



Time out!

Report Card on Wait Times in Canada

June 2011

Overview

It is now time to discuss the renewal of the 2004 Health Accord that is due to expire in 2014. The 2004 Accord devoted considerable attention to improving access to timely care for Canadians. It promised significant reductions in wait times and provided \$41 billion in ongoing funding, including \$5.5 billion specifically to address wait times for five “priority areas”: cancer, cardiac care, diagnostic imaging, joint replacement and sight restoration. Since then, several wait-time developments have taken place, including:

- research into maximum or medically acceptable wait times for the five priority areas;
- the release of the Wait Time Alliance’s (WTA) maximum acceptable wait times for all five priority areas in August 2005;
- an announcement of provincially agreed wait-time targets for four of the five “priority areas” in December 2005 (diagnostic imaging was not included);
- the release of annual reports by the WTA and Canadian Institute for Health Information (CIHI) on provincial progress in meeting the wait-time targets;
- the WTA release of wait-time benchmarks for an additional 5 specialty areas including psychiatry, emergency care, plastic surgery, gastroenterology and pain management (anesthesiology) and later for obstetrics and gynecology;
- the 2007 federal announcement of \$612 million in funding for the provinces and territories to establish a wait-time guarantee for one procedure, to be implemented by March 2010;
- the establishment of the Canadian Paediatric Surgical Wait Times (CPSWT) Project through a financial contribution from Health Canada; and
- the first Parliamentary review of the 2004 Accord in 2008.

During this period, provinces and territories have also increased their efforts to improve timely access to care for their citizens through a number of wait-time related initiatives.

As discussions ramp up for a 2014 Accord and a federal parliamentary committee undertakes its second review of the 2004 Accord, there is a need to assess progress made to date on improving access to care for Canadians and the areas requiring greater attention in the years ahead. The WTA’s 2011 report card provides both.

The 2011 WTA report card contains five sections:

- 1. Grading the original five “priority areas” to government benchmarks, including a five-year assessment:** The 2011 WTA report card shows slight improvement over the previous year in wait times for the five priority areas (Table 1). This year Ontario, Quebec and BC are strong performers, while Nova Scotia and Alberta are lagging. There is wide variation in wait times between provinces and among regions within provinces. A review of WTA national grades from 2007-2011 provides an overall national grade of “B” for the five priority areas (Table 2).
- 2. Grading beyond the five “priority areas” using WTA benchmarks:** Governments are reporting on just over 10% of the important procedures selected by the WTA beyond the original five priority areas. Ontario, Alberta, Nova Scotia, BC and Saskatchewan provide wait-time data on the greatest number of treatments. Those grades that could be assigned are very low in most instances, indicating that the waits for these other important services fall outside of the WTA’s maximum acceptable wait-time benchmarks.
- 3. Grading provincial wait-time websites:** There has been progress on public wait-time reporting in the past year, but there is still considerable room for improvement in terms of the comprehensiveness of services reported and the provision of more precise wait-time data.
- 4. The impact of alternate levels of care (ALC) stays on wait times:** This year’s report card highlights the significant impact that ALC stays are having on wait times for both emergency and elective/scheduled care to the detriment of all patients. WTA members recognize that the most important action to improve timely access to specialty care for Canadians is by addressing the ALC issue.
- 5. Highlighting WTA members’ ongoing work to mitigate, measure, monitor, and manage wait times:** WTA members continue to undertake several activities to improve timely access for their patients.

The good news is that there has been some progress on improving Canadians’ access to timely care within the five priority areas since 2004. There has also been progress on

how the provinces are collecting and publicly reporting wait-time data. Furthermore, several provinces have established their own access targets and are reporting on their progress (e.g., 90% of patients treated within the benchmark).

The bad news:

- Not all Canadians have benefited from these improvements, since some provinces provide better access than others. In addition, there is enormous variation in access to care among regions within all provinces.
- Based on the WTA's analysis, Canadians' access to timely care beyond the five priority areas is often poor.
- While reporting is improving, many problems remain, including:
 - Not all provinces report on wait times the same way. For example, some provinces include emergency and urgent cases with elective cases, thereby distorting the reporting time it takes for elective patients to receive care.
 - Some provinces still do not report on wait times beyond the five priority areas.
 - Most provinces do not report on wait times beyond surgical procedures, and none reports on wait times for gastroenterology (consultations or endoscopic procedures), psychiatry or the use of anesthesiology to treat chronic pain.
- Complacency: The original benchmarks set by the WTA and provinces should be seen as maximum

acceptable wait-time targets, or at best initial targets. While there has been progress on the number of patients receiving treatment within six months, this only represents one wait-time interval (the time between the decision to treat by the specialist and the actual start of treatment). When you add up the complete wait time (e.g., the time to see a specialist and/or the time waiting to have diagnostic testing), the total wait can be much, much longer (Figure 1).

