THE WAIT TIME STRATEGY
REPORT ON PHASE I AND
A PREVIEW OF PHASE II
March 29, 2005

INTRODUCTION

Reducing wait times for key health services is one of the Ontario government's top priorities and an important part of its strategy to transform the province's health system. Wait times are a symptom of a broader problem: managing how patients get access to care.

On November 17, 2004, the Minister of Health and Long-Term Care, George Smitherman, officially announced Ontario's Wait Time Strategy. The Strategy is designed to reduce wait times by improving access to healthcare services for adult Ontarians in five areas by December 2006: cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements, and MRI and CT scans.

This is the second in a series of progress reports on the Wait Time Strategy.[1] It presents:

- The highlights and major accomplishments of Phase I of the Strategy; and
- Key initiatives launched in Phase I that will play a prominent role in Phase II.

Please see Appendix A of this document for a summary of Phases I-IV of the Strategy.

HIGHLIGHTS AND MAJOR ACCOMPLISHMENTS OF PHASE I

Phase I of the Strategy officially began with the Minister's announcement in November 2004, and ends on March 31, 2005. The Minister allocated $107 million to support Phase I. The highlights and major accomplishments thus far have established a permanent foundation for improved access and lower wait times in Ontario.

Increased System Capacity Through More Funded Volumes

In Phase I, the Minister allocated $35 million to Ontario hospitals to increase the number of procedures in the five selected areas by March 31, 2005. The major purpose of this investment was to begin immediately to reduce the backlog of patients waiting for these services. A unique feature of this investment is that a price per case was set for incremental surgical volumes, after consultations with hospitals through the Joint Policy and Planning Committee. Since hospitals are appropriately and fairly compensated for the full cost of incremental cases, this additional funding should not negatively affect hospitals' other activities.

[1] The *Wait Time Strategy*, December 8, 2004 (English and French long and short versions) is available on: www.health.gov.on.ca/transformation/wait_times/wait_mn.html.

- $10 million was provided to 20 hospitals to perform 1,700 additional cancer surgeries by March 31, 2005. Cancer Care Ontario provided advice to the Ministry on this allocation.
- $4 million was provided to seven hospitals to offset the cost of more complex cardiac valve surgeries in 2004/2005.
- $1.5 million was provided to 27 hospitals to perform 2,000 additional cataract cases by March 31, 2005. A price per case of $750 was determined to be appropriate.
- $12.8 million was provided to 35 hospitals to perform 1,680 additional hip and knee total joint replacements by March 31, 2005. An additional $1.7 million was allocated to community care access centres to provide home-based rehabilitation to Ontarians returning home after these surgeries.
- $5 million was provided to 29 hospitals to provide 13,000 additional MRI hours by March 31, 2005. This means that 19,000 more MRI scans can be performed using existing MRIs. The MRI and CT Expert Panel provided advice to the Ministry on this allocation.

Increased Efficiency Through Newer Equipment

Older, lower quality MRI and CT scanners can be slower, less efficient and produce poorer images that may need to be redone, resulting in delays in diagnosis and treatment. In January 2004, the Ministry allocated $50 million to replace aging MRI and CT scanners, and diagnostic cardiac imaging equipment. In addition, the Ministry targeted $24.8 million from the Diagnostic Medical Equipment Fund for new equipment. A total of 33 hospitals were able to replace 7 MRIs, 27 CTs and 5 diagnostic cardiac catheterization imaging units. About 119,900 more exams will be conducted because of this newer more efficient equipment.

Bulk purchasing was used to reduce administrative costs, achieve greater standardization, and negotiate the best price and service package. This process has resulted in a 25% savings off the list price for the purchase of the MRI and CTs.

Increased Efficiency Through Innovation and Education

In December 2004, all hospitals in Ontario were invited to submit proposals for innovation and education funding. These funds were designed to:

- Help develop and implement evidence-based quality improvement activities to promote surgical and operational efficiencies, improve access and reduce wait times; and
- Support education activities targeted at improving quality processes.

