

Health Results Team

Second Annual Report 2005-06

A Focus on Access
and Quality Improvement

October 2006

Imagine a health care system that...

...can provide Ontarians with the care they need when they need it.

...offers timely and quality care.

...has been redesigned to operate based on the needs of the patient.

...aspires to work in a coordinated way to guide the patient efficiently and effectively.

...can track improvements made and those still needed.

...seeks expert advice on how to get results.

...gets the most value for taxpayer dollars.

**Ministry of Health
and Long-Term Care**

**Assistant Deputy Minister
Health System Accountability
and Performance Division**

**10th Floor, Hepburn Block
Queen's Park
Toronto ON M7A 1R3**

**Telephone: (416) 212-1134
Facsimile: (416) 212-1859**

**Ministère de la Santé
et des Soins de longue durée**

**Sous-ministre adjoint
Division de la responsabilisation et de la
performance du système de santé**

**Édifice Hepburn, 10^e étage
Queen's Park
Toronto ON M7A 1R3**

**Téléphone : 416 -212-1134
Télécopieur : 416 -212-1859**



Dear Premier McGuinty and Minister Smitherman:

On behalf of the Health Results Team, I respectfully submit to you our second annual report.

We began our work accepting your challenge – new money must be used to buy change. From this came our focus – to find new and innovative ways of delivering better, safer and quicker patient care for taxpayer dollars.

I am pleased to report to you that we have found more efficient and effective ways to do so, and have put these into action. And when we have spent money, we have used new approaches such as pay for performance, to make sure that we are getting good value for the dollars invested.

The Health Results Team is indebted to you, Premier, for chairing our monthly meetings, and to you, Minister, for meeting regularly with us on pressing matters. You have both played a key role in encouraging and supporting the many consultations, expert panels, and groups that have been created to help get results.

This government has demonstrated the political will to make these stakeholders a real part of the transformation process. It has taken a lead role in expecting value and results for taxpayer dollars, and in ensuring that the changes needed to ensure a high standard of care take place.

I also want to thank and recognize Ontario's health care providers, members of the Health Results Team and our colleagues in the ministry for their tireless dedication. They have given generously of their time, energy, expertise and creativity to help make this transformation happen.

Ontario's public health care system helps to define who we are and must show what we value: quality health care for everyone.

Together, we will make our health care system work for us now, and for future generations.

Sincerely,

Hugh MacLeod
Assistant Deputy Minister
Health System Accountability and Performance Division
Executive Lead, Health Results Team

Connecting and Engaging the Innovators for System Change

At our first Health Results Team meeting with the Premier and the Minister, we concluded that we needed to reconnect with the many innovators on the front lines of health care and those who have spent entire careers studying it – to give them a voice in planning the transformation of our health care system and a role in implementing change initiatives. In that way, the system would be helping the system. We did so through a variety of mechanisms, which are described in this section.

Expert Panels

We made space at the table for experts in the field and health care providers to help us not only plan the changes that needed to happen, but to figure out how to make them work in practice. We created expert panels and asked them to think beyond the short term in coming up with solutions. We marked our destination and asked them to produce a road map to get us there.

As a result, expert panels have contributed significantly to our success by shaping the strategies that have impacted on the policies and decisions related to the Health Results Team initiatives, while creating momentum for widespread change.

The recommendations of our expert panels are available on the ministry's website at www.health.gov.on.ca.

Coaching Teams

And we did not stop there. We created coaching teams from hospitals across the province who have been helping other hospitals make improvements in operating room processes and critical care.

Operating rooms and critical care bed utilization are absolutely pivotal to supporting and sustaining improved access to health care services and reductions in wait times. Surgeries that are delayed or cancelled due to inefficient utilization of operating rooms and critical care beds result in increased wait times,

backups in emergency services, longer lengths of hospital stay, staff stress, increased patient anxiety and a decrease in the quality and safety of patient care.

By the end of October 2006, coaching teams will have shared their experiences and knowledge with 54 hospitals across the province – a great example of how the system is helping the system.

Leadership Groups

We also created leadership groups of physicians, nurses, nurse practitioners, dietitians, pharmacists and others, to advise us on how to best help Family Health Teams with their work. Many of these leaders are providing hands-on mentoring to their colleagues on practical, everyday access and service issues.

Innovation and Education Fund

Through our Innovation and Education Fund, we funded fifty-four projects designed to improve effectiveness and efficiency. For example, at Sault Area Hospital the funding has enabled the hospital to train Respiratory Technicians (RTs) to provide anaesthesia support. To date, 12 RTs have completed their clinical training and are now practicing.

Celebrating Innovations in Health Care Expo

To promote greater knowledge transfer, we co-sponsored with the Local Health Integration Networks (LHINs) the first ever Celebrating Innovations in Health Care Expo.

This expo showcased advances across the system. Awards were given out in five areas: meeting community needs through integrated care; improving efficiency through process redesign; improving quality and patient safety; innovative use of health human resources; and innovative use of information management. For instance, the Trillium Health Centre, a 750-bed hospital in Mississauga, won an award for its work in streamlining the ordering of medications, treatments, procedures and consultations. This innovation enhances quality and frees up time for direct patient care.

Leveraging Dollars for System Change

What follows is an account of how we have contributed to delivering greater access and quality care for Ontario patients by leveraging the significant investments that have been made by the government. As this section will show, we have done so by working to implement innovative service delivery models and practices that are more efficient and effective, as well as a new primary care model designed to facilitate timely access to care: Family Health Teams. And we have done so by emphasizing accountability for results to drive change – a pivotal element of the government’s plan for transforming health care.

Results – A First: Released Wait Time Priority Levels and Targets

On December 16, 2005, Ontario-specific targets, including priority levels and wait time targets, were

released for each of the five service areas that are part of Ontario’s Wait Time Strategy – cancer surgery, cardiac bypass surgery, cataract surgery, hip and knee replacement and MRI and CT scans (see Table 1).

Health care providers, hospital boards and administrators, LHINs and the Ministry of Health and Long-Term Care can now use patient priorities and targets to manage and improve access to care. Additionally, the Wait Time Information System (WTIS), which underpins the strategy, will tell us how we are doing by procedure, by hospital and by LHIN.

In a recent edition of *Healthcare Papers*, the past president of the Canadian Medical Association had this to say about our targets: “The wait time targets announced by Premier McGuinty are in fact much more closely aligned with those of the Wait Time Alliance than were the pan-Canadian benchmarks released by provincial and territorial ministers of health.”

