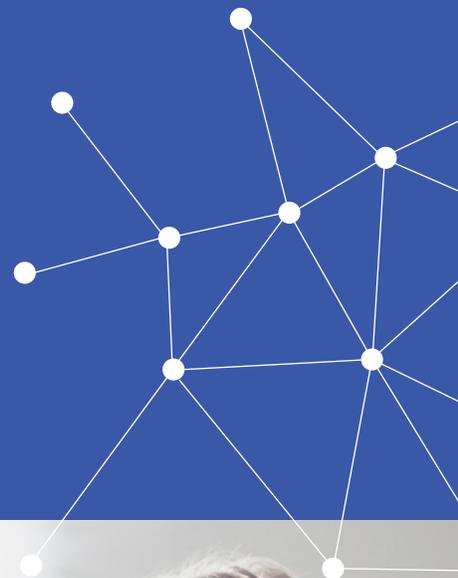


A Healthy Ontario: Building a Sustainable Health Care System

2nd Report from the Premier's Council on Improving Healthcare and Ending Hallway Medicine

June 2019



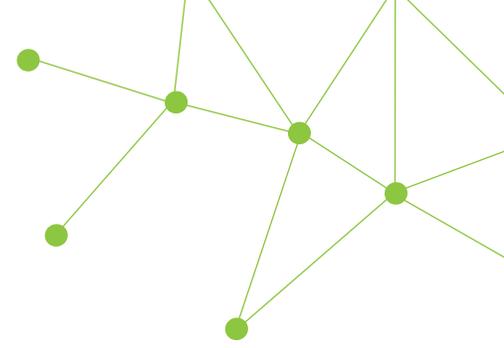


Table of Contents

3	Letter to the Premier of Ontario and the Ministers of Health and Long-Term Care
4	Executive Summary
6	Introduction <ul style="list-style-type: none">• Findings from Report 1
8	Chapter 1: We Hear You, Ontario
13	Chapter 2: The Vision for Health Care in Ontario
17	Chapter 3: Ten Recommendations to Improve Health Care <ul style="list-style-type: none">• Integration• Innovation• Efficiency & Alignment• Capacity
39	Chapter 4: Reporting Progress Throughout the System
43	Next Steps
44	Appendix A: Summary of Feedback and Engagement
49	Biographies
57	Acknowledgments

Letter to the Premier of Ontario and the Ministers of Health and Long-Term Care

Dear Premier Ford, Minister Elliott, and Minister Fullerton,

Since the release of our first report, *Hallway Health Care: A System Under Strain*, significant initiatives have been announced that will help build a modern, sustainable and integrated health care system.

This is a new vision for health care in the province.

As a Council, we support this vision and are encouraged by your commitment and progress to date. Many Ontarians have questions about what modernization will mean for the future of health care. At engagement sessions across the province we learned that there is enthusiasm among patients, caregivers and health care providers for this new vision, and there is hope for meaningful change.

The structural changes made by your government will go a long way towards ensuring the sustainability of our publicly funded health care system. The new Ontario Health agency will manage the system more efficiently, and Ontario Health Teams will ensure services are delivered in communities in a way that puts the patient at the centre of health care service delivery.

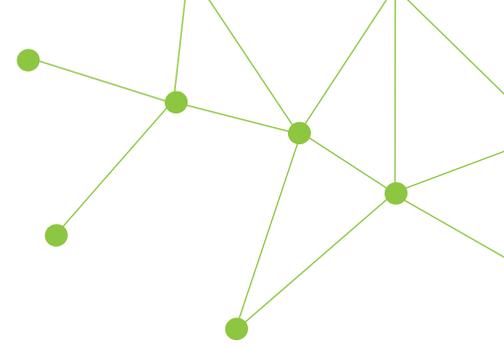
While these actions are a good start, there remains much more to do to support patients, relieve immediate capacity pressures, and build a health care system ready for future challenges and opportunities. In every community we visited, there was one clear message: the health care system can do better to meet the real day-to-day needs of patients, families and caregivers.

Ending hallway health care also requires a long-term plan. Health care is an ever-evolving sector, and while progress is made on the issues of today, we should also build a resilient system ready for the challenges of tomorrow. The recommendations in this report provide our best advice on how to plan for and protect the sustainability of our publicly-funded health care services.

As a Council, we are pleased to provide you advice with ten strategic policy recommendations that are aimed to end hallway health care and build a new health care system in Ontario. In this new system, care should be organized around each patient, health providers must work collaboratively, and services should be more readily available and accessible within our communities. These are the changes that matter to Ontarians, and this is what the health care system of the future should look like.

Dr. Rueben Devlin, *Chair*

Premier's Council on Improving Healthcare and Ending Hallway Medicine



Executive Summary

The Premier's Council released its first report in January 2019, which identified the main challenges facing Ontario's health care system. The first report, *Hallway Health Care: A System Under Strain*, explored what many Ontarians — and health system leaders — already suspected: the current health care system isn't working as well as it could for patients, providers, families, caregivers or taxpayers.

The Council's first report also identified emerging themes and opportunities for ending hallway health care, such as integrating care around patients, innovating in care delivery, finding more alignment and efficiency across system goals, and planning for long-term capacity needs. Since the release of its first report, the Premier's Council has conducted 10 regional engagement sessions in communities across the province and has heard from hundreds of individuals through its public email account. Although this is only the beginning of public engagement activities,

the Premier's Council has already received many important considerations directly from patients, providers and sector leaders about how to improve the system and end the problem of hallway health care.

The system — and Ontarians — are ready for bold change to improve and protect our publicly-funded health care system. There are many opportunities to improve the design and delivery of services in the province to ensure that the system is providing the right care, at the right time and in the right setting. This is about more than ending hallway health care, it's about building a better health care system that works for Ontarians of all ages.

The Council's second report to the Premier and Ministers of Health and Long-Term Care provides advice on how to achieve that new vision for health care in Ontario: a vision for a modern, sustainable and integrated health care system that is centred on the patient.

The Council's Ten Recommendations



Integration

1. Put patients at the centre of their health care. Patients should be well-supported and treated with dignity and respect throughout all interactions with the health care system.
2. Improve patients' and providers' ability to navigate the health care system, simplify the process of accessing and providing care in the community, and improve digital access to personal health information.
3. Support patients and providers at every step of a health care journey by ensuring effective primary care is the foundation of an integrated health care system.



Innovation

4. Improve options for health care delivery, including increasing the availability and use of a variety of virtual care options.
5. Modernize the home care sector and provide better alternatives in the community for patients who require a flexible mix of health care and other supports.



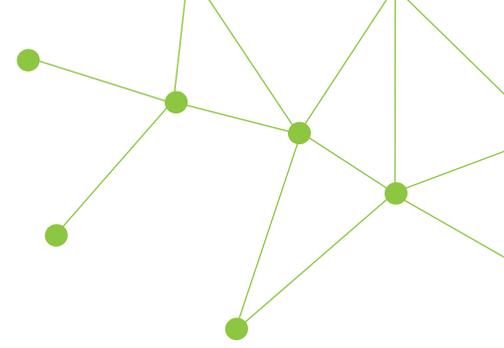
Efficiency & Alignment

6. Data should be strategically designed, open and transparent, and actively used throughout the health care system to drive greater accountability and to improve health outcomes.
7. Ensure Ontarians receive coordinated support by strengthening partnerships between health and social services, which are known to impact determinants of health.
8. As the health care system transforms, design financial incentives to promote improved health outcomes for patients, population health for communities and increased value for taxpayers.



Capacity

9. Address short- and long-term capacity pressures including wait times for specialist and community care by maximizing existing assets and skills and making strategic new investments. Build the appropriate health care system for the future.
10. Champion collaborative and interprofessional leadership development focused on system modernization capabilities.



Introduction

Since the release of the Council's initial report, *Hallway Health Care: A System Under Strain* there have been many important changes introduced in the health care system.

The government has launched new initiatives — such as Ontario Health Teams — that will create a health care system that is integrated, innovative and able to respond to short- and long-term capacity pressures. These initiatives are currently underway; however, there is much more work to be done to better connect patients, families, providers and caregivers with high-quality health care services.

Since releasing the last report in January, Council members have travelled to

communities across Ontario seeking feedback from patients, families, caregivers, providers and system leaders about how hallway health care has impacted their lives, and what can be done to reduce wait times and improve interactions with the health care system. The Premier's Council will continue to engage communities and is always open to more feedback about how to improve health care.

The Premier's Council has reviewed a substantial amount of research, listened to Ontarians, and developed a set of 10 strategic policy recommendations to help the government stay on track to end hallway health care and build a sustainable health system.

Findings from *Hallway Health Care: A System Under Strain*

In its first report to government, the Premier's Council identified three key challenges facing Ontario's health care system.

Key Findings

1. Patients and families are having difficulty navigating the health care system and are waiting too long for care. This has a negative impact on their own health and on provider and caregiver well-being.
2. The system is facing capacity pressures today and does not have the appropriate mix of services, beds or digital tools to be ready for the projected increase in complex care needs and capacity pressures in the short- and long-term.
3. There needs to be more effective coordination at both the system level and at the point-of-care. This could achieve better value for taxpayer money spent throughout the system. As currently designed, the health care system does not always work efficiently.

The first report also explored what these challenges look like throughout the health care system, and what this means for patients, families, caregivers and providers.

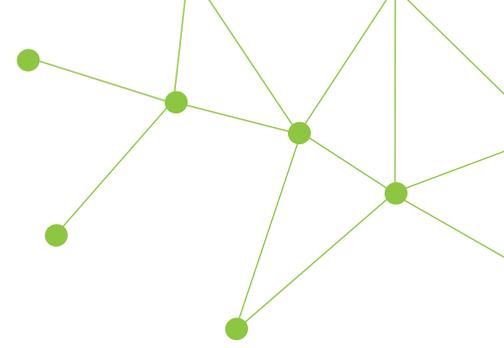
The report highlighted that patients and families are having a difficult time navigating the health care system. Ontarians cannot always see their primary care provider when they must, wait times for some procedures and access to specialist and community care are too long, and emergency department use is increasing. A lack of early intervention and prevention is contributing to more patients seeking care in hospitals rather than being cared for in their homes and communities. All of these challenges are connected to the problem of hallway health care.

Health care providers, family members and friends all feel the impact of a system that doesn't make it easy to access care. This leads to high levels of stress and places a heavy burden on caregivers to act as advocates for timely and high-quality health care services.

