



Health Care in Canada, 2012

A Focus on Wait Times



Canadian Institute
for Health Information

Institut canadien
d'information sur la santé

The page features decorative wavy lines in grey and teal that flow across the top and sides, framing the central content area.

Our Vision

Better data. Better decisions.
Healthier Canadians.

Our Mandate

To lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care.

Our Values

Respect, Integrity, Collaboration,
Excellence, Innovation

Table of Contents

About the Canadian Institute for Health Information	iii
Acknowledgements	v
Want to Know More?	vii
Foreword	ix
The Next Chapter	x
Executive Summary	xiii
Introduction and Wait Time Overview	1
Chapter 1: Waits for Routine Care	11
Access to Family Physicians	13
Access to Specialist Physicians	14
Early Detection, Timely Diagnosis, Faster Treatment: Waits for Screening and Diagnostic Testing	15
Strategies for Reducing Waits	19
Conclusion	20
References	21
Chapter 2: Waits for Emergency Department Care	27
Waits Before Entering the ED	28
Waits in the ED	28
Waiting to Leave the ED	32
Strategies for Reducing Waits	34
Conclusion	35
References	36
Chapter 3: Waits for Acute Care	41
Waiting for Elective Surgery	41
Waiting for Discharge	47
Strategies for Reducing Waits	49
Conclusion	51
References	52
Chapter 4: Waits for Specialized Care	57
Waits for Rehabilitation Services	57
Waits for Mental Health Services	60
Waits for Residential Care and Home Care	63
Strategies for Reducing Waits	64
Conclusion	65
References	66

Looking Back, Looking Forward 71

 Summary of Report Findings 71

 Issues on the Horizon 72

 Putting the Pieces Together 76

 References 77

Index 79

About the Canadian Institute for Health Information

The Canadian Institute for Health Information (CIHI) collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information. CIHI's goal: to provide timely, accurate and comparable information. CIHI's data and reports inform health policies, support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health.

For more information, visit our website at www.cihi.ca.

As of September 1, 2012, CIHI's Board of Directors consists of the following members:

Dr. Brian Postl

Chair of the Board, CIHI
Dean of Medicine, University of Manitoba

Mr. John Wright (ex officio)

President and Chief Executive Officer
CIHI

Dr. Luc Boileau

President and Director General
Institut national de santé publique du Québec

Dr. Marshall Dahl

Consultant Endocrinologist
Vancouver Hospital and Health Sciences Centre and Burnaby Hospital

Ms. Janet Davidson

Canadian Head of the Global Healthcare Center of Excellence
KPMG

Dr. Chris Eagle

President and Chief Executive Officer
Alberta Health Services

Dr. Vivek Goel

President and Chief Executive Officer
Public Health Ontario

Mr. David Hallett

Associate Deputy Minister
Ministry of Health and Long-Term Care, Ontario

Mr. John McGarry

Private Health Administration Consultant

Mr. Peter Morrison

Assistant Chief Statistician
Statistics Canada

Dr. Cordell Neudorf

Chair, CPHI Council
Chief Medical Health Officer, Saskatoon Health Region

Dr. Marlene Smadu

Associate Dean of Nursing
University of Saskatchewan

Mr. Howard Waldner

President and Chief Executive Officer
Vancouver Island Health Authority

Mr. Graham Whitmarsh

Deputy Minister
Ministry of Health Services, British Columbia

Acknowledgements

CIHI wishes to acknowledge and thank the many individuals whose work contributed to the development of this report.

Thank you to the following expert advisors for their review of relevant materials:

Eric R. Bohm, BEng, MD, MSc, FRCSC
Associate Professor of Surgery, University of Manitoba
Co-Chair, Canadian Joint Replacement Registry Advisory Committee

Laurie Bourne
Senior Manager
Access to Care Informatics, Cancer Care Ontario

Brie DeMone
Executive Director
Acute, Tertiary and Specialty Care, Manitoba Health

Sheryl Harris
Assistant Director
Acute Care and Quality Health Care Strategies Directorate, Strategic Policy Branch,
Health Canada

Howard Ovens, MD, FCFP(EM)
Director, Schwartz/Reisman Emergency Centre, Mount Sinai Hospital, and Associate
Professor, Department of Family and Community Medicine, University of Toronto; Toronto
Central LHIN Lead for Emergency Medicine and Ontario Provincial Lead

Janice Sanger
Director
Access and Clinical Efficiency Division, Department of Health and Community Services,
Government of Newfoundland and Labrador

Claudia Sanmartin, PhD
Chief
Health Analysis Division, Statistics Canada

Sonya Stasiuk
Director
Information Management Branch, Alberta Health and Wellness

Stephen Vail
Director
Research and Policy Development, Canadian Medical Association

In addition, the core team and CIHI would like to thank Dr. Jennifer Zelmer, Senior Vice President, Clinical Adoption and Innovation, Canada Health Infoway, for marking our last *Health Care in Canada* by authoring the foreword to this report.

It should be noted that the analyses and conclusions in this report do not necessarily reflect the opinions of the affiliated organizations.

Health Care in Canada, 2012: A Focus on Wait Times represents a collaborative effort across much of CIHI. We would like to thank all those who contributed their expertise and time in various capacities: conducting research, literature reviews and environmental scans; compiling, analyzing and validating the data; writing and editing chapters; reviewing content; and providing generous and ongoing support to the core team.

The project team responsible for the development of this report is as follows:

- Hani Abushomar, Senior Analyst
- Jessica Burnett, Analyst
- Allie Chen, Senior Analyst
- Alexey Dudevich, Senior Analyst
- Josh Fagbemi, Program Lead
- Cheryl Gula, Manager
- Sharon Gushue, Senior Analyst
- Kristen Hart, Analyst
- Hong Ji, Senior Analyst
- Mark McPherson, Senior Analyst
- Kathleen Morris, Director
- Michelle Parker, Senior Program Coordinator
- Karen Poon, Analyst
- Rob Ranger, Program Lead
- Agustina Silva, Analyst
- Jeremy Veillard, Vice President

We also acknowledge the support and advice received from many areas of CIHI. In particular, we would like to thank Rachel Armstrong, Debra Chen, Shirley Chen, Natalie Damiano, Kinga David, Cathy Davis, Nicole De Guia, Colleen Dwyer, Jennifer Frood, Jun Gao, Tracy Johnson, Robert Kyte, Christina Lawand, Claude Lemay, Jenny Lineker, Nawaf Madi, Deborah McCartney, Ryan Metcalfe, Connie Paris, Ben Reason, Yvonne Rosehart, Sonia Shukla and Isabel Tsui. We are appreciative, as well, for the contribution of other CIHI staff members for their work on translation, communications, web design, print and distribution.

Want to Know More?

CIHI welcomes comments about this report and would like to know how future reports can meet your information needs. Please send your comments via email to healthreports@cihi.ca.

For more specific information about any area of interest or research involving health care in Canada, please visit CIHI's website (www.cihi.ca). Highlights and the full text of *Health Care in Canada, 2012: A Focus on Wait Times* are available free of charge in English and French on CIHI's website.



Foreword

To everything there is a season, and with this edition of *Health Care in Canada*, the series' time comes to an end as the analytical program of the Canadian Institute for Health Information (CIHI) evolves in new directions. My own personal path has also evolved. For several years now, I have been a reader of *Health Care in Canada* rather than a writer or editor, and it is from this perspective that I was asked to reflect on the development of the series.

Since it began in 2000, *Health Care in Canada* has broken ground in a number of important areas. Here are just a few examples of the policy-relevant information first published in the series:

- Region-by-region comparisons of key health and health care indicators, as well as trends over time;
- The extent to which population growth, inflation and other changes in private- and public-sector spending explain recent increases in health expenditures;
- The number of Canadians who say that they have experienced a preventable adverse event in their own health care or that of a family member, and the consequences of those events;
- The relationship between volumes of care and outcomes in Canada's hospitals, how often different types of surgery are performed at high-, medium- and low-volume centres, and Canadians' views on trade-offs between proximity of health services and quality of care;
- The change in recent years of a patient's chances of dying in hospital within 30 days of an initial admission with a heart attack or stroke, how these rates vary across the country, and which patient and hospital factors affect these rates;
- How often Canadians undergo surgery and receive other types of care that the evidence suggests may not improve outcomes; and
- The number of seniors taking multiple prescription medications, how many seniors are taking drugs that are potentially inappropriate for people their age, and the consequent increased risk of interactions and side effects.

As important, the reports have been a go-to source for a consolidation of the latest research and data on important health care issues.

“The enemy of anecdote,” said Ted Marmor, Yale University Professor of Public Policy, of *Health Care in Canada*. “An invaluable resource for decision-makers, health care professionals and, indeed, perhaps most importantly, all Canadians,” said a federal health minister. Over the years, the series has been cited in legislative debates, led to action by governments and non-governmental organizations, triggered utilization and quality reviews by hospitals and health regions, contributed to the public debate through thousands of media stories reaching millions of Canadians and served as a textbook for university courses.

That’s not to say that its job is done. While many of the “what we don’t know” items listed in early reports can now be checked off as complete, a number of them remain works in progress. So I look forward to reading results from CIHI’s continuing analytical program in its new dissemination vehicles.

Dr. Jennifer Zelmer
Senior Vice President
Clinical Adoption and Innovation
Canada Health Infoway

The Next Chapter

Canadians’ health and their health care systems continue to evolve. And so do the information needs of our customers and stakeholders. Looking forward, CIHI plans to address these changing health information needs. We will continue, as always, to produce relevant and actionable analysis. We will also enhance our efforts to build understanding and use of health information that will yield better-informed decisions. And we will roll out innovative performance management products, services and tools to our clients across the country.

To do so, some of our traditional ways of releasing information will change. While providing comprehensive and reliable pan-Canadian information on our health care systems remains a priority for CIHI, the vehicle through which we do so needs to grow and change. One such change is the retirement of the *Health Care in Canada* series of reports. This will make way for new initiatives that will continue to support system decision-making but better respond to the ways decision-makers prefer to use data today.

Please join me in thanking all those, within CIHI and outside, who have made the *Health Care in Canada* series and its outcomes possible over the last 12 years. Together, we look forward to the next chapter.

John Wright
President and CEO
Canadian Institute for Health Information



Executive Summary

Access to care—particularly wait times—is often the focus of intense media coverage and public debate. Although still far from perfect, the information available on wait times today is much better in terms of quality and quantity than in early 2006 when CIHI released its last overview report on the subject. *Health Care in Canada, 2012: A Focus on Wait Times* presents what is known about wait times in Canada, within the context of access, across the continuum of care.

The report opens by acknowledging that Canada's current wait time performance is poor compared with that of other countries, and presents a brief history of the evolution of wait time measurement in Canada. A discussion about waits for routine care follows. Although access to primary care is important for preventing and managing most conditions, Canada fares poorly when compared with other countries. For example, a 2010 comparison of 11 countries showed that Canada ranked lowest for wait times to see a doctor or nurse when sick. Canadians also reported the longest waits for a specialist appointment, with 41% reporting waits of two or more months. Despite access to and waits for family physicians in Canada being long by international standards, most Canadians report that their wait times are acceptable. It is access to and waits for specialists where Canadians were more likely to report challenges.

Despite the best preventive efforts, many people still require care in hospitals. The report next presents information on waits in emergency departments (EDs) and acute care settings. Waits in Canadian EDs are longer compared with those in other countries, and compared with ideal response times recommended by the Canadian Association of Emergency Physicians. Among 11 international comparators, Canada has the largest proportion of adults waiting in the ED for 4 hours or more before being treated (19% higher than the international average). Overall lengths of stay in the ED are just over 4 hours, with 90% of visits completed within 8 hours.

Turning to acute care, trends since the introduction of wait time priority areas are examined next. There is little evidence at the national level that the focus on priority area surgeries has crowded out other surgeries. But variation exists at the provincial level, likely the result, at least in part, of jurisdictions pursuing different strategies to address local wait time and access to care issues. Challenges also persist for patients waiting for discharge from acute care, with the national rate of alternate level of care stays in acute beds stable at roughly

5% since 2008–2009. Across Canada, people who are most likely to wait include those with dementia and those who receive palliative care, followed by those waiting for rehabilitation and convalescence.

The report moves on to discuss waits experienced for and in specialized care, including rehabilitation and mental health services. Based on available information, clinical condition and discharge destination appear to be the main factors affecting waits for both rehabilitation and mental health services. Those patients in rehabilitation awaiting residential care tend to wait longest for discharge, with variation by Rehabilitation Client Group. Similarly, patients with personality disorders tend to have the longest waits for discharge from mental health care. The most common discharge setting for mental health patients in alternate level of care is continuing care. The accompanying report *Seniors and Alternate Level of Care: Building on Our Knowledge* provides information on patients waiting for placement in home care and residential care.

Looking Back, Looking Forward

Since it was recognized as a priority area in 2004, wait times has been at the forefront of health care planning. Significant investments have been made to increase resources and improve knowledge—all with the ultimate goal of reducing waits experienced by patients for health care services. Progress has been made in the five priority areas identified in 2004, but much work remains to be done, both here and in other sectors of the health care system. This report can help system decision-makers by facilitating a better understanding of the current landscape and informing prioritization for the future.

Strategies and pilot programs used to reduce wait times are profiled throughout the report. The conclusion of *Health Care in Canada, 2012: A Focus on Wait Times* summarizes these programs and highlights what makes such programs successful—key information for those looking to implement similar programs in their jurisdictions. Wait time knowledge can be improved with better data, and technology can play a role in improving the timeliness and quality of the data collection. The use of benchmarks has proven successful in reducing specific wait times; suggestions are made regarding some areas that would benefit from implementing further benchmarks. Taking a broader perspective, reducing demand for health care services through prevention efforts would help to lower wait times overall. In considering any strategy for improving wait times, it is helpful to keep the patient perspective in mind. To this end, *Health Care in Canada, 2012* underscores the patient experience throughout and closes with this thought.



Over the past decade, significant efforts have been made in Canada to increase health care resources, with the goal of improving access and shortening wait times.

Introduction and Wait Time Overview

Access to care is most broadly defined as “the degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health care system.”¹ Access is influenced by many factors, but from the patient’s perspective, perhaps the most important is how long they must wait for the care they need. Not all waits are created equal: some may be necessary from a clinical perspective, while others are more simply an inconvenience. But some waits can have negative consequences for patients. Research has shown that long waits for care can contribute to declines in health status and poorer outcomes of care, and can impact the health care system overall. When asked, Canadians report that such waits lead to increased worry, anxiety, stress and pain.²

Over the past decade, access to care, and specifically wait times, has received increasing attention from government, health system decision-makers, the media and the general public. When concerns were initially raised about how long patients were waiting to receive care, there was little comprehensive, comparable national data to inform the debate. Although some gaps remain, much progress has been made in measuring and reporting on wait times, particularly for areas identified as priority.

Health Care in Canada, 2012: A Focus on Wait Times highlights what is currently known about the waits patients experience in different settings across the health care continuum. In this introduction, a description of the evolution of wait time measurement and reporting is presented, including areas where measurable progress has been made. As well, the effectiveness of adding more resources as a means to reduce waits within the health care system is examined. By bringing together data, previous research and evidence from scientific literature, this introduction sets the stage for the remainder of the report, which discusses areas of Canada’s health care system that would benefit from a focus on wait times.

Resources and Wait Times

Although not alone in its challenges to providing appropriate and timely access to health care services, Canada lags behind other countries. A 2010 survey ranked Canada lowest among 11 countries for wait times in the following areas:

- **Seeing a doctor or nurse when sick:** 33% of patients surveyed reported waiting six days or more for an appointment, 5% more than the country ranked second-lowest;
- **Seeing a specialist:** 41% reported waiting two months or more, 7% more than the country ranked second-lowest; and
- **Having elective surgery:** 25% reported waiting four months or more, 3% more than the country ranked second-lowest.³

An often suggested approach to improve wait times is to increase associated resources for providing the care. Canada has historically ranked below other Organisation for Economic Co-operation and Development (OECD) countries on several key indicators of available resources for health care services, such as number of beds per population, bed occupancy rate and diagnostic imaging rates. Over the past decade, significant efforts have been made in Canada to increase health care resources, with the goal of improving access and shortening wait times. In the 2000s, several policy changes were implemented to increase the number of physicians working in Canada (for example, facilitating internationally trained physicians working in Canada and increasing the number of seats in faculties of medicine).⁴

In 2003, the OECD undertook a study of countries that publicly report on wait times to understand whether greater availability of resources was associated with shorter waits for elective surgeries (such as knee replacement and cataract removal). Resource measures such as overall health care funding, number of hospital beds, and number of physicians and how they are remunerated were found to be important contributors (in varying degrees) to wait times but on their own did not translate directly to better access to care or shorter wait times.⁵

The Canadian Institute for Health Information (CIHI) used the same methodology employed by the OECD to examine variations in waits across Canada's 10 provinces, considering the following resource measures:

- Funding (per capita health expenditure);
- Capacity (number of acute care beds, overall number of physicians and specialist physicians);
- Hospital activity (bed occupancy rate, number of inpatient and day surgeries); and
- Operating room activity (unit-producing personnel hours).

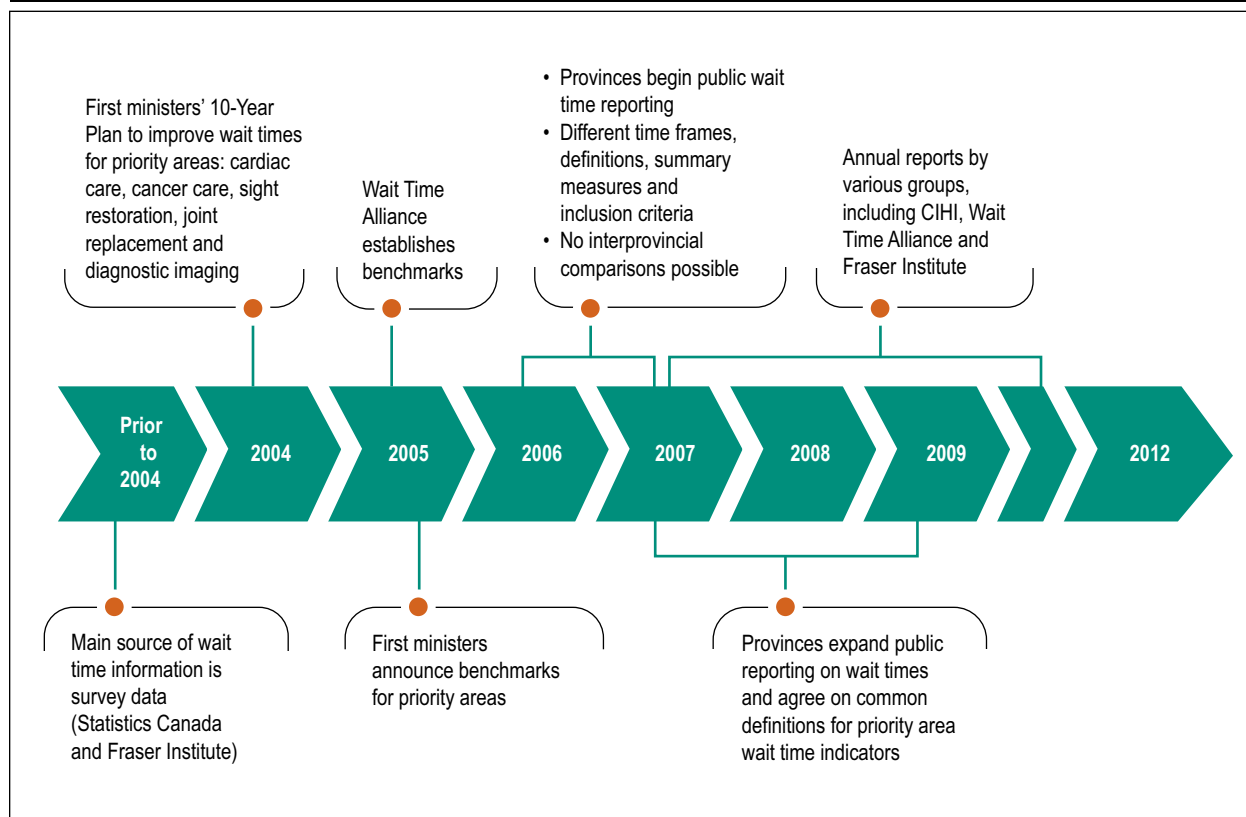
The results of CIHI's analysis of Canada's data supported the OECD's finding that more system inputs do not necessarily translate directly to better access to care or shorter wait times. Interrelated factors, however—differences in policies and procedures, strategies and care delivery structures, supply and demand management, efficiency and productivity issues, appropriateness and utilization rates, and the incentives/disincentives inherent to different funding models—may influence wait times across provinces. With governments facing constraints on health care spending, it would be helpful to look beyond increased spending for other strategies to improving access to care.

