THE WAIT TIME STRATEGY
REVIEW OF ACTIVITIES

UPDATE #9 – October 30, 2007

INTRODUCTION

When the Ontario Government announced the Wait Time Strategy in November 2004, we committed ourselves to providing you with regular reports on our directions, initiatives and progress. Since our first wait time update on December 2004, we have sent out eight reports to the field, the last one on April 30, 2007.[1] Although we continued to make progress on improving access and reducing wait times since April, communications to the field have been delayed because of the provincial election. Now that the Liberal Party has been re-elected and George Smitherman reappointed Minister of Health and Long-Term Care, we are resuming our regular updates.

EMERGENCY DEPARTMENT WAIT TIMES

As you may be aware, on October 12, 2007 immediately following the election, Premier McGuinty and Minister Smitherman held a press conference and announced that the Wait Time Strategy is being expanded to include emergency department wait times. I was honoured to be appointed to lead this major government initiative. I am delighted to work along with Dr. Michael Schull, Chair of the Expert Panel on Emergency Departments, and with many other colleagues around the province to address this issue. Although ED wait times are complex, a lot of good work has already been done. Over the last two years, various groups have been working on different elements of the ED process. Now, all ED activities in the province will be pulled together into a coherent initiative so that rational management decisions can be made on the basis of up-to-date electronic data. Our plan is to measure and manage emergency department activities and the flow of patients from acute care to other facilities and community services. As you are all aware, controlling the demand for emergency services is a very important part of tackling ED wait times and, so, we will be addressing in some detail topics such as aging in place, chronic disease management, mental health and addictions, and other related issues.

EXPERT PANELS

The advice that we have received from the Expert Panels has been the foundation upon which the Wait Time Strategy has been built. I would like to thank all of you who volunteered on these panels for your commitment and invaluable expertise and advice. In particular, the Expert Panel Chairs have carried their responsibilities with distinction.

Over the next few weeks, we will be reviewing the status of the 15 Expert Panels and anticipate some changes. Some panels will be concluded, other new panels will be

[1] See www.ontariowaittimes.com for the Wait Time updates.

announced, and some panels will be asked to modify their function and the composition of their membership.

NEUROSURGERY EXPERT PANEL

The Neurosurgery Expert Panel – which is being chaired by Dr. James Rutka – has been meeting over the summer and is expected to finish its work by the end of this year. The panel's report will present a provincial plan for equitable and timely access to quality neurosurgical services in Ontario.

WAIT TIME OVERVIEW OF ACTIVITIES: SEPTEMBER 2006-SEPTEMBER 2007

Attached you will find an overview of wait time initiatives and results from September 2006 to September 2007 (Attachment A). This information was published in Hugh MacLeod's, *Health Results Team Third Annual Report 2006/07: A Focus on Results and Sustainability*. Although Hugh distributed this report widely, we have excerpted those sections that featured the Wait Time Strategy and have reproduced them, for your information.

CONSULTATIONS WITH THE FIELD THROUGH LHIN VISITS

Dr. Joann Trypuc and I will resume our visits to LHIN Boards around the province this fall. We look forward to meeting with you again and, in particular, hearing your questions, suggestions and criticisms.

IN CONCLUSION

I would like to express my thanks to all of you for participating in the broad range of Wait Time initiatives, and I extend my congratulations for the impressive results that have been achieved due to your dedication and efforts. As a result of everyone's hard work, Ontario has made significant gains to improve access to care for the people of this province. I look forward to continuing to work with all of you.

I ask that everyone reading this update take responsibility for communicating the Strategy to others by circulating this communiqué as broadly as possible.

Alan R. Hudson, OC, FRCSC
Lead of Access to Services and Wait Times

Acknowledgement: Thanks are extended to Joann Trypuc for producing this update.

ATTACHMENT A

ONTARIO'S WAIT TIME STRATEGY
OVERVIEW OF ACTIVITIES

September 2006- September 2007

This material is excerpted from, Health Results Team Third Annual Report 2006/07: A Focus on Results and Sustainability (September 2007). Submitted by Hugh MacLeod, Assistant Deputy Minister, Health System Accountability and Performance Division to the Premier of Ontario and the Minister of Health and Long-Term Care.

INTRODUCTION

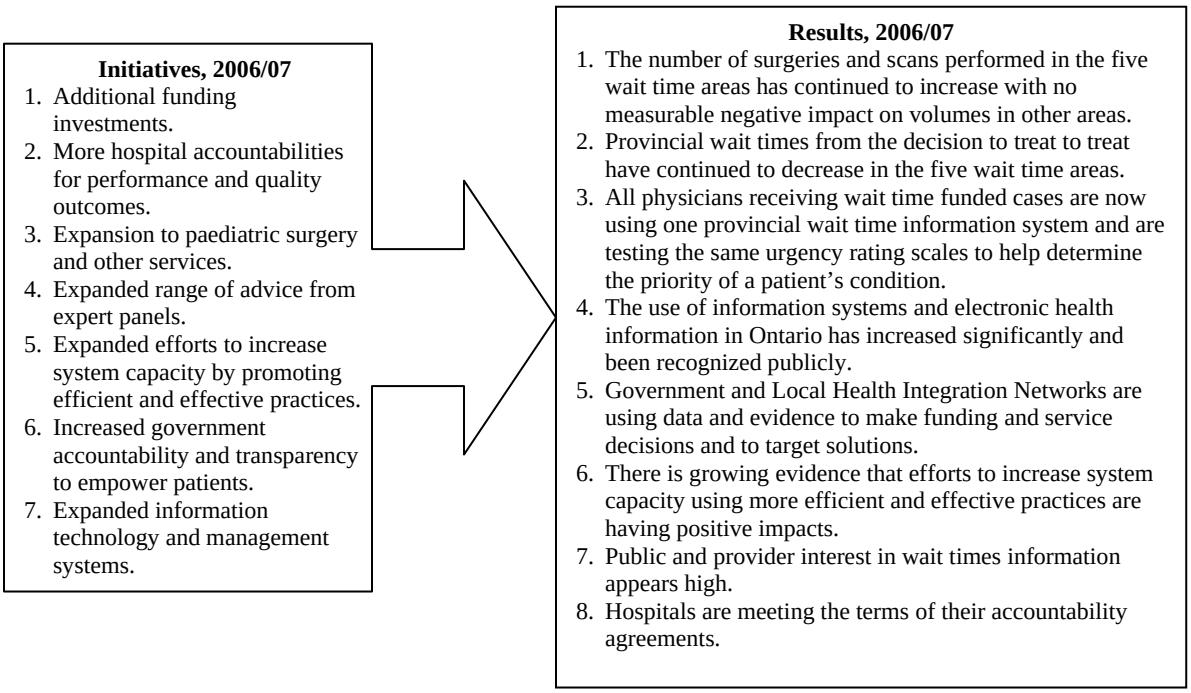
On November 17, 2004, the Minister of Health and Long-Term Care, George Smitherman, officially announced Ontario's Wait Time Strategy. The Strategy is designed to improve access to health care services in the public system by reducing the time that adult Ontarians wait for services in five areas by December 2006: cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements, and MRI/CT scans. These five were just the beginning of an ongoing process to improve access to, and reduce wait times for, a broad range of health care services beyond 2006.