At the same time, the health care needs of Ontario's population are changing and the system needs to adapt. There are more patients with complex needs and there is an increase in chronic diseases that require careful and coordinated management. Fair and easy access to health care across the province continues to be a concern, and there isn't the right mix of services or beds to address the capacity pressures of today or prepare for long-term challenges in the future.

Chapter 1:

We Hear You, Ontario



The Premier's Council has heard from over 1,500 patients, caregivers, families, health care professionals and organizations on the future of health care in the province. In addition to drawing from their own professional experience, Council members gathered a wide range of perspectives and ideas from Ontarians through:

- Ten regional engagement sessions with over 650 participants from the following communities: London, Kingston, Ottawa, Toronto (Central and West), Sault Ste. Marie, Sudbury, Kenora, Thunder Bay and Sioux Lookout;
- A virtual engagement session with over 250 Francophone stakeholders and participants in 16 sites across the province;
- Initial dialogue with Indigenous communities and partners;
- Ongoing input from over 80 health sector leaders participating in six Premier's Council Sub-Committees; and,
- Over 500 written survey responses and emails.

Many Ontarians read the first report and responded by sharing their own personal experiences through the email address:

hallwayhealthcare@ontario.ca.



There were over 50 formal submissions from individual health care professionals or associations, and many people took the time to meet with us, providing research and helpful perspectives on how to improve the health care system and end the problem of hallway health care.

Ontarians are encouraged by the speed of progress and change and want to make sure the quality and availability of care won't be impacted while the sector transforms. All of the feedback received through these engagement activities was reviewed and considered in the development of this report. The Premier's Council is grateful to Ontarians for their interest in and commitment to modernizing health care in the province.

Regional Engagement Map



Common Feedback Across Ontario

Although the province is home to many unique communities — large and small, rural and urban, a wide range of cultures — Ontarians generally spoke with a common voice on very clear themes.

For the most part, Ontarians want the same from their health care system: publicly available services that are easy to understand

and access. Patients want more options and flexibility in how they access health care, and they want to know that the system is supporting them throughout the process, ensuring they are engaged and empowered throughout their health care journey. Ontarians would feel more confident in a health care system knowing their primary care provider was acting as a quarterback for them: championing their needs, guiding them through a complex system and providing leadership they can count on.

Patients across the province also have a broad understanding of what “health care” should mean in Ontario. They want to see closer partnerships between housing, social services and health care. They want to have more choices in how they connect with their care providers; if they can video-chat with friends and family, why can't they do the same with a health care professional? Although not every patient wants to — or is able to — use more digital solutions, there was broad support for improving options for connecting with care while maintaining patient choice.

We know that these perspectives from patients are echoed by the friends and family members who care for them. Research from The Change Foundation on the experience of caregivers in Ontario has uncovered concerns with accessing and navigating services across the province. Family caregivers are frustrated that health care providers do not always communicate with one another, resulting in caregivers having to re-tell a patient's story, and spend unnecessary time clarifying information. In fact, caregivers and health care providers are both looking for one clear point of contact that ensures patients' needs are met at every segment of their health care journey.

Caregivers are also looking for improved scheduling and timing of appointments. A report from 2016, titled *Ontario's Family Caregivers / The Caring Experience* called attention to the fact that primary care

appointments and home care visits can cause significant stress for a caregiver who must shift their personal commitments to accommodate a disjointed schedule of health care appointments. For family caregivers supporting patients with dementia, extended hours for respite or additional access to support overnight would help make it possible to keep their family member at home longer rather than moving them to a long-term care home. These examples point to areas where the health care system can redesign and re-orient services to better support the day-to-day realities facing patients, their families and caregivers.

Personal health information and a patient's health record should be digitally available and easily shared at the discretion of the patient.

Patients want to be partners in their health care. They view health care as a shared responsibility between patients and providers. Patients are doing their best to keep track of appointments, follow medication and rehabilitation instructions, and provide helpful updates to their primary care providers. Patients and providers would both prefer a health care system where health information was easily shared across providers working in different parts of the system, and more readily available to patients.

There are already many good examples of local integration and digital solutions – build on these models rather than starting from scratch.

The public strongly believes that existing partnerships throughout the health care system should be maintained and protected – especially now, during a time of significant transformation. The Premier’s Council heard clearly that patients and providers like the care that’s currently delivered through integrated primary care teams, and they appreciate creative solutions and partnerships that already exist between care settings in their local communities. Patients believe that when they receive care, it is generally of high quality. Despite the positive feedback from patients about the quality of care, access remains a challenge. In many instances, access to care is delayed and the system continues to struggle with transitions in care due to a lack of system-wide integration.

There are many examples of digital health services already working across the province. In the current system, telemedicine has been a critical tool in improving access to care in remote, rural, Francophone and Indigenous communities that do not always have sufficient

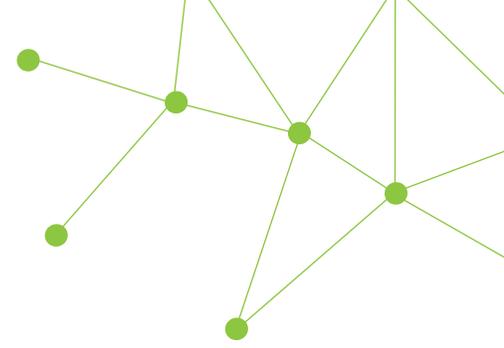
in-person capacity to meet local health care needs. Both remote patient monitoring and digital self-care, such as monitoring blood pressure at home, enable a small number of providers to coach a large number of patients. The province can and should continue to build on these successes by ensuring technology continues to supplement health care resources.

The current mix of health care and related services are not meeting local needs.

Even though hallway health care occurs in hospitals, part of the problem can be addressed by improving access to quality health care in other care settings – especially home and community care, and mental health and addictions services. Ontarians want more flexible home care services that respond to their individual needs and easier access to mental health and addictions services and supports in community settings. Some communities have access to a range of assisted living, supportive housing or other congregate care models, but these are not consistently available across the province. As innovative approaches emerge throughout the province, patients expect the system to encourage this kind of health care.

Chapter 2:

The Vision for Health Care in Ontario



There is a new bold vision for health care in the province of Ontario. The initiatives currently underway — such as Ontario Health Teams — will help create a system that is integrated, innovative, efficient and able to respond to the short- and long-term needs of our patients. There is a clear commitment from the government to end hallway health care by building a modern, sustainable and integrated health care system that starts with the patient.

This new vision for health care in Ontario is well-aligned with the “Quadruple Aim,” an internationally-recognized framework that designs and delivers an effective health care system. The four objectives of the Quadruple Aim are:

1. Improving the patient and caregiver experience;
2. Improving the health of populations;
3. Reducing the per capita cost of health care; and,
4. Improving the work life of providers.



The recommendations included in this report are aligned with the new vision and will make a positive difference in each area of the Quadruple Aim. In addition to the work already underway at the ministries, these recommendations will provide a roadmap to a new approach to health care that will keep patients from having to go to the emergency department to access service and avoid an admission to the hospital, if possible.

What Does An Integrated Health Care System Look Like?

The Ontario Health agency and Ontario Health Teams are important parts of building an integrated health care system in Ontario. When teams of health professionals work together to serve the same group of people, and when they are supported by common resources, performance expectations and planning tools at the provincial level, patients will receive coordinated and integrated health care.

In an integrated health care system, resources would follow the patient. There would be an emphasis on prevention and well-being, which would help divert patients from hospital-level care or from seeking care from the emergency department. Efficient processes, such as centralized intake and shared electronic medical records, are key features of a well-integrated health care system because they are tools designed to improve the allocation

of services and connect patients with the right level of care at the most appropriate time. An integrated health care system will improve access and availability of services throughout the health care system, will have a positive impact on wait times and will help solve the problem of hallway health care.

In the current system, health care providers in different care settings don't always work well together to provide coordinated care to patients. Transitioning between services can be difficult — especially for patients moving between youth and adult care. In an integrated health care system, patients could connect or visit their primary care provider's office and leave with a clear and well-defined treatment plan. With the patient's consent, integrated digital solutions would make a patient's medical history easily and electronically available to a full team of professionals working together to support the best outcomes for the patient.

What Will Sustainable Change Look Like?

Now	After Transformation
The Patient and Caregiver Experience	
<ul style="list-style-type: none">• Patients can't always see their primary care provider when they need to.• Patients and families are using the emergency department to access services that might be better treated in other care locations.• Patients are repeating personal health information to many health workers.• There is confusion and uncertainty about who is responsible and accountable for the health outcomes of a patient.• Caregivers spend more time on the phone with providers scheduling appointments and advocating for the patient instead of spending time with the patient themselves.	<ul style="list-style-type: none">• Patients have access to their own personal health information and are making healthy choices by accessing preventative services in the community after talking with their primary care provider about their health needs.• Patients know there is a team of health care professionals working with their primary care provider.• Patients are confident they are receiving wrap-around care that will keep them out of a hospital unless they need to be there. If emergency services are needed, they are readily available.• Patients and caregivers have access to a comprehensive care plan with appropriate and flexible community services available to support the transition between hospital and home or community service.

Now

After Transformation

Health of the Population

- Patients have increasingly complex and chronic health needs that could benefit from more support in the community.
- The current system waits until patients are in crisis or experiencing an acute episode rather than providing proactive and comprehensive health care.

- Patients of all ages can easily locate and receive services in community settings for their unique health needs, including mental health and addictions services and supports.
- Ontarians are healthier and know how to access a full range of health care services at the right time and in the right place in the system.

System Sustainability

- The current system does not have the right mix of beds, services or digital tools, and given the anticipated projections regarding population growth there will be significant capacity pressures in the near future unless the system adapts.

- A long-term capacity plan will be developed that identifies the right mix of services, health care workers, infrastructure and tools needed to ensure the equitable allocation of health care is attained in the province.

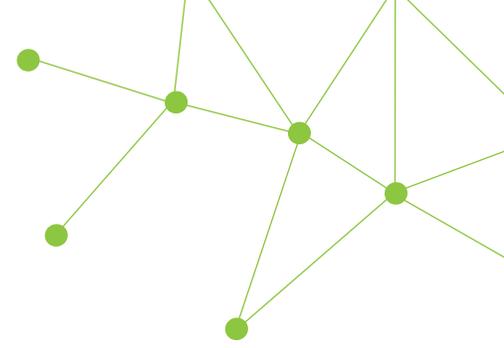
Provider Experience

- Providers can't find available services in the community for their patients, and don't feel connected to professional supports like training or access to specialists for patient referrals.
- Providers are frustrated with spending too much time on administrative work that does not directly help patients.

