The Taming of the Queue III: Wait Time Measurement, Monitoring and Management: Where the Rubber Meets the Road

Conference Report

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Canadian Policy Research Networks Inc.

March 30 and 31, 2006
Ottawa, Ontario

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

Bell Canada Enterprises

Canadian Healthcare Association
Association canadienne des soins de santé

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The Steering Committee of *the Taming of the Queue III: Wait Time Measurement, Monitoring and Management* Conference gratefully acknowledge:

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Preface

Over the past three years, the *Taming of the Queue* series of conferences have sought to bring together a community of interest from across the country to discuss access and wait time issues from a range of perspectives. Sponsored by a broad range of national health stakeholders, these conferences have contributed to enhancing knowledge about the issue, exchanging best practices, and helping to shape the public policy agenda.

This year's conference took place at the Chateau Laurier in Ottawa on March 30 and 31, 2006. Some 150 experts, health provider leaders, and senior representatives from major governmental and non-governmental health organizations were in attendance. The conference had two key objectives:

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

The conference was chaired by Alan Hudson (Lead, Access to Services and Wait Time Strategy, Health Results Team for the Province of Ontario) and Maura Davies (President and CEO of the Saskatoon Health Region). It featured a series of presentations and panel discussions by leading authorities on issues such as provincial and regional innovations in wait time management, evidence-based wait time benchmarks, measurement strategies, information technology, the role of physicians and other providers as well as queuing theory (see Appendix II).

This report provides a synopsis of the presentations and discussion at the two-day conference. It is based on the presentations provided by the participants and the notes taken by CPRN researchers during the event. Electronic versions of presentations given at the conference are available on the CPRN website at www.cprn.org

Day One

Introduction

For the third time in as many years a group of leading health system stakeholders, with the support of the federal government, national health organizations and the private sector, brought together researchers, scientists, practitioners and policy analysts to assess the progress being made across the country in the area of wait time measurement and management.

In her welcoming address, co-chair Maura Davies (President and CEO of the Saskatoon Health Region) emphasized the importance of the event in terms of it providing the "neutral space" for dialogue between governments, stakeholders, researchers, analysts and practitioners that allowed participants to have the kind of open discussion that is necessary to tackling the multiple dimensions of such a politically sensitive issue. She noted that there have been some key developments since the last *Taming of the Queue*[1] symposium which serve as important backdrops to current discussions including:

- The development of Pan-Canadian wait time benchmarks;
- The change in the federal government and the prioritization of wait time guarantees; and
- The Chaoulli Supreme Court decision.

Setting the Scene

The first day was devoted to taking stock of best practices in wait list management across the country. The scene was set by Brian Postl (President and Chief Executive Officer of the Winnipeg Regional Health Authority and Federal Advisor on Wait Times) who connected the current political context with the measurement, monitoring and management of wait times across the country.

Postl began by discussing the interconnections between the commitments to wait time reductions made by the First Ministers in the September 2004 Accord with the ongoing changes and developments occurring within the system itself. As the Federal Advisor on Wait Times he visited the many sites in Canada where innovations in wait time management are taking place and had devoted significant time talking with experts, researchers and governments across Canada exploring solutions to improve timely access to quality care. He also referred to the opinion polls which note that Canadians, for the most part, find the current situation unacceptable.

[1] See: Tom McIntosh. 2005. **The Taming of the Queue II: Wait Time Measurement, Monitoring and Management** (Colloquium Report). Ottawa: Canadian Policy Research Networks. [http://www.cprn.org/en/doc.cfm?doc=1274]

Dr. Postl outlined the following two phases for the activities of the Canadian Wait Time Project**:**

Phase One: The development of benchmarks for the five priority areas (cancer; cardiac care, joint replacement, sight restoration, and diagnostic imaging). Postl noted two key issues that needed to be addressed as wait list management moved forward. First, the benchmarks needed to be sustainable over time. Second, he cautioned that the system needed to be careful about the risk of diverting resources from other services in order to meet the benchmarks established for the priority services.

The "real money", Postl argued, is not in the development of benchmarks and indicators (tools and levels); it is in how we use them to transform the health system to best suit Canadians.

Phase Two: The second phase centers on transforming the system by making improvements in:

- Ongoing research to support benchmarking and operational improvements;
- Adoption of modern management practices and innovations in health systems;
- Accelerating the implementation of IT solutions;
- Cultural change among health professionals;
- Development of regional surge capacity; and
- Public education to support system transformation.

Postl also called for improvements in management and further innovation including the adoption of new business practices, patient-centred models which incorporate centralized navigation, the incorporation of queuing theory used in other industries, and the development of a training program for health care professionals in key roles. Finally, the second phase requires changes in the roles and responsibilities of providers. This encompasses changes in culture and in the expectations of health professionals, the optimization of professional standards, the development and incorporation of team-based approaches to system management, and the value of service oriented approaches. Key to any successful change is the engagement of professionals.

Postl ended his presentation by arguing that there are other important considerations that need to be addressed in discussions around wait times including:

- Prioritizing access to health service for children;
- Contingency planning for surge capacity;
- Addressing health human resources needs;
- Paying attention to "Cinderella diseases" that have been overshadowed by attention given to the five priority areas;
- Incorporating a gender-based analysis to accessibility; and
- Recognizing provincial priority lists, needs and priority setting processes.

Discussion

The question and answer period with Postl focussed mainly on the following issues and concerns:

- The need for alternative funding mechanisms which would facilitate the incorporation of physicians within a service-oriented framework.

- The intersections between accessibility and the comprehensiveness of care. For instance, concerns were raised between increasingly expensive drugs and services for cancer care and the need to ensure comprehensive care. These concerns could be addressed by the development of evidence-based outcomes and a political process which incorporates advice from various stakeholders.

- The development of a discourse over care guarantees without having any firm targets or benchmarks in place. This was likened to putting a roof on a house without any walls. Postl noted that care guarantees have evolved from discussions on wait time management and that as a concept it is not likely to go away. Thus, we need to better understand and manage care guarantees.

- The availability of funding to sustain wait list management was also raised as a concern by the participants. For instance, while monies are needed at the front-end, there will be saving incurred through advances in efficiencies. However, funding will be needed to increasing accountability for volumes and waits, especially as regions are being asked to be more specific and provide more performance indicators based on evidence.

Provincial Focus

The rest of the morning of the first day was devoted to examining the progress being made across the country in wait time management in the provinces. This year's symposium heard reports from five provinces.

Newfoundland and Labrador

Janice Sanger (Provincial Wait Time Coordinator with the Department of Health and Community Services, Newfoundland & Labrador) presented an overview of the activities of Newfoundland and Labrador in the past year by outlining four main milestones:

- **Milestone One**: In April 2005, four new Regional Integrated Health Authorities (RIHAs) became legal entities. Sanger pointed out that while they previously did not have processes in place to monitor and manage wait lists, there was a strong commitment from various stakeholders including RIHA management and the Chief Executive Officers to make this a priority.

- **Milestone Two:** Between May to June 2005, an assessment of the provincial landscape was undertaken in order to determine the future focus of wait list management activities.

- **Milestone Three:** In September 2005 a methodology was developed including templates and the pilot testing of tools. Though mainly a manual collection process, many charts were audited. The success factors included the engagement of patients, a commitment by physicians and regions, as well as the development of local solutions For instance, the Eastern RIHA developed a centralized surgical wait list registry system.

- **Milestone Four:** In December of 2005 the Minister and Deputy Minister of Health met with RIHA CEOs, medical presidents and other senior executives for a discussion on shared challenges with data collection and commitments. As well, the Minister reported to the public about progress on benchmarks and will be reporting to the public on quarterly basis.

In conclusion Sanger argued that there is a need for substantial investments in IT infrastructure to effectively measure, monitor and manage wait times. In the long term the province will expand the strategy to capture wait time measures for other areas including speech language pathology, physiotherapy and mental health services, for example.

Prince Edward Island (PEI)

Anne Whalen (Director of Nursing at the Queen Elizabeth Hospital, Charlottetown) presented an update on Prince Edward Island and the current work being undertaken on measurement and access management. The background to these initiatives is the recent restructuring process within PEI. They have had some challenges including the need for improvements in their information technology infrastructure; thus, information had to be collected through manual chart reviews.

Within this context, Whalen noted that PEI has been working on making improvements in information technology, including a clinical information system and websites. They are developing measurable indicators, for instance, on outcomes for patients. Access management within the province is being facilitated through the collaboration of multidisciplinary task forces within the four health priorities, the development of multi-year plans, and the establishment of centres of excellence.

Options are also being explored to meet targets, for instance, incorporating queuing theory into the management of wait times and making improvements. The full implementation of their plans around wait list management is, however, dependent upon facility development and incorporating effective change management policies. They are also working towards ensuring that the process does not have a negative impact on other services. She also notes that success is also dependent upon an inclusive process (even though it is more time consuming), being realistic, and having sustainable funding.

