THE WAIT TIME STRATEGY
REVIEW OF ACTIVITIES
SEPTEMBER-DECEMBER 2008

UPDATE #13 – December 18, 2008

INTRODUCTION

A great deal has happened since the last Wait Time Strategy update in August 2008. The significant changes in the economy are profoundly challenging healthcare organisations to continue providing services with less resources. The economic changes are also challenging healthcare leaders to sharpen their focus on and direct their efforts towards clear priorities. Given these turbulent times, I am very pleased that the Ontario government remains committed to improving access to, and reducing wait times, for healthcare services including emergency room services. Premier Dalton McGuinty, Minister of Health and Long-Term Care David Caplan, and Deputy Minister Ron Sapsford strongly support reducing wait times in ERs and improving access to family health care as the government's two most important health priorities. These individuals also recognise the critical link between reducing ER wait times and reducing the number of Alternate Level of Care (ALC) patients and days across the system. I believe that with renewed focus and targeted efforts, we can continue building on the successes of the Wait Time Strategy.

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

HIGHLIGHTS AND MAJOR ACCOMPLISHMENTS

1. WAIT TIMES FOR SURGICAL AND IMAGING PROCEDURES: OCTOBER 2008 [2]

Increasingly, more information is being reported publicly on wait times for adult and paediatric procedures. In addition to the five original services (cancer, cardiac, cataract, hip and knee joint replacements, MRI and CT) and paediatric surgery, Ontario now has adult wait times for general surgery, all of ophthalmic surgery and all of orthopaedic surgery. The baseline wait time for these additional procedures is more recent (April 2008) than the original procedures (August/September 2005).

An analysis of wait time data from each procedure's baseline date to October 2008 indicates that Ontarians are waiting less time from the *decision to treat, to treat* for almost all wait time procedures as measured by the 90th percentile (i.e., the point at which

[1] See www.ontariowaittimes.com for the first 12 updates.
[2] This information is publicly available on www.ontariowaittimes.com. The website also includes the 90th percentile wait times by procedure for each LHIN and by the four priority ratings (click *Health Care Professionals* link).

nine out of 10 patients received their treatment). Even though other ophthalmic surgery and other orthopaedic surgery waits have increased (16 days and 1 day, respectively), over 90% of these procedures are completed within the target.

Wait Times From the Decision to Treat to Treat: 9 Out of 10 Patients Receiving Treatment Within the Target
– Baseline Date (Varies by Procedure) to October 2008 –

Procedure	Days			Completed Within Target*	Current vs. Baseline Change (Days)
	Baseline Wait [1]	Current Wait (Oct/08)	Access Target		
General Surgery	121	120	182	96%	-1
Cancer Surgery	81	63	84	94%	-18
Cardiac Surgery					
Angiography [2]	56	26	-	-	-30
Angioplasty [2]	28	12	-	-	-16
Bypass Surgery [2]	49	45	182	100%	-4
Ophthalmic Surgery [3]	130	121	84-182	97%	-9
Cataract Surgery	311	120	182	97%	-191
Other Ophthalmic Surgery	114	130	84-182	92%	16
Orthopaedic Surgery	190	183	182	90%	-7
Hip Replacement	351	185	182	90%	-166
Knee Replacement	440	204	182	87%	-236
Other Orthopaedic Surgery	175	176	182	91%	1
MRI	120	98	28	45%	-22
CT	81	36	28	85%	-45
Paediatric Surgery	273	234	182	85%	-39

Source: Ontario Wait Time Information System.
*Priority Level 4 Target.
[1] The baseline wait time for Cancer Surgery, Cardiac (angiography, angioplasty, bypass surgery), Cataract Surgery, Hip and Knee Replacements, and MRI/CT scans is how long people waited for the procedure in August/September 2005.
The baseline wait time for General Surgery, Ophthalmic and Other Ophthalmic Surgery, and Orthopaedic and Other Orthopaedic Surgery is how long people waited for the procedure in April 2008.
The baseline wait time for Paediatric Surgery is how long infants, children and youth waited for the procedure in April/May 2006.
[2] Cardiac wait times only include elective referrals.
[3] Ophthalmic surgery priority 4 access targets vary by service details: cataract (182); glaucoma (112), corneal transplant (182), vitrectomy (84), generic (182).