- Providers are working in a team environment and have access to a full continuum of care for their patients, as well as continued professional development support and resources.
- Overall stress is reduced, and more time, energy and resources are devoted to providing care to patients.

Chapter 3:

Ten Recommendations to Improve Health Care



Actions to end hallway health care and improve the design and delivery of Ontario's health care system are needed. The Premier's Council has a mandate to provide strategic advice to the government on how to address a broad scope of concerns heard from patients, providers, caregivers, sector leaders and as outlined in its first report.

Strategic policy advice for government provides a clear, strong vision on the best way forward given available evidence, research and input from the community. The strategic policy advice in this report includes a range of actions designed to remove current barriers and introduce key enablers to create the sustainable, publicly-funded health care system patients deserve.

These recommendations are intended to shift the way we think about health care in Ontario. It's not just about reducing wait times, or getting to the right number of beds, it's about preparing our workforce to be ready for a new way to deliver care. More than a transformation of structure, these recommendations will support a fundamental change in culture and organization of health care service planning and delivery. It is time to build a robust



community system and monitor how it's working. It is time to build bridges between primary care providers, home and community services, and hospitals. It is time to build a system designed to keep Ontarians healthy, rather than just responding to sickness.

During a period of significant structural modernization, this report also provides guidance for a complex system that must keep pace with technological change and prepare for future challenges and opportunities. The following recommendations are designed to help keep the many moving parts and people working together towards one common objective: a better health care system for Ontarians.



Recommendations 1-3

These recommendations build on the work already underway in the province to create an integrated health care system in Ontario. They identify *how* health care should be integrated around patients and across providers to ensure it works for all our communities and for all of our patients, including children and youth.

Modernized approaches to health care service delivery, such as easy — and safe — access to digitized personal health information will be critical to the success of this work. A modern, integrated and primary care-driven health care system is a fundamental shift in how the



government can help patients and providers navigate the health care system, and will improve patient, provider and caregiver well-being by putting patients at the centre of their health care decisions.

1

Put patients at the centre of their health care. Patients should be well-supported and treated with dignity and respect throughout all interactions with the health care system.

Action Items

The government should:

- Work with health sector leaders to provide more readily accessible and effective information to patients, families, caregivers and providers about the range of health services available at every age and stage of life.
 - This could include sharing real-time

emergency department wait times or introducing mechanisms for sharing meaningful and timely information to assist patients to make informed decisions about accessing services.

- Ensure health care service providers have the right skills and the appropriate training and support to communicate information to patients and families with clarity and compassion.

- Conversations about health care — especially at the end of life — can be difficult, making it even more important that providers are doing all they can to ensure patients have the information they need to make decisions about their health care journey.
- Measure patient experience and patient engagement along each stage of a health care journey by collecting and using standardized and digitally-enabled Patient Reported Experience Measures (PREMs).
 - This should be done in partnership with patients and providers to optimize meaningfulness and engagement.

What Will These Actions Accomplish?

These actions will provide the tools needed to build a system that patients and their caregivers feel comfortable with, and to know that the system is working well. Patient experience information will allow the government to course-correct when improvements are needed to ensure patients are at the centre of their own health care and satisfied with the system.

INNOVATION IN ONTARIO

Patient Oriented Discharge Summary (PODS)

PODS provide patients with easy-to-understand instructions upon hospital discharge and facilitates a tailored and clear discussion between health care providers and patients about what to do when they return home. PODS were co-designed by patients and providers and piloted in eight Toronto-area hospital departments spanning adult, pediatric, rehabilitation, acute and surgery in 2015. Results showed that patient satisfaction scores related to discharge experience increased using PODS. Not only did they benefit patients, but providers also reported that PODS

gave their discharge conversations greater structure and didn't add to their workload, enabling them to communicate the most critical information to their patients consistently and efficiently.

PODS have been adopted in 25 hospitals across Ontario, reaching more than 80,000 patients annually, through the support of Health Quality Ontario and the Council of Academic Hospitals of Ontario's Adopting Research to Improve Care (ARTIC) program. They are being further spread to 16 organizations across Canada through the Canadian Foundation for Healthcare Improvement's Bridge to Home Collaborative.

2

Improve patients' and providers' ability to navigate the health care system, simplify the process of accessing and providing care in the community, and improve digital access to personal health information.

Action Items

The government should:

- Shift its approach to personal health information oversight and introduce legislation that keeps patient information secure while also creating a data information system where patients own their information and have control over consent.
- Modernized legislation should find the right balance between improving comprehensive access to personal health information and keeping the information secure. This would require changes to the Personal Health Information Protection Act (PHIPA).
- Changes to PHIPA could include:
 - Maintaining the principles of consent and security and give patients access to their health data in formats that are easy to use;
 - Enabling health data to be shared between providers so that patients receive better-integrated care, and so that providers will have a more complete picture of their patients' health status; and,
- Making appropriate data available to researchers and others who will use it to further our understanding of how to deliver safe, effective and high-quality care in Ontario.
- Lead the development of one digital identity for each Ontarian to help ensure a patient's full story is understood by care providers.
 - Develop a policy to govern basic requirements for sharing information throughout the system; and,
 - Create standards for data and for sharing information between electronic clinical systems.
- Modernize and implement programs that help patients better navigate the health care system. This would include current system components such as Telehealth Ontario, Health Care Connect and Healthline, but also new innovative technologies.
- Continue developing systems that enable providers to access patient information and to communicate with and refer patients to other providers, such as eConsult, eReferral and Health Report Manager, and encourage their adoption and use by providers.

What Will These Actions Accomplish?

Patients, families and caregivers feel a significant amount of personal responsibility for their own health outcomes. Staying healthy, taking preventative actions, and investing in their own health and wellness is important to Ontarians. These actions will help the system shift by ensuring patients have access and ownership of their own personal health information and giving providers a full patient record.

These changes would help multiple service providers identify the right supports to connect patients with integrated health care, regardless of the care setting. This would mean that barriers to sharing health information with patients, across providers and between care settings will be removed, and patients will have better access to coordinated and integrated services without having to share their personal story with multiple providers.

INNOVATION IN ONTARIO

BASE eConsult: Connecting Primary Care Providers to Specialists Electronically

Building Access to Specialists through e-Consult (BASE) is an online platform connecting primary care providers with specialists. It was developed to address the challenge of long wait times for patients requiring non-urgent care and guidance from specialists. A secure web-based application allows primary care providers to request a consultation from a group of specialists, and a response is provided within one week. To date, 43,000 cases have been processed, with the following results:

- In over 40% of eConsult cases, an in-person visit to the specialist was being contemplated but was deemed not to be

required after the eConsult. This meant less unnecessary wait times for patients, and specialist resources were more available for the patients who needed them most.

- When a patient needed a specialist visit, those visits were often more effective and productive due to steps or treatments initiated based on the eConsult prior to the in-person visit.
- In nearly 60% of cases, specialists provided information to help primary care providers deliver the best care for their patients, resulting in positive health care provider experiences.

3

Support patients and providers at every step of a health care journey by ensuring effective primary care is the foundation of an integrated health care system.

Action Items

The government should:

- Work with health professionals to ensure all patients — especially those with complex needs — are well-connected to a comprehensive range of health services in the community.
 - The primary care provider and team provide the foundational care in the medical “home” of the patient, and they should be encouraged to quickly and efficiently connect patients with additional services as required.
 - Work with primary care providers to ensure they have information sharing and referral tools to link with all appropriate community providers, enabling seamless transitions for patients, with continued involvement by primary care.
 - Work with health sector leadership to improve patient access to services, such as laboratory services or urgent care, by extending or modifying service hours and/or delivery models to better match population needs.
 - This can occur through partnerships with community providers; for example, mental health walk-in clinics offered through community mental health and addictions agencies. This will require careful attention to and action on a health human resources plan.
 - Facilitate connections between primary care and community mental health and addictions services and supports.
 - Build on existing models such as co-location, shared care models or embedded community agency staff in primary care facilities, where primary care providers and mental health and addictions agencies work together.
 - Increase the visibility of and simplify access to community-based mental health and addictions services.
 - Ensure Ontario Health Teams facilitate clinician leadership and support strong and meaningful partnerships with the primary care sector.
 - These partnerships should be encouraged for all primary care providers, regardless of their model of payment or care.
-

What Will These Actions Accomplish?

Access to primary care is a key component of a successful health care system. Primary care providers have significant expertise; however, they often do not have the capacity to provide the entire range of comprehensive mental health and addictions supports patients need.

The actions listed above will ensure primary care providers have clear, established

connections to community service providers, allowing patients to access the entire range of services they require. Children and youth — who typically have a connection to a primary care provider — will be easily connected to specialized community services, where and when required. Ontario Health Teams could be the vehicle to achieve integrated care at the local level.

INNOVATION IN ONTARIO

Windsor Family Health Team

The Windsor Family Health Team expanded their service delivery through a Team Care Centre (TCC) model, in partnership with the City Centre Community Health Centre.

This model serves the rostered patients of 100–125 solo primary care practitioners in the Windsor area, or approximately 200,000 people.

The TCC model provides solo primary care providers with an interdisciplinary team-based, patient-centred approach in mental health diagnosis, and treatment plans for individuals with mental health/addictions and complex care needs.

It also increases access to wrap-around services and programs to meet the health care needs of the community.

The success of this model is seen through 100 community physicians providing over 1,000 referrals since September 2018. Patient outcomes have improved, patient satisfaction rates have increased and unnecessary visits to health care providers have reduced. Moreover, mental health patients have experienced enhanced quality of life, and benefitted from improved care coordination and navigation.



Recommendations 4-5

There are gaps in health services that can't be addressed by offering more of the status quo. It is time to nurture innovative ideas and design new solutions to solve long-standing problems. These recommendations address the growing demand and opportunity to innovate in care delivery, particularly in the use of virtual care and by creating the right conditions for modern programs to scale across the province and deliver better care to patients.

As the population ages and patients' needs become more complex, finding the right mix of services can be challenging for families and caregivers. Other factors, such as low



population densities, can make it difficult to access specialists close to home. These recommendations address the pressing need to provide access to innovative, modern and publicly-funded health care options for all Ontarians, in all our communities.

4

Improve options for health care delivery, including increasing the availability and use of a variety of virtual care options.

