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The Taming of the Queue V: In Search of Excellence

Ron Saunders

with Romilly Rogers

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The Taming OF THE Queue

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Ron Saunders and Romilly Rogers
June 2008

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Executive Summary

The Taming of the Queue (TQ) is an annual conference bringing together health care providers, system managers, policy-makers and researchers to examine the progress that Canadian and international jurisdictions have made in reducing wait times for medically necessary services. It provides an opportunity to hear about pilot projects, learn from success stories, and identify the challenges that remain to be addressed. The fifth conference in the series took place in Ottawa on April 15-16, 2008.

The first day of the Taming of the Queue V began with various perspectives on what has been accomplished, and what gaps remain, since the First Ministers' Health Accord of 2004. This included a speech by the Honourable Tony Clement, the Federal Minister of Health. The day continued with an analysis of wait time issues related to the interface between different medical services along the continuum of care, with particular attention to wait times in the emergency department.

The final half day of TQ V began with a panel discussion of the remaining challenges in reducing wait times. The rest of the conference focused on issues related to timely access to mental health services, a first for the TQ series. This session was capped by remarks from Dr. John Service, the Executive Director of the recently established Mental Health Commission of Canada.

This report summarizes the presentations and addresses made to the Taming of the Queue V conference, as well as key points from the general discussion of the presentations.

Several key themes emerged from the presentations and discussion over the day and a half of the conference. Perhaps the most recurrent theme is that the cup is half empty and half full, with some speakers emphasizing the former, others the latter. On the one hand were those who noted that we lack comparable data across provinces; that there is some evidence of increased wait times for surgeries outside of those targeted as priorities; and that, for those indicators where comparisons can be made across countries, Canada does not rank highly among developed nations. There was the suggestion from one speaker that broad systemic change is required along the lines of the reforms in England, where funding for acute care is tied to the patient, and surgeons have performance contracts with the hospitals.

On the other hand, many speakers pointed to signs of progress – evidence that for key procedures, wait times had been reduced. There were case examples showing remarkable results in wait time reduction. While some of this came from increased resources and capacity, much improvement was reported through measures requiring only modest investments, such as central referral/intake mechanisms and active wait list management – moving people up the queue who have an urgent need for care or who have been waiting a long time.

Another theme involved the importance of looking beyond the "big five" procedures and of measuring and managing wait times throughout the continuum of care, not just from the time of specialist consult to treatment. Moreover, it was demonstrated that better supports for family physicians, particularly regarding mental health issues, can lead to a higher percentage of cases where treatment is completed earlier in the continuum of care, reducing the demand for treatment

later on. At the other end of the care spectrum, several speakers noted that increased capacity in the chronic care and home care systems, and better discharge planning, can free up acute care beds and reduce wait times in the emergency room.

The importance of human resource planning, as in past conferences, was also noted by several speakers. This related not only to ensuring that the capacity of the system is and will be adequate to meet current and anticipated demand, but also to the importance of actively managing human resource contingencies to minimize the need for bed closures.

There is clearly room for further improvements, for a greater effort to achieve common metrics, and for spreading the implementation of practices that have been found to be effective in reducing wait times. We look forward to reports of continued progress at future Taming of the Queue conferences.

The Taming of the Queue V: In Search of Excellence

Introduction

The Taming of the Queue (TQ) is an annual conference bringing together health care providers, system managers, policy-makers and researchers to examine the progress that Canadian and international jurisdictions have made in reducing wait times for medically necessary services. It provides an opportunity to hear about pilot projects, learn from success stories, and identify the challenges that remain to be addressed. The fifth conference in the series took place in Ottawa on April 15-16, 2008.

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What follows are summaries of the presentations and addresses made to the Taming of the Queue V conference. We have also summarized key points that emerged in the general discussion of the presentations. The presentation slides are available on the website of Canadian Policy Research Networks (www.cprn.org) along with those from past conferences and past conference reports.

Day 1: Tuesday, April 15, 2008

1. Opening Comments and Welcome from the Co-Chairs

The conference was opened by co-chairs Mr. André Picard and Dr. Donald Milliken.[1] Mr. Picard welcomed participants on behalf of the Steering Committee. He noted that it is important to have a neutral space in which to share experiences and analysis about wait time issues, and that the TQ series provides this neutral space.

Dr. Milliken reviewed some of the key milestones in the recent history of the wait time issue in Canada: the first TQ conference in the spring of 2004, the First Ministers' Health Accord later that year, the Western Canada Waiting List Project benchmarks in 2005, the pan-Canadian wait time benchmarks in December 2005, and the wait time guarantees announced a year ago. The Taming of the Queue conferences provide an opportunity to keep learning and to examine how to meet the remaining challenges in wait times for medically necessary services. The topic is an important one, because how this issue is addressed has practical implications for people who are in distress.

[1] Brief biographies of conference speakers are provided in Appendix 2.

2. 2004 Accord: Accomplishments and Challenges

National Overview

Dr. Les Vertesi, Health Council of Canada

Dr. Vertesi's presentation, "Waiting for Waitlists: Five Years Later," began with a brief history of recent national efforts at reform of the health care system, including the Romanow and Kirby reports in 2002; the federal-provincial-territorial Accord of 2003, which led to the formation of the Health Council of Canada; and the First Ministers' Health Accord of 2004. The latter was more specific in giving priority to the reduction of wait times and led to the development in 2005 of wait time benchmarks in five priority areas – cancer, cardiac care, diagnostic imaging, joint replacement, and sight restoration – encouraged by a number of efforts including the work of the Wait Time Alliance.

The Accords were accompanied by considerable transfers of funds from the federal government, including $5.5 billion specifically for the reduction of wait times in the five target areas: hip/knee joint replacement, cataract removal, radiation therapy, MRI or CT imaging, and coronary bypass surgery. The 2007 wait time guarantees (with each province having considerable discretion to select within the target areas) added an additional $612 million of federal transfers.

In the fall of 2005, the Health Council of Canada (HCC) and the Canadian Institute for Health Information (CIHI) issued reports with similar recommendations on the setting of wait time benchmarks, namely:

- Define the start and end points of the wait time period.
- Agree on metrics (e.g. which percentile is to be used, and what percentage of those at this percentile are to have wait times within the benchmark).
- Identify which patients are to be included/excluded (e.g. do not mix emergency patients with those waiting for electives).
- Set priorities.
- Track the time it takes to obtain a referral (as well as time from referral to procedure).
- Be clear about what the benchmarks mean – what are the implications of not meeting them.

Dr. Vertesi then noted that there are some indicators of progress in the effort to measure and reduce wait times.

- Wait times no longer dominate the headlines.
- Provinces are measuring and making public data on wait times.
- The data suggest that wait times have been reduced.

However, he also pointed to a number of remaining problems, drawing on the February 2008 CIHI Wait Times Report.

- Reported wait times are not comparable across the provinces. There are inconsistencies in measuring the start time of the wait period (e.g. "decision to treat" vs. "ready for treatment"). There are also differences in the set of procedures that is measured.
- No province is measuring the time from referral by the family physician.
- Some mix emergency referrals with elective patients.
- Different provinces use different metrics (percentiles, target percentage within benchmark).
- Data cleaning can change the numbers, which makes it hard to tell if improvements in the numbers are due to actual improvements in service.
- There is a wide variation across provinces in reported results.

Dr. Vertesi emphasized the importance of establishing common metrics if we want to be able to compare wait times across provinces. He did note that it may be possible to estimate results at different percentiles than what a province reports, using the fact that the distribution of wait times generally follows the pattern of an exponential function.

Dr. Vertesi also pointed to a major concern about what is measured. Specifically, the practice of measuring wait times only for people who have had the procedure completed means that we are ignoring the experience of people who are still waiting as well as those who drop off the queue because they become discouraged by the long wait. Dr. Vertesi noted that patients with non-urgent issues can be moved backwards in the queue when more urgent cases arise, and that emergency cases may be a large part of what gets measured. He cited an example of one Health Authority in British Columbia where emergency cases plus transfers from other hospitals amounted to 86 percent of all cases – the "elephant in the waitlist."

Provincial Perspectives

Dr. Alan Hudson, Ontario

Dr. Alan Hudson reported on Ontario's wait time strategy, noting that it has benefited from the experience of other provinces and other countries.

Ontario has been monitoring wait times for adults in the five priority areas and is now beginning to monitor wait times in paediatric cases and in surgical procedures outside of the "big 5." The terminology is that of "targets" rather than "benchmarks" and the start time of measurement is from the time that the patient agrees to have surgery.

Dr. Hudson then reported on the experience of wait times at the 90th percentile for each of several monitored procedures. The data show a steady trend of improvements for cataract surgery, cancer surgery, hip replacements, knee replacements, and CT scans, but a slightly negative trend (longer wait times) for MRIs. The improvement for hip replacements has been a particular success in that demand for the procedure has risen as wait times were reduced, but steady reductions in wait times have continued.

Dr. Hudson indicated that, overall, Ontario is meeting its targets in 90 percent of the cases. However, results vary across the Local Health Integration Networks (LHINs). The comparative information is provided to the LHINs (but not made public) so that those who are performing relatively poorly can see where they need to improve.

Ontario is now reporting wait times for four categories of priority, from most urgent cases to least urgent, since low wait times are particularly important for the urgent cases.

Dr. Hudson noted that reducing wait times to admission in the emergency room (ER) has become a priority in Ontario – identified as such by the Premier. Experience in the ER is linked to the rest of the health care system. For example, in Ontario, a key problem is that, in the larger hospitals, there are many people in hospital who no longer require acute care, but for whom there are delays in finding an "alternate level of care (ALC)" bed. This creates a scarcity of hospital beds for new admissions, lengthening ER wait times. Solving this problem may require a change to accountability systems, so that accountability extends beyond the hospitals to the LHINs and to community partners such as the Community Care Access Centres.

Dr. Luis Oppenheimer, Manitoba

Dr. Oppenheimer presented a review of Manitoba's efforts to reduce wait times. This began well before the recent federal-provincial-territorial Accords. Manitoba launched wait times initiatives for cataract surgery in the mid-1990s, cardiac surgery in 1998, and arthroplasty in 1999. Moreover, its current wait list priorities go beyond the "big 5" to include paediatric dental care, pain, and sleep issues.

