“Wait” Watchers II…

Measuring Progress on Wait Time Strategies Across ACAHO Members

March 2006

Association of Canadian Academic Healthcare Organizations
Association canadienne des institutions de santé universitaires

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WAIT WATCHERS II:

MEASURING PROGRESS OF WAIT TIME MANAGEMENT STRATEGIES ACROSS ACAHO MEMBERS

An ACAHO Member Survey
March 2006

WHO WE ARE…

The Association of Canadian Academic Healthcare Organizations (ACAHO) is a member-based association that represents more than 40 teaching centres - which are a combination of Teaching Hospitals, and Regional Health Authorities and their Research Institutes. 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 integrated activities:

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

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.

For more information on the activities of the Association, please visit our web-site at www.Acaho.org.

ACKNOWLEDGEMENTS

This report was prepared by Emily C. Gruenwoldt (Senior Advisor, Research & Policy Development, ACAHO) and Glenn G. Brimacombe (Chief Executive Officer, ACAHO).

The Association of Canadian Academic Healthcare Organizations would like to acknowledge the following members for their participation in this report: Vancouver Coastal Health, Provincial Health Services Authority, Capital Health (Edmonton), Calgary Health Region, Regina Qu'Appelle Health Region, Saskatoon Health Region, London Health Sciences Centre, St. Joseph's Health Care (London), St. Joseph's Healthcare (Hamilton), The Hospital for Sick Children, Hotel Dieu Hospital (Kingston), Kingston General Hospital, SCO Health Service, Children's Hospital of Eastern Ontario, IWK Health Centre (Halifax), Capital District Health Authority (Halifax), and the Eastern Regional Integrated Health Authority (St. John's).

Special thanks to Owen Adams and Marcel Saulnier for their review and feedback in the preparation of this report.

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PREFACE

More than any other health policy issue in the recent past, wait times has arguably received the most public attention. This is not surprising when one considers that much of the national dialogue on the future of health and health care in Canada has focused on the "sustainability" of our system, and is directly linked to Canadians' ability to access a range of health services on a timely basis.

To accelerate work already underway to reduce wait times across the country, in September 2004, First Ministers agreed to a "Ten Year Plan to Strengthen Health Care". Not only did this agreement contain $5.5 billion earmarked for wait times initiatives (through the Wait Times Reduction Fund), but it also established a timeline to develop a series of pan-Canadian benchmarks and targets in five priority areas (cancer therapy, cardiac surgery, cataract surgery, hip and knee replacement surgery, and diagnostic imaging).

More recently, the federal government has committed to accelerating the development and implementation of benchmarks by the end of 2006. Furthermore, the government will work with the provinces to develop a Patient Wait Times Guarantee to ensure that all Canadians receive essential medical treatment within clinically acceptable wait times, or can be treated in another jurisdiction.

In January 2006, the Association of Canadian Academic Healthcare Organizations (ACAHO) surveyed its members (Teaching Hospitals and Regional Health Authorities) for the 2nd consecutive year to better understand the series of investments and initiatives that are underway to more effectively manage wait times. This included a review of efforts to increase system capacity – in its dimensions, introducing new health information management strategies, as well as improved quality of care processes.

Based on this survey of members, it is evident that there are a number of important pockets of innovation across the country which are having a positive impact on how long Canadians are waiting for care, and how they are navigating through the system. From the Alberta Hip and Knee project to the Wait Time Strategy in Ontario, there are notable success stories across the country. New care pathways, centralized registries, and evidence-based benchmarks are, in part, the result of research carried out within ACAHO member institutions.

It is also clear that depending on local circumstances, a mixture of different investments is required. In many ways, members of ACAHO are working with governments and providers to strengthen the public system so that it will remain flexible, innovative and responsive to the changing health needs of Canadians for years to come.

Finally, the report highlights that the health system is a dynamic structure that is, in some ways, in perpetual motion. Framed in this context, we look forward to seeing a number of progressive wait time management strategies that will continue to meet a number of public policy objectives, including: transparency, accountability, efficiency, accessibility, and evidence-based.

A MESSAGE FROM THE PRESIDENT OF ACAHO

Given the current national health policy discussions, it is clear that wait times are the barometer by which Canadians perceive the performance of the health system. Yet, as important as wait times are, their very existence is closely linked to a range of other policy issues.

For example, the lack of available family physicians, specialists, nurses or technicians has a direct impact on the availability of health services. At the same time, limited operating revenues for teaching hospitals and/or regional health authorities can also impact on the number of surgical suites, as can restricted capital budgets limit the number of diagnostic and therapeutic pieces of equipment in use – not to mention wards. In other words, as much as there has been an appropriate focus on the amount of time one waits for care, there are a combination of policy pressures related to the overall *capacity* of the system that must also be considered.

We must also recognize that we need to continue to improve the manner in which we effectively manage resources in an efficient and responsible way that is accountable to Canadians. In effect, giving the public a clearer sense as to the new strategic initiatives underway to make our health system increasingly flexible, innovative and responsive.

In September 2004, a new era of system accountability was ushered in by First Ministers with the commitment to benchmarks and targets for five priority areas. As part of this approach to addressing wait times, members of ACAHO have been active in a number of areas – which are outlined in this report.

Notwithstanding some of the important challenges we all face in terms of ensuring that we have the capacity to provide timely access to a range of quality health services, the intent of this document is to examine – in some detail – the range of innovative management processes and strategies that have been adopted by members of ACAHO. The intent of the paper is also to build on the information presented in our first release of a year ago.

In reviewing the findings contained in this paper, we hope that you will begin to recognize the transformation that is occurring at the local level when it comes to how teaching hospitals and regional health authorities are introducing transformative change to better manage patient flow through in the system.

In closing, we would welcome your comments on the content of this report. In this regard, feel free to contact Ms. Emily Gruenwoldt at (613) 730-5818, extension 324, or via e-mail at gruenwoldt@acaho.org. For more information on the activities of the Association, I would invite you to visit our web-site at www.acaho.org.

Sincerely yours,

Ms. Lynda Cranston
President of ACAHO

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EXECUTIVE SUMMARY

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, Canadians' confidence in the health system is closely aligned with their ability to access quality health services on a timely basis.

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.

At the national level, there have been two recent critical developments related to the wait time discussion. First, is the September 2004 First Ministers' Accord which sets out a series of timelines to develop evidence-based benchmarks and targets in five key areas. Second, is the potential impact of the Chaoulli/Zeliotis Supreme Court ruling on the exclusive role that the public system occupies in providing core medical services to Canadians.

As important as both of these landmark occurrences are, it is clear that much of the national thinking about the need to more effectively manage wait times across the country has dramatic implications for the provinces and territories, and for those who manage health systems and large institutions *locally*.

Given the intensity and focus on wait times across the country, the purpose of this report is to acknowledge and take stock of progress the members of the Association of Canadian Academic Healthcare Organization (ACAHO) have made developing and implementing wait time management strategies for publicly funded health services. This progress has evolved as a result of a collaborative and working relationship between ACAHO members, providers and their respective provincial governments. This report also reviews outcomes as a result of wait times initiatives.

Based on the responses of this survey, the report provides a national overview of a series of connected and innovative investments and strategies that are having a constructive impact on the management of wait times in Canada. That is, the report identifies a number of "pockets of innovation", and reinforces the notion that our health system is a dynamic structure that is adopting a number of progressive strategies to better respond to the changing health needs of Canadians.

This report—the second of its kind—highlights specifically how ACAHO members have responded to the pressures associated with wait times, the barriers or challenges they have faced, as well as the successes they have realized; that is linking investments in "inputs" to system "outputs".

This report – the second of its kind - highlights specifically how ACAHO members have responded to the pressures associated with wait times, the barriers or challenges they have faced, as well as the successes they have realized; that is linking investments in "inputs" to system "outputs". It is important to note that as important as they are, this report does not address provincial government wait time initiatives more generally.

This report is structured around six inter-locking themes:

First, this survey takes stock of *provincial investments* targeted towards the reduction of wait times, towards wait time research, as well as investments in information technology.

Measures to increase capacity –in its dimensions are reported in the second theme; third, *wait time management initiatives, including benchmarking, the role of information technology, central booking systems, prioritization tools and clinical appropriateness guidelines* are described.

The fourth theme explores *public- private partnerships* as they exist in the health sector, specifically with respect to contracting out services to other public or private providers in order to reduce the length of time patients wait for health services.

Prior to, and since the 2004 First Ministers Accord, a number of provincially-funded wait times initiatives have taken root in Teaching Hospitals and Regional Health Authorities across the country. In many cases, these investments are targeted towards initiatives which would realize a reduction in wait times—such as increasing surgical volume; in other cases, funding has been earmarked for wait times research, or investments in information technology.

The fifth theme discusses *outcomes measurement* or initiatives which have successfully reduced wait times, length of stay or increased patient throughput.

The sixth theme takes aim at *future wait time priority areas*, above and beyond those which have been identified by First Ministers.

Please note that the detailed and collated surveys from all seventeen respondents can be found online at the Association's website, www.acaho.org.

WAIT TIME INVESTMENTS

Prior to, and since the 2004 First Ministers Accord, a number of provincially-funded wait times initiatives have taken root in Teaching Hospitals and Regional Health Authorities across the country. In many cases, these investments are targeted towards initiatives which would realize a reduction in wait times – such as increasing surgical volume; in other cases, funding has been earmarked for wait times research, or investments in information technology.

In Alberta, the provincial government partnered with the regions, physicians and the Alberta Bone & Joint Institute to reorganize the care pathway associated with hip and knee surgery. Specifically, $20 million was invested to compare the outcomes of joints replaced using the new care pathway, with joints replaced using the existing system. In Ontario, the provincial Wait Time Strategy focuses on five elements: Accountability, Access Management, Capacity, Evaluation, and Communication. A number of Ontario Teaching Hospitals are involved in the strategy, as this report documents.

Select ACAHO members report provincial investments specifically targeted towards health research, including graduate fellowships for evidence-based practice initiatives.

Provincial investments in information technology were common. ACAHO members report enhancing their central electronic registry with urgency measures, procedures and patient information. Considerable investments were also being made towards the development, or refinement of Electronic Health Records (EHR) as in British Columbia, Alberta, Ontario and Newfoundland. Almost every member reported taking measures to increase the connectivity amongst delivery points in the health system.

Overall capacity, be it within a Teaching Hospital, a Regional Health Authority, or the health system as a whole, plays a critical role impacting the timeliness with which Canadians receive health services.

MEASURES TO INCREASE CAPACITY

Overall capacity, be it within a Teaching Hospital, a Regional Health Authority, or the health system as a whole, plays a critical role impacting the timeliness with which Canadians receive health services.

In principle, there are a number of policy levers to consider in order to increase capacity within the health care system. While many ACAHO members have taken steps to augment the number of providers of health care (including physicians, nurses and technologists), nearly every institution or health region surveyed had in place coordinated care processes in order to increase patient throughput. A number of ACAHO members

have also made significant investments in medical technology, while others have expanded the hours of operation for existing surgical suites in order to maximize throughput or increased the number of suites in general.

WAIT TIME MANAGEMENT INITIATIVES

Wait time management initiatives vary considerably across ACAHO members. Reflecting local circumstances, a mixture of different investments and strategic initiatives are underway to strengthen the public system so that it will remain flexible, innovative and responsive to the changing needs of Canadians for years to come. Independent of the technology or tools in place, ultimately, an individual, or a team of individuals are required to measure, monitor and manage wait time initiatives on an ongoing basis. From Provincial Steering Committees to Internal Executive Committees, a number of effective management frameworks or models are reported by ACAHO members to oversee initiatives associated with wait times.

Reflecting local circumstances, a mixture of different investments and strategic initiatives are underway to strengthen the public system so that it will remain flexible, innovative and responsive to the changing needs of Canadians for years to come.

This chapter reports on measures members are taking to meet benchmarks identified by the First Ministers in 2004, as well as the barriers or challenges they encounter along the way. Physical capacity and financial resources, in addition to human resource shortages were the barriers most frequently cited, however establishing partnerships between Regions, provider groups and governments for the purposes of working collaboratively on initiatives to benefit patients continues to be a challenge for many ACAHO members. Respondents who provide care exclusively to paediatric populations cite the lack of paediatric benchmarks for timely access to care to be problematic as well.

Lastly, this chapter remarks on the role of information technology in wait list management, as well as the prevalence of central booking systems, prioritization tools, and clinical appropriateness guidelines. Central booking systems were organized at three levels—institutionally, regionally and provincially. Regional systems were most prevalent amongst ACAHO members. Almost every member had a clinical assessment or prioritization tool in place by which to moderate demand and ensure that available resources are used appropriately. The same can be said for clinical appropriateness guidelines.

PUBLIC-PRIVATE PARTNERSHIPS

A Public-Private Partnership (or P3) is a contractual arrangement between a public payer and a private provider that obligates the private provider to deliver a specified level of services, under particular terms, in exchange for public financing. ACAHO asked survey participants whether their institution or Region has considered contracting out services to other public or private providers in order to reduce the length of time patients wait for a particular health service. The majority of respondents indicate that they currently do not contract out services.

MEASURING OUTCOMES

There is no single "solution" for solving wait times. Rather, queues will slowly diminish over a period of time as a result of focus on the continuum of care and an emphasis on evidence-based outcomes. Ultimately, the policy discussions at the federal, provincial/territorial and regional levels, and the investments dedicated to reducing wait times aim to achieve this one goal: improved clinical outcomes. On balance, improved

outcomes are the ultimate measure of success when wait time reduction strategies are reviewed and evaluated. Outcomes are what matter most to Canadians.

From increased patient flow, to reduced length of stay, ACAHO members report wait time reductions across the spectrum of care. The Alberta Hip and Knee Project is a leading example where wait times for patients involved in the project have dropped from between 6 and 18 months to less than 5 weeks. A centralized point of entry, centralized data repository for tracking and analysis, standardized referrals, regional triage criteria and use of evidence based care pathways, protocols and guidelines are largely responsible for the reduction in wait times. The project also features comprehensive follow-up services. ACAHO members in Alberta also credit the collaboration between Academic Centres, the provider groups and the government for their success. Working collaboratively with other health regions across the province has reduced inter-regional variations and supports best practice development on a larger scale.

This chapter highlights many other successful initiatives in ACAHO member institutions across the country.

OTHER WAIT TIME PRIORITY AREAS

Consistently, members of ACAHO raised the concern that a relentless focus only on the five priority areas identified by First Ministers could have a negative impact in terms of minimizing investments that are required in other areas of the health system.

Consistently, members of ACAHO raised concern that a relentless focus only on the five priority areas identified by First Ministers could have a negative impact in terms of minimizing investments that are required in other areas of the health system. Every respondent to the survey was able to readily identify further priority areas, above and beyond hip and knee replacement surgery, cancer therapy, cardiac surgery, cataract surgery and diagnostic imaging.

Specifically, wait time benchmarks for paediatrics are long overdue according to the vast majority of ACAHO members, as are benchmarks for mental health, chronic disease management, and continuing care.

Canadians place tremendous value on their health system. They expect a health system which provides them with timely access to a range of quality health services. Canadians also realize their health care system must be both sustainable and affordable. This report highlights a number of initiatives which are ongoing within Teaching Hospitals and Regional Health Authorities across the country. In many tangible ways, ACAHO members are implementing a series of innovative measures that serve to improve the overall flexibility, responsiveness, efficiency and effectiveness of the health system.