Action Items

The government should:

- Work with health care providers to increase access to virtual visits for patients who want them, while also protecting patient choice.
- Use legislative and/or policy tools and appropriate incentives to increase the availability and use of virtual care, including telephone calls, secure email and texting, video visits, or internet-based psychotherapy, to provide new delivery options for patients and providers.
- This could include modifying home and community care regulation to refine the definition of a home care visit to more clearly include virtual visits.

What Will These Actions Accomplish?

Patients and providers should be able to use technology to access health services in the most efficient way possible. Virtual visits and technology tools should be used to supplement in-person care but not replace it. This will mean that patients would have the choice to avoid travelling over two hours for a 15-minute health care appointment if it

could be delivered through a virtual platform instead. This will make the health care system work better for patients by delivering care that fits into patients' and families' lifestyle, and also help improve access to services by reducing wait times and avoiding emergency department use.

INNOVATION IN ONTARIO

Ontario's Structured Psychotherapy Program

Ontario is delivering a Structured Psychotherapy Program to treat depression and anxiety. It is based on a UK program that has demonstrated treating depression and anxiety in the community pays for itself by reducing health care costs, decreasing disability and social assistance payments and increasing tax revenue.

Clients access a stepped-care pathway depending on their needs, participating in psychoeducation groups, using clinician-supported internet-based

cognitive behavioural therapy (iCBT), self-management workbooks or in-person psychotherapy. Primary care providers support clients with medication and are kept up to date on their progress with data sent through electronic medical records.

Care is consistently delivered across four specialty mental health hospital hubs and multiple community sites. The program has demonstrated decreased use of acute care services and positive client recovery rates.

5

Modernize the home care sector and provide better alternatives in the community for patients who require a flexible mix of health care and other supports.

Action Items: Home Care and Congregate Care

The government should:

- Modernize home care legislation so that innovative care delivery models focused on quality can spread throughout the province. Legislative changes for consideration could include:
 - Providing flexibility to Ontario Health Teams and their partner organizations to provide all services and perform all home and community care functions, including all aspects of care coordination; current rules around referral to community care should be relaxed so that Ontario Health Teams and groups of providers can refer patients easily to the care that is best for them;
 - Establishing an oversight model for congregate care to facilitate delivery in the most appropriate environment whether it be hospitals, long-term care homes, clinics, supportive housing or retirement homes; and,
 - Enabling care coordination and navigation throughout the full continuum of care, rather than narrowly prescribing resources to a limited set of services.
- Review existing policies and make appropriate changes to support more innovation in the home care sector.

- This could include policy changes that would facilitate more flexible staffing models and services to improve the range of supports available to patients.

Action Items: Long-Term Care

The government should:

- Update the rules around access to long-term care beds to ensure these beds are available for patients who need the service the most.
 - The long-term care home placement eligibility criteria should be reviewed to ensure applicants with medium to higher acuity care needs are prioritized into placement for long-term care and ensure that there are other options available to more appropriately meet the needs of people with lower acuity needs.

What Will These Actions Accomplish?

Patients will have access to innovative options for receiving care and a mix of flexible services in multiple locations such as homes, community facilities and long-term care homes — including more options for models of care in the community and access to more wrap-around services. Innovative and flexible congregate care models — like campuses of care — would relieve pressure on hospitals

by helping people stay in their communities longer and by providing new care settings for patients who are not yet able to return home after a hospital stay.

Taken together, these actions will create a full continuum of community-based care for patients and caregivers who require a more flexible mix of health care and related supports. These changes will mean that patients can stay in their homes longer and maintain their independence with an

appropriate and broad mix of supports. This will help a wide range of patients, including children with complex needs who, with the right supports, could stay at home rather than spend more time in a hospital. Patients will have new options for receiving affordable, timely and appropriate care within their communities, and patients who need a place in a long-term care home for medical reasons will have access to the appropriate level of care.

INNOVATION IN ONTARIO

Pine Villa Reintegration Care Model

Sunnybrook Health Sciences Centre, together with LOFT Community Services and SPRINT Seniors Care, collaborated to deliver an innovative, integrated care and accommodation model in Toronto. Pine Villa is a 69-bed transitional supportive housing site in a former retirement home, where clients are supported by personal support workers, Registered Practical Nurses, case managers, social workers and recreational therapists. It provides care in a community setting for clients who no longer need to be in a hospital but who are not yet able to return to their own home.

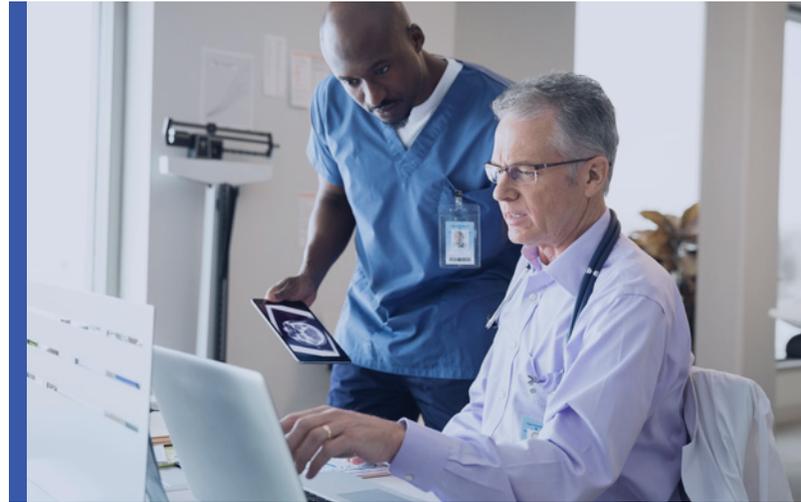
At Pine Villa, clients regain their strength and independence outside the hospital. Together with their caregivers, they are better able to make informed, realistic decisions about their future care needs and living arrangements. There is an on-site nursing clinic that supports the surrounding community, and clients at Pine Villa receive clinical support from an interprofessional team with expertise from hospital, mental health and addictions, and community support services. Caring for appropriate clients in the community, rather than in a hospital, is a less expensive solution for the health care system and benefits the patient by providing care in a more appropriate setting.



Recommendations 6-8

The health of a population is connected to certain economic and social factors, known as the social determinants of health. Having a job, eating healthy food and having a safe place to sleep are all foundations to good health; however, many of these economic and social issues are handled outside of the health care system in other ministries and governments.

If we were to design a health care system from scratch, it could look very different than the health care system we have today. These recommendations will help us overcome traditional barriers and achieve an efficient and sustainable health care system that delivers high-quality care that is well-aligned with other services and supports.



Ontarians should be supported by wrap-around services and have access to a full continuum of care. These recommendations identify short- and long-term actions to unlock greater efficiency across government, and will go a long way towards providing coordinated, strategically designed and financially sustainable care in the province.

6

Data should be strategically designed, open and transparent, and actively used throughout the health care system to drive greater accountability and to improve health outcomes.

Action Items: Short Term

The government and the new Ontario Health agency should:

- Ensure that data is used effectively as a management tool to improve care and

develop a clear vision and standards for data collection and use in Ontario.

- Stop collecting data that isn't being used to improve care, collect the right data and ensure indicators are used to manage the system, and standardize collection throughout and across care settings.

- Develop a data use strategy to support the development of evidence-informed policy.
 - Improve data collection practices in mental health and addictions organizations and the community services sector.

Action Items: Long Term

If changes to PHIPA are made in the short term, it will enable more effective use of data in the future, which will increase the inherent value of the data currently going unused in the system.

In the long term, the government should:

- Work in partnership with the new Ontario Health agency to consolidate its data assets to help enable long-term and evidence-informed modernization.
- Work with health sector leadership and providers to use predictive analytics and artificial intelligence to unlock more efficiency in the system and provide high-quality care to patients.
 - The government should put the building blocks in place now to support the widespread use of this technology in the future.

INNOVATION IN ONTARIO

MyPractice Reports

Physicians and administrators in Ontario are dedicated to quality improvement; however, they do not always have the comparable regional and provincial data they need to inform their improvement efforts. To help address this gap, Health Quality Ontario

created personalized reports for the primary care, long-term care, specialist and hospital sectors. Using existing administrative health databases, these confidential reports give physicians data about their practice, and share change ideas to help drive quality improvement. Today, thousands of clinicians access this information.

What Will These Actions Accomplish?

Data should be used at the system-level to inform planning to improve system-wide performance; at a population level to inform health teams; and at the point-of-care to support clinicians with real-time data that

helps inform their work. This data will enable accountability for the province and health service providers, and partners will be more accountable for improving patient outcomes. A modern health care system should be strategically designed to support the use of future technologies to improve care.

Patients may not feel the impact of these actions immediately, but implementation will go a long way in improving how services are planned, funded, organized and delivered. It will help the day-to-day work of health care providers by freeing up more of their time to

provide care to patients, rather than spending time collecting and reporting data. Ultimately, better planning, service organization and provider support will result in better patient experiences for everyone receiving health care in Ontario.

INNOVATION IN ONTARIO

Humber River Hospital Command Centre

The Humber River Hospital was North America's first fully digital hospital, demonstrating how integrated technology solutions can deliver better value to the health care system and improve patient experience.

The Command Centre uses real-time data, advanced algorithms, predictive analytics and adherence to operating procedures to ensure timely, seamless treatment for

patients. The centralized team staffing the Command Centre are able to quickly address patient care delays in an efficient and coordinated way.

Using technology and communication, the Command Centre has allowed Humber River Hospital to provide its patients with faster tests and decrease their length of stay in hospital, and to serve approximately 4,000 more patients each year.



Ensure Ontarians receive coordinated support by strengthening partnerships between health and social services, which are known to impact determinants of health.

Action Items: Short Term

The government should:

- Review and identify shared objectives and goals across government ministries and programs to ensure effective alignment at the system level and at the point of service delivery.
- A cross-ministry review of services, policies, legislation and regulation with implications for key populations such as Indigenous patients, Francophone patients, children and youth with complex health care needs, and seniors should lead to more appropriate integration of services.
- Work with the new Ontario Health agency to facilitate planning and data sharing between the Ministries of Health and Long-Term Care and other ministries including — but not limited to — Children, Community and Social Services, Education, Training, Colleges and Universities, and Municipal Affairs and Housing as well as third parties to ensure better data integration.
 - This may require amendments to the Freedom of Information and Protection of Privacy Act (FIPPA) and could also be

helped by aligning the administrative boundaries between health and social services to support data collection efforts.

Action Items: Long Term

- In the long term, more integration should occur between ministries and orders of government such as municipalities, or the federal government, and at the point-of-care when patients, families and caregivers are accessing services.
 - Governance structures should never prevent Ontarians from receiving access to timely and high-quality health care services.