Agreements to Reduce Wait Times in Canada

In 2004, Canada's first ministers recognized wait times as a priority in the 10-Year Plan to Strengthen Health Care. The wait time component of this accord prioritized five clinical areas for achieving wait time reductions: cardiac care, cancer care, diagnostic imaging, joint replacement and sight restoration. The first ministers agreed to work toward meeting evidence-based benchmarks for medically acceptable waits, which were established in late 2005 for some priority procedures. A timeline was set for achieving meaningful reductions but allowed for each jurisdiction to pursue its own strategy with target setting and annual reporting. CIHI was tasked with reporting on progress on wait times across jurisdictions.⁶

The \$41 billion in federal funding in support of the 2004 health accord included a \$5.5 billion Wait Times Reduction Fund to augment existing provincial and territorial investments in reducing wait times in the priority areas. The federal government committed to investing \$4.25 billion over five years, beginning in 2004–2005. These funds were made available to provinces and territories on an equal per capita basis to be drawn down at the discretion of the provinces. Beginning in 2009–2010, the remaining \$1.25 billion was provided to the jurisdictions through a Wait Times Reduction Transfer of \$250 million annually.⁷ The primary uses of the Fund were designated as follows: for priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, and expanding appropriate ambulatory and community care programs and tools to manage wait times.⁶ The federal government also provided \$1 billion in support of Patient Wait Times Guarantees (PWTG), comprising \$612 million for the PWTG Trust, \$400 million for guarantee-related investments via Canada Health Infoway, and up to \$30 million for the PWTG Pilot Project Fund, a contribution program that allowed jurisdictions to pilot and test approaches to putting their guarantees in place.⁸

Figure 1: Evolution of Wait Time Measurement and Reporting in Canada



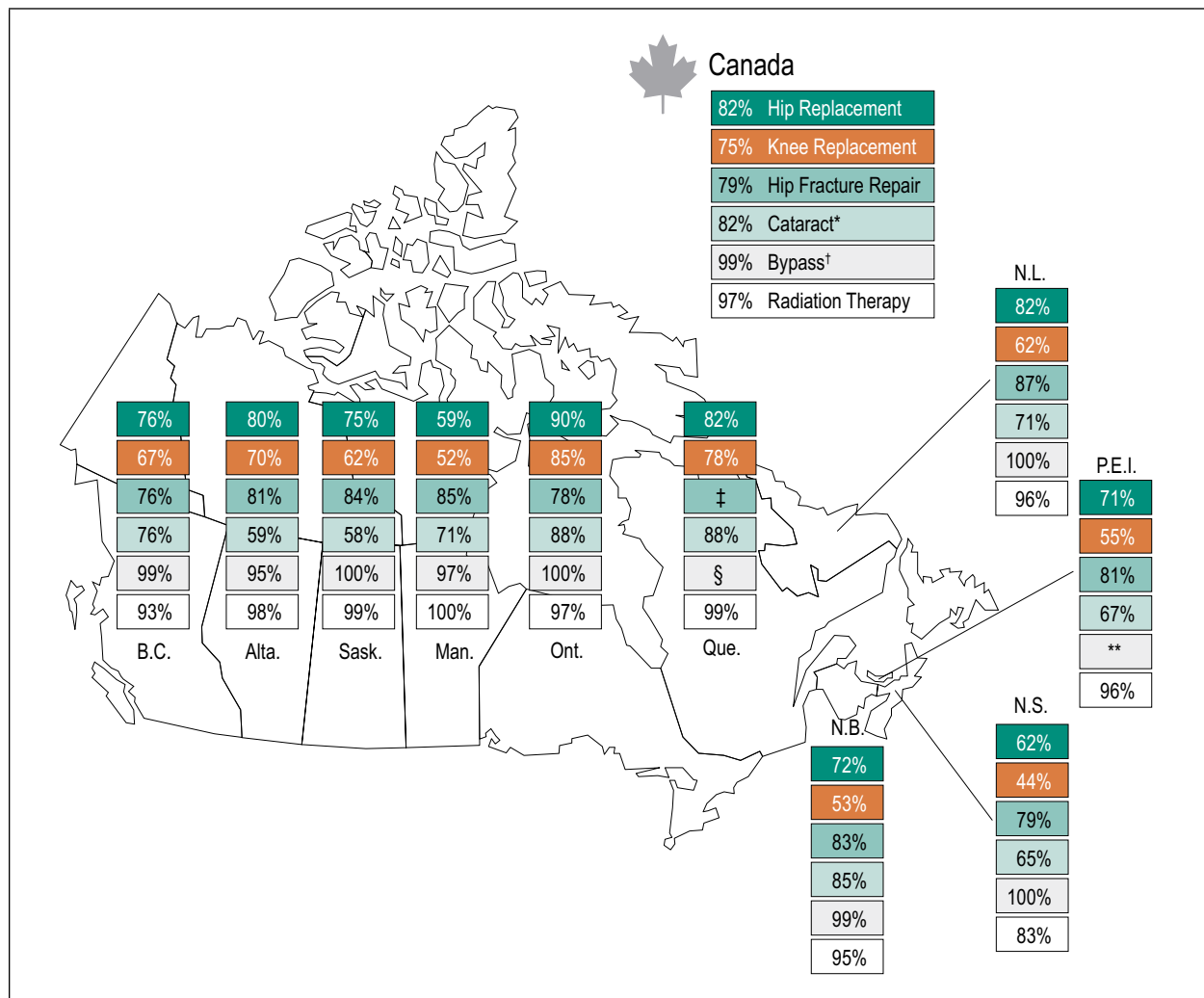
Source

Canadian Institute for Health Information.

Tracking Progress on Wait Times in Priority Areas

At the time of the 2004 health accord, information on how long Canadians waited for care was limited. With improvements in measuring and reporting wait times, progress can now be tracked for many priority procedures. Certainly the largest gains in wait time reductions were observed in the first years following the start of the 10-Year Plan; in more recent years, the gains have levelled off for the majority of procedures. Overall, by 2011, about 80% of Canadians were receiving priority procedures within the benchmark time frames; across the provinces, however, variation remains (see Figure 2).⁹

Figure 2: Proportion of Patients Receiving Care Within Benchmarks, Canada, and by Province and Priority Area, April 1 to September 30, 2011



Notes

- * The pan-Canadian benchmark specifies cataract surgery within 16 weeks (112 days) for patients who are at high risk. There is not yet consensus on a definition of “high risk,” so the benchmark is applied across all priority levels.
- † The pan-Canadian benchmark specifies bypass surgery within 2 to 26 weeks (14 to 182 days), depending on how urgently care is needed. As there is a lack of comparability for urgency levels, provinces are reporting the percentage of patients treated within a 6-month time frame.
- ‡ Quebec wait times for hip fracture repair are not included due to methodological differences in the data. For information on Quebec hip fracture wait times, see CIHI’s report *Comparing Wait Times for Hip Fracture Repair in Quebec With Those in Other Jurisdictions*.
- § Quebec reports the percentage of bypass patients receiving care within the benchmark for their assigned urgency level.
- ** P.E.I. does not offer cardiac services; patients receive care out of province.

Source

Canadian Institute for Health Information.

Beyond Priority Areas: Waiting Across the Continuum of Care

Focusing on reducing wait times for specific priority areas has yielded some encouraging results to date. However, Canada's health care system encompasses a wide range of services beyond surgeries and diagnostic imaging. Many have called for a more integrated approach to examining wait times across the continuum of care, to understand from a patient's perspective what it really means to wait for health care services, and to implement proven strategies on a wider scale.^{10–13} Moving forward requires a comprehensive review of the current state of knowledge.

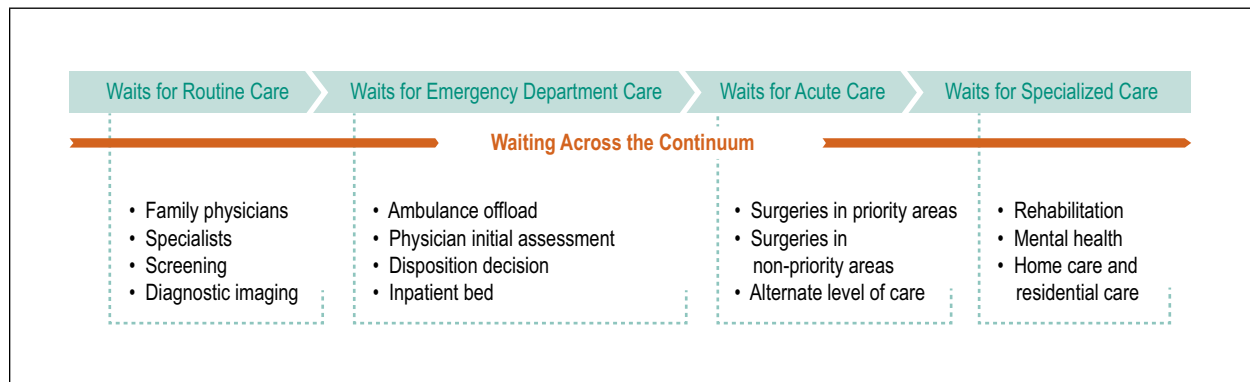
Health Care in Canada, 2012: A Focus on Wait Times broadly describes waits across different dimensions of the health care continuum, as experienced by the patient. The report contains four chapters, each describing what is currently known about selected waits experienced for a particular segment(s) of care, and identifying important data gaps. Each chapter also contains examples of initiatives that have been successful in improving wait times, including those that focus on financial incentives, human resources policies, technology, patient flow and efficiencies. Taken together, this information can help inform policy-makers' understanding of where some of the most significant waits are happening. The conclusion of this report summarizes the initiatives described in the chapters and suggests areas where policy-makers may consider targeting future knowledge-gathering efforts.

To highlight the patient perspective, the report features short vignettes throughout narrating the journey of a typical patient. **Hani's Story** follows a fictitious 55-year-old Canadian immigrant who has recently made his home on Vancouver Island. These vignettes illustrate Hani's patient experience across the health care continuum as he waits for knee replacement surgery. **Hani's Story** is also featured in an online companion product accompanying this report. This interactive timeline allows users to navigate Hani's experience waiting for care and to learn more about individual segments of his waits.



Figure 3 outlines the content of the report, by chapter. This structure appears at the beginning of each chapter.

Figure 3: Structure of Health Care in Canada, 2012: A Focus on Wait Times



Chapter 1: Waits for Routine Care

Chapter 1 contains information on waits that patients experience for routine care. It describes waits to see family physicians in primary care, provides information on waits to see specialists and highlights the role of referrals. Waits for select diagnostic imaging and screening tests are also discussed.

Chapter 2: Waits for Emergency Department Care

Chapter 2 describes wait times experienced in emergency departments, and the potential causes and consequences of long waits in this setting.

Chapter 3: Waits for Acute Care

Chapter 3 describes waits for services in acute care settings, including an examination of whether the focus on specific priority areas—which began in 2004—had an impact on access to other types of surgical care. The chapter concludes with a profile of patients who occupy acute care beds while waiting for an alternate level of care.

Chapter 4: Waits for Specialized Care

Chapter 4 describes waits for specialized care, including rehabilitation, mental health, and long-term care and home care. Where possible, it explores the waits experienced for both in-hospital and outpatient settings, and the factors influencing them.

Looking Back, Looking Forward

This conclusion summarizes the main findings of the report, as well as strategies that research suggests may facilitate shorter wait times. Both comparable data and an increased use of benchmarks are essential to measuring and evaluating progress of these strategies, all of which would benefit from a patient-centred focus in their development and implementation.

References

1. US National Library of Medicine. Medical subject headings. US National Library of Medicine. http://www.nlm.nih.gov/cgi/mesh/2012/MB_cgi. Updated 2012. Accessed July 19, 2012. N5.300.430.
2. Berthelot JM and Sanmartin C. *Access to Health Care Services in Canada*. Ottawa, ON: Statistics Canada; July 11, 2006. <http://www.statcan.gc.ca/pub/82-575-x/82-575-x2006002-eng.pdf>. Accessed March 28, 2012. 82-575-XIE.
3. The Commonwealth Fund. *2010 Commonwealth Fund International Health Policy Survey in 11 Countries, Chartpack*. New York: Commonwealth Fund; November 18, 2011. <http://www.commonwealthfund.org/Surveys/View-All.aspx>. Accessed March 29, 2012.
4. Tepper J, Larente S. Health human resources: a key policy challenge. *Health Policy Research Bulletin* 8 Ottawa, ON: Health Canada; 2004:6.
5. Siciliani L, Hurst J. Explaining waiting time variations for elective surgery across OECD countries. *OECD Economic Studies*. March 10, 2005;2004(1):95-123. <http://www.oecd.org/eco/productivityandlongtermgrowth/35028282.pdf>. Accessed March 28, 2012.
6. Health Canada. A 10-year plan to strengthen health care. Health Canada. <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php>. Updated May 9, 2006. Accessed June 13, 2012.
7. Department of Finance Canada. Federal investments in support of the 10-year plan to strengthen health care. Department of Finance Canada. http://www.fin.gc.ca/fedprov/typhc_-eng.asp. Updated May 5, 2011. Accessed June 28, 2012.
8. Government of Canada. *The Budget Plan 2007. March 19, 2007*. <http://www.budget.gc.ca/2007/pdf/bp2007e.pdf>. Accessed June 26, 2012. F1-23/2007-3E.
9. Canadian Institute for Health Information. *Wait Times in Canada—A Summary, 2012*. Ottawa, ON: CIHI; March 22, 2012. https://secure.cihi.ca/free_products/WaitTimesSummary2012_EN.pdf. Accessed April 25, 2012.
10. Wait Time Alliance for Timely Access to Health Care. *It's About Time! Achieving Benchmarks and Best Practices in Wait Time Management*. Ottawa, ON: Canadian Medical Association; August 5, 2005. http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Media_Release/pdf/2005/wta-final.pdf. Accessed June 26, 2012.
11. Primary Care Wait Time Partnership. *The Wait Starts Here*. Mississauga, ON: College of Family Physicians of Canada; Canadian Medical Association; December, 2009. http://cfpc.ca/uploadedFiles/Resources/Resource_Items/ENGLISH20PCWTP20FINAL20-20DECEMBER202009.pdf. Accessed June 28, 2012.

12. Health Council of Canada. *Wading Through Wait Times: What Do Meaningful Reductions and Guarantees Mean? An Update on Wait Times for Health Care*. Toronto, ON: Health Council of Canada; June, 2007. http://www.healthcouncilcanada.ca/tree/2.05hcc_wait-times-update_200706_FINAL_ENGLISH.pdf. Accessed June 28, 2012. H174-7/2007E.
13. Canadian Nurses Association. *Registered Nurses: On the Front Lines of Wait Times—Moving Forward*. Ottawa, ON: Canadian Nurses Association; March, 2011. http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Wait_Times_Paper_2011_e.pdf. Accessed June 28, 2012.



Waits for family physicians are acceptable to the majority of Canadians, even though they are long by international standards. However, Canadians are more likely to report challenges in waits for specialists.

chapter

Waits for Routine Care

Waits for Routine Care

Waits for Emergency Department Care

Waits for Acute Care

Waits for Specialized Care

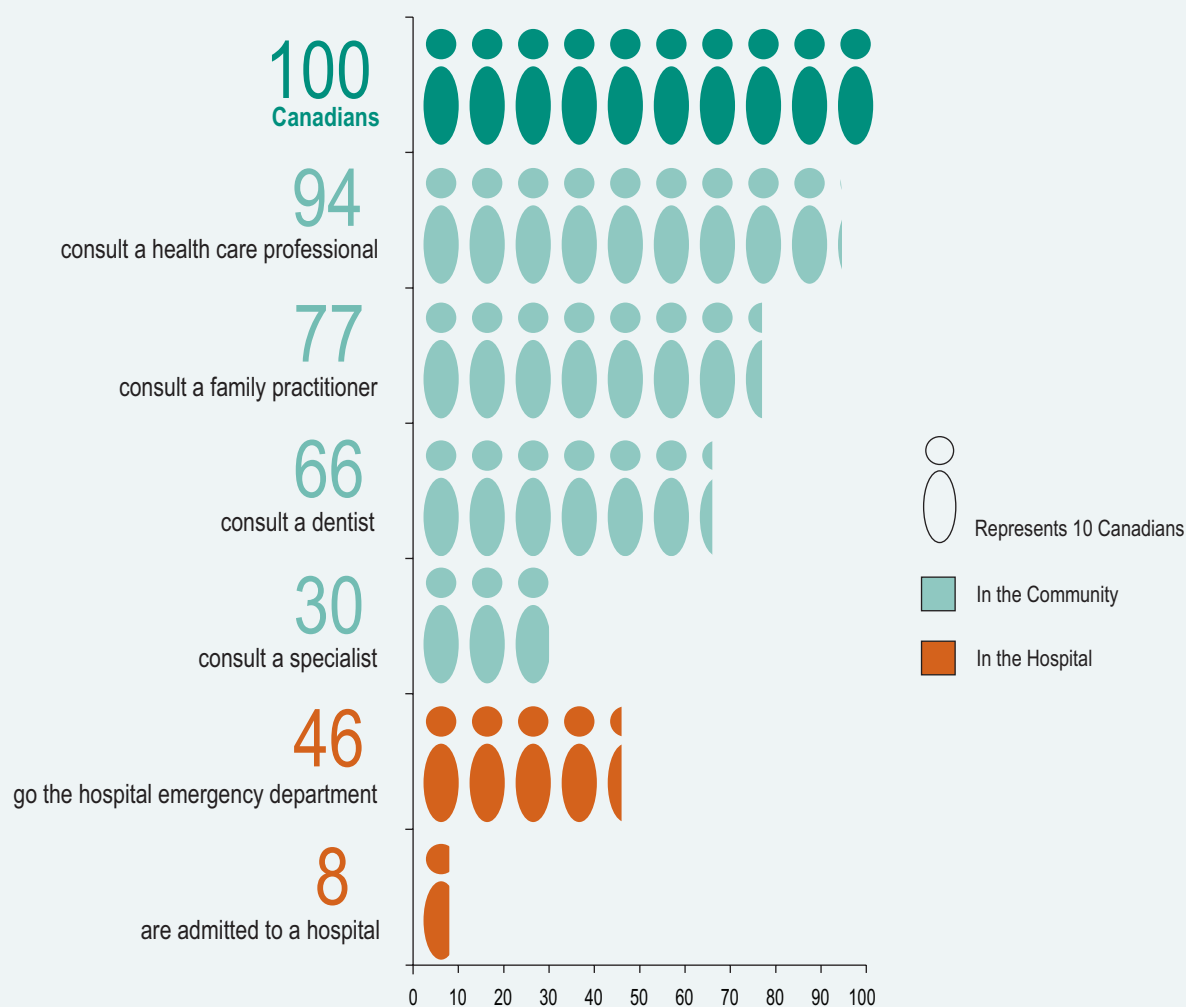
Waiting Across the Continuum

This chapter brings together information on waits Canadians experience when accessing publicly funded health care services in the community, including waits for and access to primary care services (for example, a family physician), referral to specialists, and selected screening and diagnostic testing. Although long by international standards, some waits seem to be acceptable to most Canadians, such as waits for appointments with family physicians: only 15% of Canadians report such waits as unacceptably long. Canadians more often report challenges with other waits, such as those for appointments with specialists.

Putting Care in Context

The figure below illustrates the average number of Canadians in a given year who access different types of health care services, showing the scale of service use in the community, relative to hospital, institutional and post-acute care.

Figure 4: Health Care Services



Notes

Hospital-based statistics represent the total number of visits or admissions, not the total number of patients. They do not account for readmissions or multiple visits, and include obstetric and pediatric cases.

Community statistics pertain to those age 15 and older.

Data excludes responses of Not stated, Refused and Don't know.

Emergency department data includes only those provinces submitting data to the National Ambulatory Care Reporting System.

Sources

Canadian Community Health Survey, 2009–2010 and Census 2010, Statistics Canada; Discharge Abstract Database 2010–2011 and National Ambulatory Care Reporting System 2010–2011, Canadian Institute for Health Information.

Access to Family Physicians

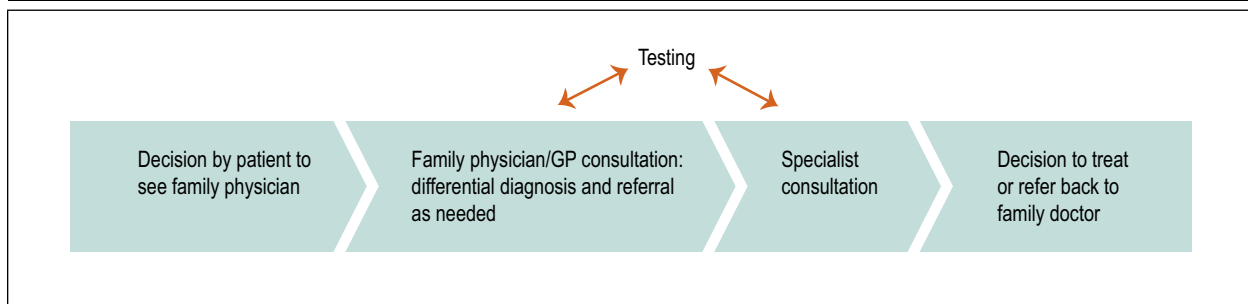
Family physicians are the most common point of first contact for primary health care services. The majority (85%) of Canadians age 12 and older report having a regular family physician but report having to wait an average of two days to see one for routine or ongoing care.ⁱ Among those with regular sources of primary care who reported access difficulties,

- 45% report having to wait too long for an appointment;
- 32% report having difficulties getting an appointment; and
- 10% report that the time spent waiting in the physician's office before their appointment started is too long.

In a 2010 comparison with other countries, Canada ranked lowest (along with Norway) for wait times to see a doctor or nurse when sick,¹ with only 45% of Canadians reporting having seen a doctor or nurse on the same or next day. Over time, Canada's performance has not improved. In 2004, one in four (25%) Canadians reported waiting six or more days to see a doctor when sick or in need of medical attention;² by 2010, one in three (33%) waited six or more days.¹ Yet only 15% of Canadians reported that waits to see their family physician were unacceptable.³

While many health issues can be dealt with in a family physician's office, some patients require referrals to see a specialist or to undergo additional testing (see Figure 5). Some of the waits for these more specialized services are discussed in the following sections.

Figure 5: Wait Times to See Physicians



Note

GP: general practitioner.

Source

Adapted from a prototype shared by the College of Family Physicians of Canada and from Institute for Clinical Evaluative Sciences (ICES), *Access to Health Services in Ontario*, Fig. 1.1.

i. Wait times based on respondents' self-reporting may be affected by the respondents' capacity to remember the length of time they waited for a specific health service. Because of a lack of definition as to what constitutes the starting point of a wait time, its duration can be difficult to estimate, which can lead to varying responses among respondents.

Connecting Patients With Family Physicians

Provinces and territories across Canada are working to increase the number of patients with a regular physician. One barrier reported by patients trying to find a regular doctor is difficulty locating a physician in their community who is accepting new patients.⁴ Several innovative programs have been introduced to connect patients with available physicians:

- In 1998, Prince Edward Island established a province-wide program for registering patients.⁵ The Patient Registry Program maintains a list of individuals who do not have a regular doctor and assigns them to appropriate providers as they become available. From 2011 to 2012, more than 6,500 people were assigned to a family physician through this program.
- Introduced in 2009, Ontario's Health Care Connect program allows people without a regular doctor to register for a referral either online or by phone.⁶ Once registered, a nurse or "Care Connector" in the person's community works to find them a physician or nurse practitioner who is accepting patients. Priority is given to those with a greater need for a regular doctor, as determined by a questionnaire. Between February 12 and December 31, 2009, more than 108,000 (68%) people registered with Health Care Connect were referred to a provider, and 80% of high-need individuals were referred.
- The College of Physicians and Surgeons of British Columbia provides an online tool that allows people to search their community for physicians accepting new patients.⁷ Specific criteria can be used to find a physician, including gender and languages spoken. Physician information is collected every year through the Annual License Renewal Form, and physicians are responsible for keeping the college up to date on any changes to the status of their practice throughout the year. Similar systems are in place in Alberta and Newfoundland and Labrador.

Access to Specialist Physicians

The waiting period between when a referral is made and when a specialist consultation occurs has been acknowledged as important by governments and experts alike.^{8, 9} Some jurisdictions are now reporting on these wait times for certain specialties. Prince Edward Island, Ontario, Saskatchewan and Alberta report on consultation wait times for the treatment of cancer, with a target wait time of 14 days between referral and consultation. Saskatchewan reports on referral wait times for certain procedures (such as gall bladder or thyroid removal) and Nova Scotia reports on a selection of specialties.

In 2009, half of Canadians age 15 and older reported waiting over a month for a specialist physician visit, with 14% waiting more than three months. While overall reported wait times have remained relatively stable since 2003, the percentage waiting more than three months rose from 10% in 2003 to 14% in 2009.¹⁰ Despite many reported challenges in access to care for those in rural and remote areas, one study found that Canadians in rural areas were 70% less likely than urban residents to report their waits to see specialists as unacceptably long.¹¹ Overall, approximately one-third of Canadians reported unacceptably long waits to see a specialist.¹²

In an international comparison (among 11 countries) of wait times for a specialist appointment, Canadians again reported the longest waits for a specialist appointment. More specifically, 41% of Canadians waited two or more months, while only 7% and 9% of Germans and Americans waited that long.¹

The impact of what may be perceived as prolonged waits goes beyond patient satisfaction. Research shows that delays in seeing specialists do affect patients, often negatively. Nearly one-quarter of Ontarians reported waiting for specialist care in 2009–2010. The reported consequences of these waits included increased worry (73%) and pain (43%), problems carrying out activities of daily living (29%), worrying for family or friends (27%) and deterioration in overall health (26%).⁴

Sometimes a specialist may order diagnostic tests to determine the diagnosis and best treatment plan for the patient. Waits for these diagnostic services can add to the perceived delay. What is known about these waits is discussed in the following section.

Early Detection, Timely Diagnosis, Faster Treatment: Waits for Screening and Diagnostic Testing

Wait Times for Screening Tests

For some conditions, timely access to early screening and detection contributes significantly to positive treatment outcomes. Clinical guidelines recommend specific screening tests, depending on the symptoms, age and health history of the patient.



