



Health Santé
Canada Canada

PATIENT WAIT TIMES GUARANTEE
PILOT PROJECT FUND
SUMMATIVE EVALUATION

Final Report

Approved by

Executive Committee

Finance, Evaluation and Accountability (EC-FEA)

Health Canada

March 14, 2011

Canada 

TABLE OF CONTENTS

- **Management Response for the Patient Wait Times Guarantee - Pilot Project Fund — Summative Evaluation — Final Report**
- **Patient Wait Times Guarantee - Pilot Project Fund — Summative Evaluation — Final Report**

MANAGEMENT RESPONSE
Patient Wait Times Guarantee – Pilot Project Fund – Summative Evaluation
November 2007 – March 2010
Table of Findings and Conclusions

Note: This evaluation does not include any specific recommendations. As such, this table presents the findings and conclusion of this evaluation. The evaluation information and responses provided below will inform the broader evaluation of the Health Care Policy and Contribution Program (HCPCP) to be completed in 2012-13.

| Finding/Conclusion | Management Response | Further Considerations/ Comments/Action |
|--|---|---|
| 1. Based on the findings of the evaluation, the evaluation concludes that the Patient Wait Times Guarantee Pilot Project Fund (the Fund) appears to have successfully addressed the Government of Canada priority of informing the establishment of patient wait times guarantees. | <ul style="list-style-type: none"> • Agree. • No further immediate action is required given the Fund has ended. | This line of evidence will be used to support the larger HCPCP evaluation to be completed in 2012-13. |
| 2. In general, pilot projects have been successful at testing new approaches and tools to reduce wait times and implement patient wait times guarantees. Provinces and territories have benefited from their projects, and intend to move forward with the knowledge gained and with systems and processes put in place during their pilot projects. According to provinces and territories participating in the Fund, the pilot projects would likely not have gone ahead in the absence of the Fund. | <ul style="list-style-type: none"> • Agree. • No further immediate action is required given the Fund has ended. | This line of evidence will be used to support the larger HCPCP evaluation to be completed in 2012-13. |
| 3. At the level of short-term outcomes, the Fund demonstrated considerable success related to two of its three expected outcomes. The Fund resulted in a) a greater understanding of tools and approaches associated with the reduction of wait times and the establishment of patient wait times guarantees, and b) a greater awareness and understanding of policy and operational issues associated with the establishment of patient wait times guarantees. This was evidenced through the diversity of tools and approaches that were developed as part of the projects, which ranged from instruments to manage patient volumes and flow to IT systems and other tools, and the implementation of new tools and approaches specifically to address the policy and/or operational issues associated with the establishment of patient wait times guarantees in the jurisdictions. | <ul style="list-style-type: none"> • Agree. • No further immediate action is required given the Fund has ended. | This line of evidence will be used to support the larger HCPCP evaluation to be completed in 2012-13. |

| Finding/Conclusion | Management Response | Further Considerations/ Comments/Action |
|---|---|--|
| <p>4. The evaluation found that there had been comparatively weaker results in achieving the third short-term outcome: strengthened collaboration and exchange of best practices among provinces and territories. In all but a few instances, at the time of the evaluation, pilot projects had not collaborated or shared the knowledge they had obtained with other provinces or territories. This was the result of many factors, including that the provincial or territorial pilot project officials were sometimes not in the best position to identify their counterparts in other provinces or territories and share information across jurisdictions. The evaluation finds that this weakness in the area of information-sharing suggests a potential future role for Health Canada in supporting the dissemination of learning from the pilot projects.</p> | <ul style="list-style-type: none"> • Agree. • Sharing the Fund evaluation with patient wait times guarantee pilot project officials will reinforce this finding and serve to encourage further collaboration and exchange of best practices among provinces and territories as they continue to seek innovative ways to reduce waits and implement their guarantees. • A revised HCPCP Guide for Applicants was developed and put into use as of December 2009. It more clearly defines Health Canada's expectations regarding the dissemination of project results for funding recipients, which should support and encourage recipients, including provinces and territories, to share the knowledge obtained through their projects. • Lessons learned from the evaluation of the Fund will be used to continue to enhance efforts to link funding recipients undertaking similar projects and to support mechanisms for collaboration and sharing of knowledge obtained through projects under the HCPCP. | <p>This line of evidence will be used to support the larger HCPCP evaluation to be completed in 2012-13.</p> <p>The management response to this evaluation finding should strengthen collaboration and exchange of best practices for future projects under the HCPCP. The success in meeting this objective will be assessed through the larger HCPCP evaluation.</p> |
| <p>5. While medium- and long-term outcomes can typically take years to achieve, the Fund had begun to demonstrate some results in these areas at the time of the evaluation. Jurisdictions indicated an increased understanding of how guarantees fit within overall access strategies and system reform, and were better positioned to reduce wait times and address patient wait times guarantees. Although the Fund's long-term outcomes of wait times reductions and guarantees of timely access to care were more difficult to assess given that the projects were time-limited, there were a few examples of projects that were clearly able to demonstrate a reduction in wait times as a result of project activities and several jurisdictions were able to implement recourse options. Finally, many provinces and territories have decided to expand on the scope of the pilot project tools and approaches in the future.</p> | <ul style="list-style-type: none"> • Agree. • No further immediate action is required given the Fund has ended. | <p>This line of evidence will be used to support the larger HCPCP evaluation to be completed in 2012-13.</p> |

| Finding/Conclusion | Management Response | Further Considerations/ Comments/Action |
|---|---|--|
| <p>6. Given that the Fund had met or is on track to meeting its outcomes, and that program funds had been managed appropriately, the evaluation concludes that the Fund was implemented efficiently and economically.</p> | <ul style="list-style-type: none"> • Agree. • No further immediate action is required given the Fund has ended. | <p>This line of evidence will be used to support the larger HCPCP evaluation to be completed in 2012-13.</p> |
| <p>7. Based on the findings of the evaluation, it appears that the Fund has successfully supported three of the expected immediate outcomes of the HCPCP. The Fund’s support for knowledge-building related to the tools and approaches associated with the reduction of wait times and the implementation of patient wait times guarantees, and for greater awareness and understanding of the policy and operational issues associated with the establishment of patient wait times guarantees, have contributed to the achievement of the HCPCP’s immediate outcome of increased knowledge and understanding of health care system performance and new approaches, models, and best practices. Within the provinces and territories, the Fund has also contributed to improved collaboration and coordination in the pilot project area of focus, supporting the HCPCP immediate outcome of improved collaboration on, and coordination of, responses to priorities and barriers. The intent of all provinces and territories to continue with all, or aspects of, their pilot projects indicates that health care systems are better positioned to reduce wait times and address patient wait times guarantees, supporting the HCPCP immediate outcome of adoption of new approaches, models, and best practices.</p> | <ul style="list-style-type: none"> • Agree. • No further immediate action is required given the Fund has ended. | <p>This line of evidence will be used to support the larger HCPCP evaluation to be completed in 2012-13.</p> |

PATIENT WAIT TIMES GUARANTEE

PILOT PROJECT FUND

Summative Evaluation

November 2007 to March 2010

February 2011

Canada 

Prepared by:
Government Consulting Services
Public Works and Government Services Canada

TABLE OF CONTENTS

| | |
|--|------------|
| Executive Summary | iii |
| 1. Introduction and Profile of the Fund | 1 |
| 1.1 Background..... | 1 |
| 1.2 Fund Profile | 2 |
| 2. Evaluation Methodology | 8 |
| 2.1 Evaluation Context/Purpose | 8 |
| 2.2 Evaluation Questions/Issues | 8 |
| 2.3 Evaluation Approach | 9 |
| 2.4 Methodological Considerations/Limitations..... | 10 |
| 3. Key Findings..... | 11 |
| 3.1 Relevance..... | 12 |
| 3.2 Performance and Effectiveness in Meeting Objectives | 15 |
| 3.3 Performance – Efficiency, Economy | 22 |
| 3.4 Design and Delivery | 25 |
| 4. Conclusion | 27 |
| Annex A – Selection Criteria..... | 29 |
| Annex B – Pilot Project Descriptions | 31 |
| Annex C – Evaluation Template..... | 33 |
| Annex D – Evaluation Interviews | 36 |
| Annex E – Tools and Approaches Implemented by Pilot Projects..... | 37 |
| Annex F – Collaboration and Exchange of Best Practices | 41 |
| Annex G – Documented Reduction in Wait Times in Area of Focus | 42 |
| Annex H – Recourse Activities in Pilot Projects | 44 |
| Annex I – Future Impact on Reduction of Wait Times and Establishment of PWTGs | 47 |
| Annex J – Interview Guides (Funded Participants and HC Staff)..... | 50 |

LIST OF ACRONYMS

| | |
|-------|---|
| BGSC | Bridging General and Specialist Care |
| CABG | Coronary Artery Bypass Graft |
| DI | Diagnostic Imaging |
| FY | Fiscal Year |
| GCS | Government Consulting Services |
| GoC | Government of Canada |
| HC | Health Canada |
| HCPCP | Health Care Policy Contribution Program |
| HCSD | Health Care System Division |
| IT | Information Technology |
| MOU | Memorandum of Understanding, Memoranda of Understanding |
| OR | Operating Room |
| PART | Patient Access Registry Tool |
| P/Ts | Provincial/Territorial Governments |
| PWTG | Patient Wait Times Guarantee |
| RMAF | Results-based Management Accountability Framework |
| RMWT | Recommended Maximum Wait Time |

Executive Summary

This report presents the findings of the evaluation of the Patient Wait Times Guarantee (PWTG) Pilot Project Fund (the Fund), which was in place from November 2007 through March 2010. The evaluation was undertaken for Health Canada by Government Consulting Services (GCS) from November 2009 to September 2010.

The results of the evaluation are expected to feed into the summative evaluation of the Health Care Policy Contribution Program (HCPCP), of which the Fund was a component, scheduled for completion in Fiscal Year (FY) 2012-2013.

Fund Background and Profile

In the 10-Year Plan to Strengthen Health Care, announced in September 2004, governments committed to the reduction of wait times in five priority clinical areas. Priority areas included: cardiac care, cancer care, joint replacement, sight restoration and diagnostic imaging. In support of the 10-Year Plan, the federal government made an investment of \$5.5 billion over 10 years (currently \$250 million per year through 2013-14) via a Wait Times Reduction Fund to support meaningful reduction in wait times in the five priority areas.

In April 2007, building on the work underway on the reduction of wait times, the Prime Minister announced that each province and territory had committed to establishing a PWTG in at least one clinical area, of its choosing, by 2010. These commitments were confirmed through Memoranda of Understanding with all provinces and territories (P/Ts) except Quebec, which had already committed to a guarantee of access.

Guarantees were to consist of two components: a medically acceptable maximum timeframe within which the guaranteed procedure would be provided and access to alternate care options (recourse) should that timeframe be exceeded. Guarantees represent a tool to help provide certainty for patients, build public confidence in the public health care system and further enhance system accountability.

Budget 2007 provided over \$1 billion in new federal funding to support provinces and territories in the advancement of guarantees. This amount consisted of up to \$612 million in a Patient Wait Times Guarantee Trust (the Trust) available to P/Ts that committed to the establishment of a guarantee, \$400 million for health information technology (through Canada Health Infoway) to assist in advancing guarantees, and \$30 million over three years (2007-08 to 2009-10) for the Fund.

The purpose of the Fund was to support P/T projects that developed, implemented and tested innovative approaches to reduce wait times and establish PWTGs.

Funding was allocated on the basis of successful proposal submissions, assessed against established criteria. The Fund supported 11 projects in eight provinces and territories, encompassing a wide variety of clinical areas and approaches, between November 1, 2007 and March 31, 2010.

Evaluation Scope, Methodology and Considerations

The evaluation followed an evaluation framework developed by GCS in 2007, in consultation with Health Canada and consistent with Treasury Board guidelines. The evaluation examined the issues of relevance (i.e., the extent to which a program addresses a demonstrable need, is appropriate to the federal government, and is responsive to the needs of Canadians) and performance (i.e., the extent to which effectiveness, efficiency and economy are achieved by a program), as well as lessons learned regarding design and delivery of the Fund.

The evaluation included two data collection methods: a review of available documents (e.g., pilot project evaluation reports, Government of Canada funding authorities, HCPCP Results-based Management Accountability Framework (RMAF), PWTG Pilot Project Fund RMAF, etc.) and key informant interviews.

Methodological Considerations

Key methodological considerations for this evaluation included:

- Funded projects included a wide diversity of activities, target audiences and clinical areas, and were conducted in different parts of the country.
- Funded projects sometimes placed greater emphasis on ensuring successful implementation, delaying the start of their evaluation activities. Consequently, some funded projects had not yet had time to fully examine the achievement of outcomes at the time of their project evaluations.
- Attributing changes in patient wait times specifically to this Fund was not appropriate given that changes may have come about as a result of other investments (e.g. the PWTG Trust).
- Evaluations undertaken by P/Ts of their funded projects were often very detailed, informative and methodologically robust. P/Ts also completed an Evaluation Template and interviews that requested specific information related to Fund objectives.
- Multiple lines of evidence enabled the validation of findings. The data submitted by P/Ts was further enhanced and cross-validated for accuracy in interviews with recipients and Fund staff.

Key Findings:

Relevance

The Fund was well aligned with departmental and government-wide objectives and priorities. Specifically, the Fund supported the key Government of Canada priority of PWTGs (2006 Speech from the Throne). The Fund also aligned with Health Canada’s Strategic Outcome — to provide “an accessible and sustainable health system responsive to the health needs of Canadians” by contributing to wait times reductions and guarantees of timely access to care. The expected outcomes of the Fund were also directly aligned with those of Health Canada’s HCPCP.

Project representatives indicated there was a need for the federal government to invest in pilot projects related to PWTGs and reducing wait times, allowing them to implement and test new ideas in order to make progress in fulfilling broader PWTG commitments their governments had made. Project representatives noted that the Fund complemented existing federal, provincial and territorial funding.

No other federal government program was identified with the same objectives as the Fund. It complemented other federal funding aimed at addressing wait times and supporting the development of PWTGs. Also, at the provincial and territorial level, interviewed representatives from the pilot projects noted that as the pilot projects were designed by the P/Ts, they did not overlap or duplicate other efforts, but were designed to complement existing initiatives.

Fund Performance – Effectiveness of Meeting Outcomes

In the short-term, the Fund was expected to: provide a greater understanding of tools and approaches associated with the reduction of wait times and the implementation of PWTGs; strengthen collaboration and exchange of best practices amongst P/Ts; and permit a greater awareness and understanding of policy and operational issues associated with the establishment of PWTGs. This evaluation demonstrated that:

- Fifteen pilot project stakeholders indicated that their project had increased their understanding of the tools and approaches needed to establish guarantees and/or reduce patient wait times.
- Fifteen pilot project stakeholders indicated that their project had increased their understanding of policy and operational issues needed to establish guarantees and/or reduce patient wait times.
- While it was expected that results of the pilot projects would be shared between P/Ts, and collaboration would occur in the course of the projects, this had not yet happened to any large degree at the time of the evaluation. Six pilot project stakeholders indicated that their project had contributed “to a great extent” to strengthened collaboration and exchange of ideas. There was greater consensus that projects had increased collaboration and knowledge exchange within their jurisdiction – which addressed their own needs and priorities.

The expected medium-term outcomes for the Fund were to increase understanding amongst jurisdictions of how PWTGs best fit within overall access strategies and reforms, which would allow health care systems to be better positioned to reduce wait times and address PWTGs. The expected long-term outcomes for the Fund were wait times reductions and guarantees of timely access to care.