Furthermore, five million Canadians don't have a regular family physician/GP and may have to wait longer at the beginning of their treatment.

1. Grading the original five "priority areas"

Using governments' own wait-time benchmarks, the 2011 WTA report card shows some improvement over the previous year in wait times for the five priority areas (Table 1). There is no overall change in letter grades from last year to this year; however, there is a slight improvement in the colour grades from 2010. It is important to stress that these benchmarks represent maximum acceptable wait-time targets and should not be viewed as desired targets. This year, Ontario, Quebec and BC are strong performers while Nova Scotia and Alberta are lagging. It must be noted that there is wide variation in wait times between provinces, and among regions within all provinces.

Figure 1. Wait times from the patient's perspective

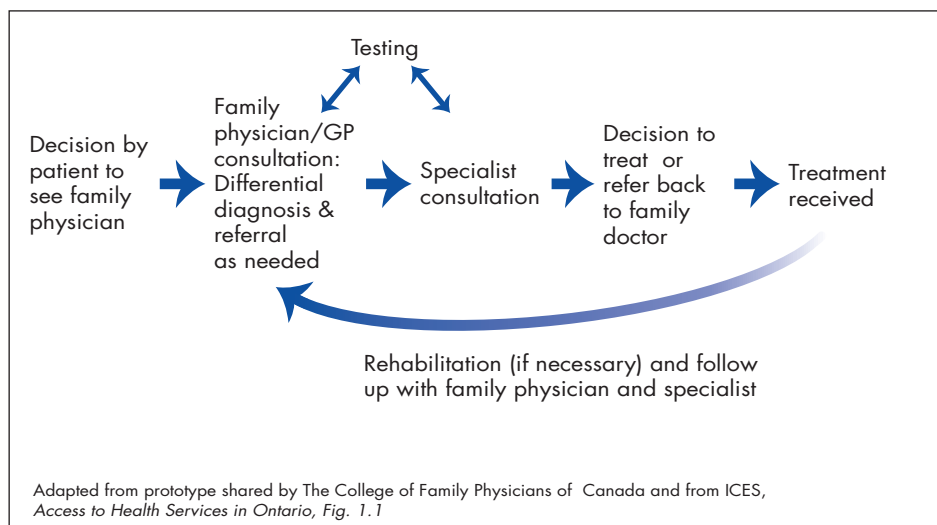


Table 1. Wait times based on government benchmarks

Province	Diagnostic imaging				Joint replacement				Radiation Oncology [⊕]		Cataract Surgery		CABG [♥]	
	CT		MRI		Hip		Knee		4 weeks		16 weeks		26 weeks	
	4 weeks				26 weeks				4 weeks		16 weeks		26 weeks	
NL	nb	?	nb	?	B	↓	C	↔	A	↓	A	↔	A	↔
PEI	nb	↔	nb	↓	B	↔	D	↑	A	↔	B	↔	na	/
NS	nb	?	nb	?	D	↓	F	↓	A	↔	C	↔	A	?
NB	nb	?	nb	?	B	↑	D	↔	A	↓	A	↓	A	↔
QC	nb	?	nb	?	A	↔	A	↔	A	?	A	↔	na	?
ON	nb	↓	nb	↓	A	↔	A	↔	A	↓	A	↔	A	↓
MB	nb	↔	nb	↔	C	↓	C	↓	A	↔	B	↓	A	↓
SK	nb	?	nb	?	B	↓	D	↓	A	↓	C	?	A	↔
AB	nb	↔	nb	↓	B	↔	C	↔	A	↓	D	↔	A	↓
BC	nb	?	nb	?	A	↔	B	↓	A	↔	B	↓	A	↓
National grade[†]	nb		nb		B		C		A		B		A	

Table 1 letter grading methodology – based on provincial websites from March–May 2011:

- A: 80–100% of population treated within benchmark
- B: 70–79% of population treated within benchmark
- C: 60–69% of population treated within benchmark
- D: 50–59% of population treated within benchmark
- F: Less than 50% of population treated within benchmark
- na: no data are provided or data do not lend themselves to estimates of performance. The diagonal line / in white squares indicates that the service is not provided (i.e., CABGs in PEI)
- nb: ‘no benchmarks’ – benchmarks for diagnostic imaging in Canada have not yet been established. Where provinces have reported wait times a colour grade is assigned to note progress made over the last 12 months.
- † National Grades are based on a weighted average of provincial letter grades.
- ♥ The category of bypass surgery (CABG above) represents only a small part of the full continuum of cardiac care to patients. Please refer to the Canadian Cardiovascular Society website at www.ccs.ca for a full range of benchmarks for cardiovascular services and procedures. All of these benchmarks need to be adopted to meaningfully address wait times.
- ⊕ Cancer radiotherapy. Wait times currently reflect only waits for external beam radiotherapy, while waits for brachytherapy (implanted radiation treatment, e.g., for prostate and cervical cancers) go unreported.

