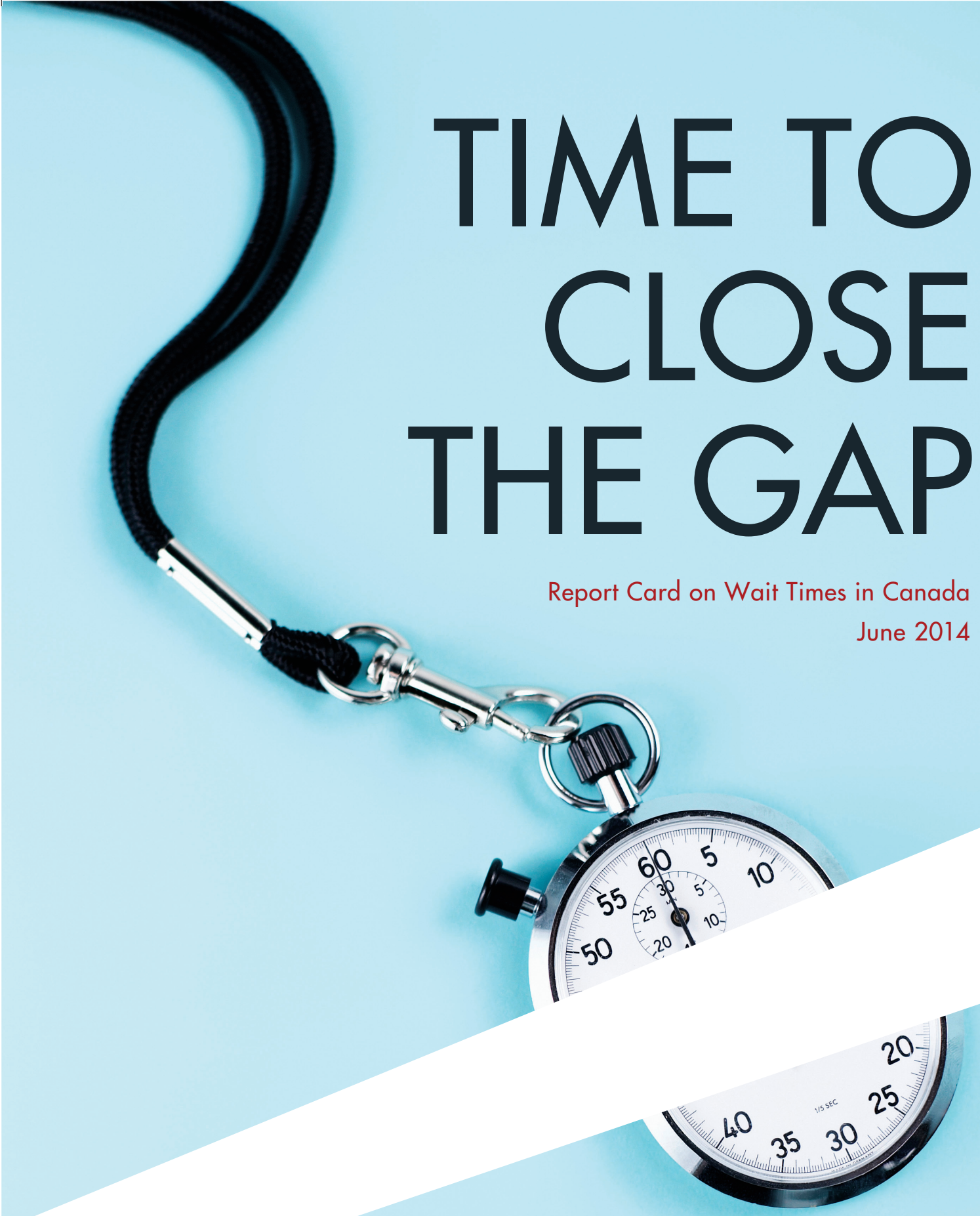
TIME TO CLOSE THE GAP

Report Card on Wait Times in Canada

June 2014



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WTA ATA

WAIT TIME ALLIANCE | L'ALLIANCE SUR LES TEMPS D'ATTENTE

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"No one said it would be easy to tackle growing waiting lists given the complexity of the issues involved. Nor, for that matter, did anyone suggest that a quick solution could be found. Yet Canadians deserve to have timely access to care. We believe that this is an achievable goal."

— Wait Time Alliance (WTA), Presentation to the House of Commons Standing Committee on Health, 2008

"Our biggest fear is that governments become complacent thinking that the wait times issue in Canada has been largely addressed. Let us not forget that most other OECD countries with universal, publicly funded health care systems provide timelier access for their citizens than in Canada. That is not to say we haven't made progress — we have. But the access agenda requires much more work."

— Dr. Chris Simpson, Chair of WTA, Presentation to Senate Standing Committee on Social Affairs, Science and Technology, 2011 statutory review of the 2004 10-Year Plan to Strengthen Health Care, *Sept. 29, 2011*

Executive summary

It has now been a decade since the 2004 Health Accord was signed by First Ministers. Among other things, the Health Accord called for the establishment of evidence-based benchmarks for medically acceptable wait times *starting with* cancer, heart, diagnostic imaging procedures, joint replacements and sight restoration as part of an effort to achieve "meaningful reductions" in wait times. Have meaningful reductions in wait times been achieved such that Canadians can access medical care to levels consistent with those available to the citizens of other leading industrialized countries?

For the past two years the Wait Time Alliance (WTA) has reported a worrisome trend of little to no progress in reducing waits for a range of necessary medical care in Canada. A review of the 2014 provincial wait-time data reveals that some provinces have or are beginning to make substantive and sustained progress to reduce wait times in the four initial areas where benchmarks exist — notably Ontario, Newfoundland and Labrador and Saskatchewan.

Others have continued to struggle to make any sustained improvements over the past three to four years. In addition to this provincial variation, there remains significant variation in wait times within provinces and within communities. However, while wait time reductions vary across the country, the volume of procedures handled by provincial health care systems — particularly those five initial areas identified in the 2004 Health Accord — has increased.[1] This fact should not be overlooked.

This year's WTA report card also includes a grading of provincial wait-time websites for the fifth consecutive year. Once again, we are pleased to report that the quality and transparency of reporting continues to improve for most provincial websites. This has included more provinces reporting emergency department wait-times, increased reporting of cancer surgery wait times, more provinces reporting pediatric wait times and the reporting of endoscopy wait times in a few provinces.

The last section of this year's report card identifies what the WTA believes are the biggest challenges to be addressed for Canadians to have the same level of timely access as citizens in most other industrialized countries and provides recommendations to address these challenges.

Introduction — The consequences of long waits in Canada

Imagine a land where:

- A patients' charter of rights and responsibilities is in place that includes wait-time guarantees.
- Over 90% of patients requiring elective care are treated within 18 weeks: from referral by a family physician to start of treatment/procedure *including* all diagnostic testing and specialist consultations.*
- Over 98% of in-patient procedures and day-surgery cases are treated within 12 weeks of agreement to treat.
- Over 90% of patients are seen within four hours in the emergency department (i.e., admitted, transferred or discharged).
- Citizens can access the most appropriate member of their primary care team within 48 hours.

* These waiting time standards are set by Scotland's National Health Service. For more information, see the following link: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/GPAccessStandard (accessed 13 May 2014).

- Up-to-date statistics and reports on wait times and health system performance indicators are publicly available.

In addition to providing timely access, this land has been successful in improving other dimensions of quality of care (e.g., significantly reducing levels of hospital-acquired infections, reducing the level of inappropriate care), and performance in all of these dimensions is being tracked through the measurement and reporting of performance targets available for use by patients, providers and system managers alike.

Fortunately, this land already exists — Scotland. But these types of results can be found in other leading health systems that use a variety of targets, guarantees and sanctions, such as in the English National Health Service (NHS) or in the health system of the Netherlands.*

For Canada, this desired state remains a work in progress. While there has been considerable effort over the past 10 years toward improving timely access to care for Canadians, much work remains to achieve the levels of performance seen in other countries.

Some may argue that long waits are the price Canadians must pay for having a universal health care system. Some also argue that the focus on wait times in Canada over the past decade has been misguided and has detracted from efforts to address other pressing health reforms. We do not see it this way. The focus on wait times is necessary for several reasons.

