PRIMARY CARE-FAMILY PRACTICE

WAIT TIMES EXPERT PANEL

January 10, 2007
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SECTION A: INTRODUCTION

1. PRIMARY CARE-FAMILY PRACTICE WAIT TIMES EXPERT PANEL

In June 2006, the Ministry of Health and Long-Term Care established the Primary Care-Family Practice Wait Times Expert Panel (The Panel) made up of family physicians and primary care nurse practitioners from geographic locales representing all 14 Local Health Integration Networks. The Panel is diverse in that its members practice in the wide variety of practice models within Ontario’s primary health care system, as well as in urban, rural, and remote locations. As actively practicing professionals, the panel members are familiar on a day-to-day basis with the challenges facing Ontarians to access health care.

Ontario’s Wait Time Strategy aims to increase access to and reduce wait times for five key services: cataract surgeries, cancer surgeries, hip and knee total joint replacements, MRI/CT scans, and selected cardiac procedures. A critical success factor in increasing access to these procedures is the role of primary care and family practice professionals in early detection and management of disease, appropriately referring their patients for specialised assessments or diagnostic procedures and to specialists and/or facilities for further assessments and interventions. Throughout this “patient journey” primary care and family practice professionals continue to provide ongoing coordinated management for their patients.

Several expert panels have been created to advise the Ministry of Health and Long-Term Care on effectively executing the Wait Time Strategy. The Primary Care–Family Practice Wait Times Expert Panel is the first panel to address the broader continuum of care from initial presentation to post acute hospital services. The purpose of the Primary Care-Family Practice Wait Times Expert Panel is to advise the Ministry on how primary care-family practice professionals can be an integral part of the Wait Time Strategy for the benefit of Ontarians.

Patients who need care depend on the primary care sector to provide care directly, and to gain access to needed services within and across health system sectors. System driven inefficient and ineffective processes and practices in managing the patient’s transition across different levels of care along the continuum result in bottlenecks. These bottlenecks lead to delayed access to needed care, increased wait times, unnecessary appointments, poor health care outcomes, and sub-optimal system performance. It is crucial that primary care providers are engaged in ensuring that their patients are able to access timely diagnostic, treatment and rehabilitative services.

The mandate of the Panel is to:

1. Identify effective methods to involve and engage the primary care-family practice community in the Wait Times Strategy.

2. Identify how primary care-family practice professionals – who refer patients for diagnostic procedures and specialised assessments – can lead, contribute to, and support improvements in access to services and reductions in wait times for their patients as part of the Wait Time Strategy.
3. Advise on the information and tools needed by primary care-family practice professionals to support effective and timely referrals to specialised assessments and diagnostic procedures, and appropriate ongoing patient management (including post-hospital care and follow-up).

4. Recommend changes to the Wait Times Strategy website and wait time data to assist primary care and family practice professionals in their referral decisions.

2. A CONTEXTUAL MODEL FOR PRIMARY HEALTH CARE

Health care systems are complex however, and primary care the most complex of these. Complex adaptive systems in health care\(^1\) are characterized by:

- Fuzzy, rather than rigid boundaries – perturbations in one system component can have unpredictable consequences on other components.
- Agents’ actions are based on internalized rules – these rules need not be shared, explicit, or logical when viewed by another agent.
- The agents and systems are adaptive – adaptations may be perceived as better or worse, depending on whose point of view is being considered.
- Systems are embedded within other systems, and they co-evolve – since systems are nested within each other, evolving together, one cannot understand one component without reference to the other.
- Tension and paradox are natural phenomena, not necessarily to be resolved – seemingly opposing forces of cooperation and competition often work together.
- Interaction leads to continually emerging, novel behaviour – observable outcomes are not merely the sum of the parts.
- Inherent non-linearity – small differences in initial variables can translate into huge differences in outcomes.
- Inherent unpredictability – the only way to understand what a complex system will do is to observe it.
- Inherent pattern – there is often an overall pattern that affords one to make generally true and practically useful statements about the behaviour of the system.
- Inherent self organization through simple locally applied rules – order, innovation, and progress may emerge naturally from internal to the system, without being imposed by outside (central) forces.

A comprehensive definition of primary health care is contained within the report of the “Subcommittee on Primary Health Care of the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations,”\(^2\) which accepted the following modified definition from the World Health Organization:

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\(^2\) New Directions in Primary Health Care: Prepared by the Subcommittee on Primary Health Care of the Provincial Co-ordinating Committee on Community and Academic Health Science Relations (PCCCAR) July 1996
"Primary health care consists of a first-contact assessment of a person and the provision of coordinated care for a wide range of health concerns with a sustained relationship. It combines a focus on individuals and families with a focus on the health of a defined population within a community. Primary health care is delivered by a variety of health professionals and providers working collaboratively with the consumer to maintain health, support wellness, and treat illness. Full participation of consumers and accountability to consumers and to the community for high quality and comprehensive services are essential features of primary health care".

The salient features of primary health care service delivery are:

a) **First contact**: refers to the extent to which primary care provides entry into the health care system;

b) **Comprehensive care**: includes prevention, screening, curative, and rehabilitative services;

c) **Coordination**: refers to the ability of primary care providers to coordinate use of other levels of health care;

d) **Longitudinality**: refers to care that is patient focused over time;

e) **Family and community orientation**: refers to placing the patient within the wider familial and social context necessary for addressing multiple causes of illness or health.² ³

Research has demonstrated that **countries that invest more effectively in primary care achieve greater benefits in the health of its population, including all cause mortality, all cause premature mortality, and cause specific mortality including asthma, bronchitis, emphysema, cardiovascular disease and heart disease, than do countries with an immature primary health care system.⁵**

Prominent researchers emphasize that primary care involves a sustained partnership between patients and providers that addresses the majority of a population’s health needs over time. "The 35 most common problems in practice and the 40 important problems with serious but preventable outcomes represent nearly 70% of community need and define the core content of family practice."⁶ The primary care system thus provides a far greater proportion of total health services in any time period than those provided from the secondary level health care (first level of referral, hospitals) and only a small minority require the most specialized services unique to the tertiary health care systems (second level referral, academic hospital).

In Ontario in most instances that provider would be a family physician or a primary health care nurse practitioner. Other members of team-based models (such as Family Health Teams and Community Health Centres) often include nurses and allied health care professionals.

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⁵ Rosser, W., Sustaining the 4 principles of family medicine in Canada. [Editorial] CFP Journal October 2006
Finally, however effective health service delivery may be, there are many determinants of health, such as genetic profile, environment, income, and employment that affect health status regardless of the volume and scope of health services.