Nova Scotia

Michael Dunbar (Director of Orthopaedic Research at the QE II Health Sciences Centre in Halifax Nova Scotia and chairman elect for the National Standards Committee of the Canadian Orthopaedic Association) discussed the utilization of a two-week orthopaedic blitz by Capital Health in Nova Scotia to reduce backlogs in the system and waiting lists. During the Blitz, the orthopaedic team was able to perform 122 knee and hip replacements during this two week period, or a rate of four cases per day. The usual rate of replacements is about 100 per month. It also generated a positive story for patients waiting for services.

The blitz required the following elements:

- A team approach which included the services of a variety of people including bed managers, equipment managers, administrators and health providers;
- Buy-in by health providers;
- Planning ahead, for instance setting a date due to the inevitable disruption in service**s;**
- Using a different case mix and computer modelling to increase efficiency and increase numbers;
- Bringing idle operating room units online;
- The dedication of required staff - for instance, additional operating room nurses, anaesthetists, and physiotherapists;
- Alternative funding processes; and
- Requesting that satellite hospitals provide services for local trauma.

The challenges centre on system requirements (e.g., surgeons) and the sustainability of blitzes. Dunbar maintained that while blitzes are useful in clearing backlogs, they are not panaceas and may only serve to shuffle excessive waiting lists.

Discussion

A question was raised about the need for long term care within an orthopaedic blitz as described by Dunbar. Dunbar noted that with the aging population, there is a need to identify alternative care models (e.g., primary care). To increase capacity (e.g., physical space) which is in short supply there may be a need to look to private partners.

Dunbar was then queried about achieving economies of scale and if the there was a lower cost per case achieved through the blitz. Dunbar noted that it is not possible to case cost in Nova Scotia with their current information system; however there are case costing models from other provinces which could be investigated.

Finally, the panel was asked about their opinions about utilizing stand-alone clinics for reducing waits. All of the panellists noted that these have not been taken off the table. Dunbar noted that there is a need for a paradigm shift first which would allow for later discussions about stand-alone clinics.

Ontario

Rachel Solomon (Project Manager of Ontario's Access to Services and Wait Time Strategy, Ontario Ministry of Health and Long-Term Care) outlined Ontario's Wait Time Strategy. She also described the recommendations by the Expert Panel on Surgical Process Analysis and Improvement (SPAI) on improving peri-operative efficiency. Her comments also touched on an information system for sequencing patients for the surgical day, and the tracking of the starting time of waits, cancellations and delays for Ontario hospitals.

Solomon then outlined some key surgical process improvement initiatives which are at various stages of development and implementation in Ontario. These include:

1) **Peri-operative Improvement Coaching Teams:** This involves the development of interdisciplinary coaching teams who have experience in the effective management of peri-operative resources. Thus far, these teams have assisted in identifying opportunities to improve efficiency in peri-operative processes.

2) **Surgical Efficiency Targets Program**: This program will evaluate how hospitals are performing compared to their peers and identify any areas for improvement and what the system issues are (e.g., productivity and efficiency).

3) **Education and Innovation Projects:** These projects set the foundation within various hospitals for decreasing wait times by surveying, assessing, and testing new ways to improve peri-operative processes. These innovations have led to improvements being made in access across Ontario hospitals.

4) **New Models of Service Delivery**: Solomon discussed the Centre of Excellence being established at the Holland Orthopaedic and Arthritic Institute which incorporates best practices in referral management and human resource utilization and integration, and the Kensington Eye Institute which will provide the option to get patients into first available slot within the program rather than an individual surgeon.

5) **MRI Efficiency**: Additional funding for wait time management is tied into the operation of MRI machines at a minimum of 80% of the Expert Panel's recommended rate of efficiency. Opportunities for improvement will be identified by the expert panel for those hospitals unable to achieve the recommended rate.

Solomon also noted that Ontario held a two-day event in April, 2006 which was devoted to Celebrating Innovations in Health Care. They had over 600 submissions and the conference featured 190 posters, 150 booths and 35 interactive panels.

Saskatchewan

Ben Chan (CEO of the Saskatchewan Health Quality Council) outlined various pilot projects being developed and implemented in various stages across the province to improve access to primary care and specialist treatments:

1) **Saskatoon Community Clinic:** This pilot project is making advances in access to primary care by:

   - Developing targets for success (e.g. 3rd next available appointment and patient satisfaction) and good measures of demand and supply to meet these targets;
   - The rebalancing between demand and supply, for instance, to reduce backlogs (e.g., blitzes) and the better use of available resources and timeframes; and
   - Reshaping demand through a variety of mechanisms (e.g., phone consults, making better use of other providers, or using group visits rather than individuals).

2) **The Saskatchewan Chronic Disease Management Collaborative**: The Collaborative was launched in November, 2005 to not only reduce waiting times for services but to incorporate and disseminate best practices around disease management techniques for coronary artery disease (CAD) and diabetes across the province (e.g., diabetes education clinics).

3) **The Health Quality Council Cancer Care Project:** The project is based on identifying opportunities to improve the flow of patients with breast cancer through the system by reshaping demand for selected services, improved access scheduling, etc. There is a report expected on the project in June 2006.

4) **Emergency Department (ED) Patient Flow Project.** The aim of this project is to decrease the average waiting time in the ED, to standardize the processes and reduce the variability in wait times and high level process times.

Finally, updates of several initiatives by Saskatchewan Health were provided including accomplishing the Action Plan initiatives for surgery and reducing the number of "long-waiters" in 2005-2005. Another initiative is a multi-year Diagnostic Imaging Strategy which includes the development of a Diagnostic Imaging Network in Saskatchewan.

The key messages from Saskatchewan are that changes are taking place in a variety of health settings and that changes in the system require its redesign. Chan emphasized that these changes require communications, linkages, training, information technology infrastructure and technical skills. Above all, effective change is dependent on partnerships.

Discussion

The first question was directed at Solomon and focussed on whether changes in referral mechanisms were part of Ontario's overall strategy. She replied by noting that the Kensington eye clinic was working on getting the referral community to become more involved in this change. Ontario is also working on mechanisms to change referral practices, for instance, an advertising campaign aimed at primary care physicians which provides information about waiting times and referral practices.

Participants also raised the issue of care guarantees: what the provinces felt about the issue and specifically if they were seen as a safety valve or as a legal commitment. One participant noted that the legal community is waiting in the wings and are viewing this as a major opportunity.

Solomon noted that while there has been discussion on the topic of care guarantees, Ontario has not taken a formal position on the issue. Chan stated that there may be a role for care guarantees, but that getting the system to change first takes a lot of time and work and such work needs to be linked to a well-designed process, proper funding, and infrastructure**.** For instance, Saskatchewan has given cancer a high priority in setting targets; however, there are still variations, due in part to the variability in cancer types. What are needed, he said, are evidence-based guides.

Measuring What You Want to Manage

The rest of the morning was devoted to discussions concerning the availability and quality of data. To begin, Glenda Yeates (President and CEO of the Canadian Institute for Health Information (CIHI)) provided an overview of the CIHI report *Waiting for Health Care in Canada* which was released in March, 2006. Yeates argued that while there has been much activity around the development of data, challenges remain in comparability.

According to Yeates, wait times for patients can be segmented into a series of waits from the beginning to the end of the process and include waits for routine care, to see a specialist, for tests, for results, for surgery, and for post-acute care. There are variations in wait times depending on the type of care needed, whose list the patient is on, the urgency of a case, and special factors related to individual patients or conditions. More specifically, Yeates classified the waiting periods into three areas:

1) **Early Waits:** this includes the more "front-end" periods of waits for:

- *Routine care*: More than half of Canadians (56%) sought routine or ongoing care in 2005. Of these, one in six reported having difficulties accessing routine care.
- *Specialist services*: Yeates reported that about 41% of Canadians have a wait time of 1-3 months for specialist services for a new illness or condition and when compared to other countries, Canada is second only to the UK for the proportion of patients who waited more than 4 weeks to see a specialist.

- *Non-emergency diagnostics*: Approximately 75% of patients waited 2 months or less for non-emergency diagnostic imaging. However, even though there has been an increase in the number of diagnostic imaging tests being done 10% of patients waited 3-4 months or more for non-emergency MRIs, CTs and angiography. Yeates noted that many of the waits are variable. For instance, the wait for patients who come through the emergency department or from a hospital bed is typically shorter than the wait for outpatients.

2) **Waits for non-Emergency Surgery**: Approximately 75% of Canadians who had non-emergency surgery in the past 2 years reported a wait of 3 months or less while 10% reported a wait of 5-6 months or more. International comparisons showed that Canada has one of the lowest proportions of patients having non-emergency surgery in less than a month. Yeates noted that there has been a growth in surgical volumes, especially in angioplasty so more is being done to increase capacity for services especially in the five priority areas.

