



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 anti-rheumatic 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.