First and foremost, it is not right to force Canadians to wait two or three times longer for necessary medical care than citizens of other countries that also have universal publicly funded health systems. Furthermore, as seen in many other countries with universal health systems, it is indeed possible to have timely access to medical care — long waits are not an unavoidable price to pay nor are they tolerated by their citizenry.

Second, there is a significant cost to unnecessary waiting. It begins with a human cost to patients (and their families) whose health often suffers and deteriorates while waiting unnecessarily for care. There is also an economic cost to both the patient/family and society through lost labour productivity and lost tax revenue (see Box 1).

Third, long waits are detrimental to strong health system performance. They lead to additional costs, such as increased spending on drugs (e.g., to manage pain) or testing to monitor patients while they wait, as well as medical complications requiring more invasive treatment and follow-up. At the same time, long waits can lead to situations where treatments that would otherwise be provided are not because the wait is too long, resulting in less effective care being provided. High-performing health systems provide timely access to care for their citizens.

Box 1: The economic cost of waiting

Lengthy waits can have serious health consequences. We know that for some conditions, such as cancer, heart disease and mental health, the longer the wait for treatment, the worse the health outcome.[2] Long waits for children to access necessary care can be particularly harmful. Given that physical development in children and youth occurs very quickly, especially in the earliest years, delaying surgery could have a lifelong impact on young patients and their families. There is also the mental anguish and uncertainty associated with waiting for necessary care.

The impact of long waits goes beyond the patient's health to include an economic cost to both the patient and society. For individuals and their families, a lengthy wait can mean a substantial loss of income, particularly if they do not have insurance to cover any period of economic inactivity associated with the wait. A longer wait can also mean greater deterioration in the patient's health and a longer recovery time, potentially leading to a further loss of income.[3] We also know that low-income patients experience more problems accessing primary care and some types of specialty care than patients with higher incomes.

The substantive financial costs of lengthy waits for both patients and Canada's economy have been previously documented. A 2008 study prepared by The Centre for Spatial Economics for the Canadian Medical Association and the British Columbia Medical Association calculated the economic impact of excess wait times for five procedures (hip and knee replacement surgery, MRIs, CABG surgery and cataract surgery) in all 10 provinces. It found that, in addition to the obvious emotional, physical and financial toll endured by patients and their families, lengthy waits for these medical treatments cost Canada's economy an estimated $14.8 billion overall in 2007 in reduced economic activity ($16.9 billion in 2014 dollars). This took a $4.4 billion chunk out of federal and provincial government revenues.[4] Keep in mind that this study examined only a limited number of procedures and therefore underestimates the full cost of waiting that Canadians experience for a wider range of services.

Unnecessary waiting leads to substantive health and economic costs to patients and their families. Improving timely access to necessary care therefore has both health and economic benefits for all.

* For a review of what other countries have done on wait times see Siciliani L, Borowitz M, Moran V, editors. Waiting time policies in the health sector: What works? OECD Health Policy Studies. Paris (France): OECD Publishing; 2013.

Box 2: Commitments made in the First Ministers' 10-year plan

First Ministers commit to achieve meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration by March 31, 2007, recognizing the different starting points, priorities, and strategies across jurisdictions.

The Wait Times Reduction Fund will augment existing provincial and territorial investments and assist jurisdictions in their diverse initiatives to reduce wait times. This Fund will primarily be used for jurisdictional priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, expanding appropriate ambulatory and community care programs and/or tools to manage wait times.

First Ministers agree to collect and provide meaningful information to Canadians on progress made in reducing wait times, as follows:

Each jurisdiction agrees to establish comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to their citizens to be developed by all jurisdictions by December 31, 2005.

Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration will be established by December 31, 2005 through a process to be developed by Federal, Provincial and Territorial Ministers of Health.

- Multi-year targets to achieve priority benchmarks will be established by each jurisdiction by December 31, 2007.
- Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait time targets.
- The Canadian Institute for Health Information will report on progress on wait times across jurisdictions.

Source: Federal-Provincial-Territorial First Ministers. *A 10-year plan to strengthen health care.* Ottawa: Health Canada; September 2004.

Finally, long wait times are usually a symptom of poor health system performance or poor coordination between systems (e.g., lack of safe and affordable housing options for seniors) that need to be addressed. Poor health system performance and poor coordination between systems can be due to a number of factors, such as poor use of operating room resources within a region or an overreliance on hospital emergency departments in part because of poor access to primary or specialty care. Thus, strategies to improve timely access to care should lead to improvements in the other dimensions of quality care, such as improvements in efficiency and safety as well as improvements in the appropriateness of care (the right care provided by the right provider to the right patient in the right venue at the right time).[5]

The contribution of the Wait Time Alliance

It has now been a decade since the 2004 Health Accord was signed by First Ministers (see Box 2). Among other things, the accord called for the establishment of evidence-based benchmarks for medically acceptable wait times *starting with* cancer care, cardiac care, diagnostic imaging procedures, joint replacements and sight restoration as part of an effort to achieve "meaningful reductions" in wait times.

The Wait Time Alliance (WTA) was formed following the 2004 Health Accord in response to physicians' concerns over Canadians' access to health care and physicians' interest in working collaboratively with governments and other stakeholders to improve timely access for their patients. Over the past 10 years, the WTA has undertaken, and continues to undertake, several important activities:

- *Developing benchmarks*: In 2005, the WTA developed clinically derived, maximum wait-time benchmarks for the five specialty areas set out in the 2004 Health Accord: joint replacement, cataract surgery, radiation therapy (cancer care), coronary artery bypass graft (CABG) surgery, and diagnostic imaging (computed tomography [CT] scans and magnetic resonance imaging [MRI]), as well as for nuclear medicine. Since then, WTA members have established wait-time benchmarks for more specialty areas, most recently for rheumatology and general surgery, and to see a family physician (see Box 3). In addition, revised benchmarks for emergency care and diagnostic imaging have been developed that illustrate how the setting of wait-time benchmarks evolves as more is learned. In some cases, the WTA benchmarks are the same as the pan-Canadian benchmarks agreed to by all provinces in December 2005. However, in other cases they differ immensely: for CABG surgery, for instance, the WTA benchmark is six weeks and the pan-Canadian benchmark is 26 weeks.
- *Calling for standardization of data and definitions:* Since 2005, the WTA has called for a uniform, pan-Canadian approach to measuring and reporting on wait-time benchmarks. Although some standardization has taken place (e.g., the Paediatric Canadian Access Targets for Surgery [P-CATS], which are diagnosis-based access targets for outpatient consultation and waits for surgery for 867 diagnoses), there remain inconsistencies in how wait times are categorized among provinces

(e.g., agreement may be lacking on when the wait should start and on urgency categories, and even though standardized targets may be available, such as P-CATS, they may not yet have been adopted by all provinces).

- *Grading provincial performance:* Since 2007, the WTA has graded provincial wait-time performance against both pan-Canadian and WTA wait-time benchmarks. In the first five years, progress was made in most provinces to reduce wait times. For the past two years, the process has stalled and there have been setbacks in some provinces. However, as will be shown, improvements have taken place for most provinces in 2014.
- *Measuring wait times for the entire patient journey*: Most of the data on wait times collected and reported in Canada refer to the wait period from when the procedure (or treatment) is booked by the hospital to the day the procedure is started. But patients also wait at other points, such as to access a family physician, to access a specialist referral and for diagnostic tests. When all of the wait periods in a typical health care journey are considered together, an even more striking picture of delayed care emerges. The WTA has shown in previous reports that the waits for a specialist consultation can sometimes be longer than the actual wait to start treatment.[6]
- *Grading provincial wait-time websites*: Just as important as collecting wait-time data is the reporting of the data for use by the public and providers. Since 2010, the WTA annual report cards have included grading of provincial wait-time websites. Provinces have made substantive progress since then to improve the breadth and level of reporting on wait times.
- *Examining factors contributing to wait times*: The past three WTA report cards have highlighted particular factors that contribute to long wait times in Canada. These factors include the high number of alternate-level-of-care (ALC) patients, the majority of whom have dementia and other chronic health conditions, who occupy acute care beds while waiting for more suitable placement such as in the home with supports or a more appropriate residential facility; and the need for structural changes in health systems to enable further progress to be made in reducing wait times.
- *Providing solutions*: The WTA has shifted its approach from one of watchdog to one of solutions-focused partner. We continue to profile specialty-led innovations in health care access and advocate for more effective, integrated models of care (e.g., ALC prevention programs); at the same time, we are excited to collaborate where possible with officials from the Canadian Institute for Health Information (CIHI) and provincial governments in the measurement and collection of wait-time data, with a view to improving system access and quality.