A broad contextual model for primary health services might therefore reflect this complexity as follows:

CONCEPTUAL MODEL FOR PRIMARY HEALTH CARE

In summary, the primary health care system is of great importance in any country that wishes to optimize the effectiveness of its health care system. Its core competencies include

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7 The model presented above provides a contextual overview of the role of primary care within the healthcare system. A framework for understanding the entire primary care enterprise encompasses an organized set of reference models that provide different views of the primary care system. A standard approach to defining such a framework and its component models in the Government of Ontario adopts the Business Architecture domain (the contextual and conceptual models) of an Enterprise Architecture as articulated in the Government of Ontario Enterprise Architecture Process & Methods (EAPM). The models within the Business Architecture typically include a program service alignment model, a service integrated accountability model, a program logic model (PLM), and others. In the current context of the Wait Time Strategy, a realization of the logic model would be most useful to drive accountability and to derive the program indicators as a result of the stated goals and agreed-upon causal logic.
comprehensiveness, the ability to coordinate care, care provided over time, and care that is oriented to the family and community. The primary health care system, however, is extraordinarily complex. Its service delivery boundaries and communication linkages are not well defined. The Primary Care-Family Practice Wait Times Expert Panel is cognizant of the risk that recommendations on one system component may cause unintended consequences on other components, unless clearly representative of a strong base of evidence. It is also worth noting that because of the geography and diverse nature of Ontario it is critical to avoid a “one size fits all” approach to the delivery of primary health care.

3. OVERVIEW OF THE REPORT

This is the report of the Primary Care-Family Practice Wait Times Expert Panel. It presents recommendations to reduce wait times and increase patient access through different levels of health service delivery. This plan focuses on strengthening the interconnection between health system components through cross-system efficiencies including the individual/group/team practice level (or provider’s office) and moving along the layers of care towards achieving effective coordination throughout the patient’s entire care experience. The goals include seamless patient transition through health system sectors, patients’ accessibility to the right service at the right time, collaborations between different levels of providers, a framework for tracking and reporting quality and efficiency indicators, and formalizing an infrastructure for primary care to inform policy and service planning at the community level.

The Panel believes its recommendations will improve access and remove barriers to reducing wait times to diagnostic tests, specialist consultations, post-acute hospitalization follow up care, and primary care providers, as well as providing an opportunity for future monitoring and evolving system performance.
SECTION B: APPROACH AND DELIBERATIONS

1. Primary Care – Family Practice Wait Times Expert Panel Approach to Information Gathering and Deliberation Process

The Panel approached its mandate from the perspective of the patient’s journey, and pursued a work plan based on the following goal:

Goal 1:
Identify the Pressure Points in Primary Care/Family Practice and How they Affect Wait Times Within the Broader Health Care System, and in Relation to the 5 Key Service Areas and Other Health Services

2. Methods Used to Gather Information

The Panel used a number of methods and strategies to gather information. The main methods used included:

1. Survey of Chiefs of Family Medicine
2. Focus groups with practising family physicians and nurse practitioners across the province
3. Focus groups with academic leaders in Family Medicine and Primary Care Nurse Practitioner programs from across Ontario
4. Selected expert interviews
5. Practice experiences and knowledge of panel members
6. Literature review

Family physicians and primary care nurse practitioners ascertained through the feedback provided to the Panel that being the first point of contact as well as the longitudinal direct care providers and cross-system care coordinators for patients with undifferentiated and
differentiated health/illness conditions, makes their day-to-day practice as complex and diverse in scope as the broader primary care system in which they function. Inherent in this complexity are many of those general characteristics of a system such as non-linear relationships with other health system components. These system relationships place extraordinary strain on providers, as they attempt to enable care for their patients despite conflicting and inefficient demands on their time. In addition, increasing administrative demands compete with time available for patient care.

The comments received by the Panel underscored the need to reflect on the confluence of external and internal factors that influence the core elements of each practice setting, including the service scope, activities, clinical decisions, and approaches to care delivery. Contextual factors such as:

- the health care needs, lifestyles, demographic characteristics and social contexts of the patients served by the practice,
- differences in availability and distribution of services among geographic locales, including rural and urban areas, and
- the type and mix of providers, funding, and operational framework of the practice

are all-important considerations when assessing the potential for achieving optimal outcomes at the practice level.

The Panel identified the following Top of Mind contextual challenges:

- Despite recent improvements there still exists areas of the province where additional primary care providers are needed in some geographic areas to enable practices to increase capacity and reduce wait times and/or facilitate access for orphan patients who have been unsuccessful in finding a regular primary care provider.
- New models of care should include a greater focus on high needs population segments; a compelling argument is that if a small proportion of the population utilizes a majority of resources (e.g. patients with chronic disease or complications use over 60% of hospital bed days; 2/3 of patients admitted as medical emergencies are experiencing an exacerbation of a chronic disease or have an underlying chronic disease; in the US, the care of persons with chronic conditions consumes about 78% of all healthcare spending)\(^8\), then the system redesign policies should make a priority the development of service delivery models that address these greater needs first. Many sicker adults in Canada and other advanced industrialized countries report safety risks, poor care coordination, and deficiencies in care for chronic conditions.\(^9\)
- Primary care physicians in rural practices are often in situations where they need to provide secondary and tertiary care because there is no one else to provide it. Wait times in rural areas are very dependent on the number of providers and recruitment strategies.


\(^{9}\) Schoen C OR, Huynh PT, Doty M, Zapert K, Peugh J, Davis K. Taking The Pulse Of Health Care Systems: Experiences Of Patients With Health Problems In Six Countries. Health Aff (Millwood) 2005
- Funding models should better reflect the dynamics of team-based practices, geographic diversity, and higher service needs of some segments of the population. In addition, new funding models ought to encourage health promotion, chronic disease management and the care of patients after acute hospitalization (which may include evidence-based home-based interventions).\textsuperscript{10}

- There is often a lack of timely access to appointments [to primary care provider] for patients who have a provider (not the orphan patient) for acute and not so acute conditions due to limited practice capacity.

- Information technology has not yet reached the forefront of physician practices and there exists significant opportunity to operationalize innovations within practice settings which could increase practice capacity, including information technology tools, process redesign including scheduling systems, telephone nursing access, and triage tools.\textsuperscript{11}


- There is a lack of local primary care infrastructure for harnessing the efficiencies associated with widespread availability and use of information technology, including the ability to create and share electronic patient records, to access and track relevant patient care information as the patient moves from one level of care to another, and to communicate with other health system components.

- Finally, while the Panel was impressed with some of the province wide developments as well as local innovations, there remains wide variation in service expectations. There needs to be a continued focus on improving access to primary care and addressing wait times for patients in these settings.

To address these challenges, the panel makes the following recommendations. Some recommendations address specific wait times as identified above, while others address issues that apply to the broader primary health care system as a whole and will improve all wait time parameters.


Section C: Recommendations

1. **SYSTEM - ALL WAITS** – Information Technology and Performance Measurement

To manage the system and reduce wait times requires the collection of reliable and valid data to enable system development and improvement (‘if you can’t measure it, you can’t manage it’). Feedback received by the Panel supported the use of information technology tools to enhance operational efficiencies and productivity at the practice level by reducing time spent on administrative duties. This time saved could be used to see more patients and provide more patient care. Information technology is the “advanced technology” of primary care, just as neuro-imaging technology is the advanced technology necessary for many consultant services. Many of the comments received called for:

“Improved mechanisms to share the patient’s record among providers...Expanded use of electronic medical records, and other means to reduce tasks and time associated with record keeping”. “IT infrastructures should facilitate electronic access and communication between labs and diagnostic agencies and primary care providers. This would enable timely coordination of care, which is as important as effective coordination of care”.

