THE WAIT TIME STRATEGY
REVIEW OF ACTIVITIES
JANUARY-MARCH 2009

UPDATE #14 – April 15, 2009

INTRODUCTION

Significant changes in the economy continue to profoundly challenge healthcare organisations and leaders to provide services with constrained resources. Given that the provincial government is also challenged with meeting multiple priorities, I am very pleased that the 2009 Ontario Budget has made a significant commitment to improving access and reducing wait times for healthcare services. The budget has provided funds to help reduce emergency room wait times, ease the pressures of Alternate Level of Care, support critical eHealth initiatives and improve access to family healthcare. I believe this commitment of funds is a vote of confidence in our abilities to build on the success of the Wait Time Strategy. We must continue our relentless and determined commitment to improve access and system performance, and be accountable for the efficient and effective use of valuable taxpayer dollars.

This is the 14th in a series of updates on Ontario's Wait Time Strategy.[1] It presents the highlights and major accomplishments from January to March 2009.

HIGHLIGHTS AND MAJOR ACCOMPLISHMENTS

1. WAIT TIMES FOR SURGICAL AND IMAGING PROCEDURES: FEBRUARY 2009 [2]

A review of wait times in February 2009 – compared to the baseline dates when we first began to report wait times – indicates that Ontarians continue to wait 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 nine out of 10 patients received their treatment). Cardiac bypass surgery patients are waiting longer but 100% of these procedures are completed well within the access target. Although improvements have been made in paediatric surgery, these patients continue to wait longer than the target.

Compared to August/September 2005, Ontarians can now expect to have their cataract surgery 204 days sooner (66% improvement), knee replacement surgery 256 days sooner (58% improvement), hip replacement surgery 198 days sooner (56% improvement), and a CT scan 46 days sooner (57% improvement). These are the most significant improvements in wait times. I am especially pleased to note that wait times for hip and

[1] See www.ontariowaittimes.com for the first 13 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).

knee replacement surgeries have finally reached their access targets, and the wait time for CT is almost at its target wait time.

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 February 2009 –

Procedure	Days			Completed Within Target*	Current vs. Baseline Change (Days)
	Baseline Wait [1]	Current Wait (Feb/09)	Access Target		
Cancer Surgery	81	63	84	96%	-18
Cardiac Surgery					
Angiography [2]	56	23	-	-	-33
Angioplasty [2]	28	14	-	-	-14
Bypass Surgery [2]	49	57	182	100%	8
General Surgery	121	113	182	96%	-8
Ophthalmic Surgery [3]	130	107	84-182	98%	-23
Cataract Surgery	311	107	182	98%	-204
Other Ophthalmic Surgery	114	108	84-182	94%	-6
Orthopaedic Surgery	190	174	182	91%	-16
Hip Replacement	351	153	182	93%	-198
Knee Replacement	440	184	182	90%	-256
Other Orthopaedic Surgery	175	175	182	91%	0
MRI	120	106	28	45%	-14
CT	81	35	28	86%	-46
Paediatric Surgery	273	249	182	84%	-24

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).

Ontarians are waiting 18 days less for cancer surgery with Priority 4 cancer patients getting their surgery sooner than the access target (22% improvement). We are working

closely with Cancer Care Ontario to ensure that Priority 1-3 cancer patients get their surgeries within the access targets.[3]

Although the wait time for MRI has improved, Ontarians continue to wait longer than they should in spite of a number of improvements.[4] We have launched three more initiatives to help improve access to MRI.

- The Ministry will soon be releasing *Ontario Best Practice Guidelines for Managing the Flow of Patients Requiring an MRI or CT Examination* to assist radiologists, medical radiation technologists, administrators, physicians and other clinicians to establish and manage effective, efficient and safe MRI and CT programs. The guidelines were developed under the leadership of Dr. Julian Dobranowski, Chair of the MRI and CT Expert Panel, and included an extensive review by a broad range of expert clinical and administrative leaders. The guidelines will be available shortly on www.ontariowaittimes.com.

- In November 2008, we began implementing the MRI Process Improvement Project to help hospitals improve patient flow and increase their MRI efficiency and capacity. Seventeen hospitals will participate in this project over the next two years. Hospitals were picked based on an analysis of their MRI efficiencies and volumes, the number of scanners/shifts, high wait times and LHIN support. Ten coaches, who are radiologists or administrators with diagnostic imaging expertise, have been trained on coaching and Lean methodology. A second group of 10 coaches will come from the hospitals participating in the first year of the program. One hospital has completed the program and coaches have begun working with two more hospitals. Preliminary data indicates that "booking turnaround time" has decreased from 4-6 weeks to four days. Compared to baseline measures, the number of scans per week and efficiencies have increased and wait times have decreased.