Table 1: Summary of Targets with Priority Levels

Service Area		Pan-Canadian Benchmarks	Ontario’s Targets (in weeks)	Ontario’s Wait Times (90 th percentile)	Wait Time Alliance’s Proposed Benchmarks	
Cancer	Surgery	N/A	PI: Immediate	3.4 weeks	Emergency: less than 24 hrs	
			PII: 2 weeks		Urgent: based on need	
			PIII: 4 weeks		Routine: consultation within 2 weeks, surgery within 2 weeks	
			PIV: 12 weeks			
	Radiation	4 weeks of being ready to treat	N/A	Available on Cancer Care Ontario by disease site only	N/A	
Cardiac-CABG		N/A	PI: Immediate	2.1 weeks	Emergency: within 3 days	
			Level 1: 2 weeks		Urgent: within 2 weeks	
			Level 2: 6 weeks		PIII: 6 weeks	Routine: within 8 weeks
			Level 3: 26 weeks		PIV: 26 weeks	
Cataract Surgery		16 weeks for patients at risk (which correlates with Ontario’s PIII priority rating)	PI: Immediate	14.1 weeks	Emergency: N/A	
			PII: 6 weeks		Urgent: depends on priority	
			PIII: 12 weeks		Routine: 16 weeks	
			PIV: 26 weeks			
Hip & Knee Surgery		Hip fracture: 2 days	N/A	N/A	N/A	
		Hip: 26 weeks	PI: Immediate	Hip: 17 weeks	Emergency: 24 hours	
		Knee: 26 weeks	PII: 6 weeks PIII: 12 weeks PIV: 26 weeks	Knee: 21 weeks	Urgent: within 30 days Routine: 3 months consultation, 6 months surgery	
Diagnostic Scans	MRI	N/A	PI: Immediate PII: 48 hours PIII: 2-10 days PIV: 4 weeks	MRI: 4.6 weeks	Emergency: 24 hours Urgent: within 7 days Routine: within 30 days	
	CT	N/A		CT: 1.8 weeks		
Screening	Mammogram	ages 50-69 every 2 years	N/A	N/A	N/A	
	Cervical Screen	ages 18-69 every 3 years after 2 normal scans	Cancer Care Ontario has Clinical Practice Guidelines	N/A	N/A	

Results: Increased Access and Reduced Wait Times through the Funding of 657,000 Additional Procedures

Ontario is meeting its commitment to reduce wait times in five major service areas and, since the launch of the strategy, its investment in additional procedures has been significant – \$611 million.

We now have twelve months of data on wait times for each of the five procedures (i.e., from August 2005 to July 2006). An analysis of the data indicates that:

- Wait times for all procedures have decreased as measured by the 90th percentile (i.e., the point at which 90 per cent of patients received their treatment). (See Table 2.)
- Ontario is meeting its wait time targets for cancer surgery and cardiac bypass surgery when the 90th percentile is viewed in relation to the Priority IV access targets (i.e., the least urgent cases). Our goal for cancer and cardiac surgery is to ensure that wait times stay within these targets.

Cancer Care Ontario advises that radiation wait times from referral to the start of treatment have dropped by 38 per cent from 2003 (Q1) to 2006 (Q1). The Cardiac Care Network advises that wait times for coronary artery bypass has declined by 22 per cent from 2003/04 (Q4) to 2006/07 (Q1).

- The provincial 90th percentile wait time for cataract surgery has decreased by 19.6 per cent or 61 days.

Although Ontario is not yet meeting its access target for cataract surgery when the 90th percentile is viewed in relation to the Priority IV access target (182 days), 82 per cent of people who need cataract surgery are now within this range. Working in partnership with hospitals and LHINs, our goal is to meet the cataract targets by April 2007. We are confident that we will meet this goal, given the available capacity in the system to do more of these surgeries and the innovative approaches that are being used to perform this procedure.

- The provincial 90th percentile wait times have decreased by 17.9 per cent or 63 days for hip replacements and by 11.8 per cent or 52 days for knee replacements. Although Ontario is not yet meeting its access targets for hip and knee joint replacement surgery when the 90th percentile is viewed in relation to the Priority IV access targets (182 days), 77 per cent of hip replacements and 65 per cent of knee replacements are now within this range. Physicians and hospital staff have worked very hard to perform 37 per cent more joint replacements from November 2004 to March 31, 2006. Working in partnership with hospitals and LHINs, our goal is to meet the targets for hip replacements by April 2007.
- The provincial 90th percentile wait times have decreased by 23.3 per cent or 28 days for an MRI scan and by 13.6 per cent or 11 days for a CT scan. Although Ontario is not yet meeting its access targets for MRIs and CTs when the 90th percentile is viewed in relation to the Priority IV access targets (28 days), 42 per cent of MRIs and 68 per cent of CTs are now within this range. Ontario hospitals have worked very hard to perform eight per cent more CT scans and 42 per cent more MRI scans from November 2004 to March 31, 2006. They are also using scanners more efficiently.

Table 2: Wait Times Data: 90% Completed within Target

	Days			Completed Within Target	Current vs. Baseline	
	Baseline Aug./Sept. '05	Current June/July '06	Access Target (days)		Net Change (days)	% Change (in days)
Cancer Surgery	81	78	84	91%	-3	-3.7%
Angiography	56	28	-	-	-28	-50.0%
Angioplasty	28	21	-	-	-7	-25.0%
Bypass Surgery	49	53	182	100%	4	8.2%
Cataract Surgery	311	250	182	82%	-61	-19.6%
Hip Replacement	351	288	182	77%	-63	-17.9%
Knee Replacement	440	388	182	65%	-52	-11.8%
MRI Scans	120	92	28	42%	-28	-23.3%
CT Scans	81	70	28	68%	-11	-13.6%

Results – A First: Wait Time Information

When we started our work, no one in Ontario was accountable for making sure that patients had appropriate access to our five targeted health care services. We changed all that with the creation of a tracking system to monitor patient access to these services and the introduction of agreements which tied funding to the provision of accurate and timely information about waits.

In October 2005, Ontario’s first wait times website (ontariowaittimes.com) began presenting standardized wait time data by procedure, hospital and LHIN. To date, the site has received more than 1.6 million hits.

Since then, considerable progress has been made in building the Wait Time Information System (WTIS), which underpins the strategy. In January 2006, five hospital demonstration sites went live. By December 2006, another 50 hospitals will have implemented the system (accounting for 80 per cent of cases) and by June 2007, all Ontario hospitals receiving wait time funded cases will be on line.

Clinical leaders from our expert panels provided input into the design of the system, which can accommodate the future monitoring of wait times for all surgeries. It will not only provide us with near real-time information, but it will also prioritize cases according to their severity and urgency.

Table 3 highlights the differences between the current website reporting system and the WTIS.

Impact of the New Wait Time Information System

Once the new system is in place, health care providers, LHINs and the ministry will be able to:

- know, in near real time, what the waits are for surgery at a physician (with permission), hospital, LHIN and provincial level;
- determine, using real data, where the most effective “next dollar” investment should be placed to realize the greatest impact on access to care;
- know how many people are in the queue for what, where, and for how long;
- compare actual waits to provincially set targets, at a priority-specific level;
- receive near real-time information about key indicators of surgical suite efficiency, allowing for quick action to improve performance; and
- provide continued impetus for innovation among providers (witness the identification of new models of care to date).

