THE WAIT TIME STRATEGY
REVIEW OF ACTIVITIES
APRIL-AUGUST 2008

UPDATE #12 – August 14, 2008

INTRODUCTION

The Wait Time Strategy is continuing to build on its successes and increase its efforts to improve access to, and reduce wait times for, a broad range of healthcare services. In October 2007, Premier Dalton McGuinty announced that the Strategy was being expanded to include emergency department wait times. This was followed in April 2008 with the announcement that reducing wait times in emergency departments and improving access to family health care are the government's two most important health priorities over the next four years. The new Minister of Health and Long-Term Care, the Honourable David Caplan, and Deputy Minister Ron Sapsford strongly support these priorities. The Premier, Minister and Deputy Minister recognise the critical link between reducing ER wait times and reducing the number of Alternate Level of Care (ALC) patients and days in acute hospitals. Indeed, the recent discussions between the Ministry and Local Health Integration Networks (LHINs) – as part of the annual update of the Ministry-LHIN Accountability Agreement – highlighted the importance of ER wait times and ALC to the government. The Deputy reiterated this point in his letter to LHIN Chief Executive Officers in June 2008.

This is the twelfth in a series of updates on Ontario's Wait Time Strategy.[1] It presents the highlights and major accomplishments from April to August 2008 which include our increasing focus on ER/ALC.

HIGHLIGHTS AND MAJOR ACCOMPLISHMENTS

ADULT WAIT TIMES: AUGUST/SEPTEMBER 2005 TO JUNE 2008 [2]

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

Compared to August/September 2005 – when wait time information was first available – Ontarians got their knee joints replaced 217 days sooner in June 2008, their cataracts removed 193 days sooner, their hip joints replaced 176 days sooner, an angiography 33 days sooner, their cancer surgery 22 days sooner and an angioplasty 13 days sooner. Ontarians also got their CTs 40 days sooner and their MRIs 27 days sooner. Ontarians

[1] See www.ontariowaittimes.com for the first 11 updates.
[2] This information is publicly available on www.ontariowaittimes.com.

waited one more day for bypass surgery (50 days) which continues to be well below the target set by clinical experts for safely receiving routine bypass surgery (182 days).

Adult Wait Times Data: 9 Out of 10 Patients Receive the Treatment Within Target – August/September 2005 to June 2008 –					
Procedure	**Days**			**Completed Within Target***	**Current vs. Baseline Change (Days)**
	Baseline Aug/Sept 2005	**Current June 2008**	**Access Target**		
Cancer Surgery	81	59	84	96%	-22
Angiography	56	23	-	-	-33
Angioplasty	28	15	-	-	-13
Bypass Surgery	49	50	182	100%	1
Cataract Surgery	311	118	182	96%	-193
Hip Replacement	351	175	182	90%	-176
Knee Replacement	440	223	182	85%	-217
MRI	120	93	28	47%	-27
CT	81	41	28	83%	-40

*Priority Level 4 Target

More than 80% of adults are receiving their treatments within the targets set for all procedures except for MRI. This is in spite of the fact that the number of MRI scans in Ontario has doubled from 2002/03 to the present, five more MRI scanners were funded this year, the MRI funding formula was adjusted so the same funding supports more hours of operation, a third MRI technologist training class has been funded, and a Value Stream Mapping Project is being piloted to improve diagnostic imaging work flow.

We will be paying closer attention to the appropriateness of MRIs and CTs following a recent chart abstraction study funded by Ontario's Wait Time Strategy.[3] A review of over 11,800 CTs and 11,800 MRIs performed on outpatients in Ontario found considerable and unexpected variations in ordering practices between hospitals. The study found as much as a 70-fold difference between hospitals in the frequency of scans ordered for a specific indication, less than 2% of CT scans of the brain for headache found abnormalities that could explain the headache, and although over 90% of MRI scans of the spine for back pain were abnormal, the clinical importance of the abnormalities was unclear. Although the researchers note that negative scans have value in ruling out disease, many patients with a very low pre-test probability of disease can be reassured without performing a scan. From the perspective of Ontario's Wait Time

[3] You, J.J., I. Purdy, D. Rothwell, R. Przybysz, J. Fang and A. Laupacis. 2008 (June). "Indications For and Results of Outpatient Computed Tomography and Magnetic Resonance Imaging in Ontario" *Canadian Association of Radiologists Journal* 59(3): 135-143.

