THE WAIT TIME STRATEGY
REVIEW OF ACTIVITIES
OCTOBER-DECEMBER 2007

UPDATE #10 – December 19, 2007

INTRODUCTION

The Wait Time Strategy is continuing to increase its efforts to improve access to, and reduce wait times for, a broad range of healthcare services for all Ontarians. This is the tenth in a series of updates on the Strategy.[1] It presents the highlights and major accomplishments from October to December 2007.

HIGHLIGHTS AND MAJOR ACCOMPLISHMENTS

ADULT WAIT TIMES: AUGUST/SEPTEMBER 2005 TO OCTOBER 2007

An analysis of 26 months of wait time data indicates that adult Ontarians waited less time from the "decision to treat, to treat" for all wait time procedures as measured by the 90th percentile (i.e., the point at which nine out of 10 patients received their treatment).

Adult Wait Times Data: 9 Out of 10 Patients Receive the Treatment Within Target – August/September 2005 to October 2007 –					
Procedure	**Days**			**Completed Within Target***	**Current vs. Baseline Change (Days)**
	Baseline Aug/Sept 2005	**Current Oct 2007**	**Access Target**		
Cancer Surgery	81	69	84	93%	-12
Angiography	56	22	-	-	-34
Angioplasty	28	14	-	-	-14
Bypass Surgery	49	53	182	100%	4
Cataract Surgery	311	141	182	95%	-170
Hip Replacement	351	218	182	85%	-133
Knee Replacement	440	285	182	80%	-155
MRI	120	122	28	46%	2
CT	81	56	28	77%	-25

*Priority Level 4 Target

Compared to August/September 2005 – when wait time information was first available in the province – Ontarians got their cataracts removed 170 days sooner in October 2007,

[1] See www.ontariowaittimes.com for the first nine updates.

their knee joints replaced 155 days sooner, their hip joints replaced 133 days sooner, an angiography 34 days sooner, an angioplasty 14 days sooner and their cancer surgery 12 days sooner. Ontarians also got their CTs 25 days sooner. Although Ontarians waited four days more for bypass surgery (53 days in October 2007), this was well below the target set by clinical experts for safely receiving routine bypass surgery (182 days).

Adult MRI Wait Times

One area of concern continues to be wait times for MRI. Even though the Ministry of Health and Long-Term Care has made significant investments in MRI since the fall of 2004, MRI wait times have stayed the same. We will be increasing our efforts to improve this situation in 2008 and ***look to all of you to help in this effort***. The Strategy has been successful because of the efforts of physicians, clinicians, administrators and others. I am confident that by working together, we can improve access to MRI services.

At this point, ***hospital boards and CEOs are asked to***:

- Track their hospital's MRI performance regularly; and
- Ensure their hospital has systems to address inappropriate imaging requests and to triage appropriate requests quickly.

PAEDIATRIC WAIT TIMES: APRIL/MAY 2006 TO OCTOBER 2007

I am pleased to report that the Wait Times website is starting to include wait times for paediatric surgery. Currently, the five Paediatric Academic Health Science Centres are voluntarily submitting their surgical wait times:

- Children's Hospital of Eastern Ontario (Ottawa)
- Children's Hospital of Western Ontario (London)
- McMaster Children's Hospital (Hamilton)
- South Eastern Ontario Health Sciences Centre (Kingston)
- The Hospital for Sick Children (Toronto)

In the future, other hospitals performing paediatric surgery will submit their wait times. The paediatric wait time information will also continue to be refined. (Currently, the measure of "wait time" may include medically appropriate or planned waits where a surgery is delayed until a child is older or more developed. These planned waits need to be removed from the actual time that is spent waiting for a procedure.)

Using April/May 2006 as the baseline, infants, children and youth received their surgery 30 days sooner in October 2007 in the five hospitals; 82% of surgeries were completed within the target.

Paediatric Wait Times Data: 9 Out of 10 Patients Receive the Treatment Within Target Paediatric Academic Health Science Centres – April/May 2006 to October 2007 –					
Procedure	**Days**			**Completed Within Target***	**Current vs. Baseline Change (Days)**
	Baseline April/May 2006	**Current Oct 2007**	**Access Target**		
Paediatric Surgery	273	243	182	82%	-30

*Priority Level 4 Target

The table below indicates the type of paediatric wait time information that is being tracked by subspecialty.