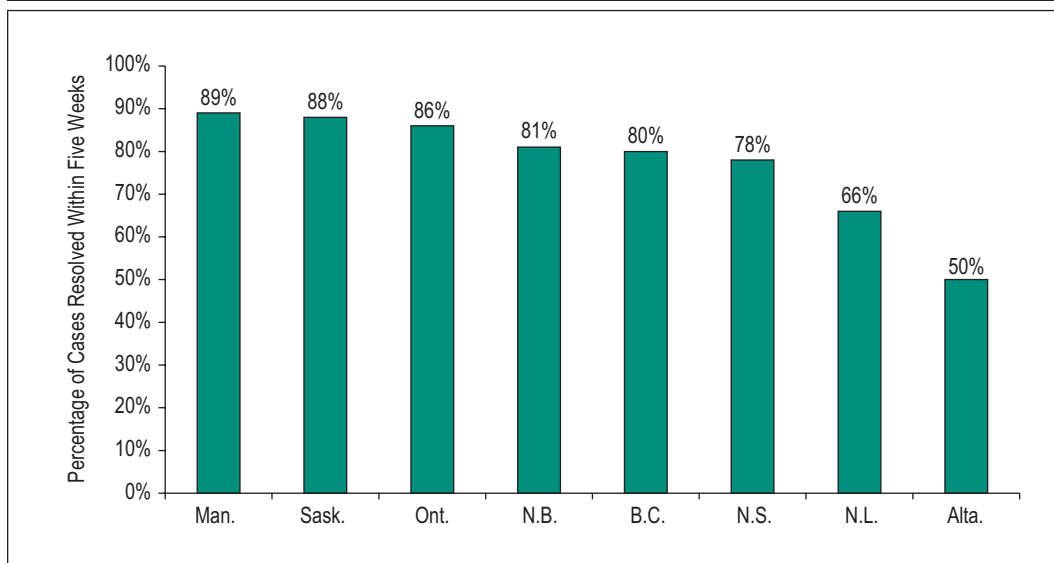
Hani's Story

Hani is 55 years old. He is a new Canadian, recently making his home on Vancouver Island. Like the majority of Canadians, Hani was able to find and make an appointment with a family physician. In addition to needing a general check-up, Hani wanted his doctor to have a look at his increasingly sore knee. Based on Hani's age, his doctor recommended several routine screening tests—including an electrocardiogram, and blood and urine tests—to understand Hani's current health status. Noting a family history of osteoarthritis, Hani's doctor referred him for testing to confirm the source of his knee pain. His doctor also requested a routine X-ray, as well as an MRI (magnetic resonance imaging) test to assess the condition of the soft tissues around his knee.

In general, Canadians do not report that waits for routine health services (blood pressure checks, eye and dental examinations) are an issue.⁴ Most provinces and territories publicly report detailed information on waits for two important screening tests: bone mineral density testing and screening mammography.

1. Bone mineral density testing is recommended for adults over age 50 and is used to detect osteoporosis and predict a higher risk of bone fractures. Timely testing of bone mineral density can help ensure that risk factors are optimally managed.¹³ Pockets of wait time information exist: the Winnipeg Regional Health Authority reports mean wait times of 21 days,¹⁴ while median wait times in Regina are reported as 33 days (for urgent patients),¹⁵ and vary among hospitals in Nova Scotia, ranging from 14 to 91 days.¹⁶
2. Breast cancer is the most common cancer in Canadian women,¹⁷ and mammography can help detect it at an early stage. Among women age 50 to 69 who were asked whether they had received a routine mammogram in 2006 or 2007, mammogram participation varied by province, from 61% in Prince Edward Island to 74% in New Brunswick and Alberta (information was unavailable for Nunavut).¹⁸ The wait time from an abnormal screen to resolution is measured in most provinces (see Figure 6). For women not requiring a tissue biopsy, 90% of cases should be resolved within the target time of five weeks.¹⁹

Figure 6: Percentage of Women Age 50 to 69 Not Requiring Tissue Biopsy, Who Received Resolution of Abnormal Breast Screen Within Target Time of Five Weeks, by Province, 2010



Notes

The target time for resolution of abnormal breast screens for patients who do not require a tissue biopsy is five weeks.

Only provinces with available data are included.

Data for Alberta includes only screen tests (10–12% of screening mammograms in the province).

Data collected is relevant for women receiving mammograms or clinical breast exams through organized provincial breast screening programs. Program enrolment rates vary by province.

Source

Used with permission from the Canadian Partnership Against Cancer.

Timely Diagnosis of Autism Spectrum Disorder

In Canada, autism spectrum disorder (ASD) is the most common neurological disorder affecting children and one of the most common developmental disabilities overall. It is estimated to affect 1 in 200 children nationwide.²⁰ Physicians and psychologists are regulated in most jurisdictions to diagnose ASD.²¹ Although a valid diagnosis can be made as young as age 2, it is often not diagnosed until age 4 or older.²²

Timely access to diagnostic services allows for earlier detection of ASD and for more positive intervention outcomes. Benefits of early diagnosis include timely access to intervention services, which can result in improvements in intellectual functioning and adaptive behaviour.^{23, 24} The optimal age for intervention remains undefined; however, studies demonstrate treatment efficacy in children younger than age 4.²⁵ Early diagnosis can also maximize access to intervention services. For example, the British Columbia government provides up to \$22,000 annually for a child with ASD, until age 6.²⁶

The typical age of diagnosis varies across the country. Analysis from the National Epidemiological Database for the Study of Autism in Canada—of children diagnosed between 1997 and 2005 in six regions—found a range in the median age of diagnosis from 39 to 54 months. In addition, this study examined the impact of certain factors on the age of diagnosis and found that²²

- Neither socio-economic status nor gender greatly influenced age of diagnosis;
- Having an affected sibling was associated with an earlier diagnosis;
- With the exception of Aboriginal children, visible minority children were diagnosed earlier than Caucasian children;
- Foreign-born children were diagnosed later; and
- Asperger's and pervasive developmental disorder were diagnosed considerably later than autism.

Wait Times for Diagnostic Imaging

Another tool often employed by physicians is diagnostic imaging. Measuring waits and improving access to diagnostic imaging services such as computed tomography (CT) and magnetic resonance imaging (MRI) were identified as priorities in the 2004 health accord. However, as of 2012, there are no pan-Canadian wait time benchmarks established for these services. Some provinces have established their own targets:

- Ontario: Immediately for priority I (emergency); within 48 hours for priority II (potential for deterioration); within 10 days for priority III (semi-urgent); and within 4 weeks for priority IV (non-urgent).²⁷
- Prince Edward Island: 48 hours for emergency patients; 14 days for urgent patients; 28 days for semi-urgent patients; and 84 and 56 days (MRI and CT scans, respectively) for non-urgent or routine patients.⁵

Among jurisdictions reporting wait time information (Table 1), waits were generally longer for MRI scans than for CT scans. In most provinces, the majority of CT scans were done in about five weeks, compared with nine out of ten MRIs carried out within three to eight months. As of March 2012, available data indicates that waits for MRIs have shortened in the last three years, while waits for CT scans have remained stable or decreased for most patients.

Table 1: Provincial Wait Times (Median and 90th Percentile) for CT and MRI Scans

Jurisdiction	Diagnostic Imaging					
	CT Scans			MRI Scans		
	50th Percentile (Median)	90th Percentile	Other Summary	50th Percentile (Median)	90th Percentile	Other Summary
Newfoundland and Labrador*	N/A	N/A	Ranges from 1 day to 2 weeks based on body site and facility	N/A	N/A	Ranges from 3 weeks for an MRI of the abdomen/pelvis to 10 weeks for an MRI of the extremity/joint
Prince Edward Island†	8 days	29 days		32 days	86 days	
Nova Scotia†	20 days	74 days		52 days	135 days	
Ontario†	7 days	34 days		34 days	94 days	
Manitoba†	16 days	35 days		55 days	119 days	
Saskatchewan†	10 days	39 days		48 days	148 days	
Alberta†	13 days	37 days		51 days	235 days	
British Columbia‡	N/A	N/A	88% meeting wait time benchmark	N/A	N/A	66% meeting wait time benchmark

Notes

* The Western Health region for Newfoundland and Labrador reports by facility and body site for both CT and MRI scans. Based on non-urgent outpatient examinations. Reported wait times are as of July 9, 2012.

† Denotes data collected by CIHI. The time frame for both CT and MRI scans is April 1 to September 30, 2011.

‡ Data is regional level, as reported on the Vancouver Island Health Authority's website. Regional data retrieved on May 24, 2012. Stat, urgent and semi-urgent cases are not included.

N/A: not applicable.

As with many areas where wait time data is relatively new, there are important considerations for interpreting the information. For more detail on the specific measurements reported here, please see the data sources below.

50th percentile: Half the patients wait less time and half wait more time than the number of days indicated in the column.

90th percentile: 90% of patients wait less time and 10% of patients wait more time than the number of days indicated in the column.

Sources

Wait times for priority procedures in Canada, 2012, Canadian Institute for Health Information.

Performance measures, Vancouver Island Health Authority.

Medical (Diagnostic) Imaging Services, Western Health Region.



Hani's Story

Although Hani now has an appointment scheduled for his MRI, he must wait for that appointment—as of December 2011, the Vancouver Island Health Authority (VIHA) reported that 66% of patients received their MRIs within 91 days of referral—and then Hani's doctor must wait for the test results to make a confirmed diagnosis of the source of his knee pain. Even so, there are options to help manage the pain he is currently experiencing, including prescribing analgesics.

Diagnostic ultrasound is another type of diagnostic imaging used for visualizing body structures, including organs, tendons, muscles and joints. Three provinces publicly report on wait times for diagnostic ultrasound:

- In Newfoundland and Labrador, wait times varied by hospital and by anatomical location, with highest waits reported for the pelvis (29 weeks in one hospital).²⁸
- In Nova Scotia hospitals, median wait times for diagnostic ultrasounds range from 2 weeks to 18 weeks.²⁹
- Manitoba average wait times are 11 weeks but range from 2 to 16 depending on the facility.³⁰

Strategies for Reducing Waits

Preventing the conditions for which health care services are needed is one way to help minimize the waits for those requiring care (read more about prevention in the report's conclusion). A key component of prevention and health promotion is timely access to primary health care services. Strategies for improving access to primary health care include the following:



Financial Incentives

- As part of a three-year deal for Prince Edward Island physicians in 2007, new incentives were designed to ease shortages in the medical system, including a \$150 bonus for taking a patient off the list of people waiting for a family physician; a higher fee-for-service for radiology to address delays in CT scans, MRIs, ultrasounds and X-rays; and bonuses for rural practice (physicians with at least 1,200 patients were eligible). Four months after the incentives were offered, more than 350 people had been taken off Prince Edward Island's patient registry.³¹
- Under a compensation package developed by the Alberta government, in collaboration with the Alberta Pharmacists' Association, pharmacists would be compensated for clinical services such as developing yearly care plans for patients with chronic conditions; conducting medication reviews; injecting medications; adapting prescriptions; and assessing patients in need of medication renewals, medication in an emergency and new prescriptions. Increased access to primary care services (especially in rural areas) and improved medication management are among the potential benefits of this approach.³²



Human Resource Policies

- When Prince Edward Island experienced a shortage of radiologists in 2009, a collaborative initiative between diagnostic imaging staff in Prince Edward Island and a radiology group in Halifax served as a temporary solution. A teleradiology project was created, in which images taken in Prince Edward Island could be sent via secure link to an onsite server in Nova Scotia. The Halifax-based radiologists interpreted a predefined number of scans each day (X-ray, CT, MRI and nuclear imaging) and committed to a specified turn-around time for reports. Staff in Prince Edward Island had access to radiologists in Nova Scotia

if consultation was needed. This partnership allowed an increase in the number of scans that could be performed, as well as provided support to diagnostic imaging staff in Prince Edward Island. Decreases in wait times for CT and MRI also ensued.³³



Technology, Patient Flow

- Telehealth systems can be beneficial to patients outside urban settings. In 2010, there were about 94,000 Telehealth consults in rural and remote areas of Canada. Videoconferencing that eliminates the need for travel has been shown to reduce wait times for specialist consultations anywhere from 20–90%. Telehealth activity across Canada has resulted in an estimated annual system cost avoidance of \$55 million and personal travel cost savings of \$70 million.³⁴ Due to implementation of Teledermatology programs in Ontario, wait times for a dermatologist consultation are no more than 10 days compared with the Canadian average wait time of 7.1 weeks for the initial visit and 5.3 weeks for a follow-up. Another example from Ontario is the Teleophthamology program; with its implementation, the average wait time for a diabetic patient to obtain retinal screening from a specialist was reduced from six months to four weeks.³⁴ In British Columbia, the implementation of the Interior Health's Telenephrology service resulted in a reduction in wait times from 212 to 156 days (a 26% decrease) due to the Telerenal System.
- Queuing theory, the mathematical and statistical theory of queues and waiting lines,³⁵ has been applied in several industries.^{36–38} Experts suggest that applying it to the health care system can result in a significant reduction in waits, without adding resources.³⁹ One known application of queuing theory in the health care system is advanced access scheduling, also called open access or same-day scheduling.³⁹ Advanced access has received endorsement from the College of Family Physicians of Canada and the Institute for Healthcare Improvement^{40, 41} and has been applied in several jurisdictions across a variety of health care sectors (see Chapter 3 for examples). One application in British Columbia resulted in half of participating general practitioners experiencing a reduction in wait times for urgent appointments (from 2.2 days to 0.2 days, on average), while three-quarters of the same physicians saw reduced wait times for regular appointments (from 6.8 days to 2.2 days, on average).⁴² Of the participant physicians, 64% were able to reduce their patient backlog and 61% were able to start and end their day on time.⁴²

Conclusion

This chapter described what is known about several different elements of routine health care services that affect Canadians, not only when they become ill, but in their daily lives. It showed that Canada continues to fare poorly compared with other countries on access to primary care. Similarly, access to a specialist remains a challenge, with more Canadians waiting longer than three months for an appointment in 2009 than in 2003. This chapter also provided information on waits for selected screening and routine tests.

In some areas, wait times for diagnostic scans such as MRIs and CTs are improving. Knowledge of waits is increasing in several other areas; many jurisdictions are now reporting information on waits for early detection and screening and for referral to certain specialist consults. More information on access to health care services offered by other health care professionals, including pharmacists, physiotherapists and speech therapists, would be

valuable in examining the totality of waits that patients experience outside of hospital settings. The next chapters explore what is known about waits experienced by patients in those care sectors.

References

1. The Commonwealth Fund. *International Health Policy Survey in Eleven Countries*. New York, US: November, 2010. http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2010/Nov/Int%20Survey/PDF_2010_IHP_Survey_Chartpack_FINAL_white_bkgd_111610_ds.pdf.
2. The Commonwealth Fund. *2004 Commonwealth Fund International Health Policy Survey of Adults' Experiences With Primary Care*. New York, US: 2004. <http://www.commonwealthfund.org/Surveys/2004/2004-Commonwealth-Fund-International-Health-Policy-Survey-of-Adults-Experiences-with-Primary-Care.aspx>.
3. Statistics Canada. *Canadian Survey of Experiences With Primary Health Care*. Ottawa, ON: Statistics Canada; 2008. <http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=5138&lang=en&db=imdb&adm=8&dis=2>.
4. Statistics Canada. *Canadian Community Health Survey 2009/2010 Annual Component*. Ottawa, ON: Statistics Canada; 2011.
5. Health PEI. *Health PEI Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) Scan*. Health PEI. <http://www.healthpei.ca/index.php3?number=1037886&lang=E>. Updated 2012. Accessed August 30, 2012.
6. Ontario Ministry of Health and Long-Term Care. *Health Care Connect. Ontario Ministry of Health and Long-Term Care*. <http://health.gov.on.ca/en/ms/healthcareconnect/public/>. Updated 2012. Accessed August 30, 2012.
7. College of Physicians and Surgeons of British Columbia. Find a Physician. College of Physicians and Surgeons of British Columbia. <https://www.cpsbc.ca/node/216>. Updated 2012. Accessed August 30, 2012.
8. Wait Times Alliance. *No Time for Complacency: Report on Wait Times in Canada*. Ottawa, ON: WTA; 2010.
9. The Primary Wait Time Partnership. . . . *And Still Waiting: Exploring Primary Care Wait Times in Canada*. Ottawa, ON: CMA and CFPC; 2008.
10. Health Canada. *Healthy Canadians—A Federal Report on Comparable Health Indicators 2010*. Ottawa, ON: Health Canada; 2011.
11. Sanmartin C, Berthelot JM, McIntosh C. *Determinants of unacceptable waiting times for specialized services in Canada*. *Healthcare Policy*. 2007;2(3):e140-e154.

12. Statistics Canada. *Access to Health Care Services in Canada*. Ottawa, ON: Statistics Canada; 2005. <http://www.statcan.gc.ca/pub/82-575-x/82-575-x2006002-eng.pdf>. 82-575-XIE.
13. Papaionnaou A, Morin S, Cheung A, and et al., eds. *2010 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada: summary*. CMAJ. 2010;182(17):1864-1873.
14. Government of Manitoba. *Diagnostic Services—Bone Density Tests*. Manitoba Health. <http://www.gov.mb.ca/health/waittime/diagnostic/bone.html>. Updated 2012. Accessed August 30, 2012.
15. Government of Saskatchewan. *Bone Mineral Densitometry (BMD) Wait Times*. Government of Saskatchewan. <http://www.health.gov.sk.ca/diagnostic-imaging-bmd-wait-times>. Updated 2011. Accessed August 30, 2012.
16. Government of Nova Scotia. *Wait Times—Bone Density*. Government of Nova Scotia. <http://gov.ns.ca/health/waittimes/procedure.asp?pid=1030&catid=di>. Updated 2011. Accessed August 30, 2012.
17. Canadian Cancer Society's Steering Committee on Cancer Statistics. *Canadian Cancer Statistics 2012*. Toronto, ON: Canadian Cancer Society; 2012.
18. Statistics Canada. CANSIM Table 105-0543—Mammogram obtained within the last 2 years by age group, females aged 50 to 69 year. Statistics Canada. <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1050543&paSer=&pattern=&stByVal=1&p1=1&p2=-1&tabMode=dataTable&csid=>. Updated 2009. Accessed August 29, 2012.
19. Canadian Partnership Against Cancer. *The 2011 Cancer System Performance Report*. Toronto, ON: CPAC; 2011.
20. Autism Society of Canada. *Canadian Autism Research and Strategy Agenda—White Paper*. http://www.autismsocietycanada.ca/DocsAndMedia/ASC_Internal/WhitePaperPRE_final.pdf. Updated 2004. Accessed August 30, 2012.
21. Nachshen J, Garcin N., Moxness K., and et al. *Screening, Assessment, and Diagnosis of Autism Spectrum Disorders in Young Children: Canadian Best Practice Guidelines*. Montreal, QC: Miriam Foundation; 2008.
22. Coo H, Ouellette-Kuntz H, Lam M, et al. Correlates of age at diagnosis of autism spectrum disorder in six Canadian regions. *Chronic Dis Inj Can*. 2012;32(2):90-99.
23. Barbaro J, Dissanayake C. Autism spectrum disorders in infancy and toddlerhood: a review of the evidence on early signs, early identification tools, and early diagnosis. *J Dev Behav Pediatr*. 2009;30(5):447-459.
24. Eldevik S, Hastings R, Hughes J, Jahr E, Eikeseth S, Cross S. Meta-analysis of early intensive behavioral intervention for children with autism. *J Clin Child Adolesc Psychol*. 2009;38(3):439-450.

25. Burrows K, Canadian Paediatric Society MHaDDC. Early intervention for children with autism. *Paediatr Child Health*. 2004;9(4):267-270. <http://www.cps.ca/english/statements/pp/pp04-02.htm>.
26. British Columbia Ministry of Children and Family Development. Autism Funding Program. British Columbia Ministry of Children and Family Development. http://www.mcf.gov.bc.ca/autism/funding_programs.html. Updated 2012. Accessed May 10, 2012.
27. Ontario Ministry of Health and Long-Term Care. Ontario Wait Times. Ontario Ministry of Health and Long-Term Care. <http://www.health.gov.on.ca/en/pro/programs/waittimes/surgery/target.aspx>. Updated 2010. Accessed September 7, 2012.
28. Western Health Regional Health Authority. Medical (Diagnostic) Imaging Services - Ultrasound. Western Health Regional Health Authority. www.westernhealth.nl.ca/index.php/newsroom-2/wait-times-2/medical-imaging-services. Updated 2012. Accessed August 30, 2012.
29. Government of Nova Scotia. Wait Times - Ultrasound. Government of Nova Scotia. www.gov.ns.ca/health/waittimes/procedure.asp?pid=1040&catid=di. Updated 2012. Accessed August 30, 2012.
30. Government of Manitoba. Diagnostic Services - Ultrasound Exams. Government of Manitoba. www.gov.mb.ca/health/waittime/diagnostic/ultrasound.html. Updated 2012. Accessed August 30, 2012.
31. Government of Prince Edward Island. Provincial Government Reaches New Agreement With Physicians. Government of Prince Edward Island. <http://www.gov.pe.ca/news/getrelease.php3?number=5841>. Updated 2008. Accessed September 7, 2012.
32. Government of Alberta. *Compensation for Pharmacy Services*. Calgary, AB: Government of Alberta; 2012.
33. Callaghan T. *In Recent Years, a Growing Satisfaction With the Imaging Wait Times on PEI Emerged*. Charlottetown, PEI: Health PEI; 2010. http://www.gov.pe.ca/photos/original/art_ct_wait_tim.pdf.
34. Gartner Inc. and Praxis Information Intelligence. *Telehealth Benefits and Adoption: Connecting People and Providers Across Canada*. Commissioned by Canada Health Infoway; May 30, 2011. https://www2.infoway-inforoute.ca/Documents/telehealth_report_summary_2010_en.pdf.
35. Merriam Webster Dictionary. Queuing Theory. <http://www.merriam-webster.com/dictionary/queuing%20theory>. Updated 2012. Accessed August 31, 2012.
36. Nosek JR, Wilson J. Queuing theory and customer satisfaction: a review of terminology, trends, and applications to pharmacy practice. *Hosp Pharm*. 2012;36(3):275-279.

37. Troutbeck RJ and Brilon W. *Unsignalized Intersection Theory*. Washington, DC: U.S. Department of Transportation: Federal Highway Administration; 2010. <http://www.fhwa.dot.gov/publications/research/operations/tft/chap8.pdf>.
38. Giambene G. *Queuing Theory and Telecommunications: Networks and Applications*. New York, NY: Springer Science + Business Media Inc; 2005.
39. Murray M, Berwick D. Advanced access: reducing waiting and delays in primary care. *JAMA*. 2003;289(8):1035-1040.
40. Cameron S, Sadler L, Lawson B. Adoption of open-access scheduling in an academic family practice. *Can Fam Physician*. 2010;56(9):906-911.
41. Hudec J, MacDougall S, Rankin E. Advanced access appointments: effects on family physician satisfaction, physicians' office income, and emergency department use. *Can Fam Physician*. 2010;56:e361-e367.
42. MacCarthy D, Kallstrom L, Gray R, Miller J, Hollander M. Supporting family physicians in British Columbia: the experience of the Practice Support Program. *BCMJ*. November, 2009;51(9):394-397.

Waits in emergency departments are longer than international standards or ideal response times recommended by the Canadian Association of Emergency Physicians.