Table 1 colour grading methodology

This table identifies the change in wait times using the most recent publicly available data for each of the 5 priorities by province as follows:

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

Specific observations of the 2011 report card:

- Wait times for cataract surgery, and to a lesser extent hip surgery, increased over last year;
- Knee replacements continue to have the longest waits among the graded priority areas;
- While some provinces still do not report for this service, diagnostic imaging wait times improved over last year for some reporting provinces;
- In most cases, wait times are not broken down by urgency, which would provide a more accurate assessment and in many instances would reveal longer wait times experienced by elective patients.

Observations about progress over five report cards

A review of WTA national grades over the five-year period of 2007–2011 provides an overall national grade of “B” for the five priority areas (Table 2). Only heart bypass surgery received an overall grade of “A”, while knee replacement received the lowest grade, “C”. The remaining three procedures (hip replacement, radiation therapy and cataract surgery) received a five-year grade of “B”.

While there has been progress over the five years, the WTA notes that this improvement is related to meeting maximum acceptable wait-time benchmarks, not ideal wait-time targets. As such, the progress achieved should be seen as an initial step toward improving Canadians’ access to care, not as

an accomplishment. Furthermore, the WTA has consistently argued that some government benchmarks are inappropriate. These include a 26-week benchmark for elective open heart surgery (CABG) — rather than the six weeks set by the Canadian Cardiovascular Society — and four weeks for cancer care (radiation therapy); only Ontario (Cancer Care Ontario) reports radiation therapy wait times using the WTA’s two-week benchmark (established by the Canadian Association of Radiation Oncology).

On a positive note, the WTA is pleased that several provinces have adopted or are considering the adoption of standardized wait-time access targets called the Paediatric Canadian Access Targets for Surgery (P-CATS)¹ developed by the Canadian Paediatric Surgical Wait Times (CPSWT) Project. In December 2010, the BC Ministry of Health implemented the use of these access targets to measure wait times for all pediatric surgery across the province. The Patient Access Registry of Nova Scotia (PAR-NS) incorporates P-CATS-coded pediatric information from the IWK Health Centre capturing approximately 70% of Nova Scotia’s pediatric surgical cases. This allows for consistent reporting of adult and pediatric surgical cases. The Patient Access Registry Tool (PART) of Manitoba also uses and collects P-CATS data from the Winnipeg Children’s Hospital. Finally, in a recent initiative in Alberta, the P-CATS model is being considered to develop the pediatric and adult wait-time strategy.

Table 2. National grades 2007–2011

National grades	Diagnostic imaging		Joint replacement		Radiation Oncology	Cataract Surgery	CABG♥
	CT	MRI	Hip	Knee			
	4 weeks		26 weeks		4 weeks	16 weeks	26 weeks
2007	nb	nb	B	B	C	B	A
2008	nb	nb	B	B	B	B	A
2009	nb	nb	B	C	A	A	A
2010	nb	nb	B	C	A	A	A
2011	nb	nb	B	C	A	B	A
5-year trend	nb	nb	B	C	B	B	A
5-year national grade: B							

¹James G. Wright and Rena J. Menaker, Waiting for children’s surgery in Canada; the Canadian Paediatric Surgical Wait Times project. *CMAJ* 2011, doi:10.1503/cmaj.101530. A full list of Pediatric Canadian Access Targets for Surgery (P-CATS) is available at http://www.waittimealliance.ca/wait_times.htm

2. Grading beyond the five “priority areas” using WTA benchmarks

Since 2007, the WTA has been calling for governments to set national wait-time targets for health services beyond the original five priority areas. The WTA’s 2009 Report Card reported on total waits across a wide range of treatments and diagnoses. Now that there has been progress in the first five priority areas, it is time to apply what we have learned to improve timely access for other important treatments. Recognizing the importance of reducing waits for all patients, the WTA’s 13 National Specialty Society members have established wait-time benchmarks for 925 treatments or diagnoses.²

As in the 2010 report card, the 2011 WTA edition reports on wait times for 30 additional types of treatments for which wait-time benchmarks have been established by WTA members. The procedures in Table 3 are the 30 with the highest volumes, the greatest potential for improvement or the greatest return-on-investment. Waits were then graded based on publicly available information on provincial websites. A question mark (?) is assigned if the province does not report wait times for the particular treatment/service. An eyeglasses symbol (⎵) indicates that the province tracks wait times for this specialty but not for the specific procedure in a manner that would permit it to be graded by WTA measures.