But more importantly...

...the Ontario public will be able to assess, in almost real time, the wait times by procedure, hospital and LHIN.

Table 3: Comparison of Current Wait Times Reporting and the Wait Time Information System

Features		Current Wait Times Reporting	WTIS (Dec. '06)
Data Collection	Collect wait times for completed cases	✓	✓
	Collect wait times for cases still waiting		✓
	Near real time		✓
	Web-based entry from surgeon’s office		✓
Public Reporting	By hospital	✓	✓
	By Local Health Integration Network	✓	✓
	By province	✓	✓
	By priority level		✓
Tools to manage wait lists (for clinicians, surgeons, hospitals and LHIN administrators)	Track delays within treatment		✓
	Flag cases approaching wait time target		✓
	Allow doctor-specific wait list management		✓
	Track number of people waiting and their priority level		✓
Prioritize Cases	Uses consistent assessment tool		✓
Measure Outcomes	Links to other databases to measure outcomes		✓

Results – A First: Access and Quality Improvement through the Introduction of New Models

A number of innovative service delivery models have been introduced this year, as part of the Wait Time Strategy. Here are some examples of models that will change how health care is accessed in Ontario.

Champlain Regional Cancer Plan (Champlain LHIN)

The Champlain Regional Cancer Plan is a partnership between all cancer hospitals in the Champlain LHIN, centered around The Ottawa Hospital. The partners are working to develop a comprehensive, coordinated strategy for cancer management in the region.

This innovative model will improve access to quality cancer surgery and decrease wait times by not only maximizing capacity throughout the LHIN, setting regional standards, and developing communities of practice, but also by better aligning resources and redistributing cancer surgery appropriately across the region using real-time performance data.

The Regional Assessment Centre, located at The Ottawa Hospital, will serve as the hub for the region and as the gateway for access to cancer services. Based on a common set of mutually determined standards and linked performance data, regional institutions will develop unique satellite cancer programs based on their own capacity and community needs.

North York General Hospital – Markham Stouffville Hospital Hip and Knee Joint Assessment Centre (Central LHIN)

The Hip and Knee Joint Assessment Centre is being developed at North York General Hospital's Branson site. It will be a resource for the Central LHIN and beyond. Its goal is to decrease patient waits, optimize patient readiness for surgery and coordinate medical care from the first visit through to recovery. This centre will also enable orthopaedic surgeons to spend less time

in the office and more time in the operating room. A specially trained team of interdisciplinary staff will work in partnership with orthopaedic surgeons, assessing and case managing patients requiring primary joint assessment. This will lead to increased efficiency in the operating room, comprehensive disease management, coordinated use of resources and reduced wait lists.

Kensington Eye Institute (Toronto Central LHIN)

The Kensington Eye Institute is a Centre of Excellence for the delivery of cataract surgery. Opened in January 2006, the institute performs basic cataract surgeries, freeing up hospital operating rooms for more complex surgeries. The institute's unique model of care delivery enables patients to be referred directly to the centre and see the first available surgeon. It has already completed more than 4,025 procedures, and will be able to perform more than 6,700 procedures annually.

Holland Orthopaedic and Arthritic Centre (Toronto Central LHIN)

The Holland Orthopaedic and Arthritic Centre (HOAC), a part of Sunnybrook Health Sciences Centre, is being developed as a Centre of Excellence for total hip and knee replacement surgery.

The centre is bringing a number of innovative approaches to patient access to care in this area and is the hub of a Toronto Central LHIN Joint Health and Disease Management Program. The objectives of the program are to:

- improve access and reduce wait times for hip and knee replacement surgery;
- increase cost-effectiveness and efficiencies as a result of an integrated model of care and surgical room efficiencies; and
- improve the quality of care for patients, through the development and implementation of best practice guidelines.

The HOAC will play a key role in the design and implementation of a training program for advanced practice roles, including Registered Nurse First Assistants, Anaesthesia Assistants, Nurse Practitioners and Advanced Practice Physical Therapists.

The HOAC also boasts Canada's largest team of musculoskeletal specialists, has more than 13,000 ambulatory visits and performs more than 3,500 surgical procedures a year. It is recognized nationally for the complex surgeries performed, strength in patient focused care and innovative approaches to research, treatment and rehabilitation.

Total Joint Replacement Program (Hamilton Niagara Haldimand Brant LHIN)

Hamilton Health Sciences is partnering with other hospitals in the Hamilton Niagara Haldimand Brant LHIN, to establish a total joint replacement program that will increase capacity to perform hip and knee joint replacements. The assessment clinic will ensure patients are prioritized according to the urgency of their condition rather than the timing of the referral, the length of the wait list, or the capacity of an individual surgeon.

In addition, this program will also include:

- pre- and post-operative conditioning and rehabilitation schedules delivered in cooperation with the YMCA and local Community Care Access Centres (CCACs);
- pre-operative health education; and
- formal communication for case management by primary care providers.

Regional Eye Medicine and Eye Surgery Centre (Hamilton Niagara Haldimand Brant LHIN)

St. Joseph's Healthcare Hamilton, in partnership with other hospitals within the Hamilton Niagara Haldimand Brant LHIN, is developing a centralized referral system

for cataract surgery which will increase surgical volumes by 1,200 cataract surgeries this year, with the potential for even greater future expansion. The centre will make it easier for ophthalmologists from multiple sites in the Hamilton Niagara Haldimand Brant LHIN to access ambulatory facilities at the Regional Eye Medicine and Eye Surgery Centre. A major focus of the centre will be on providing a primary outpatient program with a strong focus on eye diseases associated with aging and the promotion of eye health.

Integrated Plan for Total Joint Replacement Surgery (Central West LHIN)

A number of local area hospitals and CCACs are partnering to develop a centralized wait list, a joint protocol for the transfer of patients between facilities, and a cross-credentialing system where physicians will be able to perform surgeries at various sites. This model will improve patient access across the region, shorten wait lists for joint replacement surgery, and increase overall health system efficiency. The model will also reduce the need for multiple patient transfers, promote clinical consistency and standardization through the continuum of care and, more importantly, it will be truly patient centred.

Integrated Model of Care for Total Joint Disease (North Simcoe Muskoka LHIN)

Local area hospitals and CCACs are working together to offer a single point of entry and referral to the first available surgeon in the region. This initiative will increase the local surgical capacity, standardize pre-surgery preparations, and strengthen the communication and integration with local CCACs for post-procedure care. This collaborative approach will ensure a seamless continuum of care for patients in a timely manner, while making the most efficient use of health care resources.

Results – A First: Critical Care Response Teams

Critical Care Response Teams (CCRTs) are a major innovation in hospital practice that is gaining worldwide recognition for delivering dramatic improvements in both patient safety and access to critical care resources.