What Will These Actions Accomplish?

Services should work in concert to support the best outcomes for Ontarians, regardless of which ministry, agency, organization or government is responsible for delivering a service. There are many areas where patients and taxpayers would benefit from greater integration between health and social services.

For example, the Ministries of Health and Long-Term Care should continue to work with Infrastructure Ontario and the Ministry of Municipal Affairs and Housing to identify opportunities to utilize surplus provincial lands for health care delivery purposes. Similarly, ensuring strong collaboration between the Ministries of Health and Long-Term Care and the Ministry of Children, Community and Social Services is critical for improving the outcomes of children with complex needs.

Furthermore, as part of the broad review of long-term care home placement requirements, the Ministries of Health and Long-Term Care should engage other ministries about the delivery of social services to ensure alignment while system modernization occurs. Greater coordination, alignment and accountability will help ensure Ontarians are receiving the right mix of services, at the right time and place to support the best outcomes possible.

INNOVATION IN ONTARIO

Integrated Services for Homeless Individuals: Ottawa Inner City Health and the Targeted Emergency Diversion (TED) Program

Ottawa Inner City Health provides health care services to people with complex needs who are chronically homeless. It offers primary care, palliative care, and mental health and addictions services in both shelters and supportive housing settings. The Targeted Emergency Diversion (TED) program provides 24-hr monitoring to homeless people under the influence of drugs and alcohol, and allows them to safely detox in the community rather than in hospital emergency departments.

Evaluation of the program estimates that for every dollar spent on TED, two dollars are saved in paramedic and police services and emergency department visits. Moreover, homeless individuals receive person-centred care that meets their needs in a more appropriate manner. Based on their 2017 annual report, there were 1,501 unique clients admitted to the program with a total of 5,065 care episodes in the TED program.

Mobile Integrated Health Response Teams

Niagara Emergency Medical Services (EMS) have partnered with local community partners to create integrated interdisciplinary response teams for non-urgent low acuity EMS callers. These response teams engage with clients and provide alternative pathways to connect them with the care or service they need through primary care, urgent care or other community health and social resources to avoid an unnecessary emergency department (ED) visit. The program includes technology and access to data, such as Clinical Connect, to ensure the response team is aware of care plans in place for these clients and to help ensure continuity in following their plan.

Based on data from the Niagara EMS, some early results in 2018 showed:

- 5% reduction in transports to ED for calls related to mental health, despite a 7% increase in mental health call volume in the region;
- 2% reduction in transports to ED due to calls for falls (call volume for falls remained stable compared with previous year); and
- 6% reduction in transports to ED due to calls for generally unwell (call volume for generally unwell remained stable compared with previous year).



As the health care system transforms, design financial incentives to promote improved health outcomes for patients, population health for communities and increased value for taxpayers.

Action Items

- The government should review current funding models and system objectives to ensure appropriate alignment between goals and incentives.
- This can be accomplished by identifying innovative funding models that promote

value and quality. Primary care models should be reviewed to determine cost-effectiveness, and impact on access to care in addition to value and quality considerations.

What Will This Action Accomplish?

A re-alignment of funding models will mean providers are supported by the right financial incentives to encourage integrated and collaborative health care service delivery that puts the patient at the centre of every health care decision and ensures they are cared for in the best setting to optimize their experience

and outcomes. In the long term, patients will become more comfortable navigating an integrated system of health care, and these improvements will help contribute to the appropriate use of resources in addition to improved provider, system and funder accountability.

INNOVATION IN ONTARIO

Bundled Care

How health care providers are compensated can be either an obstacle or an enabler to providing high-value care. Bundled care models provide a single payment for an episode of care, such as a hip surgery, knee replacement or cardiac surgery, across multiple settings and providers. With bundled care, services are integrated to create seamless transitions and ease a patient's move from hospital to home. Providers share risks and gains and are incented to collaborate and integrate care and are accountable for quality outcomes.

In 2015, the ministry partnered with the Health System Performance Research Network (HSPRN) to evaluate the implementation of bundled care pilots across six sites. The findings included

overall improvements in key measures such as:

- A reduction in hospital length of stay by 1.26 days, on average; and,
- A reduction in total costs within 30 days by \$2,110 and within 90 days by \$3,035.

In addition, patients reported positive experiences and engagement when asked about their care. Findings from surveys and interviews showed that:

- 87% of surveyed patients reported a sense of involvement in the decision-making process.
- 87% of surveyed patients reported receiving sufficient information about their condition prior to discharge.



Recommendations 9-10

These recommendations recognize the need to maximize existing capacity in the system and relieve immediate capacity pressures, while also working on a long-term plan to ensure we have the right mix of health professionals, services, beds and leadership skills to meet the population's changing health care needs.

Health care capacity planning is a technical exercise that benefits from a clear vision. Determining the appropriate mix of beds and health care services in the community in the longer term (over 10 years from now) will require taking a detailed look at anticipated population needs in relation to the current mix of infrastructure and services.



The health care system of the future will be built in collaboration with leaders in our health workforce. Championing collaborative and interprofessional leadership development will ensure Ontario has access to the leadership talent it needs to deliver a patient-focused, modern and integrated health care system.

9

Address short- and long-term capacity pressures including wait times for specialist and community care by maximizing existing assets and skills and making strategic new investments. Build the appropriate health care system for the future.

Action Items: Short Term

Maximize Existing Capacity

The government should:

- Conduct a review of current processes to remove duplication and ensure more time and resources are spent delivering care to patients.
- Patient assessments can be streamlined and common evidence-based assessment tools can be mandated through policy changes. Program application processes, such as the Northern Travel Grant, should be simplified.
- Identify and spread technology solutions that can help with process improvements,

such as scheduling and routing decisions, that could be used to create more efficiency.

- Consider managing access pressures within Francophone communities by building a navigation system that connects Francophone patients to services in French throughout the continuum of care.
- Support hospitals and other service providers to implement strategies and leading best practices, such as the Alternate Level of Care (ALC) leading practices, to optimize access to services.
 - This can include reviewing and expanding hours of service across the health care system, as appropriate to better connect patients with care.
- Review the roles and responsibilities of health care professionals, and ensure providers are well-supported and maximizing their permitted scope of practice.
 - This could include targeted support for Personal Support Workers (PSWs) in areas such as retention, distribution, compensation or training, and supporting staff through modernization.

Target New Investments

The government should:

- Expand the mix of services and beds in communities where the capacity challenges are greatest.
 - Investments in reactivation care, supportive housing and home care

supports outside of hospitals would help to reduce pressure on hospitals and long-term care homes, and support patients to transition out of hospital when they no longer need acute care.

- Target new investments earmarked for mental health and addictions services towards evidence-based community mental health and addictions services and supports.
 - Creating visible and viable pathways to these services in the community while also investing in greater service availability will divert people from using hospitals when other options are available.

Action Items: Long Term

The government should develop a comprehensive and strategic long-term capacity plan for health care. Ontarians deserve an evidence-based approach to ensuring there is equitable and quality health care available across the province.

A long-term capacity plan should include the following considerations:

- This capacity plan should be guided by transparent principles for planning, it should be a dynamic exercise that draws on foresight and scenario modelling and is refreshed every three years.
- Use available data to identify priority populations and target resources towards anticipated health system pressures and include a focus on prevention and early-intervention.

- This capacity plan should include smart infrastructure, number of beds in the system, services, technology and workforce considerations, and support the equitable allocation of system resources.
- Explore a range of options, such as increasing access to capital, and consult with Ontarians on how to pay for and ensure the sustainability of our publicly-funded health care system.

What Will These Actions Accomplish?

Effective health care governance requires system leaders to take strategic actions that support short- and long-term system objectives. No policy changes would be required to accomplish these goals; however, a shift in planning ideology would be significant. To ensure the long-term sustainability of the health care system, policy makers should shift their focus to designing and investing in a system that provides preventative, strategic and integrated supports while embracing technology and evidence-based solutions. These actions will ensure patients have a system that is working for them at every step of the way by having consistent, reliable access to appropriate services.

INNOVATION IN ONTARIO

Personal Support Neighbourhood Model

The Personal Support Neighbourhood Model was developed in 2018 to address Personal Support Worker (PSW) resource challenges and to improve patient care and provider satisfaction rates in Waterloo-Wellington. Traditional home and community care service models compensate PSWs based on the number of visits they make. This can lead to inconsistent weekly schedules, and corresponding income, and contributes to higher turnover rates and dissatisfaction among the PSW workforce.

The Personal Support Neighbourhood Model employs PSWs as full-time salaried staff to deliver care in urban communities. This model gives PSWs flexibility to deliver care in smaller increments of time, but more frequently, based on patient need. An early review of the model found that patient experience is improved through greater continuity of care (fewer PSWs per patient) and fewer missed visits. PSW provider experience is improved, as measured by a reduced workforce turnover rate and reduced absenteeism amongst staff. This model is an example of how cost-effective care can be delivered in urban communities with limited PSW staffing resources.

10

Champion collaborative and interprofessional leadership development focused on system modernization capabilities.

Action Items

The government should:

- Support health sector leaders and ensure they have the skills and tools to lead by example and support the sector through a fundamental culture change.
- Health professionals working within the system will quickly learn that sharing information, striving for improvement and working collaboratively are foundational skills to building an integrated health care system.
- Clinical leadership should be an important part of health system modernization.
- Support intersectoral leadership development to help build new relationships between care providers in our communities while supporting innovative approaches to providing integrated care around patient needs.
- There should be higher expectations for all leaders working in health care, including clinical leaders, to be accountable for the value they provide to the system.

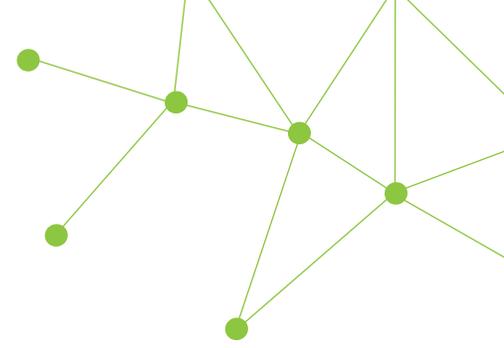
What Will These Actions Accomplish?

Health care is moving in the right direction towards team-based integrated care, but it won't work without effective leadership and the right mix of skills. Without partnerships throughout the health care sector and strong relationships with system leaders, significant transformative change will not occur.