2

chapter

Waits for Emergency Department Care

Waits for Routine Care

Waits for Emergency Department Care

Waits for Acute Care

Waits for Specialized Care

Waiting Across the Continuum

Canadians make close to 16 million visits to emergency departments (EDs) each year, and more than 1 million result in inpatient hospital admission.¹ Potential waits for care can begin before people arrive in the ED, can persist when they are ready to leave and can exist at several points in between. These long waits can be more than an inconvenience to patients—they can have adverse effects on patient outcomes. Patients waiting longer in the ED are more likely to experience delays in the treatment of pain or suffering, to express higher dissatisfaction and to leave without receiving treatment.² From the system's perspective, patient flow through the ED is also a challenge. Waits in Canadian EDs are longer than in other countries. An international comparison of 11 countries³ found that Canada had not only the highest percentage of people with at least one visit to the ED in the past two years (44%, 14 percentage points higher than the average) but also the highest percentage waiting for four hours or more before being treated (31%, 19 percentage points higher than the average).

Measuring the waits, exploring the factors that contribute to wait times, and understanding the reasons Canadians are seeking care in EDs can help improve the care experience for patients, providers, and for the system as a whole. CIHI's National Ambulatory Care Reporting System (NACRS) collects information on ED use in six provinces and one territory (Prince Edward Island, Nova Scotia, Ontario, Manitoba, Saskatchewan, Alberta, and Yukon), with varying participation rates. NACRS data is used in this chapter to understand how long patients spend in the ED and where some of the waits occur.

Waits Before Entering the ED

A 9-1-1 call can be the starting point for emergency medical service (EMS). While there is no pan-Canadian data on how long patients wait for an ambulance to arrive, good provincial data is available. For example, the Ontario government tracks 9-1-1 and EMS response times and has created benchmarks to monitor performance for regions and municipalities. The target response time is 8 minutes for severe cases requiring resuscitation and 6 minutes for a call requiring a defibrillator.⁴ Some evidence suggests that these targets may not always be met.^{5–7} In British Columbia, the British Columbia Ambulance Service (BCAS) has set a target of less than 9 minutes for an ambulance to arrive on the scene in urban and metropolitan areas.⁸ However, in 2009–2010, average response times ranged from almost 9.5 minutes (Vancouver Island) to nearly 11 minutes (Interior), and the percentage of calls responded to in less than 9 minutes ranged from 47% (Lower Mainland) to 61% (Vancouver Island).⁸

Once in the ambulance, a patient may also experience waits when arriving at the ED. (Data for 2010–2011 shows that approximately 12% of ED patients arrived by ambulance.) Upon arrival, the responsibility for patient care is transferred from ambulance staff to hospital staff. The time it takes for this to happen is called ambulance offload time. In Ontario, benchmarks proposed for ambulance offload time (based on industry best practice) suggest that 90% of patients should be seen by ED staff within 30 minutes of arriving at the hospital.⁹ Ontario data for 2010–2011 showed that while the majority of patients (81%) were seen by ED staff within 30 minutes, 10% of patients waited 54 minutes or longer. Ambulance offload delays have been shown to affect not only how quickly treatment can be offered but also the availability of EMS to attend the next 9-1-1 call.

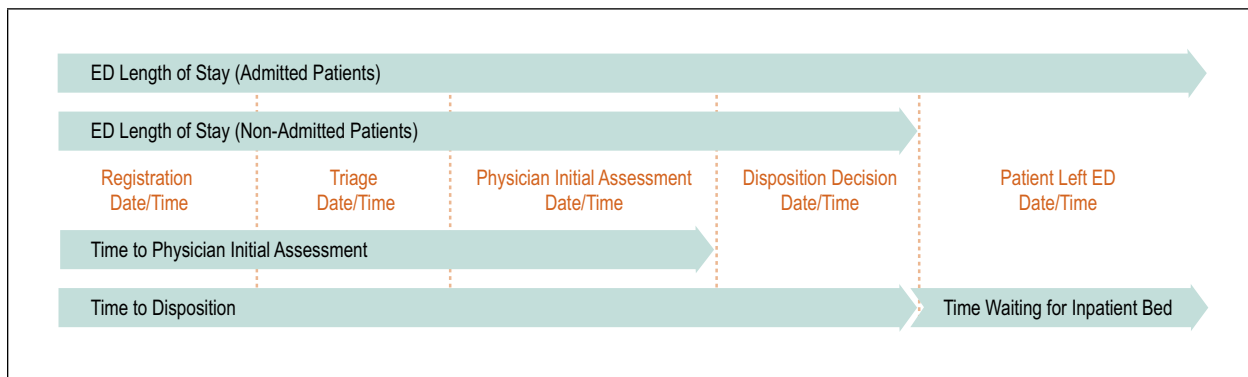
Waits in the ED

Once the ED has assumed responsibility for a patient's care, that patient may experience waits for further assessment and treatment. Several measures, routinely calculated from NACRS data, can be helpful in understanding how long patients spend in the ED and where some of the waits occur:

- **ED Length of Stay:** Time from patient registration or triage to the time the main service provider (usually the ED physician) makes the decision to discharge the patient or to the time the patient is admitted. The remaining measures provide contextual understanding of what proportion of these hours represented time spent waiting.
- **Time Waiting for Physician Initial Assessment:** Time from patient registration or triage to the time a physician (or a nurse) first assesses the patient.
- **Time to Disposition:** Time from patient registration or triage to the time the main service provider makes a decision about the patient's care needs (that is, the decision to discharge or admit the patient).
- **Time Waiting for Inpatient Bed:** Time from making a decision to admit the patient to an acute care bed to the time the patient leaves the ED to go to the inpatient unit.

Figure 7 illustrates how these measures relate to one another.

Figure 7: Relationship of the ED Wait Time Measures Routinely Reported From NACRS



Source

Canadian Institute for Health Information.

Factors Determining ED Waits

Although a variety of factors can drive ED waits, experts have identified two that are key, both of which speak to the complexity of the patient's needs:

- Admission to inpatient care: In 2010–2011, about 1 in 10 ED visits resulted in inpatient admission.
- Seriousness of the patient's condition, measured by the Canadian Emergency Department Triage and Acuity Scale.ⁱ The five levels (in decreasing order of acuity) are as follows:¹⁰

High Acuity

- Level I (Resuscitation): Conditions that are threats to life or imminent risk of deterioration, requiring immediate aggressive interventions (e.g. cardiac arrest, major trauma or shock states).
- Level II (Emergent): Conditions that are a potential threat to life or limb function requiring rapid medical intervention or delegated acts (e.g. head injury, chest pain, gastrointestinal bleeding, abdominal pain with visceral symptoms, neonates with hyperbilirubinemia).
- Level III (Urgent): Conditions that could potentially progress to a serious problem requiring emergency intervention (e.g. mild moderate asthma or dyspnea, moderate trauma, vomiting and diarrhea in patients younger than age 2).

Low Acuity

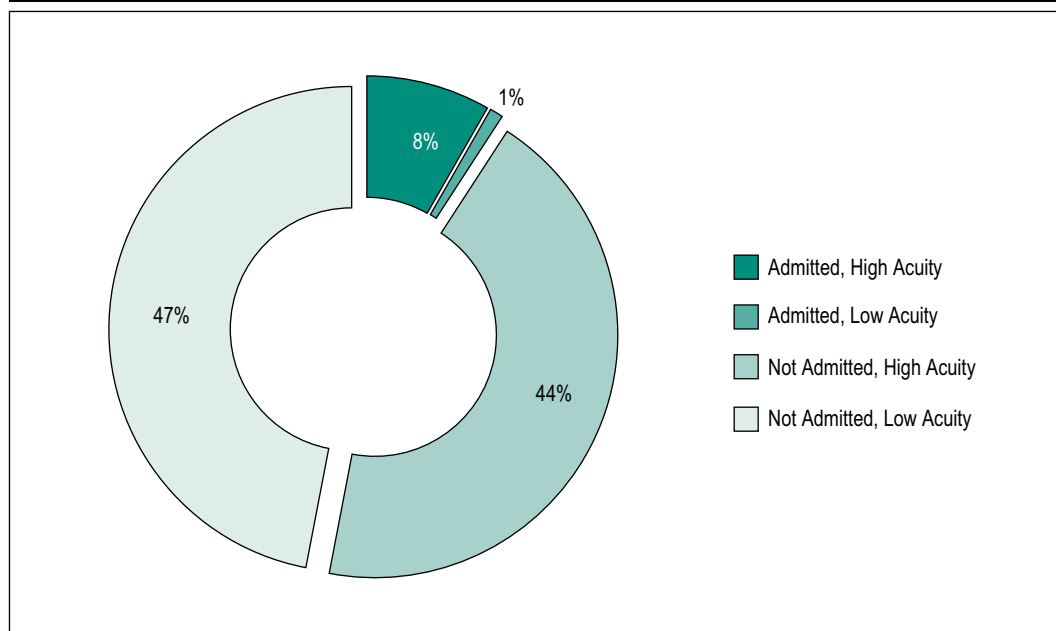
- Level IV (Less Urgent): Conditions related to patient age, distress or potential for deterioration or complications that would benefit from intervention or reassurance within 1 to 2 hours (e.g. urinary symptoms, mild abdominal pain, earache).
- Level V (Non-Urgent): Conditions in which investigations or interventions could be delayed or referred to other areas of the hospital or health care system (e.g. sore throat, menses, conditions related to chronic problems, psychiatric complaints with no suicidal ideation or attempts).

For ease of presentation and understanding, CTAS levels can be further combined to classify high acuity cases (levels I, II and III) and low acuity cases (levels IV and V).

i. The Canadian Emergency Department Triage and Acuity Scale (CTAS) was implemented in 1999. It aims to more accurately define patients' needs for timely care and provide operating objectives to standardize this care.

The relative share of ED patients that fall into these categories is presented in Figure 8.

Figure 8: Relative Percentages of ED Patients Who Were Admitted or Not Admitted to Inpatient Care, by Acuity Level, 2010–2011



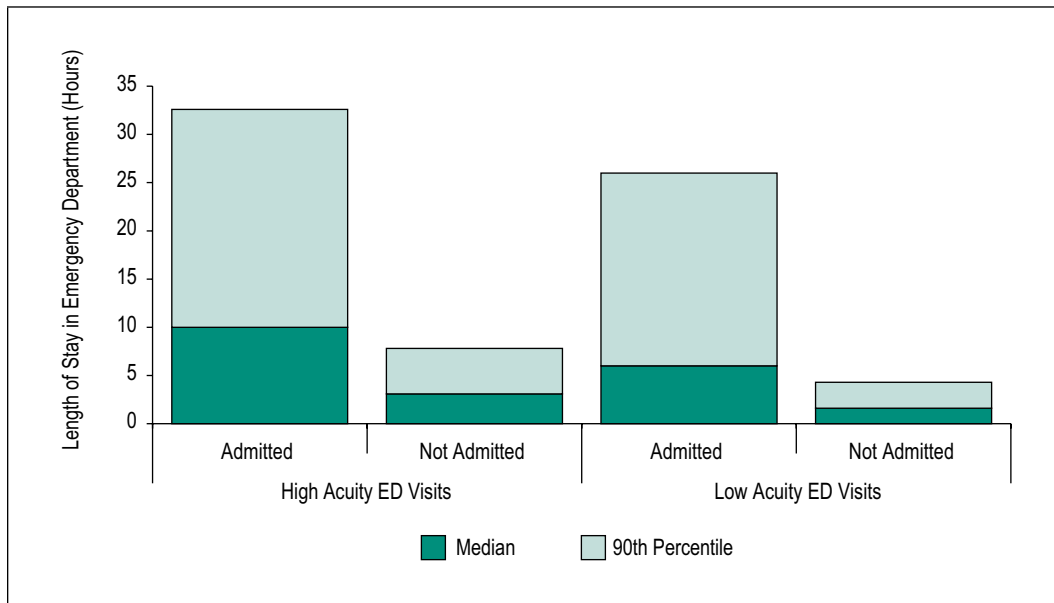
Source

National Ambulatory Care Reporting System, 2010–2011, Canadian Institute for Health Information.

The level of acuity and patient admission/non-admission affected ED wait times as follows:

- **ED Length of Stay:** In 2010–2011, the overall average length of stay in the ED was approximately 4.4 hours, with 90% of visits completed within 8 hours. Patients who were ultimately admitted spent far longer in the ED than those who were not admitted, and the length of stay was further exacerbated by the seriousness of their medical problem (see Figure 9).

Figure 9: Overall Length of Stay in Emergency Departments (Median and 90th Percentile), by Admission Status and Acuity Level, 2010–2011



Source

National Ambulatory Care Reporting System, 2010–2011, Canadian Institute for Health Information.

- Time Waiting for Physician Initial Assessment:** Overall and by CTAS level, waits to see a physician are longer than the ideal response times recommended by the Canadian Association of Emergency Physicians (CAEP). Table 2 presents a breakdown of these waits by CTAS level, outlining ideal response time targets—longer for lower acuity (that is, less serious) conditions—and how often they are met. While these targets are met for 50% of the low acuity cases (CTAS level V), they are not met for 90% of visits in any CTAS level.

Table 2: A Comparison of Recommended and Actual Times From Triage to Physician Initial Assessment, by CTAS Level

CTAS Level	Time to Physician Initial Assessment		
	Ideal Response Time*	Actual (Median)	Actual (90th Percentile)
I (Resuscitation)	Immediate (<5 minutes)	11 minutes	47 minutes
II (Emergent)	15 minutes or less	54 minutes	190 minutes
III (Urgent)	30 minutes or less	79 minutes	229 minutes
IV (Less Urgent)	60 minutes or less	66 minutes	188 minutes
V (Non-Urgent)	120 minutes or less	53 minutes	165 minutes

Note

* Adapted from CTAS Implementation Guidelines.

Source

National Ambulatory Care Reporting System 2010–2011, Canadian Institute for Health Information.

The applicability of these ideal response times in certain situations has been questioned. For example, resuscitation efforts often begin before registration or triage. As well, physicians in rural hospitals have noted that the recommended physician response times are unrealistically short for rural EDs.¹¹ In urban EDs, physicians are physically present in the ED during their shift, but in rural EDs, the on-call physician may be at home, in the clinic or on nursing home rounds for much of the day.¹¹ CAEP has acknowledged that these response times are ideals (objectives) and not established care standards, with the overall intent to improve patient care through more appropriate triaging of patients.¹²

- **Time to Disposition Decision:** Wait times for disposition were largely driven by whether the patient was admitted or not. For 90% of admitted patients, a decision was made about their further care needs within 13 hours, approximately twice as long as for patients who were not admitted.

Appropriate use of ED services by patients with chronic conditions has received significant attention as potentially contributing to extended waits in the ED. Many of the complications associated with chronic conditions such as congestive heart failure and chronic obstructive pulmonary disease can be avoided or delayed through appropriate delivery of primary care.¹³ For this reason, they are considered ambulatory care sensitive conditions (ACSCs).ⁱⁱ

As discussed in Chapter 1, although the majority of Canadians reported having a regular family physician, many reported having difficulty in accessing them on the same or next day. This has led to speculation that patients with chronic illnesses are turning instead to EDs for care that could otherwise be handled by their family doctor, in turn putting additional pressure on an already strained system.

However, data from 2010–2011 shows that patients presenting to the ED with an ACSC as their main problem represented a very small segment (4%) of ED users. Additionally, most patients (85%) in this group were assessed by ED staff at high acuity (CTAS levels I, II and III) compared with just 57% for overall ED visits. Visits for ACSC conditions were also more likely to result in admissions to acute inpatient care: 33% compared with just 10% of ED visits overall. The same pattern was found at all CTAS levels. This data suggests that patients seeking care in EDs for ACSCs did require hospital treatment. Whether or not different community care options could have prevented some of these complications is unknown.

Waiting to Leave the ED

Once patients receive care in the ED, some may be discharged home, others admitted to hospital and still others discharged to further care settings. In all of these situations, waits can occur.

- **Time Waiting for Inpatient Bed:** Among patients who were admitted, half of high acuity patients were admitted to an inpatient bed within 3 hours, more than double the wait time experienced by low acuity patients. Within 24 hours, 90% of high acuity patients were admitted to an inpatient bed, 8 hours longer than the wait experienced by low acuity patients.

ii. In Canada, ACSC conditions are angina, asthma, COPD, epilepsy, diabetes, heart failure and pulmonary edema, and hypertension

While the above result appears counterintuitive, there are many factors that impact time waiting for an inpatient bed, including time needed for patient monitoring, diagnostic or laboratory test results or specialist consultation. Another reason ED patients may wait for admission is limited bed availability. One factor often identified as influencing bed availability is the number of alternate level of care (ALC) patients. ALC describes patients in acute care beds who are waiting to be moved to another care setting, most often long-term care or rehabilitation. Across Canada in 2010–2011, about 5% of inpatient hospitalizations were ALC-related.

An analysis of Ontario data for 2010–2011 did not show a strong relationship between ALC and ED waits. Other factors—such as a high number of ED visits (50,000 or more per year) and a higher proportion of high acuity patients (two-thirds of visits or more per year)—played bigger roles in influencing ED waits than did ALC.

The relationship between ALC and ED wait times may exist under specific circumstances or in certain settings. For example, for large and teaching hospitals in urban areas with a large proportion of high acuity (CTAS levels I, II, III) ED visits, analyses have revealed some evidence of a relationship with ALC. Specifically, time waiting for an inpatient bed in the EDs of those hospitals increased as the proportion of ALC days increased. The reason such hospitals have ALC days accounting for a greater percentage of their acute care length of stay may be due to clinical factors such as underlying patient mix. This will be explored further in Chapter 3.

Wait Times in Quebec EDs

The Quebec Ministry of Health and Social Services established a targeted average wait time of 12 hours in the emergency department (before being transferred or admitted to other floors/facilities, to intermediate resources or discharged).¹⁴ Unlike targets in other jurisdictions, this target takes into account only patients on a stretcher, who are typically in greater need of care. The challenge of meeting the 12-hour target is also due in part to increased ED volume. In 2010–2011, there were 111,802 additional visits to Quebec EDs compared with the number of visits the year before (a 3.4% increase). Other contributing factors include an increased workload in the ED due to a rising number of older patients (more than 25% of patients arriving on stretchers were age 75 or older) and a 4.6% increase in patients arriving by ambulance.¹⁴

Strategies for Reducing Waits

In recent years, all jurisdictions across Canada have worked toward shortening ED wait times. Many success stories exist. Here are some examples:



Financial Incentives

- In Ontario, the Emergency Room Wait Times Strategy was launched in 2008, designed to reduce total length of stay in the ED. Key principles included clear performance metrics, targets focused on improvements in the 90th percentile total ED length of stay and financial incentives providing dedicated funding to hospitals that demonstrated measurable reductions in ED wait times.¹⁵ As of May 2012, the average ED wait time had improved by up to 14% from the 2008 baseline, with 86% of ED visits occurring within the target range.¹⁶
- Pay-for-Performance incentives exist for hospitals that reach efficiency targets or for physicians whose patients achieve health outcome goals. These incentives come in the form of quality bonuses, performance fee schedules or increased reimbursement rates for higher-quality providers.¹⁷ In 2007, Vancouver Coastal Health launched a Pay-for-Performance model that rewarded hospitals for meeting ED length of stay targets. Between 2007 and 2008, improvements were achieved in a number of ED wait time targets, ranging from 13% to 24%.¹⁸



Human Resource Policies

- In Nova Scotia, the Extended Care Paramedic (ECP) program involved Advanced Care Paramedics trained to address the needs of nursing home patients (geriatric assessment, management and skills such as suturing and blood draws) in the Capital District Health Authority. A single paramedic was on duty seven days per week from 9 a.m. to 9 p.m., supported by an Emergency Health Services (EHS) Medical Oversight Physician. After 67 weeks, 961 nursing home calls were made. Of these, 74% were treated on site, 23% had transportation arranged to minimize wait times and only 3% required immediate transfer. The program's success has led to the creation of a framework and evaluation to roll out the program province-wide.^{19–21}
- In August 2008, Toronto Emergency Medical Services (EMS) implemented an EMS Offload Nurse program, which centred on a dedicated offload nurse having responsibility for the care of EMS patients until they are treated in the ED. In December 2007, the average offload time was 61.2 minutes; one year later, it had dropped to 51.9 minutes. For Toronto EMS, this equates to three extra ambulances available each hour.²²



Technology, Patient Flow

- The Health Quality Council in Saskatchewan developed a computer simulation model that examined a layout redesign for EDs in Regina. This model investigated the impact of designating a special area of the ED for less critical patients—rather than occupying beds in the main ED—and resulted in a two-week pilot in Regina General Hospital and Pasqua Hospital EDs. Considerable improvements were observed in the typical time from patients arriving in the ED to physician assessment (at Pasqua, from 63 to 35 minutes) and in the percentage of patients leaving the ED before being assessed by a physician (at Pasqua, from 8.8% to 2.3%). Patient and staff satisfaction also improved.²³
- Alberta Health Services began the Emergency to Home: A Seniors Journey to the Right Care initiative in early 2010. With pilot sites in Edmonton, Calgary and Red Deer, the program was aimed at reducing the number of avoidable ED visits and unnecessary hospital admissions for seniors (who accounted for up to 20% of all ED visits provincially).²⁴ Seniors in the ED were assessed and cared for by emergency and home care staff, along with a care coordinator, and were safely discharged to home care and other community supports.²⁴ Within one year of implementation, 17% of seniors (up from 8%) were connected with home care programs in their community to better manage their health needs, and significant reductions in their acute admissions were observed (up to 50% in Red Deer, for example), enabling others to have more timely access to emergency care services.^{24, 25} Due to its success, the initiative was expanded into other areas (Fort McMurray, Ponoka, Wetaskiwin, Grande Prairie, and Medicine Hat, as well as additional sites in Edmonton) in the fall of 2011.^{24, 25}

Conclusion

This chapter described time spent in Canada's emergency departments. In 2010–2011, most ED visits were completed in 8 hours or less. Patients who were admitted and of higher acuity had the longest overall length of stay. Even after adjusting for seriousness of their condition, most patients waited longer to see a physician than suggested by CAEP's ideal response times. Additionally, survey data shows that ED wait times in Canada are long compared with those in other countries. Moving forward, as pan-Canadian data collection increases, the quality and understanding of that data will likely improve, giving rise to an increase in number and quality of jurisdictional comparisons.

Ambulatory care sensitive conditions and alternate level of care are two of the most often cited factors related to long waits in EDs. However, current analyses have identified that most ED visits where patients were seeking care for ACSCs were likely appropriate. Further, it appears that factors such as the volume of ED cases and share of high acuity patients were better predictors of ED wait times than were any of the examined measures of the impact of ALC stays. The next chapter will delve further into ALC and other waits experienced in the acute care setting.