Wait time measurement in Manitoba includes people who drop off the list before the procedure is completed, since, as Dr. Vertesi noted, looking only at completed procedures can miss people who have been waiting for a long time and who may drop off the queue. This is a different approach than what may be used by other jurisdictions.

Wait lists can include people who are not fit for surgery or not willing to proceed – there are people who prefer to wait longer. Manitoba has focused its efforts on reducing wait times for those who are willing and fit and who have been waiting longer than the benchmark – 41 weeks in the case of joint replacement surgery. While some people had been waiting for a long period for this surgery, others were being booked for surgery after very short waits. Manitoba found that by giving priority to the former group, the percentage of procedures completed within the benchmark could be greatly improved.

In other words, it is possible to perform much better against the benchmarks through more active wait list management. The process has been extended beyond joint replacements to cataract surgeries with similar results.

Efficiency in the referral process has been aided by making data on individual specialist wait lists available to family physicians. Manitoba is now compiling a compendium of referral patterns and guidelines on referral practices, in consultation with general physicians, specialists, and diagnostic services. It is to be piloted in five percent of GP practices.

Discussion

Dr. Mary-Lynn Watson, President of the Canadian Association of Emergency Physicians, thanked Alan Hudson for pointing to the complexity of the issue of wait times in emergency rooms – that the issue is not simply one of too many people going to the emergency room, it's also the bottleneck created by having hospital beds occupied by people no longer requiring acute care. However, Dr. Vertesi pointed out that even if we solve the latter problem, this alone will not eliminate lengthy wait times in the ER.

Dr. Richard Williams, a psychiatrist from Victoria, pointed to the need for a human resource planning model that can take into account changes in demand as demographics change. For example, hip replacement demand is likely to increase as baby boomers age but then will decline again.

Subsequent questions raised the issue of how to keep wait times down when shorter waits lead to increased demand (such as for MRI diagnostics). Dr. Hudson noted that in Ontario there is ongoing consultation with providers to monitor trends in demand, which can then be used to shift resources from procedures where demand is declining to those where it is rising.

In response to a question about the possibility of negative effects of attending to the "big 5" on wait times for other procedures, Dr. Hudson noted that billing data are not showing a decline in service in the non-priority areas.

Dr. Oppenheimer was asked how much of the improvement in wait times in Manitoba came from additional resources, and how much from wait list management. He estimated that 60 percent of the gain was from the latter.

Medical Perspective

Senator Dr. Wilbert J. Keon

Senator Keon offered the view that considerable improvements have occurred since the 2004 Accord. He also cautioned, quoting a 2006 report by Dr. Brian Postl, that wait times are a symptom of a wider problem – the key is developing a more patient-centred health care system. Dr. Postl recommended ongoing research to support benchmarking, adoption of modern management practices, accelerated implementation of information technology solutions, a culture change among health professions, the development of regional surge capacity, and public education to support the transformation.

Senator Keon cited the example of Ontario's Cardiac Care Network as an initiative that has improved wait list management. It involves moving people up the queue if their situation worsens. This led to a large improvement in median wait times and a reduction in patient mortality on wait lists, with the one exception of arrhythmia interventions.

Senator Keon also noted that while Canada has increased spending on health care delivery, we under invest in the social determinants of health. As a result, we do not rank highly in comparison with other developed countries on some important indicators of health, and we rank poorly on measures of health outcomes per dollar spent.

Citing the Population Health Study of the Senate Standing Committee on Social Affairs, Science and Technology, Senator Keon indicated that we need to give special attention to eliminating health disparities, and to do this we need to target certain groups such as low-income mothers and children, and Aboriginals. He reiterated that this necessitates going beyond health care delivery to acting on social factors such as poverty, inadequate housing, and low educational attainment.

Hospital Perspective

Francine Bordage, New Brunswick Heart Centre (speaking on behalf of Dora Nicinski, Atlantic Health Sciences Corporation)

Ms. Bordage spoke about efforts to reduce wait times for interventional cardiac services at the New Brunswick Heart Centre. The Centre opened in 1991. With growing demand for services, wait times grew and by 2000 had reached over nine months for elective patients. Physicians in some regions of the province began referring patients outside the province for these services.

In 2004, an external review[2] of cardiac services in New Brunswick was conducted and recommendations were put forth. One of the recommendations was to establish a wait list and wait time management system at the New Brunswick Heart Centre with dedicated cardiac triage personnel. The infusion of additional resources for the program by the NB Department of Health allowed for the addition of a third cardiac catheterization laboratory, which opened in April 2006.

Today, the New Brunswick Heart Centre has implemented an access management system where all referrals to the program (inpatient or outpatient) are processed. Drawing on Ontario's experience with urgency classification and the recommendations of the Wait Time Alliance for timely access to health care, referrals are triaged and given an urgency rating using published tools such as the TIMI risk scoring system and the Ontario urgency rating system. Wait time data are collected and reported on based on the Canadian Cardiovascular Society benchmarks for accessing cardiovascular services and procedures within recommended maximal wait time (RMWT). Key features of the system include: enhanced communication between the New Brunswick Heart Centre and all stakeholders (government, referring facilities, referring physicians and other health care professionals, and patients); collection, auditing and reporting of accurate wait time data; benchmarking with the Cardiac Care Network of Ontario to enable comparisons with other Canadian heart centers; and ongoing publication of wait time data on the New Brunswick Heart Centre website[3] and newsletter.[4]

[2] See www.ahsc.health.nb.ca/Programs/NBHC/images/report2004.pdf.
[3] www.ahsc.health.nb.ca/Programs/NBHC/wait_time/NBHC%20Wait%20Time%20Chart%20Oct%2005-Mar%2008%20(eng).pdf
[4] See www.ahsc.health.nb.ca/Programs/NBHC/newsletter.shtml.

As a result of the creation of the access management process and the infusion of new resources into the New Brunswick Heart Centre, in the past four quarters, nearly 100 percent of patients, in all categories of urgency, accessed interventional cardiology services within RMWT. Key success factors include: excellent communication between the decision-makers, administrators and New Brunswick Heart Centre clinicians, flexibility, transparency, the setting of clinical priorities based on objective criteria, and the ongoing communication with stakeholders. It also helped that the recognition of the problem at the New Brunswick Heart Centre coincided with the 2004 Accord, so that there was the political support for additional resources.

Discussion

In response to a comment that some governments are reducing overall revenues through tax cuts, Senator Keon noted that, even in the absence of tax cuts, the system is facing a cost crunch. We need to become more efficient, he stated, and that requires putting more emphasis on prevention.

Some doubt was expressed by a conference participant about chances for progress on investment in social determinants of health, since the need for such investment had already been identified long ago. Senator Keon expressed some optimism that governments will recognize that they have to move on this.

Public/Patient Perspective

Mr. André Picard, *Globe and Mail*

Mr. Picard offered a journalist's perspective on wait time issues in Canada since the 2004 Accord. He noted that the Accord provided few restrictions on how provinces actually used the new health care resources, though they promised meaningful wait time reductions by 2007. In addressing his own question regarding what has happened since those resources began to flow, he suggested:

- There is no common definition across provinces of what a wait time is.
- Targets/benchmarks differ among provinces.
- The targets that provinces have set are not ambitious.
- There is little or no consequence to missing the targets. There are no real guarantees.
- Wait times have probably come down for the "big 5," but we cannot tell how much because of poor data. Results of a survey of physicians suggest that outside of the "big 5," some waits have lengthened.
- Since we lack reliable, comparable data, it is difficult to manage the system to achieve better outcomes.
- The $600 million fund announced a year ago was supposed to bring wait time guarantees, but has not done so in any meaningful way. The provinces were able to choose their own priority area and to set targets that they were already reaching.

Mr. Picard concluded by echoing the view of previous speakers that wait times cannot be tackled in isolation from broader reform of the health care system towards more patient-centred care.

Mr. Denis Morrice, Public Representative

Mr. Morrice focused on wait times for hip and knee replacements. The central theme of his presentation is that patient involvement in health care is critical to improving the system. Patients are demanding more decision-making power. However, they need the information and support to be able to do this effectively.

Mr. Morrice pointed out that arthritis and musculoskeletal (MSK) conditions are the leading cause of long-term work disability in Canada and the United States, but that hip and knee replacement and new drugs are making effective treatment much more possible. He emphasized access to rheumatologists and new therapies is critical. He also cited examples of successful efforts to reduce wait times and improve patient satisfaction in Calgary, Edmonton, Toronto, and British Columbia. In the case of Toronto, the number of joint replacements has risen from 4,000 in 2004-05 to over 6,000 in 2006-07. The provincial government is now looking to extend the Toronto program across the province.

Mr. Morrice noted that, in every case, one of the keys to success has been greater teamwork among health professionals. Individual leadership has also been important and has driven the launch of pilot programs. He argued that we need to learn from the successful pilots and broadly adopt the practices they have shown to be effective.

Ms. Colleen Savage, Cancer Advocacy Coalition of Canada

Ms. Savage presented on "Waiting Times in Cancer: Finding Success in the Waiting Times Game."

Ms. Savage echoed the concerns of Mr. Picard that provinces are picking what works well for them and measuring this in order to meet their commitments. Six provinces and one territory picked a cancer treatment for their wait time guarantee. However, they vary widely in what they measure. Many provinces begin their measurement of the wait time with "ready to treat," whereas for patients what matters is the time from first suspicion of cancer (e.g. abnormal test result to treatment). This is when the clock should start.

Nevertheless, Ms. Savage identified some examples of real progress in reducing wait times for cancer patients, typically through better co-ordination among different players in the system. For example, the Calgary Rapid Access Clinic has reduced time from referral to diagnosis of prostate cancer from 95 days to 27. Toronto East General, together with several other partner health centres, reduced the wait time from referral to treatment for lung cancer from 17 weeks to 3.5 weeks. Ms. Savage also had praise for the degree of transparency in reporting by Cancer Care Ontario: they provide a lot of detail on wait times, available publicly on their website.

Ms. Savage noted that new screening programs (e.g. for colorectal cancer) improve early detection, but it can be difficult for the system to respond quickly when such screening leads to a surge in demand. She emphasized the need to link abnormal test results to rapid diagnostic centres, and to measure wait times across the full patient pathway.