In September 2007, Hugh MacLeod, Assistant Deputy Minister, Health System Accountability and Performance Division, submitted the *Health Results Team Third Annual Report 2006/07: A Focus on Results and Sustainability* to the Premier of Ontario and the Minister. When commenting on reducing the time that adult Ontarians wait for services in five areas by December 2006, Hugh noted:

> *I am pleased to report that this goal has been achieved. Furthermore, significant efforts have been made to expand Ontario's Wait Time Strategy, increase accountabilities, encourage expert stakeholders to advise government, and transform the health care system into one that is more efficient, effective and safe.*

Figure 1 summarizes the wait time initiatives and results in 2006/07, followed by detailed descriptions of each.

Figure 1: Overview of Wait Time Initiatives and Results, September 2006 to September 2007



WAIT TIME STRATEGY INITIATIVES 2006/07

WAIT TIME INITIATIVE 1: ADDITIONAL FUNDING INVESTMENTS

Since November 2004, the Ontario government has invested almost one billion dollars in additional funding – about $986 million – to support Ontario's Wait Time Strategy. These funds have paid for additional medical procedures in the five service areas, new and updated equipment, initiatives to improve efficient and effective practices, and wait time information technology.

Over the past year (September 2006 to September 2007), the Ontario government invested about $331.8 million to pay for *additional* adult wait time cases in the five service areas (Table 1). Government also invested $4.3 million more to pay for 2,319 *additional paediatric* surgeries from April 1, 2007 to March 31, 2008.

Table 1: Investments for Additional Wait Time Cases, September 2006-September 2007

	Investments	Additional Wait Time Cases
September 12 2006	**$50 million**	***Additional Adult Procedures*** • 71,858 more CT scans • 46,300 more MRI scans • 6,100 more cataract surgeries • 3,008 more hip and knee joint replacements
April 27 2007	**$281.8 million**	***Additional Adult Procedures*** • 71,859 more CT scans • 223,773 more MRI scans • 33,225 more cataract surgeries • 12,429 more total hip and knee joint replacements • 117,664 more cardiac procedures • 6,199 more cancer surgeries
May 10 2007	**$4.3 million**	***Additional Paediatric Surgeries*** • 130 more paediatric general surgeries • 520 more paediatric ophthalmology surgeries (eyes) • 656 more paediatric dental/oral surgeries • 100 more paediatric orthopaedic surgeries (bone and joint) • 753 more paediatric otolaryngology surgeries (ear, nose and throat) • 72 more paediatric plastic surgeries • 88 more paediatric urology surgeries

WAIT TIME INITIATIVE 2: MORE HOSPITAL ACCOUNTABILITIES FOR PERFORMANCE AND QUALITY OUTCOMES

The Wait Time Strategy requires hospitals boards, administrators and medical representatives to sign accountability agreements to get additional funding for wait time cases. Hospitals are accountable for maintaining a base volume of cases funded through their global budgets, performing the additional cases funded through wait times, managing the waits for all cases (base and additional), providing wait time data using the Wait Time Information System (WTIS) on *all* cases, and installing and maintaining the provincial WTIS and the provincial Enterprise Master Patient Index (patient registry). Hospitals must also agree that additional wait time cases will not lead to a decrease in surgical volumes or diagnostic images in other service areas or any other hospital services. Each hospital's performance is regularly audited. If hospitals do not meet these conditions, wait time funding is taken back.

Since the Strategy began, hospital accountabilities have been increasing. This past year has been no different. In 2006/07, performance conditions and accountabilities for

quality and safety – a first in Ontario – were introduced as conditions of wait time funding (Table 2). We will continue to increase the requirements on hospitals to collect and submit more extensive quality and safety information, and will use this information to monitor and improve performance.

Table 2: Additional Conditions of Wait Time Funding as of April 1, 2007	
New Quality and Safety Conditions	• The Chair will ensure that the hospital board has a Quality Committee that regularly reports to the full board on measures of hospital safety and quality. • The Quality Committee of the board and management will conduct a quarterly review of the hospital's standardized mortality rate. • Hospitals will work towards submitting data to *Safer Healthcare Now!* on central line infections, surgical site infections and ventilator-associated pneumonia by March 31, 2008.
Increased Cataract Surgery Conditions	• Cataract surgery funding includes the insertion of a standard foldable lens implant which is an insured service under OHIP and provided to the patient free of charge by the institution where the surgery is performed. If a patient wants an added feature lens, the discussion about lens options and informed consent will be documented in writing in the patient's chart. The patient will pay the cost difference directly to the institution. No additional fees will be charged to patients for this discussion or for implanting the lens (both of which are insured services under OHIP). In addition, hospitals will actively explore the use of anaesthesia care teams for their cataract surgery volumes.
Increased Total Hip and Knee Joint Replacement Conditions	• Hospitals receiving hip and knee funding will capture readmission rates for patients readmitted within three months of a total joint replacement.
Ongoing Surgical Efficiency and Critical Care Conditions	• Hospitals receiving surgical wait time funding will continue to submit monthly data requirements as part of the Surgical Efficiency Targets Program, use this data improve operating room efficiencies, and participate in the Critical Care Information System, were applicable.
Ongoing MRI Efficiency Conditions	• Hospitals receiving MRI funding will maintain or increase their MRI efficiency rate at a minimum of 80%.

WAIT TIME INITIATIVE 3: EXPANSION TO PAEDIATRIC SURGERY AND OTHER SERVICES

Since Ontario's Wait Time Strategy began, health care providers, administrators and the public have strongly encouraged us to expand the Strategy beyond the current five service areas (cancer, cardiac, cataract, hip and knee joint replacements, MRI and CT scans). In 2006/07, the Strategy was expanded to paediatric surgery and other services.

Paediatric Surgery

In May 2007, the government provided $5.5 million to improve access to care for children. Almost 80% of these funds ($4.3 million) are being used to perform more than 2,000 additional paediatric surgeries from April 1, 2007 to March 31, 2008. The remaining funds are being used for initiatives to improve access to paediatric services. Paediatric surgical wait times will be entered in the Ontario Wait Time Information System (WTIS) and will be publicly available on the public website.

Other Services

In the past year, we began the process to capture – by 2009 – all surgeries being performed by hospitals receiving wait time funding. This includes general surgery, all of orthopaedic surgery (bone and joint) and all of ophthalmologic surgery (eyes). Radiation therapy wait times will also be added to the WTIS.

