

"WAIT" WATCHERS...

WEIGHING IN ON WAIT TIME INITIATIVES ACROSS ACAHO MEMBERS



Image: budgetstockphoto.com

MARCH 2005



Association of Canadian Academic Healthcare Organizations
Association Canadienne des Institutions de Santé Universitaires



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WHO WE ARE...

The Association of Canadian Academic Healthcare Organizations (ACAHO) is the national voice of Teaching Hospitals, and Regional Health Authorities who have overall responsibility for the academic mission (i.e., service provision, education & training, and research & innovation).

The Association is a member-based association that represents more than 40 teaching centres - which are a combination of teaching hospitals, and Regional Health Authorities who have jurisdictional responsibilities for teaching institutions. Members range from single hospital organizations to multi-site, multi-dimensional regional facilities.

The distinguishing characteristic of the members of ACAHO is that they have overall responsibility for the following activities:

- Providing Canadians with timely access to quality specialized health care services (and some primary care services).
- They represent all of the principal teaching sites for Canada's health care professionals. This includes all sixteen faculties of medicine (physicians), and other faculties of health (nursing, pharmacy and dentistry), and many colleges with technical and professionals in health including physiotherapy, rehabilitation therapists, laboratory technicians, respiratory therapists, speech therapists and social workers.
- They provide the large majority of infrastructure to support and conduct health research, medical discovery, knowledge creation and innovation.

OUR MISSION...

The mission of ACAHO is to provide effective national leadership, advocacy and policy representation in the three separate, but related, areas of:

- The funding, organization, management and delivery of highly specialized tertiary and quaternary, as well as primary health care services.
- The education and training of the next generation of Canada's health care professionals, and
- Providing the necessary infrastructure to support and conduct basic and applied health research, medical discovery and innovation.



Association of Canadian Academic Healthcare Organizations
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**“WAIT” WATCHERS:
WEIGHING IN ON WAIT TIME INITIATIVES ACROSS ACAHO MEMBERS**

An ACAHO Member Survey
March 2005

PREFACE

If there is one defining feature that underpins our collective confidence in the health care system, it is Canadians' access to a range of quality health services on a timely basis. Public opinion surveys continue to reinforce the notion that the most important barometer of the public's confidence in the health system is linked to their assessment of timely access to care.

Understanding this relationship has produced a series of agreements between the federal, provincial, and territorial governments so that Canadians can have a more complete understanding about how the system is performing.

At the same time, ensuring that the system remains flexible and responsive to the needs of Canadians at the local level presents providers and system managers with a significant array of policy challenges.

It is in this context, that the Association of Canadian Academic Healthcare Organizations (ACAHO) has prepared a summary report based on a survey of its members in the area of wait time management strategies. To be clear, the report is only a reflection of the range of activities that members of the Association have implemented - or are considering to implement - that impact on how they are approaching wait time management strategies in their jurisdictions. While provincial governments have introduced a number of complementary sector-wide initiatives to address wait times, they are beyond the purview of this report.

As the dialogue on the future of the health system will undoubtedly continue, it is our hope that this summary report will give the reader a clearer sense that Canada's Teaching Hospitals and Regional Health Authorities who have overall responsibility for the academic mission (i.e., service provision, teaching & education, and research & innovation) are taking a leadership role and are introducing a number of progressive approaches to wait time management strategies across the country.

NB: The detailed and collated surveys from all eighteen respondents can be found online at the Association's website, located at www.acao.org.

ACKNOWLEDGEMENTS

This report was prepared by Emily Gruenwoldt and Glenn Brimacombe. The Association of Canadian Academic Healthcare Organizations would like to acknowledge the following members for their participation in this report: The Vancouver Coastal Health Authority, the Provincial Health Services Authority, Capital Health Region (Edmonton), Calgary Health Region, Regina Qu'Appelle Health Region, Saskatoon Regional Health, Winnipeg Regional Health Authority, St. Joseph's Health Care (London), Hamilton Health Sciences Corporation, Toronto Rehabilitation Institute, Hospital for Sick Children, University Health Network, Kingston General Hospital, Hotel Dieu Hospital, The Ottawa Hospital, SCO Health Services, Capital District Health Authority (Halifax), and the Health Care Corporation of St. John's. Special thanks to Owen Adams and Marcel Saulnier for their review and feedback in the preparation of this report.

A MESSAGE FROM THE PRESIDENT OF ACAHO

The Association of Canadian Academic Healthcare Organizations (ACAHO) is the national voice of Teaching Hospitals and teaching centres that are part of Regional Health Authorities. Members of ACAHO are leaders of innovative and transformational organizations that serve a unique and essential role in the system: they educate the next generation of health care professionals, advance leading edge innovative practices through health research, and provide much of the specialized health care services to Canadians.

Since our arrival in Ottawa over 3 years ago, ACAHO has focused on a range of national policy issues, their challenges, and recommended courses of action in order to provide Canadians with timely access to a range of quality health services. Understanding that addressing wait times is a *means* to an end and not an end in of itself, the Association has identified a number of interlocking “policy actions” that must be addressed within a cohesive framework.

In so doing, ACAHO recognizes that the system must not only have the *capacity* to provide timely care, but also the ability to *demonstrate* to Canadians through accountable and transparent means, that effective and innovative change is underway.

Thus, when it comes to developing comparable health indicators, and appropriate benchmarks and targets, it is important to develop inclusive processes – particularly between those who provide care, the stewards of the system and the public.

We also need to understand that a critical mass of providers is required in order to deliver quality health services in a timely fashion. At the same time, the development of common indicators and clinical benchmarks will not be fully leveraged unless there are strategic investments to support our health information management capacity.

In addition to the “on the ground” investments which are required, there is a critical role for policy-relevant research initiatives such as pilot projects that include an evaluation component to inform the policy choices that we all must make.

Finally, it is incumbent that we look to continue to develop mechanisms that clarify the accountability relationships in the system, and the processes by which public policy decisions are made.

Given the role that members of ACAHO are playing in developing and implementing a variety of different wait time management strategies, we look forward to the deliberations of the Taming of the Queue II Colloquium, and how we can continue to work with governments, providers and the public to build a flexible and responsive health system for all. For more information on the activities of the Association, I would invite you to visit our website at www.achho.org.

Sincerely yours,



Joseph A. de Mora
President

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EXECUTIVE SUMMARY

CONTEXT AND PURPOSE

Since the mid- to- late 1990s, the future of health and health care in Canada has been the most important public policy issue on the minds of Canadians. Not unexpectedly, the confidence that Canadians place in their highly valued health system is closely aligned with their ability to access quality health services on a timely basis.

The purpose of the report is to take stock of member activities with respect to developing and implementing wait time strategies for publicly-funded health services. As important as they are, this report does not address provincial government wait time initiatives more generally.

To address these pressing healthy policy concerns that are pan-Canadian in nature, federal, provincial and territorial governments have agreed to a series of “Accords”, with the most recent being the September 2004 First Ministers Agreement.

While all governments have agreed to deliverables related to addressing wait times, many of the policy issues will need to be jointly identified, addressed and resolved at the local level.

It is with this in mind, that the Association of Canadian Academic Healthcare Organizations (ACAHO) has prepared this summary report. The purpose of the report is to take stock of member activities with respect to developing and implementing wait time strategies for publicly-funded health services. As important as they are, this report does not address provincial government wait time initiatives more generally.

Members of ACAHO are leaders of innovative and transformational organizations that serve a unique and essential role in the system: they educate the next generation of health care professionals, advance leading edge innovative practices through health research, and provide much of the specialized health care services to Canadians.

This report identifies a number of pockets of excellence and innovation across the country that are having a positive impact on the order of patients waiting for care and treatment, and the speed at which they move through the system.

Recognizing the concerns that Canadians are expressing with regard to the length of time they are waiting for health services, this report identifies a number of pockets of excellence and innovation across the country that are having a positive impact on the order of patients waiting for care and treatment, and the *speed* at which they move through the system.

This report is structured around six inter-locking themes: First, this survey considers how ACAHO member Teaching Hospitals and Regional Health Authorities are *building and managing capacity*; The second theme looks at *health indicators* or standard measures of wait times for given cohort of patients; *Clinical measures of urgency* to prioritize patients in the queue for surgery, diagnostic or therapeutic services are explored in the third theme; Fourth, *maximum wait time benchmarks and targets* are considered; The fifth theme examines *health information technology* infrastructure and financial investments to support the ability to measure, monitor and manage wait lists; The sixth theme identifies *stakeholder relationships* and collaborative partnerships to provide real time information for policy and funding decisions.

NB: The detailed and collated surveys from all eighteen respondents can be found online at the Association’s website, located at www.acao.org.

BUILDING AND MANAGING CAPACITY

The timeliness with which Canadians receive health services is thought to be largely influenced by overall capacity, be it within a Teaching Hospital, a Regional Health Authority, or the health system as a whole. This chapter reviews the interplay between the clinical processes that have been introduced to more effectively *manage* how patients move through the health system, and the series of targeted investments that increase *physical* capacity.

In the former, many Teaching Hospitals and Regional Health Authorities have introduced care pathways to improve flow through the health system. Care pathways often target reduced lengths of stay, which increase throughput. As well, productivity reviews were cited by respondents to ensure that existing surgical resources in operating rooms were being used effectively and efficiently.

Other common initiatives to reduce wait times and/or increase the volume of procedures/surgeries include a centralized point of entry into the system, a centralized data repository for tracking and analysis, standardized regional triage criteria, and comprehensive follow-up services.

In the latter, a series of targeted investments have resulted in increased *physical* capacity. Specifically, a number of measures were identified, including providing additional acute care and/or long term beds, investing in medical equipment, and developing new surgical suites.

HEALTH INDICATORS

Health indicators have a number of important roles to play across the health system. They are important management tools; they can be a reflection of how the system is performing; and they introduce a higher level of transparency and accountability into the system. In many ways, health indicators are the critical policy link between measurement, evaluation and assessment and management in the system.

In light of First Ministers' agreements to establish comparable indicators reporting on health status, health outcomes, and quality of services, all respondents to this survey identified indicators of access to health professionals, diagnostic services, and surgical procedures which have been implemented, and are routinely monitored in their respective Teaching Hospital or Regional Health Authority.