There have been significant improvements in wait times for procedures such as knee replacements (236 days less than baseline or a 54% improvement), hip replacements (166 days less than baseline or a 47% improvement), cataract surgery (191 days less than baseline or a 61% improvement) and CT (45 days less than baseline or a 56% improvement). Also of note is the fact that more than 80% of adults and children are

receiving their treatments within the targets set for all procedures except adult MRI (45%). A number of initiatives are focusing on reducing this wait time (see Wait Times Update #12, August 14, 2008).

Work has begun to expand the Wait Time Information System to include all adult subspecialty surgeries. By the fall of 2009, these waits will be reported on the public website.

2. EMERGENCY ROOM WAIT TIMES AND ALTERNATE LEVEL OF CARE

Our collective goal is to reduce the time that patients spend unnecessarily in ERs, ensure that ER flow is efficient and effective, improve diagnostic turnaround, provide patients and their families with information on how long they can expect to spend in the ER, reduce the time spent waiting for an inpatient bed if needed, and improve the patient's overall care experience.

Improving ER performance and public satisfaction can only be achieved by making improvements across the entire system. As you know, a major factor that influences the amount of time someone spends in the ER is the number of people waiting there to be admitted to an acute care bed and the amount of time they wait. ER and ALC are closely intertwined: to reduce ER wait times, we must reduce the number of ALC patients in acute care hospitals.

Information on ER wait times and activities (2.1), the extent of ALC and proposed solutions (2.2), and the ER/ALC Strategy (2.3) is presented below.

2.1 Emergency Room Wait Times and Activities

Preliminary ER Wait Times Data: April 2008-August 2008

The Emergency Department Reporting System (EDRS) is collecting information from 128 hospital ERs in Ontario with more than 20,000 emergency room visits a year. Hospitals 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. A preliminary review of the data submitted thus far indicates that in April 2008, nine out of 10 people waited 9.4 hours in the ER. By August 2008, this wait decreased 6% to 8.8 hours.

Ontario Emergency Room Visits: All Visits by Length of Stay (Hours): 90th Percentile (Preliminary Data Only)			
Baseline (Hours)	**Current Stay (Hours)**	**Current vs. Baseline**	
April/08	**August/08**	**Net Change (Hours)**	**Percentage Change**
9.4	8.8	-0.6	-6%

Source: Emergency Department Reporting System: Preliminary Data Only

The majority of people who go to hospital ERs – 90% – are not admitted to hospital. The preliminary data indicate that there is a significant difference in ER wait times depending on whether someone is admitted to hospital or not. In August 2008, 392,743 patients waited about 29.6 hours in the ER before being admitted to hospital. Of this time, 21.5 hours were spent waiting for an inpatient bed. Patients who did not need to be admitted stayed about 6.7 hours in the ER.

Ontario Emergency Room Visits: All Visits by Length of Stay (LOS in Hours) and Admission Status: 90th Percentile (Preliminary Data Only)						
All ER Visits		**Admitted Patients**			**Non-Admitted Patients**	
Total Volume	**ER LOS (Hours) August/08**	**% of Total ER Visits**	**ER LOS (Hours) August/08**	**Time to Inpatient Bed (Hours)**	**% of Total ER Visits**	**ER LOS (Hours) August/08**
392,743	8.8	10%	29.6	21.5	90%	6.7

Source: Emergency Department Reporting System: Preliminary Data Only

Public Reporting of ER Wait Times, Wait Time Targets and a New Public Website With Care Options

I am pleased to report that for the first time in Ontario, ER wait times will be publicly available on the wait times website in February 2009. ER waits will be reported provincially, by Local Health Integration Network (LHIN) and by hospital site. The Wait Time Office will continue to provide LHINs with comprehensive monthly ER wait time reports.