Paediatric Wait Times Data: 9 Out of 10 Patients Receive the Treatment Within Target and the Total Number of Patients by Subspecialty, Paediatric Academic Health Science Centres – October 2007 –		
Subspecialty	**9 Out of 10 Patients Treated Within (Days)**	**Total Number of Patients**
Cardiovascular Surgery	158	58
General Surgery	107	333
Gynaecology	87	8
Neurosurgery	108	36
Ophthalmology	295	243
Dental/Oral Surgery	371	279
Orthopaedic Surgery	246	257
Otolaryngology	199	466
Plastic Surgery	226	194
Urology	246	192
All Services	**243**	**2,066**

The Ministry invested $5.5 million to fund about 2,000 more paediatric surgeries in 2007/08. These funds were allocated to 18 hospitals by surgical area:

- General Surgery (i.e., hernia repair): 130 cases
- Ophthalmology Surgery (i.e., strabismus repair): 520 cases
- Dental/Oral Surgery (i.e., dental extractions): 656 cases
- Orthopaedic Surgery (i.e., scoliosis surgery): 100 cases
- Otolaryngology (i.e., myringotomy and tube placement): 753 cases
- Plastics (i.e., pulse dye laser): 72 cases
- Urology (i.e., orchiopexy): 88 cases

The next significant step for paediatric wait times is to include all of paediatric surgery in the Wait Time Information System (WTIS). In the Spring of 2008, the London Health Sciences Centre and St. Joseph Health Centre (London) will pilot the use of the WTIS to collect all paediatric surgeries in Ontario.

Dr. Charlotte Moore is the Ministry's Provincial Lead for Paediatrics.

EMERGENCY ROOM WAIT TIMES

On October 12, 2007 immediately following the election, Premier Dalton McGuinty and the Minister of Health and Long-Term Care, George Smitherman, announced that the Wait Time Strategy was being expanded to include emergency department wait times. As lead of this major government initiative, I am working closely with Dr. Michael Schull, Chair of the ER Expert Panel. We are committed to reducing wait times and overcrowding in Ontario's ERs.

The Emergency Department Reporting System (EDRS) will help hospitals measure and manage their ER activities and the flow of patients into and out of ERs in a timely and safe manner. Six hospitals – which have volunteered to be EDRS pilot sites – are working with the Wait Time Information Office to develop and implement the system: Grey Bruce Health Services, Hotel-Dieu Grace Hospital (Windsor), Mount Sinai Hospital, Northumberland Hills Hospital, Sault Area Hospital, and Southlake Regional Hospital. Hospitals with more than 20,000 emergency room visits will be part of the second stage of implementation. It is anticipated that by September 2008/09, about 80 hospitals will be submitting data to EDRS. Indicators that are being considered – on the advice of the EDRS Advisory Committee – include ambulance off-load time, time to physician assessment, time to admission, ER length of stay, the number of alternate level of care patients, and the number of patients in the ER. This information will be publicly reported on the wait times website by the end of 2008/09.

It is anticipated that the Minister will announce specific targets for tracking ER wait times in 2008. Pay-for-performance will be linked to managing ER wait times and resources successfully. Hospital CEOs are responsible for managing their ERs as well as the flow of ER patients to in-patient beds, operating rooms and critical care beds. Appropriately managing the flow of patients is necessary to achieve ER improvements. ***Hospital Boards should be*** asking their CEOs to provide their hospital's plan for managing ER wait times and resources, and improving the flow of ER patients. ***LHINs should be*** reviewing the performance of the hospitals in their region in this regard.

The Ministry is planning a number of projects to help control the "demand" for ER services (e.g., chronic disease management especially diabetes, aging at home, mental health and addictions). In addition, there are efforts to address the "supply" of services such as inpatient beds for those admitted to hospital through ERs, services for people discharged from ERs back to the community, and community and facility supports for alternate level of care patients.

EXPANSION OF THE WAIT TIME INFORMATION SYSTEM TO CAPTURE ALL SURGERY

The Wait Time Information System (WTIS) project team – under the leadership of Sarah Kramer and in consultation with hospitals and the chairs of the Orthopaedic, Ophthalmic and General Surgery expert panels – has been working very hard over the past few months to expand the WTIS to capture all orthopaedic, ophthalmic and general surgery procedures by March 2008. As noted above, the team is also working with London

Health Sciences Centre and St. Joseph Health Centre (London) to pilot the use of the WTIS to collect all paediatric surgeries. By March 2009, the WTIS will be capturing and reporting on paediatric surgeries performed in all Ontario hospitals and all adult subspecialty surgeries.