In February 2005, nine teaching hospitals, 20 community hospitals and three provincial organizations received $5.8 million for initiatives to educate staff about efficient practices and support hospital innovations.

Clear Hospital Accountabilities for Access and Wait Times Outlined in Purchase Service Agreements

Phase I has significantly altered the fact that no one in Ontario has been accountable for making sure that patients have appropriate access to services. Hospitals have not been accountable for measuring or monitoring wait times in their organizations, nor for making sure that patients with the same clinical needs are treated in a similar timeframe.

Purchase service agreements – signed by the Ministry and hospitals – clearly state a series of conditions that hospitals must meet for funding of additional procedures under the Strategy. If hospitals do not meet these conditions, funding will be withdrawn. The agreements hold hospital Boards accountable for delivering the increased number of funded procedures in Phase I, as well as maintaining their base volumes. As a condition of funding, hospitals must also submit to the Ministry select information on wait times and quality, as well as manage the waits for all the procedures (base and additional funded cases). Hospital boards will be expected to use this information to govern their organization's access management strategy, as well as assess their hospital's performance compared to other hospitals in the province. Hospital CEOs will be expected to use this information to manage access, waits and patient flow within their organisations. Surgeons will be expected to provide the necessary patient information to hospitals so that surgeries can be booked, waiting times tracked, and potential problems addressed.

An audit of Phase I activity will be completed in April. Preliminary reports indicate that additional volume targets will be achieved in the vast majority of facilities.

Ongoing Expert Advice and Local Input

Expert advice and local input have been the hallmark of Phase I. Expert panels were struck and continue to meet in each of the five service areas. These panels are advising the Ministry on the criteria for investments, wait list management issues, methods for prioritizing patients, and areas for quality improvements. Three other groups have also provided focused advice on the Strategy: the Ontario Hospital Association Reference Group, the Information Management Expert Panel, and the Surgical Process Analysis and Improvement Expert Panel.

Dr. Alan Hudson, Advisor to the government on the Strategy, has actively sought local input. Regional site visits have been conducted to provide information, obtain advice and discuss solutions. Issues that have consistently been raised during these consultations include:

- The definition of wait must be clearly defined and commonly understood by all stakeholders.
- The ability to achieve incremental volumes is a concern in the face of operating deficits, reductions in operating rooms, high occupancy rates, hospital staff cuts and limited numbers of medical staff.

- The impact of the Strategy on other activities will be negative if hospital Boards give a lower priority to all other areas.
- Equity of access is a particular concern in northern and smaller communities. A patient's right to choose his or her provider is particularly limited in the North unless government is prepared to pay travel costs.
- Solutions must be sensitive to local needs especially in northern and smaller communities that have limited numbers of healthcare providers and are concerned about meeting the healthcare needs of their citizens. Innovative strategies to improve access are needed to attract and keep physicians and specialists, especially in areas such as North West Ontario.
- Information technology is vital to support the Strategy and improve access.
- Additional criteria should be used to allocate incremental volumes in the future. Suggestions include: i) local access to services within a defined geographic area is improved; ii) a continuum of services to support the five areas is demonstrated (e.g., follow up care); and iii) a regional response is used to improve access using innovative approaches, excess capacity and human resources available throughout the region.

Local input has highlighted areas that need to be addressed if the Strategy is to proceed successfully. For example, it appears that some Board trustees do not have a clear understanding of their authority as governors, in general, and of their responsibilities for ensuring access and managing wait times within their hospitals. There also appears to be a lack of understanding that hospitals were individually surveyed, and voluntarily identified the number of additional cases they were willing to accept. Concerns about meeting agreed-upon targets suggest a lack of internal consultation on this issue. Finally, many hospitals appear to be focusing on individual solutions to access and wait time issues, rather than actively collaborating with other Boards, managers and providers within the Local Health Integration Network (LHIN).