In addition to public ER wait times, Minister Caplan will be announcing ER wait time targets in February as well as launching a new public website for patients seeking care. The site will provide information on available service options including Telehealth Ontario, family health teams, walk-in clinics, urgent care centres and ERs. The website will be part of a broader public education campaign on ERs that will use television, newspapers and other print media (brochures), and will involve the LHINs and the ER LHIN leads.

2.2 The Extent of Alternate Level of Care and Proposed Solutions

Extent of Alternate Level of Care

Alternate level of care is a significant issue across the continuum of care. According to the Ontario Hospital Association, acute care hospitals reported in November 2008 that about 3,074 patients are waiting in an acute bed for an alternate level of care on any given day. This represents about 20% acute beds staffed and in operation.

With regard to how long people who are designated ALC wait in acute care hospitals before they are discharged, the Canadian Institute for Health Information reported that these individuals waited a median of nine days in 2007/08. Ninety percent of these individuals waited up to 43 days before they were discharged.

Proposed Solutions

In March 2008, Dr. Kevin Smith, the provincial ALC Lead chaired a session that identified actions to reduce ALC in hospitals. A number of these actions have been fully implemented with most under active discussion or in the planning stage. Information on progress will be made available over the next few months. The actions recommended by Kevin include the following:

Actions to Develop Provincial Policies that Align with Provincial Priorities

- Change regulations to eliminate caps on maximum homemaking, personal support and nursing hours/services that CCACs can provide (Fully implemented).
- Change regulations placing people in LTC homes to enable placement in the first available appropriate level of care setting.
- Change LTC eligibility, placement and admission criteria so more complex and vulnerable residents are admitted to LTC, and less complex to more appropriate settings.

Actions to Avoid Unnecessary Admissions and Support Discharge

- Support community day programs/services to prevent LTC need.
- Create outreach teams that can complete home assessments 24 hours a day, 7 days a week.

Actions to Avoid Unnecessary Admissions and Support Discharge

- Enhance timely access to 24/7 diagnostic tests in the community for residents of LTC homes, CCC facilities and convalescent care.
- Expand convalescent care to enable more patients to stabilise and transition from acute care to home care.
- Support appropriate staffing standards for LTC homes and other settings such as supportive housing.
- Require hospitals to refer complex and vulnerable ER patients with no family physician to a FP or family health team upon discharge from the ER or hospital.
- Support hospital ER care teams made of interdisciplinary staff with specialised skills in geriatric medicine, mental healthcare and other areas to prevent unnecessary admission of potential ALC patients.

Actions to Maximize Capacity

- Identify and support physical plants capable of converting to temporary long-term care services.
- Require redeveloping LTC facilities to continue operating all beds while site is brought to current standards. Give priority to facilities in LHINs with the most severe ALC problems.
- Dedicate funds to supplement retirement homes or preferred accommodation rates in LTC as an interim solution until appropriate services are obtained in LHINs with high ALC rates.

Actions to Support Continuous Performance Improvements

- Develop provincial ER/ALC information strategy (see Section 2.3).

Actions to Support Clear Accountabilities for Results

- Identify clear accountabilities for improving access to ER services and reducing ER wait times by reducing the number of ALC patients and days in acute care hospitals.

2.3 The ER/ALC Strategy

The ER/ALC Strategy is focused on reducing demand on ERs, increasing ER capacity and throughput, and moving more quickly those patients waiting in acute care hospitals for a more appropriate level of care to this care. The ER/ALC Strategy is supported by:

- Clear accountabilities and ER/ALC performance leads in each LHIN;
- A Provincial ER/ALC Expert Panel;
- Community Care Access Centres playing a crucial role;
- An ER/ALC Information Strategy; and
- Ongoing information and education on ER/ALC.