This report reveals that health indicators are most frequently reported publicly on national, provincial and regional levels through a variety of channels, including the Canadian Institute for Health Information's (CIHI) Health Indicators project, for example. The indicators cited by respondents cover a broad spectrum of health services, providing a measure of performance and a picture of wait times, from diagnostic imaging to surgical procedures.

CLINICAL MEASURES OF URGENCY

Clinical measures of urgency speak to the development and introduction of systematic processes that allow patients to be prioritized in a fair and equitable fashion. In a sense, these measures are an explicit reflection of one of the core values of our system—that patients will be able to access care on the basis of need.

The indicators cited by respondents cover a broad spectrum of health services, providing a measure of performance and a picture of wait times from diagnostic imaging to surgical procedures.

While the prioritization of patients has always occurred in a health system with limited resources, recently, a number of specific initiatives have been developed to improve the overall efficiency of patient throughput. Lengthy wait times, have been reduced, while a higher level of transparency and equity have been introduced which makes access to the system fairer.

While the prioritization of patients has always occurred in a health system with limited resources, recently, a number of specific initiatives have been developed to improve the overall efficiency of patient throughput. Lengthy wait times have been reduced, while a higher level of transparency and equity have been introduced which makes access to the system fairer.

Members of ACAHO identified several clinical measures of urgency which have been developed in their Teaching Hospitals or Regional Health Authorities. Whether to prioritize patients in the queue for cardiac surgery, joint replacement, or diagnostic imaging, many respondents have adopted existing evidence-based, urgency scoring tools, such as those developed by the Western Canada Wait List (WCWL) project, or the Saskatchewan Surgical Care Network. Many respondents cited implementation of the Canadian Triage and Acuity Scale within their emergency departments to prioritize patients based on acuity.

Other respondents chose to prioritize patients according to individual clinicians' judgment. One Teaching Hospital created a unique consensus-based urgency scoring system which has willingly been adopted by all surgical disciplines within the hospital.

From evidence-based referrals to intake assessments to web-based programs which match residents with available space in continuing care facilities, many prioritization measures are described in this chapter.

MAXIMUM WAIT TIME BENCHMARKS AND TARGETS

This report identifies a diverse range of procedures for which benchmarks and/or targets for timely access have been established in ACAHO member teaching hospitals and Regional Health Authorities.

As set out in the 2004 First Ministers Agreement, concrete timelines and deliverables have been established for wait time benchmarks and targets. The majority of ACAHO members who responded to this survey indicate that they have adopted/established both evidence-based targets and benchmarks, or plan to in the very near future.

With the exception of two members, all respondents indicated that benchmarks were in part or entirely established as the result of consultation with external sources. Those who created benchmarks internally relied on stakeholder consultation, extensive literature reviews and best practices.

This chapter identifies a diverse range of procedures for which benchmarks and/or targets for timely access have been established in ACAHO member Teaching Hospitals and Regional Health Authorities.

HEALTH INFORMATION TECHNOLOGY

Significant financial investments into the development of integrated electronic health records or information management systems are occurring across the country.

In order to fully leverage the potential of comparable health indicators and clinical benchmarks and targets, ongoing strategic investments are required to support our collective information management capacity. This report identifies that investments and advances in technology are giving rise to increasingly complex health information management processes in a number of ACAHO member Teaching Hospitals and Regional Health Authorities.

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When asked whether a central electronic registry was in place with urgency measures, procedure and patient information, a large majority of Teaching Hospitals and Regional Health Authorities indicated that such a registry existed or was in the process of implementation. This chapter further identifies a number of health information management tools and strategies across Association members.

STAKEHOLDER PARTNERSHIPS

In many tangible ways, members of ACAHO have developed and implemented a series of measures that serve to improve the flexibility, responsiveness, efficiency and effectiveness of the health system – with Canadians being the ultimate beneficiary. At the same time, the explicit processes that have been developed to manage wait times across the country serve to improve the transparency of the decision making process and allocation of resources, and clarifies many of the accountability relationships when it comes to accessing care.

In order to advance confidence among patients and the public, survey respondents identified a number of initiatives which engage stakeholders in wait time discussions and communicate clearly why waiting lists exist and how patients move through the queue. Many ACAHO members identified their website or the Provincial Ministry of Health website as a venue for patients to self-educate regarding waiting times and access to health services in their teaching hospital or Regional Health Authority. Public announcements including print, television, and radio advertisements were also identified as a means to communicate information as to where patients should seek urgent/emergent care and how prioritization occurs.

A variety of stakeholder partnerships were identified by respondents. Alliances have been established between ACAHO members and federal, provincial and territorial officials, as well as other health providers whose common goal is to reduce wait times and increase access to health services. Collaboration with the Western Canada Wait List Project was popular among Association members geographically located in Western Provinces. In central Canada, many respondents indicated their participation with Cancer Care Ontario, the Ontario Joint Replacement Registry, and the Cardiac Care Network in Ontario.

Wait times, be they real and/or perceived, have been growing for a number of years. While there is no one magic bullet that can address this issue, this survey identified a combination of policy initiatives that can have a positive impact on the *order* of patients waiting for care and treatment, and the *speed* at which they move through the system. In many tangible ways, members of ACAHO have developed and implemented a series of measures that serve to improve the flexibility, responsiveness, efficiency and effectiveness of the health system – with Canadians being the ultimate beneficiary. At the same time, the explicit processes that have been developed to manage wait times across the country serve to improve the transparency of the decision making process and allocation of resources, and clarifies many of the accountability relationships when it comes to accessing care.

“WAIT” WATCHERS: WEIGHING IN ON WAIT TIME INITIATIVES ACROSS ACAHO MEMBERS

CHAPTER ONE: PURPOSE AND NATIONAL POLICY CONTEXT

i. Purpose

The purpose of this report is to take stock of members of ACAHO's progress with respect to developing and implementing wait time strategies for publicly funded health services.

This report does not address provincial government wait time initiatives more generally.

The purpose of this report is to take stock of members of the Association of Canadian Academic Healthcare Organization's (ACAHO) progress with respect to developing and implementing wait time strategies for publicly funded health services.

This report does not address provincial government wait time initiatives more generally. This summary focuses exclusively on the results of a survey of Teaching Hospitals and Regional Health Authorities. The following eighteen ACAHO members completed the survey, administered in February 2005:

- *Vancouver Coastal Health Authority*
- *Provincial Health Services Authority (BC)*
- *Capital Health Region (Edmonton)*
- *Calgary Health Region*
- *Regina Qu'Appelle Health Region*
- *Saskatoon Health Region*
- *Winnipeg Regional Health Authority*
- *St. Joseph's Health Care*
- *Hamilton Health Sciences Corporation*
- *Toronto Rehabilitation Institute*
- *Hospital for Sick Children*
- *University Health Network*
- *Kingston General Hospital*
- *Hotel Dieu Hospital*
- *The Ottawa Hospital*
- *SCO Health Service (Ottawa)*
- *Capital District Health Authority (Halifax)*
- *Health Care Corporation of St. John's*

The results of this survey will be disseminated at the second Colloquium on Wait Times (“*The Taming of the Queue II*”). The Colloquium is co-sponsored by ACAHO and attended by representatives of Teaching Hospitals and Regional Health Authorities, health care providers, federal, provincial and territorial government officials, and policy researchers.

The objectives of the 2005 Colloquium are three-fold: (1) to assess progress in wait time measurement, monitoring and management strategies; (2) to share best practices across Canadian jurisdictions and internationally; and (3) to identify opportunities

and challenges in moving forward First Ministers’ wait time commitments as set out in September 2004.

At the inaugural Colloquium in 2004, over 80 participants spent two days reviewing Canadian and international initiatives and discussing next steps in order for Canada to move toward better measurement, monitoring and management of wait times.¹

NB: The detailed and collated surveys from all eighteen respondents can be found online at the Association’s website, located at www.acao.org.

ii. *National Policy Context*

*The First Ministers agreed that access to timely care across Canada was a national priority.*²

When Canada’s First Ministers met in Ottawa in September 2004, a key issue on their agenda was to re-assure Canadians that they would receive timely access to quality health services according to need.² The First Ministers agreed that access to timely care across Canada was an important national priority.

Amongst a series of health policy issues of national concern, First Ministers identified the reduction of wait times for health services. In their *Ten Year Plan to Strengthen Health Care*, five priority areas of health services were identified to achieve “meaningful reductions in wait times”: cancer treatment, cardiovascular procedures, diagnostic imaging, joint replacements and sight restoration.³

As a result, a \$5.5 billion *Wait Times Reduction Fund (WTRF)* was established by First Ministers to augment provincial and territorial investments targeted towards initiatives which are intended to “reduce the queue.” As set out in the First Ministers Agreement, this fund will be dedicated for priorities including the training and hiring of additional health professionals, clearing existing health service backlogs, building physical capacity for regional centres of excellence, expanding appropriate ambulatory and community care programs, and/or tools to manage wait times.⁴

The First Ministers furthermore agreed to: (1) collect and provide Canadians with meaningful information on their progress towards reducing wait times by establishing comparable indicators of access to health professionals, diagnostic, and treatment procedures by December 31, 2005; (2) establish through a process developed by Federal, Provincial and Territorial Ministers of Health, evidence-based benchmarks for medically acceptable wait times, starting with the five priority areas by December 31, 2005; (3) develop multi-year targets to achieve priority benchmarks by December 31, 2007; and (4) report annually to Canadians, progress in meeting multi-year wait time targets.⁵

¹ Final report of the Taming of the Queue available online at: www.acao.org.

² *A Ten Year Plan to Strengthen Health Care*. Ottawa: Health Canada. September 2004. Available at: <http://www.hc-sc.gc.ca/english/hca2003/fmm/index.html>.

³ According to details of the First Ministers’ Accord, these meaningful reductions are to be achieved by March 31, 2007.

⁴ *A Ten Year Plan to Strengthen Health Care*. Ottawa: Health Canada. September 2004. Available at: <http://www.hc-sc.gc.ca/english/hca2003/fmm/index.html>.

