10 Steps to a

Common Framework for Reporting on Wait Times

November 2005

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T A K I N G T H E P U L S E

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The Health Council of Canada was created as a result of the 2003 First Ministers' Accord on Health Care Renewal to report publicly on the progress of health care renewal in Canada, particularly in areas outlined in the 2003 Accord and the 2004 10-Year Plan to Strengthen Health Care. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

The participating jurisdictions have named Councillors representing each of their governments and also Councillors with expertise and broad experience in areas such as community care, Aboriginal health, nursing, health education and administration, finance, medicine and pharmacy. Participating jurisdictions include British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Labrador, Yukon, the Northwest Territories, Nunavut and the federal government. Funded by Health Canada, the Health Council operates as an independent non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions.

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INTRODUCTION

Improving Wait Times in the Canadian Health Care System

The Canadian public understands that wait times and wait-list management are complex issues that will require time and national coordination if they are to be addressed. Despite this complexity, the objectives of a national approach to improving wait times are basic and speak to Canadians' core needs and values. Citizens want to feel confident that when they need it, they will get access to health care within a time frame that does not significantly compromise their health or well-being – and they want a system that is fair, providing the sickest people with the fastest access to care without compromising access for those whose needs are less urgent but no less real. These principles of the importance of individual access to care and equity at the system level should guide all decision-making around wait-list management and must trump the interests of providers, administrators and governments.

Common Language and Common Frameworks: Starting with the Basics

Wait-list management has been at the top of the agenda for governments across the country over the past year, and much good work has been accomplished. Each of the provinces has begun focused projects, with some reporting more results than others. The mandate of the Health Council is to report on progress in improving wait times (among other health care priorities) but this is difficult to do without agreement on common definitions and terminology related to wait lists. As governments and stakeholders begin to address wait times in priority areas, it is critical that all players agree upon a common set of definitions that will allow us all to measure success against those basic objectives. How can we know if people are waiting less when we don't know when a wait begins and when it ends? How can providers or governments agree to benchmarks for care when the goals and definitions of benchmarks remain unclear?

To its credit, the Canadian Institute for Health Information (CIHI) held a national conference in October 2005 for this specific purpose. While good focused discussion occurred on some of the issues, others remain untouched and, at the time of this writing, there still remains no national agreement on even the most basic common terminology. Common definitions are the tip of the iceberg when it comes to improving wait times. Without a common understanding of the mechanisms that may create delay and how waiting in health care systems functions, real progress will be difficult. Ultimately, we believe that the ideal system for measuring and responding to waits would embody the following features:

- real-time data coupled with patient information that alerts providers when excessive delays occur;
- access to information by authorized persons at any time and from any location;
- a common service queue for each of the major services, along with surgeons that are able to show the flexibility needed to improve waits;
- a minimum number of urgency levels;

- reports on volume, percentile and percentage of cases done within benchmark for non-emergency cases;
- an audit policy automatically triggered when any wait exceeds a critical value;
- a validated method to measure outcomes and the ability to create informed thresholds with the information.

The Health Council of Canada has prepared this paper to help identify the issues that require common agreement and to propose solutions to guide reform. This paper forms the basis of recommendations which will be reflected in the Council's January 2006 annual report to Canadians on the progress of health care renewal. The domain of surgical procedures is suggested as a reasonable starting point in the discussion of wait-time management, since this environment is relatively simple and represents part of the priority domain identified by First Ministers. Of course, any wait that threatens health or well-being must be addressed. We hope the lessons learned from progress in surgical waits will help with the management of other health services which promise to be even more complex, such as waits for diagnostic procedures.

The suggestions in this document form one possible path to a common framework for both understanding and reporting the waiting experience. But they are only a beginning. None of these will in themselves lower anyone's waiting time, but they will make the next step of doing precisely that much easier.

10 STEPS TO A COMMON FRAMEWORK

Reporting on Wait Times

Provincial jurisdictions have already made a commitment to report on progress in wait times. What then should be specifically contained in such a report?

Governments have generally chosen to target a small list of procedures to be the subject of reports. While it is their right to choose priorities, this practice runs the risk of inadvertently disadvantaging other activities. Targets should be chosen in a broad way that minimizes this risk. At the very least, monitoring for such unintended effects is essential. In the opinion of the Council, the long-range goal should be timely access to all health care interventions.

1) *Where comprehensive wait-time management does not yet exist, health ministries should choose a representative basket of procedures on which to report wait times in a way that minimizes the risk of inadvertently increasing waits for other procedures. The long-range goal should be to address wait times on all health care interventions.*

A minimum dataset for waiting:

Any path to improved management of waiting lists will require the creation of an information dataset managed by a health jurisdiction. But to be truly useful and to ensure accuracy of information, datasets must do more than simply provide information to management. They must also be able to feed information back to the providers of the service on a real-time basis and actually help them do their work. All of this requires substantial technological investment and, more importantly, some agreement on what information should be captured. The first and most essential element in the minimum dataset is the definition of the waiting period itself.