Our observation of Canada's decade-long journey to improve timely access for Canadians and an examination

Box 3: New WTA benchmarks

The 2004 Health Accord signed by First Ministers called for the establishment of evidence-based benchmarks for medically acceptable wait times starting with cancer care, cardiac care, diagnostic imaging procedures, joint replacements and sight restoration. The members of the WTA saw this as an opportunity to provide leadership in establishing clinically derived maximum wait-time benchmarks for these initial areas in 2005. However, WTA members also recognized the need to expand the list of benchmarks to other specialty areas, and in 2007 WTA benchmarks were released for chronic pain (anesthesiology), emergency medicine, gastroenterology, plastic surgery and psychiatry, followed by benchmarks for obstetrics and gynecology and pediatric surgery.

The WTA is pleased to announce newly established wait-time benchmarks for rheumatology (Canadian Rheumatology Association), general surgery (Canadian Association of General Surgeons) and for seeing a family physician (College of Family Physicians of Canada). Details on the first two of these new benchmarks are provided in appendices A and B; box 4 provides the benchmark to see a family physician.

The establishment of wait-time benchmarks is not a static process; benchmarks evolve as more evidence and greater understanding of wait times comes to light. To this end, benchmarks were revised for radiology (MRI, CT)* and most recently for emergency medicine (see the WTA website).

Ensuring Canadians have timely access to necessary medical care must be seen as a journey. We have increased our knowledge over the past decade in understanding the causes of wait times and how they can be addressed. Government wait-time reporting has improved and wait times have decreased for some procedures. But the time has come to raise the bar as we are still far from appropriately meeting patient needs, especially compared with other countries. We must move beyond the five priority areas to other surgical and non-surgical care. Furthermore, a truly patient-centred approach requires us to look at the total wait faced by patients. The total wait includes the wait to see a family physician as well as the wait to see a specialist. When you consider the total wait many Canadians are experiencing, it is clear that we all have more work to do.[7]

* Details on the new benchmarks established by the Canadian Association of Radiologists were highlighted in the 2013 WTA report card. http://www.waittimealliance.ca/2013/2013-WTA-Report-Card_en.pdf

of how other countries have reduced wait times lead us to the following conclusions:

- It is possible to have timely access in a largely publicly funded health care system, as seen in many other countries. In Canada, a number of provinces have achieved meaningful reductions in wait times, particularly in four of the initial five areas (radiation therapy, CABG surgery, hip and knee replacement and cataract surgery). But in most cases the reduced wait times are still not in line with those found in other countries and the improvements continue to be limited to just some procedures.
- Common factors in countries where more success has been achieved in wait-time reductions include a citizenry that simply does not tolerate lengthy wait times, governments that made achievement of benchmarks and targets a serious priority, and strong engagement of health care providers.
- Increased financial resources can only go so far to improve wait times. Structural changes are also required, such as by improving system efficiency, improving how we manage wait times (e.g., adopting centralized intake systems), addressing inappropriate use of resources (e.g., high number of ALC patients) and improving patient safety.
- From a patient's perspective, the total wait must be reduced: the total wait includes the wait to access a family physician and the wait for a specialist referral, not just the wait for surgery or other scheduled care.
- Wait times can vary significantly among provinces, regions and even within communities.
- "Top-down" approaches are insufficient to achieve the results that Canadians deserve. It is important to engage patients, physicians and other providers to ensure success with wait-time reduction strategies.

Recommended wait times to see a family physician

In discussions regarding the total time patients wait for care, what is often overlooked is the fact that the wait-time continuum starts when a patient has a medical problem or concern. In fact, the first part of the patient journey often occurs when the patient seeks to schedule his or her first visit with a family physician.[8] The goal of every family practice should be to implement a system that ensures appropriate timely access to appointments for all patients.

The Patient's Medical Home is a family practice defined by its patients as the place they feel most comfortable — most at home — to present and discuss their personal and family health and medical concerns. It is the central hub for the timely provision and coordination of the comprehensive menu of health and medical services patients need. A Patient's Medical Home should ensure access for patients to medical advice and the provision of or direction to needed care 24 hours a day, seven days a week, 365 days a year. A Patient's Medical Home also advocates for and coordinates timely appointments with other health and medical services needed outside the practice.[9] Every Canadian should have the opportunity to be part of a family practice that serves as a Patient's Medical Home for themselves and their families. Unfortunately, a sizeable number of Canadians (4.4 million) still do not have a family physician.[10] However, provinces such as British Columbia and Manitoba are taking the lead to remedy this problem by ensuring everyone has their own family doctor.

Given the varying degree of complexity of patients' medical problems and the variation in patients' assessment of what is urgent or needs timely attention or care, an appropriate wait time to access a family physician would be difficult to define by a particular disease or illness. Thus, the College of Family Physicians of Canada has developed a single, albeit important, benchmark of same-day access to a family physician[11] (see Box 4).

Grading Canadians' timely access to care: results for 2014

Grading performance using pan-Canadian benchmarks set by provincial governments

The top portion of Table 1 presents letter grades for procedures representing the five initial areas identified in the 2004 Health Accord: cancer care (radiation therapy), CABG surgery, diagnostic imaging procedures (MRI, CT), joint replacements (hip and knee) and sight restoration (cataract surgery). These grades are assigned using the pan-Canadian benchmarks established by the provinces in 2005.

The past two WTA report cards have reported stalled progress and even some backsliding with respect to provincial grades on wait times for the five initial areas. We are pleased to report forward movement in 2014 over the previous two years: 67% of all provincial grades were

either "A" or "A+" compared with 58% in the previous year's report card. In 33% of the cases there was noticeable improvement (i.e., an increase in the number of green squares representing at least a 5% increase in patients treated within the benchmark from the previous year) compared with 29% the previous year.

While Ontario has been and continues to be a leading performer, we note that Newfoundland and Labrador and most recently Saskatchewan also perform very well in this year's report card, the latter province improving substantially over the previous year.

Despite this progress, the WTA reiterates its previous concern that there is wide variation in timely access between some provinces and between regions/communities within provinces. For instance, hip and knee replacement grades vary greatly between some provinces (e.g., A+ in Newfoundland and Labrador and much lower grades in both Prince Edward Island and Nova Scotia). In terms of regional variation, 97% of non-emergent knee replacements performed in Saskatoon were within the 26-week benchmark compared with only 63% in Regina. Similarly, in one Ontario health region, wait times for cataract surgery vary between 51 days in one health care institution and 190 days in another.

Grading performance on a wider range of procedures, treatments and diagnoses using WTA benchmarks

Since its inception, the WTA has been calling for an expansion of wait-time reporting. This has included:

- An expansion of procedures within the five areas identified in the 2004 Health Accord (e.g., reporting on a wider range of cardiac care and reporting for nuclear medicine).
- An increase in reporting on a much broader range of specialty areas. To assist with this process, wait-time benchmarks and targets have been established in over 10 additional specialty areas (see the WTA website for a full listing: www.waittimealliance.ca).

The bottom portion of Table 1 attempts to grade, where possible, provincial performance on these other equally important areas of specialty care — almost 40 in all, using WTA's medically derived benchmarks.

The good news is that there continues to be an increase in the range of procedures being reported beyond the initial five priority areas; however, less than a quarter of procedures in the lower portion of Table 1 could be assigned a grade, with Nova Scotia, Ontario, Saskatchewan, Alberta and British Columbia reporting the most procedures for grading. Despite this low figure, many provinces are reporting more procedures but just not in a manner that could be graded using the WTA benchmarks (depicted by a "〰" symbol). We are encouraged with the reporting of endoscopy wait times — notably in Newfoundland and Labrador for colonoscopies (urgent cases at this point) with the assistance of the Canadian Association of Gastroenterology — and we expect to see improvements in reporting of gastroenterology wait times in the near future. We are also pleased to assign more grades for pediatric surgical benchmarks.