"WAIT" WATCHERS II:
MEASURING PROGRESS OF WAIT TIME MANAGEMENT STRATEGIES ACROSS ACAHO MEMBERS

CHAPTER ONE: PURPOSE AND NATIONAL POLICY CONTEXT

i. Purpose

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

The purpose of this report is to acknowledge and take stock of progress the members of the Association of Canadian Academic Healthcare Organization (ACAHO) have made developing and implementing wait time management strategies for publicly funded health services. This report also reviews outcomes as a result of these initiatives.

Specifically, members were asked to respond to the following thematic areas: provincial investments in wait times; measures to increase capacity; wait time management initiatives including benchmarking, the role of information technology, central booking systems, prioritization tools and clinical appropriateness guidelines; public private partnerships; outcomes measurement; and future wait time priority areas.

Provincial government wait time initiatives more broadly are not covered in this report which focuses exclusively on the results of a survey of Teaching Hospitals and Regional Health Authorities across the country (i.e., members of ACAHO). The survey methodology is included in Appendix A of this report. The following 17 ACAHO members completed the survey, administered in February 2006:

- **Vancouver Coastal Health Authority**
- **Provincial Health Services Authority (British Columbia)**
- **Capital Health (Edmonton)**
- **Calgary Health Region**
- **Regina Qu'Appelle Health Region**
- **Saskatoon Health Region**
- **London Health Sciences Centre**
- **St. Joseph's Health Care (London)**
- **St. Joseph's Healthcare (Hamilton)**
- **Hospital for Sick Children (Toronto)**
- **Kingston General Hospital**
- **Hotel Dieu Hospital (Kingston)**
- **Children's Hospital of Eastern Ontario (Ottawa)**
- **SCO Health Service (Ottawa)**
- **IWK Health Centre (Halifax)**
- **Capital District Health Authority (Halifax)**
- **Eastern Region Integrated Health Authority (St. John's)**

The results of this survey will be disseminated at the Third Colloquium on Wait Times *("The Taming of the Queue III"),* March 30-31, 2006. 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, as well as policy researchers.

The conference has two key objectives. The first is to take stock of current activities and lessons learned in wait time management strategies across Canada. The second is to examine key issues that have the potential to transform how access to health services is managed in Canada.

Last year, the Colloquium brought together over 125 participants from across the country and internationally to discuss access and wait time issues from a range of perspectives. Both the 2004 and 2005 colloquiums contributed towards enhanced knowledge about the issue, exchange of best practices and helped to shape the public policy agenda.[i]

Note: The detailed and collated surveys from all respondents can be found online at the Association's website, www.acaho.org.

ii. National Policy Context

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, Canadians confidence in the health care system is closely aligned with their ability to access quality health services on a timely basis.[ii]

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

To address these pressing health policy concerns which 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 entitled *"A Ten Year Plan to Strengthen Health Care"*.[iii] In this agreement, First Ministers identified five priority areas of health services to achieve "meaningful reductions in wait times": cancer therapy, cardiac surgery, diagnostic imaging, hip and knee replacement surgery and cataract surgery.

In December 2005, First Ministers and Provincial Health Ministers announced a first set of evidence-based benchmarks for medically acceptable wait times in all five of the priority areas.[iv] More recently, the federal government has committed to accelerating the implementation of benchmarks by the end of 2006.

Furthermore, the potential impact of the Chaoulli/Zeliotis Supreme Court ruling on the exclusive role that the public system occupies in providing core medical services to Canadians is significant in light of the federal government's recent commitment to work with the provinces to develop a Patient Wait Times Guarantee. This Guarantee will ensure that all Canadians receive essential medical treatment within clinically acceptable wait times, otherwise comparable treatment will be sought within other jurisdictions.

Given the intensity and focus on wait times in Canada, the purpose of this report is to acknowledge and take stock of progress the members of the Association of Canadian Healthcare Organizations (ACAHO) have made developing and implementing wait time management strategies for publicly funded health services. This report identifies pockets of excellence and innovation across the country positively impacting the order of patients waiting for care and treatment, and the speed with which they move through the system. Much of the measurable progress ACAHO members have achieved can be attributed to a collaborative and working relationship with members' respective provincial governments. Finally, this report also measures outcomes as a result of wait time initiatives.

CHAPTER TWO: WAIT TIME INVESTMENTS

When Canada's First Ministers gathered in Ottawa in September 2004, re-assuring Canadians that they would receive timely access to quality health services, according to need was the most pressing policy issue on their agenda.[v] Collectively, First Ministers agreed that access to timely care across Canada was an important national priority.

In their *Ten Year Plan to Strengthen Health Care*, five priority areas of health services were identified in which to achieve "meaningful reductions in wait times": cancer treatment, cardiovascular surgery, diagnostic imaging, joint replacements and sight restoration.[vi] Specifically, this included the establishment of evidence-based wait time benchmarks, and multi-year targets to achieve these benchmarks.

As a result of the 2004 First Ministers Accord, the $5.5 billion Wait Time Reduction Fund (WTRF) was established by First Ministers to augment provincial and territorial investments targeted towards initiatives which are intended to "reduce the queue."

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". The funding for the WTRF was confirmed in the 2005 Federal Budget, as was $110 million over five years for the Canadian Institute for Health Information (CIHI), specifically to ensure health system performance information is collected and made available to Canadians. A further $15 million over four years was set aside for Health Canada to focus on wait times.[vii]

Since late 2004, a number of provincially funded wait times initiatives have taken root in ACAHO member institutions/regions across the country. In many cases, the funds are targeted towards initiatives which would realize a reduction in wait times; in other cases, money has been earmarked for valuable wait times research, or investments in information technology.

I. PROVINCIAL INVESTMENTS SPECIFICALLY TARGETED TOWARDS THE REDUCTION OF WAIT TIMES

ACAHO asked members to describe any provincial funding they received since January 2005, specifically targeted towards the reduction of wait times.

Vancouver Coastal Health Authority reports the Ministry of Health provided surgical augmentation funding in the amount of $24 million for in fiscal year 2005/06, specifically for wait list reduction. In January 2006, the Ministry of Health provided the Health Authority with a further $25 million to perform 1,600 additional hip and knee replacement procedures for British Columbia patients through the UBC Centre for Surgical Innovation in Hip and Knee Reconstruction. **Provincial Health Services Authority (British Columbia)** received $1.9 million for wait time reduction initiatives in fiscal year 2005/06. This money has been specifically directed towards the reduction of cardiac wait lists provincially.

Capital Health (Edmonton) and the **Calgary Health Region** are both participating in the Alberta Hip & Knee study which takes aim at reducing wait times for hip and knee surgery. The provincial government partnered with the Health Regions, the physicians and the Alberta Bone & Joint Institute to reorganize the care pathway for joint replacement. Specifically, $20 million was invested to compare 1,200 joints replaced according to a new care pathway, with joints replaced as per the status quo among three other health regions.

Almost all ACAHO members report provincial investments to reduce wait times in their jurisdiction. In some cases, funding was targeted to specific surgical procedures (for example cataract surgery), in other cases, funding targeted increased capacity (expanding the number of available beds, or expanding hours of operation).

Capital Health (Edmonton) and **Calgary Health Region** are also working on three other provincial waiting list access initiatives involving breast cancer, prostate cancer and cardiac surgery. The goal is to find innovative ways to improve access and reduce waits and/or delays from diagnosis through to treatment of the disease.

Regina Qu’Appelle Health Region has received $2.6 million to reduce wait times in the Region. This funding will be used to expand the number of available beds, improve operating room scheduling, and decant some non-surgical services that have traditionally been delivered within the surgical care system. In neighbouring **Saskatoon Health Region,** funding from the province will address surgical patients who have waited in excess of 18 months for inpatient surgery and 12 months for day surgery procedures.

Beginning in January 2005, and ongoing to-date, **London Health Sciences Centre** has received specific wait time funding from the Ontario Ministry of Health and Long Term Care to support additional activity in total joint replacement, select cancer surgery, MRI and CT scanning, as well as cardiac (revascularization) services. The funding is contingent on achieving a particular volume over and above a set baseline (in most cases, 2002/03 volumes are used as a baseline). **St. Joseph’s Health Care (London)** has received provincial funding to support additional cataract procedures and additional cancer surgeries.

St. Joseph’s Healthcare (Hamilton) has received $4.6 million specifically targeted towards the reduction of wait times between January 2005 and March 2006.

The Hospital for Sick Children (HSC) received a grant from the Ontario Wait Time Strategy Innovation Fund in April 2005 in the amount of $358,000 to support development of an on-line referral management system that has the capacity to measure and report wait times for specialized paediatric care.

In September 2005, **the Hospital for Sick Children** also received $9,000 under Ontario’s Wait Time Strategy to conduct 12 additional cataract surgeries. Of note, the Hospital is a member of the Ontario Children’s Health Network (OCHN). This network of the six paediatric academic health science centres received $267,000 to address provincial challenges around surgical wait times for paediatrics.

Hotel Dieu Hospital (Kingston) received provincial funding to perform 300 cataract surgeries at a cost of $750 each. Meanwhile, at the **Kingston General Hospital,** provincial funding has targeted hip and knee surgery, cancer surgery as well as cataract surgery according to the Ontario Wait Time Strategy for Incremental Volume.

In addition to the aforementioned OCHN funding, the **Children’s Hospital of Eastern Ontario** received incremental funding to increase the hours of operation for diagnostic imaging, specifically MRIs.

In Halifax, **Capital District Health Authority** has opened an additional 25 orthopedic beds, and received funding to improve access to mental health services. The Department of Health also recently approved an upgrade of one MRI (in total, four new MRIs were announced for the province) and added a linear accelerator and new digital simulator for radiotherapy.

The Department of Health and Community Services for Newfoundland has targeted approximately $4 million to reduce wait times for services offered within Hospitals of St. John's (HSJ). **Eastern Regional Integrated Health Authority** has received $10 million earmarked specifically for capital equipment. Funding has also been set aside for diagnostic equipment (CT scanners, ultrasounds, echocardiograms, and mammography), as well as to increase operating room capacity and equipment for the priority areas of cancer therapy and joint replacement surgery.

Figure 1: Provincial Investments in ACAHO Members

ACAHO Member	Provincial Investments Targeted Towards Wait Time Reduction Initiatives?	
	Yes	Not at this time
Vancouver Coastal Health Authority	✓	
Provincial Health Services Authority	✓	
Capital Health (Edmonton)	✓	
Calgary Health Region	✓	
Regina Qu'Appelle Health Region	✓	
Saskatoon Health Region	✓	
London Health Sciences Centre	✓	
St. Joseph's Health Care (London)	✓	
St. Joseph's Healthcare (Hamilton)	✓	
Hospital for Sick Children	✓	
Hotel Dieu Hospital (Kingston)	✓	
Kingston General Hospital	✓	
Children's Hospital of Eastern Ontario	✓	
SCO Health Service		✓
IWK Health Centre (Halifax)		✓
Capital District Health Authority (Halifax)	✓	
Eastern Regional Integrated Health Authority	✓	

II. PROVINCIAL INVESTMENTS SPECIFICALLY TARGETED TOWARDS RESEARCH

In terms of funding specifically targeted towards wait times research, very few ACAHO members reported activity.

In terms of *provincial funding specifically targeted towards wait times research*, very few ACAHO members reported activity. **Capital Health (Edmonton)** and **Calgary Health Region,** both participating in the Alberta Hip & Knee study, conducted a randomized controlled study to test new care paths, process and redesign of services for hip and knee replacement.

Meanwhile, **Eastern Regional Integrated Health Authority** is currently supporting a Graduate Fellowship for Evidence Based Practice Initiatives with the target area of study for 2005/06 on Wait Time Processes for Orthopedic Surgery.

Eastern Regional Integrated Health Authority has also provided support to audit the current elective adult surgical wait list through a patient questionnaire mail out. The purpose of the questionnaire and audit is to review those waiting for surgery to determine their current health status, whether they wish to remain on the wait list, and whether they are willing to be placed on the wait list of another surgeon if it results in an earlier surgical date.

Figure 2: Provincial Investments Targeted Towards Wait Times Research in Members of ACAHO

ACAHO Member	Provincial Investments Targeted Towards Wait Times Research?	
	Yes	Not at this time
Vancouver Coastal Health Authority		✓
Provincial Health Services Authority		✓
Capital Health (Edmonton)	✓	
Calgary Health Region	✓	
Regina Qu’Appelle Health Region		✓
Saskatoon Health Region		✓
London Health Sciences Centre		✓
St. Joseph’s Health Care (London)		✓
St. Joseph’s Healthcare (Hamilton)		✓
Hospital for Sick Children		✓
Hotel Dieu Hospital (Kingston)		✓
Kingston General Hospital		✓
Children’s Hospital of Eastern Ontario		✓
SCO Health Service		✓
IWK Health Centre (Halifax)		✓
Capital District Health Authority (Halifax)		✓
Eastern Regional Integrated Health Authority	✓	

The Canadian Institutes of Health Research (CIHR) is actively engaged in a number of research projects involving wait times.[viii] In many cases, this research is taking place in ACAHO member institutions or Regional Health Authorities. "Timely access to quality care for all" was recognized as a priority health services and policy research area in the national *Listening for Direction II* consultations that took place in 2004, the themes of which now guide CIHRs Institute of Health Services and Policy Research’s (IHSPR) investments and activities.[ix]

In February 2005, IHSPR partnered with Canada's Provincial/Territorial Ministers of Health, as well as the CIHR Institutes of Cancer Research and Musculoskeletal Health and Arthritis, to launch a rapid-response Request for Applications (RFA) to fund initiatives designed to inform the establishment of evidence-based benchmarks. Funded initiatives were to detail the wait time benchmarks currently in use; synthesize the evidence on the relationships between clinical condition, wait times and health outcomes or quality of life; and identify the priority areas and questions for future research, with reports timed to meet the information needs and timelines of the Federal/Provincial/Territorial Ministers of Health.

III. INVESTMENTS IN INFORMATION TECHNOLOGY

In order to fully leverage the development of provincial benchmarks and targets, strategic investments are required to support health information management capacity. With better information management systems, health professionals and providers have improved

access to health information, including test results, in order to make informed decisions for patient care. *ACAHO asked members to describe investments in information technology which have been made* *<u>over the last twelve months</u>* *with an aim to reduce or more effectively manage wait times.*

a. Central electronic registry with urgency measures, procedures and patient information

In order to fully leverage provincial benchmarks and targets, strategic investments are required to support health information management capacity. ACAHO asked members to describe investments in information technology which have been made over the last twelve months with an aim to reduce or more effectively manage wait times.

With a provincial investment of $5 million, **Vancouver Coastal Health Authority** reports that British Columbia is building a 'live' Surgical Patient Registry with a daily extract of scheduled and unscheduled wait list and completed case information from all British Columbia hospitals. The Registry will be populated with increasing amounts of data beginning in June 2006. Part of the data captured in the registry will include specialty specific prioritization scores assigned to each scheduled patient, based on tools adapted from the Western Canada Wait List Project. The **Provincial Health Services Authority** is leading the Provincial Surgical Services Project with the BC Regional Health Authorities (RHA), and is responsible for creating this new Surgical Patient Registry for the province.