⁵ House of Commons Bill C-39 explicitly states that a review of the progress in implementing the 10 Year Plan to Strengthen Health Care (the 2004 First Ministers Accord) shall be undertaken, on or before March 31, 2008 and three years there-after.

While funding for the *Wait Time Reduction Fund* was confirmed in the 2005 Federal Budget, the government also provided \$110 million over five years to the Canadian Institute for Health Information (CIHI), specifically to ensure health system performance information is collected and made available to Canadians. Enhanced transparency by means of improved performance reporting is essential to demonstrate to Canadians the reforms being made to reduce waiting times. As well, \$15 million over four years was allocated to Health Canada to focus on wait times. Other than a reference to “build on and complement jurisdiction specific initiatives”⁶ it is not clear how these funds will be invested.

Separate from the wait time initiatives outlined in September 2004 by the First Ministers’, and the subsequent funding for Health Canada (aforementioned) in the 2005 Federal Budget, the Canadian Institutes for Health Research have launched a Request for Applications to fund initiatives to inform the work of provincial and territorial Deputy Ministers of Health in “meeting those commitments in the Ten-Year Plan to Strengthen Health Care related to establishing evidence-based benchmarks for medically acceptable wait times in five priority areas”.⁷

⁶ *Delivering on Commitments: The Budget Plan 2005*. Department of Finance: Government of Canada. February 2005. p. 79.

⁷ More information available at <http://www.cihr-irsc.gc.ca/e/26700.html>.

CHAPTER TWO: MANAGING AND BUILDING CAPACITY

Background

The timelines with which Canadians receive health services is thought to be largely influenced by overall capacity, be it within a Teaching Hospital, a Regional Health Authority, or the health system as a whole. For purposes of this report, capacity is defined in terms of the interplay between the clinical processes that have been introduced to more effectively *manage* how patients move through the health system (such as care pathways), and the series of targeted investments that increase *physical* capacity (e.g., new facilities, additional beds, and medical equipment).

In their report *Explaining waiting times variations for elective surgery across OECD countries*, Hurst and Siciliani suggest that there is a clear negative association between waiting times and capacity, either measured in terms of number of beds or number of practicing physicians.⁸ The authors further established that in a comparison between OECD countries with and without waiting times, low availability of acute care beds is significantly associated with the presence of wait times.

A second conclusion of this report finds that countries with increased capacity provide a higher volume of activity, thereby enhancing patient throughput.⁹ The level of activity is thought to be a function of the number of available beds, and as well as the availability of health professionals, but also by demand factors including the level of need.

Findings

From introducing care pathways to increasing operating room (OR) volumes, ACAHO members have implemented a series of measures to build capacity or increase activity in their Teaching Hospitals or Regional Health Authorities. Many respondents expressed throughout the survey that they are in the midst of, or have already implemented care pathways to improve flow through the OR.¹⁰ Care pathways in some instances target reduced length of stay (LOS),¹¹ as in the ***Vancouver Coastal Health Authority*** where they have developed and implemented regional hip and knee replacement pathways with target LOS of 4 and 3 days respectively. A review of the average length of stay compared to the expected length of stay indicated surgical specialties were meeting or exceeding expectations with two exceptions: hip and knee replacement, and hip fractures. ***Vancouver Coastal Health Authority*** is currently considering a centralized assessment of hip and knee replacement patients as well as developing and implementing a regional hip fracture pathway.

From introducing care pathways to increasing operating room volumes, ACAHO members have implemented a series of measures to build capacity or increase activity in teaching hospitals or Regional Health Authorities.

⁸ Hurst, J. and L. Siciliani. *Explaining waiting times variations for elective surgery across OECD countries*. OECD Working Papers. October 2003.

⁹ Hurst, J. and L. Siciliani. *Explaining waiting times variations for elective surgery across OECD countries*. OECD Working Papers. October 2003.

¹⁰ Vancouver Coastal Health Authority, Provincial Health Services Authority (BC), Capital Health Region (Edmonton), Calgary Health Region, Regina Qu'Appelle Health Region, Saskatoon Health Region, Winnipeg Regional Health Authority, Hamilton Health Sciences Corporation, Toronto Rehabilitation Institute, The Ottawa Hospital, Health Care Corporation of St. John's.

¹¹ Vancouver Coastal Health Authority, and Toronto Rehabilitation Institute.

The **Provincial Health Services Authority** in British Columbia is undertaking a better practice productivity review of OR surgeries within the largest hospitals of each region, on behalf of all BC Health Authorities. The intent is to ensure that existing surgical resources are being used as effectively and efficiently as possible. In Alberta, the **Calgary Health Region** has increased OR capacity by purchasing OR time in private facilities, until such time as sufficient space is constructed within the Region. **Calgary Health Region** is planning to build another thirty operating rooms within the next five years.

Meanwhile, in neighbouring **Capital Health Region (Edmonton)**, new infrastructure is in part responsible for increasing capacity. Construction of the new Alberta Heart Institute was officially launched in October 2003 and is scheduled to open in 2005/06. Continuing care waitlists in acute care and the community have been significantly reduced since February 2004, through a number of strategies including the addition of new long term care beds and designated assisted living spaces. The **Capital Health Region (Edmonton)** is also participating in a provincial pilot project funded by Alberta Health and Wellness to improve access to hip and knee replacement surgery and reduce waiting lists. Beginning in the spring of 2005, **Capital Health Region (Edmonton)** will perform 500 additional hip and knee joint replacement surgeries. It is expected that the new clinical pathway introduced through this pilot will improve the overall efficiency and effectiveness of arthroplasty care. The project will include a central intake booking system, assessment clinics and enhanced community follow-up after surgery.

Saskatchewan Health provided extra-funding in the 2004-2005 budget year to address surgical patients waiting longer than 18 months. The **Regina Qu'Appelle Health Region** is currently working on this initiative by adding additional OR time, over and above regular allocation of OR hours. The Region began developing clinical care pathways in 2001. In the following three years, the region has implemented nine care pathways, four of which are surgical pathways. National expected length of stay benchmarks were identified for each of these surgical populations. The region has been successful in reducing its average length of stay for these populations.

At the **Toronto Rehabilitation Institute**, collaboration with acute care and rehabilitation partners is expected to find result in improvements with the discharge, referral and admission processes related to transitioning patients in need of cardiac rehabilitation. Similar improvements have and continue to be implemented in **Toronto Rehabilitation Institute's** other programs.

In order to address wait times for radiation treatment in Central West Ontario, **Hamilton Health Sciences Corporation** expanded the Juravinski Cancer Centre. This investment included increasing the number of radiation treatment machines in order to increase throughput, provide more effective care and decrease wait lists and wait times to appropriate standards. A number of other innovative capacity enhancing initiatives are in place at **Hamilton Health Sciences Corporation**.

Respondents provided other supply side policies to reduce waiting times, including expanding hours of operation as at **The Hospital for Sick Children** and the

University Health Network. *Capital Health Authority* in Halifax and the *Toronto Rehabilitation Institute* have both expanded service delivery to groups where appropriate. *Capital District Health Authority (Halifax)* in particular has enhanced access to diabetes education in this fashion.

Other common initiatives to reduce wait times and / or increase the volume of procedures include a centralized data repository for tracking and analysis, standardized regional triage criteria, and comprehensive follow-up services.

Other common initiatives to reduce wait times and/or increase the volume of procedures/surgeries include a centralized point of entry into the system, a centralized data repository for tracking and analysis, standardized regional triage criteria, and comprehensive follow-up services.¹²

It is evident that a number of policies designed to build and manage capacity, and equally, to increase activity levels, are in place across ACAHO member Teaching Hospitals and Regional Health Authorities. From care pathways to investments in physical infrastructure, this chapter has highlighted a number of initiatives which increase access to health services, thereby reducing the length of time Canadians wait in queue for health services.

¹² Vancouver Coastal Health Authority, Provincial Health Services Authority (BC), Capital Health Region (Edmonton), Calgary Health Region, Regina Qu'Appelle Health Region, Saskatoon Health Region, Winnipeg Regional Health Authority, Hamilton Health Sciences Corporation, Toronto Rehabilitation Institute, The Ottawa Hospital, Health Care Corporation of St. John's.

CHAPTER THREE: HEALTH INDICATORS

Background

Health indicators have a number of important roles to play across the health system. They are important management tools; they can be a reflection of how the system is performing; and they introduce a higher level of transparency and accountability into the system. In many ways, health indicators are the critical policy link between measurement, evaluation and assessment and management in the system.

The September 2000 First Ministers Communiqué on Health directed Health Ministers to collaborate on the development of jointly agreed upon, comparable indicators reporting on health status, health outcomes and quality of service.¹³ In September 2002, all 14 jurisdictions (including the federal government), released reports on 67 equivalent indicators.¹⁴

In 2003, the First Ministers Accord on Health Care Renewal pronounced the development of additional indicators and reporting activities to focus on several specific health system programs and service areas. Jurisdictions released a second round of reports based on this expanded set of indicators in November 2004.¹⁵ It is in the spirit of these initiatives that in 2004, the First Ministers agreed to establish comparable indicators of *access* to health care professionals, diagnostic and treatment procedures, with a report to their citizens to be developed by all jurisdictions by December 31, 2005.

Findings

All respondents identified indicators of access to health professionals, diagnostic services and surgical treatment procedures which have been developed and are routinely monitored.

All respondents to this survey identified indicators of access to health professionals, diagnostic services and surgical procedures which have been developed and are routinely monitored in their respective Teaching Hospital or Regional Health Authority. Individually, ACAHO members have established a number of indicators to track access for health services such as inpatient chemotherapy,¹⁶ Computerized Tomography (CT) Scans,¹⁷ and orthopaedic surgery.¹⁸

Vancouver Coastal Health Authority has identified over thirty indicators which provide a measure of performance and an accurate picture of wait times, including wait times for residential care beds in the community, and the percentage of hip replacement patients meeting wait time targets.

¹³ *Comparable Health and Health System Performance Indicators for Canada, the Provinces and the Territories*. Canadian Institute for Health Information. November 2004.

¹⁴ A copy of the 2002 report can be found at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=pirc_e

¹⁵ A copy of the 2004 report can be found at:

http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=prtwg_2004_e

¹⁶ Vancouver Coastal Health Authority, University Health Network, Capital District Health Authority (Halifax), Health Care Corporation of St. John's.