Clear Accountabilities and ER/ALC Performance Leads in Each LHIN

On November 14, 2008, Assistant Deputy Minister, Ken Deane sent a letter to the Chief Executive Officers (CEOs) of the LHINs emphasizing that the success of the ER/ALC Strategy depends on aligning initiatives with the Strategy's objectives and having strong, effective local system management (effective governance and strong performance management). Ken confirmed that:

- LHIN CEOs are responsible for effective performance management and making progress towards achieving the Strategy's objectives;
- Performance management will be a standing item at monthly Ministry Management Committee-LHIN CEO meetings; and
- One or more dedicated LHIN Performance Leads for ER/ALC activities will be established in each LHIN to support LHIN coordination and implementation of the strategy, with monthly meetings held between the Ministry and LHINs to ensure alignment.

I am pleased to report that the 14 ER/ALC LHIN Performance Leads are scheduled to hold their first meeting in January 2009.

Provincial ER/ALC Expert Panel

Given that ER and ALC are interrelated, the decision was made to seek advice from experts on ER/ALC issues. In October 2008, the ER Expert Panel chaired by Dr. Michael Schull was disbanded. In its place, a new ER/ALC Expert Panel has been created and will be co-chaired by Dr. Schull and Dr. Kevin Smith. The first meeting of this new expert panel will be held in February 2009.

Community Care Access Centres Playing a Crucial Role

On December 2, 2008, the 14 Community Care Access Centres and the Ontario Association of CCACs held a day-long strategy session to identify how CCACs can make a significant contribution to the success of Ontario's ER/ALC Strategy. I was very impressed by the commitment of the CCACs to this goal and the innovative initiatives that are ongoing in various LHINs. The discussions focused on identifying priorities and

initiatives that could be developed across the province in consultation with LHINs and in support of the Wait Time Strategy.

ER/ALC Information Strategy

In October 2008, the Access to Care Expert Panel, under the leadership of Sarah Kramer, completed a comprehensive information strategy to support ER/ALC. I am pleased to report that the Panel's six recommendations and the funding to implement these recommendations have been approved. These include:

- *Emergency Department Reporting System (EDRS)*: EDRS will be expanded to improve the timeliness of ER data reporting and enable linkages with other data sets.
- *Wait Time Information System (WTIS):* The WTIS will be expanded to capture ALC data in near real-time on patients who are waiting for a more appropriate level of care, including where they are waiting and what they are waiting for. The system will be implemented in the 87 wait time-funded acute care hospitals and in 20 post-acute facilities by Spring 2011. This will capture ALC patients waiting in 95% of acute care beds and in 96% of rehabilitation, complex continuing care and mental health beds in Ontario.
- *ALC Definition Working Group*: A working group will develop a comprehensive, standard, provincial definition of appropriate level of care.
- *Client Profile Database (CPRO)*: Data from the existing Client Profile Database will be used to analyze and report on people waiting for long-term care placement in the community.
- *ED/CCAC Notification System:* The system will be expanded to high volume ERs in Ontario to reduce unnecessary inpatient admissions through the ER. The system will do two things: i) it will automatically identify ER patients who could benefit from a CCAC assessment; and ii) it will identify ER patients who are receiving CCAC services or waiting for long-term care placement. In both instances, the CCAC case manager will be notified and become involved in the care of the patient in the ER.
- *e-Referral and Resource Matching Solutions:* Provincial data and business process standards will be created for e-Referral and Resource matching to the point of Request for Quotes, and funding will be provided to LHINs to implement local solutions that meet provincial standards. Assistant Deputy Minister, Ken Deane, will be the single point of accountability for business and data standards for this initiative.