While there is a slight improvement over last year in terms of provinces reporting on these other procedures, the most striking finding in Table 3 continues to be the lack of provincial reporting on wait times outside the original five priority areas (as noted by the frequent ? symbols); governments are reporting on just over 10% of the important procedures selected by the WTA. It is unacceptable that there is no reporting of wait times for such important and substantial fields as gastroenterology (digestive diseases), psychiatric services or chronic pain anesthesiology given that these areas provide a significant contribution to the overall health care system.

Ontario, Alberta, Nova Scotia, BC and Saskatchewan report the greatest number of treatments beyond the five priority areas. This can be seen in terms of the number of grades

indicated and the number of eyeglass symbols (⎵) shown. They indicate that while it may not be possible to assign a WTA grade, the province does provide some wait-time data for a related procedure or for the specialty/sub-specialty as a whole (e.g., plastic surgery). Notwithstanding that very few procedures are reported, those grades which are assigned are very low in most instances indicating the waits fall outside of the WTA’s maximally acceptable wait-time benchmarks.

Ontario remains the leader in reporting on emergency department (ER) wait times (Alberta to a lesser extent) and for reporting on pediatric wait times. Nova Scotia leads in reporting on a range of non-surgical services, such as some specialist consultation wait times, a broad range of diagnostic imaging, including nuclear medicine, and addiction services. There will be little improvement in expanding the number of procedures or treatments reported until provinces start reporting beyond surgical services.

WTA Generated Wait-Time Data

In the absence of provincially generated data, some WTA specialties have been collecting their own wait-time data to gauge wait times for patients treated within their specialty.

The Canadian Association of Gastroenterology (CAG) has conducted two national wait-time surveys (2005 and 2009) of its specialists. Data collected in the 2009 survey revealed that median wait times for gastroenterology services have been worsening and exceed recommended benchmarks. For example, the 2009 survey found there is a median wait time of over 130 days for patients requiring a colonoscopy to explore an alarming finding of blood in their stool (a possible sign of colon cancer); the recommended wait time is 60 days.³

Provincially reported data on pediatric wait times is also lacking across Canada — only Ontario provides this information. However, the Canadian Paediatric Surgical Wait Times (CPSWT) Project⁴, in collaboration with the WTA member-Canadian Association of Paediatric Surgeons (CAPS), collects surgical wait times for children.

² A full list of WTA benchmarks is available at www.waittimealliance.ca/wait_times.htm.

³ Survey of Access to GastroEnterology in Canada: The SAGE wait times program, D Leddin, RJ Bridges, DG Morgan, C Fallone, C Render, V Plourde, J Gray, C Switzer, J McHattie, H Singh, E Walli, I Murray, A Nestel, P Sinclair, Y Chen, EJ Irvine, *Canadian Journal of Gastroenterology*. January 2010, Volume 24 Issue 1: 20- 25. <http://www.cag-acg.org/uploads/sage.pdf>

⁴ The 2010–2011 CPSWT project was made possible through a financial contribution from Health Canada and participating sites. The views expressed herein do not necessarily represent the views of Health Canada. The project is currently working toward a long-term self-sustaining model.