The concept behind these teams is simple: when patients are deteriorating on the ward, intervene sooner. Most patients who deteriorate do so over a period of eight to twenty-four hours. By monitoring selected physiological indicators, ward staff can identify patients at risk of becoming critically ill – hours before they suffer a cardiac arrest or respiratory failure.

Prior to the introduction of these teams, ward staff would often have difficulty getting the required care to the bedside quickly enough when they identified an at-risk patient. CCRTs address this challenge.

Composed of critical care physicians (intensivists), critical care nurses and respiratory therapists, CCRTs respond within minutes, bringing critical care services directly to the bedside, anywhere in the hospital, on a 24/7 basis. CCRTs work collaboratively with ward staff in assessing and responding to the needs of at-risk patients, often providing resuscitation to stabilize patients without ICU admission.

Ontario began by funding a four-site CCRT demonstration project in 2004/05 to confirm that benefits realized in hospitals in other jurisdictions could be achieved here. The project was very successful, demonstrating improvements in patient safety and access to critical care resources. Based on the successful demonstration, this project is now part of Ontario's Critical Care Strategy, and we are quickly moving into a place of global leadership. Funding has been provided to 26 CCRTs, including 22 intensivist-led teams in large hospitals and a four-site demonstration project to test the CCRT model in pediatric hospitals.

As of November 2006, all 22 intensivist-led CCRTs will be administering clinical service, and over 200 nurses and respiratory therapists will have undergone training specifically designed to enable them to work on these teams.

The appointment of critical care leaders in each LHIN is providing a system approach to this initiative.

Results – A First: Critical Care Information System

As part of the Critical Care Strategy, the Critical Care Information System (CCIS) will provide key information that, until now, has been either collected in silos, retrospectively, anecdotally, or in some cases not at all. It will provide a consistent platform for all hospitals to inform better planning and operation of critical care activities.

CCIS will ensure that critical care data will be available to the ministry, LHINs and hospitals, to support decision-making related to critical care utilization capacity planning and resourcing.

Through a secure web portal, the initial CCIS data collection will include: patient information; patient demographics; CCRT intervention status; life support interventions; and bed availability.

The CCIS will be closely aligned with CritiCall, a 24/7 emergency referral service for physicians across Ontario, to integrate system-wide critical care information and resources.

From a system perspective, the CCIS will allow for a province-wide, real-time “view” of critical care utilization capacity and help ensure that patients across Ontario have timely access to critical care services. The CCIS will help us define and promote critical care system behaviours, share information and expertise more widely, and respond to crisis situations. It will

help to position Ontario as the national leader in the development of an innovative critical care service delivery model.

In addition, the CCIS will support performance measurement of critical care by providing an evidence base to support the development and implementation of quality improvement initiatives necessary to improve both the efficiency and delivery of critical care.

This also makes Ontario the first province to undertake the development of a critical care performance measurement system, and because there are few comparable systems around the globe that demonstrate these benefits, through the implementation of this system, Ontario will become a global leader as well.

The end result will be that individual providers, the ministry and LHINs will know how our current critical care capacity is being utilized. This will help us to anticipate and plan for future needs and demand.

Ultimately, the CCIS will increase our understanding of critical care, improve access to critical care and support the delivery of high-quality critical care. And, through the provision of evidence, will help to ensure that the necessary information is available to ensure the best possible outcomes for patients who are critically ill.

Results: Emergency Department-General Internal Medicine Patient Flow Toolkit

The expert panels recognized that improvements in ER and internal medicine patient flow would contribute significantly to improving access to services, thereby reducing how long people wait for these services.

The Emergency Department-General Internal Medicine Patient Flow Toolkit is designed to be a comprehensive online resource for Ontario hospitals to facilitate

improved, sustainable emergency department access and patient flow through the hospital.

The toolkit, comprised of diagnostic tools and well-developed tested interventions that have proven benefits, offers a system approach to dealing with the current stress in acute care capacity and emergency department backlogs. The toolkit is designed to be used in combination with coaching teams experienced in developing “patient flow solutions.”

Teams from the University Health Network and North York General Hospital are currently leading the development of the toolkit, which is sponsored by the ministry.

The interventions reflect the two different hospital environments, but are aligned with a common transformation framework, i.e., improvement initiatives in the area of:

- 1) Care coordination
- 2) Care model/team alignment
- 3) Work environment
- 4) Workflow
- 5) Communication of information
- 6) Team renewal

Within this shared framework, a number of interventions address patient flow from the time of ambulance drop-off in the emergency department to admission onto an inpatient unit, to the time for discharge to post-acute care/community providers.

The toolkit can help facilitate system integration. Best practices from hospitals can be continuously added to the toolkit and shared across the province to enable operational improvements in hospitals.

Results – A First: Implemented a Surgical Efficiency Program to Improve Access to and the Quality of our Operating Rooms

As part of the Wait Time Strategy, the Surgical Process Analysis and Improvement Expert Panel identified potential blockages that can lead to surgical delays, cancellations and inefficiencies (see Figure 1).

The panel conducted a survey of hospitals to assess the use of best surgical practices in Ontario. The survey found that 28 per cent of hospitals do not have a system for sequencing patients for the surgical day, 19 per cent do not track start times, 27 per cent do not track cancellations, 29 per cent do not track delays, and 44 per cent do not coordinate post-operative rehabilitation prior to surgery.

The panel identified nine components of a provincial peri-operative improvement plan.

As a result, a provincial surgical information system will now track hospital peri-operative flow and productivity, help identify bottlenecks that lead to longer wait times, and focus efforts on areas that need to be improved.