3) **Waiting for Specific Procedures**: Yeates reported on the waits for specific services, including cataract surgery, radiation therapy, angioplasty and joint replacement surgery. She noted that early on, data collection and comparisons for these areas were limited by variations in definitions and data collection practices. It is also difficult to fully explain variations in experiences.

Yeates noted that more data is needed, especially on access to "front-end" services, and improvements are needed to ensure their comparability. She concluded her presentation by arguing that there is a need to broaden the scope of data collection to include other key service areas.

Claudia Sanmartin (Senior Researcher in the Health Analysis and Measurement Group at Statistics Canada and Adjunct Assistant Professor in the Department of Community Health Science at the University of Calgary) presented on the results from the 2005 Health Services Access Survey (HSAS) and the interplay between waiting times, the burden of waiting and outcome measures. The following are the key components of her presentation.

- **Waiting Times:** The Health Services Access Survey (HSAS) which has been integrated into the Canadian Community Health Survey has filled in voids in information for waiting times and the impact of these waits on patients. In particular, it provides information on some specialized services (e.g., specialist visits for new illness or condition, non-emergency care, and diagnostic tests). There are data needs within several areas including: specific procedures at the provincial level which are comparable across time and space; information about the "other" wait times (e.g., to primary care or the wait between GP consultation and specialist consultation); and the acceptability of waits.

- **Burden of Waiting**: Of the 12-19% of patients reported being affected by a wait to visit a specialist, for non-emergency surgery, and diagnostic tests, many reported experiences of worry, stress and pain as a result of the wait. Other information could be collected on health related quality of life, the number of years of life lost, health utility, etc. To illustrate this, Sanmartin discussed the burdens of cancer through measures of years of life lost and morbidly.

- **Outcomes of care:** Sanmartin stressed that there remains a need for population health outcomes measures and measures of patient satisfaction which are comparable across time and space as well as the appropriateness of care.

To summarize, Sanmartin stressed while there has been progress made in the development of comparable data in Canada, the next stage is to develop such data for specific procedures. She also noted that the there is a need to incorporate measures of the burdens of waiting and outcomes which are key in evaluating what we are doing and what we could do to better manage health services in general.

Discussion

The discussion session centered on the progress that has been made by both CIHI and Statistics Canada in filling in some data gaps. One participant noted that the measurement of outcomes is critical by noting that: “There is an opportunity to increase the quality of care if outcomes are measured”. Another participant noted the need to also understand cancellation rates. For instance, a patient may be deemed fit for surgery when it was booked but may have had a significant progression of disease during the wait for treatment. This suggests that wait lists need to be updated regularly if they are to provide accurate information on wait times.

A participant then raised the concern that most of the activity thus far is related to improvements in supply-side management and not to the management of demand. The participant noted, for instance, that any patient with rheumatoid arthritis needing services is a failure of the whole health care system. Moreover, the rates of obese children in Canada will have important ramifications for the demand for services. Yeates replied by stating that these relationships are currently being explored. It is important to focus on surgical areas, she noted, but other areas will have to be addressed.

There were other concerns raised by the conference participants. One noted that children’s wait times for services need to be addressed, notably around surgical wait times. Another remarked that the waiting times to referral are often neglected and that, traditionally, waiting times begin at the time of referral even though they are not independent events. Yeates noted that the waiting time is predicated on a continuum and that data needs to be improved so that we can better understand what the issues and concerns are around waits at the “front-end”. Sanmartin stated that this involves not only understanding the referral practices but the appropriateness of seeing a specialist. At issue is how patients might manage their own conditions. She noted that Ontario is doing consultations around when to seek services.

Exploring the Evidence for Wait Time Benchmarks

The first afternoon session was devoted to the development of wait time benchmarks for joint replacement therapy, cataract surgery and radiotherapy. Tom Noseworthy (Director, Centre for Health and Policy Studies, Professor, Health Policy and Management and Head, Department of Community Health Sciences, University of Calgary) and Claudia Sanmartin (see previous reference) began the session by outlining the work of the Western Canada Wait List (WCWL) Project in the development of reliable, valid WCWL Priority Criteria Scores for hip or knee replacements and cataract surgery. They described the methodology used by the WCWL Project including the integration of the inputs from clinicians, patients, and the public for the development of maximum acceptable waiting times which reflect public, patient and physician perspectives. They discussed how the inputs from these groups was integrated by a WCWL Waiting Time Panel and the many considerations they needed to consider including the use of a single value versus a range to finally arrive at an evidence-based maximum acceptable waiting time.

Noseworthy and Sanmartin discussed the experiences of the WCWL team with establishing evidence-based benchmarks for acceptable waiting times for joint replacement therapy and sight restoration. Among their main findings:

- There is evidence that a deterioration in functional status occurs in patient waiting more than 6 months for joint replacement therapy;
- Very long waits (e.g., longer than 12 months) for joint replacement therapy are associated with poor post-operative outcomes;
- Poor pre-operative functional status is associated with poor post-operative functional status for joint replacement therapy;
- A wait between 6 to 12 months for sight restoration surgery is associated with degradations in best corrected visual acuity. This affects the independence of the patient, especially when driving is essential. There is also a heightened risk for motor vehicle crashes;
- There is a substantial reduction in fall rates and the risks of fractures if corrective surgery is done early.

The WCWL completed its work in the spring of 2006. However, Noseworthy and Sanmartin argued that more work needs to done on developing valid and reliable waiting time data, including, prioritizations by urgency, the maximum acceptable waiting times by urgency and the development of standards for the appropriateness of care. We also need to better understand the gap between demand and supply through simulation modeling.

William Mackillop (Professor and Chair of the Department of Community Health and Epidemiology at Queen's University, and Head of the Division of Cancer Care and Epidemiology of Queen's Cancer Research Institute) reported on the development of standards for access to radiotherapy. His objectives were:

- To report on the progress being made around the setting of evidence based benchmarks for radiotherapy;

- To demonstrate that waiting times alone are an inadequate measure of access to care; and
- To remind the participants that there needs to be effective corrective action taken otherwise the exercises of measuring and monitoring are worthless.

MacKillop began by outlining the uses and effectiveness of radiotherapy for cancer treatment, for localized cancers, or to alleviate the symptoms in dying patients. He described the complex methodological approach taken by his team which included the utilization of expert opinion, an analysis of existing benchmarks, radiobiological models (based on the relationship between the volume of the tumour and the risk of reoccurrence and on the observed growth rate of the tumour), the direct observations of associations between wait times and reoccurrence in clinical settings and on patient opinions.

The associated risks of delays in radiotherapy are fully described by Mackillop *et al.*[2]. Mackillop emphasized that waiting times are only one element of access to care and is limited as a measure of access to radiotherapy because they overemphasize supply-side problems (e.g., availability) and deemphasize demand-side problems (e.g., awareness, spatial accessibility, affordability, and accommodation). Furthermore, indicators of access to radiotherapy include waiting times and the rates of use. The latter better enables the identification of demand side problems especially spatial accessibility and the awareness of services. Thus both sets of indicators are needed.

William Hodge (Associate Professor of Ophthalmology, University of Ottawa Eye Institute) presented on the systematic review of cataract waiting times by the University of Ottawa Eye Institute and the Chalmers Systematic Review Center. The research team looked at the both international and national passive and active wait times and how they are associated with specified outcomes (e.g., visual acuity, quality of life vision indices, adverse events, patient satisfaction with wait, and family physician attitudes about the wait).

Hodge *et al* found that there were few differences in the ways in which passive wait times (or measured wait times for sight restoration) are measured. They found that only two countries had active wait times (or those put in place as a result of an active wait list policy): Sweden (which was later abandoned) and the United Kingdom (which is pending). Hodge then described two studies which showed evidence that there is a relationship between wait times and outcome measures. There are also many variables which mediate the wait time outcome such as functional impairment or an inability to work.

[2] For more detail see: W. Mackillop, Z. Chen, R. Pearcey, W. King, W. Kerba, S. Shortt, D. Feldman-Stewart, M. Brouwers, M. Brundage, and A. Coldman. 2006. **Setting Standards for Access to Radiotherapy** which is available on the CPRN website at www. cprn.org.

Discussion

One participant noted that there is relatively little information on the effectiveness of radiotherapies for different cancer groups and stated that radiotherapy utilization could be reduced if there was a critical review done on the number of treatments required. Mackillop replied by stating that the ways in which radiotherapy is prescribed makes a difference but that guidelines for radiotherapy have not been prescriptive; thus the appropriateness of utilization is very important.