Strategy, freeing up these slots would definitely improve access and reduce wait times for MRI and CT.

PAEDIATRIC WAIT TIMES: APRIL/MAY 2006 TO FEBRUARY 2008 [4]

The five Paediatric Academic Health Science Centres continue to submit their surgical wait times voluntarily. An analysis of over two years of wait time data indicates that infants, children and youth in Ontario are waiting less time from the *decision to treat, to treat* for wait time procedures as measured by the 90th percentile (i.e., the point at which nine out of 10 patients received their treatment).

Compared to April/May 2006, infants, children and youth received their surgery 40 days sooner in the five hospitals in June 2008. Of the 1,832 surgeries performed in June 2008, 85% 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 June 2008 –

Procedure	Days			Completed Within Target**	Current vs. Baseline Change (Days)
	Baseline April/May 2006	Current June 2008	Access Target		
Paediatric Surgery	273	233	182	85%	-40

*The centres are the 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), and The Hospital for Sick Children (Toronto).
**Priority Level 4 Target

EXPANDED PUBLIC REPORTING OF WAIT TIME INFORMATION

As of July 2008, more information on wait time procedures is being reported publicly.

- The 90th percentile wait times for each procedure in each of the 14 LHINs are now available on the website (*Health Care Professionals* link). The wait times in each LHIN and the spreads between LHINs with the shortest and longest wait times are important to examine.
- Wait times for each procedure by the four priority ratings are also available on the website (*Health Care Professionals* link). These ratings were developed by the clinical expert panels along with wait time targets appropriate to the urgency of a patient's condition. Priority levels range from Priority 1 (immediate) to Priority 4 (least urgent).

LHINs must focus their efforts on providing appropriate and equitable access to services, and hold hospitals accountable for long wait times.

[4] This information is publicly available on www.ontariowaittimes.com.

EMERGENCY ROOM WAIT TIMES STRATEGY AND ALTERNATE LEVEL OF CARE PLAN TO REDUCE ER WAIT TIMES

Reducing ER wait times and improving public satisfaction can only be achieved by making improvements across the entire system. We recognise that improvements must be made to:

- Reduce inappropriate demand for ER services;
- Improve processes within the ER; and
- Increase the supply of services.

The leading cause of crowded ERs in Ontario is the lack of timely transfers of sick patients in the ER to a ward bed. Our analysis indicates that a major factor in long ER wait times is the high number of alternate level of care (ALC) patients in acute hospitals. Ontario Hospital Association surveys indicate that about 20% of ward beds are occupied by ALC patients. ER and ALC are closely intertwined: if we are to reduce ER wait times, we must reduce the number of ALC patients in acute care hospitals.

I have been working closely with Dr. Michael Schull, Chair of the ER Expert Panel, and Dr. Kevin Smith, the Ministry's Lead on Alternate Level of Care, to identify initiatives to reduce ER wait times which include addressing ALC. We are also developing budgets to support these activities over the next three years.

Emergency Room Wait Times Strategy

On May 30, 2008, the Minister announced the Emergency Room Strategy along with $109 million to fund ER initiatives in 2008/09. We have been working closely with Dr. Michael Schull and his colleagues to develop and implement key elements of the ER Strategy which include the following initiatives.

- *Pay for Results*: Twenty-three hospitals with high emergency room volumes and ER wait time pressures are getting incentives in 2008/09 to improve their performance through an innovative Pay-for-Results Program. Funding ranges from about $300,000 to just over $2 million depending on the hospital. Hospitals must reduce wait times for higher acuity patients (CTAS 1-3),[5] reduce the number of patients with extremely long waits (greater than 24 hours), and ensure that wait times for lower acuity patients do not get worse. Hospitals are also required to regularly track patient satisfaction and monitor quality of care. This Pay-for-Results Program will be substantially expanded to include additional hospitals in 2009/10.

- *Develop Information Systems to Monitor, Manage and Improve Performance*: The Emergency Department Reporting System (EDRS) has been implemented in 128

[5] CTAS refers to the Canadian Emergency Department Triage and Acuity Scale. Patients categorised as Level 1 are resuscitate, Level 2 are emergent, Level 3 are urgent, Level 4 are less urgent, and Level 5 are non urgent.

hospital ERs in Ontario. (See the section, "Continued Progress on Collecting Wait Time Information").