The bad news is that there still remain major gaps in wait time reporting:

- No province as of yet reports wait times for either pain management or psychiatry (see Box 5).
- Some provinces do report wait times for procedures

Box 4: Benchmark to see a family physician

Benchmark: Same-day access
Advanced access model: The majority of appointment slots are open for patients who call that day for routine, urgent or preventive visits.

This benchmark is predicated on the principle that at least 95% of Canadians in each community would have a family physician. Furthermore, access need not only involve face-to-face visits but could involve connecting with family physicians and other health care providers through email, phone calls and group visits, to name a few. Teams comprised of the patient's family physician, nurses and other health care professionals have a greater capacity to offer the potential for timely access to care for the patients of a practice. Care must also be appropriate. Finally, access is connected to continuity — access must be tied to a patient's own family physician and team. Same-day access alone is not sufficient. To fully achieve better access for patients, this approach must be supported by the health care system and be adequately resourced. Health care providers need supports to shift to same-day access models.

Related items

The Patient's Medical Home [link to: http://www.cfpc.ca/PMH/]

Best Advice: Timely Access to Appointments in Family Practice [link to: http://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/2012_Final_Best_Advice_Enhancing_Timely_Access.pdf]

College of Family Physicians of Canada [link to: http://www.cfpc.ca]

Box 5: "Mind" the Wait?

In 2007, the Canadian Psychiatric Association (CPA), the national voice of the country's 4,500 psychiatrists, joined the WTA to improve access to psychiatric care by developing benchmarks anchored in the best available clinical evidence.

The 2014 WTA report highlights that, for the sixth consecutive year, provincial governments have made *no* progress in publicly releasing wait times for psychiatric care. The CPA finds this unacceptable given the priority that has been placed on access to mental health services.

Although objective measures of access to psychiatric care exist in a few regions across Canada,* more must be done to link available datasets and develop a common set of indicators that accurately capture how long Canadians are waiting for access to psychiatric services. Such an approach would facilitate a "race to the top" where jurisdictions could learn from one another and measure their success through a framework of directly comparable measurements.

A number of psychiatrists have actively led the development, implementation and evaluation of innovative models of care designed to improve access and health outcomes.†‡§

Although tracking wait times in health is a provincial responsibility, the CPA believes this is one strategic area where the federal government can play a constructive and facilitative role by working with the Mental Health Commission of Canada and the Canadian Institute for Health Information to develop a common approach to measuring access to psychiatric care and by identifying and scaling up proven service delivery innovations at the local level by creating a Mental Health Innovation Fund.¶

*Alberta Health Services, Q4 Performance Report, 2012–2013.
†The Urgent Psychiatric Assessment Program in British Columbia is an innovative program that offers follow-up care for all assessed patients using group medical visits where six patients share hour-long follow-up medical appointments that include 10 minutes each for individual exchange. GMV is not group psychotherapy but instead allows patients to learn from each other and from the advice and psychoeducation received by fellow group members. Remick R, Araki Y, Bruce R, Gorman C, Allen J, Remick AK, Lear SA. The Mood Disorders Association of British Columbia Psychiatric Urgent Care Program: A preliminary evaluation of a suggested alternative of outpatient psychiatric care. *Can J Psychiatry* 2014;50(4):220–7.
‡For over 20 years the Hamilton Family Health Team has successfully integrated psychiatrists and mental health counsellors into the offices of a practice that has grown to include 150 family physicians. The presence of this team substantially increases the number of people referred for a mental health assessment, reduces waiting times, leads to more efficient assessments and improves communication and coordination of care. It also offers opportunities for earlier detection of and intervention for mental health and addictions problems, prevents relapse, reduces avoidable emergency department visits and increases the skills and comfort of primary care staff in recognizing and managing mental health problems. This applies to children, youth and adults, and it is of particular benefit to individuals who are reluctant to use traditional mental health services. Kates N, MacPherson-Doe C, George L. Integrating mental health services within primary care settings: The Hamilton Family Health Team. *J Ambul Care Manage* 2011;34(2):174–82.
§In 2010, on the basis of its 2005–2010 Mental Health Action Plan, Quebec's health ministry launched a promising new model called "médecin spécialiste répondant en psychiatrie" (MSRP). Led by the department of psychiatry in each hospital and grounded in a population-based approach, the MSRP enhances access to care by strengthening the collaboration between front-line primary care providers and psychiatrists, providing quick access to expert advice in treating adults and children, consolidating professional and functional links between partners, and promoting a shift toward the values and principles of collaborative mental health care and community-based approaches to care.
¶This would be a time-limited and strategic-focused fund to scale up clinical and systems innovations that have been demonstrated to improve access to care at the local level and to contribute to the overall performance of the mental health system.

in gynecology and plastic surgery but the way in which these procedures are defined or grouped varies among provinces.

- Despite having CABG surgery included in the 2004 Health Accord and having a full range of benchmarks for cardiac care procedures developed by the Canadian Cardiovascular Society almost a decade ago, cardiac care reporting lacks standardization across the country. Much of the focus has been on CABG surgery even though this represents a small portion (1%) of all cardiac care received. Furthermore, there is no pan-Canadian standardization on how to report wait times for CABG surgery.

Emergency department wait times

Canadians wait longer in the hospital emergency department (ED) than citizens of other leading countries. For instance, 27% of Canadians reported waiting more than four hours in the ED compared with only 1% in the Netherlands and 5% in the United Kingdom.[12] Many factors contribute to wait times in EDs, such as a shortage of acute care bed capacity (actual bed numbers may be inadequate and/or beds may be blocked for budgetary or other reasons, including a high number of ALC patients) or limited community care resources.[13] It is important to keep in mind that an eight-hour visit to an ED that includes assessment, complex diagnostics and treatment is considerably different from an eight-hour stay in an ED waiting room awaiting assessment by a physician.[13]

Unlike for the initial five procedures, the reporting on ED wait times across the country has been limited and variable. Part of the lack of ED reporting is due to numerous waiting points (e.g., the time from arrival by ambulance to the time the patient is accepted by the ED; the time to the physician's initial assessment; the time from deciding to admit the patient until the time the patient leaves the ED; and the total length of stay or the total time spent in the ED until the patient is discharged or admitted).

CIHI collects information on ED use from six provinces and one territory (Prince Edward Island, Nova Scotia, Ontario, Manitoba, Saskatchewan, Alberta and Yukon).[14] Ontario and Alberta were the