Table 3. Provincial wait times compared to select WTA benchmarks

Treatment/service/procedure	WTA Benchmark	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC
Anesthesiology (chronic pain)											
Acute neuropathic pain	30 days	?	?	?	?	?	?	?	?	?	?
Acute lumbar disc protusion	3 months	?	?	?	?	?	?	?	?	?	?
Cancer pain	2 weeks	?	?	?	?	?	?	?	?	?	?
Subacute chronic pain working age	3 months	?	?	?	?	?	?	?	?	?	?
Cancer Care (radiation therapy, curative care)											
Breast	14 days	?	?	?	?	?	A	B	?	?	?
Prostate	14 days	?	?	?	?	?	B	F	?	?	?
Lung	14 days	?	?	?	?	?	A	B	?	?	?
Cardiac Care (scheduled cases)											
Electrophysiology catheter ablation	90 days	?	?	?	?	?	?	?	?	?	?
Cardiac rehabilitation	30 days	?	?	?	?	?	?	?	?	?	?
Echocardiography	30 days	?	?	?	?	?	?	?	?	?	?
Gastroenterology											
Cancer	2 weeks	?	?	?	?	?	?	?	?	?	?
Inflammatory bowel disease (IBD)	2 weeks	?	?	?	?	?	?	?	?	?	?
Colonoscopy as a result of a positive fecal occult blood test	2 months	?	?	?	?	?	?	?	?	?	?
Emergency Department											
Non-admitted patients: CTAS level 1 (resuscitation)	8 hours	?	?	?	?	?	A	?	?	A (based on 4-hour target for all non-admitted patients)	?
CTAS level 2 (emergent)	8 hours	?	?	?	?	?	A	?	?		?
CTAS level 3 (urgent)	6 hours	?	?	?	?	?	A	?	?		?
CTAS level 4 (less urgent)	4 hours	?	?	?	?	?	A	?	?		?
CTAS level 5 (non urgent)	4 hours	?	?	?	?	?	A	?	?		?
Admitted patients: CTAS level 1 (resuscitation)	8 hours	?	?	?	?	?	D	?	?	D (based on 8-hour target for all-admitted patients)	?
CTAS level 2 (emergent)	8 hours	?	?	?	?	?	F	?	?		?
CTAS level 3 (urgent)	6 hours	?	?	?	?	?	F	?	?		?
CTAS level 4 (less urgent)	4 hours	?	?	?	?	?	F	?	?		?
CTAS level 5 (non urgent)	4 hours	?	?	?	?	?	F	?	?		?
Joint Replacement (Orthopaedics)											
Total hip arthroplasty	26 weeks	B	B	D	B	A	A	C	B	B	A
Total knee arthroplasty	26 weeks	C	D	F	D	A	A	C	D	C	B
Nuclear Medicine (scheduled cases)											
Bone scan – whole body	30 days	?	?	?	?	?	?	?	?	?	?
FDG-PET	30 days	?	?	?	?	?	?	?	?	?	?
Cardiac nuclear imaging	14 days	?	?	?	?	?	?	?	?	?	?

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Table 3. Provincial wait times compared to select WTA benchmarks (cont'd)

Treatment/service/procedure	WTA										
	Benchmark	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC
Obstetrics and Gynaecology (scheduled cases)											
Abnormal premenopausal uterine bleeding	12 weeks	?	?	?	?	?	?	?	?	?	?
Urinary incontinence	12 weeks	?	?	?	?	?	?	?	F	?	?
Pelvic prolapse	12 weeks	?	?	?	?	?	?	?	F	?	?
Plastic Surgery											
Breast cancer reconstruction	4 weeks	?	?	?	?	?	?	?	F	?	F
Carpal tunnel release	2 months	?	?	?	?	?	?	?	F	D	?
Skin cancer treatment	4 months	?	?	?	?	?	?	?	B	?	A
Pediatric Surgery*											
Advanced dental caries: carious lesions/ pain	90 days	?	?	?	?	?	?	?	?	?	?
Cleft lip/palate	21 days	?	?	?	?	?	?	?	?	?	?
Strabismus: 2–6 years old (misaligned eyes)	90 days	?	?	?	?	?	?	?	?	?	?
Psychiatry (scheduled)											
Early psychosis	2 weeks	?	?	?	?	?	?	?	?	?	?
Postpartum severe mood disorders	4 weeks	?	?	?	?	?	?	?	?	?	?
Acute/urgent mental health concerns	1 week	?	?	?	?	?	?	?	?	?	?
Sight Restoration											
Cataract surgery	16 weeks	A	B	C	A	A	A	B	C	D	B

☞ The province tracks wait times for this specialty but not for the specific procedure/treatment/service in a manner that would permit it to be graded by WTA measures.

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

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

Last year, the WTA reported on 2009 data collected from 15 participating pediatric academic health sciences centres (PAHSC) that more than 17,000⁵ children (27%), waited longer than the recommended P-CATS or beyond the benchmark. This year, 2010 data were collected and analyzed from nine PAHSC and two community hospitals participating in the CPSWT Project. Overall, approximately 15,000⁶ children (28%) waited beyond the benchmark. This means that approximately 72% of children received their surgery within the benchmarks for an overall score of ‘B’. It should be noted that Health Canada funding for the CPSWT Project has ended. New funding will need to be secured, or data collection and reporting taken over by an external organization, to maintain the collection of this important data. More details on this project are available on the WTA website.

3. Grading provincial wait-time websites

The ideal website should make it easy for a patient/family member or health care provider to determine wait times in their area in a timely fashion using reliable data.

