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Shedding Light on Canadians' Total Wait for Care

Report Card on Wait Times in Canada

June 2012

Overview

The Wait Time Alliance (WTA) has issued national report cards annually since 2007. Initially, our report cards were solely directed at provincial performance in the five areas identified in the 2004 Health Accord: cancer (radiation therapy); heart (bypass surgery); joint replacement (hip and knee); sight restoration (cataract) and diagnostic imaging (CT and MRI). Since then, the WTA has directed its attention toward: (1) broadening the scope to include Canadians' access to all areas of care; (2) improving the quality of public reporting on timely access; (3) highlighting issues that contribute to lengthy wait times; and, (4) identifying best practices to improve wait times.

The 2012 report card is the WTA's most comprehensive effort to date to shed light on all of these areas. It contains six sections:

1. Grading performance for the five initial areas using the pan-Canadian government benchmarks and grading a wider range of procedures/treatments using WTA benchmarks:

Unlike the past several years, the 2012 results show a worsening of performance with regard to patients receiving care within the pan-Canadian benchmarks set by governments. Although some provinces have shown improvement, the overall results point toward lengthier waits for Canadians. While provinces are increasing the number of procedures for which they publicly report wait times, there remains little reporting for most of the procedures identified as priorities by the WTA. Some reporting exists for procedures in obstetrics and Gynecology and Plastic Surgery, but progress is lacking on any provincial reporting for such specialties as chronic pain (anesthesiology), gastroenterology and psychiatry.

2. Assessing Canadians' total wait time to access necessary care:

What is the real wait that Canadians face to access care? Much of the focus to date on wait times in

Canada has been directed toward only the wait period between specialist consultation and start of treatment. But there is also the wait to access a family physician and the wait for any subsequent referral to see another specialist and any associated tests. This year's report sheds more light on the total wait Canadians face in obtaining necessary medical care.

3. **Identifying variation in Canadians' access depending on where they live:** Even in those instances where a province does well, there remain significant variations in wait times among its regions. These differences are striking and clearly illustrate the need to improve timely access across regions to benefit all citizens.
4. **Grading provincial wait-time websites:** The quality of provincial wait-time websites continues to improve. All provinces now have their own websites that report on wait times for at least the initial five procedures for which pan-Canadian benchmarks were established. While there is still room for improvement, the WTA believes the 2012 wait-time website grades represent a positive step forward.
5. **Shedding more light on the impact of alternate levels of care (ALC) on wait times:** Last year, the WTA reported that the most important action to improve timely access to specialty care for Canadians is to address the ALC issue. This year's report identifies a significant contributor to ALC stays and offers strategies to alleviate the problem.
6. **Highlighting efforts by the WTA and governments to improve timely access to care:** Health care providers, including the members of the WTA, as well as governments are implementing best practices to improve timely access to care for patients. We highlight some of these actions with a call to improve the sharing of best practices among provinces and regions.

1. Grading Canadians' timely access to care

For the first time, the WTA has expanded its traditional Table 1 to grade timely access for both procedures for which pan-Canadian government benchmarks exist (i.e., hip and knee replacement, cataract surgery, radiation therapy, heart bypass surgery) as well as for a range of other procedures chosen by WTA member specialties using WTA benchmarks.

The letter grades pertain to how well provinces are doing in terms of the percentage of patients receiving treatment within the benchmark (e.g., A=80% or more patients treated within the benchmark). The colour grades indicate whether the percentage of patients treated within the benchmark has increased from spring 2011 to 2012 (green), has significantly decreased (red) or stayed about the same (yellow).

A. Grading performance using the governments' pan-Canadian benchmarks

For several years, the WTA report cards have reported slight progress in improving Canadians' timely access to a narrow range of procedures: cancer (radiation therapy); heart (bypass surgery); joint replacement (hip and knee); sight restoration (cataract) and diagnostic imaging (CT and MRI). However, in 2012, this claim of "slight progress" can no longer be made (see top portion of Table 1):

- There is no improvement in the overall national grades between 2011 and 2012, and in some provinces grades have fallen. For example, there are two F grades using the government benchmarks in the 2012 report card, compared to one in 2011.
- In several instances, the percentage of patients treated within the benchmark has decreased in 2012 compared to 2011. This can be seen with the increase in the number of red squares (i.e., 9 in 2012 compared to only 2 in 2011). In addition, the 2012 report card features only 13 instances of improvement (i.e., a green square or 5% or greater increase in patients treated within the benchmark) compared to 24 in 2011.

The pursuit of more timely access to care is a journey that will see its share of setbacks. However, the WTA is concerned with the backsliding seen in most provinces. This

year's assessment clearly demonstrates the need to continue efforts to improve Canadians' access to timely care.