An environmental scan and information gathered through the methods described above identify that a very small proportion of primary care providers have or use information technology tools in day-to-day practice, including electronic patient records, decision support tools, interfaces to obtain external laboratory and diagnostic imaging results, or interoperable interfaces that allow sharing / exchanging patient information with other providers in the system. Those practices that have implemented technology have done so with varying levels of success, due in part to clinical decision tools that have not met expectations. Many have complained of inconsistent and variable levels of support and adaptability from service providers. Primary care providers, accustomed to working solo or in small groups, do not have at hand the information management infrastructure, as do other more organized sectors of the health system (e.g. I.T. departments). Whether or not they use clinical management systems, only 32% of Ontario family physicians access the Internet for knowledge translation information such as clinical databases, algorithms, content knowledge, and toolkits available on the Internet, even though Ontario is perceived as a comparatively resource rich province with wide geographic dispersion (and thus greater need of such tools).

The information system architecture envisioned by the Panel hinges on the concept of “hub and spoke”, whereby the primary care providers collect data at the office/practice level and have the capability to submit it electronically to a centralized recipient “the hub”, a community primary care information management infrastructure and data collection centre whose structure may vary depending on the geography and population density of the region.

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For example in small centres this may be local support from a primary care collective (network, group or team), a hospital if somewhat larger, a CCAC or other community agency, or in more dense urban areas a collaborative partnership involving an entire LHIN.

In order to clearly meet the information technology needs and performance needs for primary care, it is imperative that primary providers be engaged in the acquisition and/or development of their clinical management systems, and tracking of data elements. Many primary providers have had suboptimal experiences with linking to larger agencies to drive the purchase of systems, such as hospitals, whose information management requirements do not match those of primary care. On the other hand, there seems little justification for seven groups surrounding a single hospital making decisions that result in seven different stand-alone clinical management systems!

The community hub information management infrastructure would assume accountability for contract management with the appropriate vendor(s), adherence to privacy and security standards, and coordinating overall data quality and optimal system functionality, freeing providers to deal only with identifying the requirements of the clinical management system component. The local hub would be integrated with higher level and provincial bodies charged with health system planning and reporting.

The implementation plan will include a review of systems and related functionalities currently in place and possibilities for leveraging and using existing best practices as a springboard to achieving the recommendation and making best use of resources.

Most importantly to improve the quality of the clinical decision and support functions needed by primary care providers, there needs to be province wide direction on clinical management system standards that best fit provincial and primary care provider requirements.

**RECOMMENDATIONS**

*The Ministry of Health and Long-Term Care support the development of an Information Technology infrastructure for the primary care sector, which will be:*

- Organized and funded at the provincial or community level
- Based on universality (available to all primary providers) and interoperability
- Based on Clinical Management System standards to be developed and/or enhanced
- Primary care based on an established community management infrastructure scaled to the critical mass of providers and population served.

### Projected Outcomes - IT

- Increase % FP/NPs using clinical decision support technology in practice
- Increase % practices providing agreed upon data set for planning re: primary care sensitive conditions and/or service frameworks
- Increase % practices with interoperability/connectivity with hospitals/laboratories

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• Supporting the measuring, monitoring and reporting for performance indicators in primary care

2. SYSTEM – ALL WAITS - Improving Wait Times: First Establish Expectations

Making decisions regarding wait times first requires an understanding as to what level of service should be expected. The flow of the patient from one level of care to another across the system continuum should be seamless and predictable. Ontario’s health care system has made the patients’ perspectives an integral part of policy and service planning. Patients noted that they value a system that is seamless, easy to navigate, and congruent with the concept of “care-without-walls”. The primary care sector is in the best position to deliver on this concept because it provides the foundation for managing the processes, procedures, and interconnections between multi-levels of providers underlying the patient flow through the system.

The feedback received described a series of system driven care coordination inefficiencies such as “back-and-forth” processes between providers in different levels of care, lack of timely confirmations from laboratories and/or specialists of receipt of referral, and communication about the wait time for the test or appointment. These protracted delays during which the referring primary care provider is not able to reassess the patient’s urgency or look for alternative sources of consultation can result in unnecessary appointments with specialists or test orders that prolong the wait to definitive diagnosis, thus tying up system resources and provider time which could be better spent elsewhere.

Improvements in the development of standards for documentation for referrals, improved access to diagnostic technologies and more consistent triage criteria as to urgency for consultation will help in achieving a highly coordinated, effective and efficient continuum for the patient’s overall health care needs over time.

Engagement of primary care providers to develop and implement system improvements when bottlenecks appear between health system components, especially at points of handoff from one service area to another is crucial.

The need for effective coordination will become even more vital as demand escalates because of changing patient demographics and as service delivery landscapes continue to change. The Institute for Clinical Evaluative Sciences draws particular attention to the fact that “with the aging of the baby boom generation and increases in longevity, primary care physicians will be taking care of older patients with more complex chronic disease profiles. This will result in increased visit rates and visit volumes. The transfer of care from hospitals to the community, along with the prevalence of various chronic diseases, will also increase the need for care from office-based physicians”.

The information gathered by the panel through the range of methods noted above identified that:

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14 ICES Atlas 2006: Primary Care in Ontario, Ambulatory Physician Care for Adults, pg. 46
Patients with multiple co-morbidities provide a challenge for connecting efficiently and effectively with their primary care provider. Their care plan can result in multiple appointments over time and/or care with a range of providers. From a care coordination perspective this emphasizes the need for continuity with a primary care provider who would have a strong role in case managing their care to avoid fragmentation of care that risks adverse outcomes.

There is consensus that in some geographic locales there are unattached patients who make up a small proportion of the population but tend to have complex needs with a high degree of co-morbidity and a higher need for chronic disease management. The lack of access to a primary care resource over time results in delayed care, deteriorated health, and disease progression. As new models of service delivery are successful in enrolling orphan patients into the primary care system, it is hoped that the proportion of high needs patients will decrease.

The aging population of physicians may add to the high needs patient population when they retire. Their patient populations tend to age with them, and as such tend to be higher need and more difficult to engage with a new physician.

In some communities hospital physicians have difficulties connecting high need, unattached patients to primary care providers in the community, as many do not have the means/capacity or right incentives to accommodate them.

Many housebound elderly are often lost to continuity of care if they become too sick to ambulate to the provider’s office, and are likely to be transported to emergency departments when a crisis occurs. Even those patients whose mobility is constrained yet are identified as attached, may need to be transported by the system to the Emergency Department if urgent home visits by their preferred provider are not available. Those elderly who receive undifferentiated care from family caregivers while not requiring organized primary care, can also slide into the category of “unattached”, when new chronic diseases or crisis develop.