Table 1: Wait time grades based on government and WTA benchmarks, 2014

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Treatment/service/procedure		NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC	National grade†
Five initial areas: Grading using government benchmarks												
Diagnostic imaging – MRI	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb
Diagnostic imaging – CT	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb	nb
Joint replacement – Hip	26 weeks	A+	C	C	B	A	A	B	A	A	B	A
Joint replacement – Knee	26 weeks	A+	C	F	C	B	A	B	A	B	C	B
Radiation therapy✇	4 weeks	A+	A	A+	A+	A+	A+	A+	A+	A+	A+	A+
Cataract surgery	16 weeks	A+	F	A	A	A	A	B	A	B	B	B
Heart – coronary artery bypass graft (CABG)♥	26 weeks	A+	/	A+	A+	na	A+	A+	A+	A+	A+	A+
WTA selected procedures: Grading using WTA benchmarks												
Cancer care (radiation therapy, curative care)												
Wait time from referral to consult (all body sites combined)	14 days	?	A	B	?	?	A	?	🖋	D	?	
Wait time from decision to treat to start of treatment (all body sites combined)	14 days	D	D	B	?	🖋	A+	B	A	B	B	
Breast	14 days	?	?	B	?	?	A+	D	?	?	?	
Prostate	14 days	?	?	B	?	?	A	F	?	?	?	
Lung	14 days	?	?	B	?	?	A+	B	?	?	?	
Cardiac care (scheduled cases)				☼		☼	☼		☼	☼	☼	
Electrophysiology catheter ablation	90 days	?	/	🖋	?	🖋	?	?	?	?	?	
Cardiac rehabilitation	30 days	?	?	🖋	?	?	?	?	?	?	?	
Echocardiography	30 days	?	?	?	?	?	?	?	?	?	?	
CABG	6 weeks	?	/	A+	A+	?	A	🖋	A+	🖋	B	
Chronic pain (anesthesiology)												
Nerve damage after surgery or trauma	30 days	?	?	?	?	?	?	?	?	?	?	
Pain related to disc problems	3 months	?	?	?	?	?	?	?	?	?	?	
Cancer pain	2 weeks	?	?	?	?	?	?	?	?	?	?	
Exacerbations or flare-ups of chronic pain	3 months	?	?	?	?	?	?	?	?	?	?	
Diagnostic imaging (non-urgent)												
MRI	60 days	?	F	C	?	?	A	🖋	🖋	F	?	
CT	60 days	?	A+	A	?	?	A+	🖋	🖋	B	?	
Emergency department (see Table 2)			☼				☼	☼		☼		
Gastroenterology (Endoscopy)		☼		☼					🖋			
Cancer	2 weeks	?	?	?	?	?	?	?	?	?	?	
Inflammatory bowel disease	2 weeks	?	?	?	?	?	?	?	?	?	?	
Fecal occult blood test positive	2 months	?	?	?	?	?	?	?	?	?	?	
General surgery				☼	☼	☼	☼		☼	☼	☼	
Nuclear medicine (scheduled cases)				☼				☼				
Bone scan – whole body	30 days	?	?	?	?	?	?	?	?	?	?	
FDG-PET	30 days	?	?	B	?	?	?	?	?	?	?	
Cardiac nuclear imaging	14 days	?	?	🖋	?	?	?	🖋	?	?	?	
Obstetrics and gynecology (scheduled cases)				☼	☼	☼	☼		☼	☼	☼	
Abnormal premenopausal uterine bleeding	12 weeks	?	?	B	?	?	?	?	A	?	?	
Urinary incontinence	12 weeks	?	?	D	C	?	D	?	D	?	?	
Pelvic prolapse	12 weeks	?	?	F	?	?	D	?	D	?	?	
Orthopedics (joint replacement)				☼	☼	☼	☼	☼	☼	☼	☼	
Total hip arthroplasty	26 weeks	A+	C	C	B	A	A	B	A	A	B	
Total knee arthroplasty	26 weeks	A+	C	F	C	B	A	B	A	B	C	
Plastic surgery				☼	☼	☼	☼		☼	☼	☼	
Breast reconstruction	4 weeks	?	?	A+	?	?	F	?	🖋	🖋	🖋	
Carpal tunnel release	2 months	?	?	A	A+	?	?	?	B	D	☼	
Skin cancer treatment	4 months	?	?	?	?	?	?	?	🖋	🖋	?	

Treatment/service/procedure		NL		PEI		NS		NB		QC		ON		MB		SK		AB		BC	
Pediatric surgery*						☼		☼				☼						☼		☼	
Advanced dental caries: carious lesions/ pain	90 days	?		?		〰		〰		?		〰		?		?		?		?	
Cleft lip/palate	21 days	?		?		D		?		?		〰		?		?		?		?	
Strabismus: 2–6 years old	90 days	?		?		F		D		?		〰		?		?		?		?	
Psychiatry (scheduled)																					
Major depression	4 weeks	?		?		?		?		?		?		?		?		?		?	
First episode, psychosis	2 weeks	?		?		?		?		?		?		?		?		?		?	
Mania (urgent)	1 week	?		?		?		?		?		?		?		?		?		?	
Rheumatology						☼															
Rheumatoid arthritis	6 weeks (4 weeks consult; 2 weeks start of therapy)	?		?		?		?		?		?		?		?		?		?	
Spondyloarthritis	3 months	?		?		?		?		?		?		?		?		?		?	
Psoriatic arthritis	6 weeks	?		?		?		?		?		?		?		?		?		?	
Sight restoration						☼		☼		☼		☼				☼		☼		☼	
Cataract surgery	16 weeks	A+		F		A		A		A		A		B		A		B		B	

Methodology

Based on provincial websites in April and May 2014:

A+: 90%–100% of population treated within benchmark

A: 80%–89% of population treated within benchmark

B: 70%–79% of population treated within benchmark

C: 60%–69% of population treated within benchmark

D: 50%–59% of population treated within benchmark

F: Less than 50% of population treated within benchmark

na: No data provided or data do not lend themselves to estimates of performance. The diagonal line (/) in white squares indicates that the service is not provided (e.g., CABG in PEI).

nb: No benchmarks. Pan-Canadian benchmarks for diagnostic imaging have not yet been established by governments. Where provinces have reported wait times, a colour grade is assigned to note progress made over the last 12 months.

† National grades are based on a weighted average of provincial letter grades.

♥ The category for bypass surgery (CABG) above represents only a small part of the full continuum of cardiac care provided to patients. Please refer to the Canadian Cardiovascular Society website at www.ccs.ca for a full range of benchmarks for cardiovascular services and procedures. All of these benchmarks will have to be adopted to meaningfully address wait times.

☮ Cancer radiotherapy. Wait times currently reflect only waits for external-beam radiotherapy, whereas waits for brachytherapy (implanted radiation treatment, e.g., for prostate and cervical cancers) go unreported.

? Province does not report wait times for the treatment.

〰 Province reports wait times for this specific procedure but not in a manner that would permit it to be graded by WTA measures.

☼ Province reports wait times for this specialty.

* These benchmarks enable pediatric institutions to compare with peers and to share learning

Colour grading methodology

This table identifies changes in wait times using the most recent publicly available data by province as follows:

	decrease in wait times over the previous year
	increase in wait times over the previous year
	no significant change (i.e., less than 5% increase or less than 10% decrease) over the previous year
	insufficient data to make determination

first provinces to report publicly on ED wait times, although they did not do so in the same manner. Alberta was also the first province to publicly report current estimated ED wait times for hospitals in Calgary and Edmonton. More recently, Prince Edward Island, Manitoba's Winnipeg Regional Health Authority and five hospitals in the metro Vancouver area have been reporting current ED wait times, either in terms of an estimated time to see a physician on the basis of traffic over the previous few hours or in terms of the wait to be placed in a treatment area.

The Canadian Association of Emergency Physicians (CAEP) introduced revised ED wait-time targets in 2013 (see the WTA website for more information). Table 2 attempts to assess performance in Ontario and Alberta on the basis of ED length-of-stay wait-time targets. Given the nature of waits in EDs, the CAEP targets focus on both the median wait in the ED (i.e., 50% of patients treated and discharged or admitted, or the typical patient experience) as well as the 90th percentile (i.e., the point at which 90% or the far majority of ED patients have been treated and discharged or admitted). The following can be seen from Table 2:

Non-admitted ED patients: According to the available data, the length-of-stay wait-time targets for most ED patients who do not need to be admitted to the hospital are being met. Contrary to public opinion, ED overcrowding is not caused by inappropriate use of EDs or by high numbers of lower acuity patients presenting to the ED.

Admitted patients: Only some of the length-of-stay wait-time targets are being met for ED patients who require hospital admission in Ontario (Alberta's data are not reported by CTAS level and thus a determination cannot be made for that province). Most ED patients requiring hospital admission fall within the CTAS urgency categories 2 and 3 (89% according to Ontario data). While approximately half wait less than 10 hours, half can wait much longer because of what CAEP refers to as access block — patients are unable to gain access to an appropriate hospital bed within a reasonable time frame. Most of the reasons for this access block are system-wide failures such as high numbers of ALC patients and a lack of community-based services and supports.

Clearly, more work is required to standardize the collection and reporting of ED wait times across Canada. However, in most cases, addressing the problem of long waits in the ED will require system-wide solutions that include efforts to prevent ED admissions as well as efforts to prevent readmissions.

Grading provincial wait-time websites

The WTA's report card continues to include an assessment of provincial wait-time websites, as the public reporting of wait-time data is an important component of enabling timely access to care for patients as well as tracking wait times and quality improvement. These websites are linked to the websites of provincial ministries of health and are intended for use by both the public and health care providers.