B. Grading a wider range of procedures/treatments using WTA benchmarks

Since 2007, the WTA has called on governments to endorse national wait-time benchmarks/targets for health services beyond the initial five areas. In fact, the 2004 Health Accord stated governments were to "start" with the initial five areas – not to begin and end with them. Recognizing the importance of reducing waits for all patients, the WTA's 13 national specialty society members have established wait-time benchmarks for 925 treatments, procedures or diagnoses.*

Table 1 also lists over 45 medical treatments/conditions that have either the highest volumes, the greatest potential for improvement or the greatest return-on-investment, based on WTA member input. Waits were graded based on information publicly available on provincial websites. A question mark (?) is assigned if the province does not report wait times for the particular treatment/service. An eye-glasses symbol (⌚) indicates that the province tracks wait times for this specialty but not for the specific procedure in a manner that would permit it to be graded by WTA measures. **This includes grading coronary artery bypass surgery (CABG), radiation therapy and diagnostic imaging using WTA benchmarks which are significantly different than the pan-Canadian government benchmarks. For example, while all provinces providing CABG received a grade of A using the government benchmark (26 weeks), the grades were lower when compared to the WTA benchmark of six weeks.**

There remains little provincial reporting for most of the procedures listed in this section of Table 1. Some reporting exists for procedures in obstetrics and gynecology and plastic surgery but there remains a lack of progress on any provincial reporting for such specialties as chronic pain (anesthesiology), gastroenterology, emergency care (only Ontario and Alberta report on emergency department wait times) and psychiatry.

The lack of publicly reported wait-time data for mental health services was identified in the Mental Health Commission of Canada's recently released Mental Health Strategy for

*Wait Time Alliance. Wait times benchmarks. Available: www.waittimealliance.ca/wait_times.htm (accessed 2012 June 4).

Table 1

Treatment/service/procedure		NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	National grade†
Five initial areas: Grading using government benchmark												
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	D	D	C	A	A	D	C	B	A	B
Joint Replacement – Knee	26 weeks	C	F	F	C	B	A	D	D	C	B	C
Radiation Therapy [Ⓟ]	4 weeks	A	A	A	A	A	A	A	A	A	A	A
Cataract Surgery	16 weeks	B	C	C	A	A	A	D	C	B	B	B
Heart – Coronary Artery Bypass Graft (CABG)♥	26 weeks	A	na	/	A	A	na	A	A	A	A	A
WTA selected procedures: Grading using WTA benchmarks												
Anesthesiology (chronic pain) ☀												
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	?	?	?	?	?	?	?	?	?	?	?
Cancer care (radiation therapy, curative care)												
All body sites combined	14 days	F	B	?	?	?	A	D	B	B	B	?
Breast	14 days	?	?	?	?	?	A	D	?	?	?	?
Prostate	14 days	?	?	?	?	?	A	F	?	?	?	?
Lung	14 days	?	?	?	?	?	A	B	?	?	?	?
Cardiac care (scheduled cases) ☀												
Electrophysiology catheter ablation	90 days	?	na	/	?	?	?	?	?	?	?	?
Cardiac rehabilitation	30 days	?	?	?	?	?	?	?	?	?	?	?
Echocardiography	30 days	?	?	?	?	?	?	?	?	?	?	?
CABG♥	6 weeks	B	na	/	A	A	na	A	F	A	?	C
Diagnostic imaging (non-urgent)												
CT	4 weeks	?	A	?	?	?	A	?	B	A	?	?
MRI	4 weeks	?	F	?	?	?	D	?	F	F	?	?
Emergency department (Length of stay wait-time benchmarks)												
Non-admitted patients:												
CTAS level 1 (resuscitation)	8 hours	?	?	?	?	?	A	?	?	A (based on 4-hour target for all non-admitted patients)		?
CTAS level 2 (emergent)	8 hours	?	?	?	?	?	A	?	?	A (based on 4-hour target for all non-admitted patients)		?
CTAS level 3 (urgent)	6 hours	?	?	?	?	?	A	?	?	A (based on 4-hour target for all non-admitted patients)		?
CTAS level 4 (less urgent)	4 hours	?	?	?	?	?	A	?	?	A (based on 4-hour target for all non-admitted patients)		?
CTAS level 5 (non urgent)	4 hours	?	?	?	?	?	A	?	?	A (based on 4-hour target for all non-admitted patients)		?
Admitted patients:												
CTAS level 1 (resuscitation)	8 hours	?	?	?	?	?	D	?	?	D (based on 8-hour target for all admitted patients)		?
CTAS level 2 (emergent)	8 hours	?	?	?	?	?	F	?	?	D (based on 8-hour target for all admitted patients)		?
CTAS level 3 (urgent)	6 hours	?	?	?	?	?	F	?	?	D (based on 8-hour target for all admitted patients)		?
CTAS level 4 (less urgent)	4 hours	?	?	?	?	?	F	?	?	D (based on 8-hour target for all admitted patients)		?
CTAS level 5 (non urgent)	4 hours	?	?	?	?	?	F	?	?	D (based on 8-hour target for all admitted patients)		?
Gastroenterology												
Cancer	2 weeks	?	?	?	?	?	?	?	?	?	?	?
Inflammatory bowel disease (IBD)	2 weeks	?	?	?	?	?	?	?	?	?	?	?
Fecal occult blood test positive	2 months	?	?	?	?	?	?	?	?	?	?	?
Joint replacement (Orthopaedics) ☀												
Total hip arthroplasty	26 weeks	A	D	D	C	A	A	D	C	B	A	?
Total knee arthroplasty	26 weeks	C	F	F	C	B	A	D	D	C	B	?
Nuclear medicine (scheduled cases)												
Bone scan – whole body	30 days	?	?	?	?	?	?	?	?	?	?	?
FDG-PET	30 days	?	?	?	?	?	?	?	?	?	?	?
Cardiac nuclear imaging	14 days	?	?	?	?	?	?	?	?	?	?	?
Obstetrics and gynaecology (scheduled cases) ☀												
Abnormal premenopausal uterine bleeding	12 weeks	?	?	?	?	?	?	?	?	?	?	?
Urinary incontinence	12 weeks	?	?	?	C	?	C	?	F	?	?	?
Pelvic prolapse	12 weeks	?	?	?	?	?	?	?	F	?	?	?