The Perspective of the New Federal Government

The Honourable Tony Clement, the federal Minister of Health outlined several priorities of the federal government with respect to wait times:

- A patient wait times guarantee which evolves from the development of benchmarks for the previously agreed to five priority areas.
- System changes based on 4 cornerstones of health care renewal which include the following:
    - **Research:** This includes the development of common evidence based benchmarks clinically based indicators, and advances in prevention which has positive implications for waiting times;
    - **Technology:** This includes information management systems (e.g., the sharing of digital imaging across space and telehealth initiatives);
    - **Federal/provincial/territorial collaboration** which not only focuses on similarities but also respects differences. There is a need to identify and share best practices across the country; and
    - **Health human resources:** A supply of physicians, nurses and other providers is needed as well as an effective utilization of their services. This includes rethinking of how health providers work together.

- The need to go from thought into action: This requires going beyond the question of money and increasing resources to bringing about real changes to the health care system.

Discussion

The discussion focussed on the precise nature of care guarantees. In particular, the Minister was cautioned that the word "guarantee" could have potential legal implications. One participant explained that unlike targets, benchmarks and goals, care guarantees imply an entitlement, cautioning that a foundation is needed before implementing a guarantee. The Minister replied that the cornerstones noted in his address should provide the foundation needed to operationalize a care guarantee. Another participant noted that discussions around system management and care guarantees need to not only be grounded in moving the quantities of patients through the system but in understanding quality and appropriateness of the care they receive. Minister Clement commented that

we need to take a holistic view of the solutions which incorporate preventative models and screening and that discussions around care guarantees cannot be separated from wellness plans. That said, care guarantees create a focus and is a goal that Canadians can understand.

Another participant noted that there needs to be a longer-term commitment to a system based on Canadian values as outlined in the report of the Romanow Commission. Minister Clement commented on this by stating that change and innovation need to be maintained and that the key is the *Canada Health Act*. He argued that: "Innovation and the CHA are compatible".

Regional Innovations in Improving Access and Reducing Waits

The late afternoon sessions centred on improvements made within regional health authorities to improve accessibility and reduce waits. The first presenter, Carl Taillon from the Centre Hospitalier Universitaire de Québec began the session by describing the model for managing wait times introduced at his institution. He stressed that their model uses targets for certain procedures (e.g., hip and knee replacement) with resources allocated to increase capacity. Management agreements between the hospital and the Ministry of Health are reached through negotiations about what can feasibly be done. For instance, the provision of additional budgets provided an incentive for people to meet expectations in increasing volumes in services (e.g., surgery). However there are trade-offs. Because there are only two MRIs in the region, one of which is in a paediatric hospital, they cannot generate the surgical volumes that might be possible if additional MRI capacity was available and not otherwise allocated to competing priorities (e.g. children).

Cy Frank (Professor and Chief of the Division of Orthopaedics University of Calgary/Calgary Health Region, Director of the Alberta Bone & Joint Institute for the Faculty of Medicine, and Vice Chair of the Alberta Bone & Joint Health Institute) then discussed the results of the Alberta Hip and Knee Project. In collaboration with three health regions, the Alberta Orthopaedic Society and Alberta Health, the not-for-profit Alberta Bone and Joint Health Institute developed an integrated and continuum of care approach to hip and knee replacements. The approach taken by the Institute was to completely redesign the system of care with an evidence-based "continuum approach", with standards of access and quality being defined and proximity of the care path for each patient being measured to ensure better access to services. A case manger was assigned to every patient and a customized care path defined for each one.

A randomized controlled trial comparing this new approach to the existing approach was implemented to rigourously test its effectiveness. Thorough data was collected by the Institute on both the control and experimental groups including: baseline information on demographics, socioeconomics, co-morbidity, etc. The evaluation of the intervention was done through various methods including quality of life measures, a follow-up questionnaire, patient surveys, and chart reviews. The interim results of the study showed highly significant differences between the control and experimental groups with respect

to both wait times and patient satisfaction. For instance, there were reductions in average wait times from referral by their family doctor to actually receiving hip/knee surgery from 82 weeks to 11 weeks and higher rates of satisfaction due to centralized intake and the use of case managers. Frank argued that this model can be generalized to the whole province (and beyond) and that access to all appropriate joint replacements in the province can be made predictable within the next 1-2 years.

The last presentation on regional innovations in wait list management was by Brian Schmidt (Senior Vice President of Provincial Services, Public & Population Health for the Provincial Health Services Authority, British Columbia) who outlined the Provincial Surgical Services Project by the BC Provincial Health Services Authority. The Project itself was informed and assisted by the WCWL project and the Saskatchewan Surgical Care Network.

The Project is focussed on two specific areas:

- The development of an assessment tool which is now being completed by various surgical specialty groups when the decision for surgery is made with the patient. The assessment tool incorporates an urgency score to assist in prioritizing patients.

- The Provincial Surgical Registry which tracks all patients waiting for surgery. The challenges noted by Schmidt include effective change management and inconsistent business management practices. The Registry also requires parallel sustainability in networks, resources and staffing.

To date, British Columbia has been working on clinical assessment tools and pilot testing and rolling out the final phase of the Registry. They expect to have a province wide roll out of an orthopaedic hip and knee tool by the summer of 2006. Schmidt also noted other innovations taking place within British Columbia to improve patient flows by organizing resources[3].

The action plan for British Columbia is to get close to benchmark standards and improve access to care. They are using telemedicine, for instance, to improve diagnostics and follow-up for thoracic surgery to remote regions. Other areas of attention are the development of an urgency assessment tool for paediatric surgery as part of an overall National Paediatrics Wait Times Strategy, and the inclusion of paediatric cases in the BC Surgical Patient Registry.

Discussion

One participant raised the point that if many of the patients needing hip and knee replacement surgery were of lower socioeconomic status then the question remains about what can be done to increase the level of services to this group. Another participant

[3] For more detail see: B. Schmidt. 2006. **Regional Innovations in Improving Access and Reducing Waits: The BC Experience** which is available on the CPRN website at www.cprn.org.

discussed the need to reassess urgency scoring since there is a: “seductive lure to create trade-offs” and there is also a need to understand which patients require surgery at all.

Day Two

Symposium Co-Chair Maura Davies introduced the second day by making a few observations about the previous day’s presentations and discussions:

- There are on-going issues around comparability and data collection;
- There is progress within provinces around wait lists;
- The importance of enablers, for instance, information technology, partnerships and change management; and
- The challenges ahead in defining maximum acceptable wait time targets and benchmarks.

IT in Service of Improved Access

The first presenter was Sarah Kramer (Vice President and Chief Information Officer at Cancer Care Ontario) who discussed Ontario's wait time information strategy which is part of an iterative multi-pronged approach to improving accessibility, initially for the five priority areas and then expanding to other areas (e.g. paediatric surgical care). Kramer noted that this strategy allowed the data collectors (e.g., surgeons, hospitals) to see the value of data collection for identifying the problem areas and the urgency of patient needs. This created a shift in thinking from 'Who needs to know that?' to 'We need more information' creating momentum in the value of data collection.

Kramer noted that the keys to the success of the project were good communications and the engagement of the clinicians from the early stages, learning from other jurisdictions, and developing agreements. More specifically, Kramer emphasized that the lines of accountability for data submission were established mainly through contracts with hospitals which linked wait time funding with the receipt of data and implementation of a standard provincial information system.

The challenges identified by Kramer were related to the clinical up-take and adoption of the strategy, meeting the expectations around information availability, and concerns around matching, auditing, etc. Kramer also noted that there is a dearth of information about radiology and the difficulties that clinicians face when self-selecting what they should be reporting while simultaneously rolling out the system.

Michael Dunbar (Director of Orthopaedic Research at the QE II Health Sciences Centre in Halifax Nova Scotia and chairman-elect for the National Standards Committee of the Canadian Orthopaedic Association) then discussed the adoption of a specific software package (Axcess Rx) as a waitlist management tool by the Orthopaedic pilot project at the Queen Elizabeth II Health Sciences Centre in Nova Scotia. After researching other applications, Axcess Rx, which was relatively inexpensive and allowed researchers to immediately begin collecting data was found to be the most suitable for understanding

wait time management. It was rolled out in November of 2005 and currently the department of surgery is on-line with cancer surgery was added in the spring of 2006.

Dunbar argued that success was predicated on the change in attitudes from "there is no way that you are getting that software" to "this data is ours and when are you going to give it to us". He maintained that this was linked to the commitment and passion of the research team and getting the surgeons on board by demonstrating how the data could be used to detail how many patients are waiting for services and for how long.

The challenge that remains is the establishment of governance rules around access to the data and decisions about its use. Dunbar concluded by stating that there are IT solutions to wait list management, and that its implementation requires leadership by clinicians and researchers.

Kathleen Ness (Senior Director, Regional Health Services Planning and Information of Capital Health, Edmonton) provided a discussion of the integrative approach that Capital Health region in Alberta is taking to understand and manage the throughput of patients within the entire system. There are a number of key initiatives noted by Ness which have been or are in the process of being implemented within the Capital Health region.