The **Calgary Health Region** is working with the Alberta Bone and Joint Institute to coordinate and test urgency scores (using Western Canada Wait List criteria) to validate a central intake process which ranks and prioritizes patients to ensure the most urgent are seen first.

The **Regina Qu'Appelle Health Region,** the **Saskatoon Health Region** and the province of Saskatchewan together have established a comprehensive surgical registry. The data in this registry is supplied by the Regional Surgical Information System. The provincial government has provided funding to the Region to adequately resource data entry into the registry.

London Health Science Centre (LHSC) and **St. Joseph's Healthcare Hamilton** are currently participating in an initiative sponsored by the Ministry of Health to establish a central provincial registry for the five select areas of the wait time strategy. This will allow both physician offices and hospitals to enter/merge data for wait times for the five key areas outlined by First Ministers. Phase II of the Wait Time Information System (Enterprise Master Patient Index or EMPI) is targeted for implementation by December 2006. **LHSC** has been approached to participate in the Phase II implementation.

Over the last twelve months, the **Children's Hospital of Eastern Ontario** has participated in an initiative of the Ontario Child Health Network (OHCN) which seeks to specifically define priority rankings, to develop an inventory of paediatric services, and to identify a technological system that will allow for the integration of paediatric Academic Health Science Centres' capacity and service demands. The work began by looking at surgical subspecialties for paediatrics, and is currently being expanded to include medicine subspecialties and diagnostic services.

The **IWK Health Centre** has invested in a community-wide scheduling program (Meditech) which collects patient information based on referral date, triage priority, and access target standards. In Newfoundland, **Eastern Regional Integrated Health Authority** has implemented an electronic central adult surgical wait list with priority

rating documentation as of April 1, 2005. This system is specific to the adult surgery program currently, but will be used for all surgical patients within the next few months.

Figure 3:Recent Investments in Central Electronic Registries in ACAHO Members

ACAHO Member	Recent Investments in Central Electronic Registries?	
	Yes	Not at this time
Vancouver Coastal Health Authority	✓*	
Provincial Health Services Authority	✓*	
Capital Health (Edmonton)	✓	
Calgary Health Region	✓	
Regina Qu'Appelle Health Region	✓	
Saskatoon Health Region	✓	
London Health Sciences Centre	✓	
St. Joseph's Health Care (London)		✓
St. Joseph's Healthcare (Hamilton)	✓	
Hospital for Sick Children		✓
Hotel Dieu Hospital		✓
Kingston General Hospital		✓
Children's Hospital of Eastern Ontario	✓	
SCO Health Service		✓
IWK Health Centre (Halifax)	✓	
Capital District Health Authority (Halifax)		✓
Eastern Regional Integrated Health Authority	✓	

* The Institution or Region is in the process of implementing a central registry.

b. Electronic Health Records

Considerable investments have been made in British Columbia targeting the development of an electronic health record (EHR). A comprehensive submission has been made to Canada Health InfoWay to support the funding of this initiative and an eHealth Steering Committee has been formed to guide EHR related projects, comprised of representation from the Ministry of Health and the Regional Health Authorities. **Provincial Health Service Authority's** Provincial Surgical Services Project is classified as one of the province's eHealth priority projects. **Vancouver Coastal Health Authority** is involved in this initiative as well.

Capital Health (Edmonton) launched a regional electronic health record (netCARE), in April 2004. NetCARE is an integrated EHR that connects existing patient information systems located in hospitals and clinics across the region. The quality and safety of patient care is enhanced by increased access to more accurate and up-to-date information.

The **Calgary Health Region** is currently in the process of developing the patient care information system. This will assist in the collection, monitoring and measurement of patient care, including wait times. The Alberta Government has supported the introduction of electronic health records within specialty groups across the province. The Alberta Orthopedic Society has agreed to a common EHR to help manage patient information provincially as well as locally. With the common platform, the integration of waiting lists for surgeons in partnership with the regions can be accomplished. In doing

so, shared responsibility for the organization, sorting and management of the waiting list is possible.

Figure 4: Prevalence of Electronic Health Records amongst ACAHO Members

ACAHO Member	Electronic Health Record in place?	
	Yes	Not at this time
Vancouver Coastal Health Authority	✓*	
Provincial Health Services Authority	✓*	
Capital Health (Edmonton)	✓	
Calgary Health Region	✓*	
Regina Qu’Appelle Health Region		✓
Saskatoon Health Region		✓
London Health Sciences Centre	✓	
St. Joseph’s Health Care (London)	✓	
St. Joseph’s Healthcare (Hamilton)	✓	
Hospital for Sick Children	✓	
Hotel Dieu Hospital (Kingston)		✓
Kingston General Hospital		✓
Children’s Hospital of Eastern Ontario		✓
SCO Health Service		✓
IWK Health Centre (Halifax)	✓*	
Capital District Health Authority (Halifax)		✓
Eastern Regional Integrated Health Authority	✓**	

* The Institution or Region is in the process of implementing an electronic health record
** Many, but not all institutions in the region have a fully operational EHR

Increasingly, ACAHO members are reporting that networks are in place to connect their institutions to other health providers or health services in the community.

London Health Sciences Centre and **St. Joseph’s Health Care (London)** are currently involved in a region-wide electronic patient record project. This has been ongoing for over twelve months and will provide connectivity within the region.

St. Joseph’s Healthcare Hamilton is participating in the provincial roll out of the Enterprise Master Person Index (EMPI).

Capital District Health Authority has invested in, and is beginning to implement a document imaging tool (Horizon Patient Folder) which scans and stores health records.

At **Eastern Regional Integrated Health Authority** there have been no new investments in the electronic health record except funding directed to the wait list management system used for the surgical wait list that has not yet been integrated into the health information system. Discussions with the provincial government with respect to funding the next phases of implementation of the electronic health record are ongoing.

c. *Increased Connectivity Among Delivery Points*

Provincial Health Services Authority reports that the province of British Columbia has a dedicated, secure health network connecting all of the Regional Health Authorities. Some health authorities (including **Vancouver Coastal Health Authority**) have begun the process of connecting with physicians’ offices and other community services.

The implementation of "Pathways", a computer matching program in **Capital Health (Edmonton),** has helped to reduce wait lists for community care by more expeditiously matching continuing care patients in acute care, with available beds in the community.

Projects underway in **Calgary Health Region,** such as the central intake system and the electronic health record, all employ methodologies to reorganize the trajectory of care from family physician through to specialists, into acute care and back to the community. The re-organization across the continuum has resulted in significant reductions in wait times.

Regina Qu'Appelle Health Region has spent considerable time working on the issue of connectivity among delivery points and has now assumed responsibility for scheduling. This means that the Region (as opposed to the physician's office) contacts patients and books surgical appointments. This initiative has paid large dividends:

1. The **Regina Qu'Appelle Health Region** has increased their ability to functionally manage operating room time.

2. As the **Regina Qu'Appelle Health Region** "owns" the waiting list with the physicians, the Region is aware of which patients are on the list and what the status of these patients are.

3. The Region bearing responsibility for scheduling has functionally improved coordination between the Region and the physician's offices.

4. The Region has better control and ability to manage how patients are queued for surgery. As a result, scheduling changes occur proactively to improve facility utilization. For example, the system can routinely project bed capacity two or three days in advance. When the system is overcrowded, the operating room slate can be varied proactively preventing a potential crisis.

Regina Qu'Appelle Health Region has endeavored to manage surgical postponements at least two days in advance since November 2005. While nonetheless unfortunate, proactive postponements are much more welcome by patients compared to last minute cancellations. Further, when working in advance, it is possible to back fill any inpatient cases with day cases so as to fully utilize available surgical theatre time.

Through the provincial Primary Healthcare Information Program, Capital District Health Authority is supporting the implementation of electronic patient records in at least fifteen family practices throughout the district.

At the **London Health Sciences Centre,** the electronic patient record aims to improve connectivity to physicians' offices and hospitals within the Thames Valley Hospital Planning Partnership.

The **Hospital for Sick Children** has developed a web based ambulatory tool that has enhanced connectivity to community physicians' offices at no cost.

In Kingston, the **Kingston General Hospital** has recently added the Lennox and Addington County General Hospital to their wait list management system (Axcess.Rx), specifically focused on cataract and general surgery.

Through the provincial *Primary Healthcare Information Program (PHIM)*, **Capital District Health Authority (Halifax)** is supporting the implementation of electronic patient records (EPR) in at least fifteen family practices throughout the district. An EPR

provides a clinic with a fully electronic patient record, state-of-the art patient scheduling, and automated billing systems. The Department of Health is currently leading an initiative to develop connectivity between the PHIM funded practices and hospital facilities. As a result, in the coming months, these practices will also have access to lab and diagnostic imaging results. Primary care is also working to ensure that the same connectivity becomes available to the other approximately fifty physicians in the district who already have an EPR.

The Surgical Waitlist Committee at **Eastern Regional Integrated Health Authority** began a three-month pilot of physician office access to the MSM Wait list Management System in December 2005. This process links the physician's office with the wait list for data entry at point of care as well as access to the physician's specific wait list by organized patient, procedure, urgency rating and wait time.

d. Other Investments in Information Technology

ACAHO members across the country are reporting investments in information technology which are facilitating the development of operating booking systems, and management information systems, for example.

Vancouver Coastal Health Authority reports they have implemented a standard operating room booking system encompassing four of the five major urban centres within the Health Authority. The final site will be operational by March 31, 2007. **Vancouver Coastal Health Authority** has also built a software model to consistently and transparently allocate operating room time by surgeon, service and site within the Health Authority.

Central intake methodologies and partnerships with the physicians have facilitated the **Calgary Health Region** to explore better ways to manage waiting lists and to create urgency scores to help triage patients in an effective manner.

The **Saskatoon Health Region** has been participating with the province in the selection of a province-wide Surgical Information System and is now in the process of planning its initiation.

In the past twelve months, a Cerner software project specific to operating rooms (SurgiNet) has been implemented at each site within **London Health Sciences Centre**. The main purpose of this software is to act as a booking system. During the implementation of SurgiNet, attention has been paid to ensure the functionality necessary to support wait time management efforts.

At **St. Joseph's Health Care (London)** operating room booking systems are now electronic and will soon be connected to physician offices as part of the hospital Electronic Patient Record roll out. Information technology related to the provincial wait time strategy will be implemented by the end of 2006.

St. Joseph's Healthcare (Hamilton) is currently in the Request for Proposal (RFP) process for a new Peri-operative Information System. The wait list strategy reporting requirements will be included in this new information system.

The **Hospital for Sick Children (HSC)** is implementing a new management information system which will more effectively manage wait times. This system will facilitate reporting of wait times by surgical subspecialty. As part of this implementation, **HSC** is concurrently developing an IT solution to address wait times.

With respect to ambulatory services, the Innovation Fund Grant has enabled the development of an automated, online paediatric referral system that streamlines access procedures, supports more effective management of referrals, and facilitates reduction of wait times at the **Hospital for Sick Children**. Using a web-based application, the Ambulatory Referral Management (ARM) system provides electronic routing for submission, review, triage and management of internal and external patient referrals as well as calculation and reporting of wait times by clinic, by priority ranking.

In order to facilitate data gathering for initiatives such as the Ontario Children’s Health Network (OCHN) wait list project, the **Children’s Hospital of Eastern Ontario** has incorporated new knowledge into decisions made with respect to a new operating room booking system. **The Children’s Hospital of Eastern Ontario** has also supported and completed a two year project looking at internal measurement modalities to track wait times from time of receipt of new referral, to time of first appointment for ambulatory care clinical services.

Figure 5: Other ACAHO Member Investments in Information Technology

ACAHO Members	Operating Room Booking Systems	Management Information Systems	Other Investments
Vancouver Coastal Health Authority	✓		
Provincial Health Services Authority			
Capital Health (Edmonton)			
Calgary Health Region			✓
Regina Qu’Appelle Health Region			✓
Saskatoon Health Region		✓	
London Health Sciences Centre	✓		
St. Joseph’s Health Care (London)	✓		
St. Joseph’s Healthcare (Hamilton)		✓	
Hospital for Sick Children		✓	
Hotel Dieu Hospital (Kingston)			
Kingston General Hospital			
Children’s Hospital of Eastern Ontario	✓		✓
SCO Health Service			
IWK Health Centre (Halifax)			
Capital District Health Authority (Halifax)		✓	
Eastern Regional Integrated Health Authority	✓	✓	✓

Capital District Health Authority (Halifax) is involved in a number of other information technology initiatives including the installation of a surgical department management tool, specifically the tool developed at **Kingston General Hospital** (Axcess.Rx)**.** Amongst other initiatives, the Department of Medicine has developed Triage Criteria and Wait Time Standards for ambulatory care consultations for family physicians and their patients which is available on the internet. Significant efforts are

Capital District Health Authority is involved in a number of other information technology initiatives including the installation of a surgical department management tool, specifically the tool developed at the Kingston General Hospital.

being made to meet the target wait times. Several departments within **Capital District Health Authority** are reporting via this new internet tool.[x]

Eastern Regional Integrated Health Authority is currently pursuing the wait list application with their Health Information System provider, Meditech, in the Community Wide Scheduling Module for use in ambulatory clinics and diagnostic imaging departments in the Region. **Eastern Regional Integrated Health Authority** is also implementing the 'white board' wait list process for emergency case operating room management through the MSM system for the operating rooms of Hospitals of St. John's (HSC). The 'white board' system waitlists patients as per the peri-operative program urgency rating scale.

Working with Information Technology staff, **Eastern Regional Integrated Health Authority** is upgrading and linking current databases to facilitate data entry and reporting required to support benchmarks. Finally, the Region is implementing a wait list management process for Mental Health.

CHAPTER THREE: MEASURES TO INCREASE CAPACITY

Overall capacity, be it within a Teaching Hospital, a Regional Health Authority, or the health system as a whole, is about the people who provide quality care and the tools and infrastructure they need to deliver it.

Overall capacity, be it within a Teaching Hospital, a Regional Health Authority, or the health system as a whole, is about the people who provide quality health services and the "tools and infrastructure" they need to deliver it.

For the purposes of consistency, this report, as did the initial Wait Watchers report, defines capacity 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* (i.e. new facilities, additional beds, medical equipment) in the system.

Health care in Canada - a $141 billion sector[xi] operates without a national long-term human resources strategy. As a result of an aging population, a graying workforce and changing practice patterns, Canada is experiencing a serious workforce shortage in many health care disciplines. In addition to ensuring that the supply of health care providers is sufficient to meet the health needs of Canadians, health providers must have the tools and the facilities to respond to their patients.[xii]

In principle, there are a number of policy levers which exist to increase capacity within the health care system. *ACAHO surveyed members with respect to a number of measures which would contribute to increasing capacity within the public health care system.*

While many ACAHO members have taken steps to increase the number of providers of health care (including physicians, nurses and technologists), nearly every institution or health region surveyed had in place a coordinated care process in order to increase patient throughput.

While many ACAHO members have taken steps to increase the number of providers of health care (including physicians, nurses and technologists), nearly every institution or health region surveyed had in place coordinated care processes in order to increase patient throughput.[xiii] Irrespective of new or additional capacity, there is much to be gained from improving the quality of management of existing resources. Enhanced coordination and teamwork among health care providers can help reduce delays between different stages of treatment. Clinical practice guidelines and priority-setting tools can also help moderate demand for care and ensure that available resources are used appropriately or more effectively.