References

1. Canadian Institute for Health Information. *Highlights of 2010-2011 Inpatient Hospitalizations and Emergency Department Visits*. Canada: June 21, 2012. https://secure.cihi.ca/free_products/DAD-NACRS_Highlights_2010-2011_EN.pdf.
2. Canadian Association of Emergency Physicians and National Emergency Nurses Affiliation. Joint position statement on emergency department overcrowding. *Canadian Journal of Emergency Medicine*. 2001;3(2):82-84. <http://www.cjem-online.ca/v3/n2/p82>.
3. The Commonwealth Fund. *2010 Commonwealth Fund International Health Policy Survey in 11 Countries, Chartpack*. New York, USA: Commonwealth Fund; November 18, 2011. <http://www.commonwealthfund.org/Surveys/View-All.aspx>. Accessed June 26, 2012.
4. Huron County Emergency Medical Services. Response times. County of Huron. <http://www.huroncounty.ca/ambulance/restime.php>. Updated 2012. Accessed August 30, 2012.
5. Corporate and Emergency Services Department. *Land Ambulance Call Volume and Response Time*. Bracebridge, Ontario: The District Municipality of Muskoka; September 5, 2008. https://muskoka.civicweb.net/content/pdfstorage/E5868CF6FB5240C7A3085401552299C3-CES-12-2007-4_Land%20Ambulance%20Call%20Volume.pdf.
6. Nosal B. *EMS Issues Update*. Halton, Ontario: The Regional Municipality of Halton; September 20, 2007. <http://sirepub.halton.ca/cache/2/zvmtuk45451o4wuit4el3uir/11881408302012102700963.PDF>. Accessed August 30, 2012.
7. Toronto EMS. EMS 2011 recommended operating budget & 2011-2020 capital plan. City of Toronto. http://www.toronto.ca/budget2011/pdf/presentation11_ems.pdf. Updated January 11, 2011. Accessed August 30, 2012.
8. British Columbia Ambulance Service. *Annual Report 2009-2010: Helping Save Lives*. British Columbia: British Columbia Ambulance Services (BCAS); 2010. <http://www.bcas.ca/assets/About/PDFs/Annual%20Report.pdf>. Accessed July 16, 2012.
9. The Regional Municipality of York. *Report No. 5 of the Finance and Administration Committee Regional Council Meeting- Hospital MOU Capital Funding Update Report 2012*. Ontario: Regional Municipality of York; May 17, 2012. <http://www.york.ca/NR/rdonlyres/lvxurj57ooyiqsppekxu7thb6lih5sh7jfqujvnthtg57mxr2ptnlrbiibrtychyxqvk62jx3yInqpyznoexoe/rpt+5+cls+1.pdf>. Accessed August 30, 2012.
10. Ministry of Health and Long-Term Care. Ontario wait times- time spent in ER- about the data. Ontario Ministry of Health and Long-Term Care. http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/about_ts.aspx. Updated June 21, 2011. Accessed August 30, 2012.

11. Thompson J, Dodd G. Ruralizing the Canadian triage and acuity scale small urban and rural issues. *CJEM*. 2000;2(4):267-269. <http://www.cjem-online.ca/v2/n4/p267>. Accessed August 1, 2012.
12. Society of Rural Physicians of Canada Emergency committee (SRPC-ER) Working Group. CAEP and SRPC position statement - rural implementation of CTAS. Canadian Association of Emergency Physicians. <http://caep.ca/resources/position-statements-and-guidelines/caep-and-srpc-rural-implementation-ctas>. Updated 2012. Accessed August 1, 2012.
13. Porter J, Herring J, Lacroix J, Levinton C. Avoidable admissions and repeat admissions: what do they tell us? *HealthCare Quarterly*. 2007;10(1):26-28. www.longwoods.com/product/download/code/18645.
14. Ministère de la Santé et des Services Sociaux du Québec. *Rapport Annuel De Gestion 2010-2011*. Québec: Gouvernement du Québec; 2011. <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2011/11-102-01F.pdf>.
15. Ontario Ministry of Health and Long-Term Care. Ontario wait times: Ontario's emergency room wait time strategy. Government of Ontario. <http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/strategy.aspx>. Updated January 13, 2011. Accessed July 11, 2012.
16. Ontario Ministry of Health and Long-Term Care. Ontario wait times: provincial summary. Government of Ontario. <http://edrs.waittimes.net/En/ProvincialSummary.aspx?view=0>. Updated July, 2012. Accessed July 10, 2012.
17. Pink GH, Brown AD, Studer ML, Reiter KL, and Leatt P, eds. Pay-for-Performance in publicly financed healthcare: some international experiences and considerations for Canada. *Healthcare Papers*. 2006;6(4):8-26. <http://www.longwoods.com/content/18260>. Accessed August 30, 2012.
18. Ministry of Health Services British Columbia, Fraser Valley Health, and Vancouver Coastal Health. Innovation reduces ER congestion in lower mainland. Government of British Columbia. http://www2.news.gov.bc.ca/news_releases_2005-2009/2009HSERV0019-000256.htm. Updated March 2, 2009. Accessed July 9, 2012.
19. Moulton D. Paramedic program reducing emergency room congestion. *Canadian Medical Association Journal (CMAJ)*. July 12, 2011;183(10):E631-E632. <http://www.cmaj.ca/content/183/10/E631>. Accessed August 2, 2012.
20. Nova Scotia Department of Health and Wellness. Extended care paramedic program. Institute of Public Administration of Canada. <http://www.ipac.ca/documents/EMSCC%20Webinar.pdf>. Updated 2012. Accessed August 30, 2012.

21. Emergency Health Services, Emergency Medical Care Inc, and Care by Design. Nova Scotia- extended care paramedic program. Institute of Public Administration of Canada. <http://ipac.ca/documents/Extended-Care-Paramedic-Program.pdf>. Updated 2011. Accessed August 30, 2012.
22. City of Toronto. Hospital Offload Delay: Status Update. <http://www.toronto.ca/legdocs/mmis/2009/cd/bgrd/backgroundfile-18932.pdf>. Updated January 15, 2009.
23. Health Quality Council. *Reducing Emergency Department Wait Times*. Saskatoon, SK: Health Quality Council of Saskatchewan; March, 2007. <http://www.hqc.sk.ca/download.jsp?VZejh2TfFOsmWOH660fFPTBIZBf0QfLQkUwK4QBZaJt/f87E9szCng==>. Accessed August 30, 2012.
24. Alberta Health Services. Emergency to home initiative expands to northern Alberta. Alberta Health Services. <http://www.albertahealthservices.ca/5129.asp>. Updated June 20, 2011. Accessed August 8, 2012.
25. Alberta Health Services. New emergency to home program supports local seniors. Alberta Health Services. <http://www.albertahealthservices.ca/5956.asp>. Updated November 10, 2011. Accessed August 8, 2012.



Through guarantees, benchmarks and requirements for public reporting, significant progress has been made in reducing the waits in the priority surgical areas identified in 2004.

3

chapter

Waits for Acute Care

Waits for Routine Care

Waits for Emergency Department Care

Waits for Acute Care

Waits for Specialized Care

Waiting Across the Continuum

Acute care hospitals provide necessary treatment for diseases or severe episodes of illness for a short period of time.¹ In 2010–2011, there were more than 2.8 million patients discharged from an acute hospital bed.² Since 2004, the system's focus has been on reducing wait times for a select group of priority surgeries.³ This chapter examines whether the emphasis on reducing waits for a small number of priority surgeries has come at the expense of waits for other types of surgical care. The chapter also profiles patients who occupy an acute care bed while waiting for an alternate level of care.

Waiting for Elective Surgery

In urgent situations, most Canadians wait less than one day for the inpatient bed they need—90% within 24 hours of their physician's decision to admit them (see Chapter 2 for more detail). But Canadians face longer waits in less urgent circumstances, such as elective surgeries. A 2010 Commonwealth Fund Survey of 11 countries found that Canada has one of the longest reported wait times for elective surgery. One in four Canadians reported waiting four months or more for elective surgery, similar to the proportion of patients in the United Kingdom (21%) but much higher than in Germany (almost 0%) and the United States (7%).⁴

Wait Times for Hip Fracture Repair

Every year, nearly 30,000 people across Canada fracture their hip.⁵ While some hip fracture patients need medical treatment to stabilize their condition before surgery, research suggests that the majority of patients benefit from timely surgery: reductions in morbidity, pain and length of stay in hospital.^{6,7} Due to the importance of timely intervention for hip fracture repair, in 2005, a benchmark of 48 hours for surgical repair of hip fractures was set.⁸

Between April and September 2011, about 80% of patients received hip fracture surgery within the benchmark time frame. This rate has been stable for the past three years. Across the provinces (excluding Quebec), there is little variation in the ability to meet the benchmark, with the lowest in British Columbia (76%) and Ontario (78%) and the highest in Manitoba (85%).⁹

Because the majority of hip fracture patients spend some time in emergency departments (EDs), this data does not reflect the entire wait time most patients experience. The National Hip Fracture Repair Toolkit released by Bone and Joint Canada in June 2011 calls for surgery to occur within 48 hours of first admittance to the ED.⁵ By linking ED and inpatient data, such a wait can be calculated by CIHI for Alberta and Ontario. In 2011, 74% of Alberta patients and 70% of Ontario patients received their surgery within the 48-hour benchmark, compared with 81% and 78%, respectively, if only inpatient wait is considered. Newfoundland and Labrador also reports these waits, noting that 87% of patients receive surgery within the 48-hour benchmark. As more jurisdictions begin reporting comparable ambulatory care data, an improved understanding of the full hip fracture repair wait time across the continuum will be possible.

Surgeries in the Priority Areas

In Canada's 10-Year Plan to Strengthen Health Care, five priority areas were identified for wait time reductions: cancer care, cardiac care, diagnostic imaging, joint replacement and sight restoration.³ In 2005, evidence-based pan-Canadian benchmarks were established against which jurisdictions measured and reported on their wait times for non-emergency cases:

- Radiation therapy for cancer: Within 4 weeks of patients being ready for treatment;
- Hip/knee replacement: Within 26 weeks;
- Cataract surgery: Within 16 weeks;
- Cardiac bypass surgery: Level 1 within 2 weeks; Level 2 within 6 weeks; Level 3 within 26 weeks; and
- Pan-Canadian benchmarks for diagnostic imaging have yet to be established.⁹



Hani's Story

After waiting three months for his MRI and two months to see the orthopedic surgeon, Hani has now been diagnosed with osteoarthritis. The surgeon recommends that Hani have a total knee replacement to address his joint pain and to ensure he can resume the active lifestyle he had previously enjoyed. Hani is told to expect to wait at least six months for this elective surgery. The surgeon has told Hani that 67% of people in British Columbia who need this procedure receive it within 182 days, the evidenced-based benchmark time frame. Once the procedure has been scheduled, Hani can expect to be admitted to the hospital on the day of his knee replacement.

Based on the 2004 agreement, the provinces were to establish multi-year targets for achieving the benchmarks by December 31, 2007.³ Today, about 80% of patients are receiving priority procedures within benchmark time frames. Overall, the largest reductions in the priority area waits were seen in the first few years of the 10-year strategy.⁸ In more recent years, the magnitude of change has been diminishing, with five provinces showing no significant change since 2009–2010.

Waits for Other Surgeries: Are There Unintended Effects of Focusing on Selected Procedures?

There is now more information on the waits for procedures outside of priority areas. Provinces including Nova Scotia, New Brunswick, Ontario, Saskatchewan, Alberta and British Columbia are tracking waits for common surgical procedures, including gynecological surgery, neurosurgery, dental surgery and plastic and reconstructive surgery. For example:

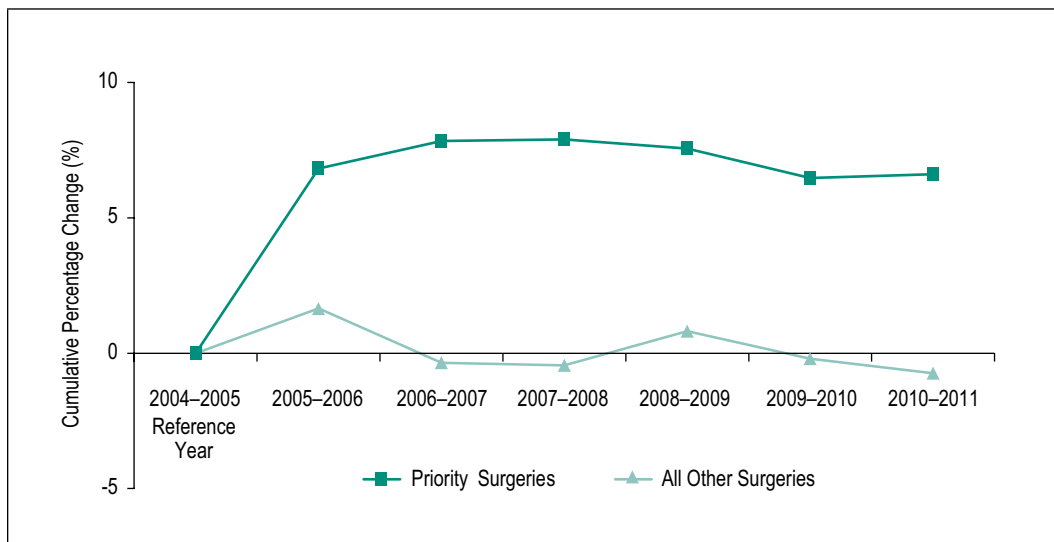
- Nova Scotia: Between January 1 and June 30, 2012, 90% of patients received carpal tunnel release surgery within 169 days.¹⁰
- Saskatchewan: The goal is, by 2014, for all patients to have the option of receiving their reportable surgeries within 3 months; between January 1 and June 30, 2012, 89% received them within 6 months of booking.¹¹
- Alberta: By May 2012, 90% of patients received brain and spinal cord surgery within 17 weeks.¹²
- British Columbia: Between March 1 and May 31, 2012, 90% of patients received bariatric surgery within 4 years.¹³

Concerns have been raised that focusing on selected surgeries has unintentionally led to longer waits in other areas.^{14, 15} In other words, increasing the number of procedures in a limited number of priority areas may have “crowded out” other types of procedures. Although collection of data on wait times for other procedures has begun, trend data is not yet available. In the absence of trend data, one way to shed light on the question is to examine overall trends in volumes and rates of procedures performed in the priority areas since 2004 and to compare these with the trends for other procedures.

Compared with figures for 2004–2005, approximately 100,000 additional priority procedures (hip replacements, knee replacements, and cataract, cancer and heart surgeries) were performed in 2010–2011. Most of the increase came from cataract (more than half) and knee replacement procedures. The biggest increases were seen in the first few years after the priorities were set, from 2004–2005 to 2006–2007; afterwards, the growth levelled off. At the same time, there was corresponding growth in the total number of all other surgical procedures, from 2.03 million in 2004–2005 to 2.28 million in 2010–2011. This includes all other surgical interventions, such as gall bladder removal and hysterectomies.

To better understand the real growth, population growth and aging were taken into account. The combined adjusted rate of the priority surgeries was 7% higher in 2010–2011 than in 2004–2005, with most of this growth occurring in the first year after the priorities had been identified. Meanwhile, the combined adjusted rate of all other surgical procedures has stayed about the same, with a slight but steady decline in the past three years.

Figure 10: Changes in Age-Adjusted Rates for Priority Surgeries Compared With Other Surgeries, 2004–2005 to 2010–2011



Notes

The Canadian rates include the territories but exclude Quebec. Estimates are presented based on where the patient lives, not the province where the facility is located. Some estimates were added from external sources.

Sources

Discharge Abstract Database and National Ambulatory Care Reporting System, 2004–2005 to 2010–2011, Canadian Institute for Health Information; Alberta Health and Wellness ambulatory care data, 2004–2005 to 2008–2009.

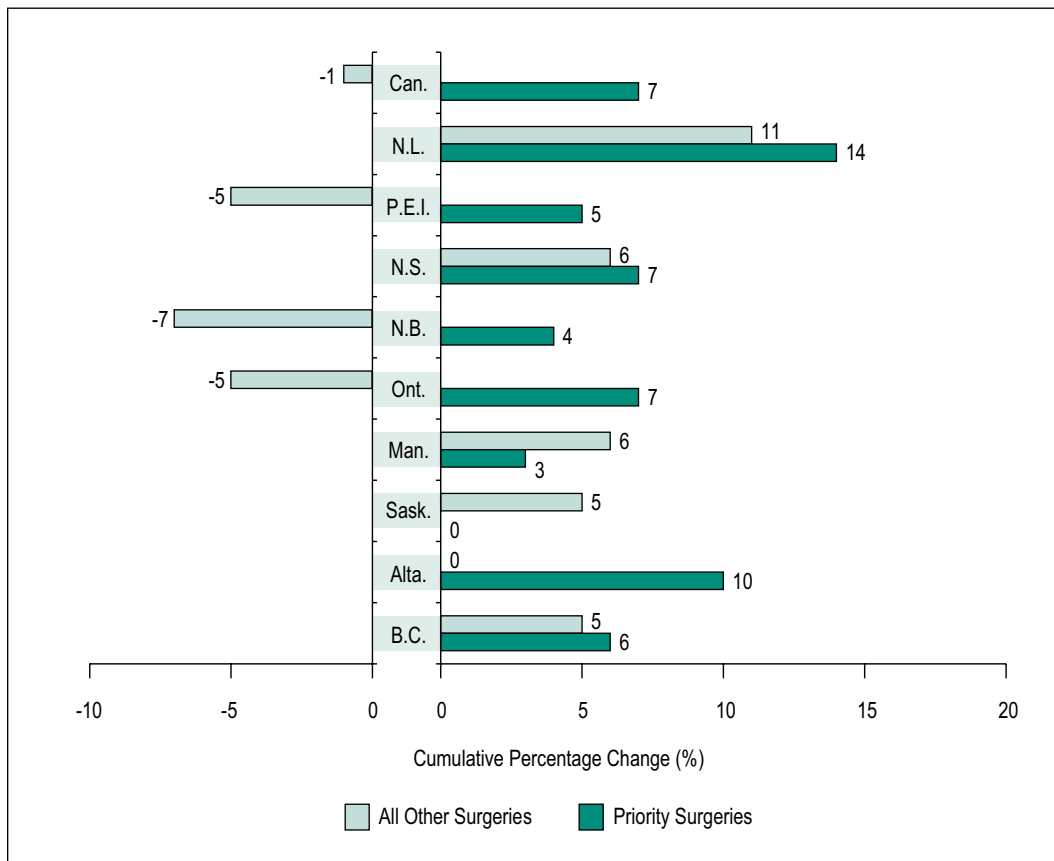
Variation Across the Country

While the overall rate of priority surgeries has increased since 2004–2005, and rates of other surgeries have remained relatively stable, there have been differences in the overall pattern of results among jurisdictions, mostly in the last three years of data. As shown in Figure 11, since 2004–2005, increases in adjusted rates of priority surgeries have been observed in Ontario (7%), Prince Edward Island (5%) and New Brunswick (4%), while decreases have been observed in adjusted rates of other procedures (-7% in New Brunswick, -5% in both Prince Edward Island and Ontario). Other provinces showed the opposite pattern. Both Manitoba and Saskatchewan had larger increases in adjusted rates of other procedures (6% and 5%, respectively) than in those of priority area surgeries (3% and 0.3%, respectively).

Beyond crowding out, other factors could affect the volumes and rates of procedures performed over time. The variation that exists at a provincial level is likely the result, at least in part, of jurisdictions pursuing different strategies to address local wait time and access to care issues. For example, introduction of overall surgical wait time guarantees, development of surgical pathways for hip and knee replacements, and recent additions to surgical capacity in Saskatchewan has led to more orthopedic surgeries (priority and other) being performed there in recent years. Advances in surgical techniques and implantable devices also play a role, as do changes in where surgeries take place. For example, New Brunswick is beginning to move certain qualifying procedures not requiring full anesthesia (such as carpal tunnel release) out of main operating rooms and into ambulatory care settings. This has

likely facilitated a recent increase in the number of cataract and hip and knee replacement procedures being performed in that province. Residents from neighbouring provinces—Prince Edward Island in particular—may be benefiting from this additional capacity to perform priority procedures. Finally, the continuation of longer-term trends that began prior to 2004 could also affect the rates observed. A 2006 Ontario study examining 14-year trends in surgical volumes found that rates for many procedures (such as gall bladder removal, insertion of ear tubes and tubal ligation) were already in decline well before 2004.¹⁵

Figure 11: Cumulative Percentage Changes in Age-Adjusted Rates for Priority Surgeries Versus All Other Surgeries, 2004–2005 to 2010–2011, Canada, and by Province



Note

"Canada" includes the territories but excludes Quebec. As a result, residents of New Brunswick who had surgeries performed in Quebec are not included; this may affect the New Brunswick rates for both priority and other surgeries.

Sources

Discharge Abstract Database and National Ambulatory Care Reporting System, Canadian Institute for Health Information; Ambulatory Care Data, Alberta Health and Wellness.

Due to differences in data collection—Quebec did not use ICD-10-CA and CCIⁱ for data capture in the baseline year of 2004–2005—analyses on Quebec data were carried out separately. Comparisons with all other surgeries were not performed. The Quebec data showed similar growth in priority surgeries compared with growth noted in other areas of the country. The number of cardiac bypass, hip and knee replacement and cataract surgeries performed increased 29% (from 88,700 to 114,400) between 2006–2007 and 2010–2011. Over the same time period, age-adjusted rates increased for knee replacement (29%), hip replacement (24%) and cataract removal (18%) procedures but decreased for cardiac bypass surgery (24%). The latter may be due to a decreased demand for the procedure or movement to an alternative procedure. For example, percutaneous coronary interventions, or PCIs, are considered a less invasive alternative to cardiac bypass. In recent years, rates of PCI in Quebec—and other jurisdictions—have increased.¹⁶

Waiting for Solid Organ Transplantation

Although a relatively small number of Canadians require solid organ transplants, the wait times for those experiencing end-stage organ failure are extensive. In 2010, there were 2,103 organ transplants (kidney, liver, heart, pancreas, small intestines and lungs) performed nationally, and 4,529 individuals were on the waiting list. Kidneys were transplanted with the most frequency (1,197 transplants); the wait-list for this organ was also the longest (3,362 individuals). The median time spent on dialysis for Canadians who received a kidney from a deceased donor was 3.7 years. Patients with an available living donor were on dialysis for approximately 1.5 years prior to their first kidney transplant. This same year, there were 247 deaths of people registered on a transplant wait list and 511 withdrawals, the majority of which involved patients awaiting a kidney or liver.¹⁷

Until very recently, organ allocations and wait lists were managed provincially, leading to variability across jurisdictions. In 2008, the Canadian Blood Services was mandated to develop a national registry and allocation system, beginning with three specialized registries:

- The Living Donor Paired Exchange (LDPE), launched in 2009 for kidneys, marked the first Canada-wide organ donation registry.¹⁸
- The National Organ Waitlist (NOW) was formally launched on June 26, 2012, and will facilitate interprovincial organ sharing for non-renal patients with end-stage organ failure.¹⁸
- The Highly Sensitized Patient (HSP) registry for patients requiring kidney transplant is in development and expected to launch in 2012.¹⁹

i International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canada, and Canadian Classification of Health Interventions.

Waiting for Discharge

Chapter 2 introduced the topic of alternate level of care (ALC) and examined its relationship to wait times in EDs. ALC stays also have implications for patient flow across other points in the continuum of care, as well as for the costs of providing care, access to care in the most appropriate setting and patient outcomes. This section will focus on the experiences of ALC patients in acute inpatient beds.

About 5% of patients wait in a hospital bed for a different type of care. This represents about 580 hospital beds occupied by ALC patients on any given day, a stable figure in recent years. Overall, most (74%) ALC patients are waiting for placement.

Wait times for ALC appear to vary by geographic location, although it is unclear how much of this variation is due to differences in data collection. For example, in Quebec, capture of ALC data is restricted to patients in acute care who are awaiting placement in long-term care. Across Canada, although about 16% of ALC patients waited 1 or 2 days for discharge in 2010–2011, 21% waited more than a month and 5% waited more than 100 days. Most (41%) were ultimately placed in long term-care, 29% went home (either with or without services) and 13% went to inpatient rehabilitation. One in ten died while waiting; in most of these cases, the patient was waiting for transfer to palliative care or admission to another facility.