Accordingly, we rated the provincial websites as of May 2011 using the following five criteria:

Provincial wait-time website rating criteria⁷

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

2011 Results

Table 4 provides the 2011 website grading. Overall, there has

been significant improvement in provincial wait-time reporting in the past year. While there is still room for progress, reporting of wait times by the provinces is growing more sophisticated:

- All provinces now have a wait-time website, and major upgrades have taken place in the past year in Alberta, Ontario, BC and Nova Scotia;
- There remains wide variation in timeliness of data reported by provinces, ranging from less than 2 months to 6 months;
- More procedures are being reported than ever before, particularly for Ontario, BC, Alberta and Saskatchewan;
- Some provinces are now improving the accuracy of their wait-time reporting by breaking down wait times (inpatient vs. outpatient, urgency category); and
- Several provinces now have their own targets and most report wait times by 50th and 90th percentiles (the point at which 5 out of 10, and 9 out of 10 patients are treated within the benchmark).

We also note that Ontario has begun publicly reporting quality indicators and wait times for placement to home care and long-term care facilities. Alberta has recently launched a website (MyHealth) that provides a comprehensive range of health and health care information, including information on tests and treatments.

While there has been progress on wait-time reporting in the past year, there is still considerable room for improvement in terms of the comprehensiveness of services reported and in terms of providing more precise data. All provinces should now be reporting on wait times according to urgency category in order to obtain a more accurate overall picture, particularly for elective care (e.g., Alberta and Saskatchewan). In terms of cancer reporting, only a few provinces (e.g., Ontario and Manitoba) provide reporting on radiation therapy by body site. As previously indicated, Ontario and Alberta are the only provinces that report on emergency department wait times — all Canadians should have access to this information.

⁵ James G. Wright and Rena J. Menaker, Waiting for children’s surgery in Canada; the Canadian Paediatric Surgical Wait Times project. *CMAJ* 2011, doi:10.1503/cmaj.101530.

⁶ Reduction in number of cases that waited beyond benchmark may be attributed to the reduced number of participating Sites in 2010–2011 as hospitals were required to fund their participation in the project without external support.

⁷ A full explanation of the website ratings can be found in the WTA’s technical backgrounder for the 2011 report card.

Table 4. Rating provincial wait time websites

Province	Timeliness	Compre- hensiveness	Patient friendly	Perfor- mance	Quality/ reliability	Average score	2011 Grade	2010 Grade	Best practices/comments
ON	4	5	5	4	5	4.6	A	A	Very comprehensive; includes Emergency Dept. (ED) wait times; strong trend data; needs to move beyond surgical services
BC	4	4	4.5	5	4	4.3	A	B	Very timely data; very comprehensive; needs to move beyond surgical services and include ED wait times
SK	3.5	4	4.5	5	4	4.2	A	B	Comprehensive; patient friendly; offers multiple ways to assess performance; needs to include ED wait times
AB	4	4	4	3.5	3.5	3.9	B	F	Major improvement over last year; patient friendly; should include ED wait times on this site
NS	3	4.5	5	2	4	3.7	B	B	Strong presentation; leader in reporting beyond surgical services (e.g., consultation wait times)
QC	4	2	4.5	4.5	3.5	3.7	B	C	Timely data but needs to report on wait times for a wider range of services
NB	3	4	4.5	4	2	3.5	B	B	Strong in providing trend data; patient friendly
MB	4	2	5	2	4	3.4	C	C	Patient friendly; needs to report on wait times for a wider range of services
PEI	3	1	4	4	3.5	3.1	C	C	Strong presentation; good performance reporting; needs to report on wait times for a wider range of services
NL	1	1	4.5	4	4	2.9	D	F	Major improvement over last year; patient friendly; needs to provide more timely data and report on wait times for a wider range of services
Overall national grade						3.7	B	C	

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

4. The impact of alternate-levels-of-care stays on wait times

WTA members recognize there are many factors behind lengthy wait times. Examples include increased demand for services, insufficient operating room time or equipment availability, and shortages of physicians and other health professionals. But system factors are also contributing to increased wait times. Poor coordination between various components of the health system often lead to inappropriate utilization of services and to long waits in the wrong queue for many patients.

This year's report card highlights the significant impact that alternate-levels-of-care (ALC) stays are having on wait times for both emergency and elective/scheduled care to the detriment of all patients. This issue has the potential to dramatically worsen as Canada's population ages.

While there is no universal definition, ALC generally refers to patients who continue to occupy an acute care hospital bed after the acute phase of their inpatient stay is complete.⁸ ALC patients are deemed well enough to be cared for elsewhere depending on their situation. The main negative effect of increased ALC patients is their affect on access to acute care beds, which are in short supply and are required for patients admitted through the emergency department or operating room.