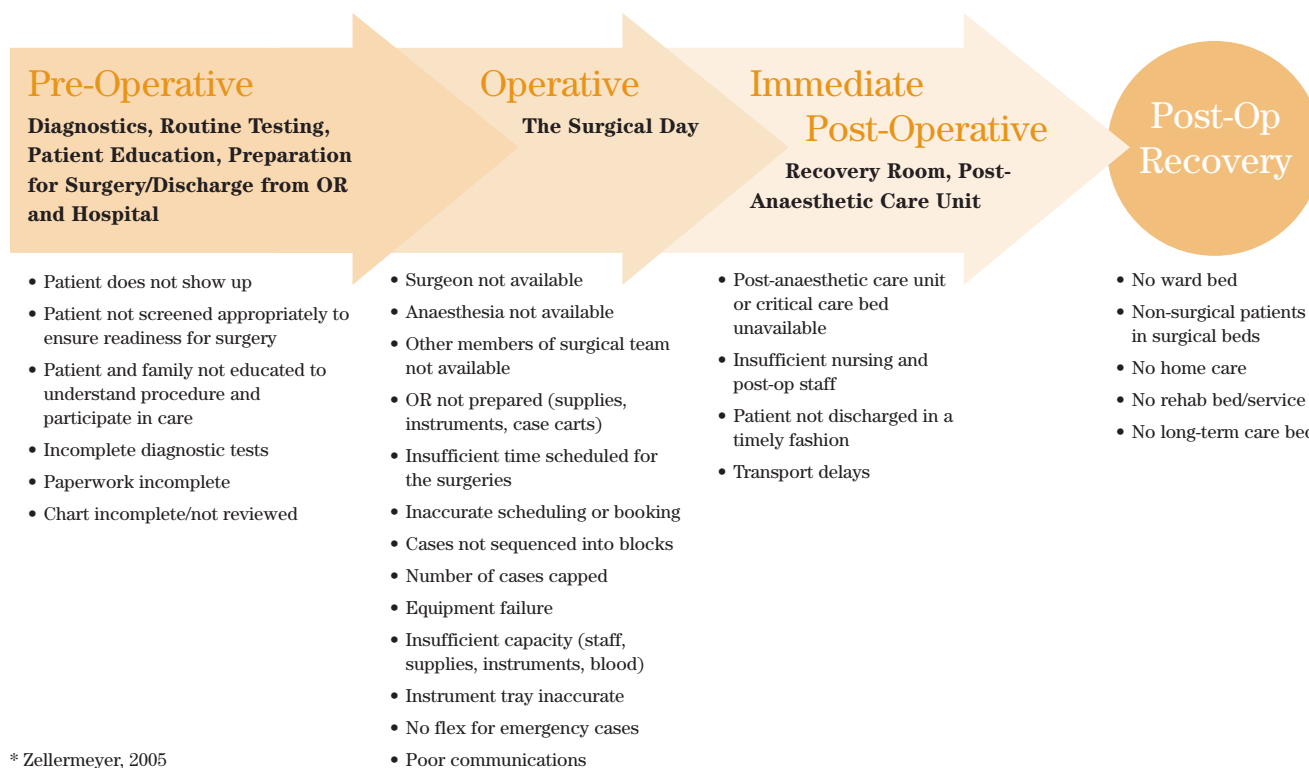
The information system is part of a broader Surgical Efficiency Program that will collect performance indicators, generating site-specific, peer group, LHIN and provincial reports on surgical activity and performance, and developing standard provincial performance benchmarks to assess all surgical programs in Ontario.

Data elements already being collected include surgery start time accuracy and hours scheduled for surgery versus hours actually used. Turnover time between surgeries, operating room downtime, length of surgery, surgical drug costs and patient outcomes are being considered as well.

Like with the Critical Care Strategy, with this program, Ontario is moving into a position of national leadership.

System development and data collection began with a small group of hospitals in 2006. The province-wide rollout will occur in 2007.

Figure 1: Potential Blockages Along the Peri-Operative Stage*



Results: Expanded Access to Primary Care through the Establishment of 150 Family Health Teams

Research and experience informs us that countries with strong primary health care systems have lower overall costs and healthier populations.

To improve access to primary health care services that focus on health promotion and help patients prevent or better manage chronic disease, the government is building on its priority of primary care renewal through the establishment of 150 Family Health Teams.

What follows is a description of five Family Health Teams and the positive impact that these teams are having on patient access to services.

A High-Level Profile of Five Family Health Teams

Brockville – The VON Brockville Community Family Health Team is expanding access to primary health care by launching a mobile primary health care service. The mobile service will allow people in rural, under-served communities to access services without having to travel long distances. The mobile service is a 29-foot recreation vehicle that has been converted with all the amenities to provide primary health care services, including comprehensive care, counseling, and health education. It will visit 16 sites in the Brockville area and will be staffed by a nurse practitioner who will deliver up to 3,500 client visits per year.

Hamilton – The Hamilton Network Family Health Team consists of nine Family Health Teams, each providing better access to comprehensive primary health care services in their communities and across Hamilton. The network currently consists of 112 physicians, seven registered dietitians, 19 mental health workers, and one addictions councillor, caring for more than 221,600 enrolled patients altogether. The network is currently aggressively recruiting for nurse practitioners, registered nurses, additional mental health workers, pharmacists, a chiroprapist, and an educator.

Hasting and Prince Edward Counties – The Prince Edward Family Health Team consists of 20 doctors, three nurse practitioners and one social worker.

Currently, the Family Health Team is aggressively recruiting for a dietician, a pharmacist and registered nurses. The team has formed a partnership with the Hastings-Prince Edward Community Access Centre to coordinate care for patients who need to use health care resources outside the Family Health Team. To quote Dr. Cliff Rice, co-Lead Physician, Prince Edward Family Health Team, “local residents will see that the Family Health Team delivery will lead to more comprehensive and accessible care.”

Kingston – The Queen’s Family Health Team is open for business and is providing better health care services to Kingston residents through a group of 18 physicians, five registered nurses, four registered practical nurses, two nurse practitioners, one social worker and one psychiatrist. Currently, the Family Health Team is aggressively recruiting additional nurse practitioners, a dietician, a social worker and a pharmacist to provide expanded services to its patients. In addition, the Queen’s Family Health Team also provides training for family practice residents and international medical graduates through its affiliation with Queen’s University.

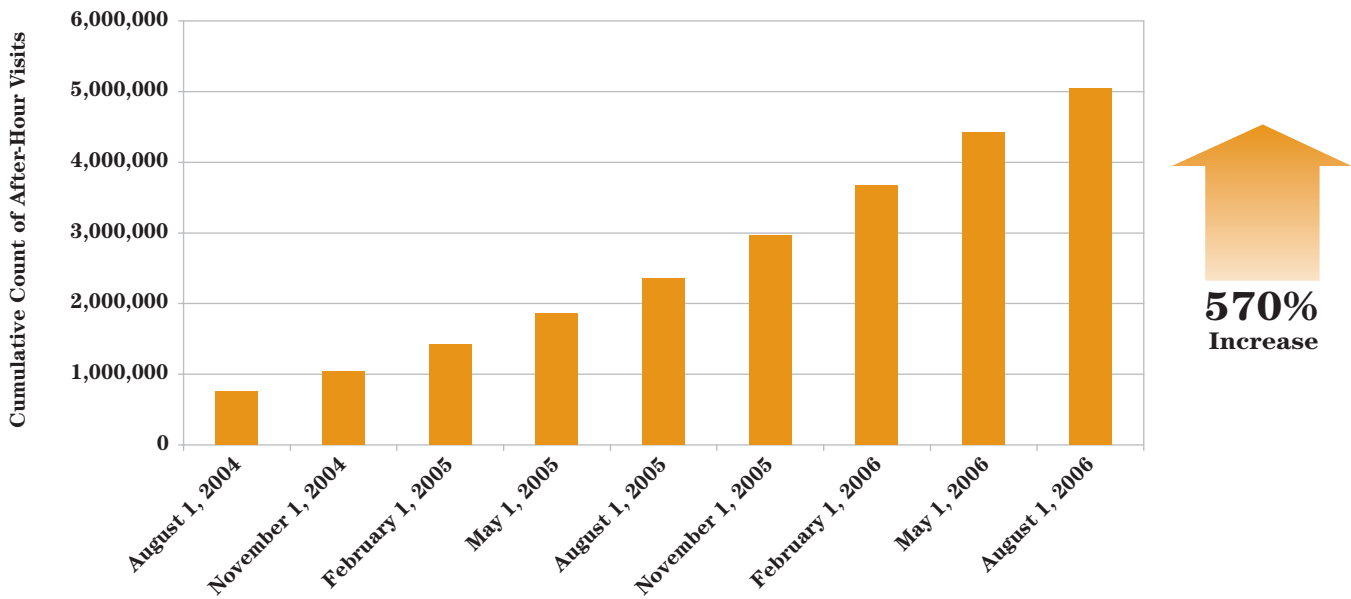
North Bay – The Blue Sky Family Health Team will be open 363 days a year. It will provide chronic disease management services to 22,800 patients, including those that require specialized care for diabetes, obesity, cholesterol management and lung disease. The team currently features a group of 16 doctors, one dietician, one social worker, one registered nurse and one nurse practitioner. Dr. Wendy Graham, Lead Physician for the Team, recently made a statement that concretely demonstrates the value of the team: “Over the last three years, working together in a team has made it possible for our practice to take on 3,000 more patients without adding any additional providers. This reflects our team’s commitment to the community and to improving our health care system.”