Discussion

Mr. Morrice asked why the provinces have not been able to agree on more standardized reporting. It was reported that CIHI has established a working group to try to achieve more standardized measures and reports.

There was also discussion about what kinds of guarantees are desirable and sustainable. One participant argued that provinces should ensure that patients can travel to another jurisdiction for care when the guarantees are not being met. Another suggested that the federal-provincial health care guarantees were never meant as guarantees to individuals – they are understandings between governments. What matters is whether the monitoring of performance leads to progress.

The Honourable Tony Clement, Federal Minister of Health

The Honourable Tony Clement addressed the conference at mid-day on April 15th. He noted several signs of progress, including governments' shared commitment to patient wait time guarantees, backed by federal funding, and the piloting of creative ideas in wait time reduction. Minister Clement also noted that we need to continue to innovate and to fully take advantage of new technology. Only one in four family doctors are using electronic patient records, so that is an area where there is room for improvement.

Minister Clement referred, in particular, to pilot projects with First Nations (including two new pilots on diabetes and prenatal care), Nova Scotia's efforts to improve access to orthopaedic services and diagnostic imaging, and Manitoba's plans to test wait time guarantee referrals from general practitioners to specialists in several areas including cancer services and mental health. He emphasized the need to treat mental health as a mainstream health issue. The Mental Health Commission announced by the Prime Minister will help in this regard.

The Minister expressed optimism that the wait time guarantee pilots will help to identify effective practices, ones that can be emulated by other provinces. There is a real opportunity to learn from one another and for governments to work together to reduce wait times.

He reiterated that progress is being made, and that he looks forward to continued progress. By the time the conference meets again next year, the Minister hopes to see early results from the pilots and more family doctors using electronic health records.

3. Wait Time Issues along the Continuum of Care

Primary Care Wait Times – Managing the Interface

Dr. Tom Bailey, Past-President of the College of Family Physicians of Canada

Dr. Bailey's presentation focused on the need to improve connections among primary, secondary, and tertiary care. He noted that 80-90 percent of first contacts with the health care system are through primary care. Primary care physicians provide continuity and coordination, and they deal with the comprehensive care of the patient.

Dr. Bailey noted several challenges and opportunities facing the delivery of primary care. These include the closing of many practices to new patients, the looming retirement of many family physicians, and payment methods that sometimes work against comprehensive care. On the other hand, opportunities are emerging for new team-based models of care and for more effective use of technology.

He emphasized the importance of measuring wait times beyond the "big 5" and to reduce the wait time to see a consulting specialist. In order to reduce this wait time, it may be necessary to speed access to advanced diagnostic testing.

Dr. Bailey reported on the results of a national physician survey conducted in 2007, which highlighted that family physicians were having trouble referring patients in such areas as orthopaedics, advanced diagnostics (CTs, MRIs), and psychiatry. He also pointed to evidence that in countries (such as Canada and the United States) where it is difficult to see a family physician quickly when ill, use of emergency rooms is higher than in countries with more rapid access to primary care. Some use walk-in clinics, but while these give access to episodic care, they do not typically provide comprehensive continuing care.

Dr. Bailey called for developing wait time benchmarks across the continuum of care:

- time it takes to find a family physician,
- time to get primary appointment,
- time to get diagnosis and care by family physician,
- time for referral to specialist, if necessary,
- time for definitive treatment to be provided, and
- time for follow-up care.

In contrast, current wait time measurement typically starts only from the time of referral to a specialist. Yet there is evidence that failure to achieve timely primary care or referral to a specialist compromises health outcomes and/or resource use. In Dr. Bailey's words, "There is no point talking about traffic improvements on the highway if you can't get on the highway."

How do we improve access to care in the early phases of the wait time continuum? Several suggestions were offered:

- Set a target that 95 percent of the population in every community should have access to a family physician by 2012.
- Increase the proportion of medical students who choose family medicine. Address the income gap between family physicians and others.
- Explore patient registries for those without a family physician.
- Establish a system for same-day booking of appointments.
- Provide after hours coverage for residential care patients. (The Vancouver Island Health Authority established an on-call service for residential care patients and halved the rate of referral to ER.)
- Increase funding for collaborative approaches to care (e.g. family physicians, registered nurses, and/or nurse practitioners working together).
- Improve collaboration among physicians (family physicians with each other and with consulting specialists).
- Improve collaboration across health disciplines (physicians, nurses, physiotherapists, social workers, nutritionists, occupational therapists, psychologists).
- Encourage the use of (and provide appropriate training for) electronic medical records.

Dr. Bailey noted that the College of Family Physicians of Canada and the Canadian Medical Association have established a partnership to explore issues of primary care wait times and to develop targets. A scoping report is to be released soon.

Discussion

Concern was expressed by one participant about how much progress can be made in access to primary care until the human resource issues are addressed, which can take 10 years. Another stressed the importance of involving patients at the outset in the design of pilot programs to improve access.

Improving Wait Times in the Emergency Department

Mr. Greg Webster, Canadian Institute for Health Information (CIHI)

Mr. Webster began his presentation with some background information on CIHI, in particular noting its role in helping to coordinate health information across Canada and to develop and maintain pan-Canadian data standards and comparable health indicators.

Webster provided some data on use of and experience in the emergency department (ED) in Canada.

- About 60 percent of hospital admissions in Canada are from the ED.
- Most patients who arrive at the ED are in less-urgent and non-urgent care categories.

- High volume EDs, which see 70 percent of the cases, have longer visit times (measured from time of arrival to time when treatment is completed or the patient is admitted to a hospital bed). However, there is considerable variance across facilities, which suggests that there is an opportunity to learn from those high volume facilities that have relatively low wait times.
- High volume times in the ED during the day are associated with shorter visits.
- For those eventually admitted to hospital, the median wait time for a bed is two hours, but at the 90th percentile it is 17 hours, and five percent wait over 24 hours.

Discussion

It was pointed out that there are issues in the comparability of data on ED visit times. For example, some treat an ED bed as a hospital bed, so the measured time to admission would be shorter.

Dr. Grant Innes, St. Paul's Hospital, Vancouver

Dr. Innes' presentation focused on innovations to address overcrowding in the ED. He emphasized that the problem is not too many people coming to look for care. Rather the key issues are not enough hospital beds (creating a bottleneck for admissions out of ED) and not enough human resources (which leads to bed closures or ER stretcher closures). In order to deal with these issues, Dr. Innes suggested the following, based on the experience at St. Paul's:

- Build a greater variety of care providers (e.g. nurse practitioners) into the staffing plan.
- Avoid redundant tasks.
- Improve the matching of care to need.
- Develop contingency plans to keep stretchers open.
- Provide treatment in the waiting room when stretchers are full. St. Paul's has been able to do this even for many level 2 and 3 patients – there are five levels based on degree of urgency – two-thirds of whom do not need to be admitted.
- Involve physicians in the triage process.
- Establish rapid assessment zones, where a stretcher is used only temporarily.
- Move discharged patients out quickly – plan for discharge well in advance so that non-acute care can be found in a timely way.
- Establish an accountability structure that creates incentives to keep hospital beds open.
- When hospital beds are not fully occupied and the ED is overcrowded, allow ED patients to be distributed to the most appropriate ward. (There will inevitably be some periods of overcrowding in ED, since the hospital cannot staff to meet the peak load.)

St. Paul's has had success with such innovations, reducing visit times considerably. However, visit times remain quite high for those with psychiatric issues.

Dr. Innes concluded by noting that small efficiency gains make a huge difference in outcomes in a high volume service.

A System Wide Approach to Reducing Emergency Department Wait Times

Ms. Carole Heatly, Kingston NHS Hospital Trust, England

Ms. Heatly spoke about efforts to reduce emergency room wait times in England, with particular attention to the experience at the Kingston Hospital in London.

Ms. Heatly noted that, in some London boroughs, over 50 percent of the population is not registered with a family doctor, which can put a strain on demand for service in the ED.

Wait times were a major issue in the 1997 election. The emergency care system at the time was dysfunctional: no co-ordination between the ED and other departments within the hospital; poor relationships among acute, community, and social care providers; and mistrust between hospital managers and clinicians. The ED was often used for primary or chronic care issues. There were lengthy ED waits, with many people waiting over 24 hours.

The new government responded with both increased funding (partly through an increase in payroll deductions) and system reform. The key elements of the reform were greater patient choice and a new payment and performance system:

- Patients can choose which health care provider to use.
- Hospital funding is based on use, so organizational success is based on service quality and cost-effectiveness.
- Performance measures related to quality and patient safety (second wave after initial focus on access/efficiency).
- Physicians' pay was increased, with a larger increase for family physicians.
- Performance targets were established and institutional performance against the target is published and available to the public. Targets are common across all hospitals in England. Targets included the following.
  - 90 percent (increasing in stages to 98 percent) of emergency room patients should be treated or admitted within four hours.
  - Appointment with a general practitioner (GP) should be provided within 24 hours of a request.
- CEOs of hospitals are now accountable for the performance of their institution.

Other reforms included:

- Improved off-hours access to GPs.
- Rapid response teams to provide short-term care at home.
- GP access to non acute beds.
- Rapid access to diagnostics. Assessment units open 24/7 so expensive equipment not sitting idle on weekends and evenings.

- Discharge planning from the time of admission, with community teams "in-reaching" or hospital teams outreaching to support timely discharge. Hospitals' payment for a patient is capped based on a maximum length of stay, creating a strong incentive for timely discharge.

At the Kingston Hospital, such reforms have led to dramatic reductions in wait times in the ER. They consistently meet the standard of 98 percent being treated or admitted within four hours. There is also much more rapid discharge from hospital for patients no longer requiring acute care.

The reform process is continuing. A new target has been set of 18 weeks from time of referral by GP to the start of first definitive treatment. Central control of decision-making on investments is being replaced by local decision-making.

Discussion

When asked if the new system of funding has led to closures of poorly performing hospitals, Ms. Heatly responded that it is leading to mergers and, in some cases, a hub and spoke model.

In terms of the nature of contracts between the hospitals and physicians, Ms. Heatly indicated that these include specific performance expectations, such as an expected minimum number of surgeries per session, and performance against these targets is reviewed regularly.