Notwithstanding these many challenges, evidence demonstrates that there is opportunity to achieve huge gains both in terms of patient outcomes as well as money saved that can be re-invested in other parts of the system through more effective management of chronic diseases.15

The Panel also explored possible solutions to address identified system problems. Specific questions were asked by the Panel around the option of introducing guaranteed target time frames, based on a ranking system of urgency of need, within which a specialist should see a patient or a test should be performed. The use of guaranteed target time frames implies a more standardized process for triaging and referring patients to secondary and tertiary levels of care, and links the three levels of care. A large majority of the respondents to the survey selected “Yes” when asked whether there are advantages to identifying on their referrals a target time

frame (wait time for patient) within which the specialist should see the patient referred or the indicated diagnostic test should be performed. More than half of the respondents said “Yes” when asked whether it would be feasible in their practice environment to implement target time frames.

Other feedback received by the Panel suggested strategies involving a range of elements that collectively build the infrastructure required for linking and bridging health system silos, and a need to develop valid measures of system performance, before establishing guaranteed targets. These elements include, but are not limited to, mechanisms for standardization of service pathways and investigations required as part of the referral to the next level of care, target time frameworks and triage tools based on levels of urgency, diagnostic service utilization programs and knowledge transfer, and collaborative service delivery between primary care and secondary or tertiary sectors.

The panel believes that an introduction of a national “care guarantee” without solid evidence as to their effectiveness could risk the creation of perverse and unintended consequences.

The Panel noted initiatives in the United Kingdom that sought to standardize and report on national service expectations for higher needs populations identified by age and/or disease condition (Appendix E). The panel believes that developing and implementing analogous service frameworks for Ontario would establish uniform expectations within the system (a prerequisite to provincial quality improvement), identify high performance areas as well as areas that may benefit from additional planning and resources. Such frameworks would establish uniform province wide expectations, however as apparently learned from the U.K. experience these frameworks would need flexibility for implementation at the community level.

The implementation approach will focus on short-term and long-term priorities for specific disease states and/or populations, as follows:

1) Tests, work up requirements for referral and components of information required as part of the referral
2) Time framework with a view to develop benchmarks and targets for access to consultation and hospital based services
3) Standards/guidelines and clinical algorithms where needed
4) Quality indicators
5) Process review and redesign

The long-term initiatives will aim to link service frameworks to population health factors, service delivery models, and broader health system policy and planning.
RECOMMENDATION

The Ministry of Health and Long-Term Care establish provincial service frameworks for common high impact conditions and other higher needs populations that would incorporate:

- Goals and objectives that are specific, feasible, and time framed
- Best practice guidelines and clinical algorithms
- Key process of care expectations, such as urgency criteria for referrals and allowable wait times for appointments or procedures
- Clinician toolkits that enable optimal performance
- Key performance measurement and tracking indicators at a system level
- Strategies that support community specific implementation
- Periodic review and opportunity to evolve

Projected Outcomes - Service Frameworks

- Number of frameworks developed
- LHIN/community based performance against service framework benchmarks
- Improved morbidity/mortality/fiscal outcomes for defined conditions/populations

3. SYSTEM - ALL WAITS - Responding to Community Need

A component of the Panel’s mandate is to identify effective methods to involve and engage the primary care/family practice community in the Wait Time Strategy. The creation of an information technology infrastructure and service expectations that facilitates data collection, provides opportunities to systematically identify areas for improvement would lead to increased access and shorter wait times. These system improvements make a compelling case for creating platforms and formalizing mechanisms within current geographic structures, such as the Local Health Integration Networks, for engaging and involving primary care providers to service planning aimed at the population level. Increasing access to primary care in the broader context of the health care system will provide a foundation for sustainability and equity of access across geographic locales.

RECOMMENDATION

Local Health Integration Networks engage and involve the primary care sector, in a significant way, in the planning and implementation of health services for the population, taking into account both provincial frameworks and local needs.

Projected Outcomes - Needs Based Planning

- Increase in number of LHINs with formal structures for FP/NP input into planning processes
- Increase in % of FPs/NPs aware of major LHIN based initiatives
- Increase in number of LHINs that engage FPs/NPs in leadership roles
- Increase in LHINs with identified structures to maintain reliable data re: activity of FPs/NPs in LHIN
4. *WAIT 1 - Enhancing Access to Primary Care*

Building a foundation of reliable data collection and reporting, establishing process of care expectations, and needs based planning of service delivery that is relevant to primary health care, will establish the foundation for managing individual wait times elements relating to primary care.

In that context, the Panel addressed Wait 1, dealing with access to primary care, with a view to build on the system wide transformation strategies that have been undertaken by the Ontario government over the past few years. The Panel acknowledges the recent efforts improving the supply of primary care practitioners in Ontario through a variety of mechanisms. These initiatives include increasing medical school enrolment, increasing the proportion of residency training positions for Canadian medical school graduates dedicated to family medicine, increasing access to training opportunities for international medical school graduates, and augmenting both training and employment opportunities for primary care nurse practitioners. The Panel encourage the MOHLTC to continue its efforts in this critical area of Health Human Resource Policy.

The Panel recognized that new models of care such as Family Health Teams have been implemented across the province to help improve access to primary care. These new models of care encompass a range of features designed to increase capacity at the primary care level, roster more patients, and improve responses to patients with higher levels of acuity and complex needs. These features include the use of interprofessional teams, 24/7 access to telephone advice and information, increased provision of services outside of regular hours, and specific incentives to provide preventive care and to manage the care of patients with chronic disease.

The information gathered suggests that family physicians and nurse practitioners are finding that working in collaborative relationships with one another, and with other health professionals, enables them to provide comprehensive and patient-centric health care. Interprofessional teams utilize the combined skills and expertise of different professionals recognizing that often no single provider or discipline is able to meet all the health care needs of many of the populations served in a sustainable fashion. Most recent evidence

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18 The concept of collaborative practice was described in the literature as “the physician-nurse dyad working together in a joint effort toward a mission of excellent patient care” (Norsen et. al., 1995) where “effectiveness is based on cooperation, assertiveness, responsibility, communication, mutuality, autonomy and coordination” (Norsen et. al., 1995; Way et. al., 2001; Siegler et. al., 1994).
indicates a greater level of professional satisfaction when working in team environments, which we would anticipate contributes to positive recruitment and retention for providers to primary health care.

Primary care models based on interprofessional teams have already been created in Ontario. Community Health Centres (CHC), which have been in existence for decades include teams of physicians, nurse practitioners, nurses, counsellors, community workers and dieticians. CHCs use a community development approach to health care that ensures Ontarians who face barriers such as race, language, poverty, physical disabilities or geographic isolation have access to primary health care and community health programs.

In the last two years 150 Family Health Teams have been identified for implementation across the province. This team based model which has evolved from other existing models (Health Service Organizations, Primary Care Pilots/Networks, Community Health Centres, Family Health Groups) are expected to not only improve access to primary health care services but will integrate strategies to improve a variety of aspects of patient care. Initiatives such as expanding after-hours access, integrating physicians and primary health care nurse practitioners with a variety of health care providers (e.g. family practice nurses, registered dieticians, psychologists etc.) and providing incentives for chronic disease management and preventative care are currently being implemented. The Panel heard that while the number of Ontarians that do not have a family doctor or primary care nurse practitioner remains a concern, particularly in some communities, there is a perception that the overall gap may be starting to decline. These initiatives facilitate patient enrolment in primary care with a view to ensure that all Ontarians have timely and equal access to a primary care provider and to strengthen links between different providers working together in partnerships characterized by common goals. Respecting the complexity that is primary health care, there continues to be a variety of models developing that allow for shaping service delivery that best meets a particular population’s needs.

