**LONG-TERM CARE**
**HOME CARE**
**PRIMARY CARE**

## Mental health

Mental health is an area where Ontario has major gaps in being able to measure the quality of healthcare services. In this report we summarize what is known with existing data and call for more investment to measure how well people are accessing the services they need and whether their symptoms or daily functioning have improved after receiving care.

- 1. Depression is a significant problem among frail or elderly individuals.** Nine percent of those in home care show serious signs of anxiety or depression, such as profound sadness or withdrawal from normal activities. Currently 22% of those living in LTC and 17% of those in complex continuing care (CCC) showed increasing symptoms of depression or anxiety in the preceding three months.
- 2. Inappropriate behaviour, such as aggression, agitation or wandering, is common among LTC residents.** About one in nine residents exhibited worsening behaviour over the past three months. These behaviours are particularly common among those with Alzheimer's or other dementias. Although there are no benchmarks for this indicator, there are many opportunities to improve.
- 3. Drug management for people in LTC homes and CCC continues to be of concern.** Among elderly LTC residents, 17% have an anti-psychotic medication prescribed with no clear reason and 30% have an anti-anxiety or hypnotic drug (sleeping pill) prescribed without having a clear diagnosis. Shortly after entering an LTC home, one in six residents receives an anti-psychotic drug and one in four receives a drug for anxiety or sleep that he/she was not receiving before. Almost one-quarter of CCC patients are on an anti-psychotic medication for no clear reason. These drugs have potentially serious side effects and should be avoided where possible. There has been little to no improvement in all of these indicators.
- 4. The rate of intentional self-harm has dropped in recent years, but there is still room for improvement.** At present, there are 89 emergency department visits per 100,000 for intentional self-harm. We note that women in lower income brackets appear to be at greatest risk. Suicide rates in Canada have remained constant from 2001 to 2005, at 12 per 100,000. Unfortunately, up-to-date data for this critical indicator is not available in Ontario.

Key questions for healthcare leaders and staff to ask:

- Are we over-prescribing anti-psychotic and anti-anxiety drugs? Are we using non-drug methods to deal with agitation, insomnia or anxiety? Are we offering people in home care or LTC social activities or counselling? To avoid frustration among LTC residents, are we using strategies such as one-sentence communication, maintaining good eye contact and conflict de-escalation techniques?
- Are we ensuring regular medication reviews by a pharmacist, with input from the client/resident, the family and staff?
- If we have an EMR, does it monitor drug utilization patterns?
- Do we screen for warning signs of depression?
- What are we doing to reach out to the most vulnerable populations to ensure they are getting the counselling they need to reduce the incidence of self-harm? Are we making sure the services we provide take into account people's culture, financial and family situation?

Key questions for family members of patients experiencing symptoms of mental illness to ask themselves, or discuss with their healthcare provider:

- Is my family member showing signs of depression? What is being done to treat these symptoms? If my family member is in LTC, is there anything in the surroundings that could be contributing? What could be done to improve participation in activities or social networks?
- Is my family member being given anti-psychotic or anti-anxiety/hypnotic drugs or sleeping pills (such as valium or ativan)? Have I discussed with his or her doctor if these medications are necessary and if there are alternative methods to deal with agitation, sleeplessness or anxiety?