- *Improve the efficient and effective flow of patients through EDs*: We are developing an ED performance improvement program based on the results of three demonstration pilots to improve ED patient flow (North York General Hospital, St. Joseph's Health Centre in Toronto, and University Health Network). The program will help hospitals improve the flow of patients from the ED to wards and back to the community. Hospital staff will get expert training in patient flow, ongoing coaching over a six month intervention period, and assistance setting up a data infrastructure to monitor flow accurately.

- *Maximize Valuable Health Human Resources*: Several new roles are being developed for nurses working in ERs. These include: 1) Emergency Medical Service nurses who are emergency department nurses dedicated to off-loading ambulance patients safely and in a timely fashion so that ambulance crews can get back on the road quickly; and 2) nurse-led long-term care outreach teams that will diagnose and treat clinical problems, as appropriate, in long-term care homes and avoid unnecessary transfers to hospital ERs. We are also working with Dr. Joshua Tepper, Assistant Deputy Minister, Health Human Resources, on addressing ER staffing by expanding the Physician Assistant pilot project to other hospitals.

- *Reduce the Unnecessary Use of ERs*: We are exploring ways to reduce the unnecessary use of ERs for targeted groups of individuals and improve their care. These include persons with cancer, congestive heart failure, respiratory diseases, and mental health and addictions.

Alternate Level of Care Plan to Reduce ER Wait Times

On March 28, 2008, the Deputy Minister of Health and Long-Term Care, Ron Sapsford, asked Dr. Kevin Smith to chair an ALC brainstorming session. The participants made 16 recommendations in the areas of legislative change, admission criteria and assessment, funding, partnerships, human resources, public education, access to convalescent care, coaching teams, data, community supports, access to diagnostic imaging, outreach teams and ALC targets. Since then, Dr. Smith has been named the Ministry's lead on ALC and has developed an *Appropriate Level of Care Execution Plan to Reduce ER Wait Times*. This document – which will be publicly available shortly – identifies 15 actions for the Deputy's consideration. The actions – which address ALC and acute flow – fall into five categories:

- Actions to develop provincial policies that align with provincial priorities.
- Actions to avoid unnecessary admissions and support discharge.
- Actions to maximize capacity.
- Actions to support continuous process and performance improvements.
- Actions to support clear accountabilities for results.

The Deputy has taken the recommendations under advisement.

Meanwhile, Dr. Smith and I have begun to work closely with the Ontario Hospital Association to plan regional ALC conferences which will be held in November-December 2008. I look forward to seeing many of you at these sessions.

CONTINUED PROGRESS ON COLLECTING WAIT TIME INFORMATION

We continue to make excellent progress on collecting the data needed to manage wait times and improve access to services. Under the leadership of Sarah Kramer, the provincial project team has been working with hospitals and LHINs to develop and implement information systems and related initiatives. I gratefully acknowledge the tremendous efforts of the Wait Time Information Office, clinician leaders, and hospital and LHIN Chief Executive Officers, Chief Information Officers, clinicians, and administrative staff.

Since my last update in March, a great deal has been achieved collecting wait time information.

Expanded Wait Time Information System to Include More Adult Surgeries

In April 2007, the Wait Time Information System (WTIS) successfully started capturing wait times from *decision to treat, to treat* for the original wait time procedures: cancer surgeries, cardiac surgeries, cataract surgeries, hip and knee joint replacement surgeries, and MRI and CT scans.

In March 2008, the WTIS was expanded to capture the wait for all ophthalmic, orthopaedic and general surgeries. This will account for about half of all surgical cases in Ontario performed by approximately 2,600 surgeons. The data that has been collected is being verified and will be available on the public website in the Fall of 2008.