Finally, regardless of improved capacity and primary care models that structurally meet local population needs, when there is a delay in patients’ ability to access their preferred primary provider, alternative routes to care are utilized such as emergency departments, walk-in clinics, and providers not registered within the primary care model. This can result in sub-optimal care given the lack of continuity of health information that often results. Innovative system redesign, such as in advanced access scheduling systems may improve access to those needing same day services.

20 Murray M, Berwick D., Advanced Access: Reducing Waiting and Delays in Primary Care JAMA Feb 26, 2003 Vol 289 No 8
21 Murray M, Bodenheimer T, Rittenhouse D, Grumbach K Improving Timely Access to Primary Care: Case Studies of the Advanced Access Model JAMA Feb 26, 2003 Vol 289 No 8
RECOMMENDATIONS

The Ontario Government continue strategies that recruit and retain family physicians and primary care nurse practitioners who practice a broad scope of comprehensive practice.

The Primary Care – Family Practice Wait Times Expert Panel endorses the continued expansion of primary care models that encompass the core principles of interprofessional team care where individual roles and scope of the team best match the needs of the population served.

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<th>Projected Outcomes- Wait 1</th>
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<tr>
<td>• Increase in provider/population ratio</td>
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<td>• Increase in proportion of FP/NP who practice comprehensive scope</td>
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<td>• Increase in comprehensive services e.g. home visits</td>
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<td>• Decline in % population without FP/NP</td>
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<td>• Decline in primary care visits to non-registered FP/NP of group</td>
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<tr>
<td>• Decline in visits to Emergency Department for primary care sensitive conditions</td>
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<tr>
<td>• Increase in visits to FP/NP with same day booking</td>
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<td>• Increase in patient satisfaction with access to primary care</td>
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5. WAIT 2 – Accessibility to (Advanced) Diagnostic Testing

Provincial data indicates continued need for improved access to the major investigative modalities of CT/MRI. The panel was concerned to discover that there were regions within the province that denied direct access to these modalities for family physicians. The panel maintains that access should be driven by patient need against acceptable criteria and not foster the introduction of an unnecessary step in the investigative process, i.e. referral to consultant for the sole purpose of ordering an MRI. National standards are now available for the ordering of MRI/CT and many local systems have established criteria and procedures for triaging requests, without limitation by the ordering physician. Finally, without limiting the foregoing the Panel heard how difficult it is for community primary providers to remain abreast of hospital based technological innovations that they may require on only an infrequent basis. As a result, access to technology, most often through hospitals, may be limited because of this gap in knowledge. Clarification as to the best investigative tool could be obtained through brief consultation with an imaging specialist, however currently fee-for-service imaging consultants do not receive an incentive for offering consultation to referring physicians, without a test already being completed.

Many hospital based laboratory procedures are accessed by primary providers. However, when these procedures are based outside of hospital the capability of family physicians to interact effectively with these services may be impaired. This can be demonstrated with evidence of
protracted delays in accessing diagnostic services or in receiving reports. Many of these problems could be addressed through electronic means of direct test ordering and reporting; however, for much of the province that technology is not yet in place.

Patients who are from remote areas face particular challenges when they travel significant distances for an advanced test/investigation, return home to wait for the report, which then requires an additional trip to the facility for the next step in investigation or management.

Capturing wait time data, such as time of referral, and discipline making the referral, for the ordering of advanced diagnostics, should be the accountability of hospitals or other facilities currently providing wait time reporting information.

RECOMMENDATIONS

The Ministry of Health and Long-Term Care support the implementation of utilization programs and standards regarding the ordering of advanced diagnostic tests to qualify and guide the ordering of tests, and this be based on patient need without limiting ordering access based on the scope of practice of the referring provider. Further, utilization programs should include triage criteria based on established levels of urgency.

The Ministry of Health and Long Term Care support incentives in the system that allow imaging consultants to provide brief telephone consultations that would provide for the right test being ordered at the right time.

Hospitals and imaging agencies provide ongoing access to information / knowledge changes to referring primary providers as necessary to guide the ordering of tests / advanced diagnostic services.

The Ministry of Health and Long-Term Care support the establishment of best practice targets for hospitals’ and imaging agencies’ engagement with primary providers in the ordering and reporting of laboratory and imaging investigations. The targets should include such best practice dimensions as:

- Acknowledgement of receipt of referral or test order
- Indication of wait time
- Time frame for submitting report of results

<table>
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<tr>
<th>Projected Outcomes- Wait 2</th>
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<tr>
<td>• % FPs/NPs able to access technology of interest</td>
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<td>• Reduction in inappropriate test ordering per condition, or</td>
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<td>• Increase in % tests ordered according to guideline</td>
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<tr>
<td>• Decrease in wait time for primary provider test ordering</td>
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<tr>
<td>• Decrease in wait time for results reporting</td>
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<tr>
<td>• Increase in primary provider/patient satisfaction with access</td>
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<tr>
<td>• Reduction in numbers of patients travelling long distances from remote locations for repeat/follow-up tests</td>
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</table>
In areas of the province where Ontarians have to travel long distances to access advanced diagnostics, consideration should be given to offer same day interpretation, in the event further investigations or interventions can be offered on the same trip.

6. **WAIT 3 – Navigating the System – Gatekeeper versus Guide**

Family physicians and primary care nurse practitioners refer for consultation when there is a requirement for:

- Knowledge expertise
  - When there is an inability to diagnose undifferentiated illness
  - When there is lack of clarity of choice for the optimal care management plan,
  - For ongoing care beyond the referring provider’s scope of practice, (e.g. ongoing psychotherapy), and/or

- Procedural expertise, (e.g. surgery, endoscopies, cardiac catheterization), beyond the referring provider’s scope of practice

Patients rely on the primary providers to not only identify when consultation is necessary, but also that the request for referral will engage the right provider for their particular need. The system relies on the provider to make informed choices that are patient centered as to “need”, and not patient or provider “want”, thus contributing to system inefficiency. At times if patients and providers do not join together in selecting the appropriate path of care, patients may perceive this gatekeeper function as a denial of care.

Many primary care nurse practitioners in interprofessional care models face a particular challenge in that consulting physicians often do not accept requests for referral from a primary care nurse practitioner, commonly due to an inability to bill for the consultation. Primary care nurse practitioners already practice to a standard with regard to seeking consultation. However they often resort to having a physician colleague “rubber stamp” the referral in order to obtain the consultation, and even in that instance some consultants have refused providing the service when it becomes known that the referring physician has not actually assessed the patient. In practices within multi-site networks where primary care nurse practitioners do not have immediate access to a physician colleague this results in additional delay for the patient as an intermediate consultation with a family physician is obtained, even though the need for consultation with a specialist may be clear and the service not otherwise available. In front-line practice environments it is the perception of the Panel that this is resolved collaboratively with improvement in practice over time. However “work around” solutions are often not optimally efficient, or at times effective from a patient’s perspective. Further, the Panel notes that remuneration for consultation is a barrier, but not the only barrier to enhanced collaboration between the physician and nurse practitioner professions. The Panel looks to the many collaborative projects ongoing involving their respective academic, professional practice, and

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22 College of Nurses of Ontario Practice Standard – Registered Nurses in the Extended Class pg 6-7 (Available at http://www.cno.org/docs/prac/41038_StrdRnec.pdf)
regulatory agencies that will further break down barriers and improve working relations between the disciplines.