The team responsible for implementation will work closely with the Ministry, eHealth Ontario, LHINs and hospitals to implement the recommendations. The team will also report regularly to the following committees and seek their advice:

- ER/ALC Clinical Expert Panel (Co-chairs: Drs. Michael Schull and Kevin Smith)
- LHIN e-Health Leads Council (Co-chairs: Lewis Hooper and Sarah Kramer)
- ER/ALC Steering Committee (Chair: Alan Hudson)
- Data Certification Council (Chair: Michael Decter)

Over the next few months, the team will be developing detailed plans to implement the ER/ALC Information Strategy. If you have any questions, please contact Joanne Walker,

Acting Director, Access to Care Program (joanne.walker@cancercare.on.ca) or Melissa Farrell, Manager, Wait Time Strategy (melissa.farrell@ontario.ca).

Ongoing Information and Education on ER/ALC

Between November 18 and December 10, 2008, the Ontario Hospital Association and the Ministry co-hosted six regional sessions on ER/ALC. These sessions were used to provide information on ER/ALC initiatives and to obtain feedback on issues faced by hospitals, LHINs and Community Care Access Centres. Over 275 people attended these important invitational sessions. For those who were not able to attend the sessions, the OHA has made available the Toronto presentations. Please see: http://www.oha.com/client/oha/oha_lp4w_lnd_webstation.nsf/page/OHA+Mediasite+-+Archived+Events. The slides for all the regional sessions are posted on the site. Thank you to OHA for planning these regional sessions.

3. 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. The Council has been reviewing ER wait time data. I extend sincere thanks to Michael Decter (Chair), Graham Scott and Tom Closson for their invaluable contributions.

4. EHEALTH ONTARIO

In September 2008, the Ontario government created eHealth Ontario, a new provincial agency responsible for all aspects of e-health in Ontario. eHealth Ontario subsumes the functions of the province's Smart Systems for Health Agency (which no longer exists) and the Ministry's internal e-Health Program (which will cease to exist this fiscal year). I was honoured to be asked by Minister Caplan to chair the eHealth Ontario board. On October 31, 2008, Sarah Kramer was appointed CEO of eHealth Ontario and began immediately. The board has already met twice and will be developing its first strategic plan this fiscal year. The Wait Time Information Office will be working closely with eHealth Ontario.

I would like to extend my thanks to Sarah for her leadership as the Lead of the Wait Time Information Management Strategy and wish her every success in her new position.

5. A THREE YEAR PROGRESS REPORT

We have been publicly reporting wait time data for almost three years and have a solid track record of improving access to services. The document, *Improving Access to Care: A 3-Year Progress Report on How Wait Time Information is Transforming Healthcare in Ontario* has been released and will be available on the wait times website early in 2009.

6. ORGAN AND TISSUE TRANSPLANTATION WAIT TIMES EXPERT PANEL

There is a need to provide Ontarians with access to timely, appropriate and safe organ and tissue transplants. The longer someone waits for an organ or tissue, the higher the risk of morbidity and mortality. As part of the Wait Time Strategy, I have asked Dr. Gary Levy to chair the Organ and Tissue Transplantation Wait Times Expert Panel. Gary is the Director of the Multi Organ Transplant Program at University Health Network. The panel will hold its first meeting in early January 2009 and is expected to complete its report by the end of April.

7. IN CONCLUSION

Congratulations to the thousands of individuals who have worked hard to reduce wait times and improve the care of your fellow Ontarians. You have a great deal to be proud of. Thank you for your commitment and your ongoing support.

I began this update by remarking on the impact that significant changes in the economy are having on healthcare organisations and leaders. I do not underestimate the magnitude of the task ahead of us. We have a great deal to accomplish in a limited period of time. This demands a relentless and determined commitment from everyone and a clear focus on action by LHINs which – as noted earlier – are responsible for effective performance management and making progress towards achieving the Strategy's objectives.

I look forward to working with you to meet these challenges and continuing our record of success with ER wait times.

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.