A review of the websites for 2014 shows continued improvement. The overall national grade of the websites is "B" and reflects modest improvement from the previous year — but the websites are much better than when they came online several years ago. By contrast, the WTA's 2010 national grade for the provincial websites was a "C." More provinces are reporting ED wait times, cancer surgery wait times and pediatric wait times. Newfoundland and Labrador and Saskatchewan are the first provinces to report some endoscopy wait times. CIHI also reports on wait times using an interactive website: http://waittimes.cihi.ca/

Nova Scotia made the most improvements over the past year, with the inclusion of trend data for all procedures to monitor progress in wait times. Although it does not include ED wait times, Nova Scotia is one of the few provinces to include wait times for some referrals to specialists and is the only province to report on wait times to access child, adolescent and adult community mental health and addictions services. While it is understood that the focus for the far majority of provincial wait-time websites has been surgical and hospital based, it is time to expand the reporting to a wider range of community services so that a more complete picture of the patient experience can be obtained, with the aim of improving it. Furthermore, governments and health care providers should have clarity on the reasons for collecting data and the benefits data can bring, such as for the use of the public and providers and for quality improvement purposes.

For the third consecutive year, patient groups were asked to assess the patient friendliness of the provincial websites, to incorporate patients' voices in the review process.*

* The WTA thanks the following patient representative groups for their participation in grading the provincial wait-time websites: Canadian Cancer Society, Gastrointestinal Society, and the National Association of Federal Retirees.

Common issues raised by the groups in their review of the provincial websites were the lack of ability to access wait times using a mobile device, the small font size often used, and an inefficient display of the information (e.g., need to download wait time data; many steps required to access data).

Accomplishments to date and recommendations

Assessments of progress on wait times in Canada have been undertaken by the Standing Senate Committee on Social Affairs, Science and Technology, the Health Council of Canada and CIHI.[15–17] The Health Council of Canada issued annual updates on the status of the commitments made in the 2003 and 2004 federal-provincial-territorial health accords. The council noted several wait-time developments that had occurred over the past decade including wait-time reductions, improved public reporting and implementation of many successful wait-time management strategies. At the same time, both the council and CIHI have acknowledged that there has been little reduction of wait times since 2010.[16]

Key accomplishments to date

In terms of accomplishments, a major development has been the tracking of wait times for some medical procedures in every province, something that was not done on a systematic basis before 2004. Furthermore, standardization of data continues to improve. With these data, we can state that over the past decade:

- Progress has been achieved in reducing wait times in most provinces for four of the five initial areas (i.e., joint replacement, cataract surgery, radiation therapy [cancer care] and CABG surgery).

Table 2: Grading emergency department wait times in Ontario and Alberta using new wait-time targets set by the Canadian Association of Emergency Physicians

		Ontario (Jan–Mar 2014)		Alberta (busiest 16 EDs, 2012–13)	
	Wait-time target set by the Canadian Association of Emergency Physicians	Median (50% of patients treated) (h)	90% of patients treated (h)	Median (50% of patients treated) (h)	90% of patients treated (h)
Non-admitted (discharged) patients					
CTAS level 1 (resuscitation)	Median: 4 h; 90th percentile: 8 h	4.4	8.3	3.1 h (combined for all urgency categories)	?
CTAS level 2 (emergent)	Median: 4 h; 90th percentile: 8 h	4.5	7.9		?
CTAS level 3 (urgent)	Median: 4 h; 90th percentile: 8 h	3.6	6.5		?
CTAS level 4 (less urgent)	Median: 2 h; 90th percentile: 4h	2.2	4.2		?
CTAS level 5 (non urgent)	Median: 2 h; 90th percentile: 4h	1.9	3.6		?
Admitted patients					
CTAS level 1 (resuscitation)	Median: 8 h; 90th percentile: 12 h for all CTAS levels	6.2	27.6	8.7 h (combined for patients of all urgencies)	?
CTAS level 2 (emergent)		10.5	32.9		?
CTAS level 3 (urgent)		10.2	31.1		?
CTAS level 4 (less urgent)		7.6	27.8		?
CTAS level 5 (non urgent)		5.4	25		?

? Province does not report wait times for this category.
(h) = hours

- Wait times have been reduced for a limited number of procedures and services in some provinces beyond the initial five areas.
- During this same period, provincial health systems have been able to handle an increase in the volume of procedures performed. For example, there was a 17% increase in hip replacements between 2011 and 2013.[1]
- Strategies are now in place to reduce wait times to see a family physician (e.g., advanced access, primary care teams) and to access a specialist consultation (e.g., support for physicians to consult, centralized intake that pools referrals).
- We have enhanced our collective knowledge on the wide range of factors that contribute to wait times and

Table 3: 2014 rating of provincial wait-time websites*

Province	Timeliness	Compre-hensiveness	Patient friendli-ness	Perfor-mance	Quality/ reliability	Average score	2014 grade	2013 grade	Best practices / comments
NS	3	4.5	4.5	5	4	4.2	A	B	Very easy to navigate; more on peformance reporting was added; provides wait times by facility; leader in reporting beyond surgical services; would like to see emergency department (ED) wait times added
SK	4	4.5	3.5	5	4	4.2	A	A	Appreciate body diagram and listing by specialist; needs to expand beyond surgical services and include ED wait times
BC	4	4	3.5	5	4	4.1	A	A	Appreciate body diagram search tool and listing by specialist; provides pediatric wait times; offers multiple ways to assess performance; needs to expand beyond surgical services and include ED wait times; needs trend data for a wider range of procedures
ON	4	4.5	3	4	5	4.1	A	A	Includes ED wait times and some pediatric wait times; strong reporting on cancer wait times; strong trend data; needs to expand beyond surgical services; could be more patient friendly (e.g., some broken links, many clicks required to get to data)
AB	4	4	4.5	3.5	4	4.0	A	B	Easy to navigate; limited reporting of ED wait times; helpful questions for patients to ask provider; able to review wait times by urgency category; needs to provide more detailed wait times for cancer care
QC	4	4	3	5	4	4.0	A	B	Timely data but needs to be more detailed on wait times by procedure; could be more patient friendly; very small font size; needs to include ED wait times
NB	3	3.5	3.5	5	4	3.8	B	B	Strong in providing trend data; very easy to navigate; should expand beyond surgical services
PEI	3	2.5	4	4	4	3.5	B	C	Added ED wait times; expanded list of reported services is still needed; good performance reporting; uses patient-friendly language
NL	2	2.5	3.5	4	4	3.2	C	C	First to report urgent colonoscopy wait times but would like to see list of procedures expanded; needs to release information on a more timely basis; hard to gather information efficiently because there are many links
MB	4	2.5	3.5	2	4	3.2	C	C	Information is timely; now has limited ED reporting; easy to navigate; needs to expand range of services; needs multiple ways to assess performance and to include trend data and links to benchmarks
					Overall national grade	3.8	B	B	

*Scoring for Wait Time Alliance rating of provincial wait-time websites: maximum of five points for each of the five criteria (perfect average score = 5).

the strategies can help improve patient flow.* These strategies include measures to improve the appropriateness of care delivered and other quality-related issues.

Remaining challenges

The WTA has issued several recommendations over its 10-year existence (see www.waittimealliance.ca for a listing of previous recommendations). In the early years, the focus of these recommendations was on the need to establish clinically derived maximum wait-time benchmarks, particularly beyond the initial five areas, and for time limits that were medically supported. Similarly, in its review of the 2014 Health Accord, the Standing Senate Committee on Social Affairs, Science and Technology issued several recommendations to move the wait-time agenda forward, the first two of which spoke to the need to expand benchmarks and strategies to all specialty care areas.[15] Early WTA recommendations were also directed at improving the collection and standardization of wait-time data.

In more recent years, the WTA recommendations have focused on implementing structural changes that can make a difference in improving timely access, such as having a national dementia strategy and creating community supports to reduce the number of alternate-level-of-care patients in acute care hospitals.