The government has a responsibility and a role to provide clear direction to the sector, especially at such a moment of significant change. By providing clear expectations, transparent information, and leadership support and guidance, the government will enable system and culture change and will deliver the integrated and modern health care services Ontarians deserve.

Chapter 4:

Reporting Progress Throughout the System



Hallway health care is a problem that presents itself in hospital hallways; however, it is really a symptom of system-wide challenges such as the availability of services in the community and low integration across care settings. The government should create a health system scorecard that measures the performance of Ontario Health Teams, aligned with the objectives of the Quadruple Aim, to track progress towards ending hallway health care in Ontario as well as overall system improvement.

It is important to keep a strong focus on transparency and accountability throughout the process of modernizing Ontario's health care system. As the government works towards shifting the focus, planning and delivery of health care in the province it may take time to see meaningful change across each of these indicators. And that's understandable, because with an appropriate set of indicators that are tracked and publicly reported, it will be possible to understand where things are working well and what may need additional attention.

The scorecard should report on access and availability of services across the health care



system. In the short term, it should report on indicators that are currently available, and over time new indicators can be added where there are gaps in the government's current data collection and reporting. Overall, the system should shift towards reporting on a small set of valuable indicators that can be used as a management tool to improve quality and value throughout the system. The indicators selected for a system-wide scorecard should cascade through the system and inform reporting and accountability of Ontario Health, Ontario Health Teams and other health service providers.

Short-Term Reporting Priorities

The following list is a possible set of indicators that the government could use to track progress on improving outcomes throughout the system.

Hallway Health Care

This is the top-line indicator for tracking progress towards improving the system and ending hallway health care, and it captures the number of patients waiting for a hospital bed in an unconventional or unexpected location. It is measured by counting the number of people admitted to a hospital but are waiting overnight in an unconventional space or emergency department stretcher for a bed to become available. In May 2019, up to 1,147 people in Ontario were in a hospital hallway waiting for a bed.

Access to Primary Care

Patients should be able to seek care from their primary care provider. Measuring primary care access reflects a patient's ability to get timely health care services in the community, preventing them having to use the hospital for non-urgent care needs.

Mental Health and Addictions in Emergency Department

When people who require mental health and/or addictions services can't access the care and support they need in the community, they often end up in hospital emergency departments. The government should measure how frequently patients with mental health and addictions issues are

accessing emergency departments for non-urgent concerns.

There is also a gap in the government's health care data about mental health and addictions services and patient outcomes. The government should work with the new Mental Health and Addictions Centre of Excellence in the Ontario Health agency to collect common data and report on indicators to demonstrate access to timely, effective and high-quality mental health and addictions services in the community.

Emergency Department Wait Times

When emergencies happen, patients don't want to have to wait a long time to access care. As the health care system provides patients with more options to access care in the community, including during the evening and weekends, fewer people should come to the emergency department seeking care.

Hospital Readmission Rate

When a patient is discharged from the hospital, they should be able to access health services in the community to keep them well. This measure would demonstrate where community supports are successful, and where there's room for improvement.

Alternate Level of Care (ALC)

ALC is a measure of the proportion of patients who occupy a hospital bed but do not require the intensity of services provided there. This indicator identifies where there are opportunities to provide more appropriate care in more appropriate settings, often at a lower cost and with better outcomes for patients.

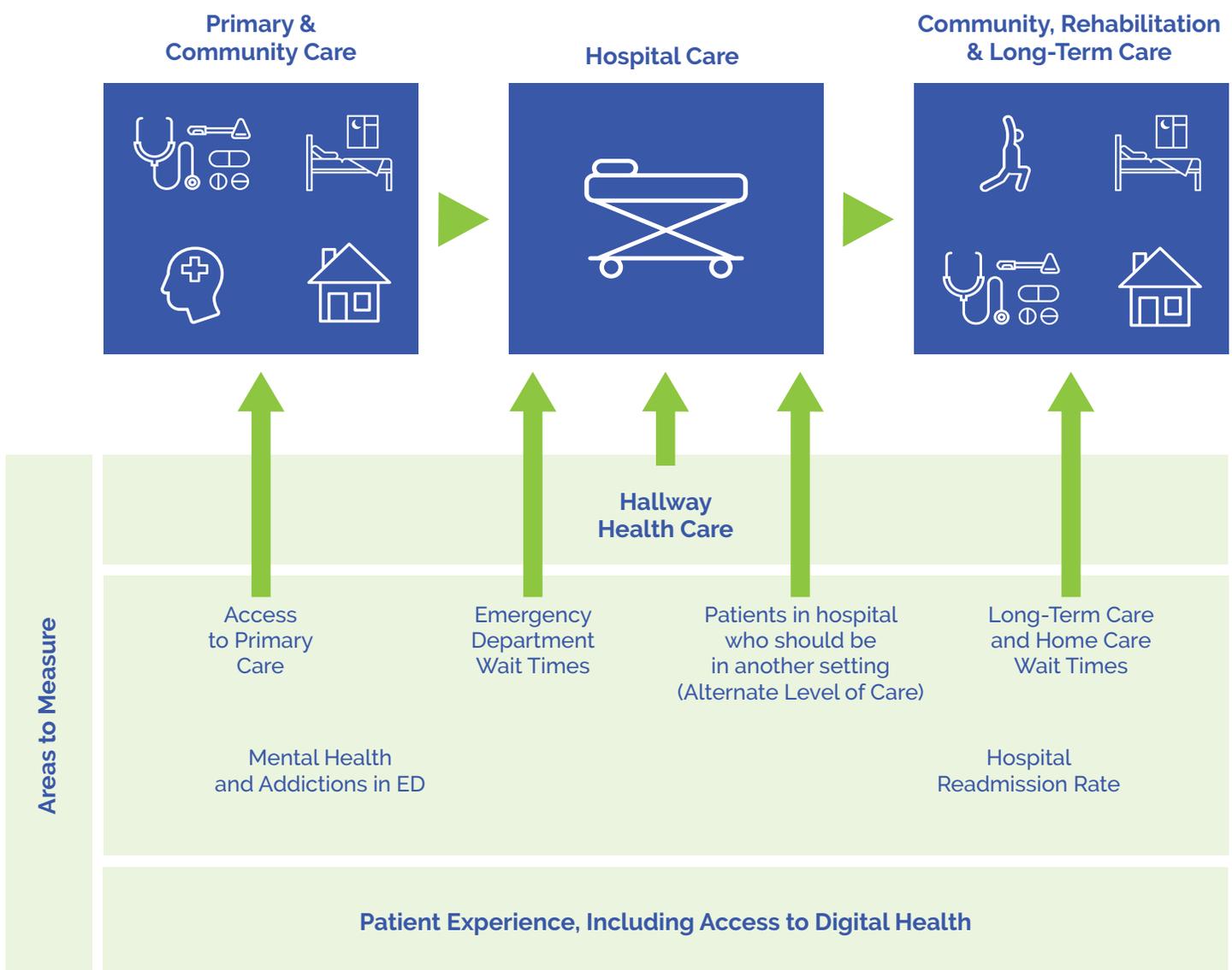
Long-Term Care and Home Care Wait Times

The median wait time for long-term care varies across the province. As new long-term care bed capacity is added and if other care models are introduced in Ontario, the time spent waiting for long-term care should decrease. Similarly, the time patients wait for home care services to become available differs depending on where they are. The government should monitor and reduce these wait times.

Patient Experience, Including Access to Digital Health

The government captures some information about patient experience and this information can be expanded to include questions about access to digital health records and availability of virtual care visits. This would demonstrate how digital innovation in Ontario's health care system is spreading across the province and identify areas of success and areas for further improvement.

Measuring Progress



Areas for Future Development

As the government continues to modernize the health care system, it should also refine its approach to indicator development and reporting. The data that is available today is not necessarily the right set of information to support a shift in health care delivery or encourage future transformation across the system. Going forward, the government should move towards developing a more direct understanding of patient and provider experience, as well as value for money. In addition to ensuring patients are at the centre of care, these indicators will help ensure patients are being supported with the appropriate use of the system.

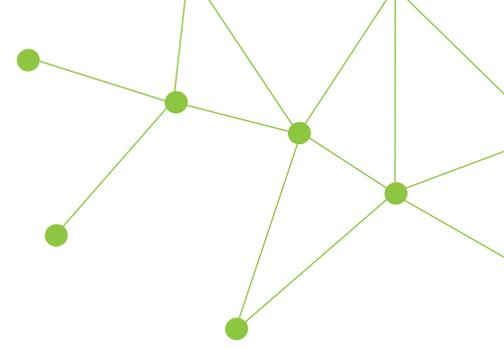
Patient and Provider Experience

The government should work with patients and providers to co-develop direct measures that accurately capture their experience with the health care system. These measures should also capture the caregiver experience and include a focus on transitions in care.

Value for Money

In keeping with the objectives of the Quadruple Aim, the government should report not just on spending in health care but develop indicators that measure the value those health care dollars provide. Indicators that measure patient and population health outcomes against the cost of delivering care will demonstrate where the system is achieving greater efficiency and achieving positive patient outcomes.

This suggested list of indicators and reporting priorities will assist the government in tracking progress towards an improved health care system and ending the problem of hallway health care. As the system modernizes, it will be important to know which indicators currently in use are no longer valuable and which ones should be tracked to demonstrate progress against the system's goals. Overall, the system should shift towards reporting on a small set of valuable indicators that can be used as a management tool to improve quality and value throughout the system. Standardized patient and provider experience data will also help the system know if it is truly delivering patient-centred, high-quality, integrated care. Rather than focus on the performance of individual care settings, the system should be evaluated on its ability to deliver quality care across the full continuum of services, and any future investments can be allocated as required to achieve this clear and measurable set of goals.



Next Steps

The Premier's Council is pleased to provide this report as advice to you, the Premier of Ontario and the Ministers of Health and Long-Term Care, and believes that the 10 strategic policy recommendations and associated actions, if implemented, could improve health outcomes and end the problem of hallway health care in Ontario.

Looking ahead, the Premier's Council will continue to provide further advice to government on long-term capacity planning, on the development of the new Ontario Health agency and Ontario Health Teams, and will explore new and innovative methods to deliver care.

As promised, the Premier's Council will also continue to engage with the public on how to improve the health care system. Ontario serves diverse communities, and we will continue to seek ways to better serve all of our patients.