Other points that came up in the questions and answers exchange included the following:

- Three new medical schools were established in the late 1990s to increase the number of physicians. Improvements to salaries have helped retain physicians in the United Kingdom, as have increased investment in training and development and the broadening of physicians' roles.
- There were problems with hygiene when cleaning was contracted out, leading to an increase in infections such as C. difficile. Now these contracts have been redesigned to create financial penalties in such circumstances.
- Kingston Hospital has a patients' forum for engagement of patients in issues in health care delivery and ancillary services (parking, food, etc.).

Ms. Susan Mumme, Capital Health, Edmonton

Ms. Mumme spoke about "A System-Wide Approach to Reducing Emergency Department Wait Times" based on the experience of Capital Health, the health authority for the Edmonton region. Capital Health is responsible for 13 hospitals with 30,000 staff; 2,400 physicians; 3,000 hospital beds; 6,500 community care beds; and 11,000 home care clients per month.

After unsuccessful efforts to reduce overcrowding in the ED, Capital Health embarked on a new approach based on better coordination of patient flow across the system. The process involved three phases: assessment, design, and implementation.

The detailed assessment of practices and experience at four acute care hospitals and the community sector identified the need for:

- more primary care in the community,
- better discharge planning,
- more community care beds, and
- clearer criteria to access to community care beds.

The key elements of the design to respond to these challenges include:

- centralized bed hubs at each hospital;
- a community care access hub: a one-stop point of entry for all referrals;
- a full capacity protocol;
- an ED care coordinator;
- an ED triage physician; and
- ED clinical care guidelines.

Capital Health is now in the midst of implementation of the new design. Frequent communication with staff has been central to this, with an active effort to engage clinicians in the change process. There is a multi-faceted evaluation strategy, including a patient survey, performance indicators, staff and physician surveys, and an assessment of financial gains from improved patient flow. Performance is being tracked on a weekly basis. There is also recognition of the need to continue to add capacity – more staff and more long-term care beds.

Discussion

In response to questions from the audience, Ms. Mumme noted that her region's initiative has been funded by Capital Health – there was no request for incremental government funding for the project. The regional organization of acute, long-term, and home care services has facilitated a system-wide approach to the issue, allowing Capital Health to move resources where most needed.

Summary of Day One from Mr. André Picard

Mr. Picard closed Day One by noting that Minister Clement summed it up when he said "we have made progress but we are not yet in the Promised Land." Everyone in the process wants us to do better and deal with wait times in a global manner.

Day 2: Wednesday, April 16, 2008

4. Panel: Remaining Challenges in Reducing Wait Times and Improving Access

Moderator: Mr. John McGurran

Mr. McGurran asked the panel to consider these key questions: Has there been progress in reducing wait times? What further steps are needed? Will the issue continue to gain attention?

Dr. Peter Glynn, Health Care Consultant

Dr. Glynn expressed the view that progress is being made, but mainly in some areas of surgery and some diagnostics. While the provinces are measuring some outcomes, it is not clear whether these data are being used to improve the delivery of care.

Wait times are largely a legacy of the 1990s. Output (volume of services provided) has been keeping up with inflow (demand) for years, but it has to exceed inflow in order to reduce the length of the queue.

Dr. Glynn expressed some concerns about reform efforts to date: the discussion is physician-centred when it needs to be multidisciplinary; successes (such as centralized booking mechanisms) are not being replicated quickly enough by health authorities; and that we have not moved far enough to provide comprehensive, multidisciplinary primary care. The elephant in the room, in his view, is the lack of a contractual relationship between physicians and hospitals, so that performance is not managed.

Mr. Denis Morrice, Public Representative

Mr. Morrice noted that a great deal of progress has been made in the last few years and that many promising initiatives are under way, mainly because of the systematic attention given to the problem of wait times (which ought to have begun earlier). He also noted that we need to continue to make progress, as the aging of the population will create increased demands on the health care system.

Ms. Susan Delacourt, *Toronto Star*

Ms. Delacourt expressed a concern that timely access to health care is fading as a political issue, because both the Liberals and Conservatives made it a central issue in the 2006 election, so that it "cancels out" politically. Although wait time guarantees were initially among the five priorities of the new Conservative government, and there was the 2007 announcement, one no longer sees much reference to wait times among current priorities of the government.

Ms. Delacourt also noted that it is difficult to continue to make a federal election issue about something that requires the provinces to act in order for real progress to be made.

Dr. Brian Day, Canadian Medical Association (CMA)

Dr. Day expressed the view that, while some progress has been made since 2004 on wait times in targeted areas, it has not been nearly enough. Canada continues to rank poorly in access to a number of aspects of health care (e.g. access to family doctors) and in value for money. And there has been some displacement of wait time issues – progress in targeted surgeries has led to longer waits for some other surgeries.

Dr. Day argued for more systemic change – patient-centred care – rooted in tying funding for acute care to the patient, like in England, rather than block funding of hospitals. That sort of reform would create the incentive for hospitals to pay more attention to quality of service.

Discussion among the Panelists

Dr. Glynn argued that much progress can be made through centralized wait lists, as demonstrated in some of the presentations on the first day of the conference, and that we should move to adopt this more widely, which will take leadership from the top. He agreed that it would be helpful to have patient-centred funding for hospitals, but that, as in the United Kingdom, this should be accompanied by performance contracts with physicians.

Dr. Day responded that central wait lists may not be effective when there is significant sub-specialization. He reiterated the view that the key is patient choice, which requires a different funding model as well as public data on physician performance. Block funding means that hospitals do not have to thoroughly examine their cost structures nor the quality of care, since they have nothing to gain from attracting more patients. He also argued that inefficiency in the system makes operating time scarce for some types of surgery, which is driving some surgeons to other countries.

Mr. Morrice felt that radical reform of the system is not required, but leadership to overcome turf protection is needed, as well as data that can be compared across provinces.

Ms. Delacourt, returning to a political perspective, noted that the Conservatives believe they won by treating voters as consumers, and they continue this approach (exemplified by the GST cut). Empowerment of the individual is a powerful theme for them.

Questions and Answers / General Discussion

Dr. Day was asked whether the CMA is in favour of having surgeons as employees on contract with the hospitals, which is the model used by the NHS in England. He replied that survey data show that most physicians do not want fee for service as their main source of income. But if you block fund doctors, you need to accompany that with pay for performance contracts.

A conference participant agreed with Dr. Day that we need to change the incentive structure in order for good practices to spread rapidly. This will have to come from the top, as it is not in the interest of hospital CEOs to push for reform along the lines of the system in England.

Another member of the audience emphasized the need for better human resource planning at the national or at least provincial level. He noted that every day he speaks with physicians who are struggling to cope with their workload. Dr. Glynn agreed that we need to do a better job of HR planning in the health sector and also to examine more closely what people do within the hospital and whether work can be organized more efficiently. We are not good at doing this in the public sector.

5. Improving Wait Times for Mental Health Services

Introduction from Dr. Donald Milliken

Conference co-chair Dr. Milliken highlighted the importance of paying more attention to access to mental health services. Failure to provide early treatment can have serious consequences, including death. Certain mental illnesses are associated with very high mortality rates, partly through suicide, but also through contributing to other complications.

Timely Access to Mental Health Services: The Realities of Today and Tomorrow

Dr. Alain Lesage, Hôpital Louis-H. Lafontaine, Montreal

Dr. Lesage began his presentation, "Improving Wait Times for Mental Health Services," with a poignant quotation from the recently established Canadian Mental Health Commission:

> [T]he fact that mental disorders exist is not in itself a tragedy, the tragedy is that we do not implement the effective treatments that we know.

Dr. Lesage pointed out that, in a given year, about one person in five has a common mental disorder (anxiety, depression, substance abuse). On a lifetime basis, it is about double that ratio. One to two percent has severe mental disorders.

He presented the following information about the use of mental health services in Canada.

- Most mental health care is outpatient, with the family physician as the most common provider. Even severe mental disorders are usually detected first at the primary care level.
- Most mental health patients experience chronic, rather than transient, disorders, with episodic flare ups.
- Physician billings data show that, on average, about 15 percent of the population is identified by the family physician as having a mental disorder over a one-year period, so most cases are detected. But there is evidence of much unmet need, in terms of treatment, sometimes because the patient does not want treatment, sometimes because of lack of access to psychotherapy.

Dr. Lesage presented evidence that there are combinations of treatment that have been found to have good results, even for patients with severe disorders such as schizophrenia and chronic depression.

At a system level, an array of primary, secondary, and tertiary mental health services are needed. Long-term residential care is expensive but needs to be part of the system. We need a "balanced system" for both common and severe mental disorders.

Panel: Wait-Time Reduction Strategies for Mental Health Services

Mr. Phil Upshall, Mood Disorders Society of Canada

Mr. Upshall presented on "Psychiatric Wait Times in the Emergency Department." He began by calling attention to a slide from Grant Innes' presentation on day one of the conference which illustrated the much longer ED wait times for psychiatric patients than for others.

He emphasized that action on reform of mental health services has been too long in coming in Canada. Hospitals and governments have neglected their responsibilities. Michael Kirby's work has been helpful in calling attention to the issues. There is a window of opportunity to make progress: we have a strong leadership now on mental health to help it get the recognition it needs.

Mr. Upshall noted the high incidence of mental illness and referred to evidence of a huge cost to the economy of the failure to provide treatment for mental illness. The Public Health Agency of Canada is now able to obtain from insurance companies data on claims for mental health reasons. This will help shed further light on the cost of mental illness.

Mr. Upshall also argued that suicide is an epidemic that is not getting nearly enough attention. Since 2000, 33,000 Canadians committed suicide– one every 2.5 hours.

Mental health patients do not get the same access to services as others. And they are often brought to emergency rooms by the police, not by ambulances.

The elephant in the room is stigma, according to Mr. Upshall. There has not been enough action on mental health because people do not want to talk about it. We need to educate the media about mental illness to help overcome this.

Mr. Upshall reported on a workshop held by the Mood Disorders Society of Canada (MDSC) in January 2008 on how to reduce wait times for psychiatric patients in the emergency department (ED). Twenty-eight experts from across the country participated. The recommendations fromr workshop participants included the following.

