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McGill University Health Centre

Report number 26

Wait times at the MUHC.

I.

DIAGNOSTIC IMAGING, JOINT REPLACEMENT,
CANCER CARE, SIGHT RESTORATION , CARDIAC CARE

September 22, 2006

*This report was prepared for the Technology Assessment Unit
(TAU)*

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Invitation.

This document was developed to assist decision-making in the McGill University Health Centre. All are welcome to make use of it. However, to help us estimate its impact, it would be deeply appreciated if potential users could inform us whether it has influenced policy decisions in any way.

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EXECUTIVE SUMMARY

BACKGROUND

The following report is the first of a series undertaken in response to a request of the Director General of the MUHC to determine the wait times experienced by patients in the MUHC in undergoing tests and procedures, and to identify the measures necessary to correct them where excessive. This report addresses the five problem areas identified by the Canadian provincial First Ministers. It differs from most reports on this subject in several important respects.

Access to the healthcare system is usually reported in terms of the numbers of individuals on waiting *lists*. Because waiting lists may be inflated we have chosen to report the *times* experienced by patients waiting for a procedure.

METHOD

The wait times reported here were obtained from each Department. They reflect the time it would take for a patient to undergo a consultation, test or procedure, according to defined levels of urgency, at the time the request was initiated. Where possible, results are compared to the benchmarks established by the Canadian Wait times Alliance (WTA), the Canadian Provincial Health Ministers(HM), and the Québec Ministry of Health and Social Services (MSSS).

Finally, wait times are often defined as the time taken from inscription on the waiting list for some procedure to the time that procedure is initiated. However, this definition can seriously underestimate the time actually taken by a patient to access the healthcare system. For this reason we also record other relevant times, such as the time taken to get an appointment to be seen by the specialist who must authorize the procedure, and in the case of tests, the time taken to complete the test report.

RESULTS

Emergency and urgent cases.

It was determined that benchmarks for emergency and urgent cases were satisfactorily met in all disciplines and for all the procedures investigated.

Scheduled (elective) cases.

Sight restoration.

The wait time for cataract surgery is now <7 days, and other elective surgical procedures are all below 2 months. However, to obtain access to this surgery requires consultation with an ophthalmologist, which takes up to 24 weeks. (This highlights the weakness of reporting only the procedural waiting lists. Although these may be satisfactory there may be other obstructions which still limit accessibility.

Diagnostic Imaging.

CT. Apart from studies at the MNH, wait times for CT of up to 110 days usually exceed WTA benchmarks (< 30 days) two to three fold .

MRI At the time data were collected (January, February 2006) wait times for most scheduled procedures were close to WTA benchmarks (< 4 weeks). However, there were major delays for most studies requiring contrast, such as ortho-arthrography (57 weeks) and abdominal studies (53 weeks) . New MRI equipment at the RVH has now become operational and these wait times are falling.

Ultrasound, Mammography, GI Barium, Angiography. There are no benchmarks defined for these procedures. Wait times vary from 2-11 weeks. These procedures are essential steps in the “work up” of many patients and constitute a significant bottleneck in the healthcare process.

Nuclear Medicine. With the exception of MIBI and stress MIBI studies, 7 and 9 weeks respectively, nuclear medicine procedures are carried out within the benchmark limits set by the WTA (< 4 weeks).

Radiation Oncology. Wait times for this discipline are close to WTA, MSSS and Health Ministers standards (< 4 weeks).

Cardiac care

Elective or scheduled procedures such as Coronary Angiography or Coronary Bypass Surgery are carried out well within the WTA benchmarks (<6 weeks). However, the time taken to achieve an appointment with a cardiologist (7-32 weeks), and the time taken for subsequent frequently required studies (Holter, Stress ECG, Cardiac ultrasound, Stress ultrasound), which range from 7-38 weeks, reflects a significant obstruction to access to health care.

Joint replacement

MSSS, WTA, and HM benchmarks for scheduled knee and hip surgery are approximately six months. In spite of increased throughput in the last two years at the MUHC, the wait times for these procedures (> 1-2 years) are clearly unacceptable. They reflect a national problem that clearly cannot be solved within any particular hospital alone.

