



## Quarterly Change

In February, the **Health Council of Canada** released its second annual report, "Health Care Renewal in Canada: Clearing the Road to Quality," which tracks how well the federal government, the provinces and the territories have done in meeting the commitments they made to renew healthcare under the federally funded 2003 and 2004 healthcare agreements. The report also recommends how to strengthen the accountability, coordination and sustainability of the healthcare system.



Some of the Council's key recommendations include:

- To improve patient safety, make accreditation for healthcare facilities mandatory, a condition of public funding. Require the public release of accreditation reports. And reexamine no-fault compensation for victims of adverse healthcare events, including the issue of job protection for whistleblowers in this effort.
- Speed up the development of electronic health records. There should be electronic health records for all Canadians by 2010. Link electronic drug information systems to electronic health records. Governments should make comprehensive, mandatory electronic drug information systems and e-prescribing a priority and integrate them into electronic health record implementation.
- Strengthen legislation to ban all forms of direct-to-consumer advertising of prescription drugs in Canada. Legislation should clearly prohibit "help-seeking" and "reminder" ads.
- Create information systems that identify patients whose waits are becoming unusually long, triggering an audit. Establish an appeal process for patients who feel they've waited too long. Set up a common service queue for major services so patients can be served based on their urgency, with the option of seeking physicians with shorter wait lists.
- Increase the number of inter-professional teams providing primary healthcare beyond the goal set out in the 2003 and 2004 agreements, which currently call for 50% of residents to have 24/7 access to healthcare teams by 2011. Make greater use of tele-triage and telehealth technologies.
- Address the needs of people without any drug coverage or without coverage that protects them from catastrophic drug costs. The National Strategy on Pharmaceuticals must provide a plan to deal with these concerns.

The full report is available online at: [www.healthcouncilcanada.ca](http://www.healthcouncilcanada.ca).

An innovative pilot project at **Manitoba's Children's Hospital** could lead to shorter wait times for diagnostic tests such as MRI and CT scans. The \$1 million project involves the use of electronic order entry software that will assist physicians making referrals to choose the most appropriate diagnostic imaging test for each patient. It does this at the time the test is ordered by providing the physician with electronic guidelines for diagnostic imaging that have been adopted by the Canadian Association of Radiologists (CAR). The criteria, which are embedded in the software, should reduce the number of unnecessary or inappropriate tests. The project is a partnership between Manitoba Health, CAR and Health Canada and is implemented through the Winnipeg Regional Health Authority.

Also in **Manitoba**, a new policy, called Aging in Place, will increase community living supports for seniors and provide alternatives to institutional care, allowing seniors to preserve their dignity, independence and health. The policy supports the values of safety and security, flexibility, choice, equity and dignity. To be phased in during the next four years, Aging in Place provides for:

- expanded capacity for long-term care models such as supportive housing,
- specialized supports and supports for seniors in group living;
- improved quality of life in personal-care homes by replacement of three- and four-bed rooms with one- and two-bed rooms; and
- more spaces to ensure more seniors can receive the care they need.

The Manitoba Housing and Renewal Corporation will also be renovating some of its apartment buildings at a cost of more than \$3.25 million to create housing units specially designed for seniors.

During the next few months, the province will work with rural and northern regional health authorities to develop their strategies to implement Aging in Place in their communities. For more information go to [www.gov.mb.ca/health](http://www.gov.mb.ca/health).

**Saskatchewan's Health**

**Workforce Action Plan** was released recently. It is an action plan designed to improve health-care in Saskatchewan by keeping and attracting healthcare professionals. Saskatchewan Health has consulted extensively with its partners in the health system, including health regions, health practitioners, health professional associations, unions, the education and training sector and Aboriginal community to help define the issues, goals, objectives and potential solutions to strengthen health human resource planning. As a result of these consultations, the solutions reflect government's commitment to:

- recognizing and retaining the health professionals that Saskatchewan has and supporting them in the work they are doing;
- improving our self-sufficiency in educating and training our own health professionals, within available resources;
- recruiting from outside Saskatchewan to supplement our own supply; and
- finding innovative ways to keep Saskatchewan youth in our province by providing them

with training and employment opportunities in the healthcare field.