Understanding ALC Patients

One key to addressing the ALC issue is better understanding the care needs of the patients experiencing the waits for discharge. ALC patients are admitted to hospital with a wide range of health issues. The most common reasons for admission in 2010–2011 were dementia (7%), general signs and symptoms (5%) and stroke (4%). Across jurisdictions, despite differences in patient mix, there is a great deal of similarity in the key conditions affecting ALC patients. While there is variability in the destination or the type of care patients are waiting for, the most common include waiting for placement (74%), convalescence (9%) and palliative care (8%).



Hani's Story

Hani's knee replacement procedure was a success. Because Hani lives alone and needs to walk up several flights of stairs to get to his apartment, his care team has recommended inpatient rehabilitation. Although physically ready for and eager to begin rehabilitation, Hani remains in his hospital bed and will likely have to wait about two days before starting this phase of recovery. He has heard of other patients having to wait up to eight days for their inpatient rehabilitation to begin and hopes his wait will not be that long. Hani's wait to be discharged is fairly typical of the 5% of patients in British Columbia who experience alternate level of care stays.

Figure 12: Most Common Reasons for Admission of ALC Patients, by Province, 2010–2011



Notes

COPD: chronic obstructive pulmonary disease.
Excludes obstetric and pediatric patients.
Territories are excluded from this analysis.

Sources

Discharge Abstract Database and Hospital Morbidity Database, 2010–2011, Canadian Institute for Health Information.

Strategies for Reducing Waits

Acute care services have traditionally been in high demand. Some patients are waiting to be admitted so they can receive these services, while others occupy beds waiting to receive care in a more appropriate setting. Decision-makers and health-system managers looking to improve the wait times experienced by both types of patients can look to many examples of success, including the following:

Financial Incentives

- By introducing income guarantees in 2007, Nova Scotia has ensured that there are greater incentives to working in an intensive care unit (ICU), particularly in rural areas. Physicians covering ICUs can choose to earn an additional \$10,000 per year or they can use a new pool of funding to recruit more physicians to help cover the ICU and thus reduce the workload. These physicians also benefit from a new income guarantee of up to \$1,850 per day for hospital-based ICU services.²⁰
- Since 2004, the government of Quebec has provided supplementary funds to centres that commit to a specified number of additional surgical procedures (can include priority and other surgeries). Lower wait times for surgeries in these centres has largely been attributed to the implementation of the Central Access Management Process (CAMP) and this incentive funding.

Human Resource Policies

- Prince Edward Island has collaborated with Nova Scotia on the development of the One Island Health System—The Collaborative Model of Care.²¹ Part of this model emphasizes that staff need to be able to practice in the full scope of their professional training. Some of the proposed changes to health human resources are in nursing: involving nurses in care planning, management and coordination, patient and family education, and continuing reassessments of patients; and including other types of nursing roles such as registered nurse, licensed practical nurse and home care worker. Acute care hospitals will be staffed through a team-based approach with providers directly involved on the unit and present 24 hours a day/7 days per week. Staff in consulting roles are engaged with patients on an as-needed basis.²²
- The Yukon Hospital Corporation has implemented a number of initiatives to improve access to inpatient beds. One initiative involves having a 24/7 clinical nurse leader to act as the point of contact to both facilitate patient movement within the hospital and coordinate repatriations from southern jurisdictions.²³



Technology, Patient Flow

- Similar to Quebec's centralized approach to address waits for joint replacements, Newfoundland and Labrador is implementing central intake and assessment clinics for patients awaiting these surgical procedures. Using a common referral tool, clinics receive and coordinate all referrals and place patients requiring surgery into one of three categories: ready for surgery; requiring additional services to optimize surgical results; or requiring medical assessment to determine fitness for surgery. The pilot clinic in Eastern Health Authority experienced reductions in waits for high priority (72% reduction) and routine referrals (45% reduction) from a primary care practitioner to an orthopedic consult. Such clinics could be expanded in the future to include all orthopedic referrals.²⁴
- Also in Newfoundland and Labrador, Eastern Health Authority commissioned a patient flow study in March 2009 aimed at identifying areas of improvement in patient care. Many recommendations have been implemented or are under way, yielding such results as a 32% reduction in the number of cancellations for cardiac surgery and decreased patient transfer times. In 2010, a review and validation of the regional adult surgical wait list was undertaken. Between July and December 2010, approximately 3,410 patients were contacted to determine whether they should remain on the waiting list for elective surgery. Approximately 860 of these patients asked to be removed from the list—thereby making room for other patients—as they had already had surgery, had changed their mind or felt they no longer needed surgery.²⁵
- In 2007, a surgical care network was introduced in New Brunswick. Through this, a clinical acuity model, and standard definitions for wait times, case times, delay codes and procedure names were developed. The surgical access registry provides real-time data that facilitates the scheduling of patients and operating rooms. Since the registry began in January 2008, there have been decreases in the median wait time for all surgery (24%) and cancer surgery (50%), and the numbers of patients waiting 12 to 18 months and longer than 18 months both decreased by 27%.²⁶
- Manitoba's Patient Access Registry Tool (PART) is an information technology system and standardized methodology for recording information on all patients waiting for medical consultation and surgical services in Manitoba (for priority procedures and others).²⁷ PART was initially implemented on a voluntary basis in 2007 and mandated in January 2010. It currently provides information on wait times to the public and more detailed information to regional health authorities. Recently, eBooking, an electronic booking request system has been integrated with PART. It tracks the progress of electronic booking forms and provides immediate information on available operating room times. Legislation similar to that mandated in Manitoba exists in Saskatchewan, Ontario and New Brunswick.²⁸
- Saskatchewan has utilized advanced access in several different areas. In 2007, one urology clinic in Saskatoon implemented advanced access, with the goal of reducing appointment wait times for patients referred to a specialist, from three to four months down to two weeks or less. Appointment slots were freed up by assessing which patients truly needed follow-up with a urologist and which could be seen instead by their own physician. This, along with a series of other process improvements, allowed office staff to assign patients

to whichever urologist had the shortest wait, preventing the return of any patient backlog.²⁹ The Saskatchewan Surgical Initiative was implemented among orthopedic surgeons in Prince Albert in March 2012, and among general surgeons at the end of May. This pooling system organized and tracked all referrals from general practitioners, matching patients with the appropriate specialist. With specialists in the larger centres (Regina and Saskatoon) having longer wait times than those in smaller surgical centres (Prince Albert and Moose Jaw), operating rooms in the latter tended to go unused as a result. The pooling system aims to eliminate this waste by creating a balance in waiting times among surgeons overall. The provincial government has committed to having all surgical practices in Saskatchewan pooled by March 31, 2016, at an annual cost of \$200,000.³⁰

Conclusion

This chapter discussed the potential waits and access issues that may be encountered by people who have been admitted to inpatient acute care. International comparisons on wait times for elective surgeries suggest that Canadians do experience relatively long waits. However, through guarantees, benchmarks and requirements for public reporting, significant progress has been made in reducing the waits in the priority areas identified in 2004. Currently, about 8 in 10 patients receive their priority area surgery within the benchmark time frame, but room for improvement still exists. The updated analyses presented in this chapter show little evidence at the national level that a focus on priority surgeries has crowded out other procedures. However, variation does exist at the provincial level, likely the result of jurisdictions pursuing different strategies to address local issues in wait times and access to care.

There also remains a persistent challenge in finding good solutions for ALC patients. Although the Canadian ALC rate has remained stable since 2008–2009 at approximately 5%, some people—particularly those with dementia and palliative care patients—are more likely to wait than others for placement in a more appropriate care setting. The next chapter looks at patients who require specialized care following their acute care stay, and the types of waits they experience.

References

1. Canadian Institute for Health Information. Acute Care. Canadian Institute for Health Information. <http://www.cihi.ca/CIHI-ext-portal/internet/EN/TabbedContent/types+of+care/hospital+care/acute+care/cihi016785>. Updated 2012. Accessed July 19, 2012.
2. Canadian Institute for Health Information. *Highlights of 2010-2011 Inpatient Hospitalizations and Emergency Department Visits*. Ottawa, ON: CIHI; 2012. <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1840>.
3. Health Canada. First Minister's Meeting on the Future of Health Care 2004. <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php>. Updated 2006. Accessed July 9, 2012.
4. Schoen C and Osborn R. *The Commonwealth Fund: 2010 International Health Policy Survey in Eleven Countries*. New York, US: The Commonwealth Fund; 2010. <http://www.commonwealthfund.org/Surveys/2010/Nov/2010-International-Survey.aspx>.
5. Bone and Joint Canada. National hip fracture toolkit. Bone and Joint Decade Canada. http://www.boneandjointcanada.com/?sec_id=310&msid=3. Updated June, 2011. Accessed July 19, 2012.
6. Bone and Joint Canada. Provincial forum: "Ontario Fracture Care: Removing Access Barriers to Return People Home." http://boneandjointhealthnetwork.ca/?sec_id=384&msid=3. Updated 2010. Accessed August 9, 2012.
7. Orosz GM MJ. Association of timing of surgery for hip fracture and patient outcomes. JAMA. April 14, 2004;291(14):1738-1743. <http://dx.doi.org/10.1001/jama.291.14.1738>. Accessed August 9, 2012.
8. Canadian Institute for Health Information. *Wait Times in Canada—A Summary, 2012*. Ottawa, ON: CIHI; March, 2012. https://secure.cihi.ca/free_products/WaitTimesSummary2012_EN.pdf.
9. Health Canada and The Canadian Federal Government. The Wait Times Issue and the Patient Wait Times Guarantee. <http://www.parl.gc.ca/content/LOP/ResearchPublications/prb0582-e.htm#a10>; <http://www.parl.gc.ca/content/LOP/ResearchPublications/prb0582-e.htm#a2>. Updated 2009. Accessed July 10, 2012.
10. Government of Nova Scotia. Carpal tunnel surgery. <http://www.gov.ns.ca/health/waittimes/procedure.asp?pid=1062>. Updated 2012. Accessed October 7, 2012.
11. Saskatchewan Surgical Initiative. What's New—Wait No Longer than Three Months by 2014. <http://www.sasksurgery.ca/>. Updated 2012. Accessed August 24, 2012.

12. Government of Alberta. Alberta wait times reporting website. <http://waittimes.alberta.ca/>. Updated 2012. Accessed July 11, 2012.
13. British Columbia Ministry of Health. Search wait times. <http://www.health.gov.bc.ca/swt/>. Updated 2012. Accessed July 11, 2012.
14. Wait Time Alliance. *Time's Up—Achieving Meaningful Reductions in Wait Times*. Ottawa, ON: Canadian Medical Association; 2007. http://www.waittimealliance.ca/images/report_times_up.pdf.
15. ICES Investigative Report. *The Ontario Wait Time Strategy: No Evidence of an Adverse Impact on Other Surgeries*. 2007. http://www.ices.on.ca/file/Wait_Time_Strategies_other_surgeries_IR.pdf. Accessed September 7, 2012.
16. Page M, Doucet M, Eisenberg MJ, Behloul H, Pilote, L. Temporal trends in revascularization and outcomes after acute myocardial infarction among the very elderly. *CMAJ*. 2010;182(13):1415-1420. <http://www.edmaj.ca/cgi/rapidpdf/cmaj.902053v1>.
17. Canadian Institute for Health Information. *Canadian Organ Replacement Registry Annual Report*. Ottawa, ON: CIHI; 2012. https://secure.cihi.ca/free_products/2011_CORR_Annua_Report_EN.pdf.
18. Canadian Blood Services. Blueprint for a National, Integrated Organs and Tissues System Release. Canadian Blood Services. http://www.blood.ca/centreapps/internet/uw_v502_mainengine.nsf/web/3424DA4DC50467E885257A23004C4BCC?OpenDocument. Updated 2012. Accessed June 21, 2012.
19. Canadian Blood Services. Update for the Organ Donation and Transplantation Community. Organ and Tissue Donation and Transplantation. <http://www.organsandtissues.ca/s/english-expert/news>. Updated 2012. Accessed July 1, 2012.
20. Nova Scotia Department of Health. Recruitment, Patient Care Get Boost Under New Agreement. Nova Scotia Canada. <http://novascotia.ca/news/release/?id=20071005006>. Updated 2007. Accessed July 25, 2012.
21. Health PEI. Collaborative Model of Care (CMoC). Health PEI. One Island Future, One Island Health System. <http://www.healthpei.ca/cmoc>. Updated 2012. Accessed July 26, 2012.
22. Health PEI. *A New Model of Care for PEI: Building a Plan to Improve Care Delivery Across the Continuum*. PEI: Health PEI; 2009. http://www.gov.pe.ca/photos/original/hpei_moc_report.pdf. Accessed July 26, 2012.
23. Yukon Hospital Corporation. *Annual Report 2010-2011*. Whitehorse, YT: Yukon Hospital Corporation; 2011.

24. Newfoundland and Labrador. A Strategy to Reduce Hip and Knee Joint Replacement Surgery Wait Times in Newfoundland and Labrador. <http://www.releases.gov.nl.ca/releases/2011/health/0304n02.htm>. Updated 2012.
25. Newfoundland and Labrador. Progress Continues in Addressing Wait Times for Health Care Services. Newfoundland Labrador Canada. Updated 2011. Accessed August 15, 2012.
26. British Columbia Ministry of Health. Access to surgery in British Columbia: the cutting edge. <http://www.health.gov.bc.ca/cap/mediasite/pdf/SAC.Final.Report.pdf>. Accessed August 3, 2012.
27. Doctors Manitoba. Patient access registry tool shows promise. Doctors Manitoba. http://www.docsmb.org/index2.php?option=com_content&do_pdf=1&id=211. Updated December, 2008. Accessed August 3, 2012.
28. Manitoba Health. eBooking: electronic OR booking. Patient Access Registry Tool (PART). <http://www.gov.mb.ca/health/mpan/pdf/ebooking.pdf>. Updated 2012. Accessed July 25, 2012.
29. Saskatchewan Health Quality Council. QReview—Finding the time to shorten wait times for patients. Saskatchewan Health Quality Council. <https://www.hqc.sk.ca/portal.jsp?W21LQum+YEhUTQFLXSnnDBIzBf0QfLQkUwK4QBZaJtC0GkpNuk4YFVvl5thiwzu>. Updated July, 2007. Accessed August 8, 2012.
30. Cornet D. Surgeons adopt cutting-edge pooling system. *The Prince Albert Daily Herald*. April 16, 2012; <http://www.paherald.sk.ca/Local/News/2012-04-16/article-2955418/Surgeons-adopt-cutting-edge-pooling-system/1>. Accessed August 24, 2012.

Waiting for specialized care tends to vary by the underlying clinical condition and ultimate discharge destination.



chapter

Waits for Specialized Care

Waits for Routine Care

Waits for Emergency Department Care

Waits for Acute Care

Waits for Specialized Care

Waiting Across the Continuum

To date, efforts to understand and measure waits in Canada have largely focused on acute care services. But the full health care continuum spans a much broader range of services. Many patients require care in specialized settings, such as rehabilitation, mental health care, home care, and residential care. This chapter explores what is known about waits for certain specialized care services, and highlights areas where information is still lacking.

Waits for Rehabilitation Services

Rehabilitation care includes a range of both hospital (inpatient and outpatient clinics) and community-based services (private clinics and home care) aimed at fostering independence among those who experience debilitating illness or injury.^{1,2} The shift in service delivery from hospitals to community-based providers in recent years was originally introduced to reduce pressure on hospitals. Indeed, today most rehabilitation takes place outside of the hospital setting.³⁻⁵



Hani's Story

In 2010–2011, 9% of the 50,000-plus knee replacement patients were subsequently admitted to inpatient rehabilitation. Due to his special circumstances (as noted in Chapter 3), Hani has been referred for inpatient care. He should not have to wait long; orthopedic patients wait approximately 1.5 days on average for admission to inpatient rehabilitation. Based on the median length of stay for orthopedic patients, Hani can expect to spend two weeks in the hospital receiving rehabilitation.

Wait times for rehabilitation in Canada are not well understood. Most published studies use wait list length as a proxy for wait times. Overall, the findings indicate that waiting for rehabilitation remains a challenge for Canadians.^{6, 7}

Waits for Community-Based Rehabilitation Services

Timely access to community-based rehabilitation can reduce the number of emergency department visits, reduce the length of hospital stays and extend the time before residential care is needed.^{8, 9} Waiting for access to rehabilitation can have several implications, including increased health care costs and increased prevalence of disability among those waiting, who may then require care in other settings.^{6, 9} One Ontario study found that a typical patient waited 15 days for occupational therapy and 29 days for physical therapy.³ Wait times for physical therapy in hospital outpatient departments were longer than for community care access centres, while waits for occupational therapy were similar in both settings.³

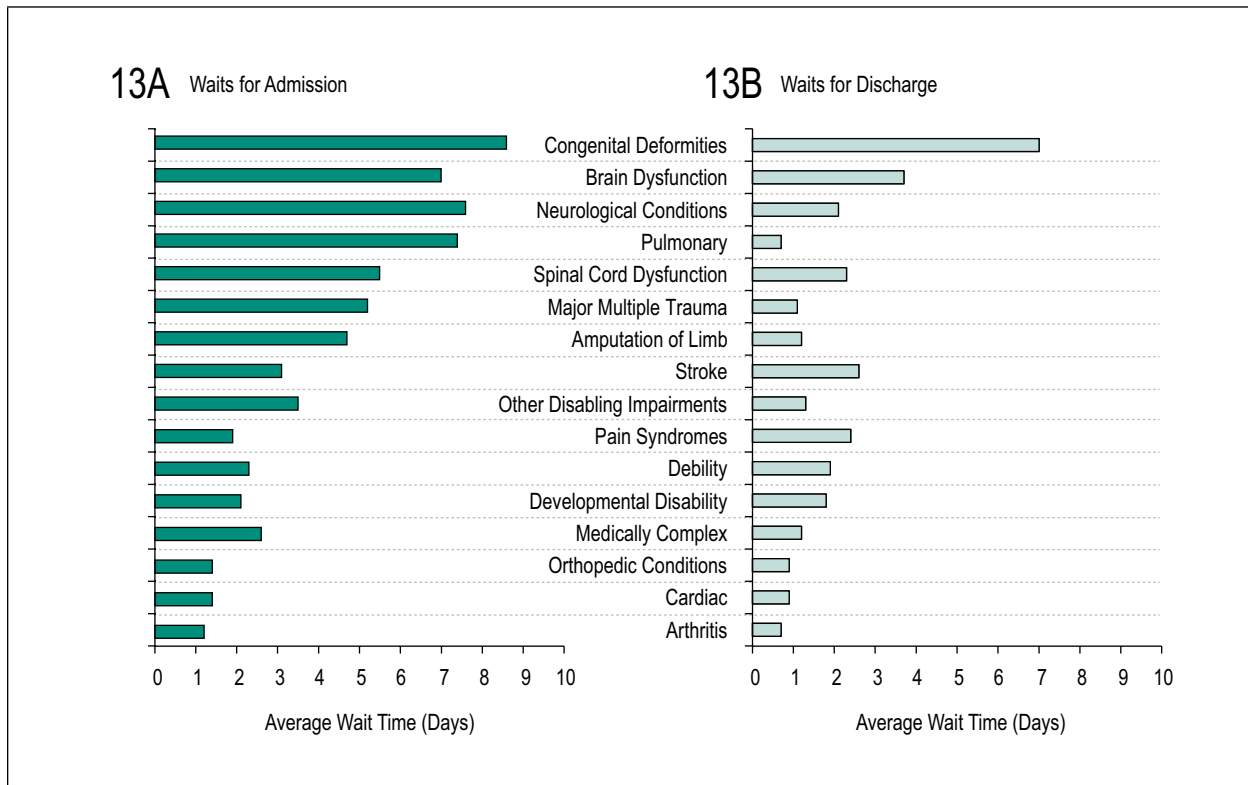
Several factors influence wait times for community-based rehabilitation, including hours of operation, the ability to pay for care, and geography. Access to publicly funded centres may be an issue, as most are not open on weekends or outside regular working hours.⁹ Wait times have been shown to be shorter for privately funded practices, as well as for patients without chronic conditions.^{6, 9} Wait times can be a bigger challenge in rural or remote settings than in urban areas because there are often few locations providing specialized rehabilitation care.⁷

Waits for Inpatient Rehabilitation Services

The average wait for admission to inpatient rehabilitation facilities is about three days. In 2010–2011, approximately 31% of patients in acute care settings who were discharged to inpatient rehabilitation had waited in the acute care setting for their rehabilitation to start. Data from CIHI's National Rehabilitation Reporting System (NRS) showed that in 2011–2012, more than 90% of rehabilitation patients were referred from acute care, while only 2% were referred from a private practice.

Despite the stability in overall waits, there is variation in wait times related to demographic and clinical factors. Factors such as a patient's clinical condition and age, the type of facility they are waiting for admission to, and where that facility is located all play a part in a patient's wait. Wait times for admission varied significantly by Rehabilitation Client Group in 2011–2012 (see Figure 13A), ranging from 1 day (Arthritis) to 9 days (Congenital Deformities). Reported wait times for admission to inpatient rehabilitation in 2011–2012 also varied by province, ranging from about 1 day in Alberta to 17 days in Nova Scotia.

Figure 13 (A and B): Average Number of Days Waiting for Admission and Discharge, by Rehabilitation Client Group, 2011–2012



Notes

Includes clients discharged in 2011–2012 with complete discharge assessments.

Date Ready for Discharge was mandatory to record in the National Rehabilitation Reporting System only if a client's service goals had been met.

Please refer to *Inpatient Rehabilitation in Canada* at www.cihi.ca for specific details on the contents of each Rehabilitation Client Group.

Source

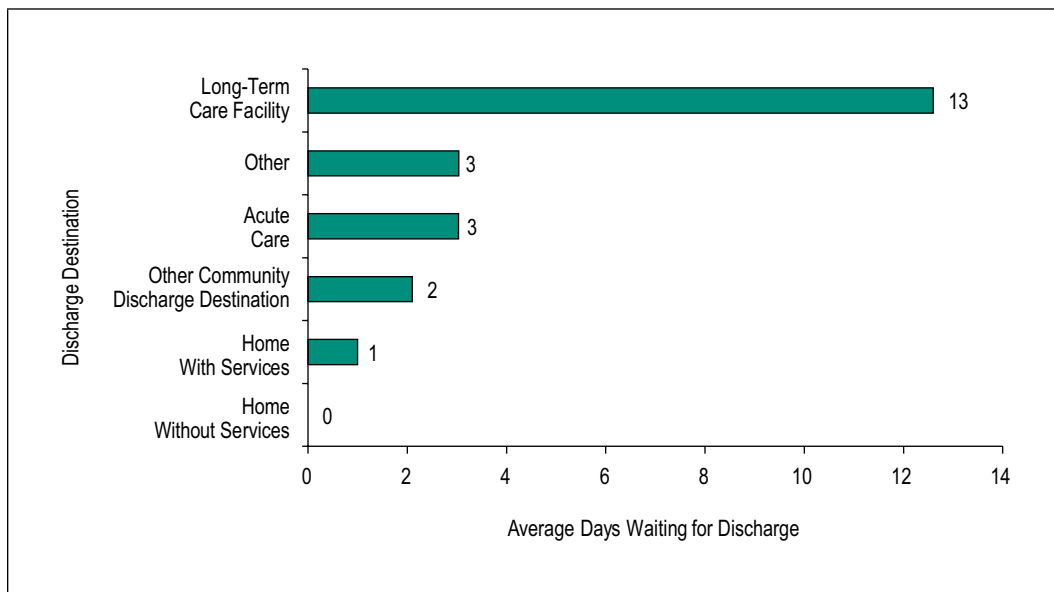
National Rehabilitation Reporting System, Canadian Institute for Health Information, 2011–2012.