This referral for consultation component of the system is thus challenged when there are conflicting expectations, whether they are those of patient, referring provider, or consulting physician. Patients often do not take the necessary steps towards optimal self-management and/or sometimes do not perceive the expertise of their primary provider as being sufficient to manage their health concern. Referring providers vary in their personal knowledge base, expertise, or expectations from consultants. Consultants vary in their expectation for information from referring providers before establishing a time for consultation. Conflicting expectations require standard, agreed upon channels of communication to enable conflict resolution, which are frequently absent in the current system.

Other inefficiencies exist in care. There are minimal supports for consultants to provide anything other than a standard consultation based on a personal face to face assessment of a patient, when often a concise focused conversation with the primary provider would be sufficient to establish next steps in the patient’s care. In effect, those attributes of team decision-making frequently do not engage the patient or consultant in the process. Alternative processes have been piloted with demonstrative results that are both effective and efficient, such as shared care collaborative mental health networks, or diabetes management models whereby a diabetologist offers case based consultations to groups of primary providers.

Currently there is no mechanism for measuring the wait time from decision to refer to the consultation taking place. Primary providers believe that they should be the accountability agent for establishing time of referral. The panel considered options such as tracking codes at time of referral with fee-based incentives to capture this information. Pending wide spread implementation of Information Technology in primary care, this seemed to be the only real-time, short-term mechanism for capturing the information.

RECOMMENDATIONS

The Ministry of Health and Long Term Care facilitate the development of province wide standardized requests for referral that are discipline specific, and incorporate the necessary information to standardize levels of urgency for the referral.

The Primary Care-Family Practice Wait Times Panel recommends that the Ministry of Health and Long Term Care facilitate a process whereby the College of Nurses of Ontario, College of Physicians and Surgeons of Ontario and respective stakeholder professional practice associations collaboratively review the processes for consultation from primary care nurse practitioners to consulting physicians outside their practice models, and make recommendations that would enable physicians to be remunerated for the consultation.

The Primary Care-Family Practice Wait Times Expert Panel endorses the provision of incentives which encourage “shared care consultative processes” that do not require a full “face to face – consultant and patient” assessment.
The initial wait times priorities centered on cardiac surgery, cancer surgery, cataract surgery, hip and knee replacement surgery, and access to the advanced technologies of MRI and CT neuro-imaging. The Panel acknowledged that although there may be some local exceptions and variability, province wide improvements were happening.

The Panel members shared practice experiences that described the following concern in relation to access to cancer diagnostic assessment. In the affiliated centres of Cancer Care Ontario consultation access is dependent upon having the tissue diagnosis of a specific cancer. In some areas there were expressed concerns that the ability to obtain that tissue could result in delays of several weeks before consultation could occur. As a result, reporting on cancer surgery (or any cancer treatment modality) specifically does not account for any delay that happens prior to the cancer consultant designating the patient for treatment intervention. Shortening this time to diagnosis should be a priority, however it cannot happen without an understanding about current wait times.

The panel considered multiple options in response to this identified gap. While some supported the designation of mandated target wait times to access cancer services, others (as previously indicated) supported system development and more consistent and valid reporting of time taken to access cancer services. Other jurisdictions where arbitrary guaranteed wait times had been established have failed to demonstrate improvements in patient centered clinical outcomes of importance. Some advocated for the introduction of “Diagnostic Assessment Units” for common cancers (e.g. lung, breast, colorectal, prostate, undiagnosed solid tumour) that would enable earlier procurement of tissue to establish diagnosis for earlier entry into the cancer system. Again as a potential province wide recommendation, the panel was uncertain as to the province wide need for these services.

Further, relating to cancer surgery wait times, the provincial web-site reports data based on targets for the least urgent cases. There is a belief that there may remain deficiencies in system performance for cancers of greater urgency that are not being adequately reflected.

**RECOMMENDATIONS**

The Ministry of Health and Long Term Care in conjunction with Cancer Care Ontario through its affiliated cancer centres examine the need to shorten the time to diagnosis. Where there is evidence of a concern leading to delay in diagnosis, pilot initiatives should be supported to establish best practice processes and interventions, such as diagnostic assessment centres or programs, and procedural centers (e.g. endoscopies).

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23 Barwick T, Scott S, Ambrose S The Two Week Referral for Colorectal Cancer: a retrospective analysis Colorectal Disease Dec 2002 6 85-91
Reporting of wait times data should be based on criteria as to level of urgency so that areas of concern may be more precisely identified.

**Projected Outcomes - Wait 3**

- Increase in % uptake on referral guidelines, including adherence to recommendations re: level of urgency
- Impact of requests for consultations from primary care nurse practitioners
- Impact of shared care consultations
- Decrease in wait time for consultation for specified conditions/disciplines
- Increase in satisfaction for provider/patient for access to specified consultative services
- Improved process of care and health outcome measures for specified conditions/populations by provincial service framework
- Reduction in time to diagnosis of cancer

7. **WAIT 4 - Primary Care and the Hospital System – Transition Risks**

Hospitals have varying levels of engagement with the primary health care system. In some hospitals, medical services are almost entirely provided by family physicians. In some centres, family physicians and consultant physicians are tightly integrated in collaborative models of care. In larger centres, hospitals and the primary health care system may act as independent silos within health care. Patients can thus expect varying levels of transition support as they enter and exit hospitals. However, lack of engagement of the primary provider post hospitalization threatens continuity of care and health outcomes.²⁷ ²⁸

In the event a patient is admitted to hospital, significant interventions and events in their health care lives may develop for which their primary provider is often unaware. Patient management in hospital to a level of stability in health status may not continue in the immediate post hospitalization period. Research has demonstrated significant risk of adverse events that occur in the immediate post-hospitalization period, often prior to the time the patient re-engages with their primary provider.²⁹ Engagement by hospitals with community providers after their patient’s hospitalization thus can substantially improve the patient’s journey back into their community.

²⁷ Forster A, Clark H, Menard A, Dupuis N, Chernish R, Chandok N, Khan A, van Walraven C. Adverse Events Among Medical Patients After Discharge from Hospital CMAJ Feb 3, 2004 170 (3)
RECOMMENDATIONS

The Ministry of Health and Long-Term Care support the establishment of best practice targets for hospitals' engagement with primary providers, in the notification of emergency and inpatient admissions, and the re-engagement with primary providers post hospitalization, with a view to incorporating such identified best practices into hospital and LHIN accountability agreements.