- Develop consistent approaches to the assessment of psychiatric patients.
- Centralize the collection of data on the experience of psychiatric patients who present to ED, to enable comparisons across organizations and jurisdictions.
- Address the issue of stigma in multi-faceted way that engages all health professions.
- Establish a clearinghouse for sharing best practices.
- Improve system coordination, including the interaction between police and emergency departments.

To help move forward, the MDSC is planning to work with the Canadian Association of Emergency Physicians and with hospital accreditation bodies.

Dr. Simon Davidson and Dr. Ian Manion, Children's Hospital of Eastern Ontario

Dr. Davidson and Dr. Manion presented on "Access and Outcomes in Child and Youth Mental Illness."

Dr. Manion noted the importance of having childhood mental health on the agenda of this conference. It has been neglected all too often, "the orphan of the orphan." Yet there is a high prevalence of psychiatric disorders among children and youth – 15-23 percent. And over 70 percent of adults with mental illness experience onset of the illness in childhood or adolescence. Unfortunately, access of children and youth to mental health services remains very limited – only one in six access the care they need.

The problem is not simply long queues, but getting in the correct queue. People wait for a referral and then find that what they were waiting for was not what they needed. They may never enter a queue, because of the stigma associated with seeking treatment for mental illness.

Dr. Manion noted that child mental health cannot be addressed in isolation. There is a need to talk about education, community care, recreational activities, etc. We need an integrated model of care, driven by the needs of the patient and their parents. Other proposals for change that he identified included:

- Collaboration among mental health professionals;
- Better training for all health care professionals in childhood mental illness;
- Service provider benchmarks;
- Attitudinal change; and
- More resources to develop and evaluate new approaches.

Dr. Davidson noted that there are pockets of excellence, but people are often unaware of them. We need a compendium of best practices. The new Mental Health Commission could be helpful in this regard.

Dr. Davidson spoke about examples of promising practices in Eastern Ontario, such as the Youth Net program, which young people helped to design – it is a youth driven program, backed by professionals. Youth Net includes health promotion, early identification, and helping people find appropriate services. Another program, the specialized psychiatric and mental health system, is an integrated tertiary care program involving centralized intake between two hospitals, a 1-800 number, and a protocol for emergency departments to facilitate quick referral to appropriate services (which do not always involve a doctor – sometimes a crisis intervention worker).

Dr. Davidson concluded with a call for a major national initiative on childhood and adolescent mental health that would engage, among others, all of the major national health professional associations.

Dr. Richard Williams, Royal Jubilee Hospital, Victoria

Dr. Williams delivered the presentation that he developed with Ms. Jan Kiraly, "Vancouver Island Early Psychosis Intervention Program Standards."

Dr. Williams noted that when he arrived in Victoria, the hospital was not linked to the mental health clinic. The buildings were physically joined, but the administration was completely separate, so that to go from the hospital to the clinic required filling out new forms with the possibility of waiting weeks to be seen. Now the two institutions are integrated.

With psychosis, the research has shown that early intervention greatly increases the chances of successful treatment, yet patients often do not recognize the need for treatment. Victoria started an early psychosis intervention program in 1996, with financial support from the provincial government. The program was extended to all of Vancouver Island in 2000. An initiative to set Island-wide standards for the program began in 2005 and was completed in 2007. These standards include:

- public education about psychosis;
- one point access in each region; and
- a rapid response protocol that involves psychiatrists holding time slots in their schedules for possible urgent referrals. (There is also a street clinic that takes patients who do not have a family physician.)

Response time targets have been set for each stage in the process from request for an appointment to the completion of diagnostic workup (which may involve a variety of assessment methods).

The next steps for the project involve analyzing resource needs; developing competencies and training plans; and collecting data to track performance.

Dr. Nick Kates, McMaster University, Department of Psychiatry

Dr. Nick Kates' presentation, "Depression: Innovative Approaches to Treating the 'Elephant in the Room'" focused on new approaches to improve access to treatment for people suffering from depression. In his view, this must involve both better management of demand for care and changes in how service is supplied, rooted in thinking about the entire course of the illness, not just acute episodes.

Managing demand better requires:

- early detection,
- early initiation of treatment,
- acting to prevent relapses,
- better triage,

- support for front-line providers (especially primary care), and
- helping people manage their own care (by establishing goals, developing a plan, accessing relevant records, and accessing peer support).

On the supply side, new resources would help, but even without them, improvement can be made, in Dr. Kates' view, by changing how services are provided, mainly through better links between mental health services and primary care. New models of care may include:

- screening for mental illness,
- telephone back-up for family physicians,
- pro-active follow up after treatment, and
- team-based care, such as visits by psychiatrists to the offices of family physicians.

Dr. Kates described the Hamilton Family Health Team's Mental Health Program, established in 1994. It involves psychiatrists working with a large team of counselors, linked to 145 family physicians. The program has resulted in many more people being treated through primary care, a large drop in hospital admissions, a reduction in wait times (with the majority of service provided on a same-day basis), and high scores on both "consumer" and provider satisfaction surveys.

Dr. Kates called for efforts to continue to improve the efficiency of the system, through such tools as capacity mapping – looking at how the available patient slots are being used – and process mapping.

Discussion

A question was raised on how mental health professionals can connect to the school system. Dr. Manion indicated that staff in the schools need training regarding how to recognize mental health issues and how to bridge to appropriate services. There are some interventions that can be school-based, especially as some parents are reluctant to go directly to a mental health professional. Dr. Manion noted that the Mental Health Commission of Canada is looking at this issue. Dr. Davidson pointed to the importance of parental education, too, about mental health issues.

Dr. Kates was asked about the impact of the Hamilton program on caseload in emergency rooms. He replied that there are no hard data, but that he has anecdotal evidence that many patients would have gone to the ER in the absence of the program.

Finally, it was noted by a conference participant that it was important to pay special attention to seniors' mental health, especially with the aging of the population and the evidence of a high suicide rate among men over age 80.

Keynote Speaker: Dr. John Service, Chief Operating Officer, Mental Health Commission of Canada

Dr. Service noted that it is historic that this conference has given special attention to mental health – it would not have happened a few years ago. He called for an end to the separation between physical and mental health care. The data are overwhelming that they are interrelated.

Dr. Service stated that *Out of the Shadows at Last*, the 2006 report on mental health and addiction services by the Standing Senate Committee on Social Affairs, Science and Technology (chaired by the former Senator Michael Kirby and co-chaired by Senator Wilbur Keon), was the first comprehensive national study of mental health in Canada. It recommended establishment of the Mental Health Commission of Canada, funding for which was announced in the 2007 Budget of the federal government.

The Commission will soon be opening its head office in Calgary. While funded by Health Canada, the Commission is independent of government.

Canada is the only G8 country that does not have a national mental health strategy. Developing one is a key task of the Commission. This work, which will draw on *Out of the Shadows*, will engage Canadians widely. But implementation of the strategy will require leadership by governments and others.

Other activities currently planned for the Commission include:

- a national anti-stigma campaign, which will involve not only the media, but also grassroots dialogue;
- facilitating knowledge exchange; and
- demonstration projects on housing and mental health.

The Commission is developing a large network of people across the country to move the agenda forward. "We want to be a movement, not an organization." In addition, Michael Kirby is developing a charitable foundation that will go beyond the mandate of the Commission, and raise funds for advocacy, program support, research and support for the social movement that will be key to bringing mental health "out of the shadows forever" in Canada.

<u>Discussion</u>

As this session on mental health, and the conference itself, drew to a close, the discussion elicited the following comments and suggestions from participants.

- We should have a session at a future conference on how to reduce risk of psychiatric re-admission.
- Let's keep child mental health on the agendas of future conferences.
- Let's engage educators of health care professionals on mental health issues.
- We should have a "right to treatment" approach to mental illness. That is the real answer to the problem of stigma.

6. Closing Comments and Key Themes

Dr. Milliken closed the session on mental health by stating that we know what treatments are needed for mental illnesses. The issue is ensuring that those who need treatment are able to obtain it.

Mr. Picard closed the conference with thanks to the many people, notably the staff of the Canadian Medical Association, involved in organizing and staging the event.

In reflecting on the presentations and discussion over the day and a half of the conference, several key themes emerge. Perhaps the most recurrent theme is that the cup is half empty and half full, with some speakers emphasizing the former, others the latter. On the one hand were those who noted that we lack comparable data across provinces; that there is some evidence of increased wait times for surgeries outside of those targeted as priorities; and that, for those indicators where comparisons can be made across countries, Canada does not rank highly among developed nations. There was the suggestion from one speaker that broad systemic change is required along the lines of the reforms in England, where funding for acute care is tied to the patient, and surgeons have performance contracts with the hospitals.

On the other hand, many speakers pointed to signs of progress – evidence that for key procedures, wait times had been reduced. There were case examples showing remarkable results in wait time reduction. While some of this came from increased resources and capacity, much improvement was reported through measures requiring only modest investments, such as central referral/intake mechanisms and active wait list management – moving people up the queue who have an urgent need for care or who have been waiting a long time.

Another theme involved the importance of looking beyond the "big five" procedures and of measuring and managing wait times throughout the continuum of care, not just from the time of a specialist consult to treatment. Moreover, it was demonstrated that better supports for family physicians, particularly regarding mental health issues, can lead to a higher percentage of cases where treatment is completed earlier in the continuum of care, reducing the demand for treatment later on. At the other end of the care spectrum, several speakers noted that increased capacity in the chronic care and home care systems, and better discharge planning, can free up acute care beds and reduce wait times in the emergency room.

The importance of human resource planning, as in past conferences, was also noted by several speakers. This related not only to ensuring that the capacity of the system is and will be adequate to meet current and anticipated demand, but also to the importance of actively managing human resource contingencies to minimize the need for bed closures.

There is clearly room for further improvements, for a greater effort to achieve common metrics, and for spreading the implementation of practices that have been found to be effective in reducing wait times. We look forward to reports of continued progress at future Taming of the Queue conferences.