A number of ACAHO members have made significant investments in medical technology,[xiv] while others still have expanded the hours of operation for existing surgical suites in order to maximize throughput,[xv] or increased the number of surgical suites in general.[xvi]

The Children's Hospital of Eastern Ontario has installed a new CT scanner and a second MRI is being acquired as well. The second MRI and the new CT scanner are considerably faster than their predecessors and may contribute to reduced wait times via increased throughput. This centre is also evaluating Digital Radiography which will also contribute to improved throughput.

In Halifax, **Capital District Health Authority** has also taken measures to increase capacity. Recruitment efforts are ramping up with regards to professional staff, physicians in particular. Given the projected retirements, the competitive marketplace, the mobility of the workforce and the changing health needs of the patient population, recruitment and retention will continue to be a challenge. With respect to medical

technology, a new CT scanner has been purchased for the new Cobequid Community Health Centre; funding for a PET scanner was also recently announced.

Of interest, Northwood Facility (a private corporation) has been given approval to begin planning for a 150 bed long term care, palliative care, community outreach and rehab service centre located within **Capital District Health Authority**. This should improve patient throughput from the acute care sector into the community.

A number of policies designed to build and manage capacity, and equally to increase activity levels are in place across ACAHO member institutions. In effect, using a mix-and-match policy approach which reflects local circumstances, these measures are contributing not only to enhance capacity in the health system, but a more efficient and effective use of resources.

Figure 6 : Policy Levers to Increase Capacity among ACAHO Members

ACAHO Members	Increase in the number of:				Expanded Hours for Surgical Suite Operation	Investments in Medical Technology	Establish Care Pathways
	MDs	RNs	Technol-ogists	Surgical Suites			
Vancouver Coastal Health	✓	✓		✓			✓
Provincial Health Services Authority		✓				✓	✓
Capital Health (Edmonton)	✓	✓	✓	✓	✓	✓	✓
Calgary Health Region	✓	✓	✓	✓	✓	✓	✓
Regina Qu'Appelle Health Region				✓		✓	✓
Saskatoon Health Region	✓	✓	✓		✓	✓	✓
London Health Sciences Centre					✓	✓	✓
St. Joseph's Health Care (London)	✓				✓	✓	✓
St. Joseph's Healthcare (Hamilton)	✓	✓		✓	✓	✓	✓
Hospital for Sick Children							✓
Hotel Dieu Hospital (Kingston)							
Kingston General Hospital							✓
Children's Hospital of Eastern Ontario	✓	✓	✓			✓	✓
SCO Health Service							
IWK Health Centre (Halifax)	✓	✓				✓	✓
Capital District Health Authority		✓	✓			✓	✓
Eastern Regional Integrated Health Authority	✓	✓	✓	✓		✓	✓

CHAPTER FOUR: WAIT TIME MANAGEMENT INITIATIVES

Planning for the health needs of 32 million Canadians is a demanding, yet significant challenge. A number of moving targets, both in terms of demand—patient expectations, demographics, and changing patterns of illness—and supply—changing standards of care, variations in practice patterns and models of health services delivery underscore the complexity of the task at hand.

Planning for the health needs of 32 million Canadians is a demanding, yet significant challenge. There is no formula that dictates the number of nurses, physicians, hospital beds and varieties of high-tech equipment required to ensure that patients receive quality health services in a timely manner.[xvii] A number of moving pieces, both in terms of demand - patient expectations, demographics, and changing patterns of illness; and supply - changing standards of care, provider demographics, variations in practice patterns and models of health services delivery underscore the complexity of the task at hand.

I. ACTIVE WAIT TIMES MANAGEMENT

ACAHO members were asked who specifically was actively involved in wait list management and monitoring and whether a committee been established. A number of innovative and progressive frameworks were reported by ACAHO members.

A Regional Resource Allocation Methodology (RAM) sub-committee of the Regional Surgical Executive Council (RSEC) was established by the **Vancouver Coastal Health Authority** to develop a regional operating room allocation model and to monitor regional performance against wait time targets. The Project Team of RSEC coordinates the distribution of dedicated funding from the Ministry for wait list reductions based on a review of performance against wait time targets, and reports performance against budgeted volumes as part of a review of surgical activity every fiscal period.

The **Provincial Health Services Authority** has taken a leadership role with the Regional Health Authorities and the Ministry of Health in developing the new surgical patient registry and the development of adult clinical assessment (urgency) tools. A provincial steering committee with Ministry of Health, Regional Health Authority and BC Medical Association representation has been established to guide this large project.

A number of other **Provincial Health Services Authority** staff are extensively involved in wait list management at the BC Cancer Agency and the Provincial Cardiac Program.

Wait list management at **Calgary Health Region (CHR)** is supported through the executive committees applicable to each clinical area. There are also a list of other committees that support wait list management including: the Alberta Bone and Joint Institute, the **CHR** Cardiac Access Committee, the **CHR** Breast Cancer Access Committee, and the **CHR** Prostate Cancer Access Committee.

Regina Qu'Appelle Health Region has a rather unique position within the Region to assist in the operation of the surgical program. This position was staffed specifically to manage surgical wait lists, but has evolved into a hybrid position that is part strategic and part operational management. This individual is tasked with working both with staff and the physician group.

A similar position exists at **Saskatoon Health Region** where the Wait List Manager has the responsibility to analyze, review, recommend and consult regarding the monitoring of the Region's surgical wait list. The Surgical Operations Committee and its executive is

actively involved in the initiatives and operational strategies required in order to achieve the objective of appropriate surgical wait times.

At **St. Joseph’s Healthcare (Hamilton),** the Peri-operative Executive Committee manages and monitors wait times. In Southern Ontario at the **London Health Sciences Centre,** pre-existing structures/committees (for example, operating room committees and senior leadership within the organization) have been involved in managing and monitoring wait times.

At **The Hospital for Sick Children,** the Vice President of Child Health Services and the Chief of Surgery have been leading a provincial Surgical Wait Time Strategy. In addition, the Vice President is leading a task force which is looking at wait times for paediatric medical services across the five paediatric academic health science centres.

Further, an Ambulatory Wait Time Strategy Steering Committee was established at the **Hospital for Sick Children** to oversee a number of initiatives associated with measuring, monitoring and managing wait lists. There are a number of smaller working groups, each responsible for a specific initiative (for example, the Ambulatory Referral Management (ARM) Team or the Decision Support Advisory Committee), that in turn report to a member of the hospital executive.

At the **Children’s Hospital of Eastern Ontario**, it has been recommended that MRI/CT wait times be tracked as a corporate performance indicator and that specific departments identify which clinics will be assessed for wait times. A small working group has been struck to be responsive to provincial requirements for reporting, as well as to facilitate participation in the Ontario Children’s Health Network initiative on an ongoing basis.

Wait list management at Eastern Regional Integrated Health Authority is one of the divisions managed under the Clinical Efficiency Unit. There is a Regional Director, a Manager of Waitlist Services, and clerical support.

In Halifax, **Capital District Health Authority** decentralizes the management and monitoring of wait lists and achievement of benchmarks to the given service areas. **Capital District Health Authority** also has representation on the Provincial Wait Times Advisory Committee.

Wait list management at **Eastern Regional Integrated Health Authority** is one of the divisions managed under the Clinical Efficiency Unit. There is a Regional Director, a Manager of Waitlist Services, and clerical support. Each regional facility of **Eastern Regional Integrated Health Authority** has a dedicated resource to monitor wait list management data collection. There is also a 0.5 full time equivalent (FTE) Information Management support specialist for wait list management.

The Cardiac Care Program has a dedicated full time equivalent to manage and coordinate the provincial Cardiac Care wait list. Newfoundland also has a Provincial Wait List Coordinator who is an employee of **Eastern Regional Integrated Health Authority** with a provincial mandate.

In addition, **Eastern Regional Integrated Health Authority** has received funding to support two FTEs for wait list management processes in the coming fiscal year.

II. BENCHMARKING

As agreed by First Ministers in the *10-Year Plan to Strengthen Health Care*, all jurisdictions agreed to establish, by December 31, 2005, a first set of evidence-based

benchmarks for medically acceptable wait times in all of the five priority areas: cancer, heart, diagnostic imaging, joint replacements and sight restoration. On December 12, 2005, the provincial health ministers announced that the provinces and territories would "strive to provide" the following benchmarks:

- Radiation therapy to treat cancer within four weeks of patients being ready to treat;
- Hip fracture treatment within 48 hours;
- Hip replacements within 26 weeks;
- Knee replacements within 26 weeks;
- Surgery to remove cataracts within 16 weeks for patients who are at high risk;
- Breast cancer screening for women aged 50 to 69 every two years;
- Cervical cancer screening for women aged 18 to 69 every three years after two normal tests.

Three additional wait-time benchmarks for cardiac bypass patients were announced to provide treatment within two weeks to 26 weeks, depending on the severity of the case.[xviii]

Vancouver Coastal Health Authority has assumed a multi-pronged approach to ensure the benchmarks announced by First Ministers will be achieved.

In this section, ACAHO reports on measures that members are taking to meet the benchmarks announced by First Ministers. Barriers or challenges associated with meeting benchmarks are also identified.

Vancouver Coastal Health Authority has assumed a multi-pronged approach to ensure the benchmarks announced by First Ministers will be achieved. For example:

- Enhanced funding from the Ministry has enabled the provision of 1,100 additional hip and knee procedures in 2005/06;
- Regional operating room allocation models assign operating room time by surgeon and service within each site based on relative net arrivals to the wait list and the gap between actual and target wait time;
- A new model will optimize surgical resources by matching operating room case mix throughout the week to bed availability in the intensive care unit and inpatient units, for example;
- A new model is being developed to smooth bed flow, matching anticipated length of stay to inpatient bed capacity throughout the week.

The shortage of peri-operative nurses has forced the closure of two operating rooms at two of the main urban sites of **Vancouver Coastal Health Authority**. As a result, sites have contracted out to private clinics in order to maintain surgical volumes. This is the largest barrier the health authority has met in terms of meeting benchmarks identified by the First Ministers.

The **Provincial Health Services Authority** is currently examining each of the benchmark areas it has responsibility for and is initiating discussions with the Ministry of Health to determine the performance targets for meeting the benchmark standards. Some resource planning discussions have taken place in areas where the **PHSA** anticipates more work will be needed to meet performance standards.

The key obstacles facing the **Provincial Health Services Authority** include physical and financial resources, gaining access to hard to reach populations (e.g. in particular, with

reference to mammography and cervical cytology), and technician and nursing human resources.

Capital Health (Edmonton) continues to strive towards the collection and submission of high quality wait list data (i.e. with less than or equal to a 5% error rate) to the provincial wait list registry. Regional integration initiatives will merge where possible with access to service initiatives that will include planning for fundamental principles of access such as standardizing processes, protocols and guidelines; use of multidisciplinary teams involved in assessment, treatment, and follow up; and the addition of in-patient beds, increased operating room time, and system/service redesign where necessary to meet benchmark guidelines.

Capital Health (Edmonton) is currently meeting national benchmarks for those wait time clinical benchmarks announced to date. Redesigning processes to improve access to services and decrease wait times requires alternative funding arrangements for physicians, change management strategies for new designs, and policies to manage demand which continues to exceed supply.

The **Calgary Health Region** continues to participate in the Alberta Hip and Knee Study. Once results have been collected, the Region intends on looking at opportunities to spread the methodology to a larger volume of patients and to other surgical procedures in order to improve access in a variety of areas.

Currently, **Calgary Health Region** meets First Ministers' benchmarks in cataract surgery, cardiac surgery and hip fracture surgery. Hip and knee replacements should meet benchmark guidelines by 2007. The Region cites the biggest challenge is establishing partners (regions, physician groups and governments) to work together on initiatives which ultimately benefit the patients. While financial pressures are an issue from time to time, additional funding has not been linked to sustainable results in the long term.

The management team at Regina Qu'Appelle Health Region has expressed concerns about prioritizing only the five procedure groups identified by First Ministers. The Region has decided to develop a long-term plan to improve access for all surgeries.

The management team at **Regina Qu'Appelle Health Region** has expressed concerns about prioritizing only the five procedure groups identified by the First Ministers. The Region has decided to develop a long-term plan to improve access for all surgeries. To date, this plan appears to be largely successful in terms of achieving program goals including increasing surgical capacity over three years. The Region will be targeting capacity increases and improved patient queuing with the goal of offering patients a surgical date within six months of referral for all services. **Regina Qu'Appelle Health Region** has a goal to achieve all surgical targets by the Fall of 2008.

Though adequate ongoing funding is critically important to **Regina Qu'Appelle Health Region**, the major barrier to meeting benchmarks has been the chronic human resource shortages. Demographic modeling suggests that these shortages will continue to be the greatest challenge to the surgical program in the Region.

Saskatoon Health Region has taken a multi-pronged approach to meeting benchmarks. Namely, they aim to increase surgical capacity for orthopedic surgical procedures, enhance operating room efficiencies, facilitate patient flow and consolidate like procedures to increase critical mass and thereby increase efficiencies. For this Region, human resources and the increasing demand specifically for orthopedic surgery are problematic.

London Health Sciences Centre is actively involved with initiatives led by the Ontario Wait Time Strategy to address reduction in wait times of the five priority areas. As it stands, MRI, CT and cancer surgeries are all very close to benchmark wait times. In terms of total joint replacement, **LHSCs** current performance is outside of benchmark timelines. The same is true for hip fractures where benchmarks are currently not being met. **London Health Sciences Centre** is however, close to meeting cardiac surgery benchmarks. Human resources, access to beds and funding are the biggest obstacles when it comes to meeting benchmarks.

With respect to meeting cataract surgery benchmarks, as described previously, **St. Joseph's Health Care (London)** is opening a dedicated cataract suite in May 2006 which should improve patient throughput. Surgery to remove cataracts within 16 weeks for high risk patients is possible, as all ophthalmologists now triage patients. At this time, **St. Joseph's (London)** cannot meet the benchmarks for diagnostic imaging, specifically MRI without an additional clinical magnet since the current clinical magnet is at capacity. Benchmarks for CTs cannot be met without additional funding to operate the scanner.

At the Hotel Dieu Hospital, a wait list management committee has been established to monitor, identify and correct reporting errors or data discrepancies in order to meet the benchmarks identified by the First Ministers.

St. Joseph's Healthcare (Hamilton) cites nursing and anesthesia human resource shortages as the biggest challenge to meeting benchmarks established by the First Ministers. The Wait Time Information System will provide more information to report on benchmarks once the pilot project has been implemented.

At the **Hotel Dieu Hospital,** a wait list management committee has been established to monitor, identify and correct reporting errors or data discrepancies in order to meet the benchmarks identified by the First Ministers. For both **Kingston General Hospital** and the **Hotel Dieu Hospital**, funding, human resources and delivery capacity were impeding progress towards meeting benchmarks.

The Children's Hospital of Eastern Ontario is committed to working with Academic Health Science Centre partners specializing in paediatrics, including the Ontario Children's Health Network, to establish and subsequently meet benchmarks for timely access to paediatric services.