The targets should include such best practice dimensions as:

- Notification of admissions, discharges, and Emergency Department visits
- Requesting of information and notification of significant events during hospitalization
- Necessary information and timelines for transfer of information back to the patient's primary provider post acute hospitalization
- Continued monitoring and follow-up of the post-acute patient until they are re-engaged with their primary provider

8. Sharing Practice Innovations - Spreading the Word

Establishing standardized processes, transparent reporting of performance measures, and implementation strategies that fit community need, will enable the identification of best practices and innovations. The information gathered by the Panel suggested a high interest among primary care providers in sharing and obtaining information and experiences regarding practice innovations that led to improved efficiencies, higher productivity, and reduced wait times. The feedback reinforced that primary care providers are exploring ways to improve service delivery and increase access at the individual practice level. A number of approaches could be successful in achieving this, including collating and making available for information practice innovations in primary care which have been implemented in different settings, asking providers for proposals and linking funding to proposed innovative models, and/or creating a centralized database for best practices in primary care and making the information accessible to providers.

RECOMMENDATION

The Ministry of Health and Long-Term Care support the dissemination of best practice innovations within the primary care sector.

Projected Outcomes- Wait 4

- Increase in % discharge summaries completed at discharge
- Increase in % of FP/NPs receiving discharge summary within one week of discharge date
- Increase % patients with chronic conditions seen within 2 weeks post discharge
- Increase % of patients receiving telephone follow-up from hospital within two weeks of discharge
- Decrease in hospital re-admission within two weeks post discharge
- Decrease in adverse medication events within two weeks post-discharge

8. Sharing Practice Innovations - Spreading the Word

Establishing standardized processes, transparent reporting of performance measures, and implementation strategies that fit community need, will enable the identification of best practices and innovations. The information gathered by the Panel suggested a high interest among primary care providers in sharing and obtaining information and experiences regarding practice innovations that led to improved efficiencies, higher productivity, and reduced wait times. The feedback reinforced that primary care providers are exploring ways to improve service delivery and increase access at the individual practice level. A number of approaches could be successful in achieving this, including collating and making available for information practice innovations in primary care which have been implemented in different settings, asking providers for proposals and linking funding to proposed innovative models, and/or creating a centralized database for best practices in primary care and making the information accessible to providers.

RECOMMENDATION

The Ministry of Health and Long-Term Care support the dissemination of best practice innovations within the primary care sector.

Projected Outcomes- Knowledge Translation

- Faster uptake of best practice process innovations

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9. Ontario’s Wait Time Strategy Website

One parameter of the mandate given the Primary Care – Family Practice Expert Panel was to assess and make recommendations with regards to the Ontario Wait Times Strategy Website at http://www.health.gov.on.ca/transformation/wait_times/wait_mm.html. This was a challenging task given that currently primary care providers infrequently access knowledge translation tools on the internet. However, when the focus groups were asked to subsequently review the site, participants made the following observations:

1. Data presented was based on three metrics, averages, medians, and 90th percentile; within a LHIN there may be significant variances between these metrics.
2. While the data may present the perception of an opportunity to refer out of your LHIN, there were no guarantees that consultants outside the LHIN would willingly accept distant referrals when they were struggling to reduce the queues in their local environment.
3. The scope of the site could be enhanced, e.g. direction to content that supports patient self-management guidelines as to care management of the condition.

RECOMMENDATION

The Ministry of Health and Long Term Care enhance its Ontario Wait Times Strategy website to assist with referrals and to assist providers with proactive self management.

SECTION D: FINAL THOUGHTS

The Panel elected to restrict its deliberations to the scope identified in the report. There are some aspects of primary care-family practice where system efficiency could be improved, which have not been discussed:

- Improving the effectiveness of screening for early detection of disease
- Improving access to rehabilitative and long term care services
- Roles and relationships between primary providers and Community Care Access Centers
- Roles of primary providers in the provision of subspecialty primary care services
- Access to Emergency Services

While each of these components of the system rely on primary providers, the Panel determined that comment on those aspects of the system was not within the mandate of this report.

The Panel respects and appreciates the contributions of those who volunteered their participation and provided their insights into their professional challenges. Should we have failed to capture any knowledgeable contribution and issue raised, it has been our error.
SECTION E: Consolidated List of Recommendations

Table of Recommendations

System – All Waits

Information Technology and Performance Measurement

The Ministry of Health and Long-Term Care support the development of an Information Technology infrastructure for the primary care sector, which will be:

- Organized and funded at the provincial or community level
- Based on universality (available to all primary providers) and interoperability
- Based on Clinical Management System standards to be developed and/or enhanced
- Primary care based with an established community management infrastructure scaled to the critical mass of providers and population served.
- Supporting the measuring, monitoring and reporting for performance indicators in primary care, including wait time indicators such as engagement with a primary provider, wait time for appointment, wait time for major diagnostic technologies, and wait time for referral for consultation and intervention.

Improving Wait Times: First Establish Expectations

The Ministry of Health and Long-Term Care establish provincial service frameworks for common high impact conditions and other higher needs populations that would incorporate:

- Goals and objectives that are specific, feasible, and time framed
- Best practice guidelines and clinical algorithms
- Key process of care expectations, such as urgency criteria for referrals and allowable wait times for appointments or procedures
- Clinician toolkits that enable optimal performance
- Key performance measurement and tracking indicators at a system level
- Strategies that support community specific implementation
- Periodic review and opportunity to evolve

Responding to Community Need

Local Health Integration Networks to engage and involve the primary care sector, in a significant way, in the planning and implementation of health services for the population, taking into account both provincial frameworks and local needs.
Wait 1 - Enhancing Access to Primary Care

The Ontario Government continue strategies that recruit and retain family physicians and primary care nurse practitioners who practice a broad scope of comprehensive practice.

The Primary Care – Family Practice Wait Times Expert Panel endorses the continued expansion of primary care models that encompass the core principles of interprofessional team care where individual roles and scope of the team best match the needs of the population served.

Wait 2 - Accessibility to (Advanced) Diagnostic Testing

The Ministry of Health and Long-Term Care support the implementation of utilization programs and standards regarding the ordering of advanced diagnostic tests to qualify and guide the ordering of tests, and this be based on patient need without limiting ordering access based on the scope of practice of the referring provider. Further, utilization programs should include triage criteria based on established levels of urgency.

The Ministry of Health and Long Term Care support incentives in the system that allow imaging consultants to provide brief telephone consultations that would provide for the right test being ordered at the right time.

Hospitals and imaging agencies provide ongoing access to information / knowledge changes to referring primary providers as necessary to guide the ordering of tests / advanced diagnostic services.

The Ministry of Health and Long-Term Care support the establishment of best practice targets for hospitals’ and imaging agencies’ engagement with primary providers in the ordering and reporting of laboratory and imaging investigations. The targets should include such best practice dimensions as:

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- Time frame for submitting report of results

In areas of the province where Ontarians have to travel long distances to access advanced diagnostics, consideration should be given to offer same day interpretation, in the event further investigations or interventions can be offered on the same trip.
Wait 3 - Navigating the System – Gatekeeper versus Guide

The Ministry of Health and Long Term Care facilitate the development of province wide standardized requests for referral that are discipline specific, and incorporate the necessary information to standardize levels of urgency for the referral.