CONCLUSIONS

Although we have reported wait times in such a way that comparison can be made with commonly described benchmarks, our primary interest is to document accessibility, ie the actual delays experienced by patients. Thus, although wait times for cardiac surgery, or cataract surgery as usually defined may be satisfactorily short, the wait times experienced by the patients requiring these procedures are often far from satisfactory. Numerous bottlenecks to patient flow have been identified. Their causes differ and are often extremely complicated. In subsequent reports these bottlenecks will be examined, their causes identified, and the specific interventions necessary for their elimination will be outlined.

ABBREVIATIONS

CNS	central nervous system
CT	computerized tomography
ENT	ear, nose and throat
FDG	fluorodeoxyglucose
HM	Canadian Health Ministers
ICD	implantable cardiac defibrillator
MCH	Montreal Children's Hospital
MGH	Montreal General Hospital
MIBI	2-methoxy isobutyl isonitrile
MNH	Montreal Neurological Hospital
MRI	magnetic resonance imaging
PACS	picture archiving and communication systems
PET	positron emission tomography
RVH	Royal Victoria Hospital
SGAS	<i>système de gestion d'accès aux services</i>
SPECT	single photon emission computed tomography
WTA	Canadian Wait Times Alliance

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Wait times at the MUHC.

Report #1

CONTEXT

On November 2, 2005, Dr. Arthur Porter, Director General and CEO-MUHC requested the TAU to conduct an investigation of wait times with the following objectives:

- To determine wait times at the MUHC in the five priority areas identified by the Provincial First Ministers (diagnostic imaging, joint replacement, cancer care, sight restoration, and cardiac care).
- To study patient internal wait times at the MUHC (appointments, tests, procedures) with the object of identifying bottlenecks in patient flow.
- To identify the measures necessary to reduce excessive wait times.

The TAU will address each of the above objectives in separate reports. The present document addresses the first objective, to determine wait times in the priority areas identified by the Provincial First Ministers.

INTRODUCTION

Within Quebec, as elsewhere, there is a gap between healthcare resources and popular expectations. One manifestation of this is the difficulty experienced by individuals in gaining access to health services, and to hospital services in particular. Excessive wait times and what to do about them are generally perceived, not unreasonably, as the responsibility of the healthcare system, and of the governments that maintain it, and in Canada the correction of excessive wait times has now become a major concern of the federal and provincial governments [1]. In 2004 the Canadian Ministers of Health set aside \$5.5 billion for wait time related initiatives and identified five areas that they considered required urgent attention: *diagnostic imaging, joint replacement, radiation oncology, cataract surgery and cardiac care* [2], and in December, 2005 they announced “evidence-based” bench marks for five types of non-emergency surgery, radiation therapy and cancer screening [3].

It is entirely appropriate that governments focus on this issue. However, most wait times, including all the wait times identified by the Health Ministers, occur within hospitals, where their causes are complex and differ from case to case. It is likely, therefore, that identification of many of the causes and the remedial measures necessary to reduce wait times will best be identified at the hospital level.

Wait time as defined by the Health Ministers does not adequately reflect the difficulty of access to the health system. (*"A wait time begins with the booking of the service, when the patient and the appropriate physician agree to the service and the patient is ready to receive it...A wait time ends with the commencement of the service"* [3]). The actual wait time experienced by patients often consists of several components. For example, to undergo elective cardiac surgery usually requires a consultation with a cardiologist, diagnostic testing culminating in a heart catheterization, and finally a consultation with a cardiac surgeon before being inscribed on the surgical waiting list. For each of these steps there is a wait time, and to truly evaluate access each component must be identified. In this way the total wait time from first contact with the system to the initiation of the intervention can be determined.

This document is the first of a series of reports that will address the issue of wait times at the MUHC. The overall objective is first to identify the present bottlenecks and obstructions to patient flow, and then in selected cases to identify the appropriate remedial measures and their costs. The present report reviews patient flow at the MUHC in the five priority areas identified by the Canadian Ministers of Health.

METHODS

Patient access is usually recorded in terms of the number of patients on the waiting list for a procedure at some given time. However, this can be misleading since patients may be inscribed on more than one list, or may be on a list for reasons that are unrelated to healthcare system performance such as unsatisfactory health status, or there may simply have been a failure to strike their name from the list.

Accordingly, in the present study we have concentrated *on the total time it would take for a patient to receive the health service in question*. To obtain this information we have visited each department, reviewed the objectives of the inquiry with departmental heads, and then interviewed the booking clerks, asking the following question, in relation to a hypothetical patient:

If a request for a service were received today, on what date would you give an appointment for that service to be delivered, for an emergency, an urgent, or a scheduled patient, as defined below?

