Wait Times are a component of our Ministry-LHIN Accountability Agreement.

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MLAA Schedule 10:

Table A: Access						
▪ **Objective**: To improve access to appropriate levels of health care services for the local health system. ▪ **Expected Outcome**: Patients/clients in the local health system will experience shorter waiting times for access to the health care services identified below. ▪ Other indicators are being considered as a measure of this expected outcome.						
Indicator	**Provincial Target**	**LHIN Baseline**	**LHIN Target**			**Data Release Dates**
			2007/08	**2008/09**	**2009/10**	
90th Percentile Wait Times for Cancer Surgery	Provincial Priority IV Target: 84 days	80	58	57	TBD	Feb. 15 May 15 Aug. 15 Nov. 15
90th Percentile Wait Times for Cardiac By-Pass Procedures	Provincial Priority IV Target: 182 days	Not applicable	Not applicable	Not applicable	Not applicable	Feb. 15 May 15 Aug. 15 Nov. 15
90th Percentile Wait Times for Cataract Surgery	Provincial Priority IV Target: 182 days	78	78	78	78	Feb. 15 May 15 Aug. 15 Nov. 15
90th Percentile Wait Times for Hip and Knee Replacement	Provincial Priority IV Target: 182 days	Hip: 223 Knee: 406	Hip: 197 Knee: 284	Hip: 180 Knee: 240	Hip: 162 Knee: 210	Feb. 15 May 15 Aug. 15 Nov. 15
90th Percentile Wait Times for Diagnostic (MRI/CT) Scan	Provincial Priority IV Target: 28 days	MRI: 89 CT: 65	MRI: 37 CT: 48	MRI: 67 CT: 46	MRI: 36 CT: 44	Feb. 15 May 15 Aug. 15 Nov. 15

**Wait Time* is the time from the "decision to treat, to time treatment is received".
*The *90th Percentile* means the point at which nine out of ten patients received their treatment.

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Table B: Quality						
▪ **Objective**: To improve the **quality** of care and service provision for the local health system. ▪ **Expected Outcome**: Users of health care services identified below will receive safer and more effective service. ▪ Other indicators are being considered as a measure of this expected outcome.						
Indicator	**Provincial Target**	**LHIN Baseline**	**LHIN Target**			**Data Release Dates**
			2007/08	**2008/09**	**2009/10**	
Readmission Rates for Acute Myocardial Infarction (AMI)	3.8%	7.12	Maintain or improve performance from baseline	5.6	3.3	Feb. 15 May 15 Aug. 15

Table C: Integration						
▪ **Objective**: To improve **coordination and integration** of health care among health service providers in the local health system. ▪ **Expected Outcome**: More patients/clients in the local health system will receive health care in the most appropriate setting as determined by their needs. ▪ Other indicators are being considered as a measure of this expected outcome.						
Indicator	**Provincial Target**	**LHIN Baseline**	**LHIN Target**			**Data Release Dates**
			2007/08	**2008/09**	**2009/10**	
Percentage of Alternate Level of Care (ALC) days	9.46%	10.9	Not applicable	10	9	Feb. 15 May 15 Aug. 15
Rate of Emergency Department Visits that could be managed elsewhere	11.79 per 1,000 population	40.48	Maintain or improve performance from baseline	33	30	Feb. 15 May 15 Aug. 15
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)	290.76 per 100,000 population	425.12	Maintain or improve performance from baseline	335	288	Feb. 15 May 15 Aug. 15
Median Wait Time to Long-Term Care Home Placement	50 days	59	Maintain or improve performance from baseline	53	50	Feb. 15 May 15 Aug. 15 Nov. 15

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Table D: Sustainability						
▪ **Objective**: To contribute to the **sustainability** of the Ontario health care system. ▪ **Expected Outcome**: More health care services in the local health system will be delivered in a more efficient and productive manner. ▪ Indicators are being considered as a measure of this expected outcome.						
Indicator	**Provincial Target**	**LHIN Baseline**	**LHIN Target**			**Data Release Dates**
			2007/08	**2008/09**	**2009/10**	

Additional MLAA items for consideration:

- The following are developmental indicators and, starting at the end of the second quarter of the 2008/09 fiscal year, the Ministry will provide the LHIN with a status report at the end of each quarter, thereafter:

  - Emergency department length of stay
  - Emergency department time to physician assessment
  - Dental/oral (pediatric) surgery wait time
  - Psychiatric re-admission rates in hospitals
  - Percentage of individuals with multiple psychiatric hospitalizations in the past fiscal year
  - Perception of change in quality of care
  - Hospital standardized mortality ratio
  - Change in hospital productivity

Wait Times

How were the incremental volumes allocated?