The plan includes dozens of proposed actions to address health human resources challenges, including:

- increasing support to the College of Medicine to train future doctors;
- establishing a provincial recruitment agency to help the province attract hard-to-recruit professionals and locate professionals in hard-to-recruit-to areas;
- developing pilot projects that encourage the hiring of new graduates across the province;
- recruiting more senior and experienced nurses to act as mentors with new graduates;
- increasing our ability to provide students with clinical placements within the province;
- creating a health labour market council to better align the planning needed to match the supply and demand of health professionals;
- hosting a western symposium on best practices in Aboriginal health professional education, training and recruitment; and
- establishing a Health Workforce Steering Committee, made up of representatives from the health and learning sectors, to guide future actions and help measure the plan's progress.

The time frame to fully implement the proposed actions will vary. Some can be undertaken immediately, while others will be considered through future budget processes. A full copy of the plan is available at [www.health.gov.sk.ca](http://www.health.gov.sk.ca).



The innovative work being done by **Saskatchewan's Health Quality Council** (HQC) was recognized at the 2006 Saskatchewan Healthcare Excellence Award (SHEA) gala in Regina. HQC was one of 10 organizations and individuals from the province recognized at the fifth annual awards ceremony.

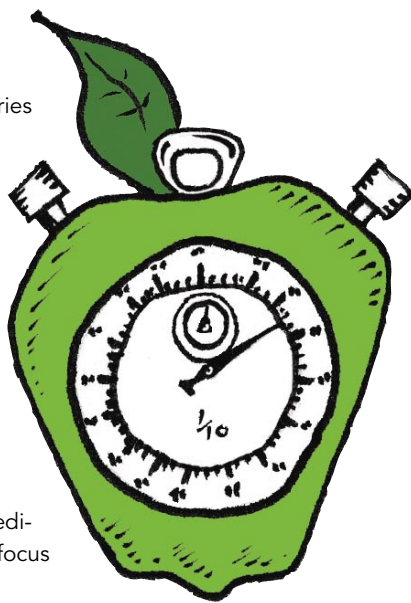
The Council is the first agency of its kind in Canada. Since being established in 2002, it has led a number of activities that are improving the quality of care for Saskatchewan residents:

- Producing the first reports on the quality of care in Saskatchewan, HQC has looked at quality for post-heart attack care, drug management for seniors and asthma and diabetes management.
- Leading the first province-wide survey of hospital patients.
- Being the first province in Canada to bring the Cochrane Library free of charge to all citizens. The Cochrane Library is the world's best single source of evidence about the effects of healthcare interventions.
- Organizing the largest quality improvement initiative in the province, the Saskatchewan Chronic Disease Management Collaborative. This project involves one-sixth of all family physicians and every health region in Saskatchewan.

HQC is an independent agency with a mandate to measure and report on health system performance and work with providers and managers to improve quality of care.

**British Columbia** has introduced a major initiative to reduce wait times for hip and knee surgeries while building long-term capacity in the health-care system that will maximize the number of surgeries. The \$60.5 million wait time management strategy includes:

- A new Centre for Surgical Innovation at UBC Hospital – \$25 million in 2006/07 to support dedicated operating rooms to help clear patient backlogs for hip and knee surgery.
- Additional funding to immediately address existing backlogs – \$25 million in 2005/06 for health authorities across the province to immediately increase the number of surgeries with a focus on joint replacement surgery.
- A Provincial Surgical Patient Registry – \$5 million to create and implement a provincewide patient registry developed by the Provincial Health Services Authority and all health authorities to help better manage the surgical backlog.
- A Research Centre for Hip Health at Vancouver General Hospital – \$5.5 million from the Ministry of Advanced Education.