This information was collected between November 30, 2005, and June 30, 2006. After compilation, the summarized data were returned to the departments for validation. Thus, the data collected are likely to accurately reflect a cross sectional quantification of the wait time experienced by patients on the day in question.

Data were kindly supplied by numerous MUHC staff, the majority of whom are listed in Appendix I.

Several authorities have defined upper limits for wait times, or benchmarks. They are usually applicable to wait times as defined by the Health Ministers, namely the time from inscription of the patient's name for a procedure to the time the procedure is commenced. The benchmarks defined by the Health Ministers [3], the benchmarks of the Canadian Wait Times Alliance [4], and the benchmarks set by the Ministry of Health and Social Services (MSSS) of Québec [5] are shown where appropriate in the following tables. The benchmarks of the *Réseau québécois de cardiologie tertiaire* [6] are shown in appendices III to V. Some standards set within the MUHC are shown in Appendix II.

DEFINITIONS

Services

Clinical consultations, diagnostic tests, and therapeutic interventions.

Wait times

The wait time is the time elapsed between identification of the request for a service and the time it would take for that service to be initiated.

Many diagnostic, and all surgical procedures require consultation with the appropriate specialist before the procedure is initiated. Furthermore, in the case of certain diagnostic services there can be a significant time lapse between the time a test is carried out and the time at which a report is completed. When relevant, these additional times are noted in the following tables and added to the total wait time.

As noted above, the wait times reported reflect the information obtained from the department concerned in response to the hypothetical question: *"Bearing in mind the urgency of a request, how long it would take for a new patient to receive the service in question, on any particular date?"*

Unless otherwise specified the definition of priority is that used by the Canadian Wait Time Alliance, as follows:

- 1 **emergency** Immediate danger to life, limb or organ.
- 2 **urgent** A situation that is unstable and has the potential to deteriorate quickly and result in an emergency situation
- 3 **scheduled** A situation involving minimal pain, dysfunction or disability (also called "routine" or "elective").

RESULTS

The results of these enquiries are shown, by procedure, in the following tables and graphs. It should be noted that the information in each case reflects only a sample of the situation at the time indicated, based on the best available information, and that this information may not reflect current or typical wait times in these areas at the MUHC.

Table 1

DIAGNOSTIC IMAGING

CT Scan

Emergency and Urgent.Cases

At both RVH and MGH emergency cases < 12 hours, urgent cases <3 days. Inpatients are given priority over outpatients.

WTA Standards *emergency <1 day. urgent <7 days*

Scheduled Cases

<u>Procedure</u>	<u>Site</u>	<u>Time to exam</u>	<u>Report Time</u>	<u>Total Time</u>
CT (non-contrast)	RVH	30 days	20 days *	50 days
(contrast)	RVH	90 days	20 days *	110 days
CT(ENT)	MGH	48 days	8 days	56 days
(chest)	MGH	58 days	8 days	66 days
(body)	MGH	60 days	8 days	68 days
(head)	MGH	10 days	8 days	18 days
CT (All)	MNH	15 days	12 days	27 days
<u>WTA Standard (all CT scans)</u>				< 30 days

Note: * *The time from the examination to completion of the report has now been reduced to four days.*

Data are for January-February 2006

Table 2

DIAGNOSTIC IMAGING

MRI

Emergency and Urgent Cases

Emergency, MGH, MNH <u>WTA Standard</u>	1-2 days <1 day
Urgent , MGH (except breast cancer) , MGH Breast cancer <u>WTA Standard</u>	<7 days 21 days <7 days

Non-emergency inpatients are given priority and treated as urgent.