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Reporting of wait times data should be based on criteria as to level of urgency so that areas of concern may be more precisely identified.

Wait 4 - Primary Care and the Hospital System – Transition Risks

The Ministry of Health and Long-Term Care support the establishment of best practice targets for hospitals’ engagement with primary providers, in the notification of emergency and inpatient admissions, and the re-engagement with primary providers post hospitalization, with a view to incorporating such identified best practices into hospital and LHIN accountability agreements.

The targets should include such best practice dimensions as:

- Notification of admissions, discharges, and Emergency Department visits
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- Necessary information and timelines for transfer of information back to the patient’s primary provider post acute hospitalization
- Continued monitoring and follow-up of the post-acute patient until they are re-engaged with their primary provider
Other

The Ministry of Health and Long-Term Care should support the dissemination of best practice innovations within the primary care sector.

The Ministry of Health and Long Term Care enhance its Ontario Wait Times Strategy website to assist with referrals and to assist providers with proactive self-management.
Appendix A

Literature Search Strategy

Literature searches were conducted in the Medline (1966-May 2006), CINAHL (1982-May 2006) and EMBASE (1980 - 2006) databases. Search strategies included subject headings such as comprehensive health care/, exp primary health care/, Family Practice/ (in MEDLINE) combined with key words and subject headings for wait times, time factors, time, and waiting lists. Base sets of results were further refined to focus on the key areas of Cardiac Surgery, Cancer Treatment, Cataract Surgery, CT/MRI scans, and Hip/Knee Replacements, and reducing the time from symptom presentation to diagnosis of Cancer. Additional searches were conducted in all three databases combining subject headings and keywords for Benchmarking and best practices as related to wait times and comprehensive health care, primary health care or family practice. Full search strategies are available.
Appendix B

National Service Frameworks – United Kingdom

National service frameworks (NSFs)

National service frameworks (NSFs) are long-term strategies for improving specific areas of care. They set measurable goals within agreed time scales.

NSFs:
- set national standards and identify key interventions for a defined service or care group
- put in place strategies to support implementation
- establish ways to ensure progress within an agreed time scale
- form one of a range of measures to raise quality and decrease variations in service, introduced in The New NHS and A First Class Service. The NHS Plan re-emphasised the role of NSFs as drivers in delivering the Modernisation Agenda.

Each NSF is developed with the assistance of an external reference group (ERG) which brings together health professionals, service users and carers, health service managers, partner agencies, and other advocates. ERGs adopt an inclusive process to engage the full range of views. The Department of Health supports the ERGs and manages the overall process.

The rolling programme of NSFs, launched in April 1998, covers:

**Coronary heart disease**
The NSF for coronary heart disease was launched in March 2000 and sets 12 standards for improved prevention, diagnosis and treatment, and goals to secure fair access to high quality services. The standards are to be implemented over a 10-year period.

- [Coronary heart disease NSF (March 2000)]
- [Main CHD area of this website]

**Cancer**

- [A Policy Framework for Commissioning Cancer Services (1995)]
- [NHS Cancer Plan (2000)]
- [Main cancer area of this website]

**Paediatric intensive care**
The national service framework for paediatric intensive care was established in 1999.

- [High Dependency Care for Children (report of an expert advisory group, 2001)]
- [Paediatric Intensive Care: a framework for the future (report from the National Coordinating Group on Paediatric Intensive Care, 1998)]
- [A Bridge to the Future (nursing standards, education and workforce planning report, 1998)]
Mental health

The NSF for mental health was launched in 1999, and is a comprehensive statement on how mental health services will be planned, delivered and monitored until 2009. The NSF lists seven standards that set targets for the mental health care of adults aged up to 65. These standards span five areas: health promotion and stigma, primary care and access to specialist services, needs of those with severe and enduring mental illness, carers' needs, and suicide reduction.

• National service framework for mental health
• Main mental health area of this website

Older people

The NSF for older people was published on 27 March 2001. It sets new national standards and service models of care across health and social services for all older people whether they live at home, in residential care or are being cared for in hospital.

• National service framework for older people

Diabetes

1.3 million people in England suffer from diabetes, and the number is increasing. The diabetes NSF is a concerted effort to make sure these people, wherever they live, receive the same excellent standard of care. Embodied in the NSF is the central value of the NHS Plan—that good service is the outcome of genuine partnership between the patient and the provider. The NSF, launched in 1999, should substantially reduce the suffering caused by diabetes.

• National service framework for diabetes

Long term conditions

The national service framework for long term conditions was published on 10 March 2005. The aim of the NSF is to improve the lives of the many people who live with neurological and other long term conditions by providing them with better health and social care services.

• Background about the long term conditions NSF

Renal

Part one of the NSF for renal services sets five standards and identifies 30 markers of which will help the NHS and its partners manage demand, increase fairness of access and improve choice and quality in dialysis and kidney transplant services. Part two of the NSF for renal services sets four quality requirements and identifies 23 markers of good practice to help the NHS limit the development and progression of chronic kidney disease; minimise the impact of acute renal failure; and extend palliative care to people dying with kidney failure.

• National service framework for renal services

Children

This NSF, published on 15 September 2004, sets standards for children’s health and social services, and the interface of those services with education.

• National service framework for children

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term covering a range of conditions including chronic bronchitis and emphysema. It is a long term condition that leads to damaged airways, causing them to become narrow, making it harder for air to get in and out of the lungs. There is no cure for COPD, but it can be managed through drug therapy.
On the 28 June 2006, the Secretary of State announced that a National Service Framework (NSF) should be developed for Chronic Obstructive Pulmonary Disease (COPD) following recommendations published in the CMO’s Annual Report 2004.

To ensure that the NSF meets the needs of COPD patients and their carers an External Reference Group has been established to produce final advice by Autumn 2007; it is hoped to have the NSF for COPD published in 2008.

- Chronic Obstructive Pulmonary Disease National Service Framework
APPENDIX C

References


Barwick T, Scott S, Ambrose S The Two Week Referral for Colorectal Cancer: a retrospective analysis Colorectal Disease Dec 2002 6 85-91.


ICES Atlas 2006: Primary Care in Ontario, Ambulatory Physician Care for Adults, pg. 46.


New Directions in Primary Health Care: Prepared by the Subcommittee on Primary Health Care of the Provincial Co-ordinating Committee on Community and Academic Health Science Relations (PCCCAR) July 1996.


Schoen C OR, Huynh PT, Doty M, Zapert K, Peugh J, Davis K. Taking The Pulse Of Health Care Systems: Experiences Of Patients With Health Problems In Six Countries. Health Aff (Millwood) 2005


# APPENDIX D

## PANEL MEMBERS:

**PRIMARY CARE – FAMILY PRACTICE WAIT TIMES EXPERT PANEL**  
Panel Chair – Philip Ellison, MD, CCFP, FCFP, MBA

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<tr>
<th>Name</th>
<th>Role and Affiliation</th>
<th>LHIN</th>
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<tbody>
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North East LHIN

Shelly Smith
Family Physician
Actra Medical Group, Mississauga
Mississauga Halton LHIN

Leslie Solomon
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Bonnie Sparrow
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Acknowledgement

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