THE WAIT TIME STRATEGY
REVIEW OF ACTIVITIES
JANUARY-MARCH 2008

UPDATE #11 – April 8, 2008

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 eleventh in a series of updates on the Strategy.[1] It presents the highlights and major accomplishments from January to March 2008.

HIGHLIGHTS AND MAJOR ACCOMPLISHMENTS

ONTARIO A CANADIAN LEADER IN WAIT TIMES

You will recall that in 2004, the First Ministers of Health agreed to achieve meaningful reductions in wait times in at least five areas by March 31, 2007: cancer, cardiac, diagnostic imaging, joint replacements, and sight restoration. (Ontario set December 2006 as its target date.) The Canadian Institute for Health Information (CIHI) has been reporting on the progress made to achieve this goal.

Recently, CIHI reported that provincial wait time comparisons are hard to make because of variations in measuring wait times.[2] However, a close look at the areas where comparisons are possible – such as joint replacement and cataract surgery – shows that Ontario is a top performer. For example, Ontario's knee replacement wait times are shorter than seven of the eight provinces that reported comparable data. I congratulate all of you on this success. In the fall of 2004, the Wait Time Strategy was just beginning. In three and a half years, Ontario has become a Canadian leader in wait times. The wait time team is working closely with CIHI and other provincial representatives to improve inter-provincial comparability.

ADULT WAIT TIMES: AUGUST/SEPTEMBER 2005 TO FEBRUARY 2008

An analysis of over 2½ years of wait time data (31 months) indicates that adult Ontarians 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).

[1] See www.ontariowaittimes.com for the first ten updates.
[2] See www.cihi.ca for Canadian Institute for Health Information. 2008 (February). *Wait Time Tables: A comparison by province, 2008* (Analysis in Brief).

Adult Wait Times Data: 9 Out of 10 Patients Receive the Treatment Within Target – August/September 2005 to February 2008 –					
Procedure	**Days**			**Completed Within Target***	**Current vs. Baseline Change (Days)**
	Baseline Aug/Sept 2005	**Current Feb 2008**	**Access Target**		
Cancer Surgery	81	66	84	95%	-15
Angiography	56	24	-	-	-32
Angioplasty	28	14	-	-	-14
Bypass Surgery	49	52	182	100%	3
Cataract Surgery	311	120	182	96%	-191
Hip Replacement	351	224	182	87%	-127
Knee Replacement	440	257	182	81%	-183
MRI	120	109	28	51%	-11
CT	81	37	28	84%	-44

*Priority Level 4 Target

Compared to August/September 2005 – when wait time information was first available in the province – Ontarians got their cataracts removed 191 days sooner in February 2008, their knee joints replaced 183 days sooner, their hip joints replaced 127 days sooner, an angiography 32 days sooner, their cancer surgery 15 days sooner and an angioplasty 14 days sooner. Ontarians also got their CTs 44 days sooner and their MRIs 11 days sooner. Although Ontarians waited three more days for bypass surgery (52 days in February 2008), this was well below the target set by clinical experts for safely receiving routine bypass surgery (182 days).

More than 80% of adult patients are receiving their treatments within the targets set for cardiac bypass surgery, cancer surgery, cataract surgery, hip and knee replacement surgery, and CT. Timely access to MRI continues to be an area of concern. MRI wait times have decreased only slightly even though the Ministry of Health and Long-Term Care (Ministry) has made significant investments in MRI since the fall of 2004. The number of MRI scans in Ontario has almost doubled between 2002/03 and 2007/08.

We are using a number of approaches to improve access to MRI as well as CT.

- *Supply will continue to be improved*. The Ministry will fund five more MRI scanners and adjust the MRI funding formula so that the same amount of funding supports more hours of operation. A third MRI technologist training class is also being funded.