WAIT TIME INITIATIVE 4: EXPANDED RANGE OF ADVICE FROM EXPERT PANELS

Expert Panels – made up of clinicians, administrators and researchers all of whom volunteer their time – continued to provide invaluable advice on improving access to health care services (Table 3). From September 2006 to September 2007:

- Four panels took on larger mandates to help guide the expansion of the strategy: Access to Care eHealth, Cancer, Ophthalmology, and Orthopaedic.
- Four new panels were created: Paediatric Surgery, General Surgery, Paediatric Critical Care, and Neurosurgery.
- Six panels submitted their reports as advice to the Ministry: Trauma, Diabetes Management, MRI and CT (Phase II), Paediatric Surgery, Primary Care/Family Practice Wait Times, and Paediatric Critical Care. (See www.ontariowaittimes.com.)

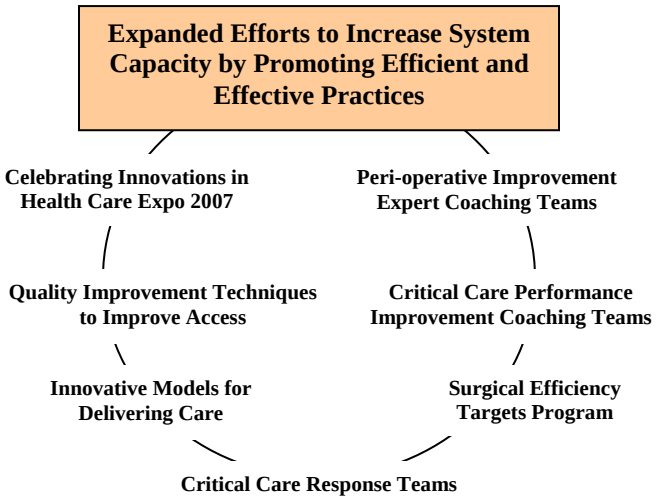
Table 3: Wait Time Strategy Expert Panels

	Expert Panels
1.	Access to Care eHealth Expert Panel: Sarah Kramer (Chair)
2.	Cancer Expert Panel: Dr. Jonathan Irish (Chair)
3.	Cardiac Care: Cardiac Care Network of Ontario (Lead Organization)
4.	Critical Care Expert Panel: Dr. Tom Stewart (Chair)
5.	Diabetes Management Expert Panel: Dr. Catherine Zahn (Chair)
6.	General Surgery Expert Panel: Dr. Ori Rotstein (Chair)
7.	MRI and CT Expert Panel: Dr. Anne Keller (Chair)
8.	Neurosurgery Expert Panel: Dr. James Rutka (Chair)
9.	Ophthalmology Expert Panel: Dr. Philip Hooper (Chair)
10.	Orthopaedic Expert Panel: Dr. Allan Gross (Chair)
11.	Paediatric Critical Care Subcommittee: Cathy Sequin, RN (Chair)
12.	Paediatric Surgery Expert Panel: Cathy Sequin, RN (Chair)
13.	Primary Care/Family Practice Wait Times Expert Panel: Dr. Philip Ellison (Chair)
14.	Surgical Process Analysis and Improvement Expert Panel: Valerie Zellermeyer RN (Chair)
15.	Trauma Expert Panel: Dr. Murray Girotti (Chair)

*Final Report of the Ontario Critical Care Steering Committee, chaired by Dr. Robert Bell and Lynda Robinson.

WAIT TIME INITIATIVE 5: EXPANDED EFFORTS TO INCREASE SYSTEM CAPACITY BY PROMOTING EFFICIENT AND EFFECTIVE PRACTICES

Performing more surgeries and scans is one way to improve access to services. Another way is to perform these procedures as effectively and efficiently, as possible. In 2006/07, efforts were expanded to increase system capacity by promoting efficient and effective practices. Significant progress has been made on initiatives that were launched in earlier years.



Peri-operative Improvement Expert Coaching Teams

Peri-operative Improvement Expert Coaching Teams – made up of clinical and administrative leaders with experience in the effective management of peri-operative resources – are working with hospitals to improve peri-operative efficiencies.[2] Coaching teams conduct an initial three-day site visit and a follow-up visit nine months later to assess improvements.

Hospital CEOs were informed of the coaching team initiative in September 2005. By August 2006, 23 peri-operative coaches were trained and coaching teams conducted initial visits in 13 hospitals. Between September 2006 and September 2007, coaching teams conducted initial visits in 27 more hospitals and nine month follow-up visits in 20 hospitals.

Critical Care Performance Improvement Coaching Teams

In the spring of 2006, the Ministry launched the Critical Care Coaching Teams Program.[3] The program includes 36 coaches with expertise in at least one of six areas: 1) critical care service appraisal; 2) end-of-life decision making; 3) intensivist-led management models; 4) surge capacity planning; 5) patient flow and inter-unit coordination; and 6) leadership and team building. Coaching teams conduct two-day site visits at hospitals that provide critical care services and monthly coaching team follow-up sessions.

[2] The peri-operative process includes three stages: 1) pre-operative (diagnostics, routine testing, patient education, preparation for surgery, preparation for discharge from the operating room and hospital); 2) operative (the surgical day); and 3) immediate post-operative (recovery room, post-anaesthetic care unit or PACU).

[3] For additional information, please see: www.health.gov.on.ca/criticalcare.

By August 2006, coaching teams with expertise in one of the six areas visited 21 hospitals; teams visited an additional 19 hospitals in September and October 2006. Using a request for applications process, 50 more hospitals were selected to receive a coaching team visit from April 1, 2007 to March 31, 2008.

Surgical Efficiency Targets Program (SET)

All hospitals receiving wait time funding must participate in the Surgical Efficiency Targets Program (SET). SET includes standard provincial surgical efficiency targets that all hospitals need to meet. SET determines whether hospitals receiving wait time funding are meeting these targets and identifies areas for improvement. In the summer of 2006, eight hospitals began working with the Ministry to develop and collect SET data. By October 2006, half of the wait time funded hospitals were participating in SET and by the end of July 2007, all hospitals receiving wait time funding were submitting Phase I surgical performance indicators (Table 4). Currently, eight hospitals are testing and collecting Phase II indicators. By November 2008, all hospitals will be required to submit Phase II indicators.

Table 4: Surgical Efficiency Targets Program Performance Indicators

Phase I (July 2007: Collected and Submitted by All Hospitals Receiving Wait Time Funding)	**Phase II (By November 2008)**
• Use of the operating room during prime time (including operating room downtime) • Surgery start time accuracy (first case of the day and each subsequent case) • Length of each surgery • Add-on percentage (the hours scheduled for surgery versus hours actually used)	• Total volume trends • Turnover time • Use of block scheduling • Surgical priority codes • Case time • Planned and unplanned operating room closures • Cancellations • Preadmission screening* • Surgical pause/time out*+ • Return to surgery within 24 hours*

*These are quality and safety indicators.
+ A communication checklist or a "surgical pause" *before* an operation helps with team communication and safe practices. A "surgical pause" occurs before the surgery starts and is when the entire surgical team pauses, and confirms such things as the plan for the case, the location of surgery, and so on.