Typically, medium- and long-term outcomes take years to achieve. However, many pilot projects were able to demonstrate the initial impact that they had had on medium-term outcomes, and a few were able to demonstrate the initial impact that they had had on the long-term outcomes. The extent to which these impacts can be sustained is not yet known, given the limited amount of time between the end of Fund and this evaluation.

For this evaluation, the extent that medium- and long-term Fund outcomes were beginning to be met was assessed by the extent that: 1) there had been a reduction in wait times; 2) recourse/access to alternate options of care had been developed and implemented; and 3) PWTGs had been established in the pilot project's area of focus. Each project may have focused on all or one of these components. The future plans of P/Ts for continuing the work launched through their pilot projects were also considered. Information on each of these components, by pilot project, is presented in the body of the report.

The knowledge generated from the implementation of these tools/approaches helped P/T health care systems to be better positioned to reduce wait times, although the extent to which this occurred was difficult to assess during the project period. For instance, some projects lacked baseline data. However, there were a few pilot projects that were clearly able to document wait times reductions within the project period.

There were various complexities that came into play which influenced the ability of some pilot projects to test recourse policies/processes including: wait times management approaches appeared to have reduced wait times, thus recourse was not required; and patients indicated a preference for waiting out the longer timeframes rather than being transferred to another region or jurisdiction. Overall, for those pilot projects that developed a recourse strategy, all intended to maintain the associated tools and approaches.

Another good indicator of the extent that this Fund contributed to health care systems being better positioned to reduce wait times and address PWTGs was the commitment of P/Ts to continue to expand on the funded pilot projects' activities. In fact, all pilot projects indicated that they were going to continue to make use of the tools and approaches resulting from their pilot projects – some P/Ts indicated that they had chosen to expand the scope of work initiated under their projects.

Overall, the Fund permitted P/Ts to address a number of issues related to implementing guarantees by developing and testing new tools and approaches.

Fund Performance – Efficiency/Economy

The Fund lapsed just over one-fifth (22.3%) of available funds, mainly due to the withdrawal of two recommended projects and to P/Ts not receiving funds until late in the first year of a three year agreement. However, surplus funds which were identified early on were used first for other projects under the Fund, with remaining funds put toward a national project to support work related to timely access to, and guarantees for, pediatric surgical care which was consistent with the broad goals of the Fund.

The assessment of efficiency and economy encompasses both relevance and performance. As noted above, there was an identified need for the federal government to invest in pilot projects related to PWTGs and reducing wait times, and the pilot projects contributed to Fund objectives. This Fund successfully funded eleven projects, all of which indicated that all, or aspects, of their pilot projects were going to continue and were expected to have a positive impact on the reduction of patient wait times in the future. Consequently, the Fund was implemented efficiently and economically by addressing an identified need with modest resources and by meeting its expected objectives.

Design and Delivery

While there was limited time to put the Fund in place, it was successfully implemented and the overall concept of supporting pilot projects was a success. In fact, 17 pilot project stakeholders indicated that their pilot project would likely not have gone ahead in the absence of the Fund. The use of contribution agreements was also effective at ensuring that resources were directed towards the projects.

Project stakeholders considered the Fund to have been an effective and well managed vehicle to support the establishment of PWTGs and the reduction of wait times. Seven pilot project stakeholders did voice concerns including: short timelines for the development of proposals, delays in receiving funding, and restrictions on spending as a result of the stipulations in contribution agreements.

Overall, the management practices for the Fund were considered effective. Health Canada staff worked through very tight timelines to put the Fund in place, and pilot project recipients overwhelmingly noted the effectiveness of the Health Canada staff and of the Fund.

Conclusions

The PWTG Pilot Project Fund appears to have successfully addressed the Government of Canada priority of informing the establishment of PWTGs.

The pilot projects have been successful at testing new approaches and tools to reduce wait times and implement PWTGs. P/Ts have benefited from their projects and intend to move forward with the knowledge gained and with the systems and processes put in place during their pilot projects.

According to recipients, the pilot projects would likely not have gone ahead in the absence of the Fund.

At the level of short-term outcomes, the Fund demonstrated considerable success related to two of its three expected outcomes. The Fund resulted in a greater understanding of tools and approaches associated with the reduction of wait times and the establishment of PWTGs, and of policy and operational issues associated with the establishment of PWTGs. This was evidenced through the diversity of tools and approaches that were developed as part of the projects, which ranged from instruments to manage patient volumes and flow to IT systems and other tools, and the implementation of new tools and approaches specifically to address the policy and/or operational issues associated with the establishment of PWTGs in the jurisdictions.

The evaluation found that there had been comparatively weaker results in achieving the third short-term outcome: strengthened collaboration and exchange of best practices among P/Ts. In all but a few instances, at the time of the evaluation, pilot projects had not collaborated or shared the knowledge they had obtained with other P/Ts. This was the result of many factors, including that project members were sometimes not in the best position to identify their counterparts in other P/Ts and share information across jurisdictions. This finding suggests a potential future role for Health Canada in supporting the dissemination of learning from pilot projects.

While medium- and long-term outcomes can typically take years to achieve, the Fund had begun to demonstrate some results in these areas at the time of the evaluation. Jurisdictions indicated an increased understanding of how guarantees fit within overall access strategies and system reform, and were better positioned to reduce wait times and address PWTGs. Although the Fund's long-term outcomes of wait times reductions and guarantees of timely access to care were more difficult to assess given that the projects were time-limited, there were a few examples of projects that were clearly able to demonstrate a reduction in wait times as a result of project activities and several jurisdictions were able to implement recourse options. Finally, many P/Ts have decided to expand on the scope of the pilot project tools and approaches in the future.

Given that the Fund had met or is on track to meeting its outcomes, and that its funds had been managed appropriately, the evaluation concludes that the Fund was implemented efficiently and economically.

This evaluation does not include any specific recommendations given that the Fund has ended. Rather, the results are intended to inform an evaluation of the HCPCP to be completed in 2012-2013. Based on the findings of the evaluation, it appears that the Fund has successfully supported three of the expected immediate outcomes of the HCPCP.

The Fund's support for knowledge-building related to the tools and approaches associated with the reduction of wait times and the implementation of PWTGs, and for greater awareness and understanding of the policy and operational issues associated with the establishment of PWTGs, have contributed to the achievement of the HCPCP's immediate outcome of increased knowledge and understanding of health care system performance and new approaches, models, and best practices.

Within the P/Ts the Fund has also contributed to improved collaboration and coordination in the pilot project area of focus, supporting the HCPCP immediate outcome of improved collaboration on, and coordination of, responses to priorities and barriers. The intent of all P/Ts to continue with all, or aspects of, their pilot projects indicates that health care systems are better positioned to reduce wait times and address PWTGs, supporting the HCPCP immediate outcome of adoption of new approaches, models, and best practices.

1. INTRODUCTION AND PROFILE OF THE FUND

This report presents the results of the evaluation of the Patient Wait Times Guarantee (PWTG) Pilot Project Fund. The evaluation was undertaken by Government Consulting Services (GCS) for Health Canada between November 2009 and September 2010.

An evaluation of the time-limited PWTG Pilot Project Fund (the Fund) was undertaken and is expected to feed into the summative evaluation of the Health Care Policy Contribution Program (HCPCP), of which the Fund was a component, scheduled for completion in Fiscal Year (FY) 2012-13. The evaluation covered the entire duration of the Fund, from November 2007 to March 2010.

The report is organized into four sections:

- Section 1 presents a description of the Fund and an introduction to the evaluation;
- Section 2 outlines the evaluation methodology and methodological considerations;
- Section 3 presents the evaluation findings; and
- Section 4 presents the overall conclusions from the evaluation.

1.1 Background

In the 10-Year Plan to Strengthen Health Care, announced in September 2004, governments committed to the reduction of wait times in five priority clinical areas, and to health system reforms to improve timely access to quality health care. Priority areas included: cardiac care, cancer care, joint replacement, sight restoration and diagnostic imaging. In support of the 10-Year Plan, the federal government announced an investment of \$5.5 billion over 10 years (currently \$250 million per year through FY 2013-14) via a Wait Times Reduction Fund to achieve meaningful reduction in wait times in the five priority areas.

In April 2007, to further build on the work underway on the reduction of wait times, the Prime Minister announced that each province and territory had committed to establishing a patient wait times guarantee in at least one clinical area, of its choosing, by 2010. These commitments were confirmed through Memoranda of Understanding with all P/Ts except Quebec, which had already committed to a guarantee of access.

Guarantees were to consist of two components: a medically acceptable maximum timeframe within which the guaranteed procedure would be provided and access to alternate care options (recourse) should that timeframe be exceeded. Guarantees represent a tool to help provide certainty for patients, build public confidence in the public health care system and further enhance system accountability.

Budget 2007 provided over \$1 billion in new federal funding to support provinces and territories in the advancement of guarantees. This amount consisted of up to \$612 million in a Patient Wait Times Guarantee Trust (the Trust) available to P/Ts that committed by 2010 to the establishment of a guarantee, \$400 million for health information technology (through Canada Health Infoway) to assist in advancing guarantees, and \$30 million over three years for the Fund.

1.2 Fund Profile

1.2.1 Fund Description

The purpose of the Fund was to support P/T projects that developed, implemented and tested innovative approaches to reduce wait times and establish PWTGs. The Fund supported P/Ts in:

- developing and assessing tools to establish and meet guarantees (including the provision of recourse for patients when guaranteed timeframes for treatment are exceeded);
- identifying and addressing policy and operational issues associated with establishing guarantees; and
- encouraging collaboration and the exchange of best practices.

The logic model for the Fund is presented in Figure 1.

Funded P/T projects were expected to produce the following types of outputs:

- new tools and approaches for reducing wait times and implementing PWTGs;
- research reports, databases and guidance documents;
- collaborative networks and information-sharing mechanisms; and/or
- identify barriers and challenges to implementing PWTGs.

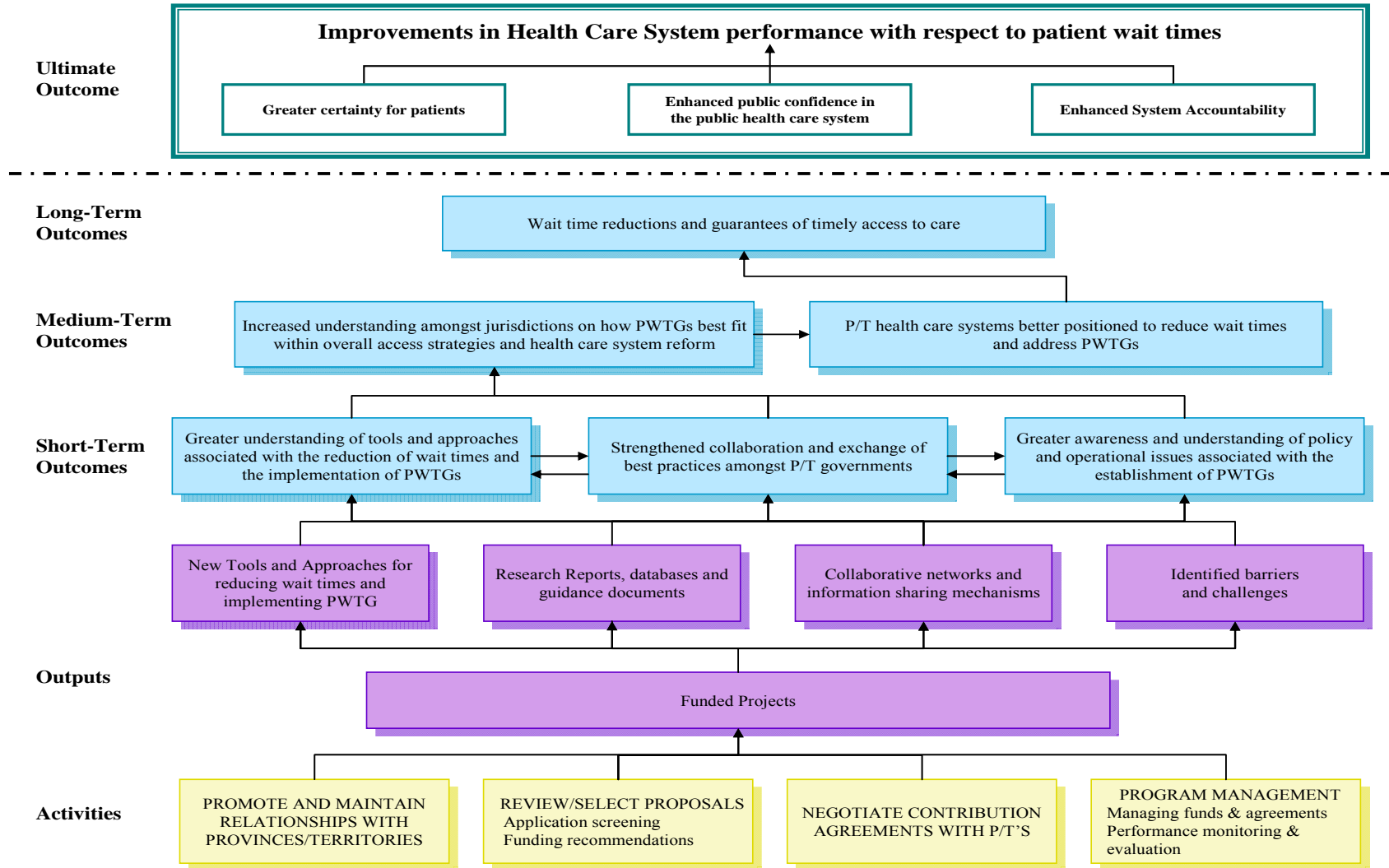
The key short-term expected outcomes of the Fund included:

- a greater understanding of tools and approaches associated with the reduction of wait times and the implementation of PWTGs;
- strengthened collaboration and exchange of best practices amongst P/Ts; and
- greater awareness and understanding of policy and operational issues associated with the establishment of PWTGs.

In the medium-term, the Fund was expected to increase understanding amongst jurisdictions on how PWTGs best fit within overall access strategies and health care system reform, which would allow health care systems to be better positioned to reduce wait times and address PWTGs. Over the long term, this was expected to contribute to wait times reductions and guarantees of timely access to care.

Intended beneficiaries of projects and their outputs and outcomes include health care institutions that were expected to benefit from the projects led by their respective P/T, as well as from the lessons learned in other jurisdictions. Ultimately, Canadians were expected to benefit from the Fund and its results through decreased wait times, greater certainty for patients, enhanced confidence in the public health care system and greater system accountability.

**Figure 1
PWTG Pilot Project Fund Logic Model**



1.2.2 Fund Implementation

In June 2007, the federal government approved the investment of \$30 million over three years (2007-08 to 2009-10) for the Fund. It was agreed that the Fund would be allocated on the basis of merit, rather than on the per capita basis used by the Trust, to support creative and innovative projects that would assist in the establishment of PWTGs.

In July and August 2007, Health Canada consulted with the P/Ts to develop the guiding principles and criteria (see Annex A) governing the Fund. The discussions focused on the nature of the selection process, the definition of recourse and the need for an efficient decision-making process that would allow projects to be implemented in a timely fashion.

Approval for the implementation of the Fund was received on September 27, 2007. The Call for Proposals was issued to P/T representatives on October 2, 2007, with a submission deadline of October 31, 2007. Although it was recognized that this was a short timeframe for the development of proposals, it was determined to be a satisfactory amount of time given that the P/Ts were involved in the development of the Fund guidelines and criteria, and given their request for an efficient process to allow for timely project implementation.

In response to the Call for Proposals, Health Canada received a total of nineteen submissions from ten jurisdictions representing \$48 million in requested funding. Three jurisdictions - British Columbia, Alberta and Nunavut - did not submit proposals. Several jurisdictions submitted more than one, notably Quebec (6), Ontario (4) and Nova Scotia (2).