Waiting to Leave Inpatient Rehabilitation

Some patients also experience waits when moving from rehabilitation to the next care setting. According to the NRS, on any given day about 8% of inpatient rehabilitation patients are waiting for discharge. These wait times have increased slightly over time, from about 1 day in 2006–2007 to just over 1.5 days in 2011–2012.

Patients requiring the most care after discharge (based on discharge destination and Rehabilitation Client Group) tended to wait the longest. Those who went home without any services waited less than 1 day, on average, while those transferring to residential care waited nearly 13 days (see Figure 14). Figure 13B shows the waits for discharge by Rehabilitation Client Group; patients with greater care needs (Brain Dysfunction, Stroke) tended to have the longest wait.

Figure 14: Average Number of Days Waiting for Discharge From Inpatient Rehabilitation Facilities, by Discharge Destination, 2011–2012



Notes

Includes clients discharged in 2011–2012 with complete discharge assessments; excludes those with unknown discharge destinations and those who died.

Date Ready for Discharge was mandatory to record in the National Rehabilitation Reporting System only if a client's service goals had been met.

"Other" includes discharge destinations such as boarding houses, assisted living facilities, shelters and public places.

Source

National Rehabilitation Reporting System, Canadian Institute for Health Information, 2011–2012.

Waits for Mental Health Services

It is estimated that about one in five Canadians, will experience mental illness in their lifetime.¹⁰ The economic burden of mental illness on the Canadian health care system is significant and has been estimated at \$51 billion among Canadians age 20 and older.¹¹

Delays in treating mental illness can have several negative consequences, including deterioration in the patient's condition.¹² Yet long wait times for mental health services remains one of many challenges faced by individuals seeking help for their condition.¹³ Lengthy wait times may also be a barrier to access, as the longer the time between initial contact and intake, the less likely the patient will persist in seeking treatment.¹⁴

Previous research has identified barriers to accessing mental health services at the system, community and individual levels. System-level factors may include

- Fragmentation in services;¹³
- Increased demand and shortage of health human resources;¹⁵
- A shortage of supportive housing;¹⁶ and
- Difficulty in getting referrals to psychiatrists.¹⁷

Community-level barriers may include

- Geographic location;¹⁴ and
- Societal perceptions of gender, socio-economic status and sexual orientation.¹⁴

Finally, individual-level barriers to seeking help and obtaining diagnosis/treatment may include

- Stigma;^{10, 14}
- Tendency or preference to seek informal help;¹⁴ and
- Previous experience with mental health care.¹⁴

In March 2006, the Canadian Psychiatric Association published a policy paper that included evidence-based benchmarks for patients with severe psychiatric illness.¹⁸ Three general urgency levels were put forth: emergent, urgent and scheduled, as well as recommended benchmark wait times in accessing a family physician and access to a psychiatrist after being referred by a family physician.

Table 3: Recommended Wait Time Benchmarks in Accessing a Family Physician and Psychiatrist for Patients With Serious Psychiatric Illnesses, 2006

Recommended Wait Time Benchmarks			
Indication	Emergent	Urgent	Scheduled
Access to family practitioner			
Acute or urgent mental health concerns	As deemed appropriate after triage	Within 24 hours	Within 1 week
Access to psychiatrist after referral by family practitioner			
First episode psychosis	Within 24 hours	Within 1 week	Within 2 weeks
Mania	Within 24 hours	Within 1 week	Not generally applicable
Hypomania with previous diagnosis of mania	Not generally applicable	Within 2 weeks	Within 4 weeks
Post-partum mood disorder or psychosis	Within 24 hours	Within 1 week	Within 4 weeks
Major depression	Within 24 hours	Within 2 weeks	Within 4 weeks
Diagnostic and management consultation (includes consultation for child and geriatric conditions not otherwise stated above)	Within 24 hours	Within 2 weeks	Within 4 weeks

Source

Wait Time Benchmarks for Patients With Serious Psychiatric Illnesses, Canadian Psychiatric Association, March 2006.

Waits for Community-Based Mental Health Services

Most people with mental illness are treated in the community rather than in hospitals.¹⁰ Yet there is no systematic collection of wait time information for community mental health services in Canada, and what does exist is somewhat disjointed. More specifically, there is wide variability in how wait times are calculated, which metrics are reported, what type of mental health service/support individuals are waiting for, and who is included in the wait time measure. The recently released Mental Health Strategy for Canada (“Changing Directions, Changing Lives”) has recommended that standards be set for wait times for community mental health services, for people of all ages.¹⁹

Good information on waits for community mental health services is available for several provinces and regions:

- The Government of Nova Scotia’s Wait Times website²⁰ includes public reporting of wait times for addiction services (for example, withdrawal management, structured treatment) for adolescents and adults. Median wait times for these services from January 1 to March 31, 2012, ranged from 0 to 6 days for withdrawal management, and 12 to 23 days for structured treatment.
- ConnexOntario, funded by the Ontario Ministry of Health and Long-Term Care, reports wait times for community mental health services.²¹ Some of the median wait times for these ministry-funded services in 2011–2012 were 1 day (case management), 13 days (counselling and treatment) and 62 days (support within housing).
- Alberta Health Services has a series of provincial- and health region–level performance measure dashboards, which include information on the percentage of children younger than age 18 who received community mental health treatment (that is, a face-to-face scheduled assessment with a mental health therapist) within 30 days.²² Third-quarter data for 2011–2012 showed that 83% of children were seen within 30 days.

Waits in Inpatient Mental Health Care

The capture of ALC data shows that many patients requiring inpatient mental health services experience waits for appropriate discharge at the end of their hospitalization. The ALC days are of concern because they contribute to the mismatching of patient need with appropriate level of care.²³ In 2009–2010, adult inpatients spent more than 2.2 million days being treated for mental illness in Canadian acute care hospitals; 23% of these days were spent in ALC. The most common discharge settings for mental health patients with at least one ALC day were continuing care (59%), home without services (16%) and home with services (14%). Those with personality disorders had the longest stays in ALC (median ALC length of stay at 25 days), followed by those treated for schizophrenic and psychotic disorders (24 days) and organic disorders, such as Alzheimer’s disease and dementia (23 days).

In Ontario, more detailed data is collected for patients in designated mental health beds. Most of these patients have a diagnosis of mood disorder (for example, bipolar disorder and depression) or schizophrenia and other psychotic disorders, or have a substance-related disorder. In 2009–2010, ALC days represented approximately 4% of the total number of days among individuals in designated adult mental health beds in Ontario. Mental health stays for

all patients averaged 16 days, with half of them staying 9 days or less in hospital. However, for patients with ALC days reported, the average length of stay was approximately four times longer (66 days) than for those with no ALC days reported, and half of these patients stayed in hospital for 37 days or more. There is some evidence that patients with ALC days had more complex needs and challenges than those with no ALC days, such as higher scores on the Cognitive Performance Scale (13% versus 2% with severe or very severe cognitive impairment), the Self-Care Index (9% versus 4% having decreased ability to care for self) and Aggressive Behaviour Scale (7% versus 3% with severe aggression).

Waits for Residential Care and Home Care

As Canada's population ages, the demands for residential care and home care are likely to increase. Indeed, many people are waiting for such services today. Currently, more than 40% of ALC patients in acute care are waiting for residential care. One study has estimated that most (59%) of the ALC patients in inpatient rehabilitation are also waiting for residential care.²⁴ In Ontario, while waits for long-term care have stabilized over the past two years, the average applicant continues to wait almost four months (113 days) for placement.²⁵ In Nova Scotia, the average wait for a bed is approximately 154 days, with 68% of patients being placed within 6 months and 95% within a year.²⁶ Ontario data suggests that although 90% of home care patients receive their first visit within 7 to 9 days, there remains room for improvement.²⁵

More information on the care needs of elderly Canadians waiting in hospital for placement in the community is available in CIHI's report *Seniors and Alternate Level of Care: Building on Our Knowledge*. Data from CIHI's Discharge Abstract Database, Home Care Reporting System and Continuing Care Reporting System was used to provide an in-depth look at transitions from acute care to the community for Canadians age 65 and older.

Key findings include the following:²⁷

- More than half (54%) of seniors who waited in acute care were discharged to a residential care facility.
- Persons discharged from acute care to residential care account for more than 5 million ALC days in total. Some of these patients may be able to be cared for at home, with the right supports in place.
- Persons with symptoms of dementia, including challenging behaviours, were more likely than other seniors to have waited in acute care prior to residential care admission, suggesting that they were waiting for specialized services such as behavioural support.
- Clinical characteristics alone did not account as well for ALC days in those persons admitted to residential care. Persons with complex care needs without a strong support system were more likely than those with support to have waited in acute care before home care admission, suggesting that they were waiting for a caregiver to be available or for services to be put in place.

Strategies for Reducing Waits

Although knowledge of wait times in specialized care settings is in its infancy, there are a variety of strategies and pilot programs to learn from. Several examples are presented here:



Financial Incentives

- One of the new (2010–2011) funding incentives available to Nova Scotia family physicians participating in continuing care is the Long-Term Care Clinical Geriatric Assessment (CGA). This evidence-based clinical process allows for interdisciplinary input to best assess the health and care needs of nursing home residents. Physicians completing the CGA are eligible to bill for a CGA fee twice per fiscal year per resident. The information included in this assessment serves as the lead clinical document that travels with the resident when a transfer occurs (to the ED or to another facility) so that subsequent caregivers receive accurate clinical information about the resident. In addition to reducing the time taken to understand the patient's clinical state, this information will help enhance the quality of care received by the patient.²⁸



Human Resource Policies

- One of the recommendations put forth in Changing Directions, Changing Lives, the mental health strategy for Canada, is to provide access to the right combination of services, treatments and supports, when and where people need them.¹⁹ One suggested mechanism is to increase access to psychotherapies and clinical counselling by service providers who are qualified to deliver approaches based on best available evidence.¹⁹



Technology, Patient Flow

- Providence Healthcare in Toronto considerably reduced its number of ALC days through targeted efforts.²⁹ To improve patient flow (that is, rehabilitation patients waiting for long-term care), this rehabilitation facility used information services to collect, manage and report on ALC data on a weekly basis, giving a clear picture of the ALC process within the organization. Several new initiatives were implemented to improve patient flow, including discussing discharge planning soon after patients' admission, regularly communicating estimated discharge dates to patients and conducting "Rapid Rounds" to identify potential discharge challenges. Through these internal process changes, and coupled with building key relationships with upstream partner hospitals and downstream Community Care Access Centres, Providence Healthcare reduced the number of ALC patients on the wait list by approximately 35% between March 2010 and June 2011.²⁹
- The former Chinook Health Region in Alberta had a clear vision for a regional health-care delivery model that was designed to closely match the needs of its specific catchment population. In 2003, the health region closed acute care beds and used the savings to strategically invest in supportive living facilities, which better suited the health care needs of its population. The result: improved management of acute care patient flow and a reduction in the percentage of ALC days, from 7% to less than 1% from 2006–2007 to 2010–2011.³⁰

Conclusion

Waiting for specialized care tends to vary by the underlying clinical condition and ultimate discharge destination. Within rehabilitation, patients needing long-term care tend to wait the longest for discharge; these waits vary by clinical condition, with patients with greater care needs (such as brain dysfunction and stroke) experiencing the longest waits. Among mental health patients, those with personality disorders appear to wait the longest for discharge. The most common discharge setting for mental health patients collectively is continuing care.


At the time of the 2004 health accord, questions about how long patients waited for home care and other services (such as long-term care placements, inpatient mental health services and other types of care) could not be answered. Several years later, some progress has been made on this front, resulting in improved understanding of wait times in these care sectors. Information on waits for inpatient rehabilitation can be gleaned from administrative data, but gaining insight into community-based rehabilitation has not come as easily. Systematic data collection on waits for community-based mental health services is still lacking, although the recently released mental health strategy for Canada may serve to remedy the situation. Waits for home care and residential care are now better understood, through recent data expansion efforts in those areas. In the upcoming conclusion of this report, key areas for future focus are given consideration, to help inform those working to address these continuing wait time challenges.

References

1. Canadian Institute for Health Information. Rehabilitation. <http://www.cihi.ca/CIHI-ext-portal/internet/EN/TabbedContent/types+of+care/hospital+care/rehabilitation/cihi010638>. Updated 2012. Accessed June 12, 2012.
2. Central East LHIN Rehabilitation Task Force. *Rehabilitation Is a Journey*. Toronto, ON: Ontario Ministry of Health; 2009. www.centraleastlin.on.ca/uploadedFiles/Public_Community/Get_Involved/Task_Groups/REHAB_REPORT_-_Final.pdf. Accessed August 30, 2012.
3. Passalent L, Landry M, Cott C. Wait times for publicly funded outpatient and community physiotherapy and occupational therapy services: implications for the increasing number of persons with chronic conditions in Ontario, Canada. *Physiotherapy Canada*. 2009;61(1):5-14. Accessed August 30, 2012.
4. Baranek PM, Deber R, Williams A. *Almost Home: Reforming Home and Community Care in Ontario*. Toronto, ON: University of Toronto Press; 2004 Accessed July 27, 2012.
5. Brekke J, Hoe M, Long J, Green M. How neurocognition and social cognition influence functional change during community-based psychosocial rehabilitation for individuals with schizophrenia. *Schizophrenia Bulletin*. 2007;33(5):1247-1256. Accessed August 30, 2012.
6. Cook L, Landry M, and Cott CA. *Wait Lists and Wait Times for Community-Based Adult Rehabilitation in Ontario*. Toronto, ON: Arthritis Community Research & Evaluation Unit; 2006. acreu.ca/pdf/pub5/06-02.pdf. Accessed August 30, 2012.
7. GTA Rehab Network. *Outpatient Rehabilitation in the GTA: Understanding the Current State*. Toronto, ON: GTA Rehab Network; 2011. www.gtarehabnetwork.ca/uploads/File/reports/report-outpatientrehab-june2011.pdf. Accessed August 30, 2012.
8. Ontario Physiotherapy Association. *Position Statement: Access to Publicly Funded Physiotherapy in Ontario*. Toronto, ON: OPA; 2009. www.opa.on.ca/pdfs/position/access2physio_pos.pdf. Accessed August 30, 2012.
9. Cott CA, Devitt R, Falter L, Soever L, and Wong R. *Adult Rehabilitation and Primary Health Care in Ontario*. Toronto, ON: Arthritis Community Research & Evaluation Unit; 2004. www.acreu.ca/pdf/pub5/04-01.pdf. Accessed August 30, 2012.
10. Health Canada. *A Report on Mental Illnesses in Canada*. Ottawa, ON: Health Canada Editorial Board Mental Illnesses in Canada; 2002. www.phac-aspc.gc.ca/publicat/miic-mmacc/pdf/men_il_e.pdf. Accessed August 30, 2012. Catalogue number 0-662-32817-5.
11. Lim K, Jacobs P, Ohinmaa A, Schopflocher D, Dewa C. A new population-based measure of the economic burden of mental illness in Canada. *Chronic Diseases in Canada*. 2008;28(3):92-98. www.phac-aspc.gc.ca/publicat/cdic-mcbc/28-3/pdf/cdic28-3-2eng.pdf. Accessed August 30, 2012.

12. Schizophrenia Society of Ontario. Psychiatric Wait Times Strategy. www.schizophrenia.on.ca/docs/Psychiatric_Wait_Times.pdf. Updated 2012. Accessed May 22, 2012.
13. Mental Health Commission of Canada. *Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada*. Ottawa, ON: 2009. www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507_MHCC_EN_final.pdf. Accessed August 30, 2012. ISBN: 978-0-9913795-0-0.
14. The Canadian Association of Paediatric Health Centres, The National Infant Child and Youth Mental Health Consortium Advisory, and The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. *Access & Wait Times in Child and Youth Mental Health: A Background Paper*. Ottawa, ON: 2011. www.excellenceforchildandyouth.ca/download/329/649/policy_access_and_wait_times.pdf. Accessed August 30, 2012.
15. Reid G, Brown JB. Money, case complexity, and wait lists: Perspectives on problems and solutions at children's mental health centers in Ontario. *The Journal of Behavioral Health Services & Research*. 2008;35(3):334-346. Accessed August 30, 2012.
16. Kirby MJ, Keon WJ. *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. Ottawa, ON: 2006. www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/rep02may06-e.htm. Accessed August 30, 2012.
17. Goldner E, Jones W, Fang M. Access to and waiting time for psychiatrist services in a Canadian urban area: A study in real time. *Canadian Journal of Psychiatry*. 2011;56(8):474-480. Accessed August 30, 2012.
18. Canadian Psychiatric Association. Wait Time Benchmarks for Patients With Serious Psychiatric Illnesses (Policy Paper). www.cpa-apc.org/media.php?mid=585. Updated 2006. Accessed April 19, 2012.
19. Mental Health Commission of Canada. *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. Calgary, AB: Mental Health Commission of Canada; 2012. strategy.mentalhealthcommission.ca. Accessed August 30, 2012.
20. Government of Nova Scotia. Wait Times for Addiction Services. www.gov.ns.ca/health/waittimes/category.asp. Updated March 20, 2012. Accessed January 31, 2012.
21. ConnexOntario Health Services Information. Average, median and 90th percentile wait times (in days) for mental health programs in the Mental Health Helpline (MHH) Database Fiscal Year 2011/2012 (Special Request). ConnexOntario Health Services Information. June 27, 2012.
22. Data Integration Measurement and Reporting. *Alberta Health Services Q3 Performance Report 2011/12*. Edmonton, AB: March 30, 2012. <http://www.albertahealthservices.ca/Publications/ahs-pub-pr-2012-03-performance-report.pdf>. Accessed August 30, 2012.

23. Mental Health Commission of Canada, Centre for Addiction and Mental Health, and Canadian Council on Social Development. *Turning the Key: Assessing Housing and Related Supports for Persons Living With Mental Health Problems and Illnesses*. Ottawa, ON: 2011. www.mentalhealthcommission.ca. Accessed August 30, 2012.
24. GTA Rehab Network. *Beyond Acute Care: Next Steps in Understanding ALC Days*. Toronto, ON: GTA Rehab Network; 2008. www.gtarehabnetwork.ca/uploads/File/reports/report-ALC-march2008.pdf. Accessed August 30, 2012.
25. Health Quality Ontario and Institute for Clinical and Evaluative Sciences. *Quality Monitor: 2012 Report on Ontario's Health System*. Toronto, ON: HQO; 2012. www.ohqc.ca/pdfs/quality-monitor-2012-full-en.pdf. Accessed August 30, 2012.
26. Government of Nova Scotia. Continuing Care Strategy. http://www.gov.ns.ca/health/ccs_strategy/faq.asp. Updated 2011. Accessed August 2, 2012.
27. Canadian Institute for Health Information. *Seniors and Alternate Level of Care (ALC): Building on Our Knowledge*. Ottawa, ON: CIHI; 2012.
28. Nova Scotia Medical Services Insurance. Physicians' Bulletin. http://www.gov.ns.ca/health/physicians_bulletin/msi-physicians-bulletin-april-2011.pdf. Updated 2011.
29. Cancer Care Ontario. *Performance Improvement Case Studies: Improving Access Through Information*. Toronto, ON: 2011.
30. Health Quality Council of Alberta. *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy*. Calgary, AB: 2012. <http://www.hqca.ca/assets/files/EDCAP%20FINAL%20REPORT.pdf>. Accessed August 30, 2012.



Ultimately, wait times matter most to the patient.

With the current health accord set to expire in 2014, policy-makers will have to determine how best to move forward with understanding and improving wait times.

Looking Back, Looking Forward

Reducing wait times for surgery and other health services is a prominent policy and service delivery challenge, both in Canada and abroad. While there has been focused attention in Canada since 2004 to reduce waits in five identified priority areas, waits for care and services exist throughout the health care continuum. Waiting for appointments with a family doctor or specialist, waiting in the emergency department (ED), alternate level of care (ALC) stays, accessing mental health services, leaving rehabilitation—the potential to wait for care exists in these and many more points of contact with the health care system. Having a better understanding of these waits is key for those working to improve the overall performance of the health system. Patients and their families would also benefit, as their overall experiences are improved by a better understanding of how long they can expect to wait for services.

Health Care in Canada, 2012: A Focus on Wait Times highlights what is currently known about the waits patients experience in different settings for different types of care. The report identifies areas where measureable progress has been made and explores factors thought to contribute to waits for care. It also looks at some of the barriers to continuing improvement.

Summary of Report Findings

This report opens by positioning wait times within the context of access, and notes Canada's poor performance in comparison with other countries. Wait time measurement has evolved considerably since 2004; its history is summarized to set the stage for future discussion. The remainder of the report centres on analysis of wait time data throughout this period of evolution, and includes data as recent as 2011.

Moving into the discussion about waits across the continuum, the report examines waits for routine care, including primary care services (those provided by a family physician), specialist referral, and screening and diagnostic testing. A 2010 international comparison of 11 countries ranked Canada lowest for wait times to see a doctor or nurse when sick, with Canadians reporting the longest waits for specialist appointments.

Information on waits in EDs and acute care settings is presented next. Data shows that average overall lengths of stay in the ED are just over 4 hours, with 90% of visits completed within 8 hours. Since the focus on reducing waits for priority area surgeries began, many have questioned whether this approach has negatively impacted access to and waits for other surgeries. The analyses presented here show no evidence of this at the national level, but variation exists at the provincial level, likely the result, at least in part, of jurisdictions pursuing different strategies to address local wait time and access to care issues. Waiting for discharge from acute care remains a challenge; those with dementia and those receiving palliative care are among those most likely to wait, followed by those waiting for rehabilitation and convalescence.

Waits for and within specialized care services, such as rehabilitation, mental health care and home care and long-term care, are discussed next. Available data on rehabilitation and mental health suggests that waits for these services are driven mainly by a patient's clinical condition and ultimate discharge destination. Among patients in rehabilitation, the longest waits for discharge were experienced by those transferring to long-term care, with variation by Rehabilitation Client Group. Among those waiting for discharge from mental health care, patients with personality disorders waited longest. The data reveals that the most common discharge setting for mental health patients in ALC is continuing care. To help policy-makers better understand waits for placement in home care and residential care, CIHI's report *Seniors and Alternate Level of Care: Building on Our Knowledge* provides an in-depth look at transitions from acute care to the community for Canadians age 65 and older.

Issues on the Horizon

Health Care in Canada, 2012: A Focus on Wait Times brings together what is currently known about waiting for health care in Canada. While definite progress has been made in specific areas since 2004, it is now time to consider what the best next steps may be in continuing to address wait time challenges. Findings from this report and a review of available literature suggest four key areas where system decision-makers could focus.

1. Implementing Proven Strategies to Help Address Known Waits

Examples of strategies and pilot programs aimed at improving wait times were profiled throughout this report—some in their infancy, others having yielded sustained success in lowering wait times. These programs and others exist across the country. Figure 15 illustrates the breadth of programs that were highlighted in this report.

Figure 15: Programs and Strategies Used to Lower Wait Times Across Jurisdictions



One key to building on successful pilot programs is concrete adoption strategies; new initiatives should benefit from what was learned during the pilot. Successful wait time reduction programs share a number of other common factors, including being evidence-based, having a champion, having strong stakeholder support and involving front-line staff from the development phase onwards.