Critical Care Response Teams[4]

Critical care response teams – made up of critical care physicians, critical care nurses and respiratory therapists – take their critical care expertise beyond the walls of the critical care unit to meet the needs of patients at risk wherever they are in the hospital. Teams help to decrease the inappropriate use of critical care units and provide preventive measures before patients become critically ill. Teams also help prevent readmission by following up with patients after they have been discharged from critical care.

[4] Ministry of Health and Long-Term Care (Critical Care Secretariat). 2007 (January). *Implementation of Critical Care Response Teams (CCRTs) in Ontario Hospitals – Year One*.

From January 2006 to September 2006, the Ministry provided funds for 26 teams in Ontario: 22 adult and four paediatric demonstration teams. In October 2006, the Ministry funded five more adult teams. Currently, 27 adult and four paediatric demonstration teams are fully operational and offering their services in Ontario's hospitals.

Innovative Models for Delivering Care

Ontario's Wait Time Strategy is supporting 16 models for delivering cancer, bone and joint, and eye care in innovative ways (Table 5). All of these models involve a wide range of organizations and providers who are improving access through more effective and efficient practices.

Table 5: Innovative Models for Delivering Care

Model and Local Health Integration Network (LHIN)	Description of Model
Cancer Models	
Champlain Regional Cancer Plan (Champlain LHIN)	Centralized cancer diagnostic assessment centre connected to all cancer hospitals in the Ottawa region. Provides standardized quality care and multidisciplinary assessments.
Bone and Joint Models	
Integrated Model of Care for Total Joint Disease (North Simcoe Muskoka LHIN)	Centralized joint disease referral and assessment centres located at three hospital sites in the LHIN. Provides multidisciplinary assessments, pre-operative care and patient education.
Total Joint Assessment (Central LHIN)	Centralized multidisciplinary assessment, standardized referral from all providers (including primary care), and option for patient to choose referral to surgeon with the shortest wait time.
Total Joint Replacement Assessment Centre (Hamilton Niagara Halimand Brant LHIN)	Centralized multidisciplinary assessment, standardized referral from all providers (including primary care), and option for patient to choose referral to surgeon with shortest wait time.
Fast Track Arthroplasty (South West LHIN)	New techniques for pain management after hip and knee surgery to support early discharge.
TC Joint Health and Disease Management Program (Toronto Central LHIN)	Centralized multidisciplinary assessment, standardized referral and intake process, and option for patient to choose referral to surgeon with shortest wait time.
Integrated Plan for Total Joint Replacement Surgery (Central West LHIN)	Centralized wait lists, transfer protocols, and pre-admission and post-surgery fracture clinic.
Regional Surgical Program in South East LHIN (South East LHIN)	Improved coordination across the continuum and management of referrals for surgery.
Orthopaedic Assessment Centre (Central East LHIN)	Assessment and treatment for osteoarthritis and the reduction of wait times for total hip and knee replacements.
Eye Models	
Kensington Eye Institute (Toronto Central LHIN)	Surgeons from participating hospitals perform cataract surgery at this single, large volume cataract site, freeing up operating rooms at academic centres for complex procedures.
Branson High Volume Centre for Cataract Surgery (Central LHIN)	Single, large volume cataract surgery site.
Cataract Program: Perth and Smith's Falls (South East LHIN)	Single large volume cataract surgery site.

Model and Local Health Integration Network (LHIN)	Description of Model
Regional Eye Centre (Hamilton Niagara Haldimand Brant LHIN)	Standardized best practices for referral and option to refer patient to surgeon with shortest wait time.
The Scarborough Hospital Eye Centre (Central East LHIN)	Surgeons from both hospitals perform surgery at the Scarborough Hospital's ambulatory centre.
Wilson Memorial Regional Model of Care for Cataract Surgery and other Ophthalmologic Services (North West LHIN)	Operating room space at Wilson Memorial General Hospital used fopr a regional ambulatory (day-surgery) program for cataract surgery and other eye procedures. Serves about 18,000 people dispersed across a vast geographic area.
Maximizing Rural Cataract Surgery Capacity (Erie St. Clair LHIN)	Cataract surgeries performed at a rural hospital to support care closer to home.

Quality Improvement Techniques to Improve Access

Increasingly, organizations across Ontario are using quality flow improvement techniques to improve access to services. The current focus is on improving the flow of patients within and between the emergency department and general internal medicine units. See Wait Time Results #6 for additional information.

Celebrating Innovations in Health Care Expo 2007

On May 23-24, 2007, the Ministry and the 14 Local Health Integration Networks co-sponsored *Celebrating Innovations in Health Care Expo 2007*. This event showcased over 200 innovative health care system solutions and projects in Ontario. At the Minister's Award Ceremony, Minister of Health and Long-Term Care, George Smitherman, presented an Innovations Award to winners in six categories (Table 6). The Minister recognized these winners for their innovation, dedication to strengthening the public health care system and improving access to high quality care for Ontarians.

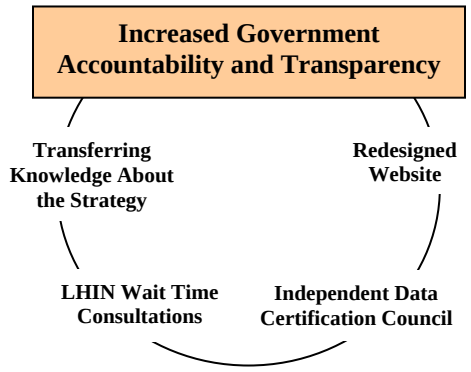
Table 6: Celebrating Innovations in Health Care Expo 2007 Award Winners

	Category	Initiative, Organization and Local Health Integration Network (LHIN)
1.	Improving Efficiency Through Process Redesign	*New Assessment Model for Hip and Knee Replacement* reduces wait times and improves care for people undergoing hip and knee replacement surgery by creating a centralized assessment centre. • Holland Orthopaedic and Arthritic Centre, Sunnybrook Health Sciences Centre – Toronto Central LHIN
2.	Improving Quality and Patient Safety	*Health Promotion Initiatives (HPI)* improve the quality of health care and help sustain a 43% reduction in hospital readmissions. • Group Health Centre, Sault Ste. Marie – North East LHIN
3.	Innovations in Health Human Resources	*HealthKick Huron* educates youth about career opportunities in health care. • Huron Family Health Team – South West LHIN
4.	Innovations in Health Information Management	*Provider-Patient Reminders in Ontario Multi-strategy Prevention Tools (P-PROMPT)* boosts screening rates in Ontario for mammograms, pap testing, influenza vaccination and childhood primary vaccinations. • Department of Family Medicine, McMaster University and Fig P. Software Incorporated – Hamilton Niagara Haldimand Brant LHIN

	Category	Initiative, Organization and Local Health Integration Network (LHIN)
5.	Innovations in Health Promotion	*Stomp Out Stigma* program encourages teenagers to create anti-stigma mental health issue teams within their own schools. • Whitby Mental Health Centre – Central East LHIN
6.	Meeting Community Needs Through Integrated Health Care	*Multi-Site Cardiac Rehabilitation Program* helps provide better care and rehabilitation for people who have cardiac illness. • Thunder Bay Regional Health Sciences Centre – North West LHIN

WAIT TIME INITIATIVE 6: INCREASED GOVERNMENT ACCOUNTABILITY AND TRANSPARENCY TO EMPOWER PATIENTS

In 2006/07, government increased its accountability and transparency of the Strategy to the public and providers. This focus on results, ongoing communication, and more and better information have helped empower patients to become more involved in their health care.