The \$60.5 million strategy builds on the success of a pilot project pioneered at Richmond Hospital beginning in 2004 that achieved a 40% increase in the number of hip and knee surgeries. The Richmond project, the first of its kind in Canada, created a specialized unit dedicated to hip and knee surgery that makes the best use of operating room resources and ensures patients are adequately prepared for surgery and post-op.

The lessons learned from the Richmond pilot project form the basis for the creation of a new specialized Centre for Surgical Innovation at UBC Hospital that will:

- Perform 1,600 additional hip and knee surgeries over the next year for patients from around the province. The first two dedicated joint replacement operating rooms at UBC are expected to open in April 2006.
- Support transformation and surgical innovation by working with providers across the province.
- Promote best-practices in surgical processes, audit processes, conduct evaluations and establish triage guidelines for wait-listed patients who may benefit from alternate options for medical treatment.
- Develop a best-practices clinical tool kit based on the Richmond pilot project experience and distribute it to all B.C. hospitals to promote efficiency and best use of resources throughout the province.

In BC, about half of all surgeries are done immediately and are never wait-listed because they are determined to be emergency or urgent cases. About 75% of elective surgeries on the wait list are done in just over three months. Surgical wait times are published on the Ministry of Health website at [www.healthservices.gov.bc.ca/waitlist](http://www.healthservices.gov.bc.ca/waitlist).

In Alberta, an interim report finds that during the first eight months of the **Alberta Hip and Knee Replacement Project**, the new care pathway has met its goal to ensure patients receive surgery within four months of initial consultation. After eight months, the highlights of the interim report on this research include:

- Decreased wait time to receive first orthopaedic consult: from 35 weeks to six weeks.
- Decreased wait time from first orthopedic consult to surgery: from 47 weeks to 4.7 weeks.
- Decreased length of stay in hospital: from 6.2 days to 4.3 days.
- Satisfaction among patients and physicians surveyed with care provided.

The new process includes the introduction of central assessment clinics, where patients who may require orthopedic surgery are examined by a team of health professionals in one visit. During the pilot, the goal is to see patients at the clinic within 17 days of a family physician referral. The new care path also includes more involvement by primary care physicians to help prepare patients for surgery and care for them following their procedure.

Further information about the Alberta Hip and Knee Replacement Project can be found at [www.albertaboneandjoint.com](http://www.albertaboneandjoint.com).

## CIHI Reports

A new report published by the Canadian Institute for Health Information (CIHI) shows that, in 2004, 9% of all physicians were located in rural and small-town Canada, where just over one-fifth of the population lives. The report also shows that family physicians are in greater supply in rural areas than are specialists. When broken down by category, nearly 16% of family physicians and slightly more than 2% of specialists worked in rural areas. However, the study also shows that rural family doctors offer a broad range of clinical procedures to meet the needs of rural populations.

*Geographic Distribution of Physicians in Canada: Beyond How Many and Where*, written by Dr. Raymond W. Pong and Dr. J. Roger Pitblado, offers an overview of where Canada's physicians work, and how family physicians work differently depending on where they provide services.

Key findings from the report include:

- Just more than 9% of Canada's doctors worked in rural and small-town Canada, where just over 20% of the country's population lives.
- In 2004, fewer than 16% of family doctors and slightly more than 2% of specialists worked in rural and small-town Canada, compared to just over 20% of the country's population.
- One-third of rural GPs delivered babies in 2004, compared 8.5% of family doctors in large urban areas.
- Family doctors in Canada's most rural communities are almost five times more likely to provide emergency room care than family doctors working in the biggest cities.
- Among all family physicians, 15% (the same percentage as rural physicians) plan to narrow their scope

of practice, according to the 2004 National Physician Survey. Only 5% of all family physicians plan to expand their practice, compared to 6% of rural physicians.

- The average distance to an obstetrician is about 158 kilometres for the most rural communities and almost 900 kilometres for the territories. This is compared to an average of 3 kilometres for Canada's largest cities.