¹⁷ Vancouver Coastal Health Authority, Winnipeg Regional Health Authority, Health Care Corporation of St. John's.

¹⁸ Vancouver Coastal Health Authority, Capital Health Region (Edmonton), Winnipeg Regional Health Authority, University Health Network, Capital District Health Authority (Halifax).

A new Surgical Patient Registry is under development in **Provincial Health Services Authority** (British Columbia) that will work in tandem with the Provincial Ministry web site which reports median wait times and numbers of patients waiting for surgery, by specialty, physician and institution.¹⁹ This new registry will be more comprehensive, populated with objective clinical assessment data to provide more active management information for physicians and health authorities to improve access to surgical care for patients.

The **Capital Health Region (Edmonton)** has several indicators of access to health services including access indicators reported nationally through CIHI Health Indicators and CIHI/Hay Group Benchmarking; access indicators reported provincially through Key Service Area quarterly reports; and access indicators reported regionally through Board and Executive Lead indicator reporting. With the new Chronic Disease Management Program, the Adult Regional Diabetes Program has developed a comprehensive evaluation framework, which includes access indicators as well.

The **Calgary Health Region** measures and monitors access to mental health services, diagnostic testing, surgery, as well as other treatments including endoscopy.

At the **Regina Qu’Appelle Health Region**, indicators have been developed to track surgical throughput (the number and the mix of cases) and the percentage of surgical cases completed within target time frames.

Hamilton Health Sciences Corporation has a performance monitor that measures access and sets targets for the Emergency Department and Neonatal ICU beds. Other examples for measuring wait times include thoraco-abdominal aortic aneurysm surgery and cardiac surgery.

The Ottawa Hospital reports tracking emergency procedures which were *not* performed within the target time frame. A number of other respondents (**Vancouver Coastal Health Authority, Regina Qu’Appelle Health Region, Hamilton Health Sciences Centre, Toronto Rehabilitation Institute, Capital District Health Authority (Halifax)**) also reported collecting data on surgical cancellations, whether initiated by patient, or as a result of emergent cases which pre-empted elective surgeries.

In the **Capital District Health Authority (Halifax)**, “responsiveness” is a major component of the corporate performance dashboard.²⁰ Indicators have been developed relating to wait times for selected services including emergency, cardiac surgery, cancer care, Magnetic Resonance Imaging (MRI), and orthopaedic surgery.

Measurement, as it occurs via the development and monitoring of indicators, is clearly a strategic priority among ACAHO Teaching Hospitals and Regional Health Authorities. Without exception, respondents provided multiple examples where

¹⁹ Please see Appendix C for more details on this Provincial initiative.

²⁰ Capital District Health Authority (Halifax) uses a dashboard of selected performance indicators to monitor how well it is doing in meeting its goals and providing quality services. For more information on the dashboard, visit: <http://www.cdha.nshealth.ca/accountability/ADashboardApproach.pdf>.

comparable indicators reporting on quality of service and access to service were routinely charted. Both indicators and subsequent reports to stakeholders (including patients) offer a meaningful “snapshot” of what is happening presently, within each Teaching Hospital and Regional Health Authority, to reduce wait times.

CHAPTER FOUR: CLINICAL MEASURES OF URGENCY

Background

Clinical measures of urgency speak to the development and introduction of systematic processes that allow patients to be prioritized in a fair and equitable fashion. In a sense, these measures are an explicit reflection of one of the core values of our system—that patients will be able to access care on the basis of need.

While the prioritization of patients has always occurred in a health system with limited resources, recently, a number of specific initiatives have been developed to improve the overall efficiency of patient throughput. Excessive wait times have been reduced, while a higher level of transparency and equity have been introduced, making access to the system fairer.

Findings

Members of ACAHO identified several clinical measures of urgency which have been developed in their Teaching Hospitals or Regional Health Authorities. Whether prioritizing patients in the queue for cardiac surgery, joint replacement, or diagnostic imaging, there are many examples where respondents have either adopted existing evidence-based urgency scoring tools (e.g. the Western Canada Wait List (WCWL) tools, Saskatchewan Surgical Care Network urgency profiles, Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) scores, etc.), or alternatively, chosen to prioritize patients according to individual clinicians’ judgment. While some waiting lists are audited regularly, for others, audits are more sporadic.

Whether prioritizing patients in the queue for cardiac surgery, joint replacement or diagnostic imaging, there are many examples where respondents have either adopted existing evidence-based urgency scoring tools, or alternatively, chosen to prioritize patients according to individual clinicians’ judgment.

As part of the Provincial Surgical Services Project, led by the British Columbia **Provincial Health Services Authority**, all Regional Health Authorities including the **Vancouver Coastal Health Authority** are developing specialty-specific prioritization tools based on tools developed by the WCWL project. Between January and December 2005, all Health Authorities, including the **Vancouver Coastal Health Authority** will pilot and evaluate reliability and validity of at least five of these tools, beginning with the hip and knee replacement tool, the cataract surgery tool and the general surgery tool. Hospitals in British Columbia are expected to have all 14 validated tools in place (as appropriate) by June 2006. Others who have elected to adopt the WCWL urgency scoring measures include the **Calgary Health Region** (Hip & Knee Surgery), **Capital Health Region (Edmonton)** (hip and knee surgery and orthopaedic surgeries) and the **Winnipeg Regional Health Authority** (child and adolescent mental health and general surgery).

Capital Health Region (Edmonton) has extended the prioritization process beyond acute care to continuing care with a new technology called PathWays. PathWays software quickly matches residents with available space in continuing care facilities to reduce waitlists.

The Saskatchewan Surgical Care Network (SSCN) has developed urgency profiles which translate to priority levels. Each priority level is associated with a target time frame which acts as a performance goal for the surgical care system. A patient’s priority level for surgery is determined through a “new patient assessment” process.

²¹ Physicians within the *Regina Qu’Appelle Health Region* use this tool to score patients in order to place them appropriately in the surgical queue.

At the *Toronto Rehabilitation Institute*, all patients of the Spinal Cord Rehabilitation Program referred to outpatient physiotherapy services undergo an “intake assessment.” The intake assessment prioritizes patients in the queue for treatment. It also serves to identify patient needs that can better be met through referral to another health care provider. In the Neuro Rehabilitation Program, a single-point entry system has been implemented for those with multiple sclerosis, regardless of the level of service required (e.g. single referral whether patient requires brain injury rehab, spinal cord injury rehab, or complex continuing care).

The Hospital for Sick Children is in the process of adopting a consistent priority ranking methodology based on the Saskatchewan Surgical Care Network model. The target time frames associated with each priority level have been adjusted to suit a paediatric caseload, based on consultation with internal physician stakeholders. Further, *The Hospital for Sick Children* has implemented an education program to support the development of evidence-based referral and triage guidelines, as well as a consistent priority ranking methodology across all clinical programs. The guidelines and methodology provide greater transparency with respect to prioritization and decision making, and ensure that care is provided to paediatric patients with the highest need.

WOMAC scores currently help to define the urgency of patients awaiting total joint replacement at the *University Health Network*. The UHN hopes to adopt a more definitive approach in the near future, with the collaboration of the Ontario Joint Replacement Registry who also apply the WOMAC instrument.

At the *SCO Health Service* (a complex continuing care, rehabilitation, palliative care and long term care centre in Ottawa), priority for admission is generally given to individuals waiting in the community, thereby preventing inappropriate admission to acute care. Patients are triaged and wait lists are managed by clinical admission coordinators. Wait list management policy and protocols are program specific and reflective of the needs of the various clientele (for example, admissions to palliative care are very time sensitive; selection of patients among those on the wait list from the tertiary care hospital is done in collaboration with their palliative care consult team).

Meanwhile, the *Capital District Health Authority (Halifax)* is applying a basic visual analogue scale at the time of booking to assign a patient priority for orthopaedic surgery. All surgeons in the orthopaedic division are participating. In his presentation at *The Taming of the Queue* (2004), Dr. Michael Dunbar stressed that although this scoring tool may not be as sophisticated as the WCWL tools, it is important to start with something that clinicians find quick and easy to use, and then through further research and validation, the tools can be modified.

²¹ Available online at: <http://www.sasksurgery.ca/sercureindex.html>.

Emergency departments within the *Capital Health Region (Edmonton)* use the Canadian Triage and Acuity Scale (CTAS) to prioritize patients based on acuity. eTRIAGE is a web-based application that was developed to provide an electronic triage tool using CTAS complaint templates. Also at the *Capital Health Region (Edmonton)*, the Adult Regional Diabetes Program uses a standardized, evidence-based triage process so those patients with diabetes are immediately matched to the most appropriate service and provider. These triage criteria were developed based on extensive stakeholder input, best practice and the Clinical Practice Guidelines of the Canadian Diabetes Association 2003. Similar criteria are being developed for other chronic diseases as part of *Capital Health Region’s* Chronic Disease Management plan.

Other models of prioritization of note include the Naylor Scoring System, which is used to flesh out urgency scores for cardiac services at the *Calgary Health Region* and *Capital Health Region (Edmonton)*. The Naylor Scoring system is a cardiac questionnaire filled out by the cardiologist following Cardiac Catheterization. It ranks specific clinical data and risk stratifies the patients. This scoring system encompasses the NY Angina Classification tool, cardiac anatomy, vessel restriction, physical findings of the patients, and a variety of other clinical indicators known to elevate risk for patients.²²

At the *Kingston General Hospital*, a one-to-five level of urgency is applied to each non-emergent surgical case. This consensus-based urgency scoring system has been willingly adopted by all surgical disciplines.²³ Each elective surgery is assigned an urgency score which has an associated target wait time (in weeks). This scoring system has been incorporated into *Kingston General Hospital’s* web-based wait list management system, *Axxess.Rx*, and has the full support of the Joint Medical Advisory Committee.

With the exceptions of the *Kingston General Hospital*, the *Hotel Dieu Hospital*, and members who have adopted the Saskatchewan Surgical Care Network framework, respondents largely did not comment on cross-procedure prioritization. In most cases, prioritization occurred within a single surgical specialty versus horizontally, or across specialties. Cross procedure prioritization takes multiple lists of people waiting for service and consolidates them into a common queue.²⁴ As one might anticipate, there will likely be considerable difficulty arriving at a consensus on the features of one universal scoring tool.