The Children's Hospital of Eastern Ontario is committed to working with Academic Health Science Centre partners specializing in paediatrics, including the Ontario Children's Health Network, to establish and subsequently meet benchmarks for timely access to paediatric services. A lack of evidence based (or consensus based) benchmarks for paediatric subspecialties is proving to be a challenge, as is insufficient funding for tools (software) and human resources to maintain/sustain measurement systems.

Capital District Health Authority organized a two week orthopedic surgical "blitz" for hip and knee replacements, using all available elective operating room time. As a result, an additional 72 patients were able to undergo joint replacement surgery. The shortage of anesthetists (and competitive remuneration) has been a barrier to increasing patient throughput for **Capital District Health Authority.** Recruitment and retention of staff and physicians for the health authority will continue to be a challenge given the projected retirements, the competitive marketplace, the mobility of the work force and the changing health care needs of the patient population. Availability of medical technology (both surgical and diagnostic) has also been a challenge.

Currently, **Eastern Integrated Regional Health Authority** is committed to improving access to meet the First Ministers' benchmarks. Measures to achieve this target include increasing capacity in the operating room, inpatient units and clinics; increasing human resources, recruitment and retention strategies; acquisition of necessary diagnostic technology and equipment and improved data collection processes to enrich accuracy of

reporting. The measures taken as well as the pace of implementation have come as a result of "new" dedicated funding to address the First Ministers' benchmarks.

Based on current projections, **Eastern Regional Integrated Health Authority** anticipates that it will meet the benchmarks, with the exception of cervical and breast cancer screening, within 12 to 18 months. Specifically:

- Curative radiation therapy: **Eastern Regional Integrated Health Authority** currently meets the four week benchmark in all major areas except prostate cancer.
- Coronary bypass surgery: Currently meeting the benchmark for Level 3 with 100% completion rate in 182 days. For Level 1 and 2, there is a discrepancy in the urgency classifications applied to patients of **Eastern Health**. All emergency patients receive care in 24 hours. Urgent and semi-urgent patients are classified as inpatients (prioritized for 2 weeks) or outpatients who receive care within 4-6 weeks depending on status.
- Sight restoration: **Eastern Health** anticipates meeting the 16 week benchmark over the next 12 months with a further increase in operating room time capacity and recruitment of an ophthalmologist.
- Hip and knee: **Eastern Health** anticipates meeting the 48 hour benchmark over the next 6 months for hip fracture with improved management processes for the medically unstable patient; the Region anticipates meeting the 6 month benchmark for hip and knee replacement over the next 12-18 months with increased operating room capacity and physical infrastructure.

Eastern Regional Integrated Health Authority believes additional capacity and infrastructure funding is critical to meeting benchmarks in a timely manner. The cervical and breast screening benchmarks will also require increased emphasis and more aggressive roll-out by the provincial screening programs.

Figure 7: Common Barriers Associated with Meeting First Ministers Benchmarks in Five Priority Areas

Common Barriers
o Health Professional Shortages (Human Resources) o Financial Constraints o Accessing Hard-to-Reach Populations o Lack of Policy to Manage Increasing Demand o Need for Alternative Funding Arrangements o Challenges with Establishing Partnerships between Regions, Provider Groups and Governments o Access to Available Beds o Mobility of Workforce o Changing Health Needs of Population o Availability of Medical Technology

III. Information Technology and Wait List Management

In order to accelerate the health system's ability to better measure, monitor, manage and evaluate performance, state-of-the-art health information management systems are essential. *ACAHO asked which tools, if any (i.e. software, etc) institutions or Regions were using to support wait list management and wait time reporting.*

The British Columbia Children's Hospital has installed an operating room booking system and an automated system for performance measurement, comparing against standards.

Provincial Health Services Authority reports that a new provincial wait list registry in British Columbia will support wait list management and reporting for all health authorities. The new registry and the associated province-wide application of clinical assessment tools is planned to support all elective surgical activity for adults in the province. **Vancouver Coastal Health Authority,** in addition to the new registry, uses a COGNOS based system to track performance against wait time targets.

The British Columbia Children's Hospital (BCCH) has installed an operating room booking system and an automated system for performance measurement, comparing against standards. BCCH has had extensive experience in the development of waiting time management tools that evaluate a patient's wait on the basis of initial or subsequent clinical assessment, patterns of expected deterioration, optimal developmental time and fairness in access to facilities. In addition, BCCH has, through OPSEI (the Centre for Operational Excellence in Surgical Education and Innovation), developed surgical scheduling software for optimal operating room resource utilization (including emergency surgical services, the intensive care unit and inpatient bed availability and operating room capacity) based on individual patient priority.

The Alberta wait list registry currently captures only elective surgical procedures and diagnostic imaging (MRI and CT scans) from regional systems. **Capital Health (Edmonton)** captures other important waitlist data for other types of procedures (i.e. angioplasties or endoscopies). However, because these are reported in various information systems they are not yet included in the Alberta Wait list Registry.

With respect to wait list management and monitoring, provincially there is an Access Steering Committee and an Alberta Wait list Registry Regional Implementation Group (RIG) which is composed of designated members from each health region within the province, and provincial waitlist registry representatives. Regionally, under the direction of the Senior Executive Vice President and Chief Operating Officer Health Services, an internal Access Steering Committee has been struck at **Capital Health (Edmonton)**. This committee oversees the strategic direction, coordination and profile of all "Access to Services" initiatives currently underway and/or forthcoming within the region. This steering committee provides executive level guidance and coordination for all access initiatives, and associated **Capital Health (Edmonton)** wait list data, throughout all stages of planning and implementation.

A dedicated department (Regional Health Services Information and Planning) at **Capital Health (Edmonton)** oversees the day to day management of most access initiatives, and day to day operation of the regional wait list data.

The **Calgary Health Region** is supporting the Alberta Wait List Registry through their existing software system. Software support with respect to reporting requirements is a financial challenge at this time.

Regina Qu'Appelle Health Region uses analysis software funded by the province to manage and model wait times.

Regina Qu'Appelle Health Region uses analysis software funded by the province to manage and model waiting lists. This software is called "Checklist" and is purchased from the United Kingdom where it is broadly in use. "Checklist" has facilitated the development of longer term capacity plans for the Region. Alternatively, the surgical information system currently used in **Saskatoon Health Region** has been instrumental in providing useful and appropriate data. This system is becoming outdated, however will be replaced by a new system to be implemented province-wide.

London Health Sciences Centre uses software (Surgi-net) to support wait list management and wait times reporting, in addition to Ontario Wait Time Strategy Information Technology software. **St. Joseph's (London)** will be part of the Ontario project as well (expected implementation: 2006). The resources to support this new era of accountability in reporting on wait times currently do not exist. Data quality problems exist between various systems as well.

The Hospital for Sick Children is currently phasing in the Surgical Information System software over the next six months, which will connect booking and scheduling functions to support wait list management. The Children's Hospital of Eastern Ontario is implementing the same system, and both institutions will be using the same queuing methodology.

The **Hospital for Sick Children** is currently phasing in the Surgical Information System (SIS) software over the next six months, which will connect booking and scheduling functions to support wait list management. The **Children's Hospital of Eastern Ontario** is implementing the same system, and both institutions will be using the same queuing methodology.

The Ambulatory Referral Management (ARM) system at **HSC** uses a web-based application that has the capacity to track key data elements associated with "W1" (date when referral is received to the date when the patient is seen by a specialist). Future development of the ARM system is planned to accommodate tracking and reporting of "W2" (date when the decision to treat is made to the date of actual treatment), as well as "W3" (the date when referral for follow-up is determined to the date when the patient is seen for a follow-up appointment).

Kingston General Hospital reports that they are using ADapCS Canada's Axcess.Rx wait list management system. Reporting is sustainable and there is little to no impact on the organization as the scope of reporting expands. The potential exists to provide data on all surgeries (retrospective and active) immediately if necessary. The **Hotel Dieu Hospital** uses the same system.

The **Children's Hospital of Eastern Ontario** has assessed the capacity of its appointment scheduling systems to track definitions of "wait" and has developed a prioritization questionnaire for clinics that are interested in assessing their waiting times. Currently, this process is addressed on a first come, first serve basis as the systems are quite complex. As the scope expands, this service will become unsustainable and the **Children's Hospital of Eastern Ontario** will need to begin prioritizing requests for wait list data.

At the **IWK Health Centre,** community-wide scheduling has proved to be an effective tool to support wait list management and wait time reporting. **Capital District Health Authority** is implementing a wait list management system developed in Kingston, Ontario (Axcess.Rx). Alternatively, **Eastern Regional Integrated Health Authority** is using a surgical booking tool (MSM) which has urgency ratings incorporated. MSM is supported for reporting purposes by a data repository (COGNOS).

The cardiac patient wait list at **Eastern Regional Integrated Health Authority** is managed on a computer system that was developed locally using MS Access Software. Allied health wait lists for physiotherapy and occupational therapy are managed on systems developed in-house using the same MS Access Software. The Region plans to use the Meditech Community Wide Scheduling wait lists system for ambulatory clinics, diagnostic imaging and diagnostic ambulatory services such as diagnostic neurophysiology. This system is presently used for scheduling but not for wait list management.

Eastern Regional Integrated Health Authority has accessed limited funding for benchmark reporting support which it has prioritized to purchase and/or develop (where possible) computerized data collection/reporting and/or data linking tools to assist in the benchmark reporting. Once the tools are in place, staff will be identified to maintain the infrastructure and reporting system.

IV. CENTRAL BOOKING SYSTEMS

Centralized booking systems can ensure that available capacity across a region is used as efficiently as possible. *ACAHO asked members whether a central booking system was in place within their institution or Region, and if so, how the system was organized.*

Provincial Health Services Authority reports that provincially, many Regional Health Authorities are planning for regional operating room booking systems. The first regional operating booking system is planned for 2007.

Provincial Health Services Authority reports that provincially, many Regional Health Authorities are planning for regional operating room booking systems. The first regional operating booking system is planned for 2007. The BC Children's Hospital and BC Women's Hospital have centralized booking for their respective surgical services and run identical software. IT support is common between the two installations.

Several programs in **Capital Health (Edmonton)** use "Capital Health Link", a centralized telephone line staffed by nurses that acts as a central point of entry into **Capital Health (Edmonton),** and in some cases, triages to various programs including bookings. **Calgary Health Region** has a central booking system as well. The Western Canada Waiting List criteria for urgency have been used in the hip and knee study to help queue patients in accordance with a maximum acceptable wait time. In cardiac surgery, the Naylor scoring system has been used to determine urgency and a maximum acceptable wait time.

Kingston General Hospital currently has three hospitals within their LHIN using a common centrally installed wait list management system. There are discussions ongoing with respect to expanding the system to all hospitals within the LHIN.

The **Regina Qu'Appelle Health Region** has a centralized operating rooms scheduling office that schedules patients for the entire region. This centralized database has almost exclusive control of the wait lists. **Saskatoon Health Region** has a central booking system for the three acute care sites within Saskatoon.

Kingston General Hospital currently has three hospitals within their Local Health Integration Network (LHIN) using a common centrally installed wait list management system. There are discussions ongoing with respect to expanding this system to all hospitals within the LHIN. The system could easily support regional central booking. This is a policy issue in Kingston more so than a technical issue. **Hotel Dieu Hospital** is part of this central booking system.

The Children's Hospital of Eastern Ontario uses a central booking system for outpatient visits to the hospital. A separate system is used for operating room booking and diagnostic imaging. At the **IWK Health Centre**, Mental Health Services use a

central referral, single point of access tool called the “Brief Child and Family Phone Interview”. This triage tool establishes clinical impressions with respect to functionality. Patients are subsequently assigned to a priority band where access targets are determined. At this stage, patients enter the community-wide scheduling program.

Capital District Health Authority reports that a patient booking system called *Pathways Healthcare Scheduling* module is available within the district. Both diagnostic imaging and the breast screening program have central booking systems as well.

In **Eastern Regional Integrated Health Authority,** the Hospitals of St. John’s have a central booking system for all ambulatory clinic appointments. Diagnostic imaging will begin a central registry for booking procedures in February 2006. There exists a central provincial cardiac surgery wait list and booking system managed through the Cardiac Program of Eastern Health. **Eastern Regional Integrated Health Authority** also has a provincial central Cancer Care program booking system for clinics, chemotherapy, and radiation therapy.

Figure 8: Central Booking Systems within ACAHO Members

ACAHO Member	Central Booking System		
	Institutional	Regional	Provincial
Vancouver Coastal Health			✓
Provincial Health Services Authority			✓
Capital Health (Edmonton)		✓	
Calgary Health Region		✓	
Regina Qu’Appelle Health Region		✓	
Saskatoon Health Region		✓	
London Health Sciences Centre			
St. Joseph’s Health Care (London)			
St. Joseph’s Healthcare (Hamilton)			
Hospital for Sick Children			
Hotel Dieu Hospital (Kingston)		✓*	
Kingston General Hospital		✓*	
Children’s Hospital of Eastern Ontario	✓		
SCO Health Service			
IWK Health Centre (Halifax)		✓	
Capital District Health Authority		✓	
Eastern Regional Integrated Health Authority		✓	

* *Central Booking System incorporates other institutions from within the Local Health Integration Network*

V. CLINICAL ASSESSMENT (PRIORITIZATION) TOOLS

Priority-setting tools can help moderate demand for care and ensure that available resources are used appropriately. *ACAHO asked members whether they had access to, or had made progress in the development of clinical assessment tools to support the prioritization of patients waiting for surgery.*

Provincial Health Services Authority is leading the Provincial Surgical Services Project with the Regional Health Authorities including **Vancouver Coastal Health Authority** as previously noted. This project will feature clinical assessment tools for all surgical specialties and adult patients undergoing urgent and elective surgeries. Urgency scores from each clinical assessment tool will soon be one component of the BC surgical registry. For paediatric services, clinical assessment tools and standardized waiting times have been developed for paediatric neurosurgery and standardized wait times for all other paediatric surgical services. At the present, the wait times are being reviewed with the Ontario Children's Health Network.

Capital Health (Edmonton) and **Calgary Health Region** are currently exploring tools to assists in the urgency and prioritization for hip and knee surgery in particular. **Capital Health (Edmonton)** and **Calgary Health Region** are participating in a study of the Western Canada Waitlist Project to validate the Total Joint Replacement Priority Tool. Plans are underway to implement the tool as part of the current hip and knee pilot project.

The Saskatchewan Surgical Care Network has developed a comprehensive set of prioritization tools that the **Regina Qu'Appelle Health Region** and the **Saskatoon Health Region** have adopted. All surgeons complete a scoring tool for patients to be placed on the surgical waitlist. The Regions plan to gradually implement a shift from scheduling using the traditional prioritization system (elective/urgent) to the urgency scoring system which uses the results from priority scoring tools. The urgency rating scale is available on the SSCN website: www.sasksurgery.ca .

The orthopedic department at **London Health Sciences Centre** has historically used a variety of assessment tools to determine urgency. Provincially, expert panels for the five priority areas have developed urgency rating scales to prioritize patients. The Ophthalmologist Department at **St. Joseph's Health Care (London)** is using the classification system provided by the Wait Time Strategy. Each ophthalmologist is responsible for triaging those patients who require intervention in a shorter time; procedure lists are organized to allow more urgent patients to receive surgery quickly.