ALC patients accounted for more than 92,000 hospitalizations and over 2.4 million hospital days in Canada in 2008–2009. This represented 5% of all hospitalizations and 13% of all hospital days, many of which were long stays.⁹ However, the percentage of hospital beds occupied by ALC patients can vary considerably — they filled 15% of Ontario's acute care beds in April 2011, with some regions reporting rates of more than 20%. Put another way, one in six beds is filled with patients who should be cared for somewhere else.¹⁰ According to the Ontario Hospital Association's calculations for April, approximately 4,256 patients were in an acute care or other inpatient bed in Ontario every day, waiting for an alternate level of care to

be provided.¹¹ Alberta reported 660 patients awaiting continuing care placement for the third quarter of 2010–2011.¹²

ALC patients are becoming an increasing problem in our society for two reasons. One is the lack of institutional and community support for patients with chronic health conditions. For example, in 2008–2009, 46% of ALC patients in Canada were discharged to a long-term care facility, 26% were discharged home, 12% were discharged to a rehabilitation facility, and 12% died while waiting placement.¹³ These data suggest that there is an urgent need to create more access for these patients.

The second reason this problem is increasing is changing demographics. The median age of ALC patients was 80 years. Their median length of hospital stay was 26 days, compared with four days for non-ALC patients, and 83% of these patients were admitted via the emergency department.¹⁴ Dementia is a common diagnosis among ALC patients. As our society ages, more patients will have chronic health conditions such as dementia, which in turn creates more demand for chronic care support.

What impact does ALC have on timely access? ALC patients themselves are suffering from a lack of timely access to more appropriate types of care, be it assisted care in the home, entry into a rehabilitation facility or placement in a long-term care facility. The hospital usually does not have the appropriate resources to properly care for these persons. This lack of appropriate placements is at the heart of the issue.

But other patients are affected too. Emergency department (ED) wait times are affected as patients in the ED cannot get admitted to hospital beds occupied by ALC patients, contributing to ED overcrowding and further anguish for patients. In hospitals with occupancy rates greater than 85%, the high number of ALC patients in inpatient beds helps explain why wait times in emergency departments are so much longer for seriously ill patients who need a bed than for ED patients who do not require admission and are discharged home. On average, one ALC patient in the ED denies access to four patients per hour to

⁸ Canadian Institute for Health Information, *DAD Abstracting Manual 2009–2010 Edition* (Ottawa, ON: CIHI, 2009), pp. 155-545.

⁹ Canadian Institute for Health Information, *Health Care in Canada 2010*.

¹⁰ Health Quality Ontario, *2010 Report on Ontario's Health System*. 2010. http://www.ohqc.ca/pdfs/2010_report_-_english.pdf

¹¹ Ontario Hospital Association, *Alternate Level of Care (ALC)*. OHA ALC Survey Results: April 2011.

[http://www.oha.com/CurrentIssues/Issues/Documents/OHA%20ALC%20Survey%20Results%20\(Apr%202011\)%20-%20at%20Apr%2025.pdf](http://www.oha.com/CurrentIssues/Issues/Documents/OHA%20ALC%20Survey%20Results%20(Apr%202011)%20-%20at%20Apr%2025.pdf)

¹² Alberta Health Services, *Performance Report, March 2011*. <http://www.albertahealthservices.ca/ahs-brd-2011-04-14-performance-report.pdf> (Accessed May 11, 2011)

¹³ Canadian Institute for Health Information, *Health Care in Canada 2010*. December 2010.

http://secure.cihi.ca/cihiweb/products/HCIC_2010_Web_e.pdf

¹⁴ Canadian Institute for Health Information, *Alternate Level of Care in Canada*. Analysis in Brief. January 14, 2009.

<https://secure.cihi.ca/estore/productFamily.htm?pf=PFC1097&lang=fr&media=0>

the emergency department.¹⁵ The lack of a proper patient flow in the ED can also affect paramedic services and first-response wait times as paramedics must wait to transfer patients at the ED.

Scheduled surgeries are also affected by high rates of ALC stays. The lack of available beds for postoperative patients results in many last-minute cancellations of scheduled surgeries, adding to even longer wait times for patients. High ALC

rates may also be contributing to longer waits for urgent surgeries that often require an ICU bed.¹⁶

There is also an efficiency cost as well. The cost of caring for ALC patients in the hospital is much more expensive than in a more appropriate setting (e.g., in the home with proper supports, or in a residential facility). The money saved each day can help finance more appropriate care settings for our patients. Consider the following example.

The Case of The Ottawa Hospital (TOH)

The Ottawa Hospital (TOH) is a 1,000 bed, multi-site bilingual teaching hospital with an emphasis on tertiary-level and specialty care serving 1.5 million residents primarily of Eastern Ontario. In 2009–2010, the hospital had over 47,000 patient admissions, over 134,000 ED visits and almost one million ambulatory care visits.