Treatment/service/procedure		NL	PE	NS	NB	QC	ON	MB	SK	AB	BC
Plastic surgery											
Breast cancer reconstruction	4 weeks	?	?	?	?	?	F	?	?	?	F
Carpal tunnel release	2 months	?	?	?	B	?	?	?	C	D	?
Skin cancer treatment	4 months	?	?	?	?	?	?	?	?	?	?
Pediatric surgery*											
Advanced Dental Caries: carious lesions/ pain	90 days	?	?	?	?	?	?	?	?	?	?
Cleft Lip/Palate	21 days	?	?	?	?	?	?	?	?	?	?
Strabismus: 2-6 years old	90 days	?	?	?	?	?	?	?	?	?	?
Psychiatry (scheduled)											
Early psychosis	2 weeks	?	?	?	?	?	?	?	?	?	?
Postpartum severe mood disorders	4 weeks	?	?	?	?	?	?	?	?	?	?
Acute/urgent mental health concerns	1 week	?	?	?	?	?	?	?	?	?	?
Sight restoration											
Cataract surgery	16 weeks	B	C	C	A	A	A	D	C	B	B

Methodology

Based on provincial websites from April–May 2012:

- A: 80–100% 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 are provided or data do not lend themselves to estimates of performance. The diagonal line "/" in white squares indicates that the service is not provided i.e., CABGs 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 of bypass surgery (CABG) above represents only a small part of the full continuum of cardiac care 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 need to be adopted to meaningfully address wait times.

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

? Symbol is assigned if the province does not report wait times for the treatment.

↻ The province reports wait times for this specialty but not for the specific procedure in a manner that would permit it to be graded by WTA measures.

☼ The province reports on procedures for this specialty.

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

Colour Grading Methodology

This table identifies the change in wait times using the most recent publicly available data for each of the five priorities 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

Canada.¹ It noted that many community services do not even keep waiting lists for mental health services “because it might give false hope to people in need that eventually their turn will come.” The strategy calls for action to improve the collection and measurement of waits for community-based mental health services (e.g., psychotherapy and clinical counselling). It also calls for standards/benchmarks to be set for the wide spectrum of community, acute and highly specialized services, similar to those that exist for some physical illnesses.

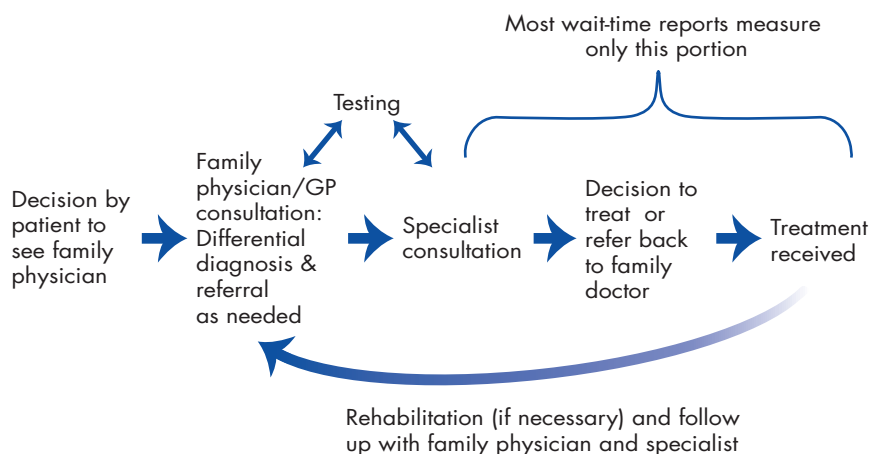
There is also a dearth of public reporting on pediatric wait times. However, pediatric wait-time data have been collected by the Canadian Pediatric Surgical Wait Times (CPSWT) Project since 2007. According to the Canadian Association of Paediatric Surgeons, data collected in 2011 from hospitals* across Canada participating in the CPSWT project demonstrated that 15,406 children (31%) exceeded the recommended wait time for surgery (P-CATS²); a 3%† increase from the year before. As of December 31, 2011, 50% of children (almost 9,000) still waiting for surgery were already past the recommended benchmark. More details on this project are available on the WTA website under “Leading Practices”. Funding is needed for an external organization to take over the collection and reporting of this important data. The CPSWT Project may be in its last year of self-funding.