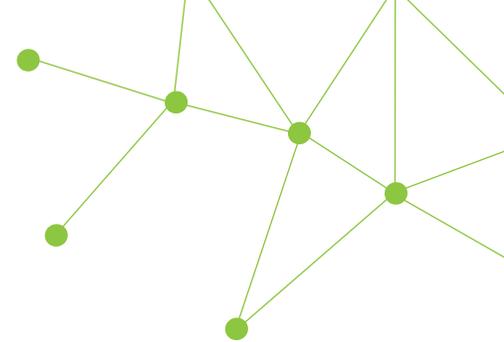


In the meantime, please continue to participate in this process by emailing the Premier's Council with any feedback on how to improve health care in Ontario.

We can be reached at:
hallwayhealthcare@ontario.ca

Appendix A:

Summary of Feedback and Engagement



Province-Wide E-mail Submissions

Following the release of the Premier's Council's first report, *Hallway Health Care: A System Under Strain*, patients, caregivers, frontline health providers, organizations and associations provided input. Below is a list of organizations and associations that provided

submissions to hallwayhealthcare@ontario.ca between January 31, 2019, and May 31, 2019. Submissions from independent or non-affiliated patients, providers and leaders were received, reviewed and shared with the Premier's Council; however, their names have not been included in the list below.

Organization/Name

AdvantAge Ontario

Alliance for Healthier Communities

Amour At Home Care

Association of Family Health Teams of Ontario

Association of Local Public Health Agencies (alPHA)

Association of Municipalities of Ontario

Association of Ontario Midwives

Black Health Alliance

Canadian Association of Physician Assistants

Canadian Centre for Accreditation

Canadian Geriatrics Society

Canadian Mental Health Association, Toronto Branch

Cancer Care Ontario

Centre de santé communautaire de l'Estrie

Centre de santé communautaire du Témiskaming

Centre de santé communautaire Hamilton Niagara

Centretown Community Health Centre

CNIB Foundation

Organization/Name

Council of Ontario Universities
Durham Region Health Department
East GTA Family Health Team
eHealth Ontario
Family Caregivers Voices
Gateway Community Health Centre
Health Innovation Rx
Healthcare Advocate
HeartHouse Hospice Inc.
Hôpital Montfort in Ottawa
Hospice Palliative Care Ontario
Hospital for Sick Children
Independence Centre and Network, Sudbury
Local Health Integration Network, Central East
Local Health Integration Network, Central East, Patient and Family Advisory Committee
Local Health Integration Network, North East
Local Health Integration Network, North West
Local Health Integration Network, Toronto Central, Citizen's Panel
LOFT Community Services
Maple
MindBeacon
Municipality of Assiginack Family Health Team, Manitowaning, Ontario
National Home Doctor
National Initiative for the Care of the Elderly (NICE)
Neighbourhood Pharmacy Association
NRC Health
Ontario Association of Cardiologists
Ontario Association of Public Health Nurse Leaders
Ontario College of Family Physicians
Ontario Fall Prevention Working Group
Ontario Neurotrauma Foundation
Ontario Osteoporosis Strategy Osteoporosis Canada
Ontario Palliative Care Network Secretariat

Organization/Name

Ontario Retirement Communities Association
Physically Handicapped Adults' Rehabilitation Association
Planned Parenthood Toronto
Provincial Geriatrics Leadership Office
Royal College of Physicians and Surgeons of Canada
Sault Area Hospital, Algoma Geriatric Clinic
Sault Ste Marie Health Links Table
Sault Ste Marie Social Services
Schizophrenia Society of Ontario
Sherwood Park Manor Long Term Care
Society of Canadians Studying Medicine Abroad
St. Joseph's General Hospital Elliot Lake
St. Lawrence Medical Clinic Family Health Organization
St. Michael's Hospital, Psychiatry
The Association of Registered Psychotherapists & Mental Health Professionals
The Ottawa Hospital, Division of Geriatric Medicine
The Speech Clinic
United Way Centraide Ottawa
University of Toronto, Department of Medicine
University of Toronto, Faculties of Medicine and Factor-Inwentash Faculty of Social Work
Voices & Choices Family Support Group
Wellesley Institute
Windsor Essex Community Health Centre
Young Carers Initiative

Feedback from Specific Communities

Although there were some common themes across each regional engagement session, it was also very clear that each local community has its own challenges with the current health care system.

For example, Northern communities have low population density and long distances to travel to receive care, and some communities face health provider recruitment and retention problems. The following is an overview of concerns we heard from specific communities in the province.

Children and Young Patients

We continue to hear from families and patient advocates that children and youth are not just small adults — they require unique health care services tailored to their specific needs. Often in the past, health care funding either overlooked children or didn't address their most pressing concerns, such as mental health.

Certain programs and initiatives are working well for children and youth, such as creating a single point of entry to mental health and addictions services in some areas and centralized referral systems and sharing health records among care providers in others.

It is important to bring care to where the children already are, and facilitate stronger collaboration between the Ministry of Education, the Ministry of Children, Community, and Social Services, and the Ministries of Health and Long-Term Care where feasible. Finally, more can be done to facilitate smooth transitions between programs designed for youth, and programs designed for adults.

Francophone Patients

Francophone patients want to ensure that they can tell their stories to health care workers in French, and that they only need to tell them once through the better coordination of care. In addition, Francophone patients in rural areas expect the same quality of care as those living in cities.

We heard that French Language Health Services work well when they are actively offered. As with all patients, communication with care providers is so important throughout the entire continuum of care. French language navigation support, preventative care, social services and community care, including French-speaking home care workers, are just as important as French language services within a larger institution like a hospital.

Indigenous Patients

Collaborative partnerships with Indigenous communities and Indigenous-governed service providers are important, and the Premier's Council has only just begun the process of engaging with them in a meaningful way.

From what's been heard so far, certain roles and programs such as First Nations Navigators and Indigenous-governed primary care are working well when they are available to communities. Services for Indigenous people, families and communities that are designed, delivered and evaluated by Indigenous people are important. It is also important to recognize the impact of systemic racism and ensure health care providers have the appropriate cultural competence, tools and supports to provide culturally safe and appropriate health care.

Much can — and should — be done to improve health outcomes and achieve health equity for Indigenous populations. While engagement

continues, it is acknowledged that there is also work underway to transform First Nations health care in Ontario through government-to-government trilateral discussions.

Patients in the North

Social isolation and loneliness due to geography and out-migration are significant concerns for patients, families, caregivers and providers in Northern Ontario. Although there is generally support for increasing the availability and range of home care services, there are concerns in the North for what this might mean to the frail elderly patient living alone.

In Northern Ontario, local partnerships drive the quality and availability of health care. However, the region could benefit from more peer support, and by leveraging paramedicine services to deliver care in more remote communities. In the North, access to care can still be a challenge. For example, communities rely heavily on the use of Ontario Telemedicine Network services. There are some concerns with the structure of the Northern Travel Grant program, and we also heard that patients are travelling to Manitoba to receive certain health care services. Hotel-health care is a concern in the North-West, since there is limited accommodation available for patients and families who must travel to receive care. Increasing the number of visiting specialists

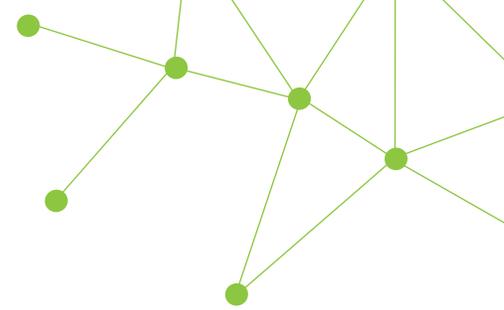
to the North to reduce travel to Winnipeg, Thunder Bay or to other centres of care would help ensure patients can access the care they require locally.

Racialized Patients

Racialized communities, especially those who may be immigrants or newcomers who do not speak English or French, may face additional burdens in accessing the health care system related to bias, language or cultural barriers. This can be especially challenging when patients transition from hospital to community care and could benefit from additional translation support or case managers who are able to facilitate effective communication, and culturally appropriate care plans.

Ontario's health system also needs to evolve to meet the needs of older adults from diverse backgrounds including more culturally appropriate health services/programs, and caregiver support. This is particularly important for older Ontarians waiting for culturally appropriate long-term care placement. A 2016 study published by the Wellesley Institute found that ethno-specific long-term care homes across the Greater Toronto Area had much longer waitlists compared to mainstream homes, and there is also evidence of long waitlists for culturally appropriate placement in the North.

Biographies



Dr. Rueben Devlin

Special Advisor and Chair of the Premier's Council on Improving Healthcare and Ending Hallway Medicine.

An orthopaedic surgeon, Dr. Devlin completed his medical school and residency training at the University of Toronto. During Dr. Devlin's 17 years practising in Newmarket, he held senior hospital positions, including Chief of Surgery and Chair of the Medical Advisory Committee.

Subsequently, Dr. Devlin served as the President and Chief Executive Officer of Humber River Hospital in Toronto from 1999 to 2016. Humber River Hospital is one of Canada's largest regional acute care hospitals, serving a catchment area of more than 850,000 people in the northwest GTA. As the CEO of Humber River Hospital he not only led the operational transformation of the hospital, Dr. Devlin was also responsible for the vision and implementation of North America's first fully digital hospital.

Dr. Devlin has a record of successfully developing and implementing corporate strategic plans at the highest levels of health care and taking bold steps to use innovation and technology to directly impact patient access care and satisfaction.

Dr. Devlin was appointed as Special Advisor and Chair of the Premier's Council on Improving Health Care and Ending Hallway Medicine in June 2018.



Adalsteinn Brown

Adalsteinn (Steini) Brown is the Dean of the Dalla Lana School of Public Health at the University of Toronto. Previous experience includes senior leadership in policy and strategy in the Ontario government, founding roles in start-up companies and global work on how to measure performance in health care. He studied government at Harvard University and Public Health at the University of Oxford.



Connie Clerici

Connie Clerici is a seasoned executive with a long history of leading large teams through Canada's complex and highly regulated health care environment. She is the founder and the Executive Chair of Closing the Gap Healthcare, an organization that focuses resources on the advancement of innovations and on building and supporting a high-quality, publicly-funded health care system that is sustainable for Canadians.

Ms. Clerici's passion is to help those most in need in society, and to accept full accountability for doing so. Her requirement that ethics and compassion accompany sound business practices was founded on her early career experiences, including being responsible for moving severely disabled children out of institutional care at the Christopher Robin Home for Children in Ajax and into the community in the 1980s, and her work with Rose Cherry's Home for Kids (now the Darling Home for Kids).