1) **Capital Health Link:** This initiative links a 24/7 nurse triage call line with netCare (the electronic health records), thus allowing the nurse to receive information about the patient in order to advise him or her on the level of care needed.

2) **Chronic Disease Management (CDM**): The CDM itself registers and tracks patients as they move throughout the system, allowing doctors to better understand which services the patient has accessed and where they have been referred. The CDM approach has led to improvements in wait times with an increase in system capacity to accept new referrals.

3) **netCare:** netCare is a patient-centred and secure electronic health record through which information about patients' prescriptions, demographics, allergies and laboratory test results are available when they are needed.

4) **Waitlist Registry:** The Waitlist Registry is a website which contains information about the number of people waiting for surgery and the number who have been served throughout Alberta. It was modeled after the B.C. Surgical Wait Times website and the Saskatchewan's Surgical Care Network.

5) **PathWays:** This is a continuing care waitlist management system developed by Strata Health Inc which matches clients need to the availability of beds or spaces. This has improved the matching of clients with the availability of beds from 44% to 74%, thereby reducing the wit time in acute care from 34 days to 12 days.

The approach being undertaken at Capital health is an overall integration of process changes within the entire system with information gathering to ensure continuous

improvements in efficiency and service effectiveness. This requires a standardized approach, a single central intake of patients to system, and the development of IT tools to support the changes being made within the processes.

Discussion

The following concerns were raised during the discussion:

- The mechanisms which could identify who is on the list for services and who is merely listed but is not available to treat (e.g., those who go to the United States for treatment). It was suggested that this information could be adapted and inputted into the system.
- The point was also raised that linkages need to be made between data sets. As information flows are developed, there is a need to dashboard and archive what is happening, develop live replicable data to support decisions and use artificial intelligence to make predictions about what will happen around population health needs and capacity.

Ensuring Appropriate Access to Diagnostic Imaging

Normand Laberge (Chief Executive Officer, Canadian Association of Radiologists) presented on ensuring appropriate access to diagnostic imaging. He began by discussing the gap between the demand for diagnostic services with the supply which will worsen over time. For instance, the volumes for exams is expected to increase by 30% over the next 6 years which is concurrent with a decline in personnel and the number and quality of diagnostic equipment. According to Laberge, Canada is not going in the right direction.

There is a need for efficiencies in resource allocation to ensure that services are available. Laberge likened the approach needed is a balance between three points: accessibility, cost control and quality of care. For instance, there are examples where capital spending increases did not coincide with reductions in waiting times. An integrative approach which addresses both demand and supply-side solutions is needed. Laberge noted that while these are valuable, a focus is also needed on the inappropriate utilization of tests (e.g. reducing repeat exams, the misuse of exams for clinical problems, etc).

Laberge then discussed the development of tools aimed at addressing inappropriate utilization, including the development and dissemination of evidence based guidelines, and the development of software which allows clinicians to input symptoms and receive pop-ups about appropriate exams. The latter was tested in New Brunswick, the results of which show that in 9% of the cases a more appropriate test should have been ordered and for 4% of all tests, the test was unnecessary but was still ordered. Laberge argued that if this was factored into the Canadian scene, there would be potential savings of $500 million and the reduction of workloads comparable to 200 radiologists.

What is needed is an effective change management process which involves clinical involvement and cooperation, and a 3-way partnership between providers, the provinces and the federal government to test the software. Manitoba has taken the lead. Laberge ended his presentation by arguing that people need to think outside of the box for solutions.

Increasing Certainty – Learning from International Experience with Care Guarantees and Related Wait Time Policies

Marit Vaagen (partner, McKinsey & Company, Stockholm) outlined the international experiences with wait times. She began by positing three main arguments: that Canada is not alone in trying to deal with wait lists; that wait lists are unacceptable; and that there are some solutions. The first segment of her presentation provided international comparative analysis of expenditures, benefits coverage, and system effectiveness which set the context for understanding wait times; however, she ended this section with an exploration of the relationship between financial structures (e.g. tax vs. insurance based systems) with wait times. She argued, for instance, within insurance based system there are negotiations between the payers and the hospitals about the number of procedures performed. If there are any extra cases, then the hospitals get extra payments. Within tax based systems which have global budgets, greater need does not translate into extra money and thus leads to the rationing of services.

Vaagen then outlined 7 types of initiatives that European countries have implemented to reduce wait times[4]:

- Mandate right to treatment by law (care guarantees);
- Increase spending;
- Buy services abroad;
- Introduce real patient choice between providers;
- Change financing system and incentives;
- Change governance model; and
- Introduce private providers.

What appears to be the most effective is changing financing systems and incentives, governance structures, and using publicly funded private providers. With regards to the latter, Vaagen discussed the introduction of publicly funded private providers by describing the successes of CAPIO which was started in Sweden 10 years ago which allows private providers to take on contracts within the public health system. Vaagen argued that it is worth considering having private partners to supplement public delivery in the publicly funded health care system if the goal is better services and better quality. She also emphasized the need to incorporate "lean techniques" within business plans.

[4] For more detail see: M. Vaagan. 2006. **Taming the Queue – What Can We Learn from European Experiences?** which is available on the CPRN website at www.cprn.org.

Vaagen concluded her discussion by outlining various key lessons on the international experiences:

- The value of measurement;
- The need not only for incentives but in ensuring that they are done right;
- Taking care when introducing care guarantees because they may, for instance, fuel mistrust in the government if not met;
- Ensuring that financing systems are fair to prevent cherry picking; and
- Allowing for patient choice.

Discussion

The discussion, which occurred both during and after Vaagen's presentation, centred on the following themes:

- **Financial-based solutions:** There also needs to be more fulsome discussion of competition and financial methods within the overall debates on reducing wait times.

- **Lessons can be learned from other countries:** Germany is an example of a situation where wait times are being reduced due, at least in part, to changes in the financial system. Vaagen argued that: "If you take the best pieces out of every system than you will get a system which will perform at least a third better".

- **Governance:** This discussion centred on the correlation between waiting times and governance restructuring. What can be learned by the Norwegian example is that regional health boards need to have experience in the management of budgets and other management techniques.

- **Private/Public**: Vaagen argued that there have been successes in the EU by applying public funding with private management.

- **Wait times as a professional management strategy**: The ethics involved in having waiting times and if they are necessary to manage one's professional life was discussed.

Message from the Government of Quebec

The afternoon session began with a brief video message from the Québec Health Minister, Philippe Couillard. He described the measures taking place within Quebec, partly in response to the 2005 Supreme Court of Canada decision overturning the province's ban on the purchase of private insurance for publicly insured services. Much of the Minister's address focussed on the changes recommended in a white paper released

by the government early in 2006[5]. The changes in Quebec are designed to improve accessibility and reduce wait times by means of a range of measures including:

- A care guarantee such that patients will receive continued intensive case management for selected surgical procedures. If service has not been received within six months patients will be referred elsewhere in the province or to a new group of private clinics affiliated to existing public hospitals. If service has not been received within nine months patients will be referred to fully private clinics or outside the province, at public expense.
- Giving citizens the options of purchasing private insurance for a limited range of surgical procedures and receiving service from physicians who have opted out of the public system; and,
- Maintaining the separation between physicians operating in the private sector and those being paid by the provincial health insurance plan.

Improved Queue Management through Operational Research and System Redesign

The first presentation in queue management was by Richard Steyn (Consultant Thoracic Surgeon, UK Institute for Innovation and Improvement). The main thesis of the presentation was that the root cause of queues is the variability in demand and capacity. Thus the solutions need to focus on understanding this variability and making changes in the process to manage it.

To summarize, Steyn recommends the following:

- Segmenting the process to control variations in demand and capacity and improve flow. This involves understanding the differential processes for various areas including emergency and elective surgery and for different specialities.
- Measuring and monitoring the variability in demand and match them to services.
- Create a value-added analysis of each point in the process and streamline any processes which incur waste.
- Make explicit plans for the elimination of queues by measuring and shaping demand and planning capacity accordingly.

Steyn then outlined various pilot projects which have shown improvements in queue reductions in the NHS including the Osprey Programme which trains clinicians and managers with a clinical background in operations management techniques proven within other industries. There also needs to be a paradigm shift towards teams based approaches, a “lean” approach to process redesign, using statistical process control to monitor in real time the variability in a system, making improvements in systems dynamics and optimizing bottlenecks. Implementing these changes requires leadership.

[5] Quebec. 2006. **Guaranteeing Access: Meeting the Challenges of Equity, Efficiency and Quality (Consultation Document).** Quebec: Government of Quebec.

The next presentation by Bruce Harries (co-founder Improvement Associates and Collaborative Director for the Canadian Collaborative to Improve Patient Care and Safety in the ICU) and Jeff Harries (General Practitioner, Penticton, British Columbia) focussed on system redesign for primary care, using Advanced Access as an illustration. Bruce Harries began by discussing the successes of Advanced Access, for instance, in improving access to primary care within the Virginia Veterans Association. He argued that the theory and methods for system optimization are centred on three things:

- Strategies around matching capacity with demand, for instance, by measuring and matching capacity with demand throughout the day;
- Continuous and sequential model improvement and knowledge production; and
- The matching of improvement models along a continuum rather than within a "yes" or "no" situation.