Appendix 1. Conference Agenda

The Taming OF THE Queue — Maîtriser LES files d'attente

Taming of the Queue V – In Search of Excellence
April 15-16, 2008, Chateau Laurier Hotel, Ballroom – Ottawa, ON

Tuesday, April 15

8:00-8:30 am	Registration and Continental Breakfast
8:30-8:45 am	Welcome Co-chairs: André Picard and Donald Milliken
8:45-10:00 am	*2004 Accord - accomplishments and challenges* o National overview: Les Vertesi, Health Council of Canada o Provincial perspectives: ▪ Alan Hudson, Ontario Access to Services and Wait Time Strategy ▪ Luis Oppenheimer, Manitoba Provincial Director of Patient Access
10:00-10:15 am	Break
10:15-11:10 am	o Medical perspective: Senator Wilbert Keon o Hospital perspective: Dora Nicinski, Atlantic Health Sciences Corporation
11:10–12:15 pm	o Public/Patient perspective: ▪ André Picard, Globe and Mail ▪ Denis Morrice, Bone and Joint Decade ▪ Colleen Savage, Cancer Advocacy Coalition of Canada
12:15-12:30 pm	Guest speaker: Honourable Tony Clement, Minister of Health
12:30-1:30 pm	Lunch (Adam Room)
	Wait time issues along the continuum of care
1:30-2:15 pm	Primary care wait times – managing the interface o Tom Bailey, College of Family Physicians of Canada
2:15-3:05 pm	Improving wait times in the emergency department o Greg Webster, Canadian Institute for Health Information o Grant Innes, St.Paul's Hospital, Vancouver BC
3:05-3:20 pm	Break
3:20-4:25 pm	A system-wide approach to reducing emergency department wait times o Carole Heatly, Kingston NHS Hospital Trust, England o Susan Mumme, Capital Health, Edmonton
4:25-4:30 pm	Summary of Day One
4:30–6:00 pm	Reception (Ballroom Foyer)

Wednesday, April 16

8:00-8:30 am	Registration and Continental Breakfast
8:30-8:40 am	Overview and objectives for day 2 Co-chairs: André Picard and Donald Milliken
8:40-9:40 am	Panel - Remaining challenges in reducing wait times and improving access: Moderator: John McGurran o Peter Glynn, Health care consultant o Brian Day, Canadian Medical Association o Susan Delacourt, Toronto Star
	Improving wait times for mental health services
9:40-10:10 am	Timely access to mental health services: the realities of today and tomorrow o Alain Lesage, Hôpital Louis-H. Lafontaine, Montréal
10:10-10:30 am	Break
10:30-12:15 pm	Panel: Wait-time reduction strategies for mental health services o *Psychiatric wait times in the emergency department*: Phil Upshall, Mood Disorders Society of Canada o *Child and youth mental illness prevention*: Simon Davidson and Ian Manion, Children's Hospital of Eastern Ontario o *Early psychosis intervention – schizophrenia*: Richard Williams, Royal Jubilee Hospital, Victoria o *Depression – innovative approaches to treating the elephant in the room*: Nick Kates, McMaster University, Hamilton
12:15-12:50 pm	Keynote speaker o John Service, Mental Health Commission of Canada
12:50-1:00 pm	Closing remarks
1:00 pm	Lunch (Ballroom)

Please note: Simultaneous interpretation will be provided

Appendix 2. Speaker Bios

Biographies

Tom Bailey

Dr. Tom Bailey has practiced as a family physician in Victoria, BC for nearly 30 years. He has an office-based practice but includes in-patient hospital and maternity care, house calls, residential care and regular shifts in a local walk-in clinic as part of his practice.

Dr. Bailey is a Clinical Associate Professor in the Department of Family Practice, Faculty of Medicine at the University of British Columbia and holds an Affiliate Appointment at the University of Victoria in the Division of Medical Sciences at the University of Victoria. He acts as a preceptor for UBC Family Medicine residents, Victoria Site.

He also serves as the Medical Director, Residential Services for the Vancouver Island Health Authority, where he is responsible for high-level oversight of the medical care provided by family doctors for more than 5,000 long-term care residents across Vancouver Island.

He is currently serving as Past President of the College of Family Physicians of Canada and has also served as President of the British Columbia College of Family Physicians (2000-01). He co-chairs the Primary Care Wait Time Partnership (a collaboration between the CFPC and CMA).

Francine Bordage (Replacement for Dora Nicinski)

Ms. Bordage's professional background is in nursing, having completed her BN from Université de Moncton in New Brunswick and her Master of Nursing from Athabasca University in 2007.

Since 1983, Ms. Bordage has worked in the field of cardiology. She began work on the implementation of the New Brunswick Heart Centre in 1990. Beginning in 1991, Francine worked at the New Brunswick Heart Centre in various capacities, including Cardiac Rehabilitation, Interventional Cardiology Nurse Associate, and as Unit Manager in Interventional Cardiology and Cardiac Surgery. Since 2005, Francine is the Administrative Director for the New Brunswick Heart Centre. In this role, she co-chairs the NB Cardiac Advisory Committee and represents the Atlantic Health Sciences Corporation and the New Brunswick Heart Centre on the Santé et mieux-être en français in New Brunswick.

Honourable Tony Clement

The Honourable Tony Clement, Minister of Health and Minister for the Federal Economic Development Initiative for Northern Ontario.

Tony Clement was elected to the House of Commons in 2006, representing the Northern Ontario riding of Parry Sound-Muskoka. He was subsequently appointed Minister of Health and Minister for the Federal Economic Development Initiative for Northern Ontario (FedNor). Mr. Clement is also the chair of the Environment and Energy Security Committee of Cabinet.

The Minister of Health is responsible to Parliament for some 20 health-related laws and associated regulations that govern the overall programs and policies of the department.

As Health Minister, he has overseen the creation of the Canadian Partnership Against Cancer and the establishment of the Mental Health Commission, and launched the Chemicals Management Plan. He has also worked with the provinces and territories to establish Canada's Patient Wait Times Guarantees.

As FedNor Minister, he has overseen the first five-year funding arrangement for FedNor and has approved major investments in research, tourism, waterfront development, and initiatives for job creation and retention. He was especially pleased to be on hand for the hiring of the 1,000th intern in FedNor's Youth Internship Program in 2006.

Prior to this, Mr. Clement was a member of Ontario's provincial legislature from 1995-2003. From 1997-2001 he held the cabinet portfolios of Transportation, Environment and Municipal Affairs and Housing. In 2001, he was appointed Minister of Health and Long-Term Care. As Health Minister, he was responsible for a ministry with a 28 billion dollar budget. He initiated primary care reform, created the successful Telehealth system, oversaw the expansion of the hospital system and provided leadership for the country during the SARS outbreaks.

Prior to his election, Mr. Clement was counsel to a national law firm, a Visiting Fellow at the University of Toronto Faculty of Law and was a small business owner.

Mr. Clement holds a Bachelor of Arts in political science and a law degree from the University of Toronto. He was born in Manchester, England in 1961. Mr. Clement is married to Lynne Golding and is the father of three children. He resides in Port Sydney, Ontario.

Simon I. Davidson

Dr. Simon Davidson is a child, adolescent and family psychiatrist. He obtained his medical degree at the University of Witwatersrand, Johannesburg, South Africa and completed his residency in Psychiatry at McMaster University, Hamilton, Ontario.

At the Children's Hospital of Eastern Ontario (CHEO), Dr. Davidson is Chief of Psychiatry, Medical Director of the Mental Health Patient Service Unit and Chief Strategic Planning Executive of the Provincial Centre of Excellence for Child and Youth Mental Health. He is Professor and Chairman of the Division of Child and Adolescent Psychiatry in the Department of Psychiatry at the University of Ottawa and a Past President of the Canadian Academy of Child and Adolescent Psychiatry (CACAP). He is the Chair of the Child and Youth Advisory Committee for the Mental Health Commission of Canada.

Dr. Davidson's interventional and academic interests include development and implementation of integrated multidisciplinary models of mental health service delivery; mental health promotion, illness prevention and identification and early intervention (Youth Net/Réseau Ado Co-Founder); adolescent anxiety, mood disorders and suicide; school refusal.

Dr. Davidson is a passionate advocate for children and youth and ensuring appropriate mental health services for them. In this capacity he is active at all levels of government.

Brian Day

Dr. Brian Day became the 140th president of the Canadian Medical Association in August 2007. Born in Liverpool, England, Brian Day graduated in medicine from the University of Manchester in 1970. After postgraduate studies in England, in both internal medicine and general surgery, he came to the University of British Columbia for a residency in orthopaedics. In 1978, following a trauma fellowship in Switzerland, England and Los Angeles, he began his medical practice at the Vancouver General Hospital and the University of British Columbia. It was there that he developed his interest and expertise in orthopaedic sports medicine and arthroscopy.

Chair of the resident academic program for UBC’s Department of Orthopaedics from 1978 to 1994, he has been a part-time associate professor at UBC since 1987. Dr. Day has chaired several international seminars on arthroscopic surgery, and from 1989 to 1994 he chaired the orthopaedic test committee for Canada’s Royal College of Surgeons. In demand as a visiting professor and lecturer, his academic teaching has taken him throughout Canada and the United States, as well as to many other countries.

His publications include more than 100 scientific articles and book chapters in areas of orthopaedics, arthroscopic surgery and sports medicine. He has been active on the editorial boards and committees of several scientific and medical journals, including the British Columbia Medical Journal. He has a long-standing interest in technology and medicine. He co-authored a paper on electronic medical records in 1979 and, in 1985, was a co-developer of the world's first surgical robot. He was also one of two participants in the first ever live satellite telemedicine broadcast between North America and mainland China.

In 1995, Dr. Day founded the Cambie Surgery Centre, a private surgical facility. He has written more than 25 articles and lectured throughout North America on health policy issues. Dr. Day is the founder and a past-president of the Canadian Independent Medical Clinics Association.

His long association with the Canadian Orthopaedic Association started early in his career when in 1979 he received COA's Edouard Samson Award for outstanding research by a young investigator. A member of the COA board of directors and chair of its membership committee from 1987 to 1998, he also was vice-president of the Canadian Orthopaedic Foundation (1989-93) and a member of the executive of the Canadian Orthopaedic Research Society (1992-94).

He is a former research committee chair and past-president of the Arthroscopy Association of North America (AANA), the world's leading academic society in his field of practice. Dr. Day was only the second Canadian to serve as president of the AANA.