Redesigned Website (www.ontariowaittimes.com)

When the wait times website was first launched in December 2004, it presented general educational information on wait time issues. By October 2005, the site provided the public – for the first time in Ontario – hospital-specific wait time information for the five service areas in hospitals that received additional wait time cases. Wait time data information is updated every two months. On December 7, 2006, Minister Smitherman appointed former Senator Michael Kirby to examine concerns expressed in the Auditor General's report about how Ontario measures and publicly reports wait times. Kirby was also asked to recommend ways to enhance public confidence in the accuracy and usability of information on the website. Partly in response to the Kirby report and partly in response to extensive stakeholder feedback, a redesigned website was launched in March 2007. The website is more user friendly, has patient and health care provider sections, and uses plain language to explain wait times data.

Independent Data Certification Council

In February 2007, the Ministry created an independent Data Certification Council to review and approve how Ontario's wait time information is collected and reported on the wait times website. Chaired by Michael Decter (Chair of the Cancer Quality Council of Ontario), the three-person Council also includes Graham Scott (Chair of the Canadian Institute for Health Information) and Hilary Short (President and CEO of the Ontario Hospital Association). In March 2007, the Council completed its first regular review of the processes used to collect and report wait time information, and approved the release

of the information on the public wait times website. The Council conducts this review every time the website information is refreshed.

Local Health Integration Network Wait Time Consultations

In 2006/07, each of the 14 LHINs hosted wait time sessions attended by a wide range of representatives from hospitals and community organisations. The sessions have been used to report on the progress made on wait times as well as listen to local issues and advice.

Transferring Knowledge About the Strategy

The Wait Time Strategy has benefited enormously from the experiences of other provinces and countries that have launched access and wait time initiatives. In the spirit of supporting others in the larger healthcare community who are working to empower patients and improve access to care, significant efforts have been made to transfer knowledge about our wait time experiences and lessons learned throughout Ontario, Canada and internationally. Articles that have been published in 2006 and 2007 include:

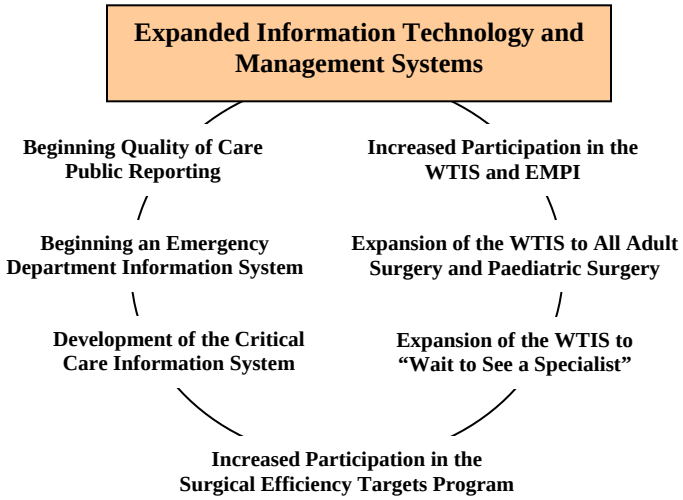
1. Trypuc, J., A. Hudson and H. MacLeod. 2006 "Ontario's Wait Time Strategy: Part 1" *Healthcare Quarterly* 9(2): 44-51.
2. Trypuc, J., A. Hudson and H. MacLeod. 2006 "Expert Panels and Ontario's Wait Time Strategy: Part 2" *Healthcare Quarterly* 9(3): 43-49.
3. Trypuc, J., A. Hudson and H. MacLeod. 2006 "The Pivotal Role of Critical Care and Surgical Efficiencies in Supporting Ontario's Wait Time Strategy: Part 3" *Healthcare Quarterly* 9(4): 37-45.
4. Trypuc, J., H. MacLeod and A. Hudson. 2006 "Developing a Culture to Sustain Ontario's Wait Time Strategy (Invited Essay)" *Healthcare Papers* 7(1): 8-24.
5. Trypuc, J., A. Hudson and H. MacLeod. 2007 "Evaluating Outcomes: Ontario's Wait Time Strategy: Part 4" *Healthcare Quarterly* 10(2): 56-65.

In addition, the Ministry commissioned the Institute for Clinical Evaluative Sciences (ICES) to evaluate the impact of the Ontario Wait Time Strategy on surgical procedures that were not one of the priority services.[5] (See Wait Time Result #1 for results of the ICES review.)

[5] Paterson J.M., J.E. Hux, J.V. Tu and A. Laupacis. 2007 *The Ontario Wait Time Strategy: no evidence of an adverse impact on other surgeries*. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences.

WAIT TIME INITIATIVE 7: EXPANDED INFORMATION TECHNOLOGY AND MANAGEMENT SYSTEMS

A significant amount of activity occurred in 2006/07 to expand wait time information technology and management systems.



Increased Participation in the Wait Time Information System (WTIS) and Enterprise Master Patient Index (EMPI)

The Wait Time Information System (WTIS) is a single electronic provincial system that collects and manages wait time information to help patients, providers and administrators improve access to care. Hospitals participating in the Strategy (i.e., those receiving wait time funded volumes) must submit their wait times to the WTIS. Physicians, hospitals, Local Health Integration Networks and the Ministry use the WTIS to monitor and manage wait times. A provincial Enterprise Master Patient Index (EMPI) is also being developed along with the WTIS. The EMPI is a registry of patient demographic information that is a cornerstone for an electronic health record in Ontario. Linking the WTIS to the EMPI enables patients who are on more than one wait list to be tracked.

The WTIS and EMPI have been implemented in three phases (Figure 2). From September 2006 to September 2007:

- Phase 2 was successfully completed one month ahead of schedule and on budget.
- Phase 3 was successfully completed on schedule and on budget.