Jeff Harries then described his personal experience with implementing the Advance Access Model within his practice in Penticton, British Columbia in response to an increased workload and a lack of spare capacity within the group practice. After getting rid of a backlog in patients, Harries noted immediate success with same day appointments and noted that the Advanced Access model has increased the satisfaction levels for both himself as a practitioner and his patients and improved patient-physician communications.

Discussion

Steyn was asked about the role of both targeting services and guarantees in making progress on wait time management and reduction. He noted that while targets can be useful, they also have some pitfalls. How you choose targets and which you choose are difficult issues. One risks paying attention only to those things that have been targeted or guaranteed to the detriment of others and the system can not make every service a target. Our attention would be better focussed on making the systemic changes necessary to make the system work better than on deciding what to target and what not to target.

Bruce Harries was also queried on the impact of Advanced Access on his income and practice. He reported that it did not have an adverse effect on his income, indeed, it went up and he is more able to take scheduled vacation time. He was also asked about the processes involved and replied that getting rid of the backlog was the first stage, but that processes need to be put into place to ensure that the backlog does not reoccur.

Toward a Service-Based Model of Patient Access – The Role of Providers

The first presentation by Chris Carruthers, (Chief of Staff, Ottawa Hospital) discussed how physician roles, responsibilities and changing work expectations can be accommodated within a service-made model of patient access. Initially the service based model of care was met with resistance; however, it is increasingly gaining in support especially as a means to support the new expectations that physicians have about their

working life. There are several examples of successful models (e.g. Women's Breast Health Centre) which have implemented service based models. However, Carruthers noted that there are several challenges for incorporating physicians within a service based model which include the following:

- A need for alternative funding mechanisms especially for physicians not working within hospitals;
- Addressing and establishing lines of responsibility;
- Human resource challenges; and
- Effective change management techniques.

The presentation then centred on the role of physicians within the climate of service prioritization. Carruthers noted that for the most part, physicians were not at the table when these priorities were drawn up yet are being asked to play a key role in their implementation. Moreover, prioritization has created tensions within and between clinical divisions as resources are increased for some surgical services (e.g. hip and knee replacement) and held constant or reduced for others. Thus, there is a need, he argued, to advocate for those patients who are waiting for services that are not included in the five priority areas.

Carruthers ended his discussion by arguing that decisions and policies over wait times cannot neglect the human resource component. He notes that there is a need for a better understanding and employment of change management principles to facilitate communication with and buy-in from providers. At the end of the day front-line personnel are needed to implement the changes.

Valerie Zellemeyer (Program Director, Perioperative Services, St. Michael's Hospital) outlined the Wait Time Strategy Blueprint within St. Michael's Hospital in Toronto and in particular, the SPAI (Surgical Process Analysis and Improvement) Expert Panel which was formed as part of Ontario's Wait Time Strategy.

The SPAI expert panel made several recommendations to make quality improvements throughout the continuum of surgical care and which will improve accessibility to care. This involves:

- Identifying and addressing the potential blockages along the peri-operative stage;
- Addressing and enhancing human resources including the maximization of professional expertise,
- Matching providers with the demand for services and
- Implementing innovative interdisciplinary teams.

The challenges related to developing interdisciplinary, patient centred teams Zellemeyer identified are:

- Training is grounded in individual achievements;
- Professional accountability is not taught;
- There is competition for control and resources; and
- There is a hierarchy which needs management and mediation

Discussion

The discussion that followed the presentations on service oriented care focussed on the need to take advantage of the potential of non physician health professionals in order to reduce the workload of physicians and to ensure appropriate care across the continuum of service needs. For instance, when a patient is discharged, he or she also needs antibiotic care provided by pharmacists.

Sounding Board: Prospects for Improving Wait Time Management in a Post-Chaoulli World

The conference was ended by a series of presentations which encapsulated the issues raised and solutions suggested. The first of these was by Ruth Collins-Nakai (President, Canadian Medical Association). The best use of our time, she noted, is in ensuring that any policy suggestions serve to strengthen the Medicare system.

Collins-Nakai stressed that there were several important moments which have underscored the activities in the past year on wait time management:

- The Chaoulli decision which catapulted waiting times to the forefront;
- The 2005 December announcement on wait time benchmarks;
- The appointment of Dr. Postl as the Federal Advisor on Wait Times;
- On-going research through the CIHR and through the wait time alliance on wait time management;
- The work by the Wait Time Alliance in outlining the 4M toolbox for mitigating, measuring, managing, and monitoring benchmarks

Collins-Nakai also outlined “next steps” including:

- Human resource planning to offset shortages including enrolment increases, repatriation programs, and the integration of international medical graduates;
- The development of a pan-Canadian HHR monitoring body;
- Research needs to be done which improves the notion of appropriate care;
- The refining of existing benchmarks;
- Expanding the discussion to other areas (e.g. child health, Aboriginal health, mental health) which were not included in the wait list alliance but are being squeezed themselves;
- Better information which provides feedback for improvement purposes; and
- Mitigation of need for services.

In conclusion, Collins-Nakai stressed that the issue of lengthy wait times should not be an issue *du jour*; it is an issue for Canadians each and every day. Canadians need to see that Medicare is there for them and work must continue to bring down waiting times. Wait times, she argued, are a surrogate for what is wrong in the health system.

Michael Rachlis (Health care consultant, Toronto) then discussed the prospects for improving wait times in a post-Chaoulli world. To begin with, he argued that access is only one dimension of the quality of care and further that access to surgery and diagnostics are only two dimensions of access. There are a variety of services which need to be understood from acute care services, to pharmaceuticals. He also made the case that we need to focus on differential access to health services by different population groups based on age, income, insurance status, etc. Our focus, for instance, has become narrowed on the health needs of older white males.

Rachlis noted that there are examples of what works and what does not, citing numerous examples of successful innovations across the country (e.g. Saskatchewan Community Clinic's success with Advanced Access). He also noted that there are examples of models and ideas which do not usually work including focusing on limited number of services. For instance, there is already evidence that focusing on hip and knee replacement surgery has increased waits for other orthopaedic surgeries. Also, clearing backlogs are only short-term solutions; waits usually come back after the blitz. Finally, prioritisation and carve outs typically make wait lists longer.

Rachlis argued that moving forward means making improvements in efficiencies, reducing demand (e.g. through effective disease prevention strategies), and above all, focusing on quality and quality improvement. For instance, redoing a hip a few months later is more expensive than doing it right the first time. Moreover, improper follow-up (e.g. blood pressure checks) for seniors after discharge contributes to a percentage ending up back in emergency.

Denis Morrice (Ambassador, Bone and Joint Decade) began his presentation by congratulating participants on the progress that is being made across Canada but cautioned that patients may have already thought that much of this was already being done. Data collection is different in the health care system, he argued, but why? Canadians would not accept this in any other industry. We will also need to deal with the privacy act which has become a bonanza for lawyers and the legal ramifications of care guarantees.

The public needs to hear about how to improve system. However there are problems in the system around streamlining the processes for research (e.g. ethics approvals), drug approvals and ensuring that best practices in wait time reductions, such as the Western Canada Wait List project are supported. In the end there is optimism about wait time reductions and this optimism needs to be communicated to the public to given them hope.

Peter Glynn (Co-Chair and founding Chair of the Saskatchewan Surgical Care Surgical Care Network, Senior Advisor, Ontario Access to Services and Wait Time Strategy and an advisor to the governments of New Brunswick and Nova Scotia as well as the Interior Health Authority, British Columbia) continued on this theme of optimism by stressing that the Taming of the Queue III has been a hopeful conference by focusing on solutions. This is, however, all about the patient who is waiting in real time and his or her access to appropriate services when they are needed. He stated that various actors can contribute to

the development of solutions in wait time management. The federal government needs to send money to the folks who run the system, make investments in training and education, and support research and IT. The provincial governments need to develop clear and well articulated strategies, improve human resource development, support research to assist in the establishment of wait time benchmarks, their appropriateness and forecasting need, implement province-wide IT/IM to support access management, make capital investments to building and equipment, and dedicate directed funding with conditions.

Glynn then outlined the needed action by health care organizations as the loci of responsibility for accessibility to services, the design, implementation and operation of "programs of care", the active management of access to care, and the IT/IM systems that facilitate clinical management, making process analysis (e.g. patient flows) more efficient, aligning incentives within the organization, and access management for patients. This may mean hiring industrial engineers, and often requires effective change management including the provision of dedicated funds to support change

These challenges will continue to be faced unless real changes are made in the volume of services (e.g. backlogs) and their provision. For instance, we cannot focus on just a few issues and not everything else. Making these changes requires time and shifts in culture.