The WTA believes that the five most significant remaining challenges for Canada's access agenda are as follows:

- Ensuring all Canadians have timely access to necessary medical care comparable with citizens of most other industrialized countries. Although there has been some progress on reducing wait times in Canada, they still frequently exceed those found in many other peer countries, such as the United Kingdom, the Netherlands, Sweden or France. Furthermore, we see wide variation in wait times across the country and in regions within provinces. Don't Canadians deserve the same level of timely access for scheduled care?
- Gaining a better understanding of the full wait that patients experience. The full wait includes first seeking an appointment with a family physician and waiting for a specialist referral and any necessary diagnostic testing. The range of wait-time reporting must be expanded to the full continuum of care, including continuing care and palliative care. Although most provinces are collecting and reporting wait times beyond the initial five areas and are continuing to expand their reporting, there is still more work to do to report on wait times across the continuum of care and across the patient's entire journey beyond the wait for just the surgery.
- Addressing key structural factors that contribute to wait times. Although the 2004 Health Accord helped bring attention to the issue of lengthy wait times in Canada and provided additional funding to help reduce them, it is clear that structural changes are also required to ensure any improvements are sustained. Many kinds of structural changes can help, as illustrated in the WTA's 2013 report,[18] and these should include mitigating demand for some specialty care by investing in primary care and community-based care systems, better managing patients with complex care needs through integrated community-based collaborative care (primary care and specialist care), and ensuring resources such as operating rooms are used as efficiently and effectively as possible to respond to increased patient needs.
- There remains a lack of a shared understanding among providers, governments and the public regarding the collection and use of wait-time data. The data should be used to improve patient care. The data should support patient options and be used to monitor wait times over time as improvements are introduced.
- Providing adequate supports for providers and administrators to collect reliable wait-time data and to put this data to effective use for all parties. For instance, who should pay for inputting wait-time data? This may seem like a minor issue but there is a cost that is often not addressed (see box 6).

Recommendations

On the basis of the above challenges, the WTA respectfully recommends the following course of action for the next decade:

1. That governments in Canada should implement a charter on rights and responsibilities that would include targets and enforceable maximum wait-time guarantees for patients to access timely care. Such charters

* For instance, see the research work of the Western Canada Waiting List Investigators. http://www.wcwl.ca/library/other_knowledge_resources/

exist in England and Scotland, while other countries, such as Finland and Denmark, have enforceable patient wait-time guarantees.[2] This charter would apply to patients, providers, funders and organizers of care. It would require robust supporting mechanisms such as funding and human resources to ensure accountability and track performance. Alberta is the first province to take steps toward implementing a health charter.[19]

2. That to address the issues of (1) increased numbers of ALC patients, many of whom have dementia and other chronic conditions, and (2) the lack of appropriate residential and community-based options for seniors, the federal and provincial/territorial governments should collaborate with stakeholders in developing a pan-Canadian seniors strategy. As previously stated by the WTA, the most important action to improve access to timely specialty care for Canadians is to address the ALC issue supported in part by a national dementia plan. The strategy should also consider how to integrate more flexible residential options that better meet the needs of seniors.
3. That governments, regional health authorities and hospital administrators along with health care providers should implement strategies to make better use of surgical infrastructure (both physical and health human resources), such as making better use of untapped health infrastructure in community hospitals and rural areas. A frequent contributing factor to wait times is not so much the lack of operating room infrastructure but how the existing infrastructure is used. Much of specialty medical care depends on institutional health care facilities such as hospitals and their resources, including operating rooms and hospitals beds. To control costs, resources such as operating room time are frequently cut.[20]
4. That a partnership be established among provincial wait-time officials, CIHI, national specialty societies and patients to:
    - Identify a common vision for the purpose, use and benefits of wait-time data collection.
    - Oversee efforts to improve the quality and uptake of wait-time data for a full range of care.
    - Identify how data collection efforts can be properly supported.

    The WTA has started working with these groups and we have appreciated their willingness to collaborate further on strategies to reduce wait times.
5. That the federal government should be an active partner in working with provinces and territories and other stakeholders to improve timely access, given that ensuing all Canadians have timely access to necessary medical care is a pan-Canadian issue. There are currently significant gaps in timely access to a wide range of care across the country. A national approach to providing timely access to care is something found in other countries with high-performing universal health care systems.

The WTA believes it is entirely feasible to ensure timely access to care for all Canadians that is comparable to that which is available to citizens in other countries. Waits would be measured in days and weeks rather than months and years. This progress would be achieved as part of a wider range of efforts to improve the overall quality of Canada's health care system.

Box 6: The value to providers, patients and the system of collecting accurate wait-time data

We've all heard the saying "garbage in, garbage out" to emphasize the importance of having accurate data on which to base decision-making. Wait-time data are no exception. To have a listing of accurate wait-time data, a considerable amount of work is required behind the scenes, including pan-Canadian agreements on definitions of wait times and when the waiting periods begin and end. If there is little reliability in the data, then the commitment to enter data and use it will quickly erode.

Certainly, great strides are being made to improve the standardization of data thanks in part to the work of CIHI and provincial ministry of health officials. In the end, though, the WTA believes it will be important to create a culture of quality improvement whereby all stakeholders see a benefit to capturing and using the data for the purposes of improving patient care. Without this culture in place, the usefulness of wait-time data will be severely limited. Supporting this cultural shift will require showcasing clear benefits for those who input the data, such as front-line health care providers, and recognizing the administrative cost of inputting data.

To this end, physicians in clinical practice must play a leadership role in developing wait-time benchmarks, identifying clinically relevant data elements through consensus, and developing standard definitions and mea-

sures for prioritization for wait lists. Physicians and other health care providers should also be involved in the active monitoring of quality-related indicators, including using wait-time data for the purposes of improving patient care. Privacy and confidentiality of patient and provider information must always be respected. Finally, systems for managing wait lists must be continually monitored and evaluated to assess reliability and identify opportunities for improvement.[21]

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Appendix A: Wait-time benchmarks for rheumatology

Introduction

Rheumatic diseases are the leading cause of disability in Canadian patients. There is a wide spectrum of rheumatic diseases and their impact can vary; they represent a major cause of pain and functional loss and consequently have a major impact on our workforce. The Canadian Rheumatology Association is committed to reducing the wait times to access specialist care for patients with rheumatic diseases. We have established wait-time benchmarks for five major autoimmune and inflammatory rheumatic diseases.

Wait-time benchmarks

The ability to triage a patient is dependent on the quality of the information received in the referral letter, and to an extent on the investigations already performed. We recognize that there is a need to define the content of these letters and to specify the investigations that should be requested before referral should be defined. With this caveat, the Canadian Rheumatology Association has developed the following advice for maximum wait times following referral:

Rheumatoid arthritis
- Recommended maximum wait time to see a patient with suspected rheumatoid arthritis: four weeks
- Ideal wait time to start of disease-modifying antirhematic drugs once diagnosis is confirmed: two weeks

Spondyloarthritis
- Recommended wait time to see a patient with potential inflammatory back pain: three months
- Ideal wait time for MRI of spine requested by rheumatologist: six weeks

Psoriatic arthritis
- Recommended wait time to see a patient with possible psoriatic arthritis: six weeks

Systemic lupus erythematosus (SLE)
- Maximum wait time to see a patient with SLE: one month

Juvenile idiopathic arthritis (JIA)
- Recommended wait time to see a patient with systemic onset JIA (SOJIA): seven days
- Recommended wait time to see a patient with JIA (except SOJIA): four weeks

Juvenile idiopathic arthritis (JIA) uveitis screening
- Ideal wait time for uveitis screening by eye-care provider in patient with oligoarticular JIA, psoriatic JIA, RF-negative JIA or undifferentiated JIA: four weeks

Methodology

The CRA approached experts and committees to establish management guidelines for these diseases and to recommend benchmarks with the help of the best available evidence. Except where specifically mentioned, wait time was defined as "the time elapsed from when the rheumatologist received the referral to the time the patient was seen by the rheumatologist."

Rheumatoid arthritis

The Arthritis Alliance of Canada is working on establishing models of care for inflammatory arthritis and helped establish the benchmarks for rheumatoid arthritis. A scoping review was conducted to gather existing quality indicators. However, there are gaps in the literature, and certain quality indicators and their performance measures do not exist. This is especially noted in the area of system-level performance measures (e.g., tracking number of rheumatologists, wait times, access to allied health care).