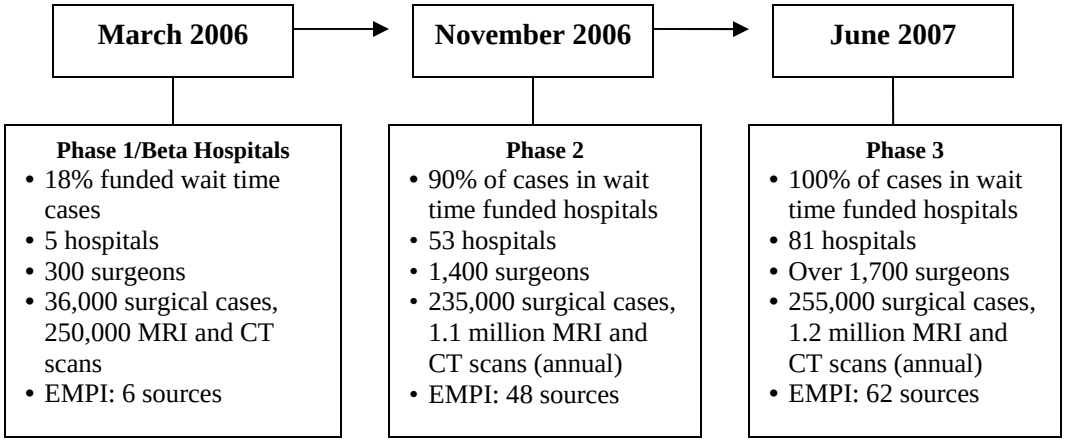
Expansion of the WTIS to All Adult Surgery and Paediatric Surgery[6]

The four surgical areas in the Wait Time Strategy (cancer, cardiac, cataract, and hip and knee joint replacements) only represent 14% of the surgeries performed in Ontario. In the past year, the Wait Time Information Office developed a schedule with clear deliverables and timelines to expand the WTIS to include all of surgery performed by hospitals receiving wait time funding. The WTIS will increase from 250,000 surgeries a year to about 1,282,000 surgeries a year. In late fall/winter of 2007, implementation will begin for all of ophthalmic (eye), orthopaedic (bone and joint) and general surgery at wait time-funded hospitals. The remaining surgical specialties – as well as radiation therapy wait times – will be included in the WTIS and on the public website by 2009.

[6] See Wait Time Initiative #3 for additional information.

The WTIS is also being expanded to include all of paediatric surgery. By March 31, 2008, the WTIS will be implemented in one Paediatric Academic Health Science Centre. By 2009, the WTIS will then be implemented in the other four centres and in community hospitals.

Figure 2: Implementation of the Wait Time Information System and Enterprise Master Patient Index



Expansion of the WTIS to "Wait to See a Specialist"

The initial focus of the WTIS has been to measure and manage the time from "decision to treat, to treat." Over the past year, the Wait Time Information Office has been working with the Toronto Central Local Health Integration Network (LHIN) to measure and report on the wait to see a specialist. A first for Ontario, the Toronto Central LHIN's Joint Health and Disease Management Program uses a central intake referral processing site and two assessment centres staffed by interdisciplinary assessment teams. This process will increase the number of patients who are being referred appropriately to an orthopaedic surgeon for a consultation in one of six acute care hospitals in the Toronto Central LHIN. Using the WTIS to develop a single wait list, patients will be given the choice of the next available appointment or a specific surgeon. Not only is the program reducing the wait time to see a surgeon, it has begun to expand the WTIS to include the wait to see a specialist.

Increased Participation in the Surgical Efficiency Targets Program[7]

In the summer of 2006, eight hospitals began working with the Ministry to develop the Surgical Efficiency Targets Program (SET) and collect data. By the end of July 2007, all hospitals receiving wait time funding were submitting Phase I surgical performance indicators to SET. Hospitals are able to compare their performance with their peer

[7] See Wait Time Initiative #5 for additional information.

hospitals, and use a web-based tool to monitor, assess and improve the use of their surgical resources. As well, LHINs and the Ministry are able to monitor surgical efficiencies at the local, regional and provincial levels.

Development of the Critical Care Information System

The Critical Care Information System (CCIS) is an electronic system that collects hospital- and patient-specific critical care data. All Ontario hospitals with critical care units will be required to provide information to CCIS. In January 2007, nine Ontario hospitals with Level 3 critical care beds began submitting data to CCIS on their adult medical-surgical intensive care patients.[8] By September 2007, 23 large hospitals with 31 intensive care units and 52% of Ontario's Level 3 critical care beds were submitting data to CCIS. Information on the remaining Level 3 ICU beds will be collected by the end of December 2007. Hospitals with Level 2 beds and specialty critical care units – such as neurosurgery, burns and paediatrics – will begin collecting data from January to June 2008. Currently, 80% of Ontario's critical care response teams are also submitting data to CCIS to determine the impact of these teams on the use of hospital and critical care resources.[9]

Beginning an Emergency Department Information System

In October 2006, the Ministry invested $142.2 million to support a three-point Emergency Department Action Plan that included: 1) initiatives to retain and recruit ED physicians and add physician assistants and nurse practitioners to EDs; 2) increased hospital capacity through an ED support fund, ED process improvements, more critical care beds, and funds for hospitals in small, rural and high growth areas; and 3) funds for more community-based services.

In August 2007, emergency department wait times became part of Ontario's Wait Time Strategy. As a first step, the Strategy has begun to develop the Ontario Emergency Department Information System (EDIS). Although EDIS will mostly use data that hospitals already collect, the electronic system will help improve the accuracy of the information, and make it easier to monitor and manage emergency services provincially, regionally and locally. Hospitals with emergency departments will be required to submit data centrally. Participating in EDIS will be a condition of subsequent wait time strategy and ED wait time funding. Emergency information will eventually be publicly reported by individual hospitals, peer group and LHIN. Similar to the Wait Time Information System, this information will be used to monitor and improve access to, and the performance of, emergency departments in Ontario.

[8] Level 3 critical care beds can provide invasive ventilation to patients for more than 48 hours and care for patients with multi-system organ failure. Level 3 units are in teaching hospitals and can be in large community hospitals. Level 2 critical care beds usually provide invasive ventilation for up to 48 hours and generally care for patients with single-system organ failure (e.g., post-surgical stepdown bed).

[9] For a discussion of critical care response teams, see Wait Time Initiative #5 for additional information.

Beginning Quality of Care Public Reporting

New quality and safety conditions for wait time funding were put in place on April 1, 2007.[10] These conditions included the requirement for hospitals to work towards submitting data to *Safer Healthcare Now!* on central line infections, surgical site infections and ventilator-associated pneumonia by March 31, 2008. This information will be publicly reported on the Wait Time Information System in 2008/09.

WAIT TIME RESULTS 2006/07

WAIT TIME RESULT 1: THE NUMBER OF SURGERIES AND SCANS PERFORMED IN THE FIVE WAIT TIME AREAS HAS CONTINUED TO INCREASE WITH NO MEASURABLE NEGATIVE IMPACT ON VOLUMES IN OTHER AREAS

From the time the Wait Time Strategy was announced in November 2004 to March 31, 2007, healthcare providers and hospitals in Ontario performed significantly more wait time surgeries and MRI and CT scans (Table 7).