Finally health care providers need to ask how they can help in integrating new roles and business models and take on leadership roles in advancing an organized system of programs of care which have patients as the focus.

Thematic Summary

If the first two Taming of the Queue were predicated on identifying the problem and the need for solutions, this year the theme is that wait time management is possible and, as Clement noted, that innovation can be consistent with the terms and conditions of the *Canada Health Act*.

Key Factors for Success

Many of the presentations identified the importance of several factors for success including:

- **Infrastructure:** The sustainability of many of the projects require dedicated funds or alternative funding arrangements, human resources (e.g. for data entry), and the development and integration of information technology systems.

- **Commitment:** Several of the presenters noted the importance of commitment by clinicians, researchers and management in advancing the need for more resources and data collection. Some presenters argued that success begets success; that is, identifying and communicating early results often results in a change in attitudes about the value of the project.

- **Leadership:** Many of the presenters argued that making changes requires leadership by clinicians, researchers, government and management. Some presenters linked this to patient advocacy – that it is the responsibility of clinicians to promote changes needed for optimal health outcomes for their patients. Others such as Glynn noted that leadership requires a culture shift in which innovators are supported and encouraged.

- **Change Management:** Much of the changes to wait time management require substantial shifts in the work environments of providers; thus, effective change management is needed to mediate the effects of changing expectations and processes on providers and management.

- **Inter-jurisdictional Learning and Cooperation**: Another important theme which is emerging throughout the conference is that of inter-jurisdictional learning and cooperation. Jurisdictions are learning from and incorporating models and software from each other. Kramer, for instance, noted that the Ontario Wait Time Information Strategy was not started from scratch; rather, it was developed by learning about what was working in systems management within other jurisdictions.

- **Partnerships and inclusion**: An essential component of success is the development of partnerships and inclusion between the various actors within the system including providers. Some, like Chan, note the importance of collaboratives in disseminating ideas and lessons learned across the health system. This takes more time, but is necessary in ensuring the "buy-in" from all of the actors involved.

Challenges

There are several challenges which remain for Canadians on wait time management including the following:

- **Care Guarantees**: Given the prominence given to care guarantees in the 2006 federal election and the commitment made by the new federal governments, the issue of how such guarantees would be operationalized was clearly an undercurrent throughout much of the conference discussions. For the most part, the discussion centred on three main areas:

    - **Its political role:** Care guarantees could serve to mitigate the concerns that Canadians have about access to health services;

    - **Its ramifications for the legal arena:** The point was raised that care guarantees may have legal consequences if the benchmarks are not met by the expected time;

    - **Its ramifications for the provision of health services**: Concerns were raised that resources may be diverted to meet the care guarantee to the detriment of other services. This was first noted by Postl in his opening

presentation to the conference and raised again by others at different points throughout the two days.

- **Sustainable funding:** Needed changes in wait time management and monitoring require sustainable and predictable funding.

- **The Management of Demand**: Several participants argued that more emphasis is needed on the management of demand in reducing wait times. For instance, one participant noted that mitigating preventable chronic illness is a necessary component of the dialogue on wait times.

- **Appropriateness:** many of the participants noted this as a priority issue and an important demand-management strategy. Laberge, for instance, explicitly connected the appropriate utilization of services with more effective wait time management. A challenge remains, however, in conceptualizing "appropriateness" within human resource models, clinical practice, etc.

- **Expanding the Scope of Activity:** Reducing the scope of the debate to five priority areas leads to several concerns:

    - **The "balloon effect":** Many participants noted that the scope of activity around mitigation, measurement, monitoring and management needs to be expanded to encompass other service areas (e.g. mental health, home care, etc). Otherwise, there is a risk that reductions in wait times in priority areas will be offset by increased wait times in other areas. Much of the on-going work on wait times and access needs to reflect the continuum of care which encompasses pre and post surgical intervention or treatment.

    - **Different population groups**: Another concern raised by the participants is that the current prioritizations reflect the needs of the aging baby boomers and are in danger of neglecting the service needs of different population groups such as Aboriginal Peoples. For instance, one recurring theme throughout the Taming of the Queue III is the need to prioritize access to services or wait times specific to children. Postl also noted that much of the analysis on wait time management needs to be framed within a gender-based analysis to more fully articulate the intersection between gender and access.

- **Data and Research Issues**: Despite significant progress over the past few years, several challenges remain:

    - **Comparable data:** While there have been improvements in the collection of data, improvements are needed in the comparability of data around specific procedures.

- **Connecting Research to Action:** A number of participants argued that the value in data collection is in its connection to clear action.

- **Outcomes:** Many of the participants pointed to an on-going need to develop outcome measures by which to judge performance including quality of care outcomes.

- **Communications and public education:** Several participants noted the need for improved communications about the successes in wait time management. Dunbar, for instance, noted that blitzes generate "good news" stories for patients. Postl noted that: "[Canadians] that actually access the system are satisfied with the health system but those who get information mainly from the media report less satisfaction. We need to understand what the reasonable expectations on the system are and how the system influences public attitudes". The goal is to communicate the complexity of the system to Canadians in an effective manner.

- **Management strategies:** Elements of successful management strategies at the institutional level are beginning to emerge:

    - **Alternative funding arrangements:** one theme which arose over the course of the conference is the need for alternative funding arrangements, most notably to ensure funding for physicians within a service-based model of care.

    - **Applying queuing theory:** Discussion around the incorporation of queuing theory within wait time management has been as on-going element within the Taming of the Queue symposiums. Many of the presenters noted that these techniques are being applied and/or investigated. Steyn noted that manufacturing techniques can be taught to clinicians. Vaagen, among others, noted that "lean techniques" can be applied successfully to health care management.

- **Human Resource Planning**: many of the presenters noted the importance of the availability of providers and a rethinking of the ways in which they work together. Carruthers, for instance, noted that at the end of the day, day front-line personnel are needed to implement the changes.

Conclusion

Many issues remain to enhance wait list measurement, monitoring and management. Although progress remains uneven across the country, the fact remains that all jurisdictions reported that improvements are made. They reported on the key challenges that they faced within planning and implementation. There are certainly "next steps" faced by all jurisdictions and service areas including human resource planning, and expanding wait list management, monitoring and management to a wider range of services.

Materials from the colloquium can be found on the CPRN Web site at www.cprn.org. For further information please contact Thomas McIntosh, Director, Health Network, CPRN. Phone (306) 337-2312, E-mail: tmcintosh@cprn.org.

Appendix I
Participant List

Mr. Owen Adams	Canadian Medical Association	Ottawa, ON
Ms. Peggy Ainslie	Health Canada	Ottawa, ON
Ms. Susan Bazylewski	Saskatoon Health Region	Saskatoon, SK
Mrs. Kathy Bell	New Brunswick Department of Health and Wellness	Fredericton, NB
Dr. Lorne Bellan	Canadian Ophthalmological Society	Winnipeg, MB
Ms. Cheryl Bishop	Vancouver Coastal Health	Vancouver, BC
Dr. Neil Branch	New Brunswick Department of Health and Wellness	Bathurst, NB
Mr. Glenn Brimacombe	Association of Canadian Academic Healthcare Organizations	Ottawa, ON
Mr. Jeffery Brown	Saskatchewan Health	Regina, SK
Ms. Judy Budgell	Central Health Corporation	Grand Falls-Windsor, NL
Dr. Christopher Carruthers	The Ottawa Hospital	Ottawa, ON
Dr. Ben Chan	Health Quality Council	Saskatoon, SK
Mrs. Heather Chappell	Canadian Cancer Society / National Cancer Institute of Canada	Toronto, ON
Ms. Alison Chick	McKinsey & Company	Toronto, ON
The Honourable Tony Clement	Health Canada	Ottawa, ON
Dr. Ruth Collins-Nakai	Canadian Medical Association	Edmonton, AB
Ms. Jean Cox	Manitoba Health	Winnipeg, MB
Ms. Lise Daigle	New Brunswick Department of Health and Wellness	Fredericton, NB
Ms. Janet Davies	Canadian Nurses Association	Ottawa, ON
Mrs. Maura Davies	Saskatoon Health Region	Saskatoon, SK
Mr. Christopher Dean	Canadian Council on Health Services Accreditation	Ottawa, ON
Dr. Carolyn De Coster	Manitoba Centre for Health Policy	Winnipeg, MB
Mrs. Trina Decker	Labrador Grenfell Regional Integrated Health Authority	St. Anthony, NL
Ms. Diane Desrochers	Sénat du Canada	Ottawa, ON
Mrs. Mariana Diacu	British Columbia Ministry of Health	Victoria, BC
Ms. Annie Doucet	New Brunswick Department of Health	Fredericton, NB
Mrs. Madeleine Drew	University of Ottawa – School of Management	Ottawa, ON
Dr. Michael Dunbar	Dalhousie University / QE II Hospital	Halifax, NS