The results of the scoping review and preliminary set of measures were presented and input was obtained from members of the working group. Revisions to the measures were made and circulated for open comment. Final benchmarks were set on the basis of these discussions.

Psoriatic arthritis

Wait-time benchmarks for psoriatic arthritis were established by consensus among experts in the field including members of the Spondyloarthritis Research Consortium of Canada (SPARCC) and other interested parties.

Axial spondyloarthritis

SPARCC is leading the spondyloarthritis research efforts and is currently developing updated treatment guidelines for the management of axial spondyloarthritis including ankylosing spondylitis.

Following a literature review, results relevant to wait-time benchmarks were presented to the SPARCC guidelines committee. MRI imaging has become an integral part of axial spondyloarthritis assessment and has helped decrease the delay in diagnosis. Availability of MRI is integral to the process of decreasing wait times for patients with axial spondyloarthritis and this is reflected in the established benchmarks. Following initial comments, a second round of discussion was conducted on the written document before the wait-time benchmarks were finalized.

Systemic lupus erythematosus

A questionnaire was administered via email to 27 rheumatologists, members of the Canadian SLE Working Group, to determine consensus on the ideal wait times for patients with SLE. Perceived current wait times for patients with suspected or potential SLE were <1 month (17% of respondents), 1–2 months (22%), 3–5 months (13%) and "other" (30%). Current wait times for patients with definite lupus were, <1 month (22% of respondents), 1–2 months (35% of), 3–5 months (4%) and "other" (26%). Comments made by respondents who indicated "other" included suggestions that wait times relied heavily on information about disease severity, organ involvement, call and triage responsibilities. An equal number of respondents reported using (43%) and not using (43%) a system for determining mild, moderate and severe SLE, and some (13%) chose not to answer this question. The group considered the influence of organ involvement and pregnancy on appropriate wait time.On the basis of the best available evidence, a consensus was reached on the ideal wait time for patients with new SLE. It was acknowledged that wait times relied heavily on information about disease severity, serology and organ involvement.

Juvenile idiopathic arthritis

The pediatric working group for the Canadian Rheumatology Association's Wait Time Alliance group led the process of establishing the Wait Time Alliance benchmarks for JIA. JIA is a heterogeneous group of arthritic conditions that starts in children younger than 16 years of age. The number and type of joints, long-term damage sustained as well as extra-articular manifestations seen in these patients can vary significantly depending on the type of JIA. Some extra articular manifestations like uveitis are potentially vision threatening while the systemic form of juvenile arthritis can be life threatening. Hence, the wait-time benchmarks would reflect these differences.

A review of literature was conducted to identify the ideal maximum wait times for patients with JIA. After this review, the working group decided on three statements to define the ideal wait time from referral to first visit with a pediatric rheumatologist. These statements were sent via electronic survey to the pediatric rheumatologist members of the Canadian Rheumatology Association and responses elicited. The response rate was 67.3%.

There may be significant challenges to meeting the benchmarks that have been set. It is well documented in the literature that the pediatric musculoskeletal examination is not performed well at all levels of physician training. Thus, referral letters may not convey the most relevant information to be able to triage patients appropriately. Many pediatric arthritides resolve within six weeks, and as such would not meet the definition of JIA. It is important to recognize that these acute arthritides are not included in the scope of these benchmarks. Finally, pediatric rheumatology in Canada is currently facing manpower issues that will make it difficult, if not impossible, to consistently meet the benchmarks for ideal wait times as defined in the statements above in the near future.

Appendix B: Wait times in general surgery

General surgery is a broad field within medicine. General surgeons deal with a myriad of diseases and employ both operative and non-operative methods. General surgeons are part of small group of physicians who make themselves available to care for patients 24 hours per day, depending on when patients present and how ill they are. The diseases general surgeons treat vary greatly in terms of the organ system affected, the potential impact on a patient's health, the timing of disease progression, the type of therapy that is most appropriate, and perhaps most importantly, the severity of the condition at presentation. Many of the medical problems addressed by general surgeons present on a continuum of severity that ranges from a mild affliction that requires timely but less urgent attention to those conditions that warrant immediate, emergent attention. For example, colon cancer can be an incidental finding at the time of colonoscopy. In this case, a patient requires attention in a less urgent time frame. On the other hand, colon cancer can present as a large bowel obstruction with evidence of bowel ischemia and compromise. In this situation, emergent attention is required. Likewise, even a problem as minor as cholelithiasis can have a wide range of urgency at presentation. Gallstones may be an asymptomatic, incidental finding on a routine ultrasound, and surgical attention may not even be warranted. At the opposite end of the spectrum, though, an acute cholecystitis with a ruptured gallbladder in a septic patient warrants emergent attention.

Given this wide range of disease severity at presentation, it is difficult, if not impossible, to assign an acceptable single wait time for the treatment of diseases commonly seen by general surgeons. The discussion of times must include a discussion of patient needs. With a wide spectrum of presentation, needs vary by situation. As such, the prescription of a single acceptable wait time may be impossible to achieve for most problems treated by general surgeons.

Despite the difficulties in discussing wait times in the context of conditions seen by general surgeons, the Provincial Committee of the Canadian Association of General Surgeons (CAGS) was tasked with determining appropriate wait-times benchmarks for procedures commonly performed by general surgeons in Canada. The CAGS Provincial Committee consists of representatives from each province. All members of the committee are practising surgeons who have expertise in the medical management of diseases commonly treated by general surgeons as well as expertise in managing wait lists in personal practices challenged by a wide range of patient needs and available resources. All members of the committee have a vested interest in improving patient care for all Canadians. This expert panel met to discuss wait lists and general surgery on several occasions. Given the above-noted challenges it became readily apparent that it would be impossible to assign wait times to individual conditions or surgical procedures. As the committee has nationwide representation it was able to look at the current attempts to manage wait lists in various jurisdictions across Canada. The committee was impressed by how Saskatchewan has addressed wait times. The system in Saskatchewan has not only been successful in defining wait times given the variability in acuity in the presentation of most general surgical disease, but it has also been successful in achieving the benchmarks it established. In-depth discussion was held around this approach, and the expert opinion of the committee members was used to define both levels of acuity and appropriate wait times for said levels. Once the provincial committee created its framework to define acuity level and wait times, further discussion was held at the level of the CAGS board to ensure the defined wait times would meet the needs of Canadians.

Three levels of acuity are proposed. Emergent cases (i.e., perforated viscus, ischemic bowel, acute perforated appendicitis) cannot wait and therefore are not part of a wait-time discussion. The three categories, along with their respective proposed wait times, are outlined in Table 1. It should be noted that the timelines for consults are defined as the time the consult is received until the time the patient is seen by the surgeon. In the case of procedures, wait times are defined as the interval between the decision to treat and the performance of the planned procedure. Examples of each level of acuity are also provided in the table.

It should be noted that in the case of referrals, urgent referrals should be made by a phone call, with further information provided in a letter or fax. A pooled consult service may offer an efficient strategy for addressing elective referrals.

The examples provided in Table 1 are meant to be illustrative, not exhaustive. Ultimately, it is up to the individual attending surgeon to determine the level of acuity on a case-by-case basis. The details of each individual case will dictate the level of urgency. Once a level of urgency is declared, however, it is incumbent on the surgeon and the medical system in general to ensure that the suggested timelines are, in fact, met.

Table 1: Proposed levels of acuity, their respective suggested wait times and examples of each level of acuity (wait time for a procedure is defined as the time from the decision to treat to the treatment itself)

Acuity level	Maximum acceptable wait time	Examples
Urgent	2 weeks	Unrelenting biliary colic, near obstructing colon cancer, lymph node biopsy for suspected lymphoma, incarcerated hernia reduced by another physician
Semi-urgent	6 weeks	Breast cancer, uncomplicated colon cancer, cancers treated by neoadjuvant chemotherapy, colo-vesicular fistula, symptomatic herniae, refractory anal fissure
Elective	16 weeks	Dupuytren's contracture, lipomas, minimally symptomatic herniae, stoma reversal, minimally symptomatic cholelithiasis