Scheduled Cases

<u>Procedure</u>	<u>Site</u>	<u>Time to exam</u>	<u>Report Time</u>	<u>Total Time</u>
MRI (non-contrast)				
(body)	MGH	4 weeks	1 week	5 weeks
(E.N.T.)	MGH	3 weeks	1 week	4 weeks
(neuro-spine)	MGH	3 weeks	1 week	4 weeks
(ortho-knee)	MGH	3 weeks	1 week	4 weeks
(ortho-spine)	MGH	3 weeks	1 week	4 weeks
(ortho-other)	MGH	4 weeks	1 week	5 weeks
(neuro-brain)	MGH	4 weeks	1 week	5 weeks
	MNH	13 weeks	2 weeks	15 weeks
<u>WTA Standard</u>		(< 30 days)		<4 weeks
MRI (contrast)				
(neuro-spine)	MGH	2 weeks	1 week	3 weeks
(neuro-brain)	MGH	4 weeks	1 week	5 weeks
(neuro)	MNH	16 weeks	2 weeks	18 weeks
(E.N.T.)	MGH	4 weeks	1 week	5 weeks
(breast, 'semi-urgent')	MGH	5 weeks	1 week	6 weeks
(orthopedic)	MGH	22 weeks	1 week	23 weeks
(abdomen)	MGH	52 weeks	1 week	53 weeks
(ortho-arthrogram)	MGH	56 weeks	1 week	57 weeks
<u>WTA Standard</u>		(< 30 days)		<4 weeks

Note: Subsequent to collection of these data a new MRI has been installed at the RVH. Current wait times are shorter than those recorded above

Data are for Jan, Feb, and June 2006. Times rounded to nearest week.

Table 3

DIAGNOSTIC IMAGING

Ultrasound, Mammography, Barium upper GI, Barium lower GI, Angiography.

Emergency and Urgent Cases

At both RVH and MGH emergency cases < 1 day, urgent cases <2 days.

No WTA Standards defined.

Scheduled Cases

<u>Procedure</u>	<u>Site</u>	<u>Time to exam</u>	<u>Report Time</u>	<u>Total Time</u>
<u>Ultrasound</u>				
(All non-cardiac)	MNH	2 weeks	2 weeks	4 weeks
(All non-cardiac)	RVH	9 weeks	2 weeks	11 weeks
(Abd, pelvis, prost)	MGH	8 weeks	2 weeks	10 weeks
(Bone)	MGH	6 weeks	2 weeks	8 weeks
<u>Mammography</u>				
(via OPD)	RVH	5 weeks	2 weeks	7 weeks
(via Breast clinic)	RVH	< 1 day	2 weeks	
<u>Barium Upper GI</u>				
	RVH	1 week	1 week	2 weeks
	MGH	7 weeks		
<u>Barium Lower GI</u>				
	RVH	1 week	1 week	2 weeks
	MGH	7 weeks		
<u>Angiography</u>				
	RVH	2 weeks	2 weeks	4 weeks
	MGH	2 days	1 week	3 weeks
	MNH	2 weeks	2 weeks	4 weeks

No WTA Standards defined.

HM Standards (mammography), "every 3 years".

Note: Except where stated times are rounded to nearest week.

Data are for January-February 2006

Table 4

DIAGNOSTIC IMAGING

Nuclear Medicine

Whole body bone scan, PET, ventriculogram, MIBI

Emergency and Urgent Cases

Emergency cases	< 1 day
<u>WTA Standard</u>	< 1 day
Urgent cases	< 2 days
<u>WTA Standard (cardiac nuclear imaging*)</u>	< 3 days
<u>WTA Standard (FDG-PET, bone scan)</u>	< 7 days

Note: At RVH and MGH inpatients are given priority over outpatients.

* perfusion; viability, LV function (SPECT or PET)

Scheduled Cases

<u>Procedure</u>	<u>Site</u>	<u>Time to exam</u>	<u>Report Time</u>	<u>Total Time</u>
Bone Scan	MGH	2 weeks	1 week	3 weeks
PET**	MGH	2 weeks	24-48 hours	2 weeks
Cardiac Ventriculogram	RVH	1 week	1 week	2 weeks
MIBI	RVH	6 weeks	1 week	7 weeks
MIBI Stress/Dipyridamole	RVH	8 weeks***	1 week	9 weeks
<u>WTA Standard</u>		< 30 days		4 weeks

Note: ** PET is reserved for oncology cases .

***Can increase to 12 weeks in summer months

Data collected in February & June 2006

Table 5

RADIOLOGY

Routine radiography of chest, skeleton, abdomen.

Emergency and Urgent Cases

At both the RVH and MGH emergency and urgent cases < 12 hours
No WTA Standard defined.