2) *Enrollment on a wait list should take place at the time the intervention is formally booked (usually by a specialist). Both the original date of referral to the specialist and the booking date for the intervention should be recorded. The waiting interval should be defined as the time from initial referral to completion of the procedure.*

Other components of the minimum dataset:

In order to make sense of a series of time intervals, a common set of descriptive variables must be captured at the same time. These will include the type of procedure being booked, the person and department or unit doing the procedure, and whether it is booked as a day or inpatient procedure. There are many possible approaches, and there are several established systems that have defined which variables to include and how to group the data. However, wide variations in what is reported and how information is displayed would destroy a fundamental purpose of a collective report, which is to make meaningful comparisons and learn from each other. In the opinion of the Council, it is crucial that all jurisdictions endorse and use a common approach.

3) *Provincial and territorial jurisdictions should designate a working group charged with the task of defining a common minimum dataset for reporting on wait times and producing a model for reporting that meets the needs of the Canadian environment.*

Determining Priority – Who Gets in First?

Priority scoring for wait times seem to make intuitive sense. Unfortunately, priority-driven management systems can become overly complex. Multiple priority levels tend to be developed in response to the existence of long waits, but they complicate the waiting process even further. The more priority levels there are, the greater the challenges for management. As waits become shorter, there is less need for multiple priority levels. It is unlikely that priority levels can be completely abandoned in the near future, but at the very least, the number of priority levels in use should be as small as possible.

4) *Cases should be prioritized on the basis of urgency in a system using no more than three levels of priority.*

5) *The term urgency level should be adopted (rather than priority) to indicate that the score refers only to timeliness required and does not constitute a judgment on the degree of need.*

The first (highest) urgency level would be for true emergencies that require intervention within 48 hours. If bundled with those for other urgency levels, these very short waits would skew the overall results. For this reason, the most urgent level should be separated out from the wait calculation and only the number of cases in the category needs to be reported. The dividing line between the second and third levels is determined by only one question: whether the condition has a chance of becoming worse or not. An affirmative answer would result in an urgency level of 2, while the remaining procedures which are by definition not time sensitive (but the need to be done is not in question) are assigned an urgency level of 3. The validity of assigned urgency levels is something that can be confirmed by routine sample audits. It should be understood that cases that do not stand a chance of worsening but also do not satisfy the criterion of "need to be done" ought not to be booked.

Benchmarks:

A wait-time benchmark is measured in units of time (weeks, months), but a benchmark should not be confused with an absolute threshold or some kind of guarantee that all cases will be done within that time frame. Rather a benchmark should declare a time within which most cases (or a specified percentage) will be done. To be meaningful then, a benchmark should consist of a time value and a percentage of cases to be done within that time. In general, the higher the percentage, the more useful the benchmark.

Achieving the benchmarks and the associated target percentage is important. But it is crucial to monitor and report on the wait-time "tail"— those cases whose waits exceed the benchmark time. Even if there are only a few cases that wait a very long time, the effect on

both the patients and on public confidence can be significant. The effectiveness of the system should be judged on two main indicators: the percentage of cases done within the recommended time and how well it deals with the wait-time tail.

Basic quality assurance requires two things: (1) that the probability of any case exceeding a benchmark be small, and (2) that an automatic case audit is triggered when a case exceeds a designated time period.

In the opinion of the Council, both the right and the responsibility for setting benchmarks belong to the provinces and to elected governments that bear the cost of health care, not to provider groups.

6) *Provinces and territories should choose benchmarks for wait times for all urgency levels, and these benchmarks should include targets for percentages of cases that should be completed within the benchmark times.*

There is no reason for all provinces necessarily to choose the same benchmarks right away. It is more important initially for the target to be achievable than to be the same across jurisdictions, but the long-term goal should be uniform national benchmarks that are supported by evidence.

Monitoring Progress: Reliable and Unbiased Reporting

Most wait times are short, even in systems where some people wait a very long time. As a result, the average wait time will tend to reflect the experience of the bulkier end of the distribution curve. Very long waits will increase the average somewhat, but the effect will be modest where such cases are relatively rare. Hence average wait times alone do not tell us what we want to know about waiting because they do not reveal what happens to people who fall outside the large group of typical cases.

Similarly, medians are completely insensitive to the rest of the distribution. If queuing measurements are to be meaningful, they must rely on percentiles (either 90^{th} or 95^{th}) which are uniquely designed to be sensitive to conditions in the tail.

7) *Jurisdictions should use percentiles to report on the distribution of wait times. This should replace the practice of quoting averages or medians.*

Eliminating reporting bias:

A good wait-time reporting system should tell us three things:

- how long typical cases wait in relation to benchmarks, according to their urgency levels;
- how long outlier cases wait (cases that would trigger an audit); and
- changes in wait times and wait-time distributions over time.