At **St. Joseph's Healthcare (Hamilton),** the Ontario Wait Times Information System pilot project is currently being implemented, specifically to address clinical assessment tools to support patient prioritization.

The wait list management system at Kingston General Hospital and Hotel Dieu Hospital includes a universal 1 to 5 urgency scoring system. It is also completely capable of handling other priority scores and any additional data elements as they are introduced.

Through the work of the Ontario Children's Health Network Surgical Services Task Force, surgical access targets at **The Hospital for Sick Children** have been developed based on diagnoses across nine surgical subspecialties. These consensus-based access targets were developed through nine expert panels which included paediatric surgical sub-specialists from the five paediatric academic health science centres.

The wait list management system at the **Kingston General Hospital** and **Hotel Dieu Hospital** includes a universal 1 to 5 urgency scoring system. It is also completely capable of handling other priority scores and any additional data elements (for example, in the case of additional data for cancer surgery reporting) as they are introduced.

At the **Children's Hospital of Eastern Ontario**, the Ontario Children's Health Network has produced a working group report for paediatrics with respect to clinical assessment tools.

The Orthopedic Department within **Capital District Health Authority** subscribes to a visual acuity scale for assessing patients awaiting joint surgery. Cancer patients meanwhile, are stratified according to specific clinical criteria (e.g. tumor stage).

The Surgical Waitlist Committee at **Eastern Regional Integrated Health Authority** has reviewed some of the clinical assessment tools that have been published prior to accepting a six-point urgency rating scale, as well as consensus-based procedure benchmarks in urgency classifications for each surgical service. [See Appendix A for Elective Surgery Priority Classification Description]

Figure 9: Clinical Assessment/Prioritization Tools within ACAHO Members

ACAHO Member	Clinical Assessment or Prioritization Tools in Place?	
	Yes	Not at this time
Vancouver Coastal Health	✓	
Provincial Health Services Authority	✓	
Capital Health (Edmonton)	✓*	
Calgary Health Region	✓*	
Regina Qu’Appelle Health Region	✓	
Saskatoon Health Region	✓	
London Health Sciences Centre	✓	
St. Joseph’s Health Care (London)	✓	
St. Joseph’s Healthcare (Hamilton)	✓*	
Hospital for Sick Children	✓	
Hotel Dieu Hospital (Kingston)	✓	
Kingston General Hospital	✓	
Children’s Hospital of Eastern Ontario	✓	
SCO Health Service		✓
IWK Health Centre (Halifax)	✓	
Capital District Health Authority	✓	
Eastern Regional Integrated Health Authority	✓*	

* Clinical Assessment/Prioritization Tool in Progress of Implementation

VI. CLINICAL APPROPRIATENESS GUIDELINES

A number of members commented on their access to, or the progress they have made in developing guidelines with respect to surgical appropriateness.

In British Columbia, there is much discussion about the development of clinical appropriateness guidelines for use in determining when a patient should be placed on a wait list.

As part of the Osteoarthritis Service Integration System (OASIS), family physicians in **Vancouver Coastal Health Authority** will use a consistent assessment tool to identify patients who require a surgical referral and those who are better served with rehabilitation, education, or other types of support. Multidisciplinary teams at one of the

three regional clinics will then determine the best treatment option. This program is being launched at the regional level, but will be rolled out provincially with interest from the other health authorities.

Ophthalmologists within **Vancouver Coastal Health Authority** have begun to evaluate the relationships between improved vision, wait times for cataract surgery, and the prioritization score prior to, and post surgery.

To date at **Capital Health (Edmonton),** triage criteria have been established for specific programs. **Capital Health (Edmonton)** expects that eventually all programs in the region will have guidelines/criteria that will determine clinical appropriateness of patients placed on waitlists. Meanwhile, a central intake methodology has assisted **Calgary Health Region** to filter patients and ensure that improved GP-to-specialist responsiveness will remove those waiting for surgery from those requiring medical management or non-surgical treatment. The goal has been to ensure that all patients get a plan of care suited to their needs, streaming those for surgery through intake into assessment, optimization and then surgery. For non-surgical patients, a team determines the best plan of care and helps the family physician to adopt the non-operative management plan for their patients. This same method holds true for breast and prostate cancer initiatives. That is, the GP referral allows for a central team to assess and help patients navigate to the right provider the first time, instead of inappropriately being put on a surgical list.

Capital Health (Edmonton) expects that eventually all programs in the region will have guidelines/criteria that will determine clinical appropriateness of patients placed on wait lists. Meanwhile, a central intake methodology has assisted Calgary Health Region to filter patients and ensure that improved GP-to-specialist responsiveness will remove those waiting for surgery from those requiring medical management or non-surgical treatment.

Beginning April 1, 2005, provincial prioritization guidelines were initiated for CT and MRI. Overall, the **Calgary Health Region** has met or exceeded all provincial wait time targets for MRI and CT since implementation of these guidelines.

Regina Qu'Appelle Health Region and **Saskatoon Health Region** use prioritization tools developed through the Saskatchewan Surgical Care Network. Currently, every patient is scored at the time they are placed on the wait list. The scoring will eventually be used to order patients on the list. The Regions have also begun looking at some demand management initiatives for orthopedics that seek to develop referral processes that ensure greater consistency in setting the threshold for treatment.

A team has been formed to discuss a single waiting list for all ophthalmologists at **St. Joseph's Health Care (London)**. The plan is to collect the same information that the Ontario Wait List Strategy is collecting in their test areas.

At **The Hospital for Sick Children,** outside of the newly developed access targets, comprehensive clinical appropriateness guidelines have not been developed for paediatrics.

Policies and guidelines have been developed which outline the wait list process for the Hospitals of St. John's surgical wait list in **Eastern Regional Integrated Health Authority.** The surgical committee and physicians have approved these policies and guidelines. The policies include management of active and inactive wait list patients, removal of patients from the wait list and standardized wait list management process definition (e.g. decision to treat, definition of wait times consistent with nationally accepted definitions).

CHAPTER FIVE: PUBLIC-PRIVATE PARTNERSHIPS

While many ACAHO members are experimenting with new delivery relationships, the majority of members are looking for solutions within their own organizations.

A Public-Private Partnership (or P3) is a contractual arrangement between a public payer and a private provider, facility or institution that obligates the private provider to deliver a specified level of services, under specified terms, in exchange for public financing.[xix]

ACAHO asked survey participants whether their institution or Region has considered contracting out services to other public and/or private providers in order to reduce the length of time patients wait for a particular health service. The majority of respondents indicate that they currently do not contract out services.

In British Columbia, the BC Children's Hospital **(Provincial Health Services Authority)** has an agreement in place with the **Vancouver Coastal Health Authority** for the provision of operating room time for paediatric patients. Three of the five main urban centres in **Vancouver Coastal Health Authority** contract out low complexity day surgery to free up capacity in their main operating rooms. Dental services are contracted out as well, to community general anesthetic facilities who meet specified standards.

Figure 10: ACAHO Members involved in Public Private Partnership Agreements

ACAHO Members	P3 Agreement in Place?	
	Yes	Not at this time
Vancouver Coastal Health Authority	✓	
Provincial Health Services Authority	✓	
Capital Health (Edmonton)	✓	
Calgary Health Region	✓	
Regina Qu'Appelle Health Region		✓
Saskatoon Health Region		✓
London Health Sciences Centre		✓
St. Joseph's Health Care (London)		✓
St. Joseph's Healthcare (Hamilton)		✓
Hospital for Sick Children		✓
Hotel Dieu Hospital (Kingston)		✓
Kingston General Hospital		✓
Children's Hospital of Eastern Ontario		✓
SCO Health Service		✓
IWK Health Centre (Halifax)		✓
Capital District Health Authority (Halifax)		✓
Eastern Regional Integrated Health Authority		✓

Capital Health (Edmonton) currently partners with non-hospital surgical facilities for the treatment of cataracts. Meanwhile, the **Calgary Health Region** contracts out approximately 7,000 ophthalmology and 1,000 other day surgery procedures to the private sector. To date, the Region has also contracted approximately 600 hip and knee surgery cases as well. The extra capacity allows the Region to meet other wait time targets.

Currently, **Regina Qu'Appelle Health Region, Saskatoon Health Region, London Health Sciences Centre, St. Joseph's Health Care (London), St. Joseph's Healthcare**

Hamilton, The Hospital for Sick Children, The Hotel Dieu (Kingston), The Kingston General Hospital, The Children's Hospital of Eastern Ontario, IWK Health Centre, Capital District Health Authority (Halifax) and **Eastern Regional Integrated Health Authority** do not contract out services.

CHAPTER SIX: MEASURING OUTCOMES

On balance, improved outcomes are a definitive measure of progress when wait time reduction strategies are reviewed and evaluated.

From increased patient flow to reduced length of stay, ACAHO members report measurable progress in addressing wait times across different components of the spectrum of care. It would appear that a mixture of provincial wait time investments and local policy initiatives have had a positive impact on the *order* of patients waiting for care and treatment, and the *speed* at which they move through the system.

More specifically, as we have provided an overview of the range of *inputs* that members have invested to more effectively managing wait times in previous Chapters, it is also important to consider what kind of impacts they have had in terms of *outputs* (i.e., outcomes). For purposes of this report, outcomes are disaggregated into four inter-related components: wait times; patient flow, length of stay and clinical efficiencies.

By measuring inputs, and to the extent possible – outcomes, this chapter takes aim at facilitating an understanding of how wait times initiatives result in both clinical and system advancements. On balance, improved outcomes are a definitive measure of progress when wait time reduction strategies are reviewed and evaluation.

Vancouver Coastal Health reports that between July 2004 and August 2005, they have reduced the number of patients waiting more than 24 weeks for hip and knee surgery at all sites within the region by more than 20%.

In this context, ACAHO asked respondents to provide examples where measurable progress has been identified: in terms of wait times, patient flow, length of stay and clinical efficiencies.

Vancouver Coastal Health Authority reports that between July 2004 and August 2005, they have reduced the number of patients waiting more than 24 weeks for hip and knee surgery at all sites within the region by more than 20%. Specifically, the number of patients waiting more than 24 weeks for hip and knee surgery at Lions Gate Hospital has decreased by 51%; at the Richmond Hospital, by 63%.

Provincial Health Services Authority reports that British Columbia continues to meet the benchmark timelines for curative radiotherapy. Cardiac CABG procedures are also being reduced in the province. With respect to diagnostic services, access to mammograms and cervical screening is better than the national average. Increased resources and collaboration with community hospitals has resulted in a reduction of paediatric surgery wait times.

Provincial Health Services Authority attributes successful reduction of wait times to unified provincial programs in radiation therapy, mammography, and cervical cytology within the BC Cancer Agency, where long range planning at the provincial level with appropriate infrastructure and human resources support has been provided over a number of years. The **PHSA** also supports a Cardiac Services Program which monitors, plans and funds cardiac surgical needs provincially.

Capital Health (Edmonton) is meeting national benchmarks identified by First Ministers. For example, the national benchmark for hip and knee replacement is 26 weeks. **Capital Health (Edmonton)** has an average wait of 20.8 weeks; in the case of the hip and knee replacement pilot project, the wait is significantly less, only 4.7 weeks. First Ministers' benchmark for hip fracture treatment was set at 48 hours or less; **Capital Health (Edmonton)** provides treatment within 24 hours. With respect to Cardiac Bypass Surgery, the average wait times for emergent patients is 0.0 weeks; for urgent in-patients,

1.4 weeks; and for planned out-patients, 9.1 weeks. Finally, the average wait time for cataract surgery in 2005/06 was 77 days.

The wait time reductions at **Capital Health (Edmonton)** came as a result of:

- A centralized point of entry (i.e. hip and knee replacement) or single point of access (i.e. to a cardiologist using a nurse practitioner);
- A centralized data repository for tracking and analysis (i.e. hip and knee surgery, cardiac surgery);
- Standardized referrals, regional triage criteria and/or use of evidence based care pathways, protocols and guidelines (i.e. hip and knee replacement, cardiac surgery);
- Multidisciplinary teams;
- Comprehensive follow-up services (i.e. hip and knee replacement);
- Dedicated ophthalmology center including assessment clinic and four operating rooms;
- Expanding capacity (i.e. increased physical space, staff, hours of service for MRI and CT);
- Implementing priority ranking scales (i.e. hip and knee replacement, cardiac surgery).

At the **Calgary Health Region**, hip and knee surgeries have fallen from between six and eighteen months to five weeks for the pilot project patients. Further:

- Access to cardiac surgery for level one patients is currently less than seven days; level two patients are seen within two weeks; and level three, within six weeks.
- For patients with prostate cancer, the duration between assessment and treatment is less than six weeks.
- Patients who have fractured their hips are seen in the operating room within 48 hours.
- Cataract surgery occurs within four months for 'priority care' patients.

Collaboration between regions, the provider groups and government support are responsible for the reductions in wait times at Calgary Health Region. Working collaboratively with health regions across the province has reduced inter-regional differences and supports best practice development on a larger scale.

Collaboration between regions, the provider groups and government support are responsible for the reductions in wait times at **Calgary Health Region.** Working collaboratively with health regions across the province has reduced inter-regional differences and supports best practice development on a larger scale.

The Regional Management at **Regina Qu'Appelle Health Region** raised concerns about exclusively prioritizing the five procedure groups identified by First Ministers. The Management believes that this strategy will unduly impact all those patients waiting for a surgery other than those considered to be "priority areas". Instead, the Region has developed a longer term plan to improve access for all surgeries. This plan appears to be achieving the desired goals.

Regina Qu'Appelle Health Region aims to increase surgical capacity over three years. The goal of increasing capacity and improving patient queuing is to offer patients a surgical date within six months of referral for all services. Saskatchewan has developed surgical benchmarks to meet their goals:

- Hip fractures within 48 hours;

- Hip replacements within 26 weeks;
- Knee replacements within 26 weeks;
- Non-emergent cardiac bypass within 14 days;
- Cataract surgery within 16 weeks for high-risk patients.

The Region has made significant progress in particular with respect to hip fracture surgery wait times as of September 2005. The Region also provides services to a large rural area. Unfortunately, these patients sometimes experience a wait in a rural hospital which, at this time, is beyond the control of **Regina Qu’Appelle Health Region.**

Ophthalmologic services are an area of success for **Regina Qu’Appelle Health Region**. The Region has taken steps to both increase capacity and improve patient access. The reduction in wait times in **Regina Qu’Appelle Health Region** has been attributed to:

- Increased capacity within the surgical care system by approximately 10%;
- Improved scheduling and queuing so as to more routinely offer surgery to those patients who have waited the longest;
- Taking greater control over the placement of patients on the waiting list and the scheduling of these patients for surgery.

This, in combination with the application of formal business rules within the scheduling office has improved patient access to surgery at **Regina Qu’Appelle Health Region.**

Over the last several years, the **Saskatoon Health Region** has achieved reductions in the wait times for both cataract surgery and cardiac bypass surgery. These reductions can be attributed to the following:

- Additional designated operating room time for patients waiting in excess of 18 months for surgery. Many of these patients include those waiting joint replacement;
- Daytime operating room hours have been designated for unscheduled orthopedic surgery. Many of these patients are those awaiting hip fracture surgery;
- Additional human resources including physical therapists and fluoroscopy technicians have assisted to increase the capacity for orthopedic surgery;
- Scheduling surgery during daytime hours on week-ends;
- Engaging both acute and support services in developing strategies to increase surgical capacity.