In 2001, he was the 80th annual Osler Lecturer for the Vancouver Medical Association and, in 2004, he was made an honorary member of the Cuban Orthopaedic Association.

Susan Delacourt

Susan Delacourt is a senior political writer with the Ottawa bureau of the *Toronto Star*. In the 20 years since she first came to work on Parliament Hill, she has been a columnist, bureau chief and political reporter with four major national newspapers. She is also a weekly panelist on CBC Newsworld's Politics broadcast.

Over the course of her long career covering politics, Delacourt has also written three books – the latest released in 2003, on Paul Martin's ascent to the top of the Liberal party. She has also freelanced extensively on radio and in magazines and has been a finalist for the national newspaper and magazine awards. The *Globe and Mail* gave Delacourt its highest writing prize for her work on the national unity battles of the 1990s.

Delacourt has a political science degree from the University of Western Ontario.

Peter A.R. Glynn

Dr. Glynn is a consultant on health care policy, planning, governance and management, both in Canada and internationally. Currently, he is very involved with advising governments, health authorities and hospitals on access management strategies. He has been the founding Chair of both the Saskatchewan Surgical Care Network and the Saskatchewan Diagnostic Imaging Network. He recently completed three years as the Senior Advisor to Ontario's Wait Time Strategy.

Dr. Glynn has been the President and Chief Executive Officer of the Kingston General Hospital; the Assistant Deputy Minister, Health Services and Promotion Branch, Health and Welfare Canada; and the Associate Deputy Minister of Health for the Province of Saskatchewan.

He has been a member of, and chaired many task forces, committees and organizations in health care and health research. He is currently the vice-chair of the Board of Frontenac Community Mental Health Services. He is the immediate past Chair of the Board of the Institute of Clinical Evaluative Sciences (ICES) and past member of the Board of the Heart and Stroke Foundation of Canada and the National Cancer Institute of Canada.

Dr. Glynn is an Associate Professor (Adjunct) in the Department of Community Health and Epidemiology at Queen's University. He holds a Bachelor of Engineering from the Royal Military College of Canada and a PhD in Engineering from the University of Waterloo.

Carole Heatly

Carole was appointed to the Board as Chief Executive in October 2003. Prior to this, Carole was Deputy Chief Executive and Director of Strategic Development at Bromley Hospitals NHS Trust. She started her career in the NHS over 25 years ago, qualifying as a Registered General Nurse and Registered Sick Children's Nurse, working mainly in Accident and Emergency in Glasgow before moving into hospital management in 1990.

Alan Hudson

On September 1, 2004, Dr. Alan Hudson was appointed Lead, Access to Services and Wait Time Strategy, Health Results Team for the Province of Ontario by the Minister of Health.

Dr. Alan Hudson was appointed President and CEO of Cancer Care Ontario as of April 1, 2002.

From 1991 to 2000, Dr. Hudson was President and Chief Executive Officer of Toronto's University Health Network.

Dr. Hudson served as McCutcheon Chair and Surgeon in Chief at Toronto Hospital from 1989-1991, and from 1970 to 1989 Dr. Hudson was Chairman of Neurosurgery at the University of Toronto.

Grant Innes

Dr. Innes obtained his MD from the University of Alberta in 1980, then completed Emergency Medicine training in Denver, Colorado. He has worked as an emergency physician for over 20 years, as Head of the Providence Health Care Department of Emergency Medicine for six years, and as Chairman of Emergency Services for the Vancouver Coastal Health Region for five years. He has led many changes in emergency care and received several awards for innovation, including the BC Ministry of Health Award for Innovation in the Delivery of Health Care (2007), the University of British Columbia's Distinguished Service Award for Continuing Health Education and Knowledge Translation (2007), the 3M National Healthcare Quality Award (a team award for reducing sepsis-related mortality in 2006), and the Physician Achievement Award (2002) for successful implementation of computerized physician order entry (CPOE) systems in two Vancouver emergency departments.

Dr. Innes was Editor-in-Chief of the *Canadian Journal of Emergency Medicine* from 1998-2007 and is currently Clinical Professor of Surgery and Emergency Medicine at the University of British Columbia. He is a nationally recognized expert in Emergency Department operations with more than 50 peer-reviewed publications and over 200 invited presentations at medical and health-related conferences.

Nick Kates

Nick Kates is a Professor in the Department of Psychiatry and Behavioural Neurosciences at McMaster University with a cross appointment in the Department of Family Medicine and is the program director of the Hamilton Family Health Team. For 12 years he was the director of the Hamilton HSO Mental Health and Nutrition Program. He is also the Ontario lead for the Quality Improvement and Innovation Partnership (QIIP), which assists Family Health Teams in Ontario to implement a quality improvement agenda. He has co-chaired the shared mental health care working group of the Canadian Psychiatric Association and College of Family Physicians of Canada since 1997 and was chair of the Canadian Collaborative Mental Health Initiative Steering Committee, a National PHCTF project.

Honourable Senator Wilbert Keon

After his medical and scientific training from Ottawa, McGill, Toronto and Harvard, Dr. Keon moved to Ottawa in 1969 to found the University of Ottawa Heart Institute, where he was the Chief Executive Officer until April 2004.

Innovation has been a hallmark of Dr. Keon's career, having drawn research grants totaling 66 million dollars during his career. His clinical innovations are numerous, but most notable include the pioneering of surgical reperfusion in acute heart attacks during the early 1970s, the first cardiac transplant in Ottawa in 1983, the first use of Jarvik 7-70 artificial heart in Canada in 1986 and, in 1989, the first Canadian infant heart transplant.

Dr. Keon remains active in health and economic policy through participation on Scientific and Clinical Advisory Boards, membership on several Boards of Directors and as a consultant to public and private sector clients, and as Senator in the Senate of Canada and as Deputy Chair of the Senate Standing Committee on Social Affairs, Science and Technology. He is presently Chair of a Senate Sub-Committee studying population health.

In 2007, the Canadian Medical Association (CMA) presented him with the 2007 F.N.G. Starr Award. That same year, he was inducted into the Canadian Medical Hall of Fame for his enormous contributions to the understanding of disease and the improved health and well-being of people everywhere.

Alain Lesage

Dr. Alain Lesage is Professor in the Department of Psychiatry at the Université de Montréal. He is researcher at the Centre de recherche Fernand-Seguin of Hôpital Louis-H. Lafontaine in Montreal since 1987.

Dr. Lesage graduated in medicine from the Université de Sherbrooke (Quebec) and did his training in psychiatry in the hospital network affiliated with the Université de Montréal. He completed his training in research with a three-year postdoctoral internship in the Institute of Psychiatry at Maudsley Hospital in London, England, and one year at the Istituto di Psichiatria in Verona, Italy. His primary research focus is an epidemiological and evaluative look at the care and service needs of people with serious mental disorders. He also directs an evaluative support module for the development of psychiatric services at Hôpital Louis-H. Lafontaine and University of Montreal's hospitals network. Dr. Lesage collaborates with national and provincial mental health and addiction services and policies researchers.

Dr. Lesage is Past President of the Canadian Academy of Psychiatric Epidemiology. He served as Editor-in-Chief of the journal Santé mentale au Québec, and is francophone associate editor with the *Canadian Journal of Psychiatry*. Dr. Lesage currently serves on the science advisory committee of the Mental Health Commission of Canada.

Ian G. Manion

Dr. Manion is a clinical psychologist and scientist-practitioner who has worked with children, youth and families presenting with a variety of social, emotional, and behavioural problems.

Dr. Manion is a clinical professor in the School of Psychology at the University of Ottawa, and a Visiting Professor at the University of Northumbria (UK). He is the Executive Director for the Provincial (Ontario) Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario (CHEO). He is actively involved in research in the areas of parent/child interactions, community mental health promotion, youth depression and youth suicide. He is a committed advocate for child and youth mental health, sitting on a number of local, provincial, national and international boards and committees. He currently chairs the Mental Health Subcommittee of the Paediatric Complex Care Coordination Expert Panel as part of Ontario's Paediatric Wait Times Strategy.

Dr. Manion is co-founder of Youth Net / Réseau Ado, an innovative, bilingual community-based mental health promotion program with satellites across Canada and in Europe. This program strives to understand the mental health issues facing youth and to better address these issues with sensitivity to gender, age, culture, and geography.

John McGurran

John McGurran is a consultant and president of Cordova Bay Research Ltd. in Victoria, BC.

John received his academic training at McMaster University earning a BA *(summa cum laude)* in Social and Political Ideas (1976) and an MSc in Clinical Epidemiology and Biostatistics (1980).

Before moving from Ontario to Alberta in 1999 to join the Western Canada Waiting List Project, John served as executive director of a district health council, director of epidemiology and statistics in a public health department and director of Central East Health Information Partnership.

As a consultant he has completed municipal public opinion and employee surveys, and has consulted with governments in Canada, Australia, Europe and the Caribbean on waiting time management issues.

John has been a faculty member in the Department of Public Health Sciences at the University of Toronto since 1997.

Donald Milliken

Trained in psychiatry at the University of Alberta, with an additional degree in health administration from the University of Colorado, Dr. Don Milliken has practiced both clinical and administrative psychiatry for almost 40 years. In Edmonton, he was the Chief of Psychiatry for the Misericordia Hospital, the Clinical Director of Forensic Services at the Alberta Hospital and taught at the University of Alberta with the rank of Clinical Professor.

As Chief of Psychiatry in Victoria, he developed a catchment-area model of services, integrating in-patient and out-patient systems with the beliefs that care must go to those most in need; that for sick people the system must provide continuity of care and support in a simple yet seamless manner, and that the organization of care must be seen as being clinically sensible by practitioners and recipients alike.

Dr. Milliken has received a Special Award for Outstanding Service from the Alberta Board of Review, and an “Exemplary Psychiatrist” Award from the US National Alliance for the Mentally Ill.

A Past-President of the Canadian Psychiatric Association, he is a signatory to the Canadian Collaborative Mental Health Initiative's "Charter for Mental Health Care," and co-chaired the first CPA / Global Business and Economic Roundtable on Addiction and Mental Health forum on "Mental Health and the Workplace."

