Appendices

APPENDIX A: Summary sample of wait-time benchmarks by priority level*

Specialty and procedure	Wait-time benchmark		
	Emergency cases	Urgent cases	Scheduled cases
Emergency care	Level 1: Immediate (e.g., cardiac arrest) Level 2: < 15 min (e.g., chest pain) Level 3: < 30 min (e.g., moderate asthma) Level 4: < 60 min (e.g., minor trauma) Level 5: < 120 min (e.g., sprains)	Not applicable	Not applicable
Psychiatric care (e.g., psychosis, mania, major depression) • Access to family practitioner for acute mental health concerns • Access to psychiatrist after referral by family physician	 As deemed appropriate after triage Within 24 h	 Within 24 h Within 1–2 weeks	 Within 1 week Within 2–4 weeks
Plastic surgery	Within 24 h (e.g., infections, burns, hand and facial trauma)	Within 2–8 weeks (e.g., most malignant neoplastic conditions, some craniofacial conditions)	Within 2–6 months (e.g., congenital anomalies, wounds, most elective hand procedures)
Gastroenterology (includes time from referral to consultation and/or treatment/procedure when indicated)	Within 24 h (e.g., acute gastrointestinal bleeding, acute severe hepatitis)	Within 2 weeks (e.g., high likelihood of cancer, painless obstructive acute jaundice) Semi-urgent: Within 2 months (e.g., iron-deficiency anemia, chronic diarrhea)	Within 6 months (e.g., screening colonoscopy, chronic gastroesophageal reflux disease)
Anesthesiology — pain management (wait time for first assessment by pain subspecialist after referral by primary physician)	See Table 8 of the fall 2007 wait time alliance report, *Time for Progress*.		

*Priority or urgency levels are defined as follows: emergency = immediate danger to life, limb or organ; urgent = situation is unstable and may deteriorate quickly resulting in an emergency admission; semi-urgent = situation involving some pain, dysfunction and disability but patient is stable and unlikely to deteriorate quickly to the point of needing emergency care; scheduled = situation involving minimal pain, dysfunction or disability (also called "routine" or "elective").

APPENDIX B: Recommendations from report

The WTA recommends:

- Governments accept all outstanding wait-time benchmarks outlined in the WTA's 2005 report, *It's About Time*, that have not yet been adopted (i.e., cardiac care and diagnostic imaging).

- Governments announce multiyear targets for meeting wait-time benchmarks in the initial 5 priority areas by Dec. 31, 2007, as promised in the 10-year plan.

- Provincial governments adopt patient wait-time guarantees for each of the initial 5 priority areas by Dec. 31, 2007, that involve a publicly funded method of recourse for patients facing waits that exceed benchmark thresholds.

- Provincial governments standardize the conditions of their patient wait-time guarantees to ensure comparable guarantees for all Canadians.

- Governments issue regular progress reports (e.g., semi-annual) on the status of implementing their patient wait-time guarantees.

- Governments adopt the new wait-time benchmarks provided in this report on a pan-Canadian basis and begin to promote their use as part of an effort to move beyond the initial 5 priority areas.

- Where it has not yet occurred, governments expand their collection and reporting of wait-time data beyond the 5 priority areas.

- Federal government commit new funding to:
    - help provinces and territories provide timely access to care for the services addressed under the new set of wait-time benchmarks, including increased funding to address health workforce shortages;
    - support the Canadian Institutes of Health Research in wait-time benchmark development research and the Canadian Institute for Health Information in the adoption of comparable wait-time data that accurately reflect the length of time patients wait for access to care.