By April 2009, the WTIS will include over 90% of all surgical cases in Ontario including specialty surgeries in gynaecology, neurosurgery, oral/maxillofacial and dental surgery, otolaryngology, plastics and reconstructive surgery, thoracic, urology and vascular. About 3,500 surgeons will be submitting surgical wait time information. Clinical Advisory Panels are developing priority ratings and wait time targets for each of these surgical specialties. The panel Clinical Leads include:

- Gynaecologic surgery: Dr. Guylaine Lefebvre
- Neurosurgery: Dr. James Rutka
- Oral/Maxillofacial surgery and dentistry: Dr. Gerald Baker
- Otolaryngological surgery: Dr. Ronald Fenton
- Plastic and reconstructive surgery: Dr. Dimitri Anastakis
- Thoracic surgery: Dr. Shaf Kashavjee
- Urologic surgery: Dr. Neil Fleshner
- Vascular surgery: Dr. Tom Lindsay

We would like to thank these individuals for their leadership and for working with their clinical colleagues and the WTIS project team to develop clinically relevant priority tools and targets. The wait times for these specialty procedures will be on the public website in the Fall of 2009.

Expanded Emergency Department Reporting System

I am very pleased to report that the Emergency Department Reporting System (EDRS) has been implemented in a large number of hospitals in a short time. We began developing and implementing the system in the fall of 2007. To date, all 128 hospital ERs in Ontario with more than 20,000 emergency room visits a year have implemented EDRS and are submitting information on their ER length of stay, ambulance offload time, the time to physician assessment in the ER, time to disposition decision, and time to hospital admission. ER wait time information will be publicly reported on the wait times website in the Spring of 2009. ER wait time targets will also be formally adopted at that time.

Development of the Alternate Level of Care Information Strategy

Currently, hospitals do not use standard methods to define or designate ALC patients or measure the length of an ALC stay. As well, the quality and availability of discharge destination data are inconsistent, and information is lacking on patients/clients who are waiting in locations other than acute care. Since ALC information tends to be retrospective and several months old, it cannot be used to manage ALC patients who are currently waiting, nor can it identify problems and solutions in a timely fashion.

The Access to Care Information Expert Panel – chaired by Sarah Kramer – is developing an Alternate Level of Care Information Strategy that will use standard definitions and reflect near real-time information. This information will be used to track, monitor and understand performance issues, plan effective solutions, and hold those accountable for improving performance and meeting performance targets. The proposed provincial strategy will measure "Wait 3" which is defined as the date someone in an acute care facility is designated ALC to the date of discharge to an alternate level of care.

An extensive stakeholder consultation process identified the requirements for an ALC information system. Potential data elements include patient-identifying information, medical condition, type of alternate care required, primary care and acute care physicians, and dates to enable ALC wait time to be calculated (e.g., when and what type of care is offered and when accepted, discharge date, priority level and discharge destination). The implementation approach will be similar to the one used for surgical wait times: implementation will occur in the 81 hospitals currently using WTIS, beginning with a smaller group of beta hospitals.

Improved Access to Data for Decision Makers

Hospitals and clinicians have been asking for help on how to use data to make strategic and operational decisions. The field has suggested "one-stop-shopping" to access data and get assistance. The Wait Time Office has developed two initiatives to meet these needs.

- iPort Access – launched in May 2008 – provides secure, web-based strategic reporting and analysis capabilities to help users analyse their wait time data. Hospitals have access to their patient/surgeon data, and can graph their information in relation to other hospitals in their peer group, LHIN and the province. LHINs and hospitals have repeatedly commented on the usefulness and flexibility of iPort Access. The goal is to expand the program to include other data sets such as the Emergency Department Reporting System, the Critical Care Information System and the Surgical Efficiency Targets Program.

- A performance improvement program is being developed to help decision makers use data. The program will interpret data and trends, provide meaningful and easily accessible data reports, identify the root causes of poor performance, and educate decision makers and managers on how to interpret data and improve their performance (e.g., workshops, seminars, case studies of high performing centres).

DATA CERTIFICATION COUNCIL

The Data Certification Council continues to advise on and review the processes that are used to ensure that accurate wait time information is collected and reported. We are indebted to Michael Decter, Graham Scott and Tom Closson for their invaluable contributions. In addition to thanking the Council members for their work, I am pleased to report that Minister Caplan asked them to continue their voluntary service for another two years. The Council will begin reviewing ED wait time data in the near future.