Wait Time Communications and the Public Website

A public website on the Strategy was launched in December 2004. Currently, it includes education information on wait time issues, an update on the Strategy, information on understanding wait times, myths about wait times, frequently asked questions, and questions to ask your doctor. Provincial and regional wait time data will be available on the site in April 2005 with a breakdown by hospitals in the summer of 2005. (www.health.gov.on.ca/transformation/wait_times/wait_mn.html)

KEY INITIATIVES LAUNCHED IN PHASE I THAT WILL PLAY A PROMINENT ROLE IN PHASE II

A number of key initiatives launched in Phase I will play a prominent role from April 1 2005 to March 31, 2006.

Analysis of Access Conducted by The Institute for Clinical Evaluative Sciences

The Institute for Clinical Evaluative Sciences (ICES) is an independent, non-profit organization based in Ontario that undertakes research on a wide range of issues facing the healthcare system. In the fall of 2004, the Strategy commissioned ICES to review the current state of knowledge about access to the five selected services. ICES is completing its in-depth analysis of volumes, rates and wait times for these five services in Ontario. Based on this information and the experiences of other jurisdictions, ICES will recommend ways to improve access to these services. In addition, it will provide advice on funding principles and measures that are needed to improve the management of waiting times and, thereby, improve access in Ontario's healthcare system. The ICES report will be released in early April 2005.

Information Management to Support the Wait Time Strategy

The Wait Time Information Management Expert Panel has focused on developing a strategy that includes:

- ***Devising a framework and the requirements for a provincial wait time information system*** that will be used to collect and report on wait times for the five service areas. The framework will address the functional and data requirements of the wait time information system that all hospitals will be expected to meet, the definitions for wait time indicators, and an implementation plan. The information will be used to *manage* wait times at the hospital level, as well as *monitor access* to services by hospital, and at the LHIN and provincial levels. Initially, standardized data will be collected for the five services. Other services will be incorporated into the wait time information system in the future.
- ***Developing consistent tools that prioritize patients by the urgency of their condition*** in each of the five service areas.
- ***Making publicly available, on the provincial website, standardized, timely and reliable wait time information*** for the five service areas, broken down by individual hospital. This will provide the public and healthcare providers with information to make rational decisions about care.

Since January 2005, the Wait Time Information Management Strategy team has reviewed and assessed the current state of wait time information management and best practices in Canada and other jurisdictions; consulted with key stakeholders in hospitals, healthcare, information management and research; and liaised with the leads of the five expert service panels to identify the information that will be collected and reported, and the processes and technology needed to prioritize patients in each area.

The Information Management Strategy will be submitted to Dr. Alan Hudson by March 31, 2005. The final recommendations will be available in April. The focus will then turn to the final business design, data model and IT solutions for implementation, starting in late 2005.

In April 2005, ICES will make available wait time information by LHIN. By the end of the summer 2005, the wait time data submitted manually by hospitals will be available on the provincial website. By December 2006, data submitted electronically to the wait time information system will be publicly reported on the website.

Increased Focus on Surgical Efficiency and Standardization

The Surgical Process Analysis and Improvement Expert Panel has focused on identifying successful innovations in clinical practice and patient management to improve surgical efficiencies in hospitals. Improvements include pre-operative assessment, elective and emergency admissions, bed management, patient flow and discharge planning. The Panel, in partnership with the Ontario Hospital Association, held a successful one-day conference on March 7th on issues associated with surgical efficiencies. The Panel's recommendations – to be released in the summer of 2005 – will focus on standardizing surgical processes and making them more efficient. It is anticipated that up to a 20% improvement will be achieved in surgical efficiencies. These proposed improvements will be integrated into the Strategy.

A Provincial Plan for MRI and CT

The MRI and CT Expert Panel is in the process of completing its deliberations, and will submit its interim report to the Minister in April 2005. The report presents a plan that provides Ontarians with equitable access to MRIs and CTs in a timely and appropriate manner. Delays in MRI and CT scanning can result in needless stress for individuals who do not have a disease. More importantly, delays in MRI and CT scanning can lead to delays in timely treatment for those who do have a life-threatening illness. The Panel's report will highlight the need for greater standardization, improved efficiencies and clear accountabilities.