Scheduled Cases

<u>Procedure</u>	<u>Site</u>	<u>Time to exam</u>	<u>Report Time</u>	<u>Total Time</u>
Chest	MGH, RVH	< 1 hour	4 weeks	4 weeks
Abdomen	MGH, RVH	2 weeks	2 weeks	4 weeks
Skeleton	MGH, RVH	2 weeks	8 weeks	10 weeks

No WTA Standard defined

Note : *Data collected in February & June 2006*

Table 6

JOINT REPLACEMENT, ARTHROSCOPY

Emergency and Urgent Cases

Emergency cases involving, trauma, time to consultation and surgery < 7 days
WTA Standard <1 day

Urgent cases involving trauma, time to consultation and surgery <2 months
WTA Standard <2 months
HM Standard Fixation of hip fractures <2 days

Cancer cases, time to consultation < 1 week. Time to surgery <1 week

Scheduled Cases

There are 3 significant components to arthroplasty wait times, the time for consultation with the orthopedic specialist, the time to undergo MRI, and the time to surgery after this intervention has been decided on.

<u>Procedure</u>	<u>Consultation*</u>	<u>Time to: MRI</u>	<u>Surgery</u>	<u>Total Time</u>
Hip Replacement	12 months		12 months	24 months
Knee Replacement	12 months		24 months	36 months
<u>MSSS Standard</u>	3 months			6 months
<u>WTA Standard</u>			6 months	9 months
<u>HM Standard</u>			6.5 months	
Hip Arthroscopy	12 months	14 weeks	12 months	27.5 months
Knee Arthroscopy	12 months	2 weeks	12 months	24.5 months
<u>WTA Standard</u>	<i>not defined</i>			

Note: * The above data reflect the average time for consultation with one of the surgeons who still accepts new cases. Most surgeons have stopped accepting appointments for new cases.

Data collected in May & June, 2006.

Table 7

CANCER CARE (RADIATION ONCOLOGY)

Emergency and Urgent Cases

All Cancer care is considered to be urgent. The Department classifies urgency according to the SGAS system (*système de gestion d'accès aux services*) under which patients are classified into 4 priority levels. Below, we will consider their level 4 to be "scheduled", levels 2 and 3 to be "urgent", and that our level 1 to be "emergency".

Emergency, or urgent cases are seen by a radiation oncologist in <1 day and <10 days, respectively. When therapy has been decided on it is initiated within 1 day.

WTA Standard. *Emergency: <1 day. Urgent: "based on individual need".*

Scheduled Cases

<u>Procedure</u>	<u>Time to consultation</u>	<u>Time to treatment</u>	<u>Total time</u>
Radiation therapy.	1 week (average)	2-4 weeks	3-5 weeks*
<u>WTA Standard</u>	2 weeks*	2 weeks**	4 weeks
<u>MSSS Standard</u>			4 weeks
<u>HM Standard</u>		<4 weeks	

Note: Data collected in January & February, 2006

* As of 2006-03-04 at the MUHC, 3 patients had been waiting for over 4 weeks, and 96 % of patients were starting treatment within 4 weeks.
Source: MSSS : <http://wpp01.msss.gouv.qc.ca/appl/q74web/Resultats.asp>

**10 working days

Table 8

SIGHT RESTORATION (OPHTHALMOLOGY)

Emergency and Urgent Cases

There is virtually no waiting time to see an ophthalmologist or to initiate necessary interventions for emergent and urgent cases.

Scheduled Cases

<u>Procedure</u>	<u>Consultation</u>	<u>Time to: Time to surgery</u>	<u>Total time</u>
Cataract surgery	24 weeks	1 week	25 weeks
<u>WTA Standard</u>		16 weeks	
<u>MSSS Standard</u>			24 weeks
<u>HM Standard</u>		16 weeks	

Other procedures. There are considerable delays for corneal transplants due to limited availability of corneas. Other elective surgical procedures vary but may involve up to two months total wait time.

Note : Data were collected in February, 2006

Table 9

CARDIAC CARE

Cardiology

Emergency and Urgent Cases

At both the RVH and the MGH there is virtually no delay for emergency and urgent cases to be seen by a cardiologist, and when necessary to undergo diagnostic cardiac catheterization, angioplasty, pacemaker insertion, ICD insertion, Holter monitoring, stress ECG, and stress echo.

WTA Standard.

Emergency <24 hours.

Urgent <7 days

Scheduled Cases

<u>Procedure</u>	<u>Site</u>	<u>Time to:</u>		<u>Total</u>
		<u>Consultation*</u>	<u>Procedure</u>	
Diagnostic Heart Cath	RVH, MGH	28 weeks	2 weeks	30 weeks
Angioplasty	RVH, MGH	28 weeks	3 weeks	31 weeks
Pacemaker (outpatