The Taming of the Queue: Wait Time Measurement, Monitoring and Management

Colloquium Report

March 31 - April 1, 2004
Aylmer, Quebec

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ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION
CIHR IRSC
Canadian Institutes of Health Research
Instituts de recherche en santé du Canada
Canadian Institute for Health Information
Institut canadien d'information sur la santé
ACHO ACSIU
ASSOCIATION OF CANADIAN ACADEMIC HEALTHCARE ORGANIZATIONS
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Acknowledgements

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This report was prepared by Cathy Fooks under the direction of the Steering Committee for the colloquium. Members of the Steering Committee are:

Glenn Brimacombe, Association of Academic Healthcare Organizations
Sylvie Gauthier, Health Canada
Pierre-Gerlier Forest, Health Canada
Emily Gruenwoldt, Canadian Medical Association
Martha Hall, Health Canada
Diane Lugsdin, Health Canada
Tom Noseworthy, University of Calgary
Marcel Saulnier, Canadian Medical Association
Sam Shortt, Queen's University
Greg Webster, Canadian Institute for Health Information

The Committee would also like to thank Dr. Les Vertesi who provided his summary of the colloquium from which we drew a number of observations.

The material reflected in this document does not necessarily reflect the views of the sponsoring organizations.

Introduction

How long should people wait to receive health care? This question has long been debated in public discussions about Canadian health care. Historically, media reports of someone waiting years for elective surgery and regular releases of survey data providing recollections of wait times contributed to a perception that people were waiting too long. The lack of standardized definitions, and comparable and regular data based on actual, rather than recollected, waits hampered an evidence-based discussion about the issue.

Health care reviews at the provincial and national level have recommended a more organized approach to managing patient queues. This, combined with a push for greater public accountability about health care spending and health system performance, has led to the development of performance indicators to be publicly reported every two years by the provinces, territories and the federal government. Included in the indicators are the time to clear the wait list, the median wait time, and the distribution of wait times for cardiac surgery, hip and knee replacement surgery, and radiation therapy.

The first set of reports in 2002 highlighted the difficulties with the state of information about wait times. This included a reliance on survey data due to a lack of administrative information, a lack of consistent information in areas other than cardiac care, and an inability to compare across jurisdictions (Saulnier 2004; Webster 2004). However, a number of exciting initiatives are underway across the country with the potential to change the environment by providing better data and improving the wait process for patients.

In the Spring of 2004, a number of organizations recognized the need to bring together those involved in wait list measurement, monitoring and management with the following objectives:

- To explore the underlying factors that drive waiting times for health services;
- To share research and experiences with wait time measurement/management among a broad cross-section of stakeholders;
- To identify the policy implications of improved wait time measurement/management from the perspective of payers, providers and patients.

Over eighty participants spent two days reviewing Canadian and International initiatives and discussing what needs to happen next in Canada to move towards better measurement, monitoring and management of wait times. This report summarizes the information and key messages from the colloquium. The agenda for the meeting can be found in Appendix A. Appendix B contains the list of participants and Appendix C contains a short survey of participants' views on wait times. The full set of presentations along with further background information on wait times can be found on the CPRN Web site at www.cprn.org.

This report summarizes the presentations from the colloquium in two sections: those providing general context and background information and those describing specific initiatives to manage wait times. A summary of the elements participants felt were required to support wait times management projects is provided along with some suggestions for next steps and further work.

General Context

Dr. Kevin Keough opened the colloquium with a key note speech focused on the importance of using evidence as the basis for discussion about wait lists. He stressed that although there is often a focus on wait lists in the public debates about health care, the system-level issues need to be addressed within the broader context of service access, quality, cost and outcomes.

International Perspective

The OECD has undertaken a large, multi-country study of wait times for elective surgery examining causes and policies in twenty countries (Siciliani 2003). The full report can be found at www.oecd.org. Key findings presented by Jeremy Hurst include:

- Approximately 50% of countries do not collect regular data on wait times but anecdotally report no problems with wait times (Austria, Belgium, France, Germany, Japan, Luxembourg, Switzerland and the United States) and approximately 50% of countries report wait times are a serious issue (Australia, Canada, Denmark, Finland, Ireland, Italy, Netherlands, New Zealand, Norway, Spain, Sweden and the UK).
- Although wait times are often a common complaint in the general population, surveys of people actually waiting for surgery suggest they are not overly worried about waits of 3-6 months. The exception to this may be in cardiovascular care.
- Definitions of what to measure differ: from GP referral to surgical assessment; average time on the list after surgical consultation until procedure; or, median waits for time on the list.
- Three approaches to tackling wait lists were examined:
  - Supply side policies: increasing expenditure and thus capacity or increasing productivity;
  - Demand side policies: clinical priorization or managing the threshold at which surgery occurs;
  - Specific wait list policies: setting targets for maximum wait times.
- Conclusion that there is a lot government can do to tackle wait times and that the "best buy" is a mixed package of measures to increase capacity, increase productivity and efficiency and better manage demand.

Canadians' Perspectives

Margaret McPhail and Mike Colledge of Ipsos-Reid presented the results from a four country study of health stakeholder perspectives that identified common concerns about wait times and pointed to a number of benefits of improved wait time management. They also presented Canadian polling data on views about wait lists (McPhail 2004). They found that:

- 40% of Canadians strongly agree and 31% somewhat agree that Canada needs a national system that measures waiting times for health treatments and diagnosis in every region of the country.
- 65% of Canadians strongly agree and 23% somewhat agree that Canadians have the right to know how long they can expect to wait for the treatments they need.
- Canadians are divided 50/50 on whether there should be provincial or national standards for wait times.

- Canadians support prioritizing access to wait lists on the basis of risk of death (69%), degree of pain (51%), loss of function (48%), length of time on the list (34%) and the general health of the patient (31%).

Data was also presented by Claudia Sanmartin of Statistics Canada on the 2001 Health Services Access Survey (Sanmartin 2004):

- 20% of those accessing specialised services reported difficulties in accessing care and waiting was cited as the number one reason for the difficulty.
- Most respondents reported wait times of less than three months but approximately 10% reported waits longer than three months for specialised services, 20% reported waits longer than three months for elective surgery and just under 10% reported waits longer than three months for diagnostic tests.
- The thresholds at which people feel waits are unacceptable are a product of the length of the wait, the impact the wait has on quality of life, and public expectations about what the health care system should deliver.

The full report on the survey can be found at www.statcan.ca.

Legal Perspective

The existence of lengthy wait times raises the question of whether Canadians have a legal right to timely access. Under the current model of public accountability, if wait times are too long, then public pressure is often the only avenue available to influence government decisions. Two presentations focussed on legal issues and in particular whether a care guarantee would make a difference to Canadians in accessing necessary medical services.

Nola Ries reviewed a number of cases before the courts asserting individuals' rights to health care services as well as discussing other legal mechanisms such as specific legislation, patient charters or care guarantees (Ries 2004). She concluded that:

- Legal challenges may not be the best mechanism for systematic reform of the health care system;
- The courts may not be in the best position to deal with "rights" claims of individual litigants balanced against societal interests of equity;
- Legal system is costly and time consuming;
- Approaches such as legislation, a charter or a care guarantee may not offer enforceable standards nor provide tools to actually manage wait lists more effectively unless they are part of a broader package of health reform measures.

Senator Kirby reviewed the Senate Committee's position on a care guarantee which would set nation wide standards for timely access to key health services and would allow Canadians to receive service elsewhere if timely access was not available. Senator Kirby also reviewed the Chaoulli case which is currently before the Supreme Court arguing that the court should stay a decision for three years to allow governments time to respond to the issue of ensuring timely access.

Media Perspective

Commentary was provided by the Globe and Mail's public health reporter, Andre Picard. He noted that:

- Wait lists capture attention because people don't like to wait for anything and the media tends to view the issue through the eyes of someone who is waiting a long time.
- There is a public perception that the lists aren't always fair and that queue jumping goes on.
- Wait lists used to be a health issue covered by health policy reporters. It has become a political issue covered by political reporters.
- Has become a resource story and a symbol of the problems with "socialised medicine" or public health insurance.
- Difficult to disentangle the science of wait lists and numbers and appropriateness from the arguments about sustainability and privatization.
- Need to focus more on the legal and ethical issues and communicate more clearly about why there are wait lists, how people do move through the queue and what some of the potential solutions might be to clearing the backlog.

Data Developer's Perspective

The Canadian Institute for Health Information (CIHI) is providing expert methodological support for the indicator process flowing from the 2000 Health Accord and the 2003 First Ministers Accord. Greg Webster reviewed the indicator development process and the reporting of comparable indicators by the provinces and territories in September 2002. He made the following points (Webster 2004):

- There is a need for consistent and relevant definitions in order to produce accurate, timely and comparable data;
- The data should be able to pass a quality audit and proper documentation of data quality and data limitations is recommended;
- A range of wait time indicators may be required to provide information to different groups (providers, funders, public) but duplication of data collection can be minimized;
- Collaboration across sectors is required to generate useful, comparable information.

Specific Wait List Initiatives

A number of presentations highlighted efforts in Canada to measure, monitor and manage wait times. Various methods of data collection are being used including using administrative data, booking systems, patient registries, priority scoring systems and clinical thresholds. Each has advantages and disadvantages which have been summarized elsewhere (DeCoster 2002).

Surgical and Diagnostic Perspectives

The Western Canada Wait List (WCWL) project is one of the more established in the country dedicated to developing evidence-based tools for health care providers to manage wait times. It has established clinical criteria to set priorities for wait list management based on an urgency rating scale. Clinical areas include hip and knee joint replacement, general surgery, children's mental health, cataract removal and MRI scanning. The group is currently working on developing maximum acceptable wait times to deal with the issue of timeliness. In his presentation, Dr. Tom Noseworthy emphasized the importance of maintaining a critical mass of knowledgeable individuals, the need for ongoing partnership between policymakers, clinicians and administrators, and the need for time to develop credible tools and evaluation processes (Noseworthy 2004). The specific rating tools and publications can be found at www.wcwl.org.

A relatively new group on the Canadian scene is the Saskatchewan Surgical Care Network (SSCN). The SSCN is establishing a surgical registry for the province using clinical prioritization scoring tools based on those developed by the Western Canada Wait List Project, and target time frames to support the regional health authorities and hospitals manage access to surgery in their regions. In his presentation, Dr. Peter Glynn emphasized the need for consistent and standardized data collection, the need for constant communication and sharing of facts with all involved, and the need for accountability for surgical access at the appropriate governance level (Glynn 2004). The network is currently live at www.sasksurgery.ca.

A third surgical initiative presented is the Wait List Management System (WLMS) for Orthopaedic Surgery in the Capital Health Region in Nova Scotia. All surgeons in the orthopaedic division are participating. A simple visual analogue scale is used at the time of booking to assign a patient priority. A forecasting model has been developed to monitor the wait times and predict which system inefficiencies are impacting patient flow. This allows resources to be redirected. In his presentation Dr. Michael Dunbar stressed that although this scoring tool may be not be as sophisticated as the WCWL tools, it is important to start with something that clinicians find quick and easy to use and then through further research and validation the tools can be modified. A full report of their results can be found at www.cprn.org.

Disease-based Perspectives

The Cardiac Care Network of Ontario (CCN) was established in 1990 in response to concerns about the quality of patient care, a lack of resources devoted to cardiac care and an absence of data upon which to assess needs. The CCN establishes urgency rating scores, monitors wait times for cardiac procedures across the province, and provides advice to the Ministry of Health and Long-term Care on matters related to adult cardiac care. The CCN also facilitates applied health services research. In his presentation, Dr. Kevin Glasgow emphasized the need for non-partisan management, consensus

building based on data and evidence and CCN's arm's length relationship from government or any of the provider hospitals (Glasgow 2004). He also stressed the importance of continued resources being devoted to infrastructure so that items such as IT can support real time data for providers. Further information about CCN activities can be found at www.ccn.on.ca.

Managing wait lists for cancer treatment was the focus of a presentation from Dr. Tom McGowan of Cancer Care Ontario (McGowan 2004). He outlined a comprehensive four point plan that focused on the cancer system as whole with managing access to services as one part of the plan. The plan includes:

- Enhancing the capacity of cancer resources: using data to target the expansion of the cancer system to areas of need, streamlining the process for bringing new facilities on-line, and expanding roles and developing the skill mix of health care professionals to increase system capacity.
- Reducing demand for services by reducing risk factors for cancer and promoting early detection: invest in tobacco reduction strategies, fund targeted prevention programs, and optimize screening for the early detection of breast, cervical and colorectal cancers.
- Coordinating access to services at the point of entry into the cancer system: coordinate patient journey from entry into the system, and establish diagnostic assessment units and rapid access models for rapid access to appropriate diagnostic services.
- Increasing the efficiency of existing cancer resources: use care paths to optimize use of hospitals beds and integration with community-based services, increase resources for supportive care and palliative care, and ensure that patients are treated according to evidence for best practices.

Regional Health Authority Perspectives

Maura Davies from Capital Health Regional Health Authority in Nova Scotia reviewed recent initiatives the Health Authority has undertaken to deal with their wait list "hotspots." Wait time data demonstrating long waits in a variety of areas prompted investments to expand capacity, develop scoring tools such as the work presented by Dr. Dunbar, establish target wait times and monitor the queue. The Health Authority now gets a daily snapshot of the emergency department waiting times, and there is a Web site with public information about wait times for surgery, radiotherapy, nursing home beds, access to MRIs and other diagnostic services, and wait times in the emergency departments. The information can be viewed at www.cdha.nshealth.ca. Ms Davies stressed that multiple strategies are required to deal with excessive wait times with funding being only one part of the solution (Davies 2004). As well, she commented that data, an implementation plan, monitoring progress and communicating broadly about results were essential to success.

Marianne Stewart from Capital Health Regional Health Authority in Edmonton presented a disease management approach to managing wait times for diabetes services (Stewart 2004). She reviewed the process re-engineering undertaken by the Health Authority to create a single point of entry for service, the use of evidence-based triage criteria and a standardized referral process to community-based teams and physician specialists. Wait times were reduced and access was increased without having to allocate new dollars. She stressed the need for extensive consultation and involvement of the affected stakeholders and the need for a strong physician champion to support the change.

Provider Perspectives

Dr. John Marshall and John Lott presented a unique software package developed at Kingston General Hospital to manage patients waiting for surgery and to provide procedure-based outcomes information for quality improvement purposes (Marshall 2004). It tracks wait times, utilization of resources and patient outcomes, and provides a variety of reports to users. Lastly, the data collected can be used by the institution to drive resource allocation based on patient need. For further information about the software see www.adapcscanada.com.

Dr. Sunil Patel offered a perspective from a practicing physician dealing with patients waiting for services (Patel 2004). He made the following comments:

- Arbitrary time frames for waiting without clinical measures of urgency are not useful;
- Continuity of care must be maintained even if patient mobility is increased as a by-product of providing timely care;
- Care guarantees are not useful where evidence-based thresholds do not exist. And even when evidence-based thresholds do exist they are not meaningful without resources to deliver the services.

Elements Required to Support Successful Wait List Management

Wait list management in Canada is still in its infancy. As described by Dr. Marshall it is:

- Mostly paper based;
- Physician-specific;
- Time consuming;
- Relies on duplicate data entry points;
- Inconsistent;
- Unable to share information across physicians or facilities.

Relative to other OECD countries, Canada has little in the way of hard data to document the true extent of the wait time problem. International research suggests that a mix of policies are needed to reduce wait times and to improve system performance.

The initiatives presented over the two days of the colloquium demonstrate that success is achievable. In these cases processes were improved, waits were decreased and in some cases, access to services was expanded. What contributed to their success?

- Evidence of wait times past reasonable or acceptable thresholds.
- Greater public expectations of accountability from governments and health care providers.
- Extensive planning and consultation involving all stakeholders.
- Some standardization for triage and urgency-based priority setting – the level of sophistication varied but all agreed some standardization was necessary.
- The ability to pick a tool or framework and "get going" – waiting for the perfect model means implementation will be delayed.
- Clear messages about how the change would assist patients and providers.
- Physician leadership in promoting the idea and establishing clinically relevant tools.
- Support from administrative and policy decision makers to proceed with the change.
- Ongoing data collection and monitoring for decision making purposes and patient care.
- Resources dedicated to infrastructure support and ongoing resources to improve capacity such as web-based tools.
- Partnerships and collaboration as no one group can do this alone.

Next Steps and Further Work

Many issues remain if we wish to promote wait list measurement, monitoring and management as a quality of care indicator in assessing health system performance. Participants had a number of suggestions for focus:

Data and Information

- Standardization of definitions and comparable indicators is still an issue and although experts recognize the need for more consistency, multiple definitions are still in use.
- Standardized booking systems with urgency measurements, procedure and patient information entered into a real-time registry is key to improving the current situation.
- Thresholds for waiting for specific procedures and urgency ratings are required. These would not be a care guarantee but rather to form the basis of targets. The development of these targets requires further research.

Policy Focus

- The focus on surgery makes sense as a starting point but needs to be broadened to include the care received before and after a surgical intervention as well as linked to primary care and emergency department data.
- A mix of strategies is required and need to be tied to accountability frameworks being developed between funders and providers.
- Have to address two difficult questions: the demand side of the wait lists and the clinical appropriateness of the actual interventions.

Resources

- Financial resources are required. In some local circumstances this may involve a reallocation. However, for major initiatives including technological supports, new dollars are probably necessary.
- Ongoing political support is required. Partnerships must include government in the collaboration and governments must be willing to stay the course as the tools become more sophisticated and provide real time information for policy and funding decisions.

Engagement

- At present, individual clinicians are providing leadership in developing this field but the medical profession as a whole has an important role to play in promoting the usefulness of centralised wait list management. "There are no losers if wait times are reduced or managed more efficiently."
- The public needs to be engaged in the discussion about why wait lists exists, what is an acceptable wait time and what they can do if they are approaching the end of the acceptable time period.

- Develop a network of interested parties – communities of interest – so local initiatives can take advantage of existing efforts elsewhere in the country.
- A systems approach focused on patient needs is required. This will necessitate a cultural shift in communities as the management of wait lists becomes a shared, rather than an individual responsibility.

Materials from the colloquium can be found on the CPRN Web site at www.cprn.org. For further information please contact Cathy Fooks, Director, Health Network, CPRN. Phone (416) 652-1242. E-mail: cfooks@cprn.org.

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APPENDIX A

THE TAMING OF THE QUEUE:
Wait Time Measurement, Monitoring and Management

Château Cartier Resort, Gatineau, Quebec

Final Agenda

Wednesday March 31

8:30-9:00a — Keynote Address
Dr. Kevin Keough, Health Canada

9:00-10:15a — Managing wait times:
An international perspective
- Wait times across industrialized countries
Mr. Jeremy Hurst, OECD
- Stakeholder views from CMA's 4-country study
Mr. Mike Colledge, Ipsos-Reid
Ms. Margaret McPhail, Ipsos-Reid

10:15-10:30a — Break

10:30-12:00p — Panel discussion: Wait times in Canada
Senator Michael Kirby
Dr. Peter Glynn, Sask. Surgical Care Network
Ms. Maura Davies, Capital Health (Halifax)

12:00-1:15p — Lunch

1:15-2:30p — Back to basics: Wait time measurement and monitoring
- Towards standardized definitions of wait times and measurement considerations
Mr. Greg Webster, CIHI
- Experiences of patients
Dr. Claudia Sanmartin, Statistics Canada

2:30-2:45p — Break

2:45-5:00p — Sectoral approaches to managing wait times
- The Ontario Cardiac Care Network Experience
Dr. Kevin Glasgow, CCN
- Nova Scotia Orthopedic Surgery Initiative
Dr. Michael Dunbar, Dalhousie University
- Cancer Care Ontario
Dr. Tom McGowan, CCO

6:00-6:30p — Wine and cheese reception

6:30p — Dinner

Thursday April 1

8:30-9:15a — Priority Setting and Maximum Acceptable Waiting Times
Dr. Tom Noseworthy, WCWL Project

9:15-10:30a — Panel discussion: Strengthening accountability and managing expectations — the law, the media and public values
Prof. Nola Ries, University of Alberta
Mr. André Picard, Globe and Mail

10:15-10:30a — Break

10:30-12:00p — Where the rubber meets the road: Perspectives of health care providers and institutions on strategies to reduce wait times
Dr. Sunil Patel, CMA
Ms. Marianne Stewart, Capital Health (Edmonton)
Mr. John Lott, Kingston General Hospital
Dr. John Marshall, Kingston General Hospital

12:00-1:00p — Lunch

1:00-3:00p — Break-out groups
- Policy implications of better wait time management from the perspective of patients, health care providers and institutions, and government
- Elements of national strategy to reduce wait times

3:00-3:15p — Break

3:15-4:00p — Reporting out and general discussion

4:00-4:30p — Ensuring timely care for Canadians: Getting from here to there
Dr. David Zussman, EKOS Research Assoc.

APPENDIX B

THE TAMING OF THE QUEUE:
Wait Time Measurement, Monitoring and Management
March 31 - April 1, 2004

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APPENDIX C

Participant survey

As part of the activities of the two-day colloquium, participants were asked to respond to a survey about wait times and timely access to health care. The results of the survey, which were collated presented at the colloquium, are displayed below.

1. Thinking about the broad range of issues confronting health care policy in Canada, would you say that the issue of wait times is currently being given too little, too much, or just about the right amount of attention it warrants?

	Number	Percent
Too little attention	18	47
Too much attention	8	21
Just about the right amount of attention	12	32
Don't know	0	0

2. Which of the following statements best describes your view of the state of wait times in Canada's health system?

	Number	Percent
There is no wait time problem in Canada's health system	0	0
The vast majority of patients receive timely care, but there are excessive waits for some treatments and services in some jurisdictions	11	29
Most patients receive timely care, but there is excessive waiting for many treatments and services across all jurisdictions	21	55
Most patients are not treated in a timely manner	5	13
Don't know	1	3

3. Do you think that timely access to health services has worsened, improved, stayed about the same over the past few years?

	Number	Percent
The situation has worsened	21	55
The situation has improved	2	5
There has been no change	8	21
Don't know	7	18

4. On a scale of 1 to 5 where 1 is low and 5 is high, please indicate the extent to which you are concerned about the state of timely access at the following service points:

	Total 4 & 5	Percent
Front-line services: hospital ER, family physician, community health centre	21	55
Specialist consultation	29	76
Advanced diagnostic services	24	63
Elective surgery	16	42
Post-discharge services: home care, long-term care, rehab	27	71

5. Based on a total of 100 points, what weight would you assign to the following approaches to address concerns about wait times for health services?

	Percent
Improved management of existing resources	38
Increased system capacity	25
Enhanced measurement and reporting of wait times	25
Other	11

6. On a scale of 1 to 5 where 1 is not significant and 5 is very significant, please indicate to what extent you believe the following issues are significant barriers to addressing concerns about wait times?

	Total 4 & 5	Percent
Non standardized definitions of wait times	30	79
Lack of tools to help physicians prioritize patients according to urgency	27	71
Insufficient health human resources and infrastructure to meet patient needs	17	45
System policies and administrative practices that inhibit efficient use of existing resources	28	74
Service availability in rural vs urban areas	10	26
Unrealistic patient expectations	9	24

7. Which of the following statements best describes your views about the prospects of improved management of wait times in Canada?

	Number	Percent
Improvements can be made with minimal additional investments and without changing the basic structure of Canada's publicly funded health system	15	39
Improvements can be made without changing the basic structure of Canada's publicly-funded health system, but only with significant additional investment	10	26
Improvements can only be made if the basic structure of Canada's health system is changed	12	32
None of the above	1	3

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