Once all project proposals were received, Health Canada established a Review Committee to ensure a standard and comprehensive review process, which included: administrative and detailed program screenings; input from regional offices and the Federal-Provincial/Territorial Relations Division; and external review by Canada Health Infoway for those projects with a significant information technology component. Throughout this process, P/Ts were given the opportunity to respond to questions and to provide additional details on their proposals.

Upon completion of the review process, and finalization of all proposals, funding recommendations were made to the Minister of Health and were subsequently approved on January 28, 2008. Health Canada then began negotiating contribution agreements with P/Ts. In order to expedite the negotiations, a template agreement was used that had been previously approved by P/Ts for use with another Health Canada funding initiative. To further mitigate delays caused by lengthy negotiations, Health Canada allowed projects to retroactively recognize all eligible expenditures as of November 1, 2007, so that P/Ts could begin to implement their projects as quickly as possible. Contribution agreement negotiations were completed on or before March 31, 2008.

1.2.3 Funded Projects

To be eligible for funding, proposals were required to:

- demonstrate how PWTGs could be operationalized within the publicly-funded health care system, including the testing of recourse and wait times management approaches needed to support guarantees;
- demonstrate substantial innovation and/or an opportunity to effect significant change;
- include an evaluation plan; and
- include a dissemination plan.

Other desirable factors that were considered when proposals were assessed included:

- involvement of jurisdictional/inter-jurisdictional collaboration;
- engagement of relevant healthcare providers, patients, other stakeholders and experts; and
- applicability to other jurisdictions.

In addition, the details of each proposal were assessed with a view to confirming project viability and cost-effectiveness.

The Fund did recognize that the Yukon, Northwest Territories and Nunavut deliver a limited range of acute care health services, and as such, proposals from these territories were not required to test in one of the five priority areas. However, these projects did have to show significant innovation or the prospect of a significant benefit to patients (e.g., via wait times reduction, access to alternate care options).

In total, eight contribution agreements covering 12 pilot projects were signed with the P/Ts, and, in the end, 11 projects¹ covering a broad range of clinical areas and approaches received funding under the Fund (Table 1). A brief description of each pilot project is presented in Annex B.

¹ A Quebec project on diagnostic imaging was withdrawn prior to commencement, as it was deemed by the province that there was insufficient time to complete the project as planned.

**Table 1
Funded Pilot Projects**

| Province | Project | Area of Focus | Federal Funding |
|-----------------|---|---|------------------------|
| SK | Coronary Artery Bypass Graft (CABG) Surgery Recourse Pilot Project | Coronary Artery Bypass Graft Surgery | \$775,000 |
| MB | Bridging General and Specialist Care: The Right Door, the First Time | Mental Health Hip and Knee Arthroplasty Low Back Pain Lower GI Endoscopy Lung Cancer Plastic Surgery Orthopaedics (Back) Orthopaedics (Shoulder) Ear/Nose/Throat Dermatology Nephrology | \$5,020,680 |
| QC | Clinique interdisciplinaire en musculo-squelettique | Orthopaedic for Musculoskeletal | \$2,592,247 |
| QC | Requête Web opératoire | Hip & Knee Replacement Surgery Cataract Surgeries | \$42,077 |
| QC | Défi qualité performance dans la réduction des délais d'attente pour les arthroplasties de la hanche et du genou | Hip & Knee Replacement Surgery | \$511,000 |
| NB | Radiation Therapy Wait Time Guarantee Pilot Project | Radiation Therapy | \$5,002,904 |
| NS | Improving Access to Diagnostic Services | Diagnostic Imaging | \$3,400,594 |
| NS | Improving Access to Surgical Services: A Patient Portal for Orthopaedics | Orthopedic Surgical Services | \$4,604,442 |
| PEI | Saving Time and Saving Lives: A Provincial Strategy for Ensuring Radiation Therapy Patient Wait Times Guarantee | Radiation Therapy | \$1,408,250 |
| NT | Screening Mammography Program: A Patient Wait Times Guarantee Pilot Project | Mammography Screening | \$560,188 |
| YK | Testing the Feasibility of Providing Recourse to a Wider Range of Service Location Options for Specified Out-of-Yukon Services and Procedures | Hip & Knee Replacement Surgery Cardiac Care Cancer Care Ophthalmology | \$1,433,000 |
| TOTAL | | | \$25,350,382 |

1.2.4 Fund Governance

The Fund was delivered through Health Canada's HCPCP, which supports the federal role of working with provincial and territorial governments and other stakeholders to respond to the challenges facing Canada's health care system. The HCPCP is designed to promote policy research and analysis, pilot projects and evaluations on current and emerging health care system priorities. The Fund was, during its lifespan, a component of the HCPCP, which also includes the ongoing Health Human Resource Strategy, Internationally Educated Health Professionals Initiative, and Health Care System Innovation components. The Fund was aligned with the goals of the HCPCP to develop, implement and disseminate knowledge, best practices and strategies for innovative health care delivery.

The Fund was managed by the Health Care System Division of the Health Care Policy Directorate, located within Health Canada's Strategic Policy Branch.

2. EVALUATION METHODOLOGY

2.1 Evaluation Context/Purpose

Health Canada was required to evaluate the Fund upon its completion. The results of the evaluation are expected to feed into the summative evaluation of the HCPCP, scheduled for completion in FY 2012-13.

Government Consulting Services, in consultation with the Health Care System Division, Health Care Policy Directorate, developed a logic model and an evaluation framework for the Fund in 2007. The evaluation framework and logic model formed the basis of the current evaluation. The following section outlines the evaluation questions and issues, data collection methods, and methodological considerations for the evaluation.

The Fund was a three-year time-limited (FY 2007-08 to FY 2009-10) program. The evaluation was conducted between November 2009 and September 2010.

2.2 Evaluation Questions/Issues

The evaluation examined issues relating to the relevance, performance, and design and delivery of the Fund. Table 2 presents the evaluation issues and questions set out in the evaluation framework.

Table 2
Evaluation Issues and Questions

| Evaluation Issue | Evaluation Question |
|--|--|
| Fund Relevance | <ul style="list-style-type: none"> • Did the pilot projects address an actual need? Is there a continued need for the pilot projects? • Were the pilot projects' objectives consistent with departmental and government-wide priorities? • Did the role of the pilot projects complement the roles of other federal and P/T programs in this field? How were the pilot project activities coordinated with these federal/provincial/territorial roles? • Do the pilot projects duplicate or overlap with any other initiative in Canada? |
| Fund Performance - Effectiveness | <p>Short-term Outcomes</p> <ul style="list-style-type: none"> • Do P/Ts have greater understanding of tools and approaches associated with the reduction of wait times and the establishment of PWTGs? • Do P/Ts have greater awareness and understanding of policy and operational issues associated with the establishment of PWTGs? • Has there been strengthened collaboration and exchange of best practices amongst P/Ts? <p>Medium-term Outcomes</p> <ul style="list-style-type: none"> • Has there been increased understanding amongst jurisdictions how PWTGs best fit within overall access strategies and health care system reform? • Are provincial/territorial health care systems better positioned to address PWTGs? <p>Long-term Outcomes</p> <ul style="list-style-type: none"> • To what extent have P/Ts achieved wait times reductions and guarantees of timely access to care? |
| Fund Performance - Efficiency, Economy | <ul style="list-style-type: none"> • Were the most appropriate and efficient means used to achieve Fund results? • Was the Fund implemented efficiently and economically? |
| Design and Delivery | <ul style="list-style-type: none"> • What lessons have been learned with regard to the planning, design and delivery of the Fund? • Have management practices for the Fund been effective? |

2.3 Evaluation Approach

The evaluation included two data collection methods: a review of documents and key informant interviews.

2.3.1 Document Review

The document review was the major source of information for the evaluation, and included:

- corporate documents, such as the funding authority for the Fund, Call for Proposals, budget and expenditure information, and the Health Canada Report on Plans and Priorities; and
- documents related to each of the funded projects, including project proposals, progress reports, and final project evaluation reports.

In addition, an evaluation template was developed by GCS and distributed to the project leads prior to the completion of their project evaluations. The template included 13 questions on project activities and results. Project managers were asked to submit a completed form with their final evaluation report. The information collected through this template was intended to supplement the information provided in project evaluation reports. A copy of the template is included in Annex C. A total of nine pilot project final evaluation reports and eight completed evaluation templates were reviewed. GCS developed and populated a document review grid which was used to organize findings according to key Fund objectives.

2.3.2 Interviews

Interviews were undertaken to supplement the information from the documents, as well as to obtain information related to program management. Two groups of key informants were interviewed for the evaluation: project managers and team members from the funded pilot projects; and current and former Health Canada managers and staff responsible for the Fund. The breakdown of interview numbers by group is illustrated in Annex D.

Project leads were asked to identify key members of their project team to be interviewed for the evaluation. In the end, 27 project representatives were interviewed by the evaluation team. Health Canada identified the former and current Health Canada staff and managers to be interviewed for the evaluation. Two interview sessions were conducted with this group, with a total of four Health Canada representatives providing input.

Interviews were undertaken in-person for those interviewees located in the National Capital Region, and by telephone for all others. Interviews were conducted in the official language of the interviewee's choice.

The interview guides are included in Annex J to this report. Notes from interviews with project representatives were entered into an interview grid, which organized interview findings by relevant evaluation question/indicator. Content analysis was then undertaken based on these notes.

2.4 Methodological Considerations/Limitations

As with any evaluation, there are some considerations that should be borne in mind when examining the results.

- Funded projects included a wide diversity of activities, target audiences and clinical areas, and were conducted in different parts of the country.
- The concept of PWTGs encompasses the establishment of a guarantee, recourse if that guarantee is not being met, and efforts to reduce wait times to ensure that the guarantee is met. Pilot projects may have focused on all of these components related to the PWTGs, or specific elements.

- Funded projects sometimes placed greater emphasis on ensuring successful implementation, delaying the start of their evaluation activities. Consequently, some funded projects had not yet had time to fully examine the achievement of outcomes at the time of their project evaluations.
- The total federal investment in PWTGs and related investments in wait times reductions over the years has been significant. Consequently, attributing changes in patient wait times specifically to this Fund was not appropriate, given that changes may have come about as a result of other investments (e.g. the PWTG Trust).
- There was limited information on two of the three funded projects in Quebec.

Despite these limitations, the evaluation benefited from the following strengths in its methodology:

- Evaluations undertaken by P/Ts of their funded projects were often very detailed, informative and methodologically robust, and, thus, these documents were very comprehensive sources of information for this evaluation. P/Ts also completed the GCS Evaluation Template that requested specific information related to Fund objectives. This data submitted by P/Ts was further enhanced by interviews with pilot project representatives.
- All pilot project recipients were interviewed (a census of pilot project recipients was undertaken). In many cases, depending on the scope of the project, additional provincial/territorial representatives were also interviewed in order to ensure a full/complete assessment of the project and of the Fund itself. In addition to the interviews with pilot project recipients, the evaluation team undertook interviews with representatives from Health Canada. The former program manager, who developed the funding authority submission for the Fund and who was familiar with the original objectives and parameters of the Fund, was interviewed. As well, the current program manager and staff who have been with the Fund since its inception were also interviewed.
- Multiple lines of evidence enabled the validation of findings. Reported project findings (e.g., final project evaluation reports and templates) were cross-validated for accuracy and supported by interviews with recipients and Fund staff.

3. KEY FINDINGS

This section of the report presents findings under four broad headings: relevance, performance related to achievement of objectives, performance related to economy and efficiency, and design/delivery as it relates to Fund implementation.

3.1 Relevance

The findings of the evaluation of the Fund on the issue of relevance are presented in this section of the report. The evaluation questions considered in addressing this issue were:

- Did the pilot projects address an actual need? Is there a continued need for the pilot projects?
- Were the pilot projects' objectives consistent with departmental and government-wide priorities?
- Did the role of the pilot projects complement the roles of other federal and P/T programs in this field? How were the pilot project activities coordinated with these F/P/T roles?
- Do the pilot projects duplicate or overlap with any other initiative in Canada?

3.1.1 Need for the Fund

According to foundational documents for the Fund, in committing to the establishment of PWTGs, P/Ts identified a number of potential issues/barriers related to implementation. These included:

- system readiness (e.g., health information technology, health human resources, capacity to provide alternative care options);
- the role of physicians in wait times management (e.g., centralized waiting lists);
- possible legal implications; and
- effects upon resource allocation across the health care system.

The Fund was intended to provide P/Ts the opportunity to develop and test innovative approaches to establishing guarantees and to address these types of concerns.

Sixteen project representatives indicated in interviews that they believed there was a need for the federal government to invest in pilot projects related to PWTGs and reducing wait times. The most common reason given to support this opinion was that it was challenging for the provinces/territories to examine new forms of innovation and examine longer-term issues, as they are habitually focused on addressing immediate needs. Six interviewees noted that the funding allowed the jurisdictions to implement and test new ideas, which does not often happen given the existing demands on available provincial and territorial funding. In the words of one interviewee, the funding was about being “strategic and not firefighting”.

Seventeen interviewed pilot project representatives noted that, in the absence of the Fund, their pilot project would not have gone ahead at all. Four indicated that it was possible that some elements of their pilot project may have proceeded without the funding, or that the project may have proceeded at a slower pace. No interviewees indicated that the project would have proceeded in the same way without the funding.

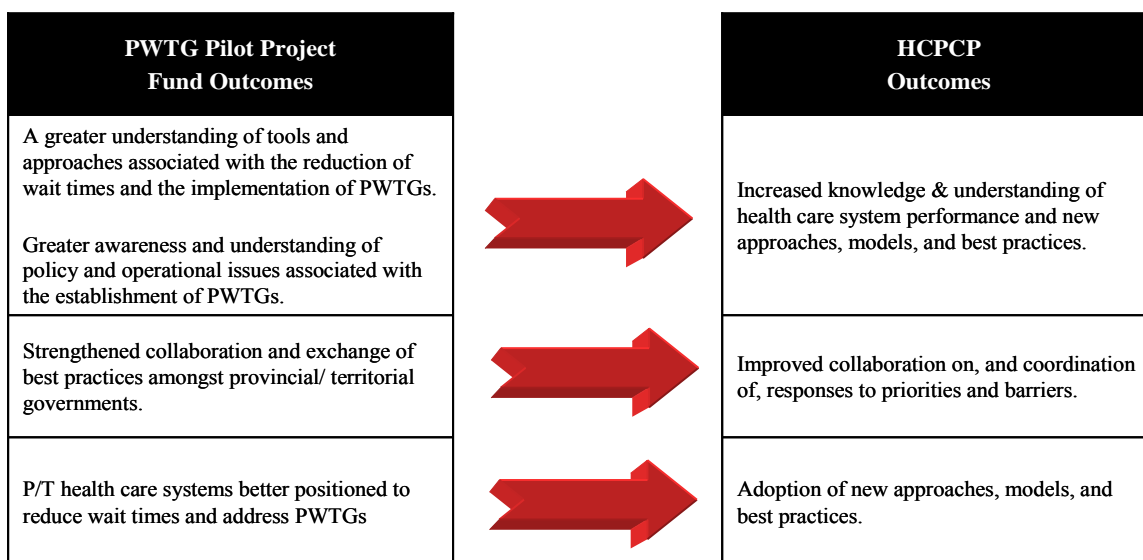
The Fund was not intended to be ongoing, as it was designed to support the establishment of PWTGs, which P/Ts had committed to put in place by 2010. Consequently the evaluation question of whether there is a continued need for the Fund was not pursued.

3.1.2 Alignment with Departmental and Government-wide Objectives and Priorities

The Fund was developed to support the key Government of Canada priority of establishing PWTGs. The 2006 Speech from the Throne stated that the federal government would “engage the provinces and territories on a patient wait times guarantee” and would “support and enable innovative approaches to health care delivery”.² The Fund was one component of more than \$1 billion in new federal funding towards the advancement of guarantees in the March 2007 Budget.