Data released from the Canadian Institute for Health Information (CIHI) show that hospitals treat the most snowmobile-related injuries in February. Snowmobile incidents remained the number-one cause of winter sports and recreation-related injuries treated in specialized trauma units in 2003–2004, accounting for 41% of these types of injuries as compared to snowboarding (20%), skiing (20%), hockey (9%), tobogganing (7%) and ice-skating (3%). Most snowmobile-related severe-injury admissions in 2003–2004 occurred in February (34%), followed by January (23%). A look at general hospital admissions across the country reveals much the same trend (32% in February and 18% in January), while visits to Ontario emergency departments for snowmobile-related injuries also peaked in February at 35%, followed by January at 28%.

The data show that young people are the most likely to sustain serious injuries in a snowmobile incident. An internationally recognized measure – the Injury Severity Score (ISS) – indicates that those under the age of 20 were treated for the most severe snowmobile-related injuries. Most of these patients sustain multiple injuries, with orthopedic injuries and head injuries the most frequently occurring traumas. In 2003–2004, those treated most often in general hospitals were between the ages of 20 and 39 years,

while the most highly represented age group treated in Ontario emergency departments was 15- to 19-year-olds (16%), followed by 35- to 39-year-olds (13%).

A recent report by the Canadian Institute for Health Information (CIHI) shows steady investment in MRI and CT scanners in Canada. The number of MRI scanners in 2005 was up more than 35% from five years earlier, while the number of CT scanners increased 19% in the same period. However, Canada continued to rank below the median among Organisation for Economic Co-operation and Development (OECD) countries in MRI and CT scanners per million population.

At the same time, new analysis in the CIHI report shows that while Canada has fewer machines per million people, it uses its MRI scanners more intensively than the U.S. and England – the only other countries collecting comparable data. In 2004–2005, numbers of MRI exams per scanner were almost 40% higher in Canada than in the U.S. or England. At the same time, the U.S. performed more than three times the number of exams, reporting 83.2 MRI exams per 1,000 population in 2004–2005, compared to 25.5 in Canada and 19.0 in England.

Canada also had about 50% more exams per CT scanner than the U.S. However, when comparing exams per population, the U.S. performed nearly double the exams, with 172.5 CT exams per 1,000 population, compared to 87.3 in Canada.

The report also contains new data which show a substantial growth in the number of exams per 1,000 population. MRI exams per 1,000 population increased 13.3% in 2004–2005 from the year before, while CT exams per 1,000 population grew by 8.0% over the previous year.

Significant progress in renewing the **public health system** has been made in the past two years but more needs to be done. Chief Medical Officer of Health (CMOH) Dr. Sheela Basrur reported as she released her first report to the Ontario legislature on the status of Ontario's public health system. The province's CMOH was granted additional powers and more independence through legislative amendments passed in 2004. As part of this new independence the CMOH must now report directly to the legislature on the state of public health every year.

The report, *Building the Foundation of a Strong Public Health System for Ontarians*, points to the progress made over the past two years and the areas of continuing concern.

Progress made to date includes:

- An ongoing review of the capacity of the province's 36 public health units.
- Planning for the creation of Ontario's first Public Health Agency.
- Strengthened capacity to control infectious diseases with the creation of a Provincial Infectious Diseases Advisory Committee (PIDAC), Regional Infection Control Networks, infection control training for frontline health care workers and increased funding to raise the number of infection control professionals.

- Establishment of the Emergency Management Unit to coordinate responses to health emergencies and outbreaks.
- The release of an updated and detailed plan for an influenza pandemic.
- Creation of the Ministry of Health Promotion to focus on health prevention.

Areas of continuing concern include:

- Shortage of staff and inadequate facilities and technology within the Public Health Laboratory System.
- Vacancies in Medical Officer of Health and other positions at public health units.
- Emergency planning and response involving First Nations communities needs to be developed and coordinated with all levels of government.
- Communications with frontline medical staff needs to be strengthened to help recognize, control and prevent infectious diseases.