The value of Family Health Teams to communities was well stated by Roger Anderson, President of the Association of Municipalities of Ontario: “Moving forward with Family Health Teams is an important step toward improving access to primary health care for Ontarians in their communities. We are encouraged by the overwhelming interest from doctors and practitioners across the province in forming collaborative community primary health care teams.”

Results: After-Hour Visits Increased by 4.2 Million

Another example of how the right incentives can begin to change traditional service patterns, thereby providing Ontarians with greater access to care, is the increase in the number of after-hour visits. There were 750,000 after-hour visits in August 2004. As of August 1, 2006, the number of after-hour visits had risen to 5 million (see Figure 2).

Figure 2 – After-Hour Visits for Primary Care Models

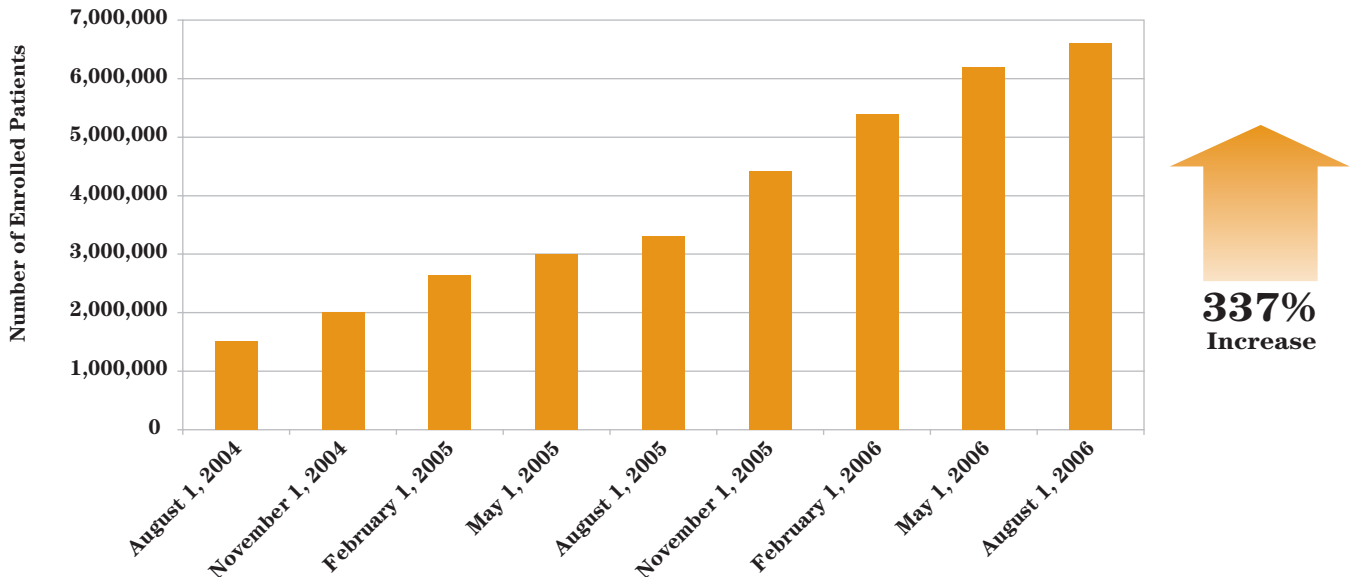


Results: 6.6 Million Ontarians Now Enrolled in Primary Care Models

The 2004 ministry-Ontario Medical Association (OMA) agreement included significant investments to support improved access to primary care models and Family Health Teams. Since this agreement was struck, its impact on patient access to services has been significant.

In August 2004, 1.5 million Ontarians were enrolled in primary care models. By August 1, 2006, enrolment had increased to 6.6 million Ontarians (see Figure 3).

Figure 3 – Number of Patients Enrolled in a Primary Health Care Model



Results: Improved Access to Physicians, Nurses and Others – 1.39 Million Ontarians Now Enrolled in Family Health Teams

Family Health Teams are the next evolution in primary health care services and are changing the way health care is delivered across the province.