The Fund was aligned with Health Canada’s Program Activity Architecture. Strategic Outcome #1 was to provide “an accessible and sustainable health system responsive to the health needs of Canadians”. Specifically, in fiscal year 2007-2008, the program activity of “Health Policy Planning and Information” was expected to contribute to improved health outcomes for Canadians by promoting the increased and more effective use of information and communications technologies by providing policy research and analysis to support evidence-based decision-making. In fiscal years 2008-09 and 2009-10, the “Canadian Health Systems” program activity was expected to improve health care system planning and performance.

As shown in the figure below, the expected outcomes of the Fund were also directly aligned/consistent with those of Health Canada’s HCPCP, of which the Fund was a component.



² Government of Canada. Speech from the Throne, April 4, 2006. Accessed online August 23, 2010 at: <http://pm.gc.ca/eng/media.asp?id=1087>.

3.1.3 Other Programs

No other federal government program was identified with the same objectives as the Fund, indicating that the Fund was not duplicative. Rather, the Fund was a complement to other federal funding related to PWTGs and the reduction of patient wait times, including the Trust.

The Trust provided up to \$612 million available to P/Ts that committed to establish a PWTG by the end of 2010. Through the Trust, P/Ts were provided base funding of \$10 million per province and \$4 million per territory to move forward with a guarantee. The remaining \$500 million was allocated on a per capita basis.

The funding mechanisms for the Trust and the Fund differed in a manner that was consistent with their specific purposes. The Trust was designed to support P/T investments to develop and establish guarantees, and provided full flexibility for jurisdictions to invest funds in a manner that suited their needs.

The Fund was a contributions program and was specific in its purpose of developing and testing tools and approaches for guarantees in the full range of priority areas, and P/Ts could apply for projects that were not necessarily related to commitments under their PWTG MOUs. Funding was allocated based on proposals which were reviewed against a specific set of criteria, and the Fund included accountability provisions consistent with the Treasury Board Policy on Transfer Payments for Grants and Contributions, including reporting and an evaluation component. This funding mechanism encouraged innovative pilot projects that could promote shared learning and the identification of best practices.

Both the Trust and the Fund built upon work already underway to reduce wait times. In 2004, the federal government announced an investment of \$5.5 billion over 10 years via a Wait Times Reduction Fund. As opposed to the Trust and the Fund, both of which were targeted specifically towards the establishment of guarantees, the Wait Times Reduction Fund was intended to support governments' broader commitments under the 2004 Health Accord to achieve overall improvements in wait times in the five priority areas.

Some examples of provincial/territorial initiatives that were related to reducing wait times (or related health care system reforms) were provided during the interviews. For example, the Saskatchewan Surgical Initiative was implemented to reduce surgical wait times to three months or less by 2014. Interviewed representatives from the pilot projects noted that as the pilot projects were designed by the P/Ts, they did not overlap or duplicate other efforts, but were designed to complement existing initiatives.

Overall, it can be concluded that there was an identified need for the Fund, and that it complemented existing federal/provincial/territorial funding.

3.2 Performance and Effectiveness in Meeting Objectives

The evaluation findings on the issues of performance and effectiveness in meeting objectives are presented in this section of the report. The evaluation questions considered in addressing this issue were:

Short-term Outcomes

- Do P/Ts have greater understanding of tools and approaches associated with the reduction of wait times and the establishment of PWTGs?
- Do P/Ts have greater awareness and understanding of policy and operational issues associated with the establishment of PWTGs?
- Has there been strengthened collaboration and exchange of best practices amongst P/Ts?

Medium-term Outcomes

- Has there been increased understanding amongst jurisdictions how PWTGs best fit within overall access strategies and health care system reform?
- Are provincial/territorial health care systems better positioned to address PWTGs?

Long-term Outcomes

- To what extent have P/Ts achieved wait times reductions and guarantees of timely access to care?

3.2.1 Knowledge of Tools and Approaches

One of the short-term expected outcomes of the Fund was P/Ts obtaining a greater understanding of tools and approaches associated with the reduction of wait times and the implementation of PWTGs. The evaluation found that all of the funded projects involved the development and implementation of related tools and approaches. The types of tools and approaches were diverse, reflecting the wide range of different pilot project activities, including:

- Instruments to help manage or plan patient volumes and flow, including, among others, an urgency rating scale for coronary artery bypass graft patients in Saskatchewan, a surgical patient prioritization tool in Nova Scotia, clinical referral pathways in Manitoba, and a cancer patient monitoring application in New Brunswick;
- Information technology systems, including a web-based operating room booking system in Quebec, and a clinical referral Information Technology (IT) system in Manitoba;

- Recourse policies and agreements, including the development of an MOU among the Atlantic provinces to assist in providing recourse options for radiation therapy patients; and
- Health care infrastructure and equipment, including two critical care ambulances in Saskatchewan and a mobile mammography unit in the Northwest Territories.

See Annex E for a complete list of tools and approaches implemented by P/Ts.

When pilot project stakeholders were asked whether their project had increased understanding of the tools and approaches needed to establish guarantees and/or reduce patient wait times (rating of 4 or 5 on a 5-point scale), 15 indicated that their project had increased their understanding. The remaining five interviewees provided a rating of 3 on a 5-point scale. Many interviewees had indicated that while they previously had had an understanding of the tools/approaches needed to address concerns related to implementing guarantees, the Fund enabled the implementation of these tools/approaches, and a more fulsome understanding of their use and the extent to which they addressed their concerns (e.g., operational issues). This increase in understanding amongst jurisdictions of the tools and approaches associated with the reduction of wait times and the implementation of PWTGs permitted P/T health care systems to be better positioned to reduce wait times and address PWTGs.

3.2.2 Knowledge of Policy and Operational Issues

Another expected short-term outcome of the Fund was increased knowledge among P/Ts of policy and operational issues associated with the establishment of PWTGs. Various pilot projects implemented new tools and approaches specifically to address operational/policy issues faced in their jurisdiction. In addition, for some pilot projects, the actual implementation of new tools/approaches resulted in new operational/policy issues that needed to be addressed. Types of policy and operational issues that were addressed or encountered during the implementation of new tools and approaches included:

- “pushback” or resistance from some healthcare professionals regarding changes implemented as part of the pilot project (e.g., refusal to pool waiting lists, resistance to implementing a process for recourse);
- inconsistent reporting practices (e.g., questionable quality of data entry and inconsistent reporting due to lack of formal training and written guidelines);
- limited IT skills among some healthcare professionals;
- lack of integration between different IT systems within different parts of a province; and
- the “balloon effect” in wait times, in which improvements in wait times in one part of the system has a negative impact on others (e.g., reduction in wait times for cataracts leading to increases in wait times for other areas of ophthalmology).

Examples of comments from interviewees regarding operational/policy issues that their project confronted included:

“Before the project, we would just sort of assume that treatments were the same in different provinces, reporting practices were the same, etc. This is not the case.”

“Process-wise, I had a lot of surprises. The first was that we had no idea many clinicians lacked computers or basic computer skills. In many cases we had to provide computers to doctors so they could participate in the pilot. Luckily we built in a budget for this. It was also a shock that there was so little collaboration among members of the system in many ways.”

“...establishing guarantees for specified service areas would have adverse effects on other service areas, and reduce our flexibility to address overall service requirements in an effective and responsive way. Thus, the pilot project confirmed our need to actively monitor and manage wait times across the system in a way that is flexible and responsive, so that we can focus on the current bottlenecks and refocus resources when the context and bottlenecks shift.”

When pilot project stakeholders were asked whether their project increased understanding of policy and operational issues needed to establish guarantees and/or reduce patient wait times (rating of 4 or 5 on a 5-point scale), 15 indicated that their project had increased their understanding. The remaining four respondents provided a rating of 3 on a 5-point scale.

3.2.3 Collaboration and Knowledge Dissemination

Another expected short-term outcome of the Fund was strengthened collaboration and exchange of best practices amongst P/Ts. According to the funding authority submission, the Fund was expected to improve outcomes for patients by ‘encouraging collaboration and the exchange of best practices amongst P/T governments’. Collaboration and the exchange of best practices between P/Ts was expected to enable the Fund to achieve its medium-term outcomes of increasing understanding amongst jurisdictions on how PWTGs best fit within overall access strategies. This, in turn, was expected to ensure that provincial/territorial health care systems were better positioned to reduce wait times and address PWTGs.

The exchange of best practices/sharing of results with other jurisdictions and the public was considered an ‘essential’ criterion in the assessment of project proposals. All proposals were required to contain a dissemination plan for sharing results. However, jurisdictional/inter-jurisdictional collaboration was only considered a ‘desired’ criterion in the assessment of proposals. Consequently, P/Ts were not, in fact, obligated to collaborate with other jurisdictions. This may explain the wide range of responses when interviewees were asked to rate the extent to which their pilot project strengthened collaboration and exchange of best practices amongst P/Ts for the advancement of PWTGs and/or reduction of wait times. When pilot project stakeholders were asked whether their project had strengthened collaboration and exchange of ideas, six had indicated that their project had contributed “to a great extent” (rating of 4 or 5 on a 5-point scale), while 4 had indicated that their project contributed “to some extent” (rating of 3 on a 5-point scale). The remaining seven indicated that the pilot projects had little or no impact in this area.

One contributing factor to the limited sharing of results between P/Ts is that many of the Fund participants had only just completed the implementation of their pilot projects, so there had been limited time to undertake the dissemination of what was learned. Also, some of the interviewees suggested that inter-jurisdictional information-sharing was of limited interest to them. One project representative stated, for example, that "the work we were doing was not that related to the work of other provinces or territories." The specificities of each health care jurisdiction may limit, to some degree, the application of lessons learned or "best practices" from other P/Ts.

However, there were instances of significant collaboration and information-sharing among P/Ts. For instance, Manitoba communicated project findings within and across jurisdictions. PEI and New Brunswick also collaborated significantly as part of their pilot projects in order to develop an MOU between the four Atlantic provinces for recourse related to radiation therapy. PEI combined all 'Ready to Treat' data into a single, common interprovincial set of reports that included all four Atlantic provinces' wait times information.

In terms of dissemination of best practices, it is not clear if pilot project representatives were always in the best position to disseminate findings across P/Ts. Pilot project objectives varied (e.g., area of focus, operational issues specific to a jurisdiction, etc.), and other P/T representatives participating in the Fund were not necessarily the appropriate audience for project findings. The onus was on the pilot project representative to identify and communicate best practices to their counterparts in other jurisdictions, and in many cases their position within the P/T was not one in which they would be regularly participating in meetings with other P/T representatives, as that may occur more often at the most senior levels. However, all interviewees were open to the idea of sharing project findings with other jurisdictions.

In terms of inter-jurisdictional collaboration, and as noted above, PEI and New Brunswick collaborated significantly in the development of an MOU between the four Atlantic provinces for recourse related to radiation therapy. Yukon collaborated with British Columbia authorities in the development of protocols for recourse to facilities in British Columbia. The level of inter-jurisdictional collaboration among the other remaining pilot projects was minimal.

Although the level of collaboration and exchange of best practices amongst P/T governments varied, there was consensus among Fund participants that their projects had increased collaboration and knowledge exchange within their province or territory, and that this type of collaboration and information-sharing better addressed their own needs and priorities. For example, within Saskatchewan, the information sharing between the Regina Qu'Appelle and Saskatoon health regions resulted in a vast amount of learning and best practices that could be applied in future projects aimed at the reduction of patient wait times in that province.

The nature of collaboration and exchange of best practices is presented in Annex F.

3.2.4 Impact on Medium- and Long-Term Outcomes

As noted earlier, the purpose of the Fund was to support projects that developed, implemented and tested innovative approaches to reduce wait times and establish PWTGs. According to the logic model, the medium-term outcomes for the Fund were to increase understanding amongst

jurisdictions on how PWTGs best fit within overall access strategies and health care system reform, which in turn was expected to better position health care systems to reduce wait times and address PWTGs. The expected long-term outcome for the Fund was wait times reductions and guarantees of timely access to care.

Typically, medium- and long-term outcomes take years to achieve. However, many pilot projects were able to demonstrate the initial impact that they had had on medium-term outcomes, and a few were able to demonstrate the initial impact that they had had on the long-term outcomes. The extent to which these impacts can be sustained is not yet known, given the limited amount of time between the end of Fund and this evaluation.

In addition to the evaluation questions that were posed to assess the Fund's performance and effectiveness, the extent to which medium- and long-term outcomes were met was assessed through an examination of whether projects observed a reduction in wait times; whether recourse/access to alternate options of care were developed and implemented; the establishment of PWTGs in the pilot project area of focus; and the future plans of P/Ts for their pilot projects.

However, it is important to note that the P/T pilot projects may not have addressed all the components that form the basis of PWTGs – the establishment of a guarantee, recourse if that guarantee is not being met, and/or efforts to reduce wait times to ensure that the guarantee is met. Therefore, the analysis of these components is presented at the project level.

3.2.4.1 Reduction in Wait Times

In the short-term, pilot projects implemented new tools and approaches for reducing wait times and implementing PWTGs. However, the extent to which these tools and approaches contributed to reducing wait times and to the implementation of PWTGs within the life of the projects themselves was difficult to assess given the limited information in final project evaluation reports.

A more detailed breakdown of the impact that pilot projects have had on the reduction in wait times in their area of focus is presented in Annex G.

There were various challenges that influenced the ability to assess the impact of pilot projects on patient wait times. One key factor was that the overall scope of the pilot projects was sometimes narrow relative to the whole of the P/T health system within which they were implemented. For instance, the Manitoba project covered approximately 10% of primary care providers and 10% of the specialist referral practice, limiting the overall potential of impact on patient wait times. The final evaluation report for the Manitoba pilot project noted that:

“...the influence of BGSC was muted by the existing demand from the system which was not required to abide by BGSC timeframes, guidelines or processes for redirection. Expansion of scope and participation is required to truly identify the impact on wait time reduction for patients.”

Another key factor for some projects was that they were implementing systems to begin to monitor wait times for the first time – so there was no prior baseline data to fully determine whether projects had an impact on reducing wait times. Therefore, while some projects were able to indicate a certain timeframe was being met X percentage of the time, it was not always clear whether this was an improvement or whether it was a percentage that had consistently been met even before the pilot project.

There were a few projects that were clearly able to document a positive impact on wait times. For example, Yukon was able to track changes in wait times from a general practitioner’s referral to consultation with a specialist, and from specialist consultation to surgery, for cataracts and for hip and knee total joint replacements. Also, the introduction of a new mammography unit in the Northwest Territories project improved access for Hay River residents and resulted in the attainment of the project goal of over 70% of eligible patients being screened in 36 months. This goal was met within only 18 months of operation under the project.

It is important to note that while pilot projects may have contributed to the reduction of wait times in their specific area of focus, there are other contributing factors within the health care system influencing patient wait times. For example, the Fund represents only a small portion of recent federal investment in health care system reform, including wait times.

3.2.4.2 Recourse

PWTGs are comprised of two core elements: 1) a defined time-frame and 2) access to alternate care should that time-frame be exceeded. Access to alternate care options (recourse) is intended to give patients certainty that, should their wait time exceed the guaranteed timeframe, the system would automatically respond by offering options for obtaining timely care. Patients would not need to initiate a process to obtain alternate care options on their own and would ultimately decide whether or not to accept the options presented to them. All pilot projects were to develop and test alternate care options (recourse).