No single measure tells us about all three aspects. Averages and medians tell us something about a) but not b), unless there is very little difference between the longest and shortest waits in an urgency category. Measures of long waits by definition tell us nothing about typical waits. It is therefore essential to include multiple measures to get a complete picture.

In addition, certain reporting practices can create an inaccurate picture of the true situation. Among these are:

- quoting average waiting times (averages always give a relatively favourable estimate of queuing situations);
- quoting median waiting times (median times are completely insensitive to the tail, no matter what level of chaos exists there);
- quoting wait times combined for all cases, especially including emergencies with the highest level of urgency (very short wait times for emergencies will dramatically lower the average);
- using a stand-by system for assigning a booking date and using the date the booking is assigned as the start date instead of the date the original request was made. Most patients are not given a specific date when the request to book a procedure is first received. Instead they are placed on a stand-by list, similar to the method used by overbooked airlines, and then assigned a date only on short notice, when a slot becomes available.
- re-booking frequently, re-assigning the procedure date, and using the date the booking is re-assigned as the start time. It is a legitimate activity and even good practice, when dealing with very long waiting lists, to review those still on the list after a prolonged period of time (e.g. a year). Many patients will have made other arrangements by then, or perhaps are no longer alive. Those that are still waiting are re-booked, but many booking systems do not track waits longer than a year.

These biases can be avoided by adopting the following standards.

8) Jurisdictions should further agree to:

a) For reporting purposes, omit cases with the highest urgency (e.g. emergency) and instead report separately on level 2 and level 3 cases.

b) Use date of original booking request as the start date (in addition to the referral date) no matter how many times the case is re-scheduled.

c) Track the number of and reasons for cancellations or re-bookings as part of the minimum dataset.

Balancing Capacity and Demand

Traditionally, there has been a reluctance to address the question of what constitutes adequate capacity, focusing instead on trying to improve efficiency and eliminating unnecessary demand. This may sound like good sense, but urgency classifications and benchmarks are not a substitute for capacity, and if capacity is below need even by a small amount, waits will grow perpetually.

It is not efficient nor is it necessary to have enough capacity to meet all the need 100 per cent of the time – the goal is to address predictable need averaged over time, not to meet each unforeseeable peak.

In theory at least, the most efficient flow will occur when all cases are the same and all patients carry the same urgency. Adequate capacity then might be defined as the capacity that would handle 95 per cent of equal priority cases within the defined benchmark 95 per cent of the time.

Hospitals in which scheduled and emergency (i.e. non-scheduled) cases compete for the same resources must ensure adequate capacity for both patient streams if they want to protect scheduled services from the unpredictability of emergency admissions.

9) *Jurisdictions should make it a matter of policy to calculate capacity requirements for both elective and emergency cases based on their best estimates of projected need.*

Is it the true need or just the demand?

One of the most difficult tasks that face health service managers is the accurate estimate of true need and demand. The situation is not helped by the fact that the two terms are often used interchangeably. Strictly speaking, demand is simply the observed level of requests for a particular service, while need goes further and implies an assessment by an independent party to verify that the request has met a set of guidelines. A system that lacks any tests at all is open to endless abuse and cost. At the same time, any form of third party assessment can attract accusations of bias and unreasonable limits to access. Theories about supply creep, about perverse financial incentives, and about the lack of outcome measurements suggest that in some cases the level of true need is lower than current utilization. However there are also studies that show the opposite and suggest that some utilization levels have been set below the true need.

This question will not be resolved overnight, nor will it be addressed in this forum. It will take a great deal of careful deliberation and analysis to reach any semblance of consensus about what constitutes need, and time to create the changes necessary to adapt to that reality. The Council supports continuing attempts to better define true need. In the meantime, our historical patterns of utilization offer the best estimate of demand. Accepting this point is crucial, since the confusion about true need has hampered our ability to understand the nature of capacity.

10) *Until some other method has been validated by actual practice, historical utilization patterns should be accepted as the best estimate of current need for the purposes of capacity calculation.*

In conclusion, these 10 suggestions present possible solutions toward a meaningful way of tracking and managing wait times. The Health Council of Canada believes that common approaches to measuring and reporting wait times are essential to making progress. But because none of these suggestions will in themselves shorten wait times, they must be seen as a beginning, not as final goals. For wait-time reform to result in lasting benefits for Canadians, there must be a commitment to success on behalf of all stakeholders and a willingness to address failures where they are found.

SUMMARY

10 Steps Suggested towards a Common Framework for Reporting on Wait Times

1) *Where comprehensive wait-time management does not yet exist, health ministries should choose a representative basket of procedures on which to report wait times in a way that minimizes the risk of inadvertently increasing waits for other procedures. The long-range goal should be to address wait times on all health care interventions.*

2) *Enrollment on a wait list should take place at the time the intervention is formally booked (usually by a specialist). Both the original date of referral to the specialist and the booking date for the intervention should be recorded. The waiting interval should be defined as the time from initial referral to completion of the procedure.*

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