Through additional funding, St. Joseph’s Healthcare (Hamilton) has been able to increase the number of joint replacements, surgical oncology and cataract procedures by augmenting elective surgical time in the operation room.

At **St. Joseph’s Health Care (London)**, breast surgery wait times are meeting the benchmarks for the province of Ontario. A new MRI (installed in December 2004), and a new CT (installed in May 2005) have resulted in more efficient scan times and increased throughput. CT scans have increased by 25% which allows **St. Joseph’s (London)** to meet the efficiency factor of three scans per hour, though wait times still remain long. MRI protocols have been shortened to allow for a 15% increase in scans. These efficiencies were feasible as a result of focusing on the clinical pathway and reducing the time in “hand off” between different components of the pathway.

Through additional funding, **St. Joseph’s Healthcare (Hamilton)** has been able to increase the number of joint replacements, surgical oncology and cataract procedures by augmenting elective surgical time in the operating room.

Median wait times in **Kingston General Hospital** for total joint replacements have decreased over the last seven fiscal quarters. Median waiting times for cancer surgery have remained relatively stable over the same period (all within the provincial medians) but vary slightly from service to service. Cataract surgery median wait times are beginning to decline. **Kingston General Hospital** believes that any reduction in wait times have occurred as a result of care processes improvements which reduce the length of stay and increase throughput.

At the IWK Health Centre, the five priority areas determined by the First Ministers do not apply, however, there are currently no wait times for paediatric cancer care at the Health Centre.

The Children's Hospital of Eastern Ontario reported that while paediatric benchmarks have now been developed through the Ontario Children's Health Network for surgical subspecialties, examples of successful wait time reduction are not yet available. At the **IWK Health Centre**, the five priority areas determined by the First Ministers do not apply, however, there are currently no wait times for paediatric cancer care at the Health Centre.

For cardiac care at **Eastern Regional Integrated Health Authority** the cardiac echocardiogram wait times have decreased from twenty weeks to nine weeks in the last twelve months. As well, cardiac surgery wait times have decreased to the recommended benchmark of 182 days. This was achieved as a result of a review of patients on the cardiac surgery wait list which resulted in many patients being removed (i.e. stable in medical management, surgery elsewhere, etc.), in combination with a decrease in the referral rate over the past fifteen months.

The wait time reduction at **Eastern Regional Integrated Health Authority** occurred as a result of the aforementioned review of the wait lists, increases in capacity through investments in technology and resources within existing programs, and increases in operating room time for targeted surgical areas. Physicians are now more attentive to selecting patients who have been waiting longer for their surgery, or who are classified more urgently as a result of the recently implemented priority scale, developed by the specific specialties in surgery.

I. CLINICAL EFFICIENCIES

a. Patient Flow

When asked to identify clinical outcomes and efficiencies which have resulted as wait times have begun to decrease, many members commented that patient throughput has increased.

Access to additional surgical resources for secondary surgical care for the **Vancouver Coastal Health Authority** has assisted in reducing the number of patients waiting for surgical services. Operating room efficiency has increased by 20-25% to enable higher throughput. Patient flow within BC's Children's Hospital of the **Provincial Health Services Authority**, in the sense of coordinated preoperative evaluation (medical, surgical and anesthesia assessments), has been optimized some years ago using preadmission clinics and a highly aggressive admit day of surgery program.

At **Capital Health (Edmonton)**, pilot orthopedic surgery patients are seen within 17 days of referral. A multidisciplinary team carries out an assessment and determines whether or not patients are suitable candidates for surgery (based on established criteria). If a patient is deemed a suitable candidate for surgery, optimizing the patient's readiness

begins immediately, thereby increasing the number of appropriate patients and throughput of these patients for surgery.

Calgary Health Region's central intake system for hip and knee surgery has improved how patients travel from non-surgical and surgical queues to appropriate providers. These health care professionals subsequently develop an appropriate care plan and are able to readily monitor the patient's convalescence. **Calgary Health Region** has discovered that using a consistent care plan and dedicated teams has increased throughput in the operating room and resulted in significant reductions in length of stay and resource consumption. Organizing care in advance of surgery in collaboration with the referring specialist has facilitated the multidisciplinary team to set up a surgical plan that includes rehabilitation, community resource planning and wellness strategies.

London Health Sciences Centre has staffed a "Patient Access Facilitator to assist repatriation efforts and overall throughput.

This year, **Regina Qu'Appelle Health Region** increased surgical capacity by approximately 10%. Through better coordination and improved patient flow, most of this increase in capacity has been accomplished within existing bed allocations.

London Health Sciences Centre has staffed a "Patient Access Facilitator" to assist repatriation efforts and overall throughput. **St. Joseph's Health Care (London)** reports that patient flow at this time has not increased as a result of wait time initiatives, however, in April 2006, they will move to Cataract Procedure Rooms and will see increased efficiencies as a result of new space and new processes.

Patient flow is reported to have increased at both **Kingston General Hospital** and **Hotel Dieu Hospital (Kingston).** Ambulatory mental health wait times in particular have decreased as patient throughput has increased at **IWK Health Centre.**

Eastern Regional Integrated Health Authority noted that patient flow has increased over the last year comparing patient admissions (year-to-date) for January 2005 to January 2006 where there have been 1209 more patients admitted; subsequently, patient days increased by 741 from the previous year as well. The Region has also added four beds to accommodate extra surgeries. As a result, occupancy rates for surgery fell from 95% to 90% at one site, and remained constant (85%) at another. For specific services such as urology, throughput has increased.

b. Length of Stay (LOS)

Vancouver Coastal Health Authority has reduced the length of stay for low complexity hip and knee reconstruction from 5 to 7 days on average, to between 3 and 4 days. Overall, length of stay for inpatient surgical treatments at **Provincial Health Services Authority's** BC Children's Hospital is in the less than fiftieth percentile for the country following risk adjustment as per CIHI. With the exception of cardiac surgery, all surgical services use day care for selected procedures. BC Women's Hospital length of stay for scheduled caesarian section is at the benchmark established by peer organizations.

Capital Health (Edmonton) and the Calgary Health Region report that in the hip and knee study, length of stay was reduced from 8 days to 4.2 days provincially for the pilot project patients.

Capital Health (Edmonton) and the **Calgary Health Region** report that in the hip and knee study, length of stay was reduced from 8 days to 4.2 days provincially for the pilot project patients. **Calgary Health Region** reports further, that with a new protocol for hip fracture patients, LOS has fallen from 14 days to 7.5 days. Cardiac surgery LOS for all three urgency categories is now 5.4 days.

The length of stay data used by **Regina Qu'Appelle Health Region** is compiled in the CIHI Discharge Abstract Database. The Region expects that the report, scheduled for release in June 2006, will report improved length of stay performance.

Particular to the orthopedic patient population, **London Health Sciences Centre** has collaborated with the Community Care Access Centre on a project that reduced LOS for total joint replacements by approximately 1 day per procedure. **St. Joseph's Health Care (London)** reports that length of stay for hip and knee surgery patients has decreased from 4 to 6 days to 2 days.

St. Joseph's Health Care (London) reports that length of stay for hip and knee surgery patients has decreased from 4 to 6 days to 2 days.

St. Joseph's Healthcare (Hamilton) has seen the length of stay for joint replacements decrease from between 5 and 6 days to between 3 and 4 days.

At **Hotel Dieu,** all procedures are day surgeries so length of stay is not recorded. **Kingston General Hospital** reports that length of stay has decreased, in particular with respect to hip and knee surgery.

Capital District Health Authority reports an overall *increase* in length of stay in several smaller sites, and an increase (less pronounced) at the QE II and Dartmouth General sites. Length of stay remains above the national average. The number of alternate level of care patients has an impact on increasing lengths of stay as wait lists for long term care placements continue to climb.

In St. John's, **Eastern Regional Integrated Health Authority** reports that LOS variance for the surgery program is 2.2% above the database while some specific services are below (i.e. orthopedics) which is a significant improvement. Previous data would have seen surgery approximately 15% over the database. The average length of stay overall for all programs has decreased year to date by 0.7 days.

c. Other Clinical Outcome Measures

By pushing daycare for surgical care in children, the BC's Children's Hospital of the **Provincial Health Services Authority** reports that they likely run higher readmission rates than adult surgical facilities. **Vancouver Coastal Health Authority** reports decreased surgical cancellation rates.

Unplanned readmission rates have dropped in the first two quarters at Capital District Health Authority in Halifax, compared to the first two quarters of the previous year.

Both **Capital Health (Edmonton)** and **Calgary Health Region** measure patient satisfaction and re-admission rates with respect to their hip and knee study. The early indications show improved patient satisfaction with the care process, as well as reductions in re-admission rates and consumption of community resources (i.e. sub-acute bed utilization).

Similarly, **St. Joseph's Health Care (London)** reports that patient satisfaction on inpatient surgery units is above the benchmark for the province of Ontario.

Unplanned readmission rates have dropped in the first two quarters at **Capital District Health Authority** in Halifax, compared to the first two quarters of the previous year.

CHAPTER SEVEN: OTHER WAIT TIME PRIORITY AREAS

Consistently, members of ACAHO raised concern that a relentless focus only on the five priority areas identified by First Ministers could have a negative impact in terms of minimizing investments that are required in other areas of the health system.

While the identification of five priority areas by the First Ministers has provided health administrators and health providers with a starting point from which to focus efforts to reduce wait times, there is concern that concentration on cancer surgery, cardiac surgery, hip and knee replacement surgery, diagnostic imagine and cataract surgery alone will "crowd out" other equally important areas. *ACAHO members were asked to address the issue of crowding out.*

In British Columbia, **Vancouver Coastal Health Authority** is very aware of the potential for attention to the big five areas to squeeze out other equally important areas. To prevent this from happening, the health authority has developed and implemented a consistent and transparent regional methodology for allocating operating time by surgeon, service and site, based on the relative net arrivals to the wait list of each surgeon (arrivals minus completed cases and removals), plus a comparison of actual versus target wait times.

Capital Health (Edmonton) has established an Internal Access (to Services) Steering Committee that is tasked with identifying opportunities to address internal access issues and/or improve the access for both residents and non-residents. The Committee also reviews Access Projects' status including progress, issues, risks, resource implications and upcoming activities.

Regina Qu'Appelle Health Region is concerned the five priority areas will squeeze out other services if wait time strategies are not achieved within a larger framework that seeks to generally improve patient access. This Region is not separating out the priority areas to address separately. The **Saskatoon Health Region** is taking steps to monitor wait times for all surgical procedures on a monthly basis. Operating room reallocations occur on a semi annual basis to respond to the shifts in wait times, as applicable.

The wait list management system at **Kingston General Hospital** captures data on *all services, all surgeons* and *all surgeries* for both completed and active cases**.** Therefore, the hospital closely monitors both priority and non-priority areas (as defined by First Ministers). Generally speaking, **Kingston General Hospital** describes bearing witness to "cannibalism" in non-priority service areas with incremental volumes.

As an organization, the **SCO Health Service** continues to monitor wait lists for continuing care services to determine whether there are opportunities to support the acute care sector. When possible, **SCO Health Service** adjusts service provisions to address the unmet needs in a timely manner.

The Department of Health in Nova Scotia is beginning to monitor wait times across many areas using physician billing system data. Wait times are calculated retrospectively from the time the procedure is performed to the time of the first previous visit.

Eastern Regional Integrated Health Authority sees many major issues with respect to the identification of focus areas nationally. There is also concern that the mainstream processes are not addressing the upstream issues including population health, community capacity, and access to social programs for example.

Eastern Regional Integrated Health Authority has begun to measure aspects of service that have been identified as priorities for their region, such as the wait time to see an oncologist for chemotherapy, gastrointestinal procedures, diagnostic imaging for MRI and ultrasound.

I. Priority Areas Moving Forward

ACAHO members were asked to identify a number of other service areas which might be considered as a priority moving forward.

a. Paediatrics

Foremost, paediatric surgery continues to be a priority for **Provincial Health Services Authority**, and as such, additional resources are being targeted in this area to reduce wait lists. Waiting time standards for paediatrics were developed in 1998, and have been the basis for regular performance monitoring. These standards are now being used as the basis for pan-Canadian standards for paediatric surgery. [xx] A number of other institutions and Regions have established paediatrics as a priority area as well.[xxi]

b. Mental Health

Capital Health (Edmonton), Calgary Health Region, London Health Sciences Centre, St. Joseph’s Health Care (London), Hotel Dieu Hospital, Children’s Hospital of Eastern Ontario, Capital District Health Authority, IWK Health Centre and **Eastern Regional Integrated Health Authority** all identified access to Mental Health as a priority area moving forward. Currently there are no universal benchmarks for Mental Health services across the country.

c. Chronic Disease Management and Continuing Care

A third trend amongst ACAHO members was chronic disease management (including diabetes, obesity and cardiovascular risk) and continuing care. The **SCO Health Service** sees integrated service delivery for the frail elderly and chronically disabled adults, mental health, and management of chronic illness as future areas of prioritization. Of great concern is the need to shift resources away from acute care to the community in order to increase capacity to support the wait time strategies. Unless there is sufficient capacity outside of the acute care environment to support the increase in demand for rapid access to and integration of primary care, home care and community services as well as diagnostic, therapeutic and rehabilitation services for the frail elderly and chronically disabled populations, there will continue to be a back log in the system given the increased pressure of clients with alternate level of care status in acute care. Chronic disease management and continuing care was identified as a priority by **Capital Health (Edmonton), Calgary Health Region, Regina Qu’Appelle Health Region, Hotel Dieu Hospital, the Children’s Hospital of Eastern Ontario, Capital District Health Authority, IWK Health Centre** and **Eastern Regional Integrated Health Authority.**

Other clinical priority areas identified by survey respondents include:

- Aboriginal Populations (**Regina Qu’Appelle Health Region**)
- Complex Cognitive Disorders (**Regina Qu’Appelle Health Region**)
- Obstetrics/Gynecology (**London Health Sciences Centre**)

- Vascular Surgery (**London Health Sciences Centre**)
- General Surgery (**London Health Sciences Centre**)
- Primary Health Care (**Eastern Regional Integrated Health Authority**)
- Cardiac Catheter (**Saskatoon Health Region**)

CHAPTER EIGHT: CONCLUDING THOUGHTS

This report - an ACAHO member survey, underscores the significant progress that has been made to make health care more accessible across Canada at a time when the demand for health care services is increasing as a result of an ageing population, a growing incidence of chronic diseases, and improved diagnostic capability, for example. Based on our survey, there is much to be said about the substantial and definable progress that has been made to-date – which was noted by Federal, Provincial and Territorial Ministers of Health.

Members of ACAHO remain committed to providing health care that is patient-centred, integrated and accessible. Innovative approaches to health services delivery are providing better access to a range of health care providers, from diagnosticians to surgical specialists. New technologies and investments in medical equipment are being harnessed to provide care more efficiently and expeditiously. Investments in community care are facilitating the transition of patients from acute care settings back into their community. At the same time, ACAHO members are demonstrating an increasing amount of transparency and accountability as Canadians now have more information than ever before about wait times in their communities, and investments to increase patient throughput.