In review of the final evaluation reports, seven of the eleven pilot projects fully developed recourse options. Given that Quebec had already committed to a guarantee of access through Bill 33, its three pilot projects were framed somewhat differently to focus on measures that supported delivery of the guarantees they were establishing. The Nova Scotia pilot project, *Improving Access to Surgical Services*, developed the Patient Access Registry Nova Scotia (PAR NS) which was intended to be an interactive patient portal for initiating patient recourse. However, due to significant privacy and security issues, the portal was changed to a static, information-based website. Nova Scotia plans to address the privacy and security issues, and will continue with PAR NS, potentially using it to initiate patient recourse in the future.

Various complexities came into play that influenced the ability of some pilot projects to test the recourse policies/processes they had developed. Some provinces were unable to test recourse options given that all applicable procedures were falling within the set timeframes and recourse was never required. For instance, PEI was already meeting its provincial guarantee and national guidelines in radiation therapy. While the pilot project members from PEI helped to establish a mutual aid agreement among the Atlantic provinces, they did not end up testing recourse through

their pilot project. For other pilot projects, some patients indicated a preference for waiting out a longer timeframe rather than accepting the recourse of being transferred to another region or jurisdiction. For instance, the New Brunswick pilot project identified two patients who could have been candidates for transfer to another centre either within the province or in another province. Both of these patients declined these recourse options.

It should also be noted that in at least one pilot project, physicians stated that they were opposed to recourse as an option, which hindered further implementation. As noted by a pilot project stakeholder:

“Physicians feel that once they have built that initial relationship with the patients, they should see it through. They don't want patients transferred. And the surgeons are not our employees, so we can't make them. Also, there were issues in terms of physicians not wanting to pool their waiting lists.”

In total, six³ pilot projects were able to offer recourse to patients, and of those, three had patients that agreed to accept alternate care options. Annexe H provides a breakdown of the extent that recourse options were developed (i.e., protocols), offered and tested in the pilot projects. As noted above, the inability to test recourse options was not indicative of failure, as the pilot project may have resolved operational/policy issues ensuring that patients were receiving care within specified timelines, and thus did not require the implementation of recourse.

Overall, for those pilot projects that have developed a recourse strategy, all intended to maintain the associated tools and approaches (i.e., protocols, transport infrastructure). Although various P/Ts offered recourse to patients who were not treated within established wait times guarantees, a key lesson learned from some pilot projects was that patients preferred to wait for treatment/care with their current specialist, rather than travel to other regions or jurisdictions when the maximum wait time was exceeded. Another noted lesson learned from the implementation of recourse strategies was that physicians may actively reduce their wait lists so that recourse is not required, above and beyond other reasons for reducing wait times for patients.

3.2.4.3 Establishment of Patient Wait Times Guarantees

The majority of pilot projects demonstrated how PWTGs can be operationalized within the publicly-funded health care system through the testing of recourse and wait times management approaches needed to implement guarantees. Pilot projects were expected to help P/Ts as they worked to establish PWTGs, regardless of whether the projects were focused on the clinical area identified in their respective provincial/territorial MOUs. Further details on the extent to which pilot projects helped to inform provincial/territorial approaches to the reduction of wait times and the establishment of PWTGs in the future are contained in Annex I.

³ Recourse for one pilot project was not tested as the guarantee was already being met.

3.2.4.4 Future of Pilot Projects

Another indicator of the extent to which the Fund contributed to better positioning health care systems to reduce wait times and address PWTGs was the commitment of P/Ts to continue to expand on the funded pilot projects' activities. In fact, all pilot projects indicated that they planned to continue to make use of the tools and approaches resulting from their pilot projects. Some P/Ts also indicated that they have chosen to expand the scope of the work initiated under their projects. For instance:

- The Northwest Territories has decided to expand the geographic area of its initiative to include the South Great Slave Lake region. This was expected to result in the reduction of wait times for breast screening for an additional 400 women.
- Prince Edward Island indicated its intention to expand the procedures, practices and tools developed to reduce radiation therapy wait times to the area of medical oncology.
- Manitoba intended to have 600 primary care providers using the BGSC system (clinical referrals pathways and IT system) and 50% of specialists receiving referrals via BGSC by 2011-12. BGSC was planned to be integrated into the electronic medical records systems in Family Practitioners' offices, which would further expand participation and use. It was expected that expansion would result in significant improvements to patient journeys, communication among providers, patient wait times and resource utilization.

Overall, pilot projects demonstrated how PWTGs can be operationalized within the publicly-funded health care system through either the testing of recourse and/or wait times management approaches. The intent of P/Ts to continue with all, or aspects of, their pilot projects reflected the fact that health care systems will be better positioned to reduce wait times and address PWTGs, thus leading to wait times reductions and guarantees of timely access to care.

3.3 Performance – Efficiency, Economy

The findings of the evaluation of the Fund on the issue of performance – efficiency and economy – are presented in this section of the report. The evaluation questions considered in addressing this issue were:

- Were the most appropriate and efficient means used to achieve Fund results?
- Was the Fund implemented efficiently and economically?

Pilot Projects:

Representatives from the pilot projects were asked whether they felt that the Fund had been a cost-efficient way to achieve results. From a P/T perspective, 10 of those with an opinion said that they felt it had been. Reasons given included that the Fund's contribution agreements had

ensured that the funding was used for particular purposes (i.e., not diverted to other P/T issues), and it had allowed the projects to use this funding to leverage additional resources/funding from their province/territory. For example, in New Brunswick, the provincial government provided additional funding to increase capacity in one of the Cancer Centres participating in the project. One interviewee noted that their project was cost-effective “*in that it provided seed funding to allow us to get systems in place that, once the pilot was over, the province stepped in and supported, such as our IT system.*”

When P/T interviewees were asked whether there were any aspects of their project that could have been delivered more cost-efficiently, among those that provided a response, 13 indicated that there were not.

Administration of the Fund:

The approved funding authority of \$30 million over three years included up to \$720,000 in operations and maintenance dollars for the administration of the Fund, and a total approved allocation of \$29,280,000 in contribution dollars for the Fund. Of these contribution dollars, \$25,350,382 was budgeted through contribution agreements to the pilot projects. In other words, 86.5% of the original budget allocated for the Fund for contributions was allocated to the pilot projects according to their contribution agreements.

Of the amount allocated through contribution agreements to pilot projects (\$25,350,382), actual contribution spending ended up totaling \$22,811,433. Table 3 provides a breakdown by fiscal year.

Table 3
Pilot Project Resources – Budget and Actual (Contribution Dollars)

| | Budget | Actuals |
|---------------|---------------------|---------------------|
| 2007/08 | \$3,666,207 | \$3,249,332 |
| 2008/09 | \$11,452,863 | \$10,373,389 |
| 2009/10 | \$10,231,312 | \$9,188,712 |
| TOTALS | \$25,350,382 | \$22,811,433 |

There appear to be two reasons for the lapsing of funds. First, although Ontario initially expressed interest in the Fund, in the end the province decided not to go forward with any projects⁴. As a result, two proposed Ontario projects that had been recommended for funding from Health Canada were withdrawn. Secondly, P/Ts did not receive funds until late in the fourth quarter of the first year. As a result, some of the projects were not able to spend all of their budgeted allocation for that first year. In some cases, the delayed start of projects subsequently had an effect on the second and third years because project “start-up” activities that should have occurred in the first year were not able to take place until the second year.

⁴ According to Health Canada, the province had expressed concern with the contribution funding mechanism used by Health Canada for these projects.

Overall, then, just over three-quarters (77.9%) of the original budget for contributions was spent (Table 4).

Table 4
Fund Resources – Budget and Actual (Contribution Dollars)

| | Total Amounts | Proportion of Approved Total Allocation |
|---|---------------|---|
| Approved Total Allocation | \$29,280,000 | 100.0% |
| Contribution Agreement Approved Amounts | \$25,350,382 | 86.5% |
| Actual Spending | \$22,811,433 | 77.9% |

Health Canada did reallocate surplus funds that were identified early on. They were first used for other projects under the Fund, with the remainder put toward a major national project funded under the HCPCP related to timely access to, and guarantees for, pediatric surgical care. The project was consistent with the broad goals of the Fund.

In addition, as is the case with all such programs, surplus funds identified later in each fiscal year (such as projects coming in under budget in the final quarter) remained unspent and were returned to departmental revenues. However, these lapses were fairly minimal as project budgets were closely monitored and any planned under-spending was identified early enough to allow most unused funds to be reallocated within the HCPCP.

Overall, pilot project representatives indicated that the most appropriate and efficient means were used to achieve Fund results. From a Health Canada perspective, the Fund was able to allocate over three-quarters (77.9%) of the original budget to pilot projects and the majority of the funds allocated were expended by P/Ts on their pilot projects. The department was also able to reallocate the majority of remaining funds to another project related to PWTGs.

The assessment of efficiency and economy encompasses relevance and performance. As noted earlier in the report, there was an identified need for the federal government to invest in pilot projects related to PWTGs and reducing wait times, and the pilot projects contributed to Fund objectives.

Comments from pilot project interviewees related to whether their project was efficient and economical included:

“... from a systems point of view, this type of project is important because it shows Canadians we are accountable.”

“Finally, although there is an initial investment in building a new system, this new project allows the whole reporting and tracking to be more cost-efficient because it takes less time and resources to do reporting.”

“Model has been looked at critically across the country. Provinces in the Atlantic will likely use it. (NS, PEI). Other cancer centers will want to use it (have shown interest). Tracking progress of patient in system.”

The Fund, having spent slightly over three-quarters of allocated funds, successfully funded eleven projects, all of which indicated that all, or aspects, of their pilot projects were expected to continue and to have a positive impact on the reduction of patient wait times in the future.

3.4 Design and Delivery

The findings of the evaluation of the Fund on the issue of design and delivery are presented in this section of the report. The evaluation questions considered in addressing the issue of Fund design and delivery were:

- What lessons have been learned with regard to the planning, design and delivery of the Fund?
- Have management practices for the Fund been effective?

3.4.1 Design

Eleven project stakeholder interviewees considered the Fund to have been an effective vehicle to support the establishment of PWTGs and the reduction of wait times. The use of contribution agreements as a funding vehicle enforced some rigor on the use of, and accountability for, the funding, in that it required that P/Ts spend the money as outlined in the agreement. One pilot project representative noted, for example, that “having the funding managed by Health Canada in the way that it was forced us to dedicate energy to meeting specific expected activities, outputs, and deadlines, which meant that we got things done as expected.” Another stated “the federal dollars forced the funding to be focused on particular system improvements.”

Seven interviewees also noted that the Fund was effective in that it afforded the opportunity for P/Ts to provide additional funds or make in-kind contributions to the projects. For example, one project representative noted:

“Our project allowed us to get more capacity moving forward than the province otherwise would have given. We are going to have two new positions that I have been wanting for a long time and would not have got without the seed of this project.”

It was noted that, by their nature, pilot projects can present a risk because, if the test project proves to be successful, there is the subsequent need to find ongoing funding to keep the project activities going. If this funding is not available, the pilot project can raise expectations that cannot be realized. However, no specific examples of this problem having materialized in the pilot projects were noted in the interviews.

While there was limited time to put the Fund in place, the overall concept of supporting pilot projects to advance policy objectives was a success. In fact, as noted earlier, 17 pilot project recipients indicated that their pilot project would likely not have gone ahead in the absence of the funding from the Fund. Setting up the funding to P/Ts as contribution agreements was effective in ensuring that resources were directed towards specific purposes with clear outputs and outcomes.

3.4.2 Delivery

Interviewed representatives of the pilot projects were asked to comment on the effectiveness of management practices for the Fund. Nine interviewees noted that their interactions with Health Canada had been very positive. It was noted that the Health Canada team had been responsive, helpful and flexible. As one interviewee stated: *“I was very happy with the Health Canada staff that were assigned to my project—they were very helpful, easy to reach, and would get me answers to my questions quickly.”*

The timelines for the development of proposals were said by four interviewees to have limited the amount of consultation with physicians that had happened in the development of the project designs. One pilot project representative stated: *“We had a very short period of time to put together our proposal [...]. Then we heard back and immediately had to get the project going. So there was very little time to engage physicians in the development of the program.”* This perceived lack of consultation during the project design was felt to have contributed to later resistance among physicians with aspects of the project’s implementation. While formal timelines were tight, all jurisdictions were aware and engaged earlier and so they had some advance notice, as P/Ts were involved in the development of the Fund guidelines and criteria.

Also related to timelines, four interviewees mentioned that it had taken considerable time to receive the funding from Health Canada once their project had been deemed successful, but only a couple indicated that this had been a significant problem for their project. In fact, in order to mitigate the initial delays in funding, Health Canada provided early notice that it would retroactively recognize expenses, thus allowing for the term of the agreement to start in November 2007.

Seven interviewees noted that the restrictions on spending as a result of the stipulations of their contribution agreements had been an issue. Re-allocating funding to different cost categories was said to have been administratively burdensome and time-consuming. Furthermore, interviewees noted that unspent funds were not allowed to be carried over into the following year, which some felt had been an unnecessary stipulation.

Although timing for the preparation of proposals was tight, and thus a challenge for recipients, overall, the management practices for the Fund were considered effective. Health Canada staff worked through very tight timelines to put the Fund in place, and overwhelmingly pilot project recipients noted the effectiveness of the Health Canada staff and of the Fund.

4. CONCLUSION

The PWTG Pilot Project Fund appears to have successfully addressed the Government of Canada priority of informing the establishment of PWTGs.

The pilot projects have been successful at testing new approaches and tools to reduce wait times and implement PWTGs. P/Ts have benefited from their projects and intend to move forward with the knowledge gained and with systems and processes put in place during their pilot projects. According to recipients, the pilot projects would likely not have gone ahead in the absence of the Fund.

At the level of short-term outcomes, the Fund demonstrated considerable success related to two of its three expected outcomes. The Fund resulted in a greater understanding of tools and approaches associated with the reduction of wait times and the establishment of PWTGs, and of policy and operational issues associated with the establishment of PWTGs. This was evidenced through the diversity of tools and approaches that were developed as part of the projects, which ranged from instruments to manage patient volumes and flow to IT systems and other tools, and the implementation of new tools and approaches specifically to address the policy and/or operational issues associated with the establishment of PWTGs in the jurisdictions.

The evaluation found that there had been comparatively weaker results in achieving the third short-term outcome: strengthened collaboration and exchange of best practices among P/Ts. In all but a few instances, at the time of the evaluation, pilot projects had not collaborated or shared the knowledge they had obtained with other P/Ts. This was the result of many factors, including that project members were sometimes not in the best position to identify their counterparts in other P/Ts and share information across jurisdictions. This finding suggests a potential future role for Health Canada in supporting the dissemination of learning from pilot projects.

While medium- and long-term outcomes can typically take years to achieve, the Fund had begun to demonstrate some results in these areas at the time of the evaluation. Jurisdictions indicated an increased understanding of how guarantees fit within overall access strategies and system reform, and were better positioned to reduce wait times and address PWTGs. Although the Fund's long-term outcomes of wait times reductions and guarantees of timely access to care were more difficult to assess given that the projects were time-limited, there were a few examples of projects that were clearly able to demonstrate a reduction in wait times as a result of project activities and several jurisdictions were able to implement recourse options. Finally, many P/Ts have decided to expand on the scope of the pilot project tools and approaches in the future.

Given that the Fund had met or is on track to meeting its outcomes, and that its funds had been managed appropriately, the evaluation concludes that the Fund was implemented efficiently and economically.

This evaluation does not include any specific recommendations given that the Fund has ended. Rather, the evaluation results are intended to inform an evaluation of the HCPCP to be completed in 2012-2013. Based on the findings of the evaluation, it appears that the Fund has successfully supported three of the expected immediate outcomes of the HCPCP.

The Fund's support for knowledge-building related to the tools and approaches associated with the reduction of wait times and the implementation of PWTGs, and for greater awareness and understanding of the policy and operational issues associated with the establishment of PWTGs, have contributed to the achievement of the HCPCP's immediate outcome of increased knowledge and understanding of health care system performance and new approaches, models, and best practices.