This chapter has identified the extensive efforts of Teaching Hospitals and Regional Health Authorities to equitably prioritize patients in the queue for health services. While single-service prioritization seems to be the current thrust of ACAHO members and their community hospital colleagues, cross-procedure prioritization is an emerging issue which will demand system-wide cooperation and standardization.

²² Naylor CD, Baigrie RS, Goldman BS, Basinski A. *Assessment of priority for coronary revascularisation procedures*. Lancet. 1990. 336 (8710): 310-1.

²³ See Appendix B for more information on this Urgency Scoring System.

²⁴ Lewis, S. and Claudia Sanmartin. *Managing Waiting Lists to Achieve Distributive Justice*. Prepared for Western Canada Wait List Project.

While single-service prioritization seems to be the current thrust of ACAHO members and their community hospital colleagues, cross-procedure prioritization is an emerging issue which will demand system-wide cooperation and standardization.

CHAPTER FIVE: MAXIMUM WAIT TIME BENCHMARKS AND TARGETS

Background

The First Ministers 2004 agreement set out concrete timelines and deliverables for the establishment of evidence-based benchmarks for medically acceptable wait times in five specific areas (cancer care, cardiovascular surgery, diagnostic imaging, joint replacement, and sight restoration) through a process to be developed by Federal, Provincial and Territorial Ministers of Health. It has been commonly understood that “evidence-based” is meant to imply that the benchmarks would be based on the best available evidence, and “medically acceptable” infers that these benchmarks would be considered acceptable to the medical community. To date, there have been no details released regarding the status of the federal, provincial, and territorial process.

While there is no single universally-accepted definition for either a “benchmark” or a “target”, *benchmark* is generally understood as a threshold wait time for a given health service and level of severity, beyond which the best available evidence and clinical consensus indicate that patient health is likely to be adversely affected. *Targets* for a given health service may be equal to, or exceed wait time benchmarks for a given proportion of patients. A wait time target spans a given period of time and represents a step along the continuum to achieving the medically-acceptable wait time for all patients.²⁵

In order to develop evidence-based benchmarks, it is important to recognize existing research and learn from the experiences of jurisdictions in Canada and internationally. Identifying gaps where there is currently insufficient evidence to support such benchmarks is a second important step to understanding where further work is needed. In February 2005, the Canadian Institutes for Health Research announced it will fund further research on wait time benchmarks to inform the work of Provincial and Territorial Deputy Ministers of Health in meeting the 2004 Health Accord commitments related to establishing evidence-based benchmarks for medically acceptable wait times.²⁶

Next steps include how the benchmarking process can be expanded to encompass a broader array of health services.

Once evidence-based benchmarks have been established in the initial five priority areas, next steps will include how the benchmarking process can be expanded to encompass a broader array of health services.

Findings

Survey results show that the large majority of ACAHO members have adopted/established both evidence-based benchmarks and targets, or plan to in the very near future.

²⁵ *No more time to wait: Towards benchmarks and best practices in wait time management*. The Alliance for Timely Access to Health Care. March 2005.

²⁶ *Toward Canadian Benchmarks for Health Services Wait Times - Evidence, Application and Research Priorities*. Canadian Institutes for Health Research. Available online at: <http://www.cihr-irsc.gc.ca/e/26700.html>

i. Maximum wait time benchmarks

The ***Vancouver Coastal Health Authority*** cites that most of the benchmarks that have been established either are based upon contractual obligations within the BC Ministry of Health Services and Health Authority annual performance agreement plan, or have been derived from benchmarks across Canada or internationally. Select benchmarks have been developed through internal processes within ***Vancouver Coastal Health Authority***.

In ***Capital Health Region (Edmonton)***, there are benchmarks under redevelopment or newly developed as a result of the work currently being undertaken in Alberta to establish reasonable and achievable access standards for priority health services. ***Capital Health Region (Edmonton)*** is a participant on these access standards committees.

In Regina, the ***Qu’Appelle Health Region*** has established three surgical benchmarks: emergent and life-threatening (surgery required within 24 hours), urgent cancer related surgery (must be performed within three weeks), and elective surgery (to be completed within 18 months). Benchmarks have also been developed in the radiology department.

The ***Winnipeg Regional Health Authority*** and the ***University Health Network*** indicate that their Cardiac Programs have adopted the evidence-based benchmarks established by the Cardiac Care Network in Ontario.

At ***St. Joseph’s Health Care (London)***, benchmarks have been developed for hip and knee replacement surgery. The ***Hamilton Health Sciences Corporation*** has established benchmarks for cardiac catheterization and cardiac surgery, access to stroke prevention clinics, as well as other treatments such as tPA (tissue plasminogen activator).

While the ***Toronto Rehabilitation Institute*** has not universally established benchmarks for access to health services, internal benchmarks for diagnostic and therapeutic services are being developed to optimally utilize the patient registration and scheduling system. The ***University Health Network*** also reports that work on benchmarks has commenced with the Ontario Joint Replacement Registry for joint replacement surgeries. Until this work is complete, benchmarks as recommended by the Canadian Orthopedic Association have been adopted.

FIGURE 1: *Has your Teaching Hospital or Regional Health Authority established evidence-based benchmarks for medically acceptable wait times?*

TEACHING HOSPITAL/ RHA	YES	NOT YET	IN THE PROCESS
Vancouver Coastal Health Authority			✓
Provincial Health Services Authority	✓ ²⁷		
Capital Health Region (Edmonton)	✓		
Calgary Health Region			✓
Regina Qu’Appelle Health Region	✓		
Saskatoon Health Region	✓		
Winnipeg Regional Health Authority	✓ ²⁸		
St. Joseph’s Health Care	✓ ²⁹		
Hamilton Health Sciences Corporation	✓		
Toronto Rehabilitation Institute		✓ ³⁰	
Hospital for Sick Children			✓
University Health Network	✓		
Kingston General Hospital	✓		
Hotel Dieu Hospital	✓		
The Ottawa Hospital	✓		
Capital District Health Authority (Halifax)	✓		
Health Care Corporation of St. John’s	✓		

ii. *Wait time targets*

At **Vancouver Coastal Health Authority**, as part of an operating room allocation model in the Health Authority, representative surgeons from each urban site will meet in regional specialty working groups in the spring of 2005 to establish wait time targets for all procedures. These targets will be established based on a review of current wait times, medically acceptable targets as identified throughout the literature, and targets established by other jurisdictions including the Western Canada Wait List Project, Saskatchewan, and other countries such as New Zealand and Sweden as able.

In Alberta, provincial targets are cited within the “Ministry of Health and Wellness Three Year Business Plan”. **Capital Health Region (Edmonton)** sets regional targets to meet or exceed these levels defined by the province.

In **Saskatoon Health Region**, there has been a push to redefine “urgent” patients into subcategories of urgency whereby treatment times would range from immediate to within four months. Currently, the provincial system and registry attempt to score all

²⁷ Specifically the BC Children’s Hospital.

²⁸ The Cardiac Program has adopted evidence-based benchmarks for medically acceptable wait times as per the Cardiac Care Network.

²⁹ Benchmarks have not been set for cataract surgery as of yet. St. Joseph’s does compare themselves with the provincial average wait time and also to the Fraser Institute’s report.

³⁰ Generally no benchmarks have been set, though there are exceptions. Please refer to detailed survey collation available at www.acao.org

surgical cases into six possible categories of urgency from emergent to purely ‘elective’. Targets have been established for each category. The *Regina Qu’Appelle Health Region* has established targets to meet medically acceptable wait time benchmarks in Radiology.

With the exception of the *Kingston General Hospital*, the *Hotel Dieu Hospital* and the *Health Care Corporation of St. John’s*, all respondents indicated that benchmarks and targets were in part, or entirely, established as the result of consultation with external sources. The *Kingston General Hospital* developed their urgency scoring system and associated target time frames in-house, using stakeholder consultation, extensive literature review and best practice. For certain conditions (undisclosed), published and professional acceptable target times were incorporated into their scoring tool. The *Health Care Corporation of St. John’s* set internal targets based on review of literature, accepted practices, and CIHI data for services designated to improve clinical efficiency.

FIGURE 2: Does your Teaching Hospital or Regional Health Authority set targets for achieving benchmarks for wait times?

TEACHING HOSPITAL/ RHA	YES	NOT YET	IN THE PROCESS	UNSPECIFIED
Vancouver Coastal Health Authority			✓	
Provincial Health Services Authority	✓ ³¹			
Capital Health Region (Edmonton)	✓			
Calgary Health Region	✓			
Regina Qu’Appelle Health Region	✓			
Saskatoon Health Region	✓			
Winnipeg Regional Health Authority			✓	
St. Joseph’s Health Care	✓			
Hamilton Health Sciences Corporation	✓ ³²			
Toronto Rehabilitation Institute				✓
Hospital for Sick Children			✓	
University Health Network	✓			
Kingston General Hospital	✓			
Hotel Dieu Hospital	✓			
The Ottawa Hospital		✓		
Capital District Health Authority (Halifax)	✓			
Health Care Corporation of St. John’s	✓			

Overall, this survey reveals that a very diverse range of procedures, from inpatient chemotherapy³³ to placement into continuing care and supportive living facilities,³⁴ for which benchmarks and targets for timely access have been established in Teaching Hospitals and Regional Health Authorities across the country.

³¹ Specifically the BC Children’s Hospital.

³² Yes for a few patient populations such as emergency department, neonatal ICU, cardiac surgery, and radiation treatments.

³³ Health Care Corporation of St. John’s.

³⁴ Capital Health Region (Edmonton).

CHAPTER SIX: INFORMATION TECHNOLOGY

Background

Complementary to the results of the survey, if we are to accelerate the systems’ ability to better measure, monitor, measure, and evaluate its performance, we must ensure that we have state-of-the-art health information management systems in place.

Thus, in order to fully leverage the potential of comparable health indicators and clinical benchmarks and targets, ongoing strategic investments are required to support our collective information management capacity.