While there is no doubt that a significant amount of progress has been realized with respect to wait time reductions, there is clearly much work that remains to be done. As a national resource, ACAHO member Teaching Hospitals and Regional Health Authorities look forward to pressing forward with work to provide Canadians with timely access to quality health services across all jurisdictions and disease areas.

APPENDIX A: WAIT WATCHERS II—MEASURING PROGRESS OF WAIT TIME STRATEGIES ACROSS ACAHO MEMBERS

PURPOSE

Thank you in advance for participating in this exercise. The purpose of this 2nd Annual Member Survey on wait times is to take stock of ACAHO members' progress in terms of developing and implementing wait time management strategies for publicly funded health care services since the inaugural *Wait Watchers* report in January 2005.

This survey is an information gathering enterprise. By recognizing, identifying and sharing areas of progress and best practice, members of ACAHO will be well positioned to learn from one another. Equally important, other health care institutions across the country will have an opportunity to implement, where appropriate, the successes of member organizations. It is also an important opportunity for ACAHO members collectively, to speak to governments and policy makers on their progress to date.

This information will be collated by ACAHO for your information, verification and review. With your permission, it is anticipated that the findings of this survey will be disseminated at the 3rd Annual Colloquium on Wait Times ("The Taming of the Queue III") on March 30-31, 2006. The colloquium is 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 3rd 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. The Colloquium attracts over 100 participants (Senior Government Officials, Regional Health Authority/ Hospital representatives, Healthcare Providers, and field experts) who spend two days reviewing Canadian and international wait time reduction initiatives, recognizing successful wait time reduction programs across the country and identifying next steps in terms of ensuring improved 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. On December 12, 2005, the Provinces and Territories announced common benchmarks as they relate to the provision of medical treatments and screening services within the aforementioned priority areas.

The benchmarks, which are based on research and clinical evidence, strive to provide:

- Radiation therapy to treat cancer within four weeks of patients being ready to treat;
- Hip fracture fixation within 48 hours

- Hip replacements and knee replacements within 26 weeks;
- Surgery to remove cataracts within 16 weeks for patients who are at high risk;
- Breast cancer screening for women aged 50-69 every two years; and
- Cervical cancer screening for women aged 18-69 every three years after two normal tests.
- Cataract surgery within 16 weeks for patients who are high risk.

As well, three benchmarks are being established for cardiac bypass surgery, reflecting how urgently care is required:

- Level 1 patients within 2 weeks;
- Level 2 patients within 6 weeks;
- Level 3 patients within 26 weeks.

It is anticipated that additional wait time benchmarks will be developed and implemented as new evidence is produced. ACAHO members, alongside the Canadian Institutes of Health Research, will likely play a large role in establishing the research upon which the evidence for new benchmarks is based.

According to the 2004 First Ministers Agreement, each provincial government is expected to pursue its own strategy to improve access, and soon establish multi-year targets to achieve the benchmarks. As per the timelines established in the Ten-Year Plan, targets must be established by December 31, 2007.

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 17, 2006.** If you have any questions or comments regarding this survey, please do not hesitate to contact Emily Gruenwoldt at (613) 730-5815 ext. 324.

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 or Regional Health Authority (RHA). You should also feel free to include all relevant documents to facilitate our understanding of your local initiatives.

Wait Time Investments

1. Describe any provincial or private funding (i.e. hospital foundations) your Institution or Region received since January 2005:

a) Specifically targeted towards the reduction of wait times.

b) Specifically targeted towards wait time research.

2. In order to fully leverage provincial benchmarks and targets, strategic investments are required to support health information management capacity. What types of investments in information technology have been made within your institution or RHA *over the last twelve months* with an aim to reduce or more effectively manage wait times? Please outline any investments you are aware of that have been made at a provincial level.

a) Central electronic registry with urgency measures, procedures and patient information?

b) Electronic Health Records?

c) Increased connectivity among delivery points? (i.e. hospital - physicians' offices)

d) Other? (ie. operating room booking systems, wait list management systems, etc.)

Increasing Capacity

3. In principle, a number of policy levers exist to increase capacity in order to meet incremental volumes within the health care system. *In the past 12 months*, have you:

Policy Lever	Yes	No
Increased the number of MDs?		
Increased the number of RNs?		
Increased the number of technologists?		
Increased the number of surgical suites?		
Extended the hours surgical suites operate?		
Purchased medical technology for diagnostics or treatment? (i.e. MRIs, PET Scanners, Radiotherapy, etc.)		
Coordinated care processes in order to increase throughput? (i.e. Care pathways)		

Clinical Outcomes

4a) Provide examples, where available, where wait times have been successfully reduced within the five priority areas identified by First Ministers.

b) Describe how your institution or Region was able to achieve the reduction in wait times.

5. Identify clinical outcomes and efficiencies which have resulted as wait times have begun to decrease in your institution or Region.

a) Has patient flow increased?

b) Has length of stay decreased? By how much?

c) Other clinical outcomes measures? (ie. patient satisfaction has increased; re-admission rates have dropped)

Wait List Registries, Prioritization Tools & Appropriateness Guidelines

6. Does your institution or Regional Health Authority have a central booking system? How is this organized? By hospital, by region or by province?

7. Does your institution or Regional Health Authority have access to, or made progress in the development of clinical assessment tools to support the prioritization of patients waiting for surgery?

8. Does your institution or Regional Health Authority have access to, or made progress in the development of guidelines so that only those patients who are clinically appropriate are placed onto a wait list?

Benchmarks

9. What measures is your institution or region taking to meet the benchmarks announced by First Ministers Dec 12th, 2005?

10. How soon do you anticipate your institution or Regional Health Authority will meet the benchmarks announced by the First Ministers? Please provide a timeline for each of the ten benchmarks announced in December 2005.

11. Identify the biggest obstacle your institution or Regional Health Authority faces trying to meet the benchmarks identified by First Ministers (i.e. funding, technology, human resources, or delivery capacity).

Other Wait Time Priority Areas

12. Much concern has been voiced about the big five priority areas squeezing out other equally important areas. Is this an issue in your institution or Regional Health Authority? What measures or processes is your institution or RHA taking to monitor wait times in non-priority areas?

13. What areas would you identify for future prioritization? (i.e. mental health, obstetrics and gynecology, paediatrics, etc.)

Public: Private Partnerships and Wait Time Management Initiatives

14. Has your institution or Regional Health Authority considered contracting out services to other public or private providers in order to reduce the length of time patients wait for a particular health service?

15. What tools, if any (ie. software, etc) are you using to support wait list management and wait time reporting? Are reporting efforts sustainable financially as the reporting scope expands?

16. Who in your institution or Regional Health Authority is actively involved in wait list management and monitoring and achieving benchmarks in wait times and volumes? Has a committee been established?

Other Comments?

17. Are there any other further comments that you would like to make with reference to wait time reduction strategies, or this survey in particular?

THANK YOU.

APPENDIX B: HOSPITALS OF ST. JOHN'S, EASTERN HEALTH ELECTIVE SURGERY PRIORITY CLASSIFICATION DESCRIPTION

Priority Classification	Description	Acceptable Time Frame	Completion Rate Target
I	Conditions which are not yet true emergencies, but which should be done quickly to prevent death or disability.	< 1 week	95%
II	Conditions which will threaten or have a profound effect on the patient's life if not done in a timely manner.	1-3 weeks	95%
III	Conditions which have a severe impact on the patient's life due to a **high degree** of pain, suffering, or loss of function	3-6 weeks	90%
IV	Conditions which cause a **moderately severe degree** of pain, suffering, and loss of function.	6 weeks-3 months	80%
V	Conditions which cause a **moderate degree** of discomfort or loss of function.	3-6 months	80%
VI	Conditions which cause a **mild degree** of discomfort or loss of function, or which have some impact on a patient's health or ability to function, but for whom delay will not adversely affect the ultimate outcome.	6-12 months	80%

PERIOPERATIVE PROGRAM

Guidelines for Booking Emergency Surgery

Classification of Emergency Cases

This classification is dependent on the needs of the patient.

Class 1-A — "Bump List." Patient cannot wait. To be done as soon as possible. Second Team, if undue delay in O.R. (Same as present.)

Class 1-B — Surgery should be performed within 1-8 hours.

Class 2 — Ideally should be done within 24 hours but not more than 48 hours.

Class 3 — Urgent cases. Non life-threatening cases but cannot wait until the next elective O.R. time.

Class 4 — Elective cases.

APPENDIX C: ACAHO CONTACT LIST FOR WAIT TIME INITIATIVES

Organization / Contact	Contact Details
Vancouver Coastal Health Authority Susan Scrivens Regional Leader, Surgical Services 855 West 12th Ave. Room 321C Heather Pavilion Vancouver, BC V5Z 1M9	Tel: 604 875 4111 ext. 6-8200 Fax: 604 875 5441 Email: susan.scrivens@vch.ca
Provincial Health Services Authority Brain Schmidt Senior VP, Provincial Services Public & Population Health 700-1380 Burrard Street Vancouver, BC V6Z 2H3	Tel: 604 675 7456 Fax: 604 708 2757 Email: bschmidt@phsa.ca
Capital Health Region (Edmonton) Kathleen Ness Senior Director, Regional Health Service Planning and Information Suite 500, North Tower Capital Health Centre 10030-107 Street Edmonton, ALTA T5J 3E4	Tel: 780 735 0764 Fax: 780 735 0766 Email: kness@cha.ab.ca
Calgary Health Region Tracy Wasylak Vice President, SW Community Portfolio 7007 14th St., SW Calgary, ALTA T2V 1P9	Tel: 403 943 3873 Fax: 403 212 1242 Email: tracy.wasylak@calgaryhealthregion.ca
Regina Qu'Appelle Health Region Diane Larrivee Vice President 4101 Dewdney Avenue Regina, SK S4T 1A5	Tel: 306 766 2594 Fax: 306 766 2696 Email: diane.larrivee@rqhealth.ca

Saskatoon Regional Health Susan Bazlewski Vice President, Hospital Services Suite 300, 410-22nd Street East Saskatoon, SK S7K 5T6	Tel: 306 655 3312 Email: susan.bazylewski@saskatoonhealthregion.ca
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St. Joseph's Healthcare Hamilton Derek McNally Administrative Director 50 Charlton Ave E Hamilton, ON L8N 4A6	Tel: 905 522 1155 ext 3852 Fax: 905 521 6139 Email: dmcnally@stjosham.on.ca
Hospital for Sick Children Cathy Seguin Vice President Child Health Services 555 University Avenue Toronto, ON M5G 1X8	Tel: 416 813 6201 Fax: 416 813 5393 Email: cathy.seguin@sickkids.ca
Kingston General Hospital John Lott Director, Information Analysis and Distribution 76 Stuart Street Kingston, ON K7L 2V7	Tel: 613 549 6666 x 4202 Fax: 613 548 6082 Email: lottj@kgh.kari.net

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Children's Hospital of Eastern Ontario Tracy Wrong Director, Quality Management 401 Smyth Road Ottawa, ON K1H 8L1	Tel: 613 737 7600 ext 3221 Fax: 613 738 4876 Email: wrong@cheo.on.ca
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IWK Health Centre Ferne Mardlin-Smith Manager, Decision Support Services 5850 University Ave Halifax, NS	Tel: 902 470 7254 Fax: 470 6651 Email: ferne.mardlinsmith@iwk.nshealth.ca
Eastern Regional Integrated Health Authority Louise Jones COO, Hospitals of St. John's SM 233 St. Clare's Mercy Hospital 154 Le Marchant Road St. John's, NL A1C 5B8	Tel: 709 777 1307 Fax: 709 777 5470 Email: louise.jones@easternhealth.ca

ENDNOTES

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[i] Final report of the Taming of the Queue II available online at www.acaho.org
[ii] Health Care in Canada Survey. Pollara. October 2005.
[iii] *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.
[iv] First Ministers communiqué available at : http://www.health.gov.on.ca/english/media/news_releases/archives/nr_05/bg_121205.pdf
[v] *A Ten Year Plan to Strengthen Health Care.* Ottawa: Health Canada. September 2004. Available online at http://www.hc-sc.gc.ca/english/hca2003/fmm/index.html
[vi] *A Ten Year Plan to Strengthen Health Care.* Ottawa: Health Canada. September 2004. Available online at http://www.hc-sc.gc.ca/english/hca2003/fmm/index.html
[vii] *Delivering on Commitments: The Budget Plan 2005*. Department of Finance: Government of Canada. February 2005.
[viii] For more information on CIHR involvement in wait times research, please visit: http://www.cihr-irsc.gc.ca/e/29902.html
[ix] Listening for Direction II available online at http://www.cihr-irsc.gc.ca/e/20638.html
[x] Divisions reporting include: Cardiology, Dermatology, Endocrinology, Gastroenterology, General Internal Medicine, Geriatric Medicine, Haematology, Infectious Diseases, Medical Oncology, Nephrology, Palliative Medicine, Physical Medicine and Rehabilitation, Respirology, Rheumatology.
[xi] National Health Expenditures Database. Canadian Institute for Health Information. 2005.
[xii] Given the concerns expressed by many organizations about the need for an effective national planning process for health human resources in Canada, ACAHO was pleased that the Federal-Provincial-Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR) had released its document "*A Framework for Collaborative Pan-Canadian Health Human Resources Planning*" for consultation.
[xiii] Vancouver Coastal Health, Provincial Health Services Authority, Capital Health (Edmonton), Calgary Health Region, Regina Qu'Appelle Health Region, Saskatoon Health Region, London Health Sciences Centre, St. Joseph's Health Care (London), St. Joseph's Healthcare (Hamilton), Hospital for Sick Children, , Kingston General Hospital, Children's Hospital of Eastern Ontario, IWK Health Centre, Capital District Health Authority and Eastern Regional Integrated Health Authority.
[xiv] Provincial Health Services Authority, Capital Health (Edmonton), Calgary Health Region, Regina Qu'Appelle Health Region, Saskatoon Health Region, London Health Sciences Centre, St. Joseph's Health Care (London), St. Joseph's Healthcare (Hamilton), the Children's Hospital of Eastern Ontario, IWK Health Centre, Capital District Health Authority and the Eastern Regional Integrated Health Authority.
[xv] Capital Health (Edmonton), Calgary Health Region, Saskatoon Health Region, London Health Sciences Centre, St. Joseph's Health Care (London), St. Joseph's Healthcare (Hamilton).
[xvi] Vancouver Coastal Health, Capital Health (Edmonton), Calgary Health Region, Regina Qu'Appelle Health Region and St. Joseph's Healthcare (Hamilton).
[xvii] The Taming of the Queue: Canadian Developments in Wait Time Measurement, Monitoring and Management. Canadian Medical Association. 2004.
[xviii] First Ministers communiqué available at : http://www.health.gov.on.ca/english/media/news_releases/archives/nr_05/bg_121205.pdf
[xix] British Columbia Medical Association. Public-Private Partnerships in Health Care. March 2004.
[xx] For more information on the Ontario Children's Health Network please visit: http://www.sickkids.ca/annualreport2003_04/section.asp?s=Ontario's+Children's+Health+Network&sID=9690
[xxi] Regina Qu'Appelle Health Region, Saskatoon Health Region, London Health Sciences Centre, the Hospital for Sick Children, Children's Hospital of Eastern Ontario, and IWK Health Centre.