Dr. David Elliott	Nova Scotia Department of Health	Halifax, NS
Mr. Mike Epp	British Columbia Medical Association	Vancouver, BC
Mr. Nadeem Esmail	The Fraser Institute	Calgary, AB
Dr. Patrick Fafard	Canadian Policy Research Networks	Ottawa, ON
Mrs. Anne Ferguson	Canadian Cardiovascular Society	Ottawa, ON
Mr. John Fleming	The Arthritis Society	Toronto, ON
Dr. Pierre-Gerlier Forest	Health Canada	Ottawa, ON
Ms. Pamela Fralick	Canadian Physiotherapy Association	Toronto, ON
Dr. Cy Frank	Alberta Bone & Joint Health Institute	Calgary, AB
Mrs. Danielle Fréchette	The Royal College of Physicians and Surgeons of Canada	Ottawa, ON
Ms. Michelle Gagnon	Canadian Institutes of Health Research	Ottawa, ON
Ms. Sylvie Gauthier	Health Canada	Ottawa, ON
Ms. Geri Geldart	River Valley Health	Fredericton, NB
Dr. Paul Genest	Bell Canada	Ottawa, ON
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Ms. Jill Greenwell	Canadian Paediatric Society	Ottawa, ON
Ms. Emily Gruenwoldt	Association of Canadian Academic Healthcare Organizations	Ottawa, ON
Ms. Martha Hall	Health Canada	Ottawa, ON
Mr. Bruce Harries	Improvement Associates Ltd.	Edmonton, AB
Dr. Jeff Harries	Improvement Associates Ltd.	Penticton, BC
Dr. Steven Harrison	Ontario Medical Association	Toronto, ON
Dr. Lyall Higginson	Canadian Cardiovascular Society	Ottawa, ON
Dr. William Hodge	University of Ottawa Eye Institute	Ottawa, ON
Dr. Alan Hudson	Health Results Team, Ministry of Health and Long-Term Care	Toronto, ON
Mr. Tim Hunt	Health Canada	Ottawa, ON
Mrs. Anne Janes	Canadian Wait Times Project / Health Canada	Winnipeg, MB
Mrs. Charlotte Johnson	Canadian Wait Times Project / Health Canada	Winnipeg, MB
Ms. Tracy Johnson	Canadian Institute for Health Information	Toronto, ON
Ms. Beatrice Keleher Raffoul	Association of Canadian Academic Healthcare Organizations	Ottawa, ON
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Ms. Kathy Kinloch	British Columbia Ministry of Health	Victoria, BC

Ms. Donna Klaiman	Canadian Association of Occupational Therapists	Ottawa, ON
Ms. Sarah Kramer	Cancer Care Ontario	Toronto, ON
Ms. Lisa Kuramoto	Centre for Clinical Epidemiology and Evaluation	Vancouver, BC
Mr. Normand Laberge	Canadian Association of Radiologists	St. Laurent, QC
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Mrs. Kathleen Ness	Capital Health Region	Edmonton, AB
Dr. Tom Noseworthy	University of Calgary	Calgary, AB
Mrs. Kelli O'Brien	Western Health	Cornerbrook, NL
Dr. Andrew Padmos	Nova Scotia Capital District Health Authority	Halifax, NS
Mr. William Pascal	Canadian Medical Association	Ottawa, ON
Mr. Greg Phillips	New Brunswick Department of Health	Fredericton, NB
Dr Marie-Pascale Pomey	Université de Montréal	Montréal (Québec)
Dr. Brian Postl	Canadian Wait Times Project	Winnipeg, MB
Dr. Jeff Poston	Canadian Pharmacists Association	Ottawa, ON
Dr. Gabriela Prada	The Conference Board of Canada	Ottawa, ON
Dr. Michael Rachlis	Consultant	Toronto, ON

Dr. Robert Rivington	Canadian Medical Protective Association	Ottawa, ON
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Mr. Marcel Saulnier	Canadian Medical Association	Ottawa, ON
Dr. Brent Schacter	Canadian Association of Provincial Cancer Agencies	Winnipeg, MB
Mr. Brian Schmidt	Provincial Health Services Authority	Vancouver, BC
Ms. Susan Scrivens	Vancouver Coastal Health Authority	Vancouver, BC
Mrs. Cathy Séguin	The Hospital for Sick Children	Toronto, ON
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Mr. Mike Sheridan	Canada Health Infoway	Montreal, QC
Mrs. Sharon Sholzberg-Gray	Canadian Healthcare Association	Ottawa, ON
Dr. Sam Shortt	Queen's University	Kingston, ON
Mr. Ian Shugart	Health Canada	Ottawa, ON
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Ms. Rachel Solomon	Ministry of Health and Long Term Care, Ontario's Wait Time Strategy	Toronto, ON
Dr. Clayne Steed	Alberta Medical Association	Raymond, AB
Dr. Richard Steyn	Heart of England National Health Service Foundation Trust	Knowle, UK
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Mr. Greg Webster	Canadian Institute for Health Information	Toronto, ON

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Ms. Valerie Zellermeyer	St. Michael's Hospital	Toronto, ON
Dr. Jennifer Zelmer	Canadian Institute for Health Information	Toronto, ON

Appendix II
Conference Program

Taming of the Queue III
Wait Time Measurement, Monitoring and Management: Where the Rubber Meets the Road
March 30-31, 2006
Château Laurier Hotel – Adam Room - Ottawa, ON

THURSDAY, MARCH 30

8:00-8:30 am	**Registration and Continental Breakfast**
8:30-8:45 am	**Welcome** - *Alan Hudson and Maura Davies*
8:45-9:15 am	**Setting the Scene** - *Brian Postl, Federal Advisor on Wait Times*
9:15-10:15 am	**Provincial Focus** • *Janice Sanger, Newfoundland & Labrador* • *Anne Whalen, Prince Edward Island* • *Michael Dunbar, Nova Scotia*
10:15-10:30 am	**Break**
10:30-11:15 am	**Provincial Focus (cont.)** • *Rachel Solomon, Ontario* • *Ben Chan, Saskatchewan*
11:15-12:15 pm	**Measuring What You Want to Manage** • *Glenda Yeates, Canadian Institute for Health Information* • *Claudia Sanmartin, Statistics Canada*
12:15-1:15 pm	**Lunch – Drawing Room**
1:15-2:45 pm	**Exploring the Evidence for Wait Time Benchmarks** • *Tom Noseworthy, University of Calgary & Claudia Sanmartin, Statistics Canada;* • *William Mackillop, Queens University* • *William Hodge, University of Ottawa*
2:45-3:00 pm	**Break**
3:00-3:30 pm	***Honourable Tony Clement,*** ***Minister of Health***
3:30-5:00 pm	**Regional Innovations in Improving Access and Reducing Waits** • *Carl Taillon, Centre Hospitalier Universitaire de Québec* • *Cy Frank, Alberta Bone and Joint Health Institute* • *Brian Schmidt, BC Provincial Health Services Authority*
6:00 pm	**Wine & Cheese Reception –** **Drawing Room**

FRIDAY, MARCH 31
Adam Room

8:00-8:30 am	**Registration and Continental Breakfast**
8:30-10:00 am	**IT in Service of Improved Access** • *Sarah Kramer, Cancer Care Ontario* • *Michael Dunbar, Capital Health District (Halifax)* • *Kathleen Ness, Capital Health (Edmonton*)
10:00-10:15 am	**Break**
10:15-10:45 am	**Ensuring Appropriate Access to Diagnostic Imaging** • *Normand Laberge, Canadian Association of Radiologists*
10:45am-noon	**Increasing Certainty – Learning from International Experience with Care Guarantees and Related Wait Time Policies** • *Marit Vaagen, McKinsey and Company, Stockholm*
12:00-1:00 pm	**Lunch – Drawing Room**
1:00-2:30 pm	**Improving Queue Management Through Operational Research and System Redesign** • *Richard Steyn, UK Institute for Innovation and Improvement* • *Jeff Harries, Penticton BC* • *Bruce Harries, Improvement Associates Ltd.*
2:30-3:15 pm	**Toward a Service-Based Model of Patient Access – the Role of Providers** • *Chris Carruthers, Ottawa Hospital* • *Valerie Zellermeyer, St-Michael's Hospital*
3:15-3:30 pm	**Break**
3:30-4:45 pm	**Sounding Board: Prospects for Improving Wait Time Management in a Post-Chaoulli World** • *Ruth Collins-Nakai, Canadian Medical Association & Wait Time Alliance* • *Michael Rachlis, Consultant* • *Denis Morrice, Bone and Joint Decade of Canada* • *Peter Glynn, Consultant*
4:45-5:00 pm	**Concluding Remarks** • *Alan Hudson and Maura Davies*
5:00 pm	**Adjournment**

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