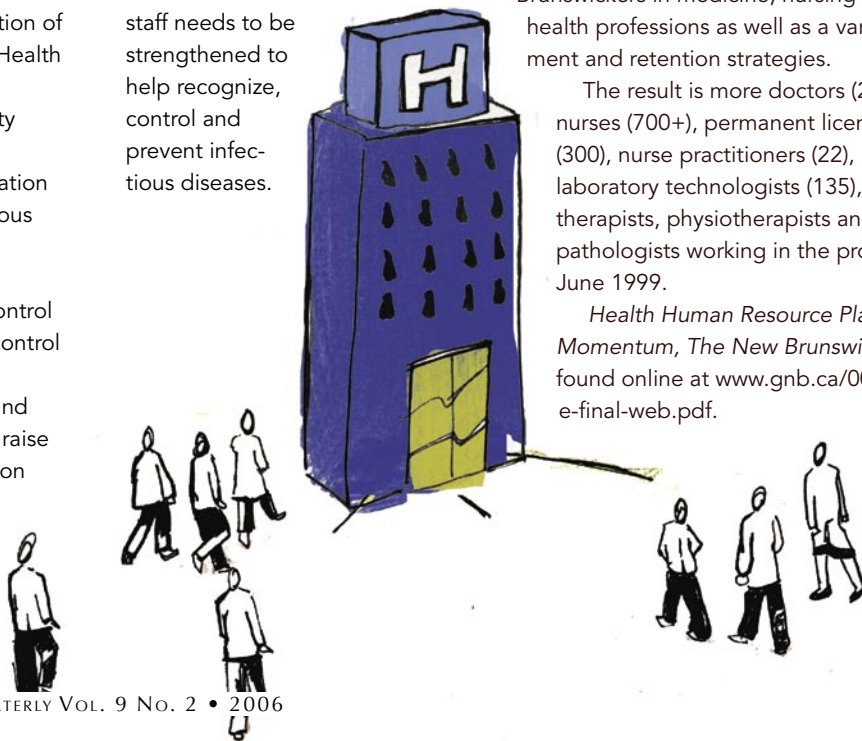
In Ontario, the **Credit Valley Hospital** and **Trillium Health Centre** will collaborate with the University of Toronto, Mississauga campus to help shape the future of healthcare delivery by physicians in Ontario. Enrollment in the MD program at U of T will increase by 26 students per year by 2007. A new Academy in Mississauga will be developed to provide medical students with a unique learning opportunity to broaden and enrich the student experience beyond the current academic/research-based hospital program. It will include primary, secondary and tertiary care based in community hospitals. The "distributed education" approach will encourage more students to think about selecting a career in family and community medicine, and the generalist specialties such as general surgery, general pediatrics, general internal medicine and general psychiatry.

**New Brunswick** also recently released a progress report on health human resources strategies and initiatives undertaken in recent years. The report, *Health Human Resource Planning: Gaining Momentum, The New Brunswick Journey*, fulfils a commitment made by first ministers to increase the supply of health professionals based on assessed needs, and to report on their training, recruitment and retention efforts by December 31, 2005.

New Brunswick was the first jurisdiction in Canada to conduct a comprehensive analysis of its current supply of health professionals and its future requirements. The studies, commissioned in 2002 and known as the Fujitsu reports, have served as the basis for policy direction and decisions on integrated health human resources planning – including the addition of training seats for New Brunswickers in medicine, nursing and various allied health professions as well as a variety of new recruitment and retention strategies.

The result is more doctors (204), permanent nurses (700+), permanent licensed practical nurses (300), nurse practitioners (22), permanent medical laboratory technologists (135), occupational therapists, physiotherapists and speech language pathologists working in the province today than in June 1999.

*Health Human Resource Planning: Gaining Momentum, The New Brunswick Journey* can be found online at [www.gnb.ca/0051/pub/pdf/3582\\_e-final-web.pdf](http://www.gnb.ca/0051/pub/pdf/3582_e-final-web.pdf).