Ms. Clerici is a life-long learner, participating in extensive training in leadership and business at a variety of business schools and universities. She is currently a board member or advisor for numerous public and private organizations, an Adjunct Lecturer at the University of Toronto's Institute of Health Policy, Management and Evaluation, a leader in the Ivey Business School supporting entrepreneurship and the co-chair of Health Quality Ontario's Quality Standards Committee.



Barb Collins

Barb Collins was appointed the President and Chief Executive Officer of Humber River Hospital on July 1, 2016. Ms. Collins is a Registered Nurse, with an MBA from Queens University in Kingston, Ontario. She has more than 40 years' experience in acute care hospitals, including nursing in Intensive Care, Operating Room and the Emergency Department, and has managed Support and Facilities Services.

Prior to assuming her current responsibilities as President and CEO, Ms. Collins served as the Humber River Hospital's Chief Operating Officer. As COO, she was the senior Executive Lead for Humber River Hospital's

redevelopment project, overseeing the design, construction and activation of the new Humber River Hospital. This 656-bed, 1.8M square-foot acute care facility provided Humber with a unique opportunity to optimize design, incorporate technology and reinvent processes to deliver more effective and efficient patient-centred care, supported by some of the world's finest medical technology.

Humber River Hospital has been recognized as North America's first fully digital hospital. That journey continues with the opening of the first Hospital Command Centre in the world focused on both patient flow and high reliability patient care. Most recently Humber River introduced a Humanoid Robot, yet another step in transformational care.



Michael Decter

Michael B. Decter is the President and Chief Executive Officer of LDIC Inc. Currently he is also Chair of Medavie Blue Cross, Board Member of Blue Cross Life and Auto Sector Retiree Health Care Trust and Chancellor of Brandon University.

Previously, Mr. Decter served as Deputy Minister of Health for Ontario, Cabinet Secretary in the Government of Manitoba and Chair of the Health Council of Canada.

Mr. Decter is a graduate of Harvard University with a major in economics. He is also the author of three health books, *Healing Medicare*, *Four Strong Winds* and *Navigating Canada's Health Care*, co-authored with Francesca Grosso.



Dr. Suzanne Filion

Dr. Filion is an experienced clinical psychologist and change leader with an ardent commitment to public and community service. She obtained her PhD in Psychology from the Université de Montréal and her master's degree in Education from the University of Ottawa. She also holds a Mental Health Law certificate from the Osgoode Hall Law School at York University.

As past director of the Mental Health and Addictions (MHA) program at the Hawkesbury and District General Hospital (HGH), Dr. Filion deployed over 15 innovative community programs in MHA to improve access to services and increase efficiency. She is currently Vice-President of Development and Integration at HGH and President and CEO of her own private practice in Eastern Ontario. Dr. Filion has taught at the University of Ottawa and Saint Paul University.

Nationally, she is known for her work in psychological trauma and with minority groups. In recognition of her outstanding achievements in the fields of mental health and addictions during more than 25 years, Dr. Filion recently received the Canadian Psychological Association Award for Distinguished Contributions to Public or Community Service.



Dr. Lisa Habermehl

Dr. Habermehl is a rural family physician living in Northwestern Ontario. She is currently practising in Red Lake where, over the better part of two decades, she has provided care in a variety of settings, including long-term care, clinic, hospital and the emergency room.

Dr. Habermehl has been a faculty member of the Northern Ontario School of Medicine since early in its inception and is currently an Assistant Professor, mentoring medical students and residents as they expand their knowledge of medicine while immersed in rural communities.

She was previously Chair of the Rural Expert Panel at the Ontario Medical Association, whose mandate is to advocate for an equitable health system for rural physicians and patients.

Dr. Habermehl completed her residency in family medicine at Family Medicine North in Thunder Bay, upon graduation from the University of Western Ontario. She has since received her Fellowship in Family Medicine from the College of Family Physicians of Canada.



Peter Harris

Peter Harris, Q.C., has a varied legal background in tax matters and general corporate advice. His tax practice places some emphasis on tax litigation, cross-border and international transactions, and he has provided tax and business counsel to some of Canada's major industrial and financial institutions.

Mr. Harris has been a special advisor to the Canada Revenue and the federal Department of Finance, and has acted as an advisor to the Ontario Government with respect to various financial matters. Mr. Harris is currently on the board of the Central West LHIN.

Apart from his income tax practice, Mr. Harris has served on the boards of directors of Atomic Energy of Canada Limited, the Ontario Sports Centre (Chair), Director of Toronto General & Headwaters Hospital (Chair). Mr. Harris is currently the Chair of the Chamber of Commerce Taxation and Economics Committee.

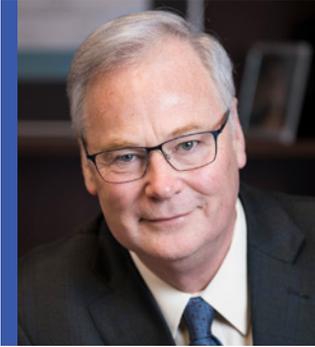


Dr. Gillian Kernaghan

Dr. Kernaghan was appointed the President and Chief Executive Officer of St. Joseph's Health Care London (St. Joseph's) in 2010. St. Joseph's is a multi-sited, academic health care organization serving London and region.

Prior to assuming this role, Dr. Kernaghan served for 17 years as the Vice President, Medical for various hospitals in London and led the medical staff during complex restructuring in which four hospitals merged to form St. Joseph's. Through this restructuring and various program transfers between organizations, the roles of the London hospitals dramatically changed. In 1984, Dr. Kernaghan joined the medical staff of St. Joseph's, Parkwood Hospital and London Health Sciences Centre as a family physician. She completed her residency at St. Joseph's Hospital in 1984 upon graduation from Western University and was awarded her Fellowship in 2000.

Gillian currently serves on the Ontario Hospital Association Board, the Council of Academic Hospitals of Ontario Executive and Council and is the Chair of the Board of the Catholic Health Association of Ontario. She served as the Co-Chair of CHLNet from 2014–2018 and as President of the Canadian Society of Physician Executives for 2010–2012.



Dr. Jack Kitts

Dr. Jack Kitts is President and Chief Executive Officer of The Ottawa Hospital. Dr. Kitts received his medical degree from the University of Ottawa in 1980 and completed specialty training in anesthesia in 1987. He spent one year as a research fellow at the University of California in San Francisco.

Dr. Kitts then joined the medical staff at the Ottawa Civic Hospital as an anesthesiologist and Research Director for the Department of Anesthesia. In 1995, he was appointed Chief of Anesthesia at the Ottawa Civic Hospital and Associate Professor at the University of Ottawa. In 1998, Dr. Kitts was appointed Vice-President of Medical Affairs and led the medical staff during a complex restructuring in which three hospitals and five large programs were merged into The Ottawa Hospital.



Kimberly Moran

Kimberly Moran is dedicated to improving the lives of children and youth with a focus on strengthening health care policy, systems and patient outcomes in Canada and internationally. Her passion for improving the delivery of child and youth mental health treatment runs deep and is rooted in her family's lived experience with mental health as a mother of a daughter who became seriously ill.

Ms. Moran is currently Chief Executive Officer of Children's Mental Health Ontario (CMHO), representing the province's largest provider of child and youth mental health services, supporting 120,000 children, youth and their families. She serves on the board of the Canadian Mental Health Association Toronto, and previously contributed to the North York General Hospital and SIM-one Simulation Healthcare Network boards.

Ms. Moran brings more than 30 years of senior leadership experience in the private and not-for-profit sectors. She is also a Chartered Professional Accountant, which underlies her passion for developing effective and affordable health care systems.

Prior to CMHO, she held positions as Special Advisor to the Dean of the Faculty of Medicine, University of Toronto, Acting CEO and Chief Operating Officer at UNICEF Canada, and senior finance positions with TD Bank and Ernst & Young.



David Murray

David Murray has long been an advocate for Northern, rural and Indigenous health issues. He is currently the President and CEO of Nipigon District Memorial Hospital, a member of the Senior Leadership Team at Thunder Bay Regional Health Sciences Centre and the Executive Director of the Northwest Health Alliance (a shared service organization). Mr. Murray has had a long career that has seen him lead 10 different organizations across Ontario across multiple sectors including being the CEO of a LHIN, 2 CCACS, 2 hospitals and the nationally recognized Group Health Centre. He has also enjoyed serving on several Ministry committees, task forces and working groups, and currently serves on the boards of OTN and ORNGE.



Dr. Richard Reznick

Dr. Reznick is the Dean of the Faculty of Health Sciences at Queen's University and a professor in the Department of Surgery. He is also Chief Executive Officer of the Southeastern Ontario Academic Medical Organization.



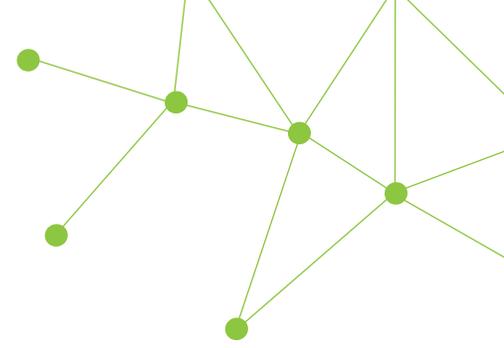
Shirlee Sharkey

Shirlee Sharkey is the President and Chief Executive Officer of SE Health. Under Ms. Sharkey's leadership, the social enterprise has enjoyed exponential growth and expansion, and facilitated transformative solutions in areas such as Indigenous health, end-of-life care, and caregiver wellness and support. Today, SE Health delivers 20,000 care exchanges daily through its team of 9,000 leaders and professionals.

Active in public service, Ms. Sharkey is the current Chair of Excellence Canada, and a board member of the C.D. Howe Institute and the Canadian Frailty Network.

Academically, she is cross-appointed to the University of Toronto's Lawrence S. Bloomberg Faculty of Nursing and the Institute of Health Policy, Management and Evaluation as an adjunct professor.

In 2017, Ms. Sharkey was presented with an honorary Doctor of Laws degree from the University of Ontario Institute of Technology for her breakthrough leadership in community-based health care.



Acknowledgements

The Council would like to thank the following organizations and groups for contributing to the development of this report:

- Converge3, the Change Foundation, the French Language Services Network of Eastern Ontario and Ontario's French Language Health Planning Entities.
- Members of the six sub-committees of the Premier's Council on: primary care, home and community care, hospital care, long-term care, mental health and addictions and digital innovation, for sharing key insights from across the health care system.