Findings

Where *Capital District Health Authority (Halifax)* is largely dependent on small, stand-alone, service-specific wait list databases, *Capital Health Region (Edmonton)* has made significant financial investment into the development of an integrated electronic health record that connects existing patient information systems located in hospitals and clinics across the region. This regional electronic health record, *netCARE*, is a secure, web-based health information system that gives physicians and health care providers access to an individual’s electronic health record wherever and whenever care is needed. The Alberta Government identified the electronic health record (EHR) as a critical building block of health reform and a cornerstone in the modernizing of the health system. *Capital Health Region’s netCARE* browser has been selected by the provincial government to become the single shared province-wide viewer for provincial and regional EHR information. There are numerous other health information technology initiatives underway in this Health Region.³⁵

At the *Vancouver Coastal Health Authority*, \$1.6 million has thus far been invested for regional OR information management systems. An additional \$2.1 million has been proposed over the next two years for the remaining facilities to migrate to one regional OR information management system. As part of the Provincial Surgical Services Project, led by the *Provincial Health Services Authority*, all Regional Health Authorities, including the *Vancouver Coastal Health Authority*, are participating in the development of a comprehensive surgical patient registry for British Columbia.

The *Regina Qu’Appelle Health Region* has implemented new client scheduling software to monitor patients that require services, and locate and schedule the best time for service, given the needed staff and resources required. This application is region wide and available to any service wanting to manage waitlists and client schedules. Over the next three to five years, *Regina Qu’Appelle Health Region* expects to be making investments in managing waitlists for Imaging Services as well as in emergency management, discharge management, primary health care, and inter-region patient transfer management. All of which will directly or indirectly affect the size and acuity of their waitlists.

³⁵ For a complete list of Health Information Technology initiatives underway in the Capital Health Region (Edmonton), please refer to detailed survey collation available online at www.achho.org.

Many other financial investments have been identified by respondents to measure, monitor and manage wait lists. *St. Joseph’s Health Care* is currently implementing *SurgiNet* and an Electronic Patient Record (EPR) which will provide the database and infrastructure to assist with waitlist management.

At *The Hospital for Sick Children*, a team has been assembled using current hospital funding (approximately \$400,000) over a period of 12 months to oversee the development of an evidence based referral and triage guidelines, and implementation of a consistent prioritization methodology across all clinical programs; the development and implementation of an online referral system; the development and implementation of an automated system to track diagnostic (e.g. MRI) and treatment (e.g. surgical and medical procedures) wait times; and the development of regular wait list reports for four key areas of focus: ambulatory, diagnostic, treatment and emergency. Further investment is planned as wait list management becomes a core process within the hospital’s strategic plan.

Interestingly, regarding further investment in wait time technologies in Ontario, the *University Health Network*, *St. Joseph’s Health Care* and *The Ottawa Hospital* noted that the Ontario Ministry of Health has advised hospitals to refrain from making decisions until the Ministry has finalized their provincial plan to monitor wait lists.

Overall, investments and advances in technology are giving rise to increasingly complex health information management processes in a number of ACAHO member Teaching Hospitals and/or Regional Health Authorities. When asked whether a central electronic registry existed in their teaching hospital/RHA, 41% of respondents indicated that there *was* in fact, an operational electronic registry with urgency measures, procedures and patient information recorded; 24% reported a central electronic registry did *not* exist; and 35% reported this electronic registry was in developmental stages with varying “go live” dates.

Overall, investments and advances in technology are giving rise to increasingly complex health information management processes in a number of ACAHO member teaching hospitals and/or regional health authorities.

FIGURE 3: *Does a central electronic registry exist with urgency measures, procedure and patient information within your Teaching Hospital / Regional Health Authority?*

TEACHING HOSPITAL/ RHA	YES	NOT YET	IN THE PROCESS
Vancouver Coastal Health Authority			✓
Provincial Health Services Authority			✓
Capital Health Region (Edmonton)	✓		
Calgary Health Region	✓		
Regina Qu’Appelle Health Region	✓		
Saskatoon Health Region			✓
Winnipeg Regional Health Authority	✓		
St. Joseph’s Health Care		✓	
Hamilton Health Sciences Corporation	✓		

TEACHING HOSPITAL/ RHA	YES	NOT YET	IN THE PROCESS
Toronto Rehabilitation Institute			✓
Hospital for Sick Children			✓
University Health Network		✓ ³⁶	
Kingston General Hospital	✓		
Hotel Dieu Hospital	✓		
The Ottawa Hospital		✓	
Capital District Health Authority (Halifax)		✓	
Health Care Corporation of St. John’s			✓

The *Vancouver Coastal Health Authority* is developing as part of their Provincial Surgical Services Project, a provincial surgical registry that will hold patient and surgical services information. Each patient assessed for surgery within the province will have an assigned urgency score classified according to a master procedure list. Isolated data will be loaded as of April 2005.

A centralized database in *Capital Health Region (Edmonton)* exists at Capital Health Link for all diabetes patients within the Adult Regional Diabetes Program. Patient demographic and clinical information is collected. The database allows for tracking and monitoring of wait times. This database will grow as other populations within the chronic disease management model are added.

Also in the *Capital Health Region (Edmonton)*, centralized waitlist management at the regional level has been implemented for cardiac surgery patients via the APPROACH database (Alberta Provincial Project for Outcome Assessment in Coronary Heart Disease). Implementation of centralized wait list management at the regional level for cardiac catheterization services will be completed by the end of April 2005.

In Kingston, a defacto elective surgery registry exists for both the *Kingston General Hospital* and *Hotel Dieu Hospital*. This registry is part and parcel of the deployment of the wait list management system Aaccess.Rx. This has been achieved through the central (web-based) deployment of the Wait List Management System *Aaccess.Rx*. This tool is being considered for deployment across regional hospitals within the newly proposed Local Health Integration Network (LHIN).

The *Health Care Corporation of St. John’s* uses the Medical Systems Management software to manage the surgical waitlist. A priority scale is currently being developed to be incorporated into the data fields, and entered once the patients’ request for surgery has been received. The Corporation plans to adopt the Meditech Community Wide Scheduling Waitlist System for ambulatory clinics, diagnostic imaging and diagnostic ambulatory services. This system is presently used for scheduling purposes in St. John’s, but not for waitlist management.

³⁶ An electronic registry with urgency measures exists for cardiac surgery and hip/knee replacement. UHN has implemented the automation of the OR booking sheet to capture the wait time data electronically.

In terms of other health information management tools, through the new Provincial Surgical Patient Registry, all Health Authorities in British Columbia and the BC Ministry of Health will have access to standard and ad hoc reports, with integrated query capability. Within the Alberta Waitlist Registry, detailed management wait list reports are under development by the province and will be used by both the province and the health regions to guide and/or assist in identifying strategies to address access and planning resource allocation. *Capital Health Region (Edmonton)* is also producing region-specific waitlist data management reports to be used internally for strategizing and resource allocation planning.

At the *Toronto Rehabilitation Institute*, a central electronic patient registration system has capacity to capture patient data from the point of referral forward (e.g. referral received, accepted into the program pending availability, admission and eventual discharge as well as any steps in between). The clinical workload measurement system is linked into this patient registration system so it is increasingly possible to record and report referral and wait list data. The system will also assist with resource planning in the future by providing information in determining the clinical workload associated with receiving and reviewing referrals and communicating with patients during their wait times.

Systems for managing wait lists require both initial and sustained investments in advanced information systems, information technology, but also importantly, dedicated human resources. *The Taming of the Queue: Toward a cure for health care wait times* underscores the need for improved data collection via investments in information systems. As part of a ten-point plan to contribute to an orderly and effective response to wait times in Canada, the authors stress that wait time data collected by health professionals and/or institutions needs to be combined into a more efficient and centralized booking system, so as to serve a *group* of health professionals and/or institutions.³⁷ This survey has identified a number of members of ACAHO who have undertaken initiatives to develop and provide reliable, current, useful and valid patient data and information.

³⁷ Saulnier, M., Shortt, S., and E. Gruenewoldt. (2004). *The Taming of the Queue: Toward a cure for health care wait times*. The Canadian Medical Association.

CHAPTER SEVEN: STAKEHOLDER RELATIONSHIPS

i. Communicating with Patients

Background

To date, the national public policy discussions on wait times’ have focused on improving the overall *order* and *speed* with which patients access care and are ultimately treated. As much as there has been an essential focus on improving the overall architecture of the system, we must be mindful that at the end of the day, patients and the general public must have a clearer sense that the system will be there for them in times of need.

It is in this context, that we were interested in how members of ACAHO were engaging with patients and members of the general public. Benefits of establishing more transparent methods of communication include: (1) patients’ and the public’s confidence in the health system will improve; and (2) patients will be informed as to their expected length of wait and their relative priority according to other patients in the queue.

Findings

In order to advance confidence among patients and the public, survey respondents have identified a number of initiatives which engage stakeholders in wait time discussions and communicate clearly why waiting lists exist and how patients move through the queue. Many ACAHO members identified their website or the Provincial Ministry of Health website as a venue for patients to self-educate regarding waiting times and access to health services in their teaching hospital or Regional Health Authority.³⁸ Public announcements including print, television and radio advertisements were also identified as a means to communicate information as to where patients should seek urgent/emergent care and how prioritization occurs.³⁹

Vancouver Coastal Health Authority’s (VCHA) Communications and Community Engagement Department connects and consults with stakeholders by: (1) providing information about how issues of access are being addressed; (2) communicating the VCHA longer-term strategic plan; and (3) communicating ongoing efforts to address demand and augment access to surgery and other procedures. **Vancouver Coastal Health Authority** has distributed press releases announcing improvements to access, shared new information at public board meetings, provided information for the media, and included background in a variety of public documents and electronic channels. The Community Engagement Team and Community Advisory Committees seek to bring the voice of the patients into the redesign of programs and process across the continuum of care.

Many ACAHO members identified their website or the Provincial Ministry of Health website as a venue for patients to self-educate with respect to waiting times and access to health services in their teaching hospital or Regional Health Authority.

³⁸ Vancouver Coastal Health Authority, Provincial Health Services Authority, Capital Health Region (Edmonton), Regina Qu’Appelle Health Region, University Health Network, Kingston General Hospital, Health Care Corporation of St. John’s.