We would like to thank the leadership, clinicians and administrative staff in all Wait Time Strategy funded hospitals for their continued efforts to implement the WTIS. We acknowledge the tremendous work that it has taken to achieve our successes in information systems, to date. The commitment of Chief Executive Officers, Chief Information Officers and surgeons in every hospital – along with the efforts of front line staff working daily with the WTIS project team – are highly commended. ***We encourage you to continue supporting efforts*** to expand and improve the WTIS which is a key tool to help manage and improve access to care for all Ontarians. If you have any questions about the WTIS, please contact Sarah Kramer at sarah.kramer@cancercare.on.ca.

NEUROSURGERY EXPERT PANEL

The Neurosurgery Expert Panel – chaired by Dr. James Rutka – has submitted its final report to the Ministry. This panel was struck in April 2007 in response to complaints from ER physicians who were having great difficulties placing emergency and urgent neurosurgical patients in appropriate neurosurgical centres. A significant number of emergency neurosurgical patients were being transferred out of province for treatment. The Panel supported treating these emergency patients in Ontario by increasing neurosurgical capacity. The Panel makes 21 recommendations as part of an Ontario Neurosurgical Plan. The plan will be coordinated with the provincial plans for ERs, trauma and critical care, as well as other major ongoing initiatives.

FEDERAL-PROVINCIAL-TERRITORIAL AGREEMENT: HIP FRACTURE SURGERY

Ontario is addressing wait times beyond the original five service areas as part of the Federal-Provincial-Territorial Ministers of Health agreement. Ontario has accepted the pan-Canadian benchmark for hip fracture surgery that was announced on December 12, 2005. The benchmark is to perform surgery within two days of a hip fracture. The Trauma Expert Panel noted that the burden of non-major trauma – such as hip fractures in the elderly – on patients and on all hospital services appears to be significant. The panel also noted that the sooner someone has hip fracture surgery, the better the outcome.

Hospital Boards and CEOs are asked to review their institution's wait times for hip fracture surgery and begin to address waits that are longer than the two day benchmark. It is anticipated that hospitals will be required to submit their hip fracture surgery wait times in 2008. These will be publicly reported on the wait times website.

MAMMOGRAPHY AND CERVICAL CANCER SCREENING

Cancer Care Ontario is advising the Ministry on a provincial access program for mammography and cervical cancer screening. The access issue for these two areas is not

wait times for screening; rather it is convincing target populations to go for screening. The provincial program will include public reporting of screening rates. Although the majority of screening programs are in the community, ***hospitals are asked to*** provide leadership and support where possible to improve screening rates and ***LHINs, in particular, are asked to*** promote improved screening rates. Hospital and LHIN efforts should be ***in partnership with the Cancer Care Regional Vice Presidents***.

EXPERT PANELS

I would like to thank all the members of the expert panels – and particularly the Chairs – for their tremendous contributions during this year. As I reported to you in October, the government is reviewing all the expert panels. Some will be discontinued and, in some instances, new ones created. This will enable us to share the load among more providers. The concept of expert panels has been very well received by government. Indeed, a recent review found that government has acted on over 80% of the expert panel recommendations.

HIP AND KNEE JOINT REPLACEMENT PROGRAMS

The Toronto Central LHIN Joint Health and Disease Management Program will undergo an external evaluation in the Spring of 2008. Reviewers will include experts from the United Kingdom, United States and Canada. Dr. James Waddell will be gathering the material for the visiting review team which will provide its report directly to government.

When the external review of the Toronto Central LHIN program is finished, Drs. Waddell and Cecil Rorabeck will review all existing hip and knee programs in the Ontario and will provide their recommendations to government. Drs. Waddell and Rorabeck may contact hospitals and programs in the near future to request data as part of their provincial review. ***You are asked to*** provide information to these two reviewers, upon request.

CRITICALL

The Neurosurgery Expert Panel Report recognised the importance of CritiCall for connecting Ontario physicians with hospital-based specialists who provide advice and assistance on caring for seriously ill patients. CritiCall has a scope that goes well beyond neurosurgery. The government is currently reviewing the function of CritiCall, its structure and its relationship to other structures in the province. ***Hospital boards and CEOs should be*** aware of the manner in which their institutions currently interact with CritiCall.

TRANSPARENCY AND PUBLIC REPORTING

Increasingly, the media is reporting healthcare information to the public. Most recently, the media gave extensive coverage to the Canadian Institute for Health Information's

report on hospital standardized mortality ratios (HSMR).[2] Many newspaper front pages prominently displayed the mortality rates of local hospitals.