The **New Brunswick Surgical Care Network** website was launched February 1 by Health and Wellness Minister Elvy Robichaud. Information on the site, which can be found at [www.gnb.ca/0217/NBSCN-RSCNB/index-e.asp](http://www.gnb.ca/0217/NBSCN-RSCNB/index-e.asp), includes:

- types of surgery performed in New Brunswick, by hospital
- specialists who offer surgery in New Brunswick
- questions to ask your surgeon
- frequently asked questions and answers on wait-time management
- wait times for various types of surgeries, by hospital

The province's surgical access management strategy will involve implementation of a series of initiatives to improve access and reduce waiting times. These include development of a computerized registry of all patients awaiting surgery in New Brunswick, from the time they have met with their surgeon and agreed to have surgery until they booked into the system. This will be completed by 2007.

In Nova Scotia, Health Minister **Angus MacIsaac** released Nova Scotia's Health Human Resource Action Plan, which highlights Nova Scotia's achievements to strengthen health human resources, such as the provincial nursing strategy, physician recruitment initiatives, bursary programs for medical laboratory technologists and other partnerships and projects. The plan also outlines the province's goals and next steps. The report can be found on the Department of Health website at [www.gov.ns.ca/health/reports.htm](http://www.gov.ns.ca/health/reports.htm).

## Appointments



The Honourable **Tony Clement** is the new federal Minister of Health and the Minister for the Federal Economic Development Initiative for Northern Ontario. Mr. Clement is a first-time Member of Parliament and was elected to the House of Commons in 2006. Prior to running for federal office, Mr. Clement was a member of Ontario's provincial

legislature from 1995 to 2003, representing Brampton South (later, Brampton West–Mississauga). From 1995 to 1997, Mr. Clement was Parliamentary Assistant to the Minister of Citizenship, Culture and Immigration and Parliamentary Assistant to the Premier. In 1997, Mr. Clement was appointed Minister of Transportation. In 1999, he became Minister of Environment and later, Minister of Municipal Affairs and Housing, and in 2001, Health and Long Term Care.

## Better bone health focus of new chair

The newly created Alliance for Better Bone Health Chair in Rheumatology will be held by **Dr. Jonathan (Rick) Adachi**, a professor of medicine in the Michael G. DeGroote School of Medicine at McMaster University, director of the Hamilton Arthritis Centre, and head of rheumatology at St. Joseph's Healthcare, Hamilton. The chair is being supported by the Alliance for Better Bone Health, a partnership between P&G Pharmaceuticals, Inc., and the sanofi-aventis Group.

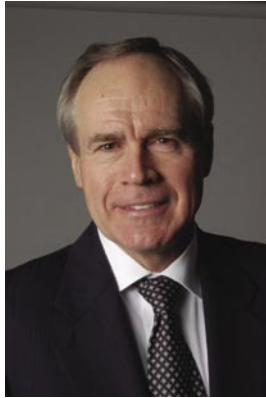
A graduate of McMaster's medical program (1979), and a specialist in internal medicine (1983) and rheumatology (1984), Adachi is a member of Osteoporosis Canada and the International Osteoporosis Foundation. He has conducted many clinical trials in osteoporosis and osteoarthritis and has published extensively on a wide variety of therapies for the prevention and treatment of corticosteroid-induced osteoporosis. He has also co-authored many systematic reviews of a wide variety of osteoporosis therapies and has participated in the development of guidelines for the treatment of primary and corticosteroid-induced osteoporosis in Canada.



The people in the photo from left to right are: Tony Wong, MPP for Markham and Parliamentary Assistant to the Minister of Research and Innovation; Jeff Davis, General Manager, P&G Pharmaceuticals Canada Inc.; Dr. Rick Adachi, Chair Holder, The Alliance for Better Bone Health Chair in Rheumatology; Dr. John Kelton, Dean and Vice-President, McMaster University; Peter George, President and Vice-Chancellor, McMaster University; John Huss, Vice-President Internal Medicine Business Group, sanofi-aventis Canada Inc.