- *Supply will be maximized* through the use of coaching and tool kits to improve MRI and CT patient flow. To be successful, everyone involved in the MRI and CT work flow – including booking staff, receptionists, assistants, technologists, radiologists, department managers and administrators – need to map work flows and eliminate activities that do not add value. Three hospitals with long wait times and low

efficiency levels will pilot the Value Stream Mapping Project in 2008. Coaching teams will be trained to expand the Project across additional hospitals.

- *Increasing emphasis will be placed on appropriate ordering of MRI and CT scans.* Efforts are underway to develop rigorous screening procedures for imaging requests, to distribute imaging guidelines developed by established organisations such as the Canadian Association of Radiologists and the American College of Radiology, and to educate physicians on ordering best practices. Consideration is also being given to developing an electronic order entry system for imaging with built-in guidelines.

PAEDIATRIC WAIT TIMES: APRIL/MAY 2006 TO FEBRUARY 2008

The five Paediatric Academic Health Science Centres continue to submit their surgical wait times voluntarily.[3] An analysis of almost two years of wait time data (23 months) 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 25 days sooner in February 2008 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 February 2008 –

Procedure	Days			Completed Within Target*	Current vs. Baseline Change (Days)
	Baseline April/May 2006	Current Feb 2008	Access Target		
Paediatric Surgery	273	248	182	82%	-25

*Priority Level 4 Target

CONDITIONS OF FUNDING FOR WAIT TIME STRATEGY ALLOCATIONS (2008/09)

Additional conditions of funding for 2008/09 wait time allocations include the following.

Increased Cataract Surgery Conditions

- Hospitals must manage their cataract wait lists and accommodate all patients within 182 days (Priority 4 target).
- Hospitals should identify a contact person to coordinate and ensure that patients receive their cataract surgery within 182 days. Hospitals are expected to provide the

[3] The five centres are 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).

name and contact information to their Local Health Integration Network (LHIN) by May 2008.

- Hospitals agree to work towards managing the following indicators to measure the quality of cataract procedures: 1) nosocomial infection (endophthalmitis) rate; 2) incidence of capsular rupture; and 3) incidence of severe postoperative inflammation (TASS).

Increased Total Hip and Knee Joint Replacement Conditions

- Hospitals agree to capture rates of patients readmitted within three months of total joint replacement or *surgery for hip fracture.*
- Hospitals agree to communicate and work with their LHIN and the Orthopaedic Expert Panel to reduce total hip and knee joint replacement wait times to the provincial target of 26 weeks by March 2009, and reduce hip fracture wait times to the provincial target of 48 hours by March 2009.
- Hospitals agree to follow best surgical pre- and post-operative practices developed by the Orthopaedic Expert Panel.

Quality and Safety Commitments

The Quality Committee of the Board will:

- Review the hospital standardized mortality rate with management on a quarterly basis.
- Review the number of patients who have been reassessed and their status as a result of waiting longer than any of the priority target time frames for each of the wait time service areas.
- Review the following quality indicators:
    - The hospital will ensure that data regarding *central line infections* and *ventilator-associated pneumonia* (as applicable) are reported through the Critical Care Information System (Phase II) and agrees that this information can be provided to *Safer Healthcare Now!* for research purposes. The hospital will collect information on the reduction of *surgical site infections* and publicly report this information on the hospital's website by December 2008.

Wait Time Information System Reporting Conditions

Additional Wait Time Information System reporting conditions are presented below in the section, "Continued Expansion of the Wait Times Information System".

INCREASING RESPONSIBILITY OF LOCAL HEALTH INTEGRATION NETWORKS FOR WAIT TIME RESULTS

Local Health Integration Networks (LHINs) are taking greater responsibility for wait time results. LHINs have been working in partnership with the provincial Wait Time Office to allocate wait time funding. For the first time since the Strategy began, LHINs

will be sending wait time funding letters to their hospitals. LHINS are expected to manage waits in the LHIN and hold hospitals accountable for long wait lists.