One of the major elements of Ontario's Wait Time Strategy has been communications and transparency.[3] The Strategy has consistently enjoyed wide-spread media coverage when I have visited local communities across the province to discuss access issues and wait time results. The Strategy empowers patients by democratising knowledge about wait times. Ontarians now have access to wait time information on a public website, and have been encouraged to engage in discussions with their providers about choosing where best to get their care. Public wait time data makes it easy to identify the hospitals and LHINs with the shortest and the longest wait times in all service areas.

As you are aware, information on hospital quality and safety will be publicly reported on the wait times website in the near future. I am sure that ***hospital Boards and management have been*** addressing quality and safety issues in response to my communications on this issue:

- In September 2006, I communicated that the newly created Quality and Safety Expert Panel (Chair, Dr. Michael Baker) was considering a number of indicators to report publicly on the wait times website including CIHI's standardized mortality rates and the six initiatives of *Safer Healthcare Now!*[4] Hospitals were informed that they "should be reviewing their hospital standardized mortality rates, and their compliance with the six *Safer Healthcare Now!* initiatives."
- In December 2006, I communicated that a *Quality and Safety Symposium in Support of Ontario's Wait Time Strategy* identified quality and safety information that should be collected and funding conditions that should be established in the short term (2007/08) and the longer term (2008/09 and beyond) to support Ontario's Wait Time Strategy.[5]
- In April 30, 2007, I communicated that the Ministry was introducing quality and safety as conditions of wait time funding in 2007.[6] These conditions included a Quality Committee of the Board, a Board/management quarterly review of the hospital's standardized mortality rate, and hospitals working towards submitting data to *Safer Healthcare Now!* on central line infections, surgical site infections and ventilator-associated pneumonia by March 31, 2008.

Hospital Boards and management should actively review their quality and safety programs. We will be seeking input on the appropriate timing to report quality and safety information publicly. I anticipate that reporting this information on the wait times

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[2] The Canadian Institute for Health Information (CIHI) reported hospital standardized mortality ratios (HSMR) for eligible acute care hospitals and health regions outside Quebec. HSMR compares the actual number of deaths in a hospital or region with the average Canadian experience, after adjusting for several factors that may affect in-hospital mortality rates such as the age, sex, diagnoses and admission status of patients. See: Canadian Institute for Health Information. 2007 (November). *HSMR: A New Approach for Measuring Hospital Mortality Trends in Canada*. Ottawa: CIHI.

[3] *Wait Time Strategy (Update #1)*: December 8, 2004.

[4] The Wait Time Strategy Review of Activities, April-September 2006 (Update #6), September 19, 2006.

[5] The Wait Time Strategy Review of Activities, October-December 2006 (Update #7), December 20, 2006.

[6] The Wait Time Strategy Review of Activities, January-April 2007 (Update #8), April 30, 2007.

website will result in much public and media attention. ***Hospital Boards and management need to consider*** two issues.

- Individual hospitals must prepare to respond to information that may show their hospital in a negative light. Hospitals will need to communicate the steps they have and are proactively taking to improve quality and safety.
- Hospitals will increasingly be called upon to answer questions from the media and the public. Hospital spokespersons should have appropriate media training and skills to communicate effectively with the media and the community.

THE 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. I would like to thank Michael Decter, Graham Scott and Hilary Short for providing an independent review of the wait times data each time it was updated on the web site. In particular, I would like to thank Hilary Short who will be stepping down from this position. I am delighted to welcome Tom Closson – as the incoming President of the Ontario Hospital Association – who will take over this responsibility.

The Council has played an invaluable role ensuring that none of the data on the public website has been manipulated by anyone associated with the Wait Time Strategy (politicians, civil service, Wait Time Office).

IN CONCLUSION

I would like to ***congratulate and thank all of you*** for your significant efforts to improve access to healthcare services this past year. I believe the Wait Time Strategy is making a real positive difference in the lives of Ontarians. ***This is a tribute to your commitment and participation.*** I look forward to working with you all in 2008.

On behalf of those who have worked closely with me this past year on the Wait Time Strategy – Melissa Farrell, Sarah Kramer and Joann Trypuc – I would like to extend all best wishes for a Safe and Happy Holiday Season.

Yours sincerely,

Alan Hudson
Lead of Access to Services and Wait Times

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

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