- A partnership of the Ministry, the Joint Department of Medical Imaging in Toronto (Mount Sinai Hospital, University Health Network, Women's College Hospital) and St. Joseph's Healthcare Hamilton has developed an appropriateness toolkit to help guide physicians requesting MRI and CT scans for their patients. The toolkit includes a database and search engine of clinical indications for MRI and CT which incorporate national and international radiology guidelines. The toolkit will be available in May on www.ontariowaittimes.com.

Currently, Ontario surgeons are submitting paediatric wait times by surgery type and adult wait times for specialty surgeries to the Wait Times Information System. These wait times will be publicly reported in the Fall of 2009. The information on paediatric

[3] The cancer surgery priorities and access targets are Priority 1: Immediate; Priority 2: 14 days; Priority 3: 28 days; Priority 4: 84 days.

[4] The Wait Times Update #12 (August 14, 2008) reported that the number of MRI scans in Ontario has doubled from 2002/03 to the present, five more MRI scanners were funded in 2008, the MRI funding formula was adjusted so the same funding supports more hours of operation, a third MRI technologist training class was funded, and Value Stream Mapping was being piloted to improve diagnostic imaging work flow (i.e., MRI Process Improvement Project).

and adult specialty surgeries will help us address specific surgical areas that have longer wait times. Currently, about 3,500 surgeons are submitting surgical wait time information.

I would like to thank hospital leadership, and medical and hospital staff for your enormous efforts thus far in reducing wait times. Congratulations on helping to improve access to the wait time services. As we look into the future, we expect that Local Health Integration Networks and hospitals will continue to monitor all wait times and focus particular efforts on those areas that have not achieved their access targets.

2. EMERGENCY ROOM WAIT TIMES

Emergency Room wait times remains a top priority of government. ER wait times and Alternate Level of Care are closely intertwined: to reduce ER wait times, we must reduce the number of ALC patients in hospitals. This section provides updates on:

- Emergency room targets and public reporting of time spent in the ER (2.1)
- Emergency room Pay-for-Results Program (2.2)
- Launch of the ED Process Improvement Program (2.3)
- Preliminary results of the Ambulance Offload and Nurse-led Long-Term Care Outreach Initiatives (2.4)
- New public website: *Your Health Care Options* (2.5)
- Patient satisfaction with emergency care (2.6)
- *Reducing Wait Times and Improving Care in Ontario Emergency Departments*: A Report from the Toronto Health Policy Citizens' Council (2.7)

Section 3 provides an update on Alternate Level of Care (ALC).

2.1 Emergency Room Targets and Public Reporting of Time Spent in the ER

Ontario leads Canada – and indeed North America – in setting targets to reduce the total amount of time patients spend in ERs and making this information publicly available on the wait times website. On February 19, 2009, the Minister of Health and Long-Term Care, David Caplan, announced targets for the length of time Ontarians can be expected to wait in ERs for final treatment. The total time spent in the ER ***begins*** when a patient registers in the ER or initially sees a triage nurse (who assesses the level of urgency for treatment) and ***ends*** when the patient is discharged home or admitted to a hospital bed. It is expected that patients are receiving treatment during their time in the ER.

Minister Caplan set two targets for time spent in the ER:

- 4 hours for patients with minor or uncomplicated conditions that require less time for diagnosis, treatment and observations.
- 8 hours for patients with complex conditions that require more time for diagnosis, treatment or hospital bed admission.

The most recent information on time spent in Ontario's ERs indicates that in November 2008:

- Nine out of ten people with complex conditions requiring more time for diagnosis, treatment or admission to a hospital bed spent 13.6 hours in the ER. This is well above the provincial access target of 8 hours.
- Nine out of ten people with minor or uncomplicated conditions requiring less time for diagnosis, treatment and observation spent 4.7 hours in the ER. This is slightly higher that the provincial access target of 4 hours.