Hospitals should be aware that LHINs are expected to:

- Continuously monitor wait lists for their service providers for all service areas under the Wait Time Strategy.
- Work collaboratively with hospitals to improve the LHIN's wait list management processes.
- Examine wait time trends throughout the year to determine areas of need and local and/or LHIN-based solutions which may include redistributing cases.
- Work towards meeting the LHIN Wait Time Information System access targets for selected surgical and diagnostic imaging services, where applicable.
- Work collaboratively with providers to maximize the adoption and use of the Wait Time Information System (WTIS), Critical Care Information System (CCIS), Surgical Efficiency Targets Program (SETP) and Emergency Department Reporting System (EDRS).
- Use monthly data from the SETP to monitor operating room efficiency and recommend evidence-based improvements in collaboration with their service providers.
- Participate in target-setting activities for operating room performance management and disseminate their practices in collaboration with the Ministry as part of the SETP.
- Use CCIS data to improve performance in critical care units and of Critical Care Response Teams.

CONTINUED EXPANSION OF THE WAIT TIME INFORMATION SYSTEM (WTIS)

The Wait Time Information System (WTIS) project team – under the leadership of Sarah Kramer and in consultation with hospitals – is continuing to expand the WTIS to support the government's commitment to capture all surgical wait times.

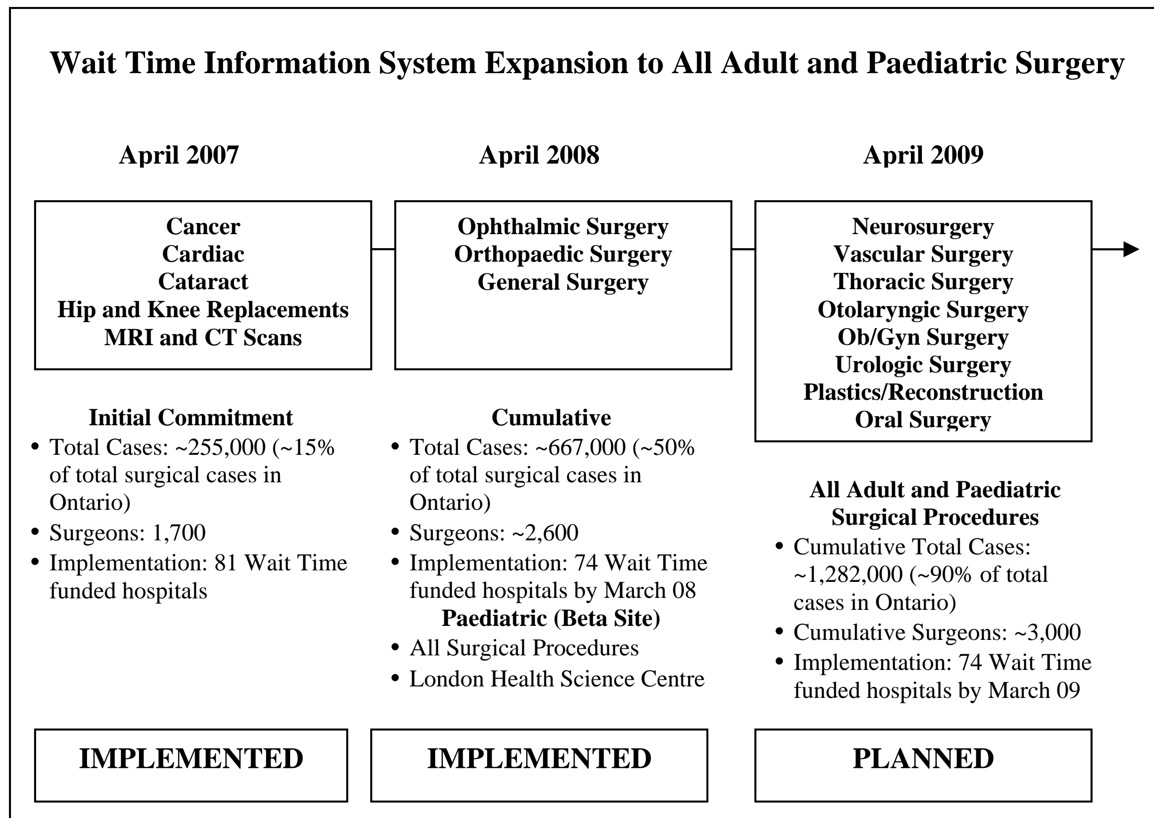
The purpose of the wait time data is to provide information to LHINs and hospitals so they can manage high waiting times and make improvements. Hospitals with long wait lists are expected to address the situation through internal management improvements and in collaboration with their LHIN and neighbouring providers.