A Critical Care Plan for Ontario

In 2004, the Ministry established the Ontario Critical Care Steering Committee to identify improvements in the quality and efficiency of Ontario's critical care system. An effective system of critical care is a necessary support to the Wait Time Strategy. If critical care is not available, surgeries can be delayed or cancelled, and wait times for surgeries increased. The Steering Committee – made up of a broad range of experts from the critical care field – developed a comprehensive list of innovative recommendations to improve access to safe critical care by better organising services, providing critical care supports, and targeting efficiencies through better management. In March 2005, the Committee submitted its report to the Minister for his review.

Audit of Compliance With Purchase Service Agreements, and Funding Conditions That Include More Sophisticated Measures of Quality and Accountability

Consistent with Phase I, additional funding will be allocated to hospitals in Phase II to increase the number of procedures and reduce backlogs in the five selected areas. A

stronger link will be made between increased capacity and improved efficiencies, cost effectiveness and quality of care. Conditions for 2005/06 funding will include more sophisticated indicators of efficiency, quality and access, and more stringent requirements for accountability.

Processes are well underway to conduct regular audits of compliance with the purchase-service agreements, and to ensure that accountabilities are being met. The next full audit will be conducted in the summer of 2005. The audit will assess surgical wait time activity for the first half of fiscal 2005/06, and further refine efficiency, quality and access indicators, and requirements for accountability in the second half of fiscal 2005/06.

IN CONCLUSION

The Wait Time Strategy is one of Ontario's top priorities in a broader agenda to transform Ontario's health system that includes creating Family Health Teams for primary care, building information systems, developing Local Health Integration Networks, and encouraging greater community involvement in planning.

The Strategy has achieved a number of major accomplishments in Phase I, and has laid a solid foundation for continued transformation in Phase II. In the summer of 2005, planning will begin for Phases III and IV.

Thanks are extended to the thousands of dedicated individuals across the province who are helping to implement the Wait Time Strategy and improve access to healthcare for Ontarians. Anecdotal evidence suggests that access to the five services has improved since the Strategy began. Wait time information will help us determine if this is indeed the case.

We are requesting that this report be circulated as broadly as possible to Board members, medical and hospital staff, and other stakeholders.

We look forward to continuing our work with you on Phase II of the Strategy (April 1, 2005-March 31, 2006).

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APPENDIX A: THE WAIT TIME STRATEGY – PHASES I-IV

Phase I **Labour Day 2004 – March 31, 2005**	• Initiate and explain the Wait Time Strategy. • Initiate the purchase service strategy, and gain momentum and buy-in from the field. • Provide initial funding for additional volumes in targeted areas. • Provide conditions of funding that demand accountability of hospitals for their wait times and the delivery of agreed-upon volumes. • Increase efficiency with newer equipment (MRIs, CTs, diagnostic cardiac catheterization imaging units). • Obtain feedback about the distribution of cases to hospitals, pricing, ability to meet conditions, and ability to accelerate from Phase I into Phase II.
Phase II **April 1 2005 – March 31, 2006**	• Continue to focus on efficiency and standardization in hospitals. • Increase the sophistication of funding conditions to include quality indicators. • Continue targeted volumes to address backlogs. • Continue fostering a competitive environment where volumes are allocated to hospitals that provide efficient, cost effective, quality care. • Develop prioritization and outcome tools and benchmarks. • Develop information systems and collect wait time data. • By the end of Phase II, develop models that relate benchmarks, volumes and dollars to guide decision making. • Develop Ontario policies for diagnostic imaging and critical care. • Reinforce accountabilities.
Phase III **April 1, 2006 – March 31, 2007**	• Continue targeted volumes to clear backlogs to start reducing wait times. Modeling from the end of Phase II will support more informed decisions on the volumes to be allocated. • Continue developing information systems, collect wait time data and establish registries for the five service areas.
Phase IV **April 1 2007…**	• Use models to forecast demand, supply and capacity for the five service areas, provincially and by geography. • Fund the systems to "right size" and support activities.