Within the P/Ts the Fund has also contributed to improved collaboration and coordination in the pilot project area of focus, supporting the HCPCP immediate outcome of improved collaboration on, and coordination of, responses to priorities and barriers. The intent of all P/Ts to continue with all, or aspects of, their pilot projects indicates that health care systems are better positioned to reduce wait times and address PWTGs, supporting the HCPCP immediate outcome of adoption of new approaches, models, and best practices.

Annex A – Selection Criteria

Guiding Principles

- The PWTG Pilot Project Fund should be used to test patient wait times guarantees in a broad range of clinical areas across one or more of the five priority areas (cardiac, cancer, joint replacement, sight restoration, diagnostic imaging), recognizing that the Yukon, Northwest Territories and Nunavut deliver a limited range of acute care health services. If a proposal does not test in one of the five priority areas, it should demonstrate significant innovation or the prospect of a significant benefit to patients (e.g. via wait times reduction, access to alternative care options).
- PWTG pilot project funding should not be used as the provincial/territorial cost-share of Infoway projects. However, where pilot projects have an information technology component, they should be undertaken to the extent possible in the context of Canada Health Infoway Inc. investments to ensure inter-operability and a pan-Canadian approach.
- To ensure the transfer of knowledge and the exchange of best practices, results of pilot projects, including evaluations, should be shared with other jurisdictions and the public.
- A PWTG is understood to consist of two key components: a defined timeframe, and access to alternative care options (recourse) should that timeframe be exceeded. Access to alternative care options (recourse) would give patients the certainty that should their wait time exceed the defined timeframe, the system would automatically respond by offering options for obtaining timely care (e.g. ranging from reassessment of patients' priority levels, to access to another provider within the same institution or region, through to service outside the jurisdiction). Patients would not need to initiate a process for recourse on their own. Whether or not the patient accepts such alternative care options, however, is ultimately their choice.

Essential criteria that project proposals must meet in order to be eligible for funding consideration include:

- Demonstrate how PWTGs can be operationalized within the publicly-funded health care system, including the testing of recourse and wait times management approaches needed to support guarantees;
- Demonstrate substantial innovation and/or an opportunity to effect significant change;
- An evaluation plan, which should address elements such as the implications for patient care, an evaluation of policy and operational issues associated with the development and delivery of a PWTG in the area tested, an assessment of the impact on patient wait times, and the viability of recourse options tested; and,
- A dissemination plan for sharing results, including evaluations, with other jurisdictions and the public.

While not essential, other desired factors could be considered while assessing proposals, such as the degree to which they:

- Involve jurisdictional/inter-jurisdictional collaboration;
- Engage relevant health care providers, patients, other stakeholders, and experts; and,
- Apply to other jurisdictions (e.g. P/Ts, regional health authorities), and/or inform the work of other jurisdictions, and provide the potential for broader implementation where appropriate

Annex B – Pilot Project Descriptions

| Province / Territory | PROJECT |
|----------------------|---|
| Saskatchewan | <p>Title: Coronary Artery Bypass Graft (CABG) Surgery Recourse Pilot Project</p> <p>Description: Pilot project designed to test and evaluate a recourse strategy that offered patients access to Coronary Artery Bypass Graft surgery at other sites as they approached the recommended maximum waiting time as determined by the Cardiac Care Network of Ontario Priority Scoring Tool.</p> |
| Manitoba | <p>Title: Bridging General and Specialist Care: The Right Door, the First Time</p> <p>Description: Pilot project that tested patient wait times guarantees, including recourse, for referrals by general practitioners to specialists. The project covered eleven practice areas, including cancer services and orthopaedics. Information technology (IT) systems were developed to support improved referral processes with the goal of providing seamless, timely and appropriate care to patients. Objectives included shorter wait times, reductions in inappropriate referrals and elimination of unnecessary lab and diagnostic tests.</p> |
| Quebec | <p>Title: Clinique interdisciplinaire en musculo-squelettique</p> <p>Description: Pilot project intended to improve access and certainty of timely care for orthopaedic services for musculoskeletal problems. The project established three clinics that tested a new continuum of care for patients who required musculoskeletal related services. The continuum was patient-centred and reorganized interdisciplinary services to allow patients quicker access to a variety of services (physical therapy, nursing, occupational therapy, dietician, pharmacists, psychologists, physical educators, etc.) that could help treat their conditions.</p> |
| Quebec | <p>Title: Requête Web opératoire</p> <p>Description: Pilot project intended to reduce wait times for hip and knee replacements and cataract surgeries. This was achieved by developing and introducing a web-based operating room booking system in which all surgeons and their secretaries were able to schedule operating room time for their patients using the Web. This tool, tested at St. Mary's Hospital in Montreal, helped providers meet the province's guarantee of access in joint replacement and cataract surgery.</p> |
| Quebec | <p>Title: Défi qualité performance dans la réduction des délais d'attente pour les arthroplasties de la hanche et du genou</p> <p>Description: Pilot project that tested whether a comprehensive continuum of patient care for hip and knee replacement surgeries could shorten the length of hospital stay and make more surgical beds available more quickly. The project developed and tested a set of tools designed to help practitioners, patients and their caregivers anticipate and meet the unique needs of each patient related to their surgery and recovery period. These tools facilitated planning and improved efficiency prior to patients' admission to hospital, during their hospital stay and following release from hospital.</p> |
| Nova Scotia | <p>Title: Improving Access to Diagnostic Services</p> <p>Description: Pilot project designed to improve access to diagnostic imaging services. The goal of the project was threefold: improve the appropriate use of diagnostic imaging services; improve efficiencies in diagnostic imaging departments; and engage patients in choosing where and when they receive care.</p> |

| Province / Territory | PROJECT |
|-----------------------|---|
| Nova Scotia | <p>Title: Improving Access to Surgical Services: A Patient Portal for Orthopaedics</p> <p>Description: Pilot project to improve access to orthopaedic surgical services by building a better information base for decision making and by testing recourse options when wait time timeframes were exceeded and the implications of these options for patients and the health care system.</p> |
| New Brunswick | <p>Title: Radiation Therapy Wait Time Guarantee Pilot Project</p> <p>Description: Pilot project that developed, implemented and tested a process to move patients efficiently through their radiation therapy care journey. This process included PWTG components triggered by recourse flags (i.e., moving patients from one facility to another or reviewing a patient’s treatment plan as they wait for treatment) and the development of a change management process to maximize provider participation.</p> |
| Prince Edward Island | <p>Title: Saving Time and Saving Lives: A Provincial Strategy for Ensuring Radiation Therapy Patient Wait Times Guarantee</p> <p>Description: Pilot project that developed and implemented a multifaceted strategic plan that was designed to ensure the ongoing ability to meet radiation therapy patient wait time guarantees by substantially increasing provincial capacity to meet projected demand for this cancer treatment modality.</p> |
| Yukon | <p>Title: Testing the Feasibility of Providing Recourse to a Wider Range of Service Location Options for Specified Out-of-Yukon Services and Procedures</p> <p>Description: Pilot project that tested the feasibility of providing patients in Yukon with recourse when they had been waiting longer than a defined timeframe for out-of-territory travel for hip or knee replacement surgery, cardiac care, cancer care or ophthalmology. This timeframe was established following the development of criteria to determine when it is appropriate to provide Yukon patients with recourse through a wider range of choice in service providers and locations.</p> |
| Northwest Territories | <p>Title: Screening Mammography Program: A Patient Wait Times Guarantee Pilot Project</p> <p>Description: Pilot project designed to improve access to and certainty of timely care in mammography screening, with the end goal of reducing breast cancer mortality and morbidity. This was to be achieved by developing a coordinated organizational approach to mammography screening, implementing a mobile mammography unit, and offering/testing guaranteed timeframes for service and recourse options should these timeframes be exceeded.</p> |

Annex C – Evaluation Template

The following template is intended to provide a framework for collecting data to support the evaluation of the Patient Wait Times Guarantee Pilot Project Fund. Please answer the following questions as they relate to your pilot project.

As you know, patient wait time guarantees have two key components: 1) an established timeframe for treatment; and 2) the provision of alternate care options (recourse) if this timeframe is exceeded (i.e., any patient not treated within the timeframe would automatically be offered an alternative, such as access to another health care provider or to service in another setting). In your responses related to patient wait times guarantees, please specify, wherever possible, to what extent one or both of these two components was addressed / affected.

A. Project Profile

| |
|---|
| 1. Please describe your pilot project's objectives. |
| |
| 2. What activities were undertaken during the pilot project? |
| |
| 3. Was the project carried out as originally planned? If not, why not (i.e., were there delays in commencing, changes to project methodology, etc.)? |
| |
| 4. What new / modified tools and approaches for <u>reducing wait times</u> were implemented, if any? (Examples of tools and approaches could include research reports, databases, guidance documents, collaborative networks, and information-sharing mechanisms.) |
| |
| 5. What new / modified tools and approaches for <u>establishing patient wait times guarantees</u> were implemented, if any? |
| |

B. Project Outcomes

| AWARENESS AND UNDERSTANDING | |
|---|--|
| 6. | Describe how your pilot project contributed to a greater awareness and understanding of policy and operational issues related to the establishment of patient wait times guarantees (e.g., system readiness, costs, role of physicians, effects on resource allocations). |
| | |
| 7. | Describe how your pilot project contributed to a greater understanding of tools and approaches associated with the reduction of patient wait times. |
| | |
| 8. | Describe how your pilot project contributed to a greater understanding of tools and approaches associated with the establishment of patient wait times guarantees. |
| | |
| 9. | Describe any best practices and/or lessons learned that were identified as a result of your pilot project that are transferrable within your jurisdiction or to other jurisdictions. |
| | |
| COLLABORATION AND KNOWLEDGE EXCHANGE | |
| 10. | Describe any collaboration or exchange that did or will occur between your province/territory and any others as a result of your pilot project. This can include provinces and territories that did not have a project funded through this fund. |
| | |

Guarantees And Health Care System Reform

11. Did your pilot project identify any barriers or challenges to establishing patient wait times guarantees? If so, describe how they were reduced or removed, or why you were unable to reduce/remove them.

12. a. What impact did your pilot project have on the reduction of patient wait times?

12. b. What impact do you expect your pilot project to have on the reduction of patient wait times in the future (if any)?

13. a. What impact did your pilot project have on the establishment of patient wait times guarantees?

For example:

- Is there increased understanding amongst jurisdictions on how patient wait times guarantees best fit within overall access strategies and health care system reform?
- Is your health system better positioned to reduce wait times and implement patient wait times guarantees?
- Have there been changes to the health care system that have resulted or may result from your pilot project (e.g. legislative changes to accommodate new tools/approaches, new policies adopted or informed)?
- Have guarantees of timely access to care been implemented?

13. b. What impact do you expect your pilot project to have on the establishment of patient wait times guarantees in the future (if any)?

Annex D – Evaluation Interviews

| Province | Project | Total # of Interviews |
|-------------------------------|---|------------------------------|
| SK | Coronary Artery Bypass Graft (CABG) Surgery Recourse Pilot Project | 4 |
| MB | Bridging General and Specialist Care: The Right Door, the First Time | 6 |
| QC | Clinique interdisciplinaire en musculo-squelettique | 1 |
| QC | Requête Web opératoire | |
| QC | Défi qualité performance dans la réduction des délais d'attente pour les arthroplasties de la hanche et du genou | |
| NB | Radiation Therapy Wait Time Guarantee Pilot Project | 3 |
| NS | Improving Access to Diagnostic Services | 4 |
| NS | Improving Access to Surgical Services: A Patient Portal for Orthopaedics | |
| PEI | Saving Time and Saving Lives: A Provincial Strategy for Ensuring Radiation Therapy Patient Wait Times Guarantee | 3 |
| NT | Screening Mammography Program: A Patient Wait Times Guarantee Pilot Project | 3 |
| YK | Testing the Feasibility of Providing Recourse to a Wider Range of Service Location Options for Specified Out-of-Yukon Services and Procedures | 3 |
| Health Canada | | Total # of Interviews |
| Health Canada Representatives | | 4 |

Annex E – Tools and Approaches Implemented by Pilot Projects

| Province | Project Title | Tools/Approaches |
|-----------|--|---|
| SK | Coronary Artery Bypass Graft (CABG) Surgery Recourse Pilot Project | <ol style="list-style-type: none"> 1) A process to identify patients who are approaching their recommended maximum wait time (RMWT) as determined by the Cardiac Care Network of Ontario urgency rating scale, which: <ul style="list-style-type: none"> - established a common data system and provincial reporting data to be used by Saskatoon and Regina Qu’Appelle Regional Health authorities for tracking, management and evaluation of CABG wait times; and - ensured that data from the APPROACH database in Regina and Saskatoon is routinely entered into the Surgical Registry System. The health authority is responsible for entering this data and for ensuring patients are deemed urgent or emergent. <p>The Regina Qu’Appelle and Saskatoon Regional health authorities will use the APPROACH system to collect and report CABG surgery data to Saskatchewan Health, which will provide the baseline and evaluation data for the Cardiac CABG Surgery Wait time project.</p> 2) A software solution within the Surgical Registry to identify patients who are approaching their RMWT. 3) A process to offer identified patients a recourse option of having their surgery at an alternative site. 4) A critical care transportation infrastructure to provide patients with safe, comfortable transportation to the alternate site at no cost to the patient. |
| MB | Bridging General and Specialist Care: The Right Door, the First Time | <ol style="list-style-type: none"> 1) Clinical referral pathways for 11 specialty areas. 2) A Catalogue of Specialized Services, which is an online, searchable listing of specialists, their office locations and contact information, and the specific services they provide. The Catalogue provides family physicians and other referring practitioners with easily accessible information to aid in the referral of patients to specialized services. 3) A Bridging General and Specialist Care (BGSC) ISS (e-referral system), which streamlines communication between the referring general practitioner and specialist. The system is used by family physicians, nurse practitioners and specialists throughout Manitoba to follow primary care pathways and send referrals and consultation requests electronically, as well as to provide notification and suggestions on how to proceed in the event that referrals do not meet selected criteria. The BGSC pathways can also be used by many clinicians who do not use the IT system (i.e., who use the paper form). 4) The Patient Access Registry Tool (PART), an electronic system for the capture and registration of patients waiting for consultation, specialist and surgical services throughout Manitoba. The use of the PART system enables clinicians and their offices to track patient wait times and ensures that no patients “fall through the cracks”. The eBooking module of PART has been launched. eBooking allows surgeons offices to send operating room (OR) booking information electronically to the facilities they operate out of, enabling more timely and seamless communication with the pre-anesthesia clinics and OR. |