Those instances where grades can be assigned frequently show low grades. It is the WTA's hope that in the near future, this table will feature more letter and colour grades than found in this year's report. We believe it is important for Canadians to have timely access to the full range of medical care. **While some provinces may have received a low grade or a glasses symbol for some procedures, the WTA views any reporting as a positive development, as opposed to instances where there is no reporting on the procedure at all.**

2. Assessing Canadians' total wait time to access care

Most of the attention on improving wait times has been directed at the wait between the specialist visit and the start of treatment (see Figure 1). In 2004, the College of Family Physicians of Canada (CFPC) stated that: “Wait times should be defined from when patients experience a problem and attempt to seek care through being seen by family physicians, through specialist consultation and specialty interventions, until definitive care is carried out.”³ This approach considers the patient's whole experience, not merely a portion of it. The first WTA report concurred with this approach, noting that “the clock starts ticking long before a patient ends up in another specialist's office.”⁴

Figure 1: Wait times from the patient's perspective



Adapted from prototype shared by The College of Family Physicians of Canada and from ICES, Access to Health Services in Ontario, Fig. 1.1

* In calendar year 2011, nine participating pediatric academic health sciences centres (PAHSC) and one community hospital.

† Increase in percentage of cases that waited beyond benchmark may be attributed to the reduced number of participating sites in calendar year 2011; hospitals were required to fund their participation in the project without external support.

Before a patient receives medical treatment, there are three preliminary stages to the wait-time continuum: 1) finding a family physician; 2) being seen by your family physician; 3) diagnostic intervention or being seen by a consulting specialist. Just over four million Canadians do not have a family doctor.⁵ These “orphan” patients often seek care from walk-in clinics and emergency rooms.

For those with their own family doctor, there may be problems obtaining timely care. Timely access is rated by patients as one of the most important elements of primary care.⁶ Yet according to international studies, only 17% of primary care practices in Canada offer patients same- or next-day appointments and Canada placed fifth out of seven nations with respect to patients being able to access care on nights or weekends.⁷

One of the most problematic access-to-care points in the wait-time continuum identified by the Primary Care Wait Time Partnership of the CFPC and the CMA (Canadian Medical Association) is the wait experienced by patients who are referred by their family physician to appointments with other specialists or specialty services.⁸ There are likely a myriad of reasons for these referral waits, such as a diminished role for family physicians in hospitals, which may have lessened communication between family physicians and other specialists.⁹ Improving access to care is the most critical step we can take to address wait times. Timely access not only emphasizes patient-centredness, it can “reduce redundancy and duplication of services (e.g., when a patient accepts and keeps a later appointment but also consults another provider in the interim), improve health outcomes, achieve better patient and provider satisfaction, and lead to a reduction in emergency visits.”¹⁰ There is an opportunity for other specialists to become involved with family physicians in new approaches to access to care that would benefit patients. These include participation with family physicians in Patient’s Medical Home practice models,¹¹ involvement with family doctors in shared care in defined clinical areas, and advanced access booking for consultations similar to the approaches being advocated for appointments with a family physician.

The CFPC’s Patient’s Medical Home seeks to address the whole wait time experienced by patients for appointments with both their family doctors, as well as the waits encountered in the referral-consultation process. With better access and care centred on the patient, Patient Medical Homes will

help to achieve better health outcomes for each person, practice population and community being served.

Wait times for specialist referrals

Currently, we know little about how long patients wait to be seen by a consulting specialist. Until recently, very few province-wide efforts were underway to capture this data. Those sources that do exist suggest the wait for a consultation is just as problematic as the wait to receive a procedure. One international survey of 11 leading industrialized countries found that Canada ranked 10th in terms of the percentage of “sicker adults” being able to see a specialist within a month (52% in Canada compared to 92% in Switzerland).¹² A 2011 survey of Canadian family physicians found that the most difficult specialties to access for their patients were: orthopedics; ear, nose and throat; gastroenterology; psychiatry; and neurology. “Long wait times” was the most frequently identified reason for these problems.¹³

In April 2012, nearly 200 gastroenterologists participated in the third national survey of wait times for digestive care. Carried out by the Canadian Association of Gastroenterology (CAG) during the week of April 16, the survey sheds more light on the issue of wait times for specialist referrals.

Participating physicians were asked to provide wait-time data on five new patients seen in consultation and five patients scheduled for investigation. Having performed similar wait-time assessments in 2005 and 2008, the CAG can plot trends in access to digestive care over a seven-year period.

In its recent survey, data were obtained on nearly 2,000 patient interactions with the health system. Data for six indications are provided in Table 2.

For example, the total wait time for a patient with a high likelihood of severe IBD is 126 days, which is 112 days longer than the target wait time. This total wait time for care is made up of a median wait for consultation of 72 days and then another wait for diagnostic testing of 44 days. These are patients with pain and bloody diarrhea, who are often unable to work or can only do so with difficulty. Analysis of total wait times indicates that the Canadian total wait time, considering all gastroenterology indications, has progressively increased from 2005–2012 and is now 30 days longer than in 2005. These results are of concern and indicate a need to pursue strategies that will ensure that patients receive the care they need in a timely manner.