Using fiscal 2003/04 as the baseline year, in Ontario in 2007/08 the number of:
- Cancer surgeries increased 14%;
- Cardiac procedures increased 33%;
- Cataract surgeries increased 39%;
- Hip and knee joint replacement surgeries increased 52%;
- CT scans increased 15%; and
- MRI scans increased 105%.

Table 7: Number of Procedures Completed in Ontario Hospitals That Received Wait Time Funding, Fiscal Years 2003/2004-2006/2007*

Procedure	Baseline 2003/2004	Fiscal Year 2004/2005	Fiscal Year 2005/2006	Fiscal Year 2006/2007	Fiscal Year 2007/2008	Increase from 2003/04 to 2007/08
Cancer Surgery	44,950	46,653	49,767	50,066	51,149	6,199 (14%)
Cardiac Procedures	88,449	96,300	103,298	112,686	117,664	29,215 (33%)
Cataract Surgery	102,182	104,182	119,857	140,832	142,107	39,925 (39%)
Hip/Knee Joint Replacement Surgery	24,006	26,366	31,553	35,996	36,435	12,429 (52%)
Scan: CT	1,035,436	1,035,436	1,116,736	1,188,594	1,188,563	153,127 (15%)
Scan: MRI	276,448	316,448	386,193	491,636	565,994	289,546 (105%)

*Fiscal years range from April 1 of one year to March 31 of the following year.

[10] See Wait Time Initiative #2 for additional information.

There was the perception that wait time-funded surgeries were having a negative impact on the number of surgeries performed in all other areas. This does not appear to be the case according to two studies released in 2006/07.

- The Canadian Institute for Health Information's study of surgical volumes in Canada (excluding Quebec) found that the number of wait time surgeries in the four priority areas – hip and knee replacements, cataracts, cardiac revascularization and cancer – increased 7% from 2004/05 to 2005/06, after adjusting for population growth and aging.[11] Over the same time period, the number of surgeries outside the priority areas either stayed the same or increased in all provinces. In Ontario, the average number of *surgeries outside the priority areas* increased by almost 2%, taking population growth and aging into account.
- The Institute for Clinical Evaluative Sciences' review of 27 surgical procedures not yet included in the Wait Time Strategy (and performed between January 1, 1992 and June 30, 2006) concluded that the Strategy did not negatively impact on the rate of these surgeries.[12] In fact, the findings suggest that the rate of a small number of non-funded orthopaedic procedures may have increased since the start of the Strategy.

WAIT TIME RESULT 2: PROVINCIAL WAIT TIMES FROM THE DECISION TO TREAT TO TREAT HAVE CONTINUED TO DECREASE IN THE FIVE WAIT TIME AREAS

An analysis of 23 months of wait time data indicates that Ontarians waited less time from the "decision to treat, to treat" for all wait time procedures as measured by the 90th percentile or the point at which nine out of 10 patients received their treatment (Table 8).

Compared to August/September 2005 – when wait time information was first available in Ontario – in June 2007, on average Ontarians got their:

- Cataracts removed 179 days sooner.
- Knee joints replaced 138 days sooner.
- Hip joints replaced 121 days sooner.
- An angiography 33 days sooner.
- CT scans 21 days sooner.
- Cancer surgery 19 days sooner.
- Angioplasty 15 days sooner.
- MRI scans 12 days sooner.

[11] Canadian Institute for Health Information. 2007 *Surgical Volume Trends Within and Beyond Wait Time Priority Areas*. Ottawa: CIHI. For the "Analysis in Brief" of the Canadian Institute for Health Information study, please see http://secure.cihi.ca/cihiweb/en/downloads/surgical_volume_trends_jan2007_e.pdf.
[12] Paterson J.M., J.E. Hux, J.V. Tu and A. Laupacis. 2007 *The Ontario Wait Time Strategy: no evidence of an adverse impact on other surgeries*. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences.

Table 8: Wait Times Data: 9 Out of 10 Ontarians Completed Within Target – August/September 2005 to June 2007 –					
Procedure	**Days**			**Completed Within Target***	**Current vs. Baseline Change (Days)**
	Baseline Aug/Sept 2005	**Current June 2007**	**Access Target**		
Cancer Surgery	81	62	84	95%	-19
Angiography	56	23	-	-	-33
Angioplasty	28	13	-	-	-15
Bypass Surgery	49	53	182	100%	4
Cataract Surgery	311	132	182	94%	-179
Hip Replacement	351	230	182	83%	-121
Knee Replacement	440	302	182	76%	-138
MRI	120	108	28	49%	-12
CT	81	60	28	74%	-21
*Priority Level 4 Target					

When comparing the Priority 4 wait time target (90th percentile) recommended by clinical experts in each of the five service areas with actual performance in June 2007, the percentage of adult Ontarians who received their procedure within the recommended Priority 4 targets is as follows:

- 100% of patients received cardiac bypass surgery within the target.
- 95% of patients received cancer surgery within the target.
- 94% of patients received cataract surgery within the target.
- 83% of hip replacement patients and 76% of knee replacement patients were within the target.
- 74% of CT scans and 49% of MRI scans were within the target.

WAIT TIME RESULT 3: ALL PHYSICIANS RECEIVING WAIT TIME FUNDED CASES ARE NOW USING ONE PROVINCIAL WAIT TIME INFORMATION SYSTEM AND ARE TESTING THE SAME URGENCY RATING SCALES TO HELP DETERMINE THE PRIORITY OF A PATIENT'S CONDITION

The Wait Time Information System was implemented in three phases. As noted previously, from September 2006 to September 2007, Phase 2 was successfully completed one month ahead of schedule and on budget, and Phase 3 was successfully completed on schedule and on budget. This means that all hospitals receiving wait time funding have now implemented the *essential WTIS*. Over 1,700 surgeons working in 81 hospitals in Ontario are now entering all their wait time cases in the WTIS (cancer surgery, cardiac surgery, cataract surgery, hip and knee joint replacements, MRI and CT scans). This amounts to 255,000 surgeries and about 1.2 million MRI and CT scans, each year.

These physicians are also using a consistent method and tool to help determine the urgency of a patient who needs cancer, cardiac or cataract surgery, a hip or knee joint

replacement, or an MRI or CT scan.[13] These urgency rating scales are being tested and refined on the advice of the expert panels. The scales will eventually be reported on the public website and will be used to plan and manage services. This consistent approach to rating urgency will support equitable care since all Ontarians who need these procedures will be prioritised the same way.

WAIT TIME RESULT 4: THE USE OF INFORMATION SYSTEMS AND ELECTRONIC HEALTH INFORMATION IN ONTARIO HAS INCREASED SIGNIFICANTLY AND BEEN RECOGNIZED PUBLICLY

As noted previously, in December 2006, Minister Smitherman appointed former Senator Michael Kirby to examine how Ontario measures and publicly reports wait times. Kirby's report noted that, "in less than two and a half years enormous progress has been made in developing and implementing a wait time information and management system in Ontario."