2. Collecting and Reporting on Comparable Data Across the Continuum, and Evaluating Waits Against Benchmarks

When the 10-Year Plan to Strengthen Health Care was introduced, no comprehensive wait time data was available to compare performance across jurisdictions. At that time, care providers, system managers and government policy-makers were wrestling with questions about who was waiting, what to measure and how long was too long to wait.¹ Today, those same decision-makers are anticipating a fifth year of comparable data in selected priority areas. Adding to the available wait time information is the establishment of agreed-upon definitions for patients waiting, common measures of progress and evidence-based benchmarks in all but one of the priority areas.¹

Following the 2004 First Ministers' Accord, CIHI highlighted several areas of health care where little was known about wait times. Since then, progress has been made toward improving understanding in many of these areas, but in several others, no clear progress can be demonstrated:

- Under what circumstances do longer or shorter waits for one service contribute to longer or shorter waits for another service?
- Are waits for routine care, assessment and diagnostic services increasing or decreasing? What strategies are effective in reducing waits for these types of care?
- How does the length of waits for surgery affect post-operative outcomes, subsequent health care services and health care costs?
- How many patients have multi-step waits for different types of care? How significant are different segments of the wait?

One way to expand the breadth and depth of information collected on wait times is to take better advantage of existing technology. Changes to CIHI's ED data collection system are an example of how existing technology can be used to acquire additional information in a timely manner. Through an interface between CIHI and existing hospital information systems, the majority of data elements are collected at the time of service, which provides hospitals with a lower cost mechanism to collect and submit ED data to CIHI. This results in more timely data and reports, such as the measures of ED wait times discussed in Chapter 2. Electronic medical records (EMRs) have the capacity to collect a wealth of wait time information; the approach used for ED data collection may be one means of populating EMRs in the future.

To evaluate and improve performance, high-quality, comparable data is required. So are benchmarks and targets. The most effective targets are evidence-based, regularly renewed and have clinical buy-in. For example, the appropriateness of testing and use of evidence-based guidelines for diagnostic imaging has received significant attention.²⁻⁶ There is some evidence that referring physicians, whether specialists or non-specialists, are not sufficiently informed about appropriate clinical use of MRI and CT. As a result, they may at times order scans that are not appropriate.⁶ The Canadian Association of Radiologists estimates that between 10% and 20% of referral requests for diagnostic imaging do not meet their referral guidelines.⁷

As shown by the progress made since 2004 in reducing waits in the five identified priority areas, having clear priorities and targets works. The next step is the identification of the next set of waits where better and more comparable data is needed to evaluate and improve current performance. Developing agreed-upon, evidence-based benchmarks will follow. Some groups, such as the Wait Times Alliance, have made specific suggestions for added focus on waits for pediatric surgery, mental health services, gastroenterology and cancer care.⁸

3. Promote Prevention as a Means of Reducing Demand for Health Care Services

Research has shown that initiatives that encourage and support all aspects of healthy living may reduce the demand for health care and other support services, through cost avoidance or shifts to lower-cost sectors.⁹ Protecting healthy people from developing disease in the first place (primary prevention), slowing or reducing the burden of illness once a disease is already present (secondary prevention), and focusing on helping people manage complicated, long-term health problems (tertiary prevention) all play a role in reducing the demand for health care services.

The Canadian Task Force on Preventive Health Care, established with the support of the Public Health Agency of Canada, is a collaborative body developed to make recommendations on preventive measures based on evidence and best practices. Its prevention and screening guidelines may be an important resource in the development and promotion of a more consolidated strategy for prevention efforts and policies that focus on promoting the health of the population as a whole. Improving the health of the population now will contribute to significant cost and time savings for the system in the future.

4. Taking a Patient-Centred Focus and Improving Coordination of Care Across the Continuum

The notion of patient-centred care is not new, nor is its application to understanding and tackling wait times. Following the introduction of the 10-Year Plan to Strengthen Health Care, many stakeholders (such as the College of Family Physicians of Canada and the Wait Times Alliance) agreed that wait times should be measured from the patient's perspective.¹⁰

To date, patient-centred care has not been well defined. The World Health Organization views patient-centered care as “a means to improve services in relation to access, quality, user satisfaction and efficiency.”¹¹ Researchers have also identified some of its key attributes. One is respect for patients' values, preferences and expressed needs;¹² another is coordination and integration of care.¹² As patients often wait during the transitions between care settings, better integration of health care services may reduce wait times and improve patient experiences. The recently struck First Ministers' Health Care Innovation Group identified several team-based models of care that have been shown to improve access and reduce wait times through better integration of services across care sectors, and with resultant greater patient satisfaction.¹³

Advanced access scheduling, discussed in several sections of this report, is an example of a successful patient-centred approach to reducing wait times. When patients of a clinic using the advanced access model call to see their physician, they are offered an appointment the same day, regardless of whether their care needs are routine or urgent.¹⁴ And patients whose regular physician is not available are given the option of seeing another physician that same day or waiting to see their regular physician later in the week.¹⁴ This allows individuals to make a choice, based on what is of more value to them: immediate access or continuity of care.¹⁴ Through balancing supply and demand, reducing backlogs, developing contingency plans for unusual circumstances and working to adjust demand profiles, advanced access improves access to primary care.¹⁵ This ultimately benefits the patient, who is seen earlier in the course of his or her illness, which may in turn result in better outcomes of care.¹⁶

Communication is a key aspect to keeping patients' perspectives at the core of their care delivery. For them, understanding how long they are likely to wait can help reduce their stress and anxiety, and facilitate planning for the interim. The more informed patients are, the more confidence patients and their families will have in the system. Communication of information to the patient, in a form that is easily understandable, and with appropriate frequency, would help accomplish this. For example, through CIHI's Canadian Hospital Reporting Project web-based, interactive tool, hospital decision-makers, policy-makers and patients alike can access clinical and financial indicators measuring clinical effectiveness, patient safety, appropriateness of care, accessibility and financial performance. Hospitals in Ontario and Alberta have begun using websites and smartphone applications as a means of communicating to patients the estimated wait times for ED care. These are updated frequently throughout the day to ensure that patients have the most up-to-date information on which to base their care decisions.

Putting the Pieces Together

Health Care in Canada, 2012: A Focus on Wait Times has provided information on many of the waits Canadians experience across the health care continuum. It has shown how much has been learned since 2004, what improvements have been made, and where further work is still required to improve understanding and to continue lowering wait times. On this latter point, this report has drawn together a series of strategies and pilot programs developed across Canada to reduce wait times.

Throughout this report, the patient experience has been highlighted, as it is the patient for whom wait times ultimately matter most. With the current health accord set to expire in 2014, policy-makers will be faced with how best to move forward with understanding and improving wait times. In addition to providing suggestions for consideration, this report has also emphasized the importance of bringing the patient perspective to the forefront of future decisions on wait times.

References

1. Canadian Institute for Health Information. *Wait Times in Canada—A Summary, 2012*. Ottawa, ON: CIHI; March 22, 2012. https://secure.cihi.ca/free_products/WaitTimesSummary2012_EN.pdf. Accessed April 25, 2012.
2. Laupacis A, Evans W. Diagnostic imaging in Canada. *Healthcare Papers*. 2005;6(1):8-15.
3. Canadian Agency for Drugs and Technologies in Health. Clinical decision support systems for diagnostic imaging. *Issues in Emerging Health Technologies*. January, 2012; (117):1-10. http://cadth.ca/media/pdf/PS4479_CDSS_Bulletin_Issue117_e.pdf.
4. Emery D, Forster A, Shojania K, Magnan S, Tubman M, Feasby T. Management of MRI wait lists in Canada. *Healthcare Policy*. February, 2009;4(3):76-86. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2653696/>.
5. You JJ, Alter DA, Iron K, et al. *Diagnostic Services in Ontario: Descriptive Analyses and Jurisdictional Review*. ICES Investigative Report. Toronto, ON: Institute for Clinical Evaluative Sciences; April, 2007. http://www.ices.on.ca/file/diagnostic_services_ontario_oct16.pdf.
6. Ontario Ministry of Health and Long-Term Care. *Ontario Best Practice Guidelines for Managing the Flow of Patients Requiring an MRI or CT Examination*. 2009. <http://www.ontla.on.ca/library/repository/mon/23006/292809.pdf>.
7. Canadian Association of Radiologists. *Diagnostic Imaging Referral Guidelines: A Guide for Physicians*. St.Laurent, QC: Canadian Association of Radiologists; 2005. <http://www.cehha.nshealth.ca/Services/downloads/Guidelines%20ENG.pdf>.
8. Wait Time Alliance for Timely Access to Health Care. *Shedding Light on Canadians' Total Wait for Care: Report Card on Wait Times in Canada*. June 19, 2012. http://www.waittimealliance.ca/media/2012reportcard/WTa2012-reportcard_e.pdf. Accessed August 23, 2012.
9. Edwards P and Mawani A. *Healthy Aging in Canada: A New Vision, A Vital Investment*. From Evidence to Action. A Background Paper Prepared For the Federal, Provincial and Territorial Committee of Officials (Seniors). Ottawa, ON: Public Health Agency of Canada; 2006. http://www.health.gov.nl.ca/health/publications/vision_rpt_e.pdf. Accessed August 10, 2012.
10. The College of Family Physicians of Canada. *Family Medicine In Canada: Vision For The Future*. November, 2004. http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/FAMILY_MEDICINE_IN_CANADA_English.pdf. Accessed June 25, 2012.

11. Grone O, Garcia-Barbero M. Integrated care: A position paper of the WHO European office for integrated health care services. *International Journal of Integrated Care*. 2001;1(e21) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525335/>. Accessed June 25, 2012.
12. Lewis S. *Patient-Centered Care: An Introduction to What It Is and How to Achieve It*. A Discussion Paper for the Saskatchewan Ministry of Health. Saskatoon: Access Consulting Ltd; July 29, 2009. <http://www.changefoundation.ca/docs/patient-centred-care-intro.pdf>. Accessed June 25, 2012.
13. The Council of the Federation. *From Innovation to Action: The First Report of the Health Care Innovation Working Group*. July 26, 2012. <http://www.councilofthefederation.ca/pdfs/Health%20Innovation%20Report-E-WEB.pdf>. Accessed August 13, 2012.
14. Murray M, Berwick D. Advanced access: Reducing waiting and delays in primary care. *JAMA: The Journal of the American Medical Association*. February 26, 2003;289(8): 1035-1040. <http://dx.doi.org/10.1001/jama.289.8.1035>. Accessed April 25, 2012.
15. The College of Family Physicians of Canada. Continuity & comprehensiveness of care. Appendix 3: Advanced/open access scheduling in family practice. Primary Care Toolkit for Family Physicians. <http://www.toolkit.cfpc.ca/en/continuity-of-care/appendix-3.php>. Updated 2007. Accessed July 9, 2012.
16. Fournier J, Heale R, Rietze L. "I can't wait": Advanced access decreases wait times in primary healthcare. *Healthcare Quarterly*. February 16, 2012;15(1):64-68. <http://www.longwoods.com/content/22763>. Accessed July 9, 2012.

Index

Note: The letter “f” preceding a page number indicates a figure or table.

911 calls, and wait times, 28

A

access to care *see also* wait times

defined, 1

family physicians, 13

international comparisons, 2

mental health services, 60

strategies to improve, 2, 72–76

wait times, f12

addiction services, wait times (Nova Scotia), 62

admissions, to rehabilitation, f59

advanced access scheduling, 76

Alberta

breast cancer screening, f16

bypass surgery wait times, f5

cataract surgery wait times, f5

diagnostic imaging wait times, f18

hip fracture repair surgery wait times, f5, 42

hip replacement wait times, f5

knee replacement wait times, f5

mental health services wait times, 62

radiation therapy wait times, f5

rehabilitation wait times, 58

strategies to reduce wait times, 19, 35, 64

surgery wait times, priority versus non-priority areas, f45

wait time tracking, 43

alternate level of care (ALC)

defined, 33

mental health services, 62–63

reasons for admission, 47, f48

residential care wait times, 63

- strategies to reduce wait times, 64
- wait times, 33, 47
- ambulances, wait times, 28
- autism, diagnosing, 17

B

- bariatric surgery, wait times (British Columbia), 43
- bone mineral density testing, wait times, 16
- breast cancer, mammography wait times, 16
- British Columbia
 - breast cancer screening, f16
 - bypass surgery wait times, f5
 - cataract surgery wait times, f5
 - diagnostic imaging wait times, f18
 - family physicians, access, 14
 - hip fracture repair surgery wait times, f5, 42
 - hip replacement wait times, f5
 - knee replacement wait times, f5
 - radiation therapy wait times, f5
 - strategies to reduce wait times, 20
 - surgery wait times, priority versus non-priority areas, f45
 - Telenephrology system, 20
 - wait time tracking, 43
- bypass surgery
 - wait times, benchmarks, 42
 - wait times, provincial comparisons, f5

C

- cancer care, as wait time priority area, 3
- cardiac care, as wait time priority area, 3
- carpal tunnel release surgery, wait times (Nova Scotia), 43
- case study *see* Hani
- cataract surgery
 - wait times, benchmark, 42
 - wait times, provincial comparisons, f5
- Changing Directions, Changing Lives, 62, 64
- communication with patients, 76

- community care
 - mental health services, 61, 62
 - rehabilitation, 58
- computed tomography, wait times, 17, f18
- continuum of care, wait times, 6
- convalescence, as reason for hospital admission, 47, f48
- coordination of care, 75–76

D

- dementia, as reason for hospital admission, 47, f48
- diagnostic imaging
 - as wait time priority area, 3
 - wait times, 17, f18, 19, 74–75
- discharges
 - from rehabilitation, 59, f60
 - wait times, 47

E

- electronic booking, 50
- emergency departments
 - hip fracture patients, 42
 - length of stay, 28, 29
 - wait times, 27–36, 74

F

- federal government, wait time reduction funding, 3
- financial incentives, for reducing wait times, 19, 34, 49, 64, f73
- First Ministers' 10-Year Plan to Strengthen Health Care, 3, f4, 74

H

- Hani
 - about his story, 6
 - wait for discharge, 47
 - wait for rehabilitation, 47, 57
 - wait for surgery, 42
 - waits for diagnosis, 15, 18

- health care resources, international comparisons, 2
- health care services, rate of use, f12
- health human resources, strategies to reduce wait times, 19–20, 34, 49, 64, f73
- health ministers and deputies, wait time priorities, 3, f4, 74
- heart failure, as reason for hospital admission, f48
- Highly Sensitized Patient registry, 46
- hip arthroplasty, funding incentives, 49
- hip fractures
 - wait times for surgery, benchmark, 42
 - wait times for surgery, provincial comparisons, f5, 42
- hip replacements *see also* joint replacements
 - wait times, benchmark, 42
 - wait times, provincial comparisons, f5
- home care, wait times, 63
- hospitalizations *see also* emergency departments

I

- international comparisons
 - access to care, 2
 - access to physicians, 13
 - access to specialists, 15
 - health care resources, 2
 - surgery wait times, 2, 41
 - wait times, 2

J

- joint replacements *see also* hip replacements; knee replacements
 - as wait time priority area, 3

K

- kidney transplants, wait times, 46
- knee arthroplasty, funding incentives, 49
- knee replacements *see also* joint replacements
 - wait times, benchmark, 42
 - wait times, provincial comparisons, f5

L

- liver transplants, wait times, 46
- Living Donor Paired Exchange registry, 46

M

- magnetic resonance imaging (MRI), wait times, 17, f18
- mammography, wait times, 16
- Manitoba
 - breast cancer screening, f16
 - bypass surgery wait times, f5
 - cataract surgery wait times, f5
 - diagnostic imaging wait times, f18, 19
 - hip fracture repair surgery wait times, f5, 42
 - hip replacement wait times, f5
 - knee replacement wait times, f5
 - radiation therapy wait times, f5
 - strategies to reduce wait times, 50
 - surgery wait times, priority versus non-priority areas, 44, f45
- mental health care
 - community-based, 62
 - economic burden, 60
 - inpatient, 62–63
 - wait time benchmarks, f61
 - wait times, 60–63
- Mental Health Strategy for Canada, 62, 64

N

- National Organ Waitlist, 46
- New Brunswick
 - breast cancer screening, f16
 - bypass surgery wait times, f5
 - cataract surgery wait times, f5
 - hip fracture repair surgery wait times, f5
 - hip replacement wait times, f5
 - knee replacement wait times, f5
 - radiation therapy wait times, f5

- strategies to reduce wait times, 50

- surgery wait times, priority versus non-priority areas, 44, 45, f45

- wait times tracking, 43

Newfoundland and Labrador

- breast cancer screening, f16

- bypass surgery wait times, f5

- cataract surgery wait times, f5

- diagnostic imaging wait times, f18, 19

- hip fracture repair surgery wait times, f5, 42

- hip replacement wait times, f5

- knee replacement wait times, f5

- radiation therapy wait times, f5

- strategies to reduce wait times, 50

- surgery wait times, priority versus non-priority areas, f45

Nova Scotia

- addiction services wait times, 62

- breast cancer screening, f16

- bypass surgery wait times, f5

- cataract surgery wait times, f5

- diagnostic imaging wait times, f18, 19

- hip fracture repair surgery wait times, f5

- hip replacement wait times, f5

- knee replacement wait times, f5

- radiation therapy wait times, f5

- rehabilitation wait times, 58

- residential care wait times, 63

- strategies to reduce wait times, 19, 49, 64

- surgery wait times, priority versus non-priority areas, f45

- wait time tracking, 43

- nurses, wait times for (when sick), 2

O

- occupational therapy, wait times, 58

- One Island Health System, 49

Ontario

- breast cancer screening, f16

- bypass surgery wait times, f5

- cataract surgery wait times, f5
- diagnostic imaging wait times, 17, f18
- family physicians, access, 14
- hip fracture repair surgery wait times, f5, 42
- hip replacement wait times, f5
- home care wait times, 63
- knee replacement wait times, f5
- mental health services wait times, 62–63
- radiation therapy wait times, f5
- strategies to reduce wait times, 50, 64
- surgery wait times, priority versus non-priority areas, 44, 45, f45
- Teleophthalmology system, 20
- wait times for specialists, 15
- wait time tracking, 43

organ transplantation, wait times, 46

P

palliative care, as reason for hospital admission, 47, f48

patient flow, strategies to reduce wait times, 20, 35, 50–51, 64, f73

patients, communication with, 76

physical therapy, wait times, 58

physicians

- access to, 13
- income guarantees, 49
- wait times for (when sick), 2

physicians, family

- access to, 13
- new patients, 14

prevention, as means to reduce health care demands, 75

Prince Edward Island

- bypass surgery wait times, f5
- cataract surgery wait times, f5
- diagnostic imaging wait times, 17, f18
- family physicians, access, 14
- hip fracture repair surgery wait times, f5
- hip replacement wait times, f5
- knee replacement wait times, f5

- radiation therapy wait times, f5
- strategies to reduce wait times, 19-20, 49
- surgery wait times, priority versus non-priority areas, 44, f45

Providence Healthcare, 64

provinces

- breast cancer screening, wait times, 16
- wait time comparisons, f5, 44–46, f48
- wait time priorities, 3, f4
- wait time tracking, 43

Q

Quebec

- bypass surgery wait times, f5
- cataract surgery wait times, f5
- hip fracture repair surgery wait times, f5
- hip replacement wait times, f5
- knee replacement wait times, f5
- radiation therapy wait times, f5
- strategies to reduce wait times, 49
- surgery wait times, priority versus non-priority areas, 46
- wait times for ALC, 47, f48

R

radiation therapy

- wait times, benchmark, 42
- wait times, provincial comparisons, f5

rehabilitation

- as reason for hospital admission, f48
- community-based, 58
- inpatient, 58–59, f60
- types, 57
- wait times, 58-59, f60

residential care, wait times, 63

rural and remote areas, rehabilitation wait times, 58

S

Saskatchewan

- breast cancer screening, f16
- bypass surgery wait times, f5
- cataract surgery wait times, f5
- diagnostic imaging wait times, f18
- hip fracture repair surgery wait times, f5
- hip replacement wait times, f5
- knee replacement wait times, f5
- radiation therapy wait times, f5
- strategies to reduce wait times, 35, 50–51
- surgery wait times, priority versus non-priority areas, 44, 45, f45
- wait time tracking, 43

screening tests, wait times, 15–16

seniors, wait times for residential care, 63, 64

sight restoration services, as wait time priority area, 3

specialists

- strategies to reduce wait times for, 50–51
- wait times for, 14
- wait times for, international comparisons, 2, 15

spinal cord surgery, wait times (Alberta), 43

stroke, as reason for hospital admission, 47, f48

surgery wait times

- effects, 41–43
- international comparisons, 2, 41
- priority areas compared with non-priority areas, 43, 44–46, f44
- regional comparisons, 44–46

T

technologies, strategies to reduce wait times, 20, 35, 50–51, 64, f73

Telehealth, as strategy to reduce wait times, 20

transplantations, solid organs, wait times, 46

U

ultrasound, diagnostic, wait times, 19

urban areas

 emergency departments and ALC patients, 33

 rehabilitation wait times, 58

W

wait times *see also* access to care

 across continuum of care, 6

 benchmarks, 42–43, f61

 case study *see* Hani

 for ambulances, 28

 for diagnostic imaging, 17, f18, 19

 for emergency care, 27–32, 33

 for home care, 63

 for mental health services, 60–63

 for organ transplantation, 46

 for physicians or nurses (when sick), 2

 for rehabilitation services, 57–59, f60

 for residential care, 63

 for screening tests, 15–16

 for surgery (elective), 2

 international comparisons, 2

 negative consequences, 1

 priority areas, 3, 42

 priority areas compared with non-priority areas, 43, f44

 provincial variations, 44–46, f48, 50

 strategies to reduce, 2, 19–20, 34–35, 49–51, 64, 72–76

 to leave emergency, 32–34

 tracking, 4

Wait Times Reduction Fund, 3

Y

Yukon, access to care initiatives, 49

Production of this report is made possible by financial contributions from Health Canada and provincial and territorial governments. The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

All rights reserved.

The contents of this publication may be reproduced unaltered, in whole or in part and by any means, solely for non-commercial purposes, provided that the Canadian Institute for Health Information is properly and fully acknowledged as the copyright owner. Any reproduction or use of this publication or its contents for any commercial purpose requires the prior written authorization of the Canadian Institute for Health Information. Reproduction or use that suggests endorsement by, or affiliation with, the Canadian Institute for Health Information is prohibited.

For permission or information, please contact CIHI:

Canadian Institute for Health Information
495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6

Phone: 613-241-7860

Fax: 613-241-8120

www.cihi.ca

copyright@cihi.ca

ISBN 978-1-77109-099-5 (PDF)

© 2012 Canadian Institute for Health Information

How to cite this document:

Canadian Institute for Health Information. *Health Care in Canada, 2012: A Focus on Wait Times*. Ottawa, ON: CIHI; 2012.

Cette publication est aussi disponible en français sous le titre *Les soins de santé au Canada 2012 : regard sur la temps d'attente*.

ISBN 978-1-77109-101-5 (PDF)

Talk to Us

CIHI Ottawa

495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6
Phone: 613-241-7860

CIHI Toronto

4110 Yonge Street, Suite 300
Toronto, Ontario M2P 2B7
Phone: 416-481-2002

CIHI Victoria

880 Douglas Street, Suite 600
Victoria, British Columbia V8W 2B7
Phone: 250-220-4100

CIHI Montréal

1010 Sherbrooke Street West, Suite 300
Montréal, Quebec H3A 2R7
Phone: 514-842-2226

CIHI St. John's

140 Water Street, Suite 701
St. John's, Newfoundland and Labrador A1C 6H6
Phone: 709-576-7006