As shown, the median wait time for a consult was longer than the median wait time for receiving the procedure, thus demonstrating that this part of the wait can be very problematic for patients and requires attention.

Efforts to improve referrals

There are efforts in place to improve the collection and reporting of referral wait times. For instance, some provinces report on consultation wait times for cancer treatment (e.g., Ontario, PEI, Saskatchewan and Alberta). Several provincial governments are working on collecting and reporting wait-time data on referral wait times across a wider number of specialties. The Saskatchewan Surgical Registry reports on some referral wait times (i.e., wait time to first appointment). While Nova Scotia already reports on specialist consultation wait times for a limited number of areas, it is in the process of standardizing referral wait-times reporting for a broad range of surgical services through its provincial Patient Access Registry.

The Canadian Medical Association, in conjunction with the Royal College of Physicians and Surgeons of

Canada and the College of Family Physicians of Canada, is working on a project funded by Health Canada to improve referral wait times. A Multi-Stakeholder Summit on the Referral and Consultation Process held in Ottawa on December 5, 2011, led to the publication of a number of projects underway across the country to improve referrals. A collection of project summaries can be found on the WTA website under "Leading Practices" (www.waittimealliance.ca).

The Northwest Territories implemented a number of measures to improve the referral process for patients. These include: having mandatory criteria for referrals; using criteria to allow for the prioritization of a patient's condition; using a territory-wide electronic medical record system; and using telehealth services to assess the appropriateness of the need for a referral.

3. Canadians' length of wait depends on where they live

While the WTA assigns grades based on province-wide performance, we acknowledge that significant variation in access occurs among regions within provinces. As shown in

Table 2: Gastroenterology wait times

Time in days for median waits from referral to consultation (TC), from consultation to investigation (TI), and total time from referral to initial investigation (TT). The desirable target time is shown in brackets.

INDICATION	Wait from referral to initial consultation (TC) (Median days)	Wait from consultation to initial investigation (TI) (Median days)	Total time from referral to initial investigation (TT) (Wait-time target) (Median days)
Clinical features of significant active Inflammatory Bowel Disease (IBD)	72	44	126 (≤ 14 days)
FOBT* positive	55	50	105 (≤ 60 days)
Bright red rectal bleeding	82	44	142 (≤ 60 days)
Chronic diarrhea or chronic constipation	126	52	162 (≤ 60 days)
Screening colonoscopy	150**	94**	279** (≤ 60 days)
All conditions/procedures: 2012	97	55	161
2008	91	50	155

* FOBT = Fecal Occult Blood Test positive; screening test for colon cancer

**Data excludes same day consultation & procedure.

Please note that the the reason that the TC wait times plus the TI wait times do not add up to TT wait times is because many more patients had only a consult than the number of patients who had both a consult and an investigation and the medians cannot be summed.

Figure 2 for wait times for hip replacement and Figure 3 for knee replacement, these differences are striking and are present in most provinces.* A variety of factors lies behind these variations (e.g., lack of operating rooms in some regions, lack of nurses and specialists, uneven demand, sub-optimal regional coordination, low rates of wait list pooling). Nevertheless, the causes need to be identified and strategies must be implemented to reduce them to the greatest extent possible.

Figure 2

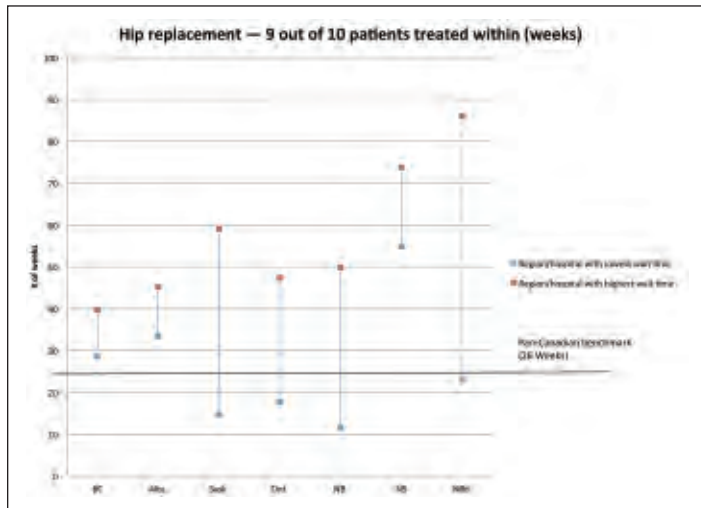
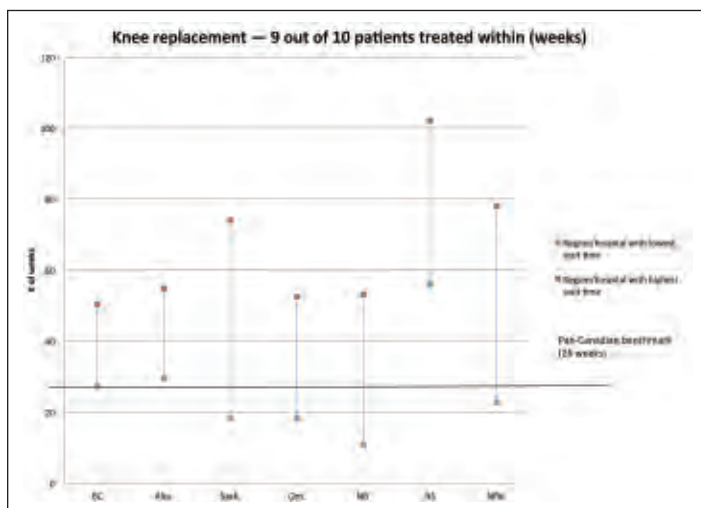