The Wait Time Information System won *The Institute of Public Administration of Canada (IPAC) Award for Innovative Management 2007*, and is a finalist for the *Canadian Information Productivity Awards 2007 (CIPA)* in the category of organizational transformation. In 2007, COACH – Canada's Health Informatics Association – awarded Sarah Kramer (Lead for the Wait Time Information Strategy) the *Leadership in the Field of Health Informatics Award* for her significant contributions to the field of health information.

The use of computers and electronic health information has increased significantly. When the Wait Time Information System (WTIS) began, 50% of Ontario's surgeons were not able to connect to the internet. Since then, more than 450 new Internet connections have been made for surgeons to allow them to connect to the WTIS. Currently, over 1,700 surgeons are connected to and use electronic technology daily to help them improve access to care and help guide their clinical practices. In addition, administrators now have accurate, near real-time data to allocate resources and monitor progress in delivering timely care.

WAIT TIME RESULT 5: GOVERNMENT AND LOCAL HEALTH INTEGRATION NETWORKS ARE USING DATA AND EVIDENCE TO MAKE FUNDING AND SERVICE DECISIONS AND TO TARGET SOLUTIONS

Increasingly in 2006/07, government and Local Health Integration Networks (LHINs) were making service and funding decisions based on wait time data and evidence. Consistent and detailed wait time information by LHINs, hospitals and individual procedures helped to identify the areas of greatest need and to allocate additional funding. This information was also used to help us understand where and why problems were occurring and to address the problem areas. For example, a review of the data showed us

[13] Under the leadership of the Cardiac Care Network of Ontario, cardiac surgeons in the province have been using a consistent priority rating scale since 1990 to help determine the urgency of patients who need cardiac surgery.

that a temporary increase in cancer surgery wait times in August/September 2006 was due to increased wait times in only three out of eleven cancer groups (gynaecology, lung, brain); wait times decreased or stayed the same in the other eight cancer groups. We examined wait time information by cancer group in each of the 14 LHINs and in every hospital to identify and solve the problem.

WAIT TIME RESULT 6: THERE IS GROWING EVIDENCE THAT EFFORTS TO INCREASE SYSTEM CAPACITY USING MORE EFFICIENT AND EFFECTIVE PRACTICES ARE HAVING POSITIVE IMPACTS

Although it is still too early to assess in objective and measurable ways whether all the wait time projects are resulting in more efficient and effective practices, there is growing evidence to suggest that these projects are having positive impacts. A few examples are provided.

One, before the Ministry formally funded **critical care response teams** across the province, it supported two teams as part of a demonstration project which began in April 2005. There is now evidence to suggest that these teams are having a significant impact on patient care and improving the appropriate use of hospital resources. One year after the teams became fully functional:

- The team at the Ottawa Hospital (General site) reported a 3.4% decrease in admissions from the ward to the intensive care unit, a 12% decrease in the length of stay in the intensive care unit, a 39% decrease in readmission rates into the intensive care unit, and a 38% decrease in Code Blue calls (cardiac arrest).
- The team at the University Health Network (Toronto General) reported a 23% decrease in respiratory arrests, a 7% decrease in cardiac arrests and an 8.4% decrease in hospital mortality.[14]

Two, in July 2007, the Ministry completed a preliminary evaluation of the **peri-operative improvement expert coaching team** initiative.[15] The evaluation identified common peri-operative issues across all hospitals, challenges to improving efficiencies and successes. The evaluation concluded that the peri-operative coaching teams have been successful: they have been well received by all hospitals which reported more efficient use of their operating resources. An in-depth evaluation will be conducted in the future.

Three, **organizations using lean management techniques** have significantly improved access to services (see Wait Time Strategy Initiative #5).

- In its emergency department initiative, the Hotel Dieu Grace Hospital in Windsor reported that over a 12 month period, patient visits to the emergency department (ED) increased steadily. Average time to be seen by a physician decreased from 166 to 80 minutes, average overall length of stay decreased from 4 to 3.1 hours, and the number of patients who walked out of the ED without being seen decreased from 10% to 4%.

[14] As reported in Ministry of Health and Long-Term Care. 2007 (March). *Ontario's Critical Care Strategy: Quarterly Report*; p 4.
[15] Ministry of Health and Long-Term Care. 2007 (July). *Peri-Operative Improvement Expert Coaching Teams: A Preliminary Evaluation Report.*

- In its emergency department-general medicine unit initiative, St. Joseph's Health Centre in Toronto reported that after three months, average ED length of stay for patients discharged home dropped from nine to 5.2 hours, patients admitted to the general medicine unit waited four hours less, and a significant number of patients were discharged earlier in the day which helped streamline admissions to available beds.
- In its emergency department-general internal medicine unit initiative, North York General Hospital in Toronto reduced its ED ambulatory care length of stay by 29%, its ED subacute length of stay by 35% and the time to clean a bed by 44%.
- In its emergency department-general internal medicine unit initiative, University Health Network in Toronto decreased its alternate level of care days by 18%, decreased the time from referral by an allied health staff to patient discharge by 68%, and a 73% decrease in discharge prior to 11 am.

Finally, the **Kensington Eye Institute** – which is a centre of excellence for cataract surgery in the Toronto Central LHIN – has been performing basic cataract surgeries since January 2006. Patients are referred directly to the centre and see the first available surgeon. In February-March 2007, a panel made up of experts from the John A. Moran Eye Center (Utah), the University of Manitoba and the University of Western Ontario conducted an in-depth evaluation of Kensington and concluded that the organization has been tremendously successful after one year of operation. The entire operation is extremely efficient, the organization has an outstanding safety record, patients and staff report high rates of satisfaction, and the site is an excellent learning facility for senior residents. In addition, Kensington has helped free up hospital operating rooms for more complex surgeries.

WAIT TIME RESULT 7: PUBLIC AND PROVIDER INTEREST IN WAIT TIMES INFORMATION APPEARS HIGH

There appears to be a great deal of public and provider interest in Ontario's wait time information.

- From the time hospital-specific wait time data was first posted in October 2005 to the present, the website has had over 4.6 million hits. The *average number of website hits in a day has increased dramatically from 2,000 in November 2005 to 10,000 in July 2007*. Significantly more daily hits occur when the Ministry makes funding announcements.
- Thirteen wait time data reports are available for practitioners and administrators to monitor and manage wait times. On average, these individuals are logging into the Wait Time Information System 600 to 800 times a day, and are extracting 2,000 reports monthly.

WAIT TIME RESULT 8: HOSPITALS ARE MEETING THE TERMS OF THEIR ACCOUNTABILITY AGREEMENTS

In 2006/07, hospitals were regularly audited to determine whether they were meeting the terms of their accountability agreements. Hospitals are meeting the terms of these agreements and fulfilled the conditions of funding. These include maintaining the base number of procedures, performing additional funded volumes, submitting required wait time information to the WTIS, and meeting efficiency conditions.