A principal author of "Wait-Time Benchmarks for Patients with Serious Psychiatric Illnesses," he sits on the CPA Board and chairs the Advocacy Committee.

He works to promote levels of care for patients with psychiatric illnesses that are equal to those provided to patients with physical illnesses of equivalent disability.

Denis Morrice

Denis Morrice was born in Hamilton, Ontario, Canada and graduated with a degree in Applied Social Science from Sir George Williams University. He spent most of his career in Community Development. As Executive Director of a Settlement House in Toronto, he helped organize community residents in establishing legal aid, income tax and dental clinics. He served as a Senior Consultant to the Provincial Government of Ontario on Community Development and Citizen Engagement. As Executive Director of The Canadian Hearing Society he directed the establishment of hearing aid programs, sign language training programs, interpreter services, mental health and telephone relay services for deaf and hard of hearing people.

While President of the Arthritis Society of Canada, he ensured resources supported the establishment of www.arthritis.ca with 140 volunteer professional and consumer representatives, the development of the Canadian Arthritis Patient Alliance, MSK Cochrane Collaboration and the Canadian Joint Replacement Registry. He served on Health Charities Coalition of Canada committees dealing with Direct to Consumer Advertising, national pharmaceutical strategy and research and scientific issues.

He continues to serve on a number of boards and committees to move the health care agenda forward and advocate for patient participation: Canadian Orthopaedic Foundation, Institute for Musculoskeletal Health and Arthritis / Canadian Institutes of Health Research, Canadian Arthritis Network / Networks of Centres of Excellence, Best Medicines Coalition of Canada, Institute for Clinical Evaluative Sciences, Cell Signaling in Mucosal Inflammation and Pain, Pharmaceutical Advertising Advisory Board, the Canadian Cochrane Network and Centre.

Mr. Morrice passionately believes that: “Those affected by a decision should be involved in making that decision.”

Susan Mumme

Susan Mumme has distinguished herself as a leader in operational and change management in health care, through over 20 years in management and executive roles for a wide range of clinical and support services with Capital Health – one of Canada’s largest health regions – in Edmonton, Alberta.

Susan’s leadership has assisted the complex health region to develop a fully integrated health system, delivering excellence and leadership in people-centred health care, education and research.

In her current role as Vice President and Chief Operating Officer for Regional Clinical Support Services, Susan is responsible for the regional integration of both the Emergency Services and System Capacity (ESSC) and Ambulatory Care Gold Standard initiatives. ESSC is a multi-part, multi-stage initiative to address the issues of emergency patient wait times and inpatient capacity management. The Ambulatory Care Gold Standard project is a comprehensive look at how to improve patient access to services and their care experience.

Susan’s operational portfolio includes Patient Information Services, Library Services, Nutrition and Food Services, Diagnostic Imaging and Pharmacy Services. Her previous role in the region was Senior Operating Officer at the University of Alberta Hospital.

Susan holds a Master’s degree in Health Studies (Leadership) and a Bachelor of Science degree in Food Science (Dietetics). She and her husband, Dan, have two children – Laura and Jason.

Capital Health, one of the country's top-rated health systems, is known internationally for groundbreaking innovations and advances in medicine. Its 14 hospitals and care centres provide complete health services to a total of 1.6 million people across central and northern Alberta, including specialized services such as trauma and burn treatment, organ transplants and high-risk obstetrics.

Dora Nicinski

Dora Nicinski is the President and CEO of the Atlantic Health Sciences Corporation, encompassing 12 facilities and outpatient centers providing primary, secondary and tertiary services across urban and rural communities, located in Southern New Brunswick. Since completing her Masters in Health Services Planning and Administration with the Faculty of Medicine, University of British Columbia, Dora has held various senior administrative positions throughout British Columbia. Dora is currently affiliated with the Canadian College of Health Service Executives (CHE designation) and the Registered Nurses Association of New Brunswick.

In addition to her recent appointment as a member of the Board of Directors of the Canadian Council of Health Services Accreditation (CCHSA), and the Advisory Council of the Executive Training for Research Application (EXTRA), she is a member of the Board of the Association of Canadian Academic Healthcare Organizations (ACAHO), and is a member of the Federal, Provincial, and Territorial Advisory Committee on Health Delivery and Human Resources.

Luis Oppenheimer

In March 2006, Dr. Luis Oppenheimer accepted the position as Provincial Director of Patient Access. In this position, Dr. Oppenheimer will work to ensure that patients receive timely access to needed surgical procedures. He will be working with all regional health authorities to reduce wait times and to provide better and faster patient care. The Faculty of Medicine, University of Manitoba and the Winnipeg Regional Health Authority announced the appointment of Dr. Oppenheimer as Assistant Dean, Innovation in System Design and Quality, Faculty of Medicine, University of Manitoba, and Director, Wait List Management, Clinical Access and System Improvement, Winnipeg Regional Health Authority effective September 1, 2006.

Colleen Savage

Colleen Savage has been President and CEO of the Cancer Advocacy Coalition of Canada since 2003. At the CACC, she is responsible for strategic planning, policy development, advocacy campaigns and production of the annual Report Card on Cancer in Canada. She has researched, written and co-authored numerous Report Card articles on screening, waiting times, guidelines and access to drugs. Ms. Savage is an independent public affairs consultant with 20 years experience in the health sector, providing strategic communications support to hospitals, community boards and the private sector. Prior to her consulting business, she managed the community health centre program at the Ontario Ministry of Health.

John Service

Dr. Service is the Executive Director for the Mental Health Commission of Canada. Prior to his appointment, John was Executive Director of the Canadian Psychological Association (CPA) for the past 14 years. Prior to his time at the CPA, John served as a clinical psychologist with the Aberdeen Hospital in New Glasgow, Nova Scotia.

Over his career, John has been involved with several important initiatives serving as Chair for the following organizations: Canadian Alliance on Mental Illness and Mental Health, the Canadian Consortium for Research, and the Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative. He has also been a member of the Management Committee of the Health Action Lobby.

Dr. Service brings extensive contacts from the federal, provincial and territorial governments to his work at the Commission.

Phil Upshall

Phil was born in Winnipeg, Manitoba, educated at Dalhousie University, Halifax, (B.Com. 1965) and the University of Toronto (LLB 1967). He was called to the Bar of Ontario in 1969. Currently, Phil is the National Executive Director of the Mood Disorders Society of Canada (MDSC), a virtual national NGO with a mandate to represent the interests of consumers and families dealing with depression, bipolar interest and other related mood disorders. MDSC has led research into the relationship between problem gambling and bipolar illness; has held workshops dealing with the stigma of mental illness; has led the way in developing collaborative working relationships with the First Nations, Inuit and Métis mental wellness communities and has developed background research for and hosted a workshop dealing with wait times in emergency rooms for patients presenting with psychiatric issues.

Phil was a member of the Institute Advisory Board of the Institute of Neurosciences, Mental Health and Addiction and has been a member of a number of expert panels for Stats Canada, Health Canada, CIHI and others. He is the immediate past National Executive Director of the Canadian Alliance on Mental Illness and Mental Health (CAMIMH).

Phil is the Special Advisor, Stakeholder Relations, to the Mental Health Commission of Canada; an adjunct Professor in the Department of Psychiatry, Dalhousie University; the Managing Director of Mental Illness Awareness Week in Canada and the Project Manager for the Canadian Collaborative Mental Health Initiative, Phase 2.

Les Vertesi

Dr. Vertesi is a career physician with over 30 years experience in major trauma referral hospitals, and with a proven track record for leadership and innovation. Best known as the founder of the Advanced Life Support paramedic ambulance program of the BC Ambulance service (1975-1985), he was also the founding chairman of the Canadian Medical Association's accreditation committee on Accreditation of EMS training. In addition to his specialty certificate in Emergency Medicine, he earned a Master's Degree in Health Sciences and Clinical Epidemiology from UBC.

His interest in international economic models and their relevance to Canadian health care led to his 2003 book – *Broken Promises: Why Canadian Medicare is in trouble and what can be done to save it*. He still maintains his clinical practice in the Emergency Department while holding an academic appointment at Simon Fraser University doing modeling and waitlist research. A few of his career appointments include; Head of the Department of Emergency Medicine at Royal Columbian Hospital (New Westminster, BC, 1989-2001), member of the advisory panel for the Senate Report on Canadian health care (2002) and BC's representative to the Health Council of Canada. He is currently a central figure in Vancouver Coastal Health Authority's introduction of a pay-for-performance proposal at four Emergency Departments in Vancouver.

Greg Webster

Greg Webster is the Director of Research and Indicator Development at the Canadian Institute for Health Information (CIHI). In this leadership role, he is responsible for providing vision and direction for CIHI's health services research, health indicator and primary health care initiatives. His most recent priorities include: emergency department wait times; hospital standardized mortality ratios (HSMR); health indicators for health regions; health outcomes; developing a pan-Canadian consensus set of primary health care indicators and launching CIHI's new primary health care information program. As a member of CIHI's Executive Committee, he also provides strategic and operational advice on CIHI's activities.

Greg has over 15 years of experience using health data, information and evidence to improve health and health care. He also has extensive experience leading and achieving results through networks and partnerships. Greg has a Master of Science in Epidemiology from the University of Toronto.

Richard Williams

Richard Williams is Director of Schizophrenia Services at the Royal Jubilee Hospital, Victoria, British Columbia, Canada. He is also Clinical Professor in the Department of Psychiatry at the University of British Columbia and Adjunct Professor of the Department of Psychology at the University of Victoria, British Columbia. He is the academic leader for the Department of Psychiatry for the Island Medical Program of the University of British Columbia, since the inception of the program in Victoria.

After qualifying in medicine in London in 1974, Dr. Williams became Clinical Lecturer at the University of Edinburgh. Between 1982 and 1996 he took up academic positions at the University of Calgary, Alberta where he became Professor. In addition, between 1994 and 1997, Dr. Williams was Research Director of the Rehabilitation Division of Calgary World Health Organization collaboration centre for research and training in mental health. He organized the first break psychosis program in British Columbia. and has both a clinical and research program in Victoria. He received the CPA's C.A. Roberts Award for Clinical Leadership in 2004.

Dr. Williams has approximately 40 publications in schizophrenia research on cost-effectiveness, epidemiology, pharmacology and movement disorders.

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