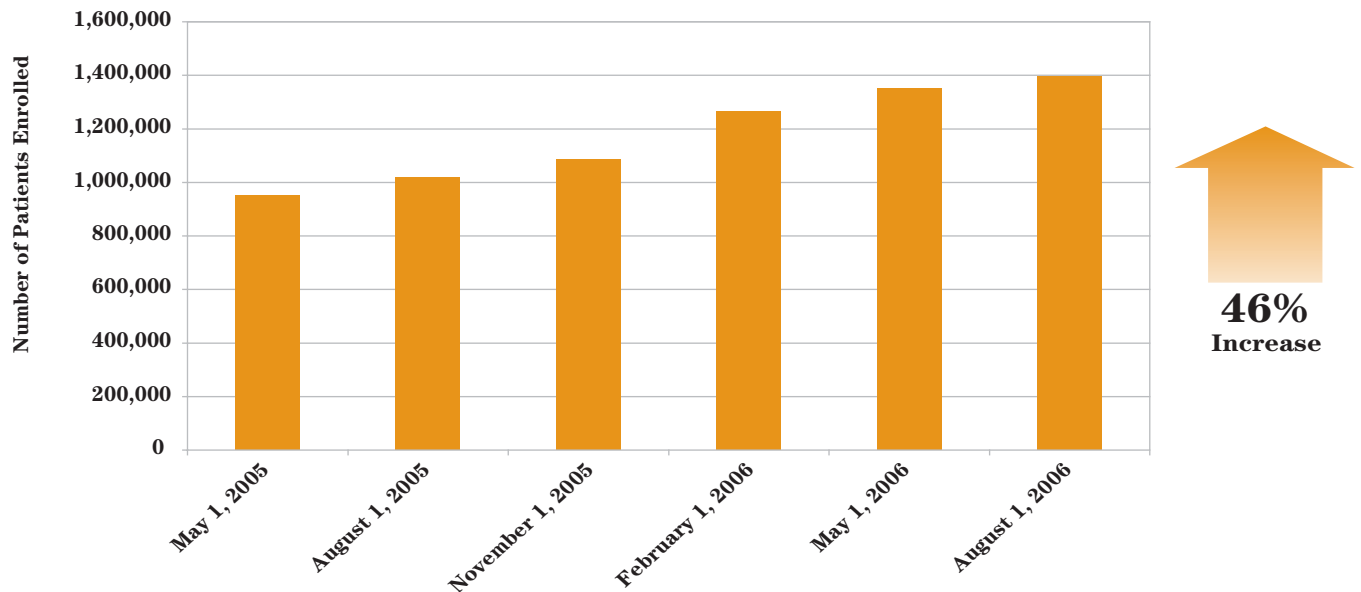
Designed around the needs of communities, they include physicians working with registered nurses, nurse practitioners, dietitians, pharmacists, physician specialists, mental health workers and others.

Family Health Teams offer many advantages to health care providers and the patients they serve. Dr. Val Rachlis, President of the Ontario College of Family Physicians,

summarized these as follows: “With the advent of family health groups and networks, we began to see the emergence of family physicians working together to provide comprehensive care. Now with the Family Health Teams, we have moved to an exciting new level of care, bringing together a whole host of health care providers. This enhanced approach to primary care will result in better care to patients, better care for communities and a more balanced lifestyle for all providers of care.”

In April 2005, during the first wave of government announcements related to Family Health Teams, 950,000 patients were enrolled in these teams. By August 1, 2006, enrolment had increased to 1.39 million patients (see Figure 4). Patient enrolment in Family Health Teams continues to grow.

Figure 4 – Number of Patients Enrolled in a Family Health Team



Results: 419,000 Previously Unattached Patients Enrolled in Primary Care Models and 90,000 Enrolled in Family Health Teams

As of August 2004, 69,000 previously unattached patients were enrolled in primary care models. By the end of July 2006, 419,000 unattached patients were enrolled, an increase of 507 per cent (see Figure 5).

As of July 2006, a total of 90,000 previously unattached patients were enrolled in Family Health Teams (see Figure 6). The ministry and the OMA estimate that today there would have been approximately 1.4 million unattached patients if the parties in the 2004 agreement between the ministry and the OMA had not included incentives to address this issue.

A joint ministry-OMA action group has been formed to develop further recommendations on how to continue to reduce the number of unattached patients.

Figure 5 – Number of Unattached Patients in Primary Care Models

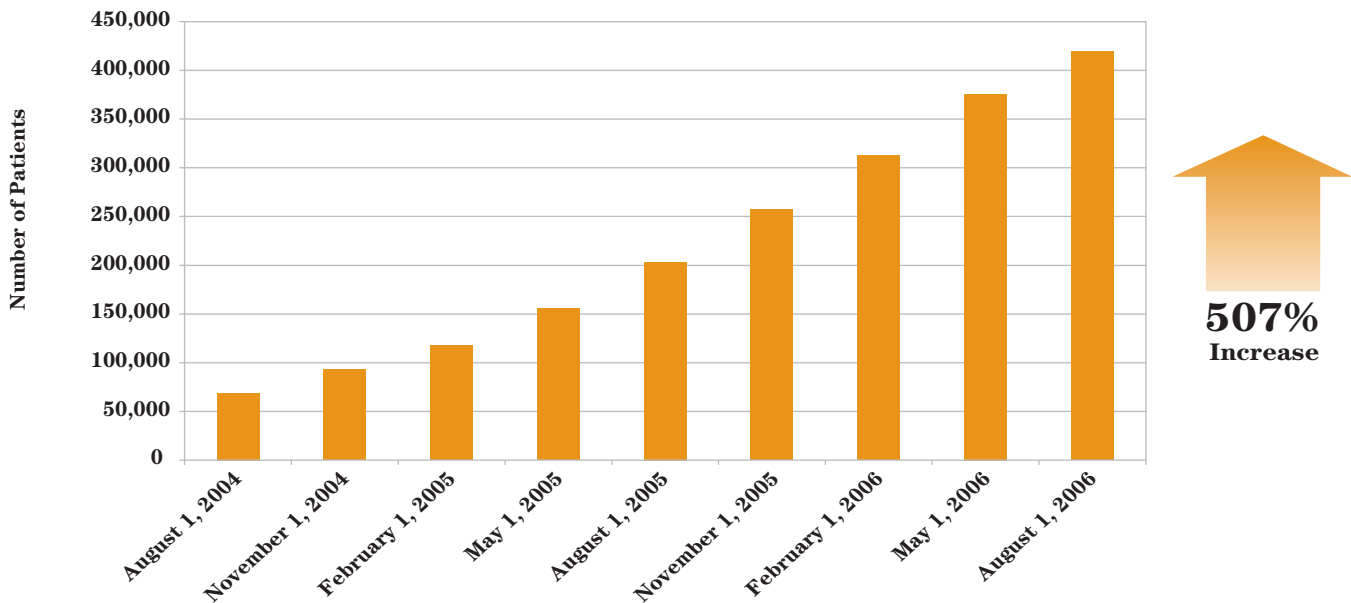
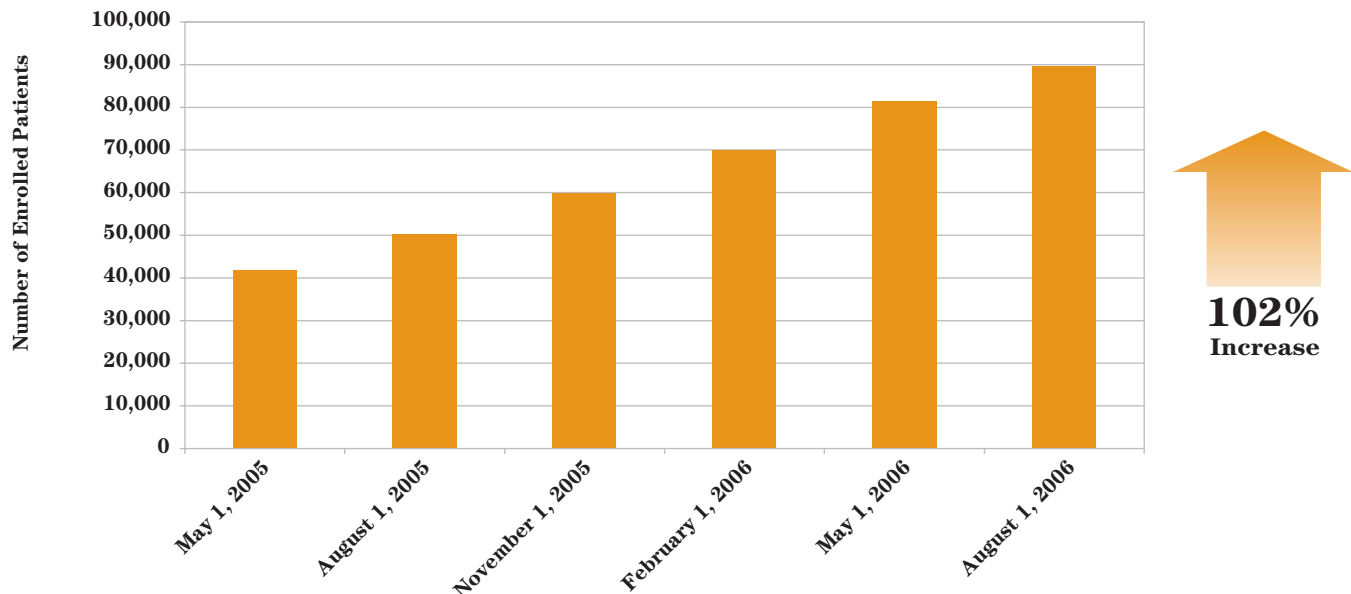