³⁹ Winnipeg Regional Health Authority, Hamilton Health Sciences Corporation, and Capital District Health Authority (Halifax).

Capital District Health Authority (Halifax) has also approached communication in a multifaceted manner, publishing op-ed pieces on the topic of surgical wait times, and hosting press conferences regarding capital expansions and results of their wait list project. *Capital Health (Halifax)* regularly posts surgical wait times on the internet, in addition to daily reports on Emergency wait times.

In order to establish orthopaedic wait time standards, *Capital District Health Authority (Halifax)* surveyed patients to identify their expectations for access. They also conduct patient satisfaction surveys on an ongoing basis.

The *Winnipeg Regional Health Authority* has taken a regional approach to communicate to patients on waiting lists with respect to Emergency Room queues. Public announcements provide information on where patients should seek urgent/emergent care and how prioritization occurs. Community Area Councils in each part of Winnipeg provide the public with a chance to voice their input.

Other respondents indicated that a letter is provided to surgical patients regarding the potential of rescheduling surgery based on priority needs of surgical services.⁴⁰ In most cases, communication occurs between the patient and the provider as necessary.

ii. Stakeholder Partnerships

Background

Reducing wait times for health services requires investment and horizontal collaboration and consensus which cut across governments (both provincial and federal), health policymakers, health researchers, health services providers and most importantly, patients. Increased demands for transparency and accountability dictate that all stakeholders be engaged in a wide variety of policy discussions.

Findings

A number of partnerships have been identified between ACAHO members and federal, provincial and territorial officials or other health providers whose common goal is to reduce wait times and increase access to health services.

Collaboration with the Western Canada Wait List project was popular among Association members geographically located in Western Canada. *Vancouver Coastal Health Authority, Provincial Health Services Authority, Saskatoon Health Region, and Winnipeg Regional Health Authority* all cited collaboration with this project. Moving towards Central Canada, a number of respondents indicated their participation with Cancer Care Ontario⁴¹, the Ontario Joint Replacement Registry⁴², and the Cardiac Care Network in Ontario.⁴³

⁴⁰ St. Joseph's Health Care

⁴¹ University Health Network, Hamilton Health Sciences Corporation, Hotel Dieu Hospital, and Kingston General Hospital.

⁴² University Health Network, St. Joseph's Health Care, and Kingston General Hospital.

⁴³ Winnipeg Regional Health Authority, University Health Network, and Hamilton Health Sciences Corporation.

The Hospital for Sick Children is actively engaging in a proposal that will support Ontario’s Ministry of Health and Long Term Care’s Wait Time Strategy. As well, the hospital is working with other organizations within the Ontario Child Health Network to develop a comprehensive and coordinated system of specialized pediatric surgical services across Pediatric Academic Health Science Centres in Ontario.

Kingston General Hospital has been invited by the Ontario Ministry of Health (MoH) to publish its surgical wait times on the MoH wait times website. The hospital is currently seeking MoH support to deploy the wait list management tool (*Access.Rx*) to its regional (LHIN) partners.

Stakeholder involvement should also extend to front line workers in the health system. Clinicians can play a leadership role identifying clinically relevant data elements through consensus; in developing standard definitions and measures for prioritizing waiting lists; and in developing benchmark waiting times. Health care providers and other stakeholders have a critical role in the development, maintenance, monitoring, management and evaluation of wait-list systems.

CONCLUSION

Wait times, be they real and/or perceived, have been growing for a number of years. While there is no one magic bullet that can address this issue, this survey identified a combination of policy initiatives that can have a positive impact on the *order* of patients waiting for care and treatment, and the *speed* at which they move through the system.

In many tangible ways, members of ACAHO have developed and implemented a series of measures that serve to improve the flexibility, responsiveness, efficiency and effectiveness of the health system – with Canadians being the ultimate beneficiary. At the same time, the explicit processes that have been developed to manage wait times across the country serve to improve the transparency of the decision making process and allocation of resources, and clarifies many of the accountability relationships when it come to accessing care.

While a significant amount of activity has already been undertaken, there is clearly more work to be done in this area. Given their role in the health system, Teaching Hospitals and Regional Health Authorities look forward to continuing to work with providers, governments, patients, the public and others when it comes to providing timely access to a range of quality health services.

APPENDIX A: MANAGEMENT OF WAIT TIMES: TAKING STOCK OF OUR PROGRESS, AN ACAHO MEMBER SURVEY

PURPOSE

Thank you in advance for participating in this exercise. The purpose of this member survey is to take stock of ACAHO members' progress in terms of developing and implementing wait time management strategies for publicly funded health care services.

This survey is an information gathering enterprise. By recognizing, identifying and sharing areas of progress, members of ACAHO will be well positioned to learn from one another. Further, other health care institutions across the country will have an opportunity to replicate, where appropriate, the successes of the Associations member organizations.

This information will be collated by ACAHO for your information, verification and review. With your permission, the findings of this survey will be disseminated at the second colloquium on wait times ("The Taming of the Queue II") that is being co-sponsored by ACAHO and attended by representatives of Teaching Hospitals and Regional Health Authorities, health care providers, government officials, and policy researchers.

The objectives of the 2nd colloquium are three-fold: (1) to assess progress in wait time measurement, monitoring and management strategies; (2) to share best practices across Canadian jurisdictions and internationally; and (3) to identify opportunities and challenges in moving forward First Ministers' wait time commitments. At the first colloquium in 2004, over 80 participants spent two days reviewing Canadian and international initiatives and discussing what needs to happen next in Canada to move toward better measurement, monitoring and management of wait times.

BACKGROUND

In September 2004, First Ministers gathered in Ottawa to develop a ten year plan to strengthen health care in Canada. Wait times and timely access to health care took centre stage as First Ministers committed to achieve meaningful reductions in wait times by March 31, 2007 in five priority areas: (1) cancer treatment; (2) cardiovascular disease; (3) diagnostic imaging; (4) joint replacement; and (5) sight restoration. First Ministers acknowledged the unique departure points, priorities and strategies each jurisdiction would present.

A ten year, \$5.5 billion Wait Times Reduction Fund (WTRF) was established by First Ministers at this time to recognize priorities which included training additional health professionals, clearing backlogs, building capacity for regional centers of excellence, expanding appropriate ambulatory and community care programs and/or establishing tools to manage wait times. Further, First Ministers agreed that each jurisdiction would establish comparable indicators of access to health care professionals, diagnostic and treatment procedures. A public report of these indicators of access would be prepared and delivered to Canadians by December 31, 2005. This date also marks the point by which provinces are expected to have established benchmarks with respect to maximum acceptable wait times.

Lastly, on the topic of reducing wait times and improving access to care, it was agreed that multi-year targets to achieve priority benchmarks would be established by each jurisdiction by December 31, 2007. Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait time targets.

TIMELINES

Please complete and return this survey to Emily Gruenwoldt, Senior Advisor, Research and Policy Development, ACAHO, electronically at gruenwoldt@acaho.org , or alternatively by facsimile transmission at (613) 730-4314 by **FEBRUARY 28, 2005**. If you have any questions or comments regarding this survey, please do not hesitate to contact Glenn Brimacombe at (613) 730-5815 ext. 322.

Once again, thank you for your participation. Your input is greatly appreciated.

MEMBER ORGANIZATION:

CONTACT INFORMATION: (Specific to wait time management initiatives)
Name:
Title:
Address:
Email:
Telephone/Fax Nos.:

SURVEY QUESTIONS: Please respond to the best of your knowledge with respect to your institution/Regional Health Authority. You should also feel free to include all relevant documents to facilitate our understanding of your local initiatives.
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| <u>Framework Policy Initiatives</u> |
| 1. According to the literature, in principle there are three policy levers or approaches which contribute to reducing wait times. Please describe how your institution/RHA has pursued the goal of addressing accessibility to health services via: |
| a. <i>Building capacity or supply side policies.</i> Supply side policies are those that are intended to increase the volume of procedures/surgeries. Examples of supply side policies include “increasing productivity or throughput of public hospitals” (e.g. funding extra-activity, introducing activity-based funding, encouraging day-surgery), “increasing capacity” (e.g. increasing the number of specialists, the number of beds, or operating suites), and “improving operating efficiency” (e.g. introducing care pathways). |
| b. <i>Introducing prioritization tools or demand side policies.</i> Demand side policies are useful if publicly funded surgery is considered adequate and if waiting times are higher than the minimum necessary to avoid unused capacity. Demand side policies include engaging in clinical prioritization processes according to need (e.g., severity of illness) and providing treatment to those with the highest need. |
| c. <i>Policies specific to wait lists.</i> These policies include setting targets and benchmarks for maximum wait times. |

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| <u>Prioritization Tools</u> |
| 2. The provision of surgery, diagnostic & therapeutic services usually takes into account the differing levels of urgency with which patients present. |
| a. Does your institution/RHA have clinical measures of urgency in place by which to prioritize patients in the queue for surgery, diagnostic or therapeutic services? If so, please specify the methodology and for which procedures these measures of urgency have been developed. |
| b. Does a central electronic registry exist with urgency measurements, procedure and patient information within your institution/RHA? |

Health Indicators

3. According to the *Ten Year Plan to Strengthen Health Care* (the 2004 First Ministers' Health Accord), each province is responsible for establishing comparable statistics which show how long Canadians are currently waiting for treatment (indicators of access to health care professionals, diagnostic and treatment procedures) by December 2005. Has your institution/RHA established any indicators of access to health services?

Maximum Wait Time Targets and Benchmarks

4. The First Ministers' further agreed in September to establish evidence-based benchmarks for medically acceptable wait times for five priority areas by December 31, 2005.
- a. Has your institution/RHA established evidence based benchmarks for medically acceptable wait times? If so, have you also established a series of targets to meet these benchmarks?
- b. Were these benchmarks established in-house or adopted from an external source?
- c. For which procedures has your institution/RHA established benchmarks and/or targets for timely access to health care services?

Stakeholder Relationships

5. Has your institution/RHA taken steps to communicate clearly to patients why waiting lists exist, how people move through the queue and steps your institution/RHA is taking to clear the backlog? How is your institution/RHA engaging the public in wait time discussions?
6. Has your institution/RHA established collaborative partnerships with federal and/or provincial government officials or any other groups (e.g. other health care providers) in order to provide real time information for policy and funding decisions?