Figure 3



* Quebec does not report on wait times using 90th percentile measure so it was not included in this chart. However, a review of wait times for hip and knee replacement in that province also shows wide variation between its regions (based on percentage of patients treated within the 6 month benchmark).

† A full explanation of the website ratings can be found in the WTA’s technical backgrounder for the 2012 report card.

†† The four participating patient representative groups included: The Canadian Home Care Association; The Canadian Epilepsy Alliance; The Canadian Arthritis Patient Alliance and The Asthma Society of Canada.

4. Grading provincial wait-time websites

The ideal website should make it easy for patients, family members and health care providers to determine wait times in their area in a timely fashion using reliable data. For the third consecutive year, the WTA rated provincial wait-time websites as of April–May 2012 using the following five criteria†:

1. **Timely:** How often are the website’s wait-time data updated?
2. **Comprehensive:** How many procedures are covered?
3. **Patient-friendly/Accessibility:** How easy it is to find the wait time by procedure?
4. **Performance oriented:** Is it easy for patients to determine how long the wait is compared to the benchmark?
5. **Quality/Reliability:** Do reported wait times reflect the actual wait times, and are they reliable?

2012 Results

Table 3 provides the results of the 2012 website grading. We are pleased to report that the quality of provincial wait-time websites continues to improve with the average score increasing from 3.7 out of 5 in 2011 to 3.9 in 2012 for an overall grade of B. This year, five provinces received a grade of A, compared to only 1 in 2010. Notwithstanding the improved grades, the WTA would like to see more comprehensive reporting by all provinces in such areas as emergency care, cancer treatment and non-surgical procedures such as psychiatry.

Although it is not included in with the provincial websites, the Government of Northwest Territories has plans to include information related to wait times as part of its public reporting on system performance. This will include the tracking and monitoring of Alternative Level of Care (ALC) bed days.

This year’s review of provincial wait-time websites includes input from four patient representative groups as part of an effort to increase the patient voice in the process.†† A summary of their comments is presented in Table 4 indicating both the strengths and weaknesses of current provincial wait-time websites.

Table 3. 2012 rating of provincial wait-time websites (maximum 5 points for each of the 5 criteria)

Province	Timeliness	Compre- hensiveness	Patient friendly	Perfor- mance	Quality/ reliability	Average score	2012 Grade	2011 Grade	2010 Grade	Best practices/comments
ON	4	5	5	4	5	4.6	A	A	A	Very comprehensive; includes Emergency Department (ED) wait times and strong reporting on cancer wait times; strong trend data; needs to expand beyond surgical services.
BC	4	4	5	5	4	4.4	A	A	B	Comprehensive; patient friendly; offers multiple ways to assess performance; needs trend data beyond five initial areas.
SK	4	4	5	5	4	4.4	A	A	B	Very timely data; very comprehensive; needs to expand beyond surgical services and include ED wait times.
AB	4.5	4	5	4	4	4.3	A	B	F	Patient friendly and comprehensive. Alberta Health Services now reports ED urgent care clinic waits in real time for some areas.
NB	4	4	5	4	4	4.2	A	B	B	Strong in providing trend data; patient friendly.
NS	3.5	4.5	5	2	4	3.8	B	B	B	Strong presentation; leader in reporting beyond surgical services but more on performance reporting required.
QC	4	2	4.5	4	3.5	3.6	B	B	C	Timely data but needs to be more comprehensive. Could be more patient friendly.
MB	4	2	5	2	4	3.4	C	C	C	Patient friendly; needs to be more comprehensive and include trend data.
NL	2	1	5	4	4	3.2	C	D	F	Continued improvement over last year; patient friendly; needs to include wait times beyond the five priority areas.
PEI	2	1	4.5	4	4	3.1	C	C	C	Good performance reporting but more info should be provided for patients; needs to include more than surgical wait times.
Overall national grade						3.9	B	B	C	

Scoring for the WTA grading of provincial wait time reporting: There is a maximum of 5 points for each of the 5 criteria (total perfect average score = 5).