## Quarterly Change

Ontario's London Health Sciences Foundation's Board of Directors is pleased to announce the appointment of **Dan Ross** as President and Chief Executive Officer of the Foundation. Mr. Ross is well known to London Health Sciences Foundation and London Health Sciences Centre as a result of his significant volunteer contributions to both organizations for more than 15 years. He served as a director and board chair of University Hospital Foundation from 1992 to 1996 and most recently chaired the Major Giving Advisory Council of London Health Sciences Foundation. He is the immediate past chair of London Health Sciences Centre, where he maintained an active role since his appointment to the board in 1990 and also served from 1996 to 2000 as a Commissioner of Ontario's Health Services Restructuring Commission.



**Kurt Pristanki** has been appointed CEO Geraldton District Hospital in Northern Ontario. He had been CEO of Glengarry Hospital in Alexandria, Ontario for the past 12 years.

**Paula Bond** the BC Ministry of Health as the Assistant Deputy Minister, Clinical Innovation Division and Chief Nurse Executive, in early February 2006. Paula most recently held the position of Vice-President, Acute Care & Chief Nurse Executive with the Windsor Regional Hospital – a multi-site community hospital and healthcare complex serving over 350,000 people in the City of Windsor and Essex County.

Newfoundlander **Reuben Noseworthy** started his term as president of the Canadian Society for Medical Laboratory Science (CSMLS) on January 1, 2006. CSMLS is Canada's national certifying body for medical laboratory technologists and medical laboratory assistants. It is also a voluntary professional society for medical laboratory professionals, representing 14,000 members in Canada and around the world.

**Bernie Blais** has accepted the position of Chief Executive Officer of Alberta's Northern Light Health Region. He had been Nunavut's deputy minister of Health since 2002.

Dr. Howard Alper, Chair of the Board of Governors of the Canadian Academies of Science (CAS), recently announced the appointment of **Dr. Peter Nicholson** as the first President of the CAS. Dr. Nicholson, who until recently held the position Deputy Chief of Staff for Policy in the Prime Minister's Office, said that he is "anxious to get on with the job of building the Canadian Academies of Science and positioning the organization as an essential voice for Canadian science, both nationally and internationally." He was one of the charter members of the Prime Minister's National Advisory Board on Science and Technology, established in 1987 by Brian Mulroney, and the founding Chair of the Fields Institute for Research in Mathematics. The purpose of the CAS is to provide expert and independent assessments of science in the public interest.

### ERRATUM:

In the last issue of *Healthcare Quarterly* (9:1), we failed to include the full list of authors of the paper "Application of Lean Six Sigma for Patients Presenting with ST-Elevation Myocardial Infarction: The Hamilton Health Sciences Experience." Here is the complete list of authors:

Ayad Al Darrab, MD

Division of Emergency Medicine, McMaster University  
Hamilton, ON, Canada

Christopher MB Fernandes, MD

Hamilton Health Sciences, Division of Emergency Medicine  
McMaster University, Hamilton, ON, Canada

James Velianou, MD

Hamilton Health Sciences, Division of Cardiology  
McMaster University, Hamilton, ON, Canada

Madhu Natarajan, MD

Hamilton Health Sciences, Division of Cardiology  
McMaster University, Hamilton, ON, Canada

Rosanne Zimmerman, RN, Med

Quality and Patient Safety, Hamilton Health Sciences  
Hamilton, ON, Canada

Rhonda Smith, RN

Quality and Patient Safety, Hamilton Health Sciences  
Hamilton, ON, Canada

Teresa Smith, RRT

Quality and Patient Safety, Hamilton Health Sciences  
Hamilton, ON, Canada

Jennifer Pickering,

Pharmacy, Hamilton Health Sciences  
Hamilton, ON, Canada