| Province | Project Title | Tools/Approaches |
|----------|--|--|
| QC | Clinique interdisciplinaire en musculo-squelettique | <ol style="list-style-type: none"> 1) Three interdisciplinary clinics, which engage hospital administrators, orthopaedic surgeons, family physicians, nurses, physical therapists, and other health care professionals, in order to provide an innovative continuum of care for patients. The clinics are patient-centred and offer integrated services to patients. 2) Clinical pathways, to help reduce the number of inappropriate visits to orthopaedic surgeons. |
| QC | Requête Web opératoire | <ol style="list-style-type: none"> 1) A web-based operating room booking system, which allows surgeons and their secretaries to schedule operating room time for their patients using the Web. 2) An organigram to map the flow of information and interconnections between departments within the hospital, the external physician's offices and the Ministère de la santé et des services sociaux. |
| QC | Défi qualité performance dans la réduction des délais d'attente pour les arthroplasties de la hanche et du genou | <ol style="list-style-type: none"> 1) Manuals for both hip and knee surgery patients, which detail the patient's journey through the process – from pre-hospital to rehabilitation. 2) An assessment grid and critical care pathway for use in determining a patient's length of stay and post-operative follow-up. |
| NB | Radiation Therapy Wait Time Guarantee Pilot Project | <ol style="list-style-type: none"> 1) The Cancer Treatment Access Repository application, a tool to facilitate the monitoring and management of patient wait times throughout the radiation treatment process, including the introduction of recourse interventions should that become necessary. 2) The Simulation Modeling tool, which allows for analysis of the impact of technology advances and resource limitations based on future population and cancer incidence projections, and which will facilitate the process of addressing issues and minimize any negative impact before problems become critical. 3) A website to publicly report on wait times in order to provide accurate and timely information on radiation therapy. 4) Establishment of common definitions associated with wait time monitoring, including for Ready to Treat date, Recourse options, Wait 1, Wait 2, Wait 3, and patient on hold (i.e., patient waiting for other treatments or events to be finished before being ready to treat such as surgery or finishing chemotherapy treatments). 5) An MOU with the Atlantic provinces in the area of external beam radiation treatment. The MOU recognizes that the provinces will work together to provide for the strategic and operational framework to guide the referral of patients between the provinces so patients who require radiation therapy services will receive timely access to their treatment within the eight week guarantee period. |
| NS | Improving Access to Diagnostic Services | <ol style="list-style-type: none"> 1) Appropriateness Component: Medicalis Smart Req software and Decision Support Server developed to assist users in making appropriate determinations of which DI test to order by offering alternate suggestions consistent with the Canadian Association of Radiology Guidelines. 2) Efficiency Component: A forecasting model for predicting diagnostic imaging (DI) wait lists, an automated reminder call system, patient notification letters containing preparatory information, and improved data sources for public wait time reporting. 3) Patient Choice Component: An approach for initiating choice from the DI department after the requisition is received and for booking outlook reports for viewing wait times at participating districts. |

| Province | Project Title | Tools/Approaches |
|----------|---|---|
| NS | Improving Access to Surgical Services: A Patient Portal for Orthopaedics | <ol style="list-style-type: none"> 1) Validation of current surgical wait lists. This allowed wait time data to be updated prior to uploading the wait lists into the provincial wait list repository (Provincial Access Registry for Nova Scotia (PAR NS)), and reduced the waitlist for four districts by approximately 25-30%. 2) Standardized policies and procedures governing the process for wait listing patients, ensuring the wait list is up-to-date, and the appropriate use of PAR NS. 3) The Nova Scotia Surgical Care Network – a multi-disciplinary collaboration of health care professionals designed to make recommendations on patient prioritization tools, time frames for access to surgery, and wait time reduction strategies. 4) Clinical Prioritization Tools – Standardized tools to assess patient acuity for all surgical specialties. 5) PAR NS – A provincial repository of wait times to enable accurate and timely wait time monitoring and reporting. 6) Provincial Report Rollout Strategy and Sustainability Plan – A provincial strategy for the release of PAR NS database reports and a provincial approach to assessing wait time data. 7) Provincial Access Manager Committee – A new Provincial Access Manager Committee to allow the districts and the Department of Health to discuss shared challenges and standardized approaches to PAR NS activities. |
| PEI | Saving Time and Saving Lives: A Provincial Strategy for Ensuring Radiation Therapy Patient Wait Times Guarantee | <ol style="list-style-type: none"> 1) An MOU that outlines the commitment of the Atlantic provinces to provide timely access to external beam radiation treatment. The MOU provides further understanding of the patient wait times guarantee by outlining the commitments of the parties involved, defining what constitutes a patient being deemed 'ready to treat', what constitutes an appropriate candidate for the recourse option, as well as the procedures and processes involved in the recourse option and data sharing. 2) Development of work-flow processes, to provide a visual procedural guide for both current and new processes within the PEI CTC, to aid in the reduction of patients wait times as well as to ensure proper process take place in regards to the guarantee and recourse options. 3) The establishment of collaborative networks (e.g. the Atlantic Interprovincial Radiation Therapy Access Committee). 4) New reporting tools to monitor each patient's wait time in the referral to treatment continuum. Alerts are given when a patient is in danger of not being treated within the eight-week guarantee. The collection of pertinent wait time data within the ARIA Oncology system was established. 5) Piloting of the Radiation Oncology Residency Elective Program, which is a response to the need to recruit additional radiation oncology specialists to the region. |
| NT | Screening Mammography Program: A Patient Wait Times Guarantee Pilot Project | <ol style="list-style-type: none"> 1) A digital mobile mammography unit, which allows for greater detail and resolution than a traditional film/screen mammography unit. 2) A focus on patient education, including the use of a video on how to perform a self-examination that features residents of the NT. 3) Follow-up protocols: all patients requiring follow-up are now contacted and an appointment is arranged as soon as possible. |

| Province | Project Title | Tools/Approaches |
|----------|---|---|
| YK | Testing the Feasibility of Providing Recourse to a Wider Range of Service Location Options for Specified Out-of-Yukon Services and Procedures | <ol style="list-style-type: none"> 1) The Arthroplasty Referral Form is now required for all Arthroplasty Referrals – Completion of the form assists with more complete and accurate data being provided by the referring physician. 2) Guidelines to Data Entry of Patient Information – The guidelines enable the determination of a patient’s wait time in a consistent manner. 3) Development of Scheduled Queries in Meditech – This tool can track more specified reasons for referral and each record; however, each visit is a stand alone record. 4) New protocol for cataract referrals – A new protocol is in place, through which every cataract referral by a physician first goes to an optometrist for initial triaging and, where appropriate, is treated by the optometrist. 5) Meditech Referral Management Module – The Module combined with the development of the Scheduled Queries will allow for the tracking of referrals and the consolidation of all records concerning referrals. 6) Delta Ware program – developed within Health and Social Services, this program allows the costs from the Recourse Option to be tracked separately and reported by finance officials within the department. 7) Reporting of wait time information by the Specialist Clinic – The Specialists Clinic will now be producing wait times reports, as set down in the information and reporting processes/ requirements. 8) Criteria to track entire patient wait time for Segment 1 (from general practitioner referral to consult with a specialist) and Segment 2 (consultation to treatment) have been established. |

Annex F – Collaboration and Exchange of Best Practices

| Province | Project | Collaboration/Exchange of Best Practices |
|----------|---|--|
| SK | Coronary Artery Bypass Graft Surgery Recourse Pilot Project | Within province. |
| MB | Bridging General and Specialist Ca`re: The Right Door, the First Time | Publications, presentations (e.g., “Taming of the Queue” conference), hosting workshops (e.g, attendees from provincial and regional jurisdictions), and contact with interested organizations. |
| QC | Clinique interdisciplinaire en musculo-squelettique | Within province. |
| QC | Requête Web opératoire | None noted. |
| QC | Défi qualité performance dans la réduction des délais d’attente pour les arthroplasties de la hanche et du genou | No information |
| NB | Radiation Therapy Wait Time Guarantee Pilot Project | MOU between the four Atlantic Provinces and NB and soon Quebec. Also, the creation of a permanent inter-provincial committee on the subject matter. |
| NS | Improving Access to Diagnostic Services | As part of the Appropriateness initiative, project team engaged in discussion with representatives from similar projects in Manitoba and Saskatchewan to share experiences and lessons learned to date. |
| NS | Improving Access to Surgical Services: A Patient Portal for Orthopaedics | NB and SK were consulted to draw from their experience and lessons learned. |
| PEI | Saving Time and Saving Lives: A Provincial Strategy for Ensuring Radiation Therapy Patient Wait Times Guarantees | Interprovincial recourse agreement with associated data sharing - meetings to arrive at signed MOU. Knowledge sharing from MB regarding electronic referrals. |
| NT | Screening Mammography Program: A Patient Wait Times Guarantee Pilot Project | Currently working with BC Breast Screening to compile a relevant policy and procedure manual. The Lendrum Breast Center in Edmonton read films in the beginning and currently provides follow-up care to clients requiring a radiologist present. |
| YK | Testing the Feasibility of Providing Recourse to a Wider Range of Service Location Options for Specified Out-of-Yukon Services and Procedures | Collaboration was required with BC health authorities to locate and provide recourse options for the project. |

Annex G – Documented Reduction in Wait Times in Area of Focus

| Province | Project | Documented Reduction in Wait Times |
|----------|--|--|
| SK | Coronary Artery Bypass Graft Surgery Recourse Pilot Project | <p>In the time period covered by the pilot project, the wait time was dramatically reduced, and now a large majority of Saskatchewan patients requiring surgery are receiving their CABG within the recommended maximum waiting time. Overall, from April 1, 2008 to March 31, 2010, 95% of patients categorized as Level I received CABG Surgery within two weeks, 93% of patients categorized as Level II received their surgery within six weeks. In total, 97% of patients were undergoing CABG Surgery within their recommended maximum wait time.</p> <p>No pre and post analysis is available.</p> |
| MB | Bridging General and Specialist Care: The Right Door, the First Time | <p>The limited scope of the project's clinical areas and participation, approximately 10% of primary care providers and specialists, was not sufficient to reflect an impact on wait times or access overall, however qualitative information suggests that with the expanded scope of the project, an impact could be achieved. 84% of patients referred through the system saw a BGSC specialist within the Wait Time Guarantee period. However, the IT data can only determine wait times for pathway-relevant patients who were referred through the IT system. As well, the IT data do not indicate how BGSC might have affected overall system wait times (i.e., for patients outside as well as within the program).</p> <p>No pre and post analysis available.</p> |
| QC | Clinique interdisciplinaire en musculo-squelettique | The multidisciplinary approach tested in the project ensures that only patients needing an orthopedist would receive an appointment. Reports indicate that waiting times were reduced. |
| QC | Requête Web opératoire | Management of the SIMASS waiting list with the Web application was not possible during the project, so no data is available on the impact on wait times. |
| QC | Défi qualité performance dans la réduction des délais d'attente pour les arthroplasties de la hanche et du genou | The length of stay has been approximately 7 to 10 days since 2004. The pilot project demonstrated that the length of stay could be reduced to 5 days. However, no data on overall impact on waits was available. |
| NB | Radiation Therapy Wait Time Guarantee Pilot Project | No data available on the impact on waits during the project and it is too early to predict the impact that this project will have on reducing wait times in the future. NB is now very confident that front line workers and managers, both at the regional and provincial levels, have the tools to track the individual patient journey and generate reports on system performance and indicators that will inform how New Brunswick is doing in respect to national benchmarks and the guarantee. |

| Province | Project | Documented Reduction in Wait Times |
|----------|---|---|
| NS | Improving Access to Diagnostic Services | <p>Efficiency Component: The effect that improved efficiencies, in a diagnostic imaging (DI) department, can have on reducing waits is not discernable given the presence of factors such as staffing levels, population demographics, physician DI referral preferences, and the presence of other interventions related to improving wait times.</p> <p>Appropriateness Initiative: The decision support tool enabled an increase in the appropriateness of submitted exams from 38% to 42% and an associated reduction in inappropriate exams from 25% to 21%. While modest, on a larger scale the improvement may affect utilization patterns and associated service costs, and influence wait times for the modalities affected.</p> <p>Patient Choice Initiative: Patients who chose to travel to another district health authority experienced a shorter wait time - 11 to 20 days less wait time.</p> |
| NS | Improving Access to Surgical Services: A Patient Portal for Orthopaedics | <p>Validation of current surgical wait lists reduced the wait list across 4 districts by approximately 25-30%.</p> <p>Not clear to what extent wait times were reduced (pre and post).</p> |
| PEI | Saving Time and Saving Lives: A Provincial Strategy for Ensuring Radiation Therapy Patient Wait Times Guarantees | The Radiation Care Path Coordinator/Radiation Clerical Navigator will have an ongoing impact on the reduction of patient wait times due to the continuous tracking of patients now available within the PEI Cancer Treatment Centre. During the course of the project, the province met national and Canadian Association of Radiation Oncologists guidelines for treatment, as well as the timeline set out in the provincial guarantee that was put in place on April 1, 2010, after the project had ended. Because of this, measureable reductions in wait times were not identified during the time period covered by the pilot project. |
| NT | Screening Mammography Program: A Patient Wait Times Guarantee Pilot Project | <p>The project goal of screening 70% or more of the 370 eligible women identified in the project's proposal in 36 months was met after only 18 months of operation of the mammography clinic. At the end of the project, 275 (74.3%) of the eligible women had been screened.</p> <p>A survey of patients found that 100% of respondents waited less than 5 weeks for an appointment. Prior to the project, the Alberta Breast Screening mobile program saw clients in Hay River and Fort Smith during a one week per year visit.</p> |
| YK | Testing the Feasibility of Providing Recourse to a Wider Range of Service Location Options for Specified Out-of-Yukon Services and Procedures | <p>Cataracts: Segment 1 (GP referral, to consult with Specialist): very significantly reduced to 3-9 weeks. (In 2009, the wait time was 12-15 months/48-60 weeks).</p> <p>Segment 2: (from Consult, to Surgery): increased to 20 to 32 weeks. (Up from 12 -15 weeks).</p> <p>Hips and knees Total Joint Replacement: Segment 1: reduced to 6-9 months. (In 2009, it was 102 weeks/24 months).</p> <p>Segment 2: reduced to 12 – 62 weeks/ 3-15 months. (This is down from up to 80 weeks/20 months).</p> |

Annex H – Recourse Activities in Pilot Projects

| Province | Project | Recourse Developed | Recourse Offered | Recourse Level | Comments |
|----------|--|--|--|--|--|
| SK | Coronary Artery Bypass Graft (CABG) Surgery Recourse Pilot Project | A recourse strategy and associated documentation were developed. The recourse strategy and critical transport infrastructure remain in place and in the event that patients are exceeding their recommended maximum wait time, recourse will be offered. | N/A | N/A | Due to the low number of patients waiting beyond the recommended maximum wait time, specific reasons for not offering recourse cannot be noted for privacy reasons. However, generally speaking, these reasons included, but were not limited to, situations such as patient refusal of surgery or physician recommendation not to undergo surgery. Physicians were also reluctant to offer recourse to their patients, preferring to reduce their patient wait lists so that recourse was not required. |
| MB | Bridging General and Specialist Care: The Right Door, the First Time | Development of a recourse strategy. The recourse strategy entailed working with specialists from outside of the BGSC pilot project to accommodate the referring Family Physician's request. | Implemented recourse for patients not seen for specialist consultation within the guaranteed time throughout March 2009 to March 2010. | 14 patients accepted recourse and were seen by a specialist outside of BGSC. | The IT system did not contain a specific data field to record whether a patient had required recourse outside the scope of the project. BGSC project team staff indicated that a recourse situation had arisen 5 times for Lower GI patients and 23 times for Hip/Knee patients. Of these, 14 declined recourse (1 chose not to see a specialist, 3 were redirected to another specialist without the BGSC project's intervention, and 10 chose to remain with the initial specialist). |
| QC | Clinique interdisciplinaire en musculo-squelettique | N/A | N/A | N/A | N/A |
| QC | Requête Web opératoire | N/A | N/A | N/A | N/A |
| QC | Défi qualité performance dans la réduction des délais d'attente pour les arthroplasties de la hanche et du genou | N/A | N/A | N/A | N/A |