Table 4: Patient representative input on provincial wait-time websites

Identified strengths	Identified weaknesses
<p>The use of patient-friendly concepts by some websites such as:</p> <ul style="list-style-type: none"> • Having a great layout (Nova Scotia and BC frequently cited). • Easy to select procedures such as the use of a human body diagram (e.g., BC, Alberta). • Simple to navigate (Manitoba, New Brunswick and Newfoundland and Labrador frequently cited). • Flow diagrams that show the care pathways and the waits that are measured (e.g., PEI). • “What patients can do,” “Questions to ask,” “How to prepare for surgery” sections (e.g., Newfoundland and Labrador and New Brunswick). • Having a search tool to view by city, hospital, region, etc. Links to Google maps (e.g., PEI, Ontario, Nova Scotia). • Identifying region/hospital with shortest wait time (e.g., Ontario); having information on patient wait time guarantee (BC, Quebec). • Having a website survey to contribute to improvements (PEI). 	<p>Factors that contributed to websites not being patient friendly included:</p> <ul style="list-style-type: none"> • confusing layout • too much text • too many clicks required to get the desired information • the use of titles for procedures that are unclear for patients • small fonts • not having information available in printable format • broken links.
<p>Having comprehensive range of services reported, including emergency department wait times (e.g., Ontario).</p> <p>Having data separated out for pediatric patients (e.g., Ontario).</p>	<p>Lack of robust list of procedures (lack of reporting on Emergency Department wait times was frequently identified as a problem).</p>
<p>Having timely data (several provinces).</p>	<p>Variation in reporting by procedure (e.g., medians for some, averages for others).</p>
<p>Reporting on cancer wait times by both wait for consultation and wait for treatment.</p>	<p>Having cancer wait times on a different website.</p>
<p>Showing wait time trends; percentage of patients treated within the benchmark.</p>	<p>Lack of trend charts/graphs; not being able to compare data to wait time benchmarks/targets.</p>

A patient representative commenting on the New Brunswick website summarized well its value:

“I liked this website very much because the information was easy to find. I also appreciated seeing the benchmarks and how they compare to the national benchmarks. I like this accountability and the transparency to the public. I also appreciated finding documents on how to prepare for the surgery and that the measurements for wait times were calculated from the day the patient came for their first visit.”

The patient representative comments are insightful and suggest that patient input can be helpful in improving both the design and utility of provincial wait-time websites.

5. Decreasing the impact of alternate-levels-of-care (ALC) on wait times

The 2011 WTA Report Card outlined the effect of ALC on wait times:

- Emergency Department (ED) wait times are affected as patients in the ED cannot get admitted to hospital beds occupied by ALC patients, contributing to ED overcrowding.
- The lack of proper patient flow in the ED can also affect paramedic services and first response wait times.
- The lack of available beds for post-operative patients leads to many last-minute cancellations of scheduled surgeries.
- High ALC rates may also be contributing to longer waits

for urgent surgeries that often require an Intensive Care Unit bed.

As a result of the above factors, the 2011 Report Card stated “WTA members recognize that the most important action to improve timely access to specialty care for Canadians is by addressing the ALC issue.”

“Addressing the ALC issue” requires that we move beyond discussing the effect of ALC on wait times and drill deeper to uncover some of the most prevalent causes of ALC. This, in turn, will inform potential solutions.

There are numerous contributors to the ALC crisis. Several reports indicated dementia is the “key diagnosis related to ALC.”¹⁴ In 2009, this was supported by the Canadian Institute for Health Information (CIHI) report *Alternate level of Care in Canada*¹⁵ (https://secure.cihi.ca/free_products/ALC_AIB_FINAL.pdf) which indicated that “overall, dementia accounted for almost one-quarter of ALC hospitalizations and more than one-third of ALC days.”

In November 2011, the Ontario Institute for Clinical Evaluative Sciences (ICES) report *Health System Use by Frail Ontario Seniors* (www.ices.on.ca/file/ICES_Aging_Report_2011.pdf) noted that:

- Current literature shows that hospitalization occurs at least three times more often for older adults with Alzheimer’s disease than for age-matched older adults without the disease,¹⁶ with the clinical outcomes of hospitalization being worse for patients with Alzheimer’s disease. Dementia is the primary cause of long-term care institutionalization among elderly Canadians.
- Just under half (43%) of older adults with dementia visited the emergency department (ED) during the year prior to baseline compared to 24.6% of older adults without dementia.
- Among older adults with dementia, 11.2% visited the ED at least once for a potentially preventable condition, whereas the rate was only 5.2% among older adults without dementia.
- 16.8% of hospitalized older adults with dementia had ALC days, whereas this was the case in only 5.2% of the remaining group.

Dementia is not usually the reason for admission. It is therefore not picked up as a cause for ALC in chart reviews. It does emerge as a main driver of ALC when complex, multi-year analysis of multiple, linked databases is carried out, as ICES and CIHI have done.