More Adult Wait Time Surgeries Added to the WTIS

By April 2007, the WTIS successfully captured the wait from *decision to treat, to treat* for all wait time related 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 over 2,600 surgeons.

By April 2009, the WTIS will include 90% of all surgical cases including neurosurgical, vascular, thoracic, otolaryngic, obstetric/gynaecologic, urologic, plastics/reconstruction and oral surgeries. About 3,000 surgeons will be submitting surgical wait time information.



Paediatric Surgeries Being Added to the WTIS

The WTIS team has been working with London Health Sciences Centre and St. Joseph's Health Centre (London) to pilot the expansion of the WTIS to all paediatric sub-specialty surgeries. Drs. Kellie Leitch and Murad Husein – who served as clinician champions – engaged the London-based clinicians who perform paediatric surgeries in this work. Dr. Charlotte Moore (Provincial Lead, Access to Paediatric Services) chaired the Paediatric Actioning Team and collaborated with ten sub-specialty working groups to develop paediatric-specific clinical support tools (e.g., priority assessment tools, case studies). On March 3, 2008, over 100 clinicians from both sites began submitting surgical wait times to the WTIS for paediatric orthopaedics, ophthalmology, general surgery, neurosurgery, otolaryngology, urology, plastics, dental, cardiology and gynaecology.

The experience gained from this pilot will guide the provincial rollout to all paediatric sub-specialty surgeries at the other paediatric academic health science centres and community hospitals in 2008/09. I would like to thank the London team for their leadership in this important work.

Increased Conditions for Wait Time Information Reporting

Hospitals receiving wait time funding for 2008/09 must meet additional wait time information reporting conditions. These include:

- Begin to report minimum wait time data for all surgical cases as new surgical subspecialties are available in the WTIS.
- Work to report all paediatric surgical procedures in the paediatric module of the WTIS, when available.
- Continue to submit data every 12 hours to the Critical Care Information System and ensure that the occupancy and utilization of critical care unit(s) are accurately reflected. If the hospital has specialty units or other units scheduled to implement CCIS in 2008/09, it will submit data in accordance with the timeframes set by the Ministry and the CCIS Project Team.
- Implement the Emergency Department Reporting System (EDRS) in accordance with the timelines set by the Ministry and the EDRS Project Team.

Wait Times Reporting to Include Patient Priority Level Information

As you are know, physicians determine the priority level of each patient who needs a wait time surgery or scan. Priority levels – and the target wait times associated with each level – range from Priority 1 (immediate) to Priority 4 (least urgent). Up until now, we have been using the Priority 4 wait time target as an interim measure to evaluate the success of the Strategy until we were confident that the priority data was valid and of high quality. We have been tracking the priority data submitted by 81 Ontario hospitals for one year. I am pleased to report that in mid-March, all of the clinical expert panel chairs and the Data Certification Council reviewed and supported the priority level wait time information. This information will be available on the wait times website in the near future (see www.ontariowaittimes.com and click the "Health Professionals" link).

I would like to acknowledge the members of the Council (Michael Decter, Graham Scott and Tom Closson) for their valuable contributions reviewing, advising on and approving the collection and reporting of Ontario's wait time information.