| Province | Project | Recourse Developed | Recourse Offered | Recourse Level | Comments |
|----------|---|--|---|---|--|
| NB | Radiation Therapy Wait Time Guarantee Pilot Project | MOU signed on recourse options. | Two patients from a center could have been candidates for a transfer within the province or recourse outside the province. Both of these patients were offered the choice but decided to decline. | N/A | During the course of the project, the province was meeting the PWTG timeframe, although this project has given the province the ability to better track the patient journey. |
| NS | Improving Access to Diagnostic Services | The Patient Choice Initiative developed a recourse strategy, wait time timeframes, booking tools, and patient surveys to support offering recourse | Patients in four District Health Authorities were provided with an alternative service delivery site if wait times in their home district exceeded established wait times. | Almost two-thirds of patients chose to travel when offered the choice; 98% of MRI patients were willing to travel again | Findings suggest that patient perceptions or preferences are an enabling factor in implementing recourse options. Organizational barriers need to be carefully considered before implementing recourse on a wider scale. |
| NS | Improving Access to Surgical Services: A Patient Portal for Orthopaedics | A recourse strategy was partially developed with the introduction of the Patient Access Registry Nova Scotia (PAR NS) and will be completed with provincial resources in the future. | N/A | N/A | PAR NS was intended to be an interactive, secure portal for initiating patient recourse. Due to significant privacy and security issues, and the lack of timely and reliable wait time data on which to base choice of surgical service(s) and choice of participating District Health Authorities, only a static, information-based version of PAR NS was created, therefore recourse was not able to be tested during the project, as planned. |
| PEI | Saving Time and Saving Lives: A Provincial Strategy for Ensuring Radiation Therapy Patient Wait Times Guarantee | Mutual aid MOU was signed between Atlantic provinces. | Not tested (guarantee was being met) | Not tested (guarantee was being met) | The current PEI Health system is ready to accommodate the patient wait times guarantee, as well as send-out or receive patients in accordance with the MOU with the Atlantic Provinces. To date, no patients have needed recourse out or into PEI. |

| Province | Project | Recourse Developed | Recourse Offered | Recourse Level | Comments |
|----------|---|---|--|---|--|
| NT | Screening Mammography Program: A Patient Wait Times Guarantee Pilot Project | A recourse strategy was developed for patients with a longer wait time than what was outlined in the project proposal. | Patients who were not able to be accommodated within the recommended timeframes were informed that Yellowknife and Edmonton were alternate options for screening. Of the patients offered recourse, 4% initially accepted, but later rescinded when it was determined that the wait times for routine screening appointments outside of Hay River would exceed the time in which the Hay River clinic could deliver the service. | N/A | Although recourse was offered, no patients exercised this option, as the wait times in other centres were longer than those in Hay River. For example, although the wait time for an appointment in Hay River might exceed the 2 weeks outlined in the original project proposal, the client may have been required to wait 4-6 weeks for an appointment in Yellowknife or Edmonton. |
| YK | Testing the Feasibility of Providing Recourse to a Wider Range of Service Location Options for Specified Out-of-Yukon Services and Procedures | Protocols, tools and structures needed to support providing the recourse options were developed for cases that meet the appropriate criteria. | Recourse for cataracts was offered to 34 people. Recourse for hip/knee replacements was offered to 38 patients. | Six people accepted the cataract recourse option offered. Eighteen arthroplasty (hip/knee) patients accepted recourse (a total of 23 trips were provided, as some patients required two trips). | The pilot project limited application of the recourse option to total hip and knee replacements and cataract surgery that were non-emergency services/procedures. Originally the project intended to consider an additional two areas of non-emergency services (cardiac and cancer) however, it was eventually determined that wait times for these services were well within the P/T benchmarks. |

Annex I – Future Impact on Reduction of Wait Times and Establishment of PWTGs

| Province | Project | Project Impact on Reduction of Patient Wait Times in the FUTURE | Project Impact on the Establishment of Patient Wait Times Guarantees in the FUTURE |
|----------|--|--|---|
| SK | Coronary Artery Bypass Graft (CABG) Surgery Recourse Pilot Project | The pilot project has been successful at reducing patient wait times for CABG surgery; the ongoing plan will be to monitor and ensure that the physicians continue to manage their patient wait lists and wait times and ensure that patients receive their surgery within the maximum recommended wait times according to CABG Pan Canadian benchmarks. | Recourse will continue to be an option to patients in the event that they reach their recommended maximum waiting time. As a broader provincial strategy, the Saskatchewan Surgical Initiative has a goal of improving the surgical experience of patients' and ensuring that within four years, no one in the province has to wait longer than three months for surgery. |
| MB | Bridging General and Specialist Care: The Right Door, the First Time | By 2011/12 Manitoba hopes to have 600 primary care providers using BGSC and 50% of specialists receiving referrals via BGSC. Moving towards integrating BGSC into the EMRs in Family Physician offices, which will further expand participation and use. | As the scope of BGSC expands, and the impact becomes clear, it is likely that there will be a stronger desire and demand to institute similar processes and tools in other clinical environments. Criteria for referral and timelines for other clinical environments will act as Patient Wait Times Guarantees. |
| QC | Clinique interdisciplinaire en musculo-squelettique | The project will likely be implemented in other areas, however, this is dependant on available funding and decisions taken by local and regional authorities. | The project could help inform future initiatives related to wait times guarantees. |
| QC | Requête Web opératoire | Once the technical difficulties are resolved between the web-based operating room booking system and the waiting list system (SIMASS), the province will implement the project at the Ste-Marie Hospital. | Not known at this time. |
| QC | Défi qualité performance dans la réduction des délais d'attente pour les arthroplasties de la hanche et du genou | Too early to predict the impact of the project, however, it may be systematized so it can be spread and shared across the province. | The project could help inform future initiatives related to wait times guarantees. |
| NB | Radiation Therapy Wait Time Guarantee Pilot Project | Too early to predict the impact that this project will have on reducing wait times in the future. Front line workers & managers have the tools to track the patient's journey and generate reports on system performance and indicators that will inform how New Brunswick is doing in respect to national benchmarks and the guarantee. | A feasibility study was also conducted that would see the Cancer Treatment Access Repository (CTAR) expanded to include systemic therapy. Systemic therapy is a modality of cancer treatment that impacts on a vast number of cancer patients. Measuring and reporting on wait times in systemic therapy should be considered a logical next step. |

| Province | Project | Project Impact on Reduction of Patient Wait Times in the FUTURE | Project Impact on the Establishment of Patient Wait Times Guarantees in the FUTURE |
|----------|---|---|---|
| NS | Improving Access to Diagnostic Services | Dependent on whether interventions piloted are continued. Appropriateness initiative: large-scale implementation could lead to more appropriate ordering which may affect Wait Times. Offering patients the choice to travel to attain a shorter Wait Time could be used in the future if certain districts in the province are experiencing particularly high wait times. Overall this project has improved sources for Wait Time data which will improve ability to monitor and manage Wait Times. | The Patient Choice initiative provided increased insight into the willingness of patients to travel, and the results of the project could help inform future initiatives related to wait time guarantees. |
| NS | Improving Access to Surgical Services: A Patient Portal for Orthopaedics | Over time, a reduction in wait times is expected, consistent with the experience in other jurisdictions with similar patient access registries, such as in New Brunswick and Saskatchewan. | The establishment of a provincial wait time data repository is expected to allow for improved decision making on resource allocation, utilization and provincial wait time strategies. |
| PEI | Saving Time and Saving Lives: A Provincial Strategy for Ensuring Radiation Therapy Patient Wait Times Guarantee | The procedures, practices and tools developed for radiation wait times could be expanded to medical oncology and/or other areas along the cancer care continuum in the future to track wait times and expediate patient transfer time, if appropriate. | The project laid the groundwork that could be used to establish guarantees in the future across the broader spectrum of cancer care. For example, a wait times guarantee for medical oncology could occur more efficiently since many of the steps have been outlined by this pilot project, which would avoid duplication of work. |
| NT | Screening Mammography Program: A Patient Wait Times Guarantee Pilot Project | The Northwest Territories has now expanded the mammography program to include all women 40 years of age and older. Geographic guidelines have been expanded to include South Great Slave Lake region. Approximately 400 women will be added to the program this year. If funded in the future, the Northwest Territories has the capacity to eliminate wait times for Breast Screening in the South Great Slave Lake area. The Minister of Health has announced new initiatives to reduce wait times, not only for Breast screening, but also for Endoscopy – specifically Colonoscopies and Gastrosopies. Patients from other areas of the Territory are now being sent to Hay River for these tests, reducing wait times for clients. | Not known at this time. |

| Province | Project | Project Impact on Reduction of Patient Wait Times in the FUTURE | Project Impact on the Establishment of Patient Wait Times Guarantees in the FUTURE |
|----------|---|--|--|
| YK | Testing the Feasibility of Providing Recourse to a Wider Range of Service Location Options for Specified Out-of-Yukon Services and Procedures | Cataract Referral Protocols have significantly reduced the wait times for cataracts. The relationships and protocols developed for recourse to facilities in B.C. can continue to be used when necessary. The improved ability to access and produce Yukon wait time information will support more informed decision making and improved management of wait times. | Yukon will continue to monitor/manage wait times across all services in order to reduce patient wait times where needed in ways that makes sense for Yukon. At this time, it is not expected that the Yukon will establish wait times guarantees (except for mammography, in accordance with the terms of the Wait Times Guarantee Trust Fund), for a number of practical reasons that were made apparent through the pilot project. Instead, wait times across the system will be actively monitored and managed in a way that is flexible and responsive, so that focus can be placed on the current bottlenecks and resources shifted when the context and bottlenecks shift. |

Annex J – Interview Guides (Funded Participants and HC Staff)

Summative Evaluation of the Patient Wait Times Guarantee Pilot Project Fund Interview Guide – Funded Projects

Government Consulting Services (GCS) has been engaged by Health Canada to conduct an evaluation of the Patient Wait Times Guarantee (PWTG) Pilot Project Fund.

As part of the evaluation, GCS is conducting interviews with key stakeholders who have been involved in the Fund. The purpose of these interviews is to obtain informed perspectives on the initiative’s relevance, performance and cost-effectiveness. The following questions will serve as a guide for our interview. In some cases, questions may not be relevant to your particular situation or experience. The interview will focus on those questions most relevant to you.

Background

1. Please describe your role/involvement with the PWTG Pilot Project.

Program Relevance

2. What need was your pilot project originally designed to address? Do you feel there is a continued need for the project beyond the pilot phase?
3. Is there a need for the federal government to invest in pilot projects related to PWTGs and reducing wait times? Please explain your answer.
4. Are you aware of any similar initiatives that complement your pilot project?
Probe:
 - Did the pilot project duplicate or overlap with any other initiative?
 - Was a joint initiative established?
5. Would the pilot project, or a similar one, have gone ahead in the absence of the funding available through the PWTG Pilot Project Fund? Are there other sources of funding that could have been accessed instead?

Outcomes and Impacts

6. Using a 5-point scale, where 1 is “To No Extent” and 5 is “To a Great Extent”, to what extent did the pilot project increase your understanding of the tools and approaches needed to establish PWTGs and/or reduce patient wait times? Please explain your response
Probe:
 - How specifically did it have an impact/or lack thereof?
7. Using a 5-point scale, where 1 is “To No Extent” and 5 is “To a Great Extent”, to what extent has there been strengthened collaboration and exchange of best practices amongst provincial/territorial governments for the advancement of PWTGs and/or the reduction of wait times as a result of your project? Please explain your response.
Probe:
 - What type of collaborations have been strengthened?
 - Which best practices (i.e., tools, approaches, etc.) will be adopted by your province/territory?
 - What type of partnerships have been developed?
8. On a 5-point scale, where 1 is “To No Extent” and 5 is “To a Great Extent”, to what extent did the pilot project increase your understanding of policy and operational issues associated with the establishment of patient wait times guarantees and/or the reduction in patient wait times in your province? Please explain your response.

Probe:

- What policy issues or barriers were identified?
 - What operational issues or barriers were identified?
 - Have there been any legislative or jurisdictional issues/barriers raised?
 - How were these issues or barriers resolved or addressed through the project?
9. As a result of your project, to what extent is your province or territory’s health care system better positioned to implement PWTGs and reduce patient wait times?

Probe:

- Has new knowledge from your pilot project(s) influenced any policy, legislative or operational decisions made to date?
 - Have there been improvements in the management of wait times due to your pilot project(s)?
10. Has the knowledge generated from funded pilot projects, in your jurisdiction and others, increased your understanding on how PWTGs best fit within the wider context of health care reform being undertaken in your province or territory?
11. To what extent has your pilot project had a direct impact on patient wait times?

Probe:

- Were PWTGs established or modified?
 - Were wait times reduced? If so, in what area(s)?
12. What lessons have been learned from your pilot projects?

Probe:

- Have these lessons been documented?
 - Have they been shared or discussed with other jurisdictions?
13. What are the future plans for the pilot project?

Probe:

- Will any or all elements of the pilot project continue?

Cost Effectiveness and Governance

14. Were all of the funds that were allocated to your project expended? If not, please explain.
15. Are there any aspects of your project that could have been delivered more cost-efficiently?
16. How has your project delivered value for money to Canadians?
17. Overall, was the PWTG Pilot Project Fund a cost-efficient way of achieving results?

Probe:

- Were there other funding vehicles or mechanisms that would have been more effective?
 - Could the Fund have been set up differently to be more effective?
 - Were there elements of the Fund that were more/ less effective than others?
 - Did participating in the PWTG Pilot Project Fund help you to leverage other funds or activities?
18. Using a 5-point scale, where 1 is “Not at All Effective” and 5 is “Very Effective”, to what extent do you consider the PWTG Pilot Project Fund to have been an effective vehicle to support the establishment of patient wait time guarantees?
19. Have management practices for the PWTG Pilot Project Fund been effective?

Probe:

- Did you feel the criteria for selection of pilot projects were fair?
 - Were funds provided in a timely manner?
 - How effective was communication/information sharing with Health Canada?
 - Were the goals and objectives for the Fund, and how the pilot projects contribute to these objectives, clear?
20. Do you have any other comments you would like to make?

Thank you for your contribution to this evaluation.

Summative Evaluation of the Patient Wait Times Guarantee Pilot Project Fund Interview Guide – Health Canada staff

Government Consulting Services (GCS) has been engaged by Health Canada to conduct an evaluation of the Patient Wait Times Guarantee (PWTG) Pilot Project Fund.

The objective of the PWTG Pilot Project Fund is to assist P/Ts in the testing, advancement and establishment of PWTGs and obtain the best outcomes for patients by:

- Identifying and addressing policy and operational issues associated with establishing PWTGs;
- Enabling the testing of innovative, new approaches to lay the groundwork for PWTGs (e.g., the development of protocols to provide recourse options for patients); and
- Encouraging collaboration and exchange of best practices amongst P/T governments.

As part of the evaluation, GCS is conducting interviews with key stakeholders who have been involved in the Fund. The purpose of these interviews is to obtain informed perspectives on the initiative's relevance, performance and cost-effectiveness. The following questions will serve as a guide for our interview.

- 1) Please outline your current/previous role with the PWTG Pilot Project Fund.
- 2) In your view, was the design and structure of the PWTG Pilot Project Fund effective at meeting the objectives of the program? What factors have impeded or facilitated the achievement of these objectives?
Probe:
 - Did you feel the criteria for selection of pilot projects were fair?
 - Were funds provided in a timely manner?
 - Were the timelines for completion of projects adequate?
 - Was a contribution agreement the most appropriate funding instrument?
- 3) In your view, were the pilot projects' objectives consistent with departmental and government-wide priorities?
- 4) Did the program produce the expected outputs/outcomes?
Probe:
 - Did projects enable the testing of innovative/new approaches?
 - Was there collaboration and exchange of best practices among P/T governments?
- 5) Did the role of the pilot projects complement the roles of other federal and P/T programs in this field? How were pilot projects activities coordinated with these F/P/T roles?
- 6) In your view, has the program delivered value for money to Canadians?
- 7) Have management practices for the PWTG Pilot Project Fund been effective?
Probe:
 - Any operational or management issues?
 - Planned versus actual expenditures for Fund?
 - Any lessons learned in terms of the planning, design and delivery of the fund?
- 8) Is there anything else you would like to add?