Figure 6 – Number of Unattached Patients Enrolled in a Family Health Team



Results: 6,423 Physicians Now Participating in Primary Care Models

As of August 2004, 3,081 physicians were participating in primary care models. By the end of July 2006, an additional 3,342 physicians were participating in primary care models (see Figure 7). This is a very promising sign that our primary care renewal initiatives are working.

As of September 2006, 59 Family Health Teams were operational and 88 had business plans approved. These plans include the approval to immediately hire 737 allied health professionals. To date, Family Health Teams have hired 195 allied health professionals.

Support for Family Health Teams

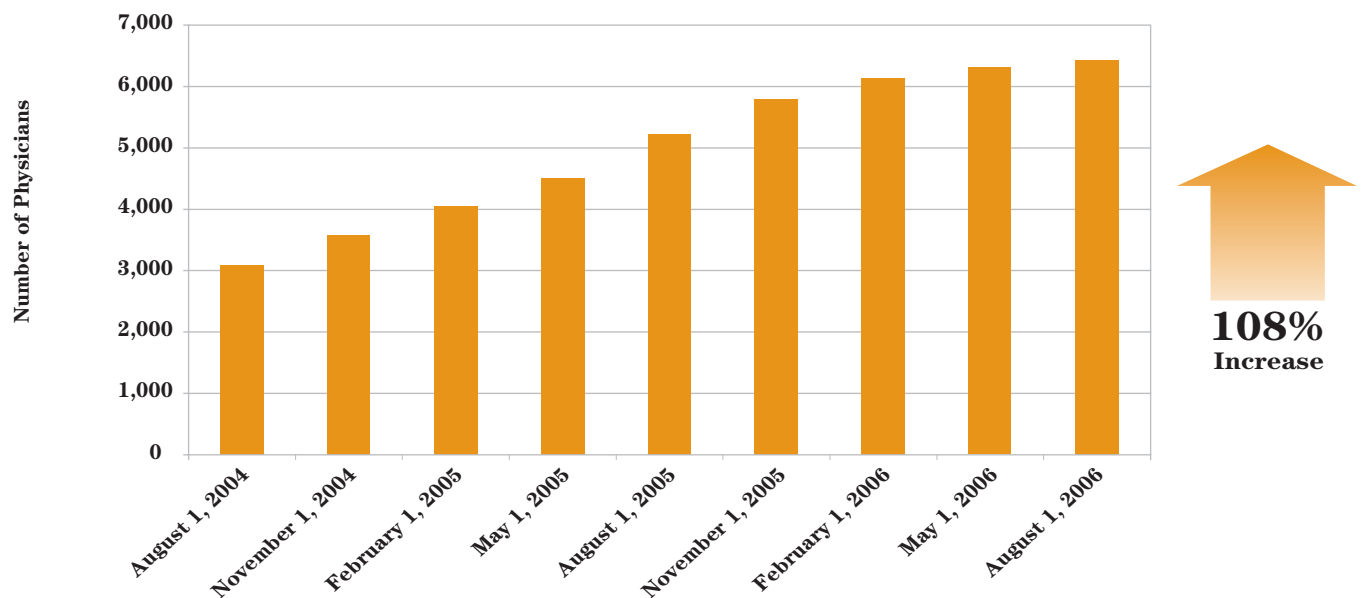
Support for the multi-disciplinary nature of Family Health Teams continues to grow. “As the representative of Ontario’s new physicians, we are very encouraged that the government is moving forward on this

initiative,” said Dr. Danielle Martin, President, Professional Association of Internes and Residents of Ontario (PAIRO). “New physicians are looking to practice in improved models of health care delivery, including inter-professional teams. PAIRO believes that Family Health Teams can be an important next step in providing better health care, and access to health care, for all Ontarians.”

Likewise, Teresa Agnew, Chair, Nurse Practitioners Association of Ontario said, “Nurse practitioners look forward to participating in a model that helps to achieve the goals of primary health care reform by providing inter-disciplinary care and improving access to quality care.”

“One of the most important features of Family Health Teams is the focus on education and prevention,” said the Heart and Stroke Foundation of Ontario’s CEO, Rocco Rossi. “A multi-disciplinary approach such as this one makes it possible for health care providers to spend valuable time educating patients to help keep them healthy.”

Figure 7 – Number of Physicians Participating in Primary Care Models



Conclusion

In closing, our achievements this year have been due to the active participation and leadership shown by thousands of individuals working within Ontario's health care system to support change, and a government with the political will to promote and support system change.

We are now moving from a place where no one or only a few were accountable for a particular set of results, to a place where a wide range of health system partners are accountable for achieving a broad range of results.

The combined effect of our strategies, as well as the emphasis that is being placed on the importance of quality information and information management, at a system level, are contributing to instilling a new culture of accountability in Ontario focused on access and quality improvement in health care.

The Ontario Health Quality Council wrote in its first report: "We believe the Health Results Team has created momentum in new directions."

It flagged four things that needed to happen to keep the momentum going:

1. Stay focused on getting good results for each part of our system.
2. Oversee the changes so that they are done effectively and smoothly.
3. Continue to deliver quality health care while the change is underway.
4. Track and measure, as well as report our progress.

As highlighted in this report, we have delivered on all four of these objectives.