LHIN Level Allocations: LHIN level allocations were determined by the Ministry using the following criteria:

Total Hip and Knee Joint Replacement and Cataract Surgery

- Number of cases not completed within the target time frame
- Population age 65 and over
- Rate of surgery per 100,000 people
- 2007/08 incremental volumes allocated
- Capacity for 2008/09

Magnetic Resonance Imaging (MRI) and Computer Tomography (CT)

Percentage of hours completed within Ontario's target wait time of 28 days (Priority IV);

- The number of machines per LHIN
- Rate of scans per 100,000 people
- 2007/08 Incremental volumes allocated
- Capacity for 2008/09

LHIN-Level Allocation - Hip and Knee			
LHIN	Initial LHIN-Level Allocations (2007/08 Fiscal Year)	Final 2007/08 LHIN-Level Allocations (Announced April 2007)	Initial LHIN-Level Allocations (2008/09)
Erie-St.Clair	735	582	588
South West	910	973	875
Waterloo Wellington	703	703	615
Hamilton Niagara Haldimand Brant	1045	2139	1245
Central West	904	608	884
Mississauga Halton	767	544	698
Toronto Central	925	1672	1006
Central	1110	1506	1072
Central East	1013	1013	1099
South East	593	479	694
Champlain	1091	1099	1313
North Simcoe Muskoka	507	221	393
North East	905	409	798
North West	481	481	534
Ontario	**11689**	**12429**	**11815**

Hospital Level Allocations: Hospital level allocations were determined by the LHINs. Guiding principles outlined by the Ministry were used by the LHINs to determine the hospital-level allocations. The guiding principles took the following factors into consideration:

- The hospital having the critical mass and capacity to support incremental volumes (e.g. capital, human resources, equipment)
- The hospital is participating in a new model of care program
- The hospital's wait times
- The hospital should be on track to achieve the incremental volume commitment and conditions of funding of fiscal year 2007/08
- The hospital should be reporting wait time data to the Ministry in accordance with the Wait Time Information Office's (WTIO's) compliance matrix
- The hospital surgeon's ability to provide incremental volumes without compromising other hospital services

Final 2008/09 LHIN-Level Allocations (TBD)	HDGH	WRH	BWH	CKHA	LDMH	Allocation Versus Capacity	Total Capacity
TBD	261	156	107	220		-156	744
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
TBD							
Proportional Allocation	**206**	**123**	**85**	**174**	**-**	**588**	

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Under what circumstances could the LHIN redistribute a hospital's allocated cases?

The reallocation process will follow the same process outlined for the 2007/08 in-year reallocation process. The LHINs will be able to redistribute service specific volumes between hospitals within their LHIN, if a hospital demonstrates that they are unable to complete the incremental volume. The volume negotiations will occur between the LHIN and the hospital and both parties must be in agreement. If volumes cannot be completed within the LHIN, the volume will be redistributed across the province. This process occurs at the end of the second quarter.

How likely is this to occur?

Very likely. There are a number of circumstances that might prevent hospitals from meeting their incremental volume commitments. The reallocation process ensures that the investment the Ministry has made to these incremental volumes is being maximized. This process is designed to reallocate volumes from hospitals that cannot meet their volume commitments and distribute to hospitals that have the capacity for more cases.

If redistribution of cases is to occur based on LHIN identification, what can hospitals expect in terms of lead time to efficiently accommodate the change in volumes?

The reallocation will only occur if hospitals demonstrate that they will not be able to complete their volumes or if they are able to take on additional capacity. The details on inter-LHIN allocation opportunities and lead time are dependent on Ministry of Health and Long Term Care (MOHLTC) initiating the reallocation process and finalizing the reallocations between LHINs. Lead time is NOT entirely dependant on being negotiated between the hospital and the LHIN. This only applies to intra-LHIN reallocations.

How do we provide stability across and during the year to maintain workflow?

Across years – We need agreement from the Ministry that allocation decreases at the LHINs level will have a maximum percentage change (e.g. 20 percent) between Year-to-Year Allocations. Are there any other suggestions?

During the year - This requires an integrated approach between hospitals, LHIN's and MOHLTC where information on Budgeted versus Actual volumes are provided on a regular basis and reallocations are pursed on a timely basis to minimize variances. At the LHIN level, we too need to ensure decreases to any particular hospital are capped at a certain percentage. What should this percentage be? Would a cap of a 20 percent decrease in any given year work?

Coordination is challenging at the inter-LHIN level and reliant on the second quarter process.

Coordination at the Hospital and LHIN level is easier because of access to Budget versus Actuals.

Other related items:

Does the condition about reassessment of patients apply to all services?

No, this condition of funding asks hospitals to ensure that patients waiting a long time are reassessed to ensure that the hospital is aware of any changes in the patient's condition prior to surgery. Reassessment is not required for diagnostic services.

Does the surgeon need to reassess the patients who have waited longer than the Priority IV target or can another health care professional perform the re-assessment?

This process is left up to the hospital to put in place. The team of health care professionals, including the surgeon, should discuss this issue with the hospital's administration to determine the best approach.

MRI Conditions

What is the basis for calculating MRI efficiency and can we track our own efficiency so that we can make operational adjustments?

A time value has been assigned to each MRI procedure by the MRI/CT Expert Panel. This time value is applied to the actual number of exams performed at a hospital and this is how the expected total operating hours are derived. This number is compared to the actual hours of operation reported by the hospital and, if the expected hours are less than 80 percent of the actual hours, then the hospital is deemed to be inefficient. **Can the hospitals please provide us with the following Exam Code volumes for 2007/08?** The LHIN can then summarize the efficiencies for each hospital.

MRI Formula details:

Fee Schedule Code	Location	Time Value (hours)
X421	Head	0.5
X425		
X431	Neck	0.75
X435		
X441	Thorax	1.5
X445		
X451	Abdomen	0.75
X455		
X461	Pelvis	0.5
X465		
X471	Extremity	0.5
X475		
X486		
X487	Gad	0.25
X488	Mult.Ext	1
X489		
X490	Ltd.Spine	0.5
X492		
X493	Int. Spine	0.75
X495		
X496	Complex Sp	0.75
X498		
X499	3D	0.25