ONGOING IMPROVEMENTS IN CRITICAL CARE SERVICES

The lack and poor use of critical care resources contribute to long wait times for services. Under the leadership of Dr. Bernard Lawless (Provincial Lead, Critical Care and Trauma), Ontario's critical care system is continuing to make significant improvements. Some of the major achievements include:

- The Critical Care Information System (CCIS) is tracking utilization and quality indicators in all Level 3 medical/surgical ICU beds. The first quarterly report – released in February – reported on September-November 2007 activity. A key finding was that 7% of ICU capacity was "lost" due to delays discharging patients from Level 3 ICU beds. CCIS will be expanded in 2008 to include speciality Level 3 and Level 2 ICU units.

- Thirty one critical care response teams are providing 24/7 services in Ontario's hospitals (27 adult teams and four paediatric teams). The adult teams reported making over 1,000 new consultations and over 3,000 follow up consultations each month. Five smaller hospitals are testing other team models led by nurses or hospitalists.
- Critical care coaching teams visited 48 hospitals in fiscal 2007/08.
- With regard to human resources, the first cohort of 18 intensivists is graduating in July 2008. In addition, $4.5 million to train about 225 new critical care nurses will begin to flow in April/May 2008.

CELEBRATING INNOVATIONS IN HEALTH CARE EXPO: APRIL 22, 2008

The Ministry and the 14 LHINs are co-sponsoring the annual *Celebrating Innovations in Health Care Expo 2008* to be held on April 22, 2008 in Toronto (Metro Toronto Convention Centre). This event will showcase innovative health care system solutions and projects in Ontario. Innovation themes include: 1) meeting community needs through integrated care; 2) improving quality and patient safety; 3) improving efficiency through process redesign; 4) innovations in health information management; 5) innovations in health human resources; and 6) innovations in health promotion. Online registration and the event program are available at www.health.gov.on.ca/innovations.

EVALUATION OF HIP AND KNEE JOINT REPLACEMENT PROGRAMS

In my last update (December 2007), I reported that the Toronto Central LHIN Joint Health and Disease Management Program will undergo an external evaluation. The evaluation will be completed in early April. Shortly afterwards, Drs. James Waddell and Cecil Rorabeck will review all existing hip and knee programs in 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.

THANKS TO HUGH MACLEOD

Hugh MacLeod, the former Assistant Deputy Minister of the Health System Accountability and Performance Division, has taken a leadership role advising Premier McGuinty on Ontario's carbon footprint and other issues relating to climate.

In his former position, Hugh had the delicate task of linking the work of thousands of individuals – represented by the expert panels – with the work of the civil servants in the Ministry of Health and Long-Term Care. Hugh also had a number of other major responsibilities including leading the negotiations with the Ontario Medical Association.

We congratulate Hugh on his achievements with Ontario's Wait Time Strategy. Hugh did a full day's work dealing with the "outside" issues as well as a full day's work directing "inside" issues. Having to do two full days' work within 24 hours is a very heavy schedule. Hugh was unfailingly optimistic and his record of results resulted in

continuing support by Premier McGuinty and Minister Smitherman. Many in the field met directly with Hugh over the years and many more benefited from his leadership. Hugh leaves with a stellar record of accomplishment and we wish him all the best in his new responsibilities.

IN CONCLUSION

The Wait Time Strategy is continuing to improve access to a broader range of healthcare services. As providers increasingly demonstrate their commitment and leadership to improving access, the public's interest in wait time information continues to grow. Since hospital-specific wait time data was first available publicly on October 24, 2005 to January 27, 2008, the Wait Times web site has had over 6 million hits. The site receives an average of about 9,000 hits a day (www.ontariowaittimes.com). The public is telling us that access to healthcare services is highly important to them. ***Thanks to all of you*** for your ongoing efforts to improve this access.

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.