Information Technology

7. In order to fully leverage common indicators and clinical benchmarks, strategic investments are required to support health information management capacity.
- a. Describe any financial investments your institution/RHA has made in support of the ability to measure, monitor and manage wait lists. Does your institution/RHA plan to (further) invest in health information technology in the next three to five years?
- b. What health information management processes does your institution/RHA currently have in place?

THANK YOU.

APPENDIX B: KINGSTON GENERAL HOSPITAL URGENCY SCORING SYSTEM

Urgency	Description	Target Time in days
1	Conditions with threat to life or limb within one week. i.e. large (> 8 cm) AAA, daily TIAs, obstructing or slowly bleeding malignancies. These conditions are not yet true emergencies but may quickly progress to a true emergency.	7
2	Conditions with threat to life over next few weeks or having a profound effect on the patient physically or psychologically, i.e. most major malignancies - breast, lung, GI tract, neurologic gynaecologic or urologic., mid-large aneurysms (> 6 cm but < 8 cm), symptomatic cerebrovascular disease, many coronary artery diseases - left main disease, severe triple vessel disease with impaired ventricle, some neurosurgical cases - intracranial aneurysm. These conditions have significant urgent impact on health.	28
3	Conditions with less impact on health due to pain, suffering, loss of time from work with some or minor risk to life i.e. biliary tract disease, diverticular disease, thyroid disease, inflammatory bowel disease, coronary artery disease.	84
4	Conditions identical to 3, but with no risk of life to patient i.e. hernia surgery, parathyroid surgery, benign anorectal surgery, joint replacement, hand surgery, back surgery.	168
5	Conditions with little impact on health and minimal effect on suffering or loss of work time i.e. cosmetic surgery, varicose vein surgery.	364

APPENDIX C: PROVINCIAL SURGICAL SERVICES PROJECT OVERVIEW

THE PROVINCIAL SURGICAL SERVICES PROJECT (PSSP) WINTER 2005

The Provincial Surgical Services Project (PSSP) is a collaborative project involving B.C.'s five Regional Health Authorities and the Ministry of Health Services, under the leadership coordination of the sixth health authority, the Provincial Health Services Authority (PHSA). The purpose of the PSSP is to improve B.C.'s system of surgical services through:

- Developing standards and guidelines for provincial surgical services;
- Creating data-collection processes for better planning and decision-making;
- Disseminating best practice resources and information to health authorities to help them improve their surgical services.

THE WORK OF THE PSSP

The PSSP's work is two-phased. Phase one involved developing draft definitions for levels of surgical need and for wait time measurements, conducting research into other jurisdictions' surgical services nationally and internationally, and creating policy papers on potential improvements to surgical services.

Phase two, which began January 2004 and continues until the fall of 2006, includes:

- The implementation of a surgical patient registry (SPR) to track all patients waiting for surgery to promote more accurate planning and scheduling for surgeries;
- The development and pilot testing of clinical assessment tools for twelve surgical specialties (thoracic, orthopedic, neurosurgery, cardiac, gynecology, otolaryngology, ophthalmology, oral, general, vascular, plastic and urology surgery). These tools developed in BC by each Specialty Working Group are based on those developed by the Western Canada Waitlist Project, and the work of the Saskatchewan Surgical Care Network.
- A productivity review of selected surgical sites to establish benchmarks for surgical services, identify key areas of improvement and ultimately ensure efficiency and effectiveness of the province's surgical system;
- A provincial utilization review to compare B.C.'s surgical services to other selected provinces in terms of relative use rates per 1,000 population and plan improvements accordingly;
- An evaluation framework for surgical services project to ensure ongoing monitoring and quality improvement.

THE STRUCTURE OF THE PSSP

The project is guided by a steering committee of representatives from B.C.'s health authorities, the Ministry of Health Services, the BC Medical Association, the BC Medical Services Commission and the UBC Faculty of Medicine. The steering committee is advised by a stakeholder consultation group comprising members of the public and health professionals. A research and evaluation sub-committee, reporting to the steering committee, is responsible for

testing the reliability of the assessment tools as well as acting as liaison with the Western Canada Waitlist Project and the Saskatchewan Surgical Care Network. Other sub-committees and task groups include an information management/technology sub-committee, a productivity review working group, 12 surgical specialty working groups (representing the surgical specialties named above), a utilization working group, and several teams associated with activities related to the implementation of the SPR.

TIMELINES AND OUTCOMES

By the end of 2005 all clinical assessment tools will have been created, and by mid 2006 the majority of surgeons will be utilizing these clinical assessment tools in their practices.

The PSSP's ultimate goal is to build a surgical system based on patients' needs with a focus on transparency, consistency, fairness and evidence. A renewed surgical patient registry, utilizing information from objective clinical assessment tools, will enable more accurate planning and policy development by government and health authorities, allow physicians and surgeons to more appropriately schedule patients for surgery as well providing better information to track their progress on the waitlist, and ensure consistency and fairness for patients who need surgery. The data captured will be used to track the performance of our surgical system across all health authorities and provide a basis for system improvements.

APPENDIX D: ACAHO CONTACT LIST FOR WAIT TIME INITIATIVES

<p>Vancouver Coastal Health Authority Susan Scrivens Director, Surgical Services Planning Project</p> <p>Dr. Heather Manson VP, Health Services Integration</p> <p>Dr. Jeff Coleman Chief Operating Officer</p> <p>855 West 12th Ave. HP C Floor, Rm 321 Vancouver, BC V5Z 1M9</p>	<p style="text-align: right;">Tel: 604 875 4111 Fax: 604 875 5441 Email: susan.scrivens@vch.ca</p> <p style="text-align: right;">Tel: 604 875 5269 Fax: 604 244 5337 Email: heather.manson@vch.ca</p> <p style="text-align: right;">Email: jeff.coleman@vch.ca</p>
<p>Provincial Health Services Authority Brain Schmidt Senior VP, Strategic Health Development</p> <p>1380 Burrard Street Vancouver, BC V6Z 2H3</p>	<p style="text-align: right;">Tel: 604 675 7456 Fax: 604 708 2700 Email: bschmidt@phsa.ca</p>
<p>Capital Health Region (Edmonton) Kathleen Ness Director, Clinical Performance, Information & Research</p> <p>Michele Lahey Senior VP, Health Services</p> <p>9th Floor, 9925-109 Street Edmonton, ALTA T5K 2J8</p>	<p style="text-align: right;">Tel: 780 413 7739 Fax: 780 413 7783 Email: kness@cha.ab.ca</p> <p style="text-align: right;">Tel: 780 407 8884 Email: milahey@cha.ab.ca</p>
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<p>Regina Qu'Appelle Health Region Patrick Dumelie Senior Vice President, Health Services</p> <p>Regina General Hospital 1440 14th Avenue Regina, SK S4P 0W5</p>	<p>Tel: 306 766 3427 Fax: 306 766 3550 Email: patrick.dumelie@rqhealth.ca</p>
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<p>Winnipeg Regional Health Authority Jan Currie Vice President and Chief Nursing Officer</p> <p>1800-155 Carlton St. Winnipeg, MA R3C 4Y1</p>	<p>Tel: 204 926 7005 Fax: 204 926 8008 Email: jcurrie@wrha.mb.ca</p>
<p>St. Joseph's Health Care, London Dr. Gillian Kernaghan VP Medical and Professional Affairs</p> <p>Ms. Sandra Letton VP Acute/ Ambulatory Care</p> <p>268 Grosvenor Street London, ON N6A 4L6</p>	<p>Tel: 519 646 6100 x 64096 Email: gillian.kernaghan@sjhc.london.on.ca</p> <p>Tel: 519 646 6100 x 65701 Email: sandra.letton@sjhc.london.on.ca</p>
<p>Hamilton Health Sciences Corporation Brenda Flaherty Executive VP, Clinical Operations</p> <p>Henderson General Hospital 711 Concession Street Hamilton, ON L8V 1C3</p>	<p>Tel: 905 521 2100 x 46826 Fax: 905 577 1402 Email: flahebre@hhsc.ca</p>

<p>Toronto Rehabilitation Institute Georgia Gerring Vice President, Programs</p> <p>550 University Avenue Suite 209 Toronto, ON M5G 2A2</p>	<p>Tel: 416 597 3422 x 3903 Fax: 416 597 7119 Email: gerring.georgia@torontorehab.on.ca</p>
<p>Hospital for Sick Children Cathy Seguin Vice President Child Health Services</p> <p>555 University Avenue Toronto, ON M5G 1X8</p>	<p>Tel: 416 813 6201 Fax: 416 813 8838 Email: cathy.seguin@sickkids.ca</p>
<p>University Health Network Tom Closson President and CEO</p> <p>585 University Avenue Toronto, ON M5G 2C4</p>	<p>Tel: 416 340 5224 Fax: 416 340 3179 Email: tom.closson@uhn.on.ca</p>
<p>Kingston General Hospital John Lott Director, Information Analysis and Distribution</p> <p>76 Stuart Street Kingston, ON K7L 2V7</p>	<p>Tel: 613 549 6666 x 4202 Fax: 613 548 6082 Email: lottj@kgh.kari.net</p>
<p>Hotel Dieu Hospital Marnie Dahl Associate Executive Director, Patient Care and Chief Nursing Officer</p> <p>166 Brock Street Kingston, ON</p>	<p>Tel: 613 544 3400 ext 2319 Fax: 613 544 9948 Email: dahlm@hdh.kari.net</p>
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<p>SCO Health Service Amy Tosh Director, Strategic Planning</p> <p>75 rue Bruyere Street, Room 119Y Ottawa, Ontario K1N 5C8</p>	<p>Tel: 613 562 4262 x 1014 Fax: 613 562 6333 Email: atosh@scohs.on.ca</p>
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<p>Health Care Corporation of St. John's Patricia Pilgrim Vice President, Quality and Planning</p> <p>First Floor, HSC Prince Philip Drive St. John's, NL A1B 3V6</p>	<p>Tel: 709 777 1306 Fax: 709 777 1347 Email: pat.pilgrim@hccsj.nl.ca</p>