The Wait Times Reduction Task Force was established in December 2016 by the minister of health, seniors and active living and tasked with examining and addressing waits for emergency care as well as priority procedures including hip and knee replacement surgeries, cataract surgeries and diagnostic tests.

The Emergency Department Wait Times Reduction Committee was co-chaired by Dr. John Ross and Dr. Alecs Chochinov, and looked at: the role of emergency care and governance; urban, rural and remote access to care; Indigenous and vulnerable populations; emergency medical services and transportation; patient flow; and the future of emergency care.

The Priority Procedures Wait Times Reduction Committee was co-chaired by Dr. Michael Rachlis and Dr. Jack McPherson, and considered issues related to magnetic resonance imaging, hip and knee replacement surgery, and cataract surgery.

The task force held consultations with both the public (six in Winnipeg, seven in rural Manitoba, and two in northern Manitoba) and health-care providers (53 staff consultations focused on emergency departments and 29 looking at priority procedures), as well as a consultation with the First Nations Health and Social Secretariat of Manitoba (Nanaandawewigamig) and health service provider Ongomiizwin (formerly the Northern Medical Unit).

In addition, the committees reviewed literature, studied best practices working in other jurisdictions, and undertook online surveys which received nearly 1,700 responses from the public and health system staff.

Health-care providers and members of the public worked on the steering committee and with the sub-committees looking at emergency department wait times and priority procedures. Participants included: Dr. Rob Grierson; Dr. Anthony Herd; Marion Ellis, R.N.; Pat Cockburn, R.N.; Dr. Harold Nyhof; Wayne Anderson; Martin Bilinkoff; and Debbie Brown. Dr. Eric Bohm Dr. Mathen Mathen and Dr. Marco Essig all provided clinical reports to the committee.

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KEY QUOTES FROM THE REPORT

Rural Access

“There is great variation in the 63 EDs in rural Manitoba – some are as large as Winnipeg’s community EDs; others treat very small numbers of very sick patients and do mostly primary care. Although people may feel reassured there is an ED in town, if the staff feel ill-equipped to deal with the sickest patients or there are frequent closures, expectations may not be met.” (Executive Summary, page xi)

“It is the opinion of the Emergency Department Wait Times Reduction Committee that it is unreasonable to expect rural residents to have to memorize, post, or look up the open and closing times of the ED when they experience an unexpected health problem that requires urgent attention. By definition, an ED is a 24/7 service.” (Page 85)

“If you ensure EDs are open 24-7 – it would be good to staff them with care providers who are current on ED techniques/recent expertise and continually learning. It doesn’t bother me if I don’t see a physician – as long as I see someone who can address by care needs appropriately at the time.” (Page 99 – public survey respondent)

“A facility that cannot reliably and consistently deliver emergency care 24/7 is not an emergency department, thought it could serve the public well in a different role.” (Page 137)

Winnipeg Clinical Consolidation

“The quality of care for true emergencies – CTAS 1s and 2s – in Winnipeg’s EDs is very high, and their wait times are generally very short.” (Page 26)

“One of the structural problems contributing to long ED waits in Winnipeg has been having six acute care hospitals, along with one UC [Urgent Care]. Each hospital and ED requires its own staffing, diagnostic resources and consultant specialists to function optimally, but it is not possible to fully resource each [site] with all the services needed on a 24/7 basis.” (Page 37)

“Consolidation of hospital and emergency services is sensible in concept, as it aims to bring together speciality, diagnostic and consultative services in a limited number of well-resourced centers, eliminating the dilution inherent in multiple acute care facilities…Ultimately, the number of Winnipeg’s EDs does need to be reduced, but concerns remain as to how many and how soon. The timing and proper planning of these changes can spell the difference between success and failure.”

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Patient Flow

“Of every 100 adult patients who go to Winnipeg’s EDs, only 13-14 require admission to hospital for continued or more advanced treatment.” (Page 71)

“Ultimately, it is fewer than 10 out of every 100 ED visits whose trajectories are blocked, but that block affects the wait times and care of countless others.” (Page 71)

Priority Procedures - MRI

“I am ok having to do this after hours or on the weekend if it can be done sooner.” (Page 187 public survey respondent)

“Existing capacity could also be improved by implementing and monitoring strategies to reduce the number of appointment slots which are unfilled because patients cancel or do not show for their appointment.” (Page 189)

Priority Procedures – Hip and Knee Replacements

“Central intake has improved the system’s ability to ensure patients who need to be seen are put on the wait list, and provided data to better track the demand for services. Further, the use of the central intake has meant that wait times for consultation are much more even across all the surgeons who are participating.” (Page 211)

Priority Procedures – Cataract Surgery

“The WRHA’s Cataract Surgery Program has undertaken multiple initiatives to establish an efficient surgical program that delivers quality, patient-centred care…Standardization of such practices has been critically important in the streamlining of program processes and the capturing of data for key indicators, necessary to inform funding allocations and to make comparisons between program wait times and established benchmarks.” (Page 237)

“A surgeon can now perform between 15 and 20, or even more, cataract procedures in a day, compared with two to four surgeries 20 to 30 years ago. However, the fee has not come down substantially and is still $450 per procedure. A $100 fee reduction would equate to an estimated $1.27 million dollars in cost-savings annually.” (Page 245)