Time Spent in the Emergency Room From the Time the Patient Registers in the ER to the Time the Patient is Discharged Home or Admitted to a Hospital Bed 9 Out of 10 Patients Within the Target – April 2008 (Baseline) to November 2008						
Type of ER Visit	**ER Visits (April 08)**	**Baseline Hours (April 08)**	**Current Wait Hours (Nov 08)**	**Access Target**	**Completed Within Target**	**Current vs. Baseline Change Hours**
Complex conditions requiring more time for diagnosis, treatment or admission to a hospital bed	219,185	13.9	13.6	**8**	80%	-0.3
Minor or uncomplicated conditions requiring less time for diagnosis, treatment and observation	153,592	4.8	4.7	**4**	85%	-0.1
Total	374,114	9.4	9.3			-0.1

Source: Emergency Department Reporting System which collects data from 128 hospital ERs in Ontario that have more than 20,000 ER visits a year .

A closer analysis of the data highlights the critical need to address ALC if we are to reduce the time Ontarians wait in the ER. The table below indicates that in November 2008, patients with complex conditions waited 35.4 hours in the ER if they were admitted to hospital; this is well above the 8 hour access target. In contrast, patients with complex conditions who did not need to be admitted to hospitals waited 8.2 hours in the ER which is close to the 8 hour access target. Patients with complex conditions who are admitted to hospital account for 11% of all ER visits in Ontario (40,034).

Time Spent in the Emergency Room by Patients With Complex Conditions Requiring More Time for Diagnosis, Treatment or Admission to a Hospital Bed 9 Out of 10 Patients Within the Target – April 2008 (Baseline) to November 2008						
Patient Status	**ER Visits (April 08)**	**Baseline Hours (April 08)**	**Current Wait Hours (Nov 08)**	**Access Target**	**Completed Within Target**	**Current vs. Baseline Change Hours**
Admitted to Hospital	40,034	35.9	35.4	**8**	39%	-0.5
Not Admitted to Hospital	179,151	8.5	8.2		90%	-0.3
Total	219,185	13.9	13.6		80%	-0.3

Source: Emergency Department Reporting System which collects data from 128 hospital ERs in Ontario that have more than 20,000 ER visits a year .

Our analysis of ER visits by the Canadian Emergency Department Triage and Acuity Scale (CTAS)[5] suggests that higher acuity patients – especially those admitted through the ER – have had greater improvements in their ER wait times. Our data also suggest that the 23 hospitals with high ER volumes and ER wait time pressures that received Pay-for-Results incentives in 2008/09 had greater improvements in ER wait times than non Pay-for-Results hospitals.[6]

Similar to wait times for surgical and imaging procedures, it is expected that LHINs and hospitals will continue to monitor ER wait times and focus efforts on improvements.

2.2 Emergency Room Pay-for-Results Program

The Pay for Results Program is one initiative of the ER Strategy. You may recall that in 2008/09, 23 hospitals with high emergency room volumes and ER wait time pressures were given incentives to improve their performance. Hospitals were required to reduce wait times for higher acuity patients (CTAS 1-3),[7] reduce the number of patients with extremely long waits (greater than 24 hours), and ensure that wait times for lower acuity patients did not get worse.

It is anticipated that in May, Minister Caplan will announce an expansion of the Pay-for-Results Program to selected hospitals in all 14 LHINs. LHINs will be required to ensure that hospitals that receive Pay-for-Results funding meet conditions such as:

- Demonstrate a 10-point improvement in the percentage of admitted patients whose ER-length of stay is 8 hours or less.
- Demonstrate a 10-point improvement in the percentage of non-admitted CTAS Level 1 and 2 patients treated within ER-length of stay of 8 hours or less, and within 6 hours or less for non-admitted CTAS 3 patients.
- Demonstrate a 10-point improvement in the percentage of non-admitted CTAS 4 and 5 patients treated within ER-length of stay of 4 hours.

Additional Pay-for-Results conditions will relate to Emergency Department Reporting System data and data quality. The LHINs and designated hospitals will be required to comply with the Ministry's auditing process. A process will also be in place to address non-compliance.

2.3 Launch of the ED Process Improvement Program

The ED Process Improvement Program (ED PIP) is designed to decrease ER length of stay, improve patient satisfaction with the ER experience, provide a better working

[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.
[6] See Section 2.2 for information on the Pay-for-Results Program.
[7] See Footnote 5 for CTAS levels.

environment for ER staff, and build provincial capacity for quality improvements. Currently, the ED PIP pilot program includes:

- On-site support provided by coaches and consultants who work with hospital staff to diagnose issues, identify and pilot solutions, and roll out initiatives.
- Regular regional forums to share best practices and obtain additional training.
- Regular leadership meetings to train senior leaders and physicians in high-level skills such as change management.