CRITICAL CARE SERVICES

Under the leadership of Dr. Bernard Lawless (Provincial Lead, Critical Care and Trauma), some major critical care achievements include the following:

- Four paediatric critical care response teams have been funded at The Hospital for Sick Children, Children's Hospital of Western Ontario, Children's Hospital of Eastern Ontario, and The McMaster Children's Hospital. Evaluations indicate that hospital mortality and critical care readmission rates have decreased since the teams were introduced. As well, mortality among children admitted from the ward to critical care units has decreased (from 88.5/1,000 patients to 35.2/1000 patients).
- Physicians caring for a critically ill child in an Ontario hospital can now get expert clinical advice by phone from a paediatric intensivist 24 hours a day, seven days a week through CritiCall. The intensivists are located at the four sites that have paediatric critical care response teams.

- Critical care coaching teams will visit 24 hospitals in Ontario in 2008/09. Coaching visits will address best practices, end of life, health human resources, patient flow and service appraisals.
- In April/May 2008, $4.5 million began flowing to 76 hospitals to support the training of 391 critical care nurses.
- On November 10, 2008, the Critical Care Strategy in partnership with the Critical Care Canada Forum 2008 is holding a pre-conference workshop *The Grey Matter: Critical Care, Ethics and the Law* which will address legal and ethical dilemmas faced in critical care units. Topics to be covered include the statutory framework, lessons from case law, consent in critical care: can it really be informed, is there a right treatment, the difference between withdrawing and withholding (legal vs. medical).

PAEDIATRIC WAIT TIMES

Under the leadership of Dr. Charlotte Moore (Provincial Lead, Paediatrics), paediatrics has been recognised as a priority in the Phase II of the Anaesthesia Care Team project. In addition, the Joint Policy and Planning Committee is reviewing the MRI funding model which will include paediatric-adjusted funding rates for MRI hours.

NEUROSURGERY

In December 2007, the Neurosurgery Expert Panel – chaired by Dr. James Rutka – submitted its final report to the Ministry. The Panel made 21 recommendations as part of an Ontario Neurosurgical Plan. Since then, the panel has prioritized these recommendations and created a Neurosurgery Action Team to oversee the development and implementation of the top five priorities. Chaired by Dr. Rutka, the Action Team's five priority workstreams to improve access to neurosurgery and help reduce ER wait times include:

- Neurosurgery capacity;
- Neurosurgical nurse capacity;
- Provincial neurosurgery image transfer system;
- Hospital neurosurgical capability rating scale; and
- Neurosurgery consultation and referral process.

PERSONNEL

In mid-August, Ken Deane will be joining the Ministry as the Assistant Deputy Minister, Health System Accountability and Performance Division. The Wait Time Strategy and the ER/ALC file will be Ken's responsibility. I welcome Ken and look forward to working with him.

Dr. Anne Keller, Chair of the MRI and CT Expert Panel, will be retiring from the University Health Network and leaving Ontario. I would like to thank Dr. Keller for her hard work and invaluable contribution to the Wait Time Strategy, and wish her well. I

look forward to working with Dr. Julian Dobranowski, the new chair of the panel. Dr. Dobranowski is the Chief of Diagnostic Imaging at St. Joseph's Healthcare, Hamilton.

Over the years, many of you have worked with Vincy Perri, my executive assistant. Vincy has a new position with the Ontario Agency for Health Protection and Promotion. She has been a great support to all of us and I wish her well in her new job.

A DEBT OF GRATITUDE TO GEORGE SMITHERMAN

The field owes a large debt of gratitude to the former Minister of Health and Long-Term Care, George Smitherman. He drove the wait time agenda with incredible energy and strongly supported the program at Cabinet. I personally would like to record my appreciation of George's leadership. The people of Ontario are the beneficiaries of his commitment. We wish him equal success as the Minister of Energy and Infrastructure.

IN CONCLUSION

We have been publicly reporting wait time data for almost three years and have a solid track record of improving access to services. In October 2008, we will be distributing a three year report of results. I would like to express my thanks to all of you for your hard work and commitment to reducing wait times for Ontarians. I particularly acknowledge the work of Melissa Farrell, Manager of the Wait Time Strategy Team, and her staff who continue to work tirelessly on the countless details of the program.

Finally, I would like to thank the Board of Cancer Care Ontario for supporting me during my tenure as Lead of Access to Services and Wait Times. I will continue to hold this position but, as of September 6, 2008, will do so on a consulting basis. I have been honoured to work on the Wait Time Strategy, thank you for your ongoing support, and look forward to continuing our work to improve access and reduce wait times.

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.