When patients develop dementia, they lose their cognitive ability to manage their other chronic diseases (e.g., diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease). This interaction between co-morbidities often results in what has been termed a “dementia domino effect” leading to destabilization of chronic diseases, ED use and hospitalization. Such patients are prone to prolonged deliriums leading to prolonged lengths of stay in hospital and, all too often, ALC.¹⁷

In planning for the future, we must therefore factor dementia into the management of other chronic diseases. A myriad of measures can be envisioned to lessen the effect of ALC on wait times. Three select community care, acute care and long-term care approaches to decrease the impact of ALC on wait times are:

1. **Community-based solutions focused on prevention of ALC:** According to the World Health Organization (WHO) report ‘Dementia: A Public Health Priority’ (whqlibdoc.who.int/publications/2012/9789241564458_eng.pdf) released in April 2012, three G7 countries have developed a national dementia plan while two others are in the process of developing one — Canada has not.¹⁸ Canada needs a National Dementia Strategy that formally integrates the functions of primary care, specialist care and home care services with a strong focus on keeping seniors in the community, out of the ED and out of hospital and preventing or delaying long-term care placement. Such a strategy would decrease the impact of dementia on ALC rates by both preventing ED use/hospitalization and by freeing up long-term care beds for those acute care patients for whom placement in long-term care is truly unavoidable.
2. **Hospital-based solutions focused on prevention of ALC:** For those seniors for whom admission to hospital is appropriate and unavoidable, acute care hospitals must develop screening approaches to detect those who are at highest risk for becoming an ALC stay (i.e., this will invariably include screening for delirium and dementia; early and aggressive mobilization). This ALC risk screen and intervention should be applied as early as possible during the admission, and should trigger rapid assessment and intervention by the most appropriate service (e.g., geriatric medicine, care of the elderly, psychiatry) even if the patient is still in the ED awaiting a hospital bed.
3. **Long-term care based solutions to open up more long-term care beds for acute care patients:** Processes and

programs are required that permit seniors who were admitted to LTC from hospital but who have improved to the point where they no longer need LTC level of services, to graduate to residential level of care (or subsidized residences if required). This would thereby free up LTC beds for acute care patients for whom placement in long-term care is truly unavoidable.

Future reporting should assess progress on activities pertaining to these three actions.

6. Best practices in improving Canadians' access to necessary care

Providing timely access to necessary care is a shared responsibility. Governments have their role to play by, for example, adequately funding the system and supporting other stakeholders in making process improvements. Providers are also part of the overall solution to improve the performance of our health care system. WTA members acknowledge that they must work collaboratively with other health care providers, patients and governments to help Canadians attain timely, appropriate and equitable access to high quality, patient-centred health care. The WTA members can assist in a variety of ways, such as:

- Identifying best practices in improving access to quality care across Canada, (such as care pathways, referral pathways and EMR-embedded checklists), and share these to bring about positive change;

- Identifying system reforms that affect access, such as advanced access models and multi-disciplinary teams; and
- Contributing toward the collection of wait-time data. Details on wait time related projects underway by WTA members are available on the WTA website: www.waittimealliance.ca/leading_practices_e.htm

We note that during the preparation of this report card, many governments informed the WTA of their own efforts to reduce wait times and/or improve the collection and reporting of wait times in their respective jurisdictions. For instance, the Government of Newfoundland and Labrador recently developed strategies to reduce wait times for hip and knee replacement surgeries, as well as for emergency department visits.¹⁹ These include such actions as tackling the backlog of patients waiting for hip and knee joint replacement surgeries, adopting best practices from other provinces, and improving the measurement, collection and public reporting of wait times in emergency departments. The Government of Nova Scotia took steps to expand the list of procedures publicly reported on its website and supports the standardization of wait-time reporting across all provinces.

The WTA salutes these efforts and strongly encourages the collection and sharing of such projects across the country for the benefit of others.

About the Wait Time Alliance

The Wait Time Alliance (WTA) was created in the fall of 2004, following the release of that year's Health Accord (*A 10-year plan to strengthen health care*). WTA members have used their unique expertise to develop and advocate for medical wait-time benchmarks, as well as monitor governments' implementation of wait-time commitments.

WTA Mission Statement

The WTA is concerned over delayed access to health care for Canadians. We work collaboratively with our stakeholders to inform, advocate, and provide solutions to achieve timely, appropriate and equitable access to high-quality health care.

The WTA is comprised of 14 national medical organizations whose members are directly involved in providing care to patients. The WTA members are:

- Canadian Anesthesiologists' Society (CAS) — www.cas.ca
- Canadian Association of Emergency Physicians (CAEP) — www.caep.ca
- Canadian Association of Gastroenterology (CAG) — www.cag-acg.org
- Canadian Association of Paediatric Surgeons (CAPS) — www.caps.ca
- Canadian Association of Nuclear Medicine (CANM) — www.csnm-scmn.ca
- Canadian Association of Radiation Oncology (CARO) — www.caro-acro.ca
- Canadian Association of Radiologists (CAR) — www.car.ca
- Canadian Cardiovascular Society (CCS) — www.ccs.ca
- Canadian Medical Association (CMA) — www.cma.ca
- Canadian Ophthalmological Society (COS) — www.eyesite.ca
- Canadian Orthopaedic Association (COA) — www.coa-aco.org
- Canadian Psychiatric Association (CPA) — www.cpa-apc.org
- Canadian Society of Plastic Surgeons (CSPS) — www.plasticsurgery.ca
- Society of Obstetricians and Gynaecologists of Canada (SOGC) — www.sogc.org

In addition to these members, the WTA is partnering with a number of other organizations including The College of Family Physicians of Canada, the Canadian Geriatrics Society and the Canadian Association of General Surgeons.

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