Based on the experience of the pilot sites, ED PIP is being launched across Ontario. ED PIP will provide the overall program structure, content, leadership training and onsite support. LHINs are expected to ensure local accountability and champion the program regionally. Participating hospitals are expected to provide local leadership, team resources, and enabling data tools.

The ED PIP vendor has been engaged and hospitals in the Waterloo-Wellington LHIN have been selected for the first wave which was launched March 23-27, 2009. Planning for Wave 2 will begin shortly. LHINs will invite hospitals to express their interest in being part of Wave 2 which will begin in October 2009.

As part of the program, a process improvement tool kit was developed and tested to help hospitals improve their performance. The *Process Improvement Tool Kit for Emergency Department and General Internal Medicine* is available at: http://www.patientflowtoolkit.ca/home.aspx. The website was created in partnership with the Ministry, the Ontario Hospital Association and contributing Ontario hospitals. The site will also be used to share best practices, tools and techniques with all Ontario hospitals.

2.4 Preliminary Results of the Ambulance Offload and Nurse-led Long-Term Care Outreach Initiatives

We have been monitoring the impact of funded ER/ALC initiatives to ensure that the investment of funds is having results. I am pleased to report on two initiatives.

Ambulance Offload

In 2008/09, the Ministry provided 14 municipalities with funds for their local Emergency Management Service providers (EMS) to arrange for dedicated nursing services to help with ambulance patients in selected hospital ERs. This investment is resulting in significant decreases in paramedic wait times in hospitals, and improved availability of ambulances and land ambulance response times. For example, the Windsor-Essex EMS reduced its off-load delay hours by 35% from January 2008 to January 2009; the Hamilton EMS reduced its hospital delay time by 12.18 minutes between December 2007 and December 2008; and the Toronto EMS recovered 70 unit hours per day compared to the first quarter of 2008.

Nurse-led Long-Term Care Outreach

In 2008/09, the LHINs were funded to create 14 nurse-led outreach teams to provide timely and appropriate on-site care to residents in long-term care homes (three full-time equivalents per LHIN). The University Health Network program (Toronto Western site) has diverted 77% of nursing home patients from the ER. The hospital has estimated that the program is about 21% less expensive than providing similar care in the hospital's ER. Most LHINs have not yet put these teams in place because of recruitment issues. I encourage these LHINs to implement these programs as soon as possible.

2.5 New Public Website: Your Health Care Options

On February 12, 2009, Minister Caplan announced a new public website to help Ontarians make informed decisions about where to go in the community for immediate care (www.ontario.ca/healthcareoptions). In addition to hospital ERs for immediate care for emergency situations, the website provides information on other healthcare options including Telehealth Ontario, family healthcare providers, family health teams, community health centres, walk-in or after-hours clinics, and urgent care centres. The website is part of a broader public education campaign on ERs that is using television, newspapers and other print media such as brochures.

2.6 Patient Satisfaction with Emergency Care

As you are aware, measuring patient satisfaction with care in hospital ERs will be required in Ontario. An enhanced version of the current National Research Corporation (NRC)-Picker survey is being used to measure satisfaction. In January 2009, hospitals were notified of the process and data requirements for patient satisfaction. Hospitals are required to submit enhanced data by April 2009. Patient satisfaction with ERs will be publicly reported quarterly on the Wait Times website beginning in the Fall of 2009.

2.7 *Reducing Wait Times and Improving Care in Ontario Emergency Departments*: Report from the Toronto Health Policy Citizens' Council

Recently, I received a copy of the Toronto Health Policy Citizens' Council report, *Reducing Wait Times and Improving Care in Ontario Emergency Departments*.[8] The Council is made up of 26 individuals who represent the diversity of Toronto and are not employed in healthcare-related occupations. The purpose of the Council – which first met in January 2008 – is to have ordinary citizens deliberate and comment about important, value-sensitive issues in healthcare from the perspective of those who use and pay for the system. At its September 26-27, 2008 meeting, the Council deliberated about EDs. (Dr. Michael Schull, Ontario's ED lead, provided background information.) I am pleased that the Council generally agreed that the broad ER Strategy is appropriate. The Council's comments and recommendations are an invaluable source of citizens' input as we continue to reduce ER wait times and improve care in ERs.