High occupancy levels are an ongoing issue for TOH. The hospital routinely has an occupancy rate of over 100%. This is a difficult situation in which to work. However, it is made worse as, on average, 15% of the hospital's beds are occupied by ALC patients. As these patients remain in hospital for prolonged periods of time, there is a heightened sense of urgency to get patients not designated ALC home as soon as possible. An indication of this factor is that 50% of patients are discharged within 3 days of admission. In addition, given that the hospital has effectively only 85% of its acute care beds to operate with, this causes challenges finding beds for patients. As a result, TOH performance has been impacted by prolongation of emergency wait times, surgical cancellations, patient dissatisfaction and staff stress.

There are several reasons for the high rate of ALC patients. They include:

- Patients waiting for a long term care bed (64%)
- Patients waiting for a complex continuing care bed (11%)
- Patients waiting for a rehabilitation bed (8%)
- Patients waiting for other services (increased home services, palliative care, retirement home) (17%)

The impact of the high rate of ALC patients is system wide:

- Less than 25% of admitted patients get to their beds within the provincial standard of 8 hours. Many patients are waiting more than 24 hours for an inpatient bed. This causes a back log in the emergency department including ambulance services and is the major contributor to its overcrowding.
- Last year TOH cancelled 580 elective surgeries because of the absence of an available bed.
- There is a tremendous pressure to discharge patients who do not require community support. There is a perception that this might lead to 'premature discharge' and many patients might experience problems after they go home. Currently, approximately 7% of patients require readmission.
- These factors place a large burden on patients and families. Prolonged wait times in the emergency department lead to physical discomfort and can lead to a loss of privacy and dignity. Hospital readmissions are very stressful for patients and their family. Cancelling an elective surgery can cause significant disruption in a patient's life and can prolong the suffering caused by the underlying condition.

¹⁵ Canadian Association of Emergency Physicians, *Taking action on the issue of overcrowding in Canada's emergency departments*. June 16, 2005. <http://www.waittimealliance.ca/waittimes/CAEP.pdf>

¹⁶ Health Quality Ontario, *2010 Report on Ontario's Health System*. 2010. http://www.ohqc.ca/pdfs/2010_report_-_english.pdf

There are cost implications of treating ALC patients in acute care facilities as well. The average per diem cost of treating an acute care inpatient is \$1200. The cost of treating a patient in a LTC facility can be much lower.

While TOH has ALC units that are committed to providing high quality care to individuals who are not able to discharge home once “active care” management is complete, a number of strategies are underway both at the hospital and region wide to address the high rate of ALC patients. Strategies at the hospital include improving patient flow such as through the use of short-stay beds for ED patients, improving communications at patient transitions, particularly at discharge, and improving clinical and electronic documentation. Strategies at the regional level include enhanced home care services under the Ontario Ministry of Health’s Home First Program (up to 60 days following acute care discharge) and increasing the number of transitional beds and assisted living spaces.

Fortunately, there are strategies to effectively address the system-wide ALC problem. They include:

- Collecting and reporting timely data on ALC patients using standardized definitions to help manage the situation (e.g., Ontario is now capturing near real-time ALC data in most of its hospitals);
- Investing in home care services to reduce demand for more costly and inappropriate types of care;
- Using multidisciplinary care teams and patient navigators to assist patients and their families in preventing emergency department admissions and to assist with more timely and successful hospital discharges;
- Investing in a broader range of residential care supports; and
- Providing supports for family caregivers.

Currently, these strategies are being implemented at only varying levels across the country. **WTA members recognize that the most important action to improve timely access to specialty care for Canadians is by addressing the ALC issue.**

5. WTA’s ongoing commitment to patients

The WTA recognizes that the effort to improve timely access to care is a shared responsibility. Governments can provide overall system leadership through funding and regulation. Health care providers, including physicians and surgeons, have a role to play as well. Since developing benchmarks, WTA members have continued to undertake several activities to mitigate, measure, monitor and manage wait times to improve timely access for their patients — the four components of the WTA’s 4-M Toolbox first identified in its August 2005 report. A couple of examples of WTA member projects include The Canadian Association of Radiologists’ experience in increasing appropriateness in imaging through computerized clinical decision support, and the Canadian Psychiatric Association’s recent examples of innovative wait time reduction strategies in psychiatry.

Details on these and other projects are available on the WTA website: http://www.waittimealliance.ca/leading_practices_e.htm

About the Wait Time Alliance

Since 2005, the Wait Time Alliance (WTA) has been issuing reports on Canadians’ access to timely specialty care. The WTA is comprised of 14 national medical organizations whose members are directly involved in providing care to patients. The WTA members are (in alphabetical order):

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