[8] The report was issued December 19, 2008 and is available at: http://www.canadianprioritysetting.ca/html/documents/cc_ed_report.pdf.

3. ALTERNATE LEVEL OF CARE

This section provides updates on:
- ER/ALC Information Strategy (3.1)
- Definition of a "Transitional Bed" (3.2)

3.1 ER/ALC Information Strategy

In the last Wait Times Update (December 2008), I reported that six recommendations from the ER/ALC Information Strategy were approved and funded.
- *Emergency Department Reporting System (EDRS)* expansion.
- *Wait Time Information System (WTIS)* expansion 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.
- *ALC Definition and Adoption Working Group* to develop a comprehensive, standard, provincial definition of ALC.
- *Client Profile Database (CPRO)* to be used to analyze and report on people waiting for long-term care placement in the community.
- *ED-CCAC Notification System* to be expanded to high volume ERs in Ontario to reduce unnecessary inpatient admissions through the ER.
- *e-Referral and Resource Matching Solutions* to be developed.

Work is ongoing in all six areas. I am pleased to report significant progress since December in two particular areas.

One, the ***ALC Definition and Adoption Working Group*** has developed a comprehensive, standard, provincial definition of ALC that will be used across the continuum of care for acute and post-acute patients waiting in hospitals. The working group included a broad range of healthcare representatives, and was co-chaired by Lynn Guerriero (Director of the Wait Time Information Program/Cancer Care Ontario) and Dr. Peter Nord (Chief of Staff, Providence Care Toronto). At its meeting on February 9, 2009, the working group developed: i) guiding principles for defining ALC and adopting the definition; and ii) a recommended *Provincial* ALC definition. The definition will be formally communicated to the field by May 1, 2009.

The Wait Time Information Program/Cancer Care Ontario is working in collaboration with the Ontario Hospital Association, the Canadian Institute for Health Information, the Ontario Health Quality Council, the Registered Nurses' Association of Ontario, and LHIN and hospital executives to ensure timely and successful adoption of the definition. Information sessions, educational tools and communication materials will be available to LHINs, hospitals and clinicians over the months of May and June 2009.

It is expected that on ***July 1, 2009***, all acute and post-acute hospitals in Ontario will use the standardized provincial ALC definition to designate their ALC patients.

The Wait Time/ALC Information System will be implemented in five beta sites by March 31, 2010. By March 31, 2011, the information system will capture near-real time ALC data in 92 acute care and 21 post-acute care hospitals.

I would like to express my thanks to the members of the working group and especially the co-chairs for their dedication and hard work in this important area. If you have any questions on this initiative, please contact Lynn Guerriero (Director, Wait Time Information Program/Cancer Care Ontario at ALCdefinition@cancercare.on.ca).

Two, the ***ER-CCAC Notification System*** will be expanded to high volume ERs to reduce unnecessary inpatient admissions through the ER. The system will:

- Use established clinical criteria to identify ER patients who should receive a Community Care Access Centre assessment; and
- 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. The system will also track and report performance.

By June 1, 2009, the plan to implement the ***provincial*** ER-CCAC Notification System will be finished and communicated to all stakeholders. The system will target 40% of ER visits by April 1, 2010 and 70% of visits by January 1, 2011. Any local or LHIN-based ER-CCAC notification systems will be required to align and comply with the provincial functions and standards.

If you have any questions on this initiative, please contact Joanne Walker (Acting Director, Access to Care Program at Joanne.walker@cancercare.on.ca) or Melissa Farrell (Manager, Access to Care and Wait Times at melissa.farrell@ontario.ca).

3.2 Definition of a "Transitional Bed"

As you may recall, one of the solutions to help address ALC that was recommended by Dr. Kevin Smith, the Provincial ALC Lead, was transitional bed capacity. Our analysis indicates that Ontario does not have a common standard definition of "transitional bed." Rather, individual acute and post-acute hospitals, and long-term care and retirement homes develop their own definitions of transitional bed.

We are in the process of finalizing a provincial definition of "transitional bed" that will be directly linked to the Ministry's agenda to reduce time spent in ERs. The purpose of a transitional bed will be to transfer ALC patients from acute care, rehabilitation, complex continuing care, mental health and addictions or the ER. Conditions that are being considered for a transitional bed include specific criteria for admission, a specified length of stay target, and restorative, functional, curative or reactivation programs to support patients to achieve optimal functioning. The time spent in transitional beds will be tracked by the Wait Time Information System.

The provincial definition and requirements for a "transitional bed" will be communicated to you shortly.

4. eHEALTH ONTARIO

As you know, in September 2008, the Ontario government created eHealth Ontario, a new provincial agency responsible for all aspects of e-health in Ontario. In January 2009, eHealth Ontario publicly released a draft strategy for input and received feedback from over 400 individuals and organisations. I hope that many of you sent your comments. The eHealth Ontario Board approved the final strategy which was released on March 19, 2009. I encourage all of you to review *Ontario's eHealth Strategy 2009-2012* which is available at: http://www.ehealthontario.on.ca.

Ontario's eHealth Strategy is grounded in the vision of the agency: *Achieving Excellence in Healthcare by Harnessing the Power of Information*. The Strategy has two intrinsically linked core priorities: 1) clinical; and 2) foundational. Within each of these priorities, explicit solutions will be achieved, specific actions and performance targets will be attained, and measurable results will be realized by 2012.

- *Clinical priorities* are directly related to patients, health and healthcare. Over the next three years, eHealth Ontario will focus its efforts on three clinical priorities: i) diabetes management; ii) medication management; and iii) wait times.
- *Foundational priorities* include a strong infrastructure of key information systems and tools, improved technology services, and effective operating practices and human resource talent. Over the next three years, eHealth Ontario will focus its efforts on four foundational priorities all of which are fundamental for building a comprehensive electronic health record by 2015: i) cornerstone information systems; ii) clinical activity information systems; iii) technology services; and iv) enabling practices and talent management. The foundational priorities are the foundation that will support achieving the clinical priorities in 2009/2012. The foundational priorities will be in place and leveraged to support additional clinical priorities beyond 2012.

5. INCREASED FOCUS ON MINISTRY-LHIN PERFORMANCE, CONSISTENCY AND ACCOUNTABILITIES

Assistant Deputy Minister, Ken Deane, is continuing to work closely with the LHINs and the Wait Time Office to implement a rigorous performance management framework that includes consistency, performance and accountabilities. As I reported in the December 2008 update, a number of initiatives have been put in place to support these efforts:

- LHIN Performance Leads for ER/ALC activities met for the first time January 2009.
- Performance management is a standing item at monthly Ministry Management Committee-LHIN CEO meetings.

On March 30-31, 2009, Ken and Bill MacLeod (CEO, Mississauga Halton LHIN) hosted an important workshop on LHINs and Consistency. Over 60 workshop participants – including LHIN Board Chairs and CEOs, provincial thought leaders, and representatives of health service organisations and the Ministry – discussed the top areas for LHIN

consistency and the structures and supports needed for LHINs to implement consistency effectively. The results of a survey administered prior to the workshop highlighted different perspectives on consistency and helped identify areas that need to be addressed as part of the Performance Management Framework.

In May 2009, Ken will begin Ministry-LHIN CEO quarterly performance management meetings. The meetings will review LHIN-specific *Stocktake Reports* that will include an assessment of current performance, trends and issues that need to be addressed. Progress on performance will be reported regularly to Minister Caplan.

6. LHIN VISITS

On March 25, I contacted each of the 14 LHINs to schedule local meetings so that I can provide information and obtain advice on: 1) ongoing initiatives related to Ontario's Wait Time Strategy; 2) the progress being made on ER/ALC; and 3) the new eHealth Ontario agency which I chair. Similar to my past LHIN visits, we hope to meet with the LHIN boards and staff, the boards and staff of key health service provider organisations in the LHIN (institution and community-based), and clinicians. We are also interested in meeting with local media representatives, where possible, to ensure that wait time information is communicated to the broader public.

I truly appreciate the efforts of the LHINs to accommodate my request. To date, almost all 14 meetings have been scheduled. These visits are invaluable for guiding our work, and I look forward to meeting with many of you in the near future.

7. IN CONCLUSION

I would like to thank all of you for your ongoing commitment and support to improve access to care and reduce wait times in this province. As I noted at the beginning of this update, significant changes in the economy continue to profoundly challenge healthcare organisations and leaders to provide services with constrained resources. The commitment of funds in the 2009 Ontario Budget is a vote of confidence in all of us. We need to continue our relentless and determined commitment to improve access and system performance, and be accountable for the efficient and effective use of valuable taxpayer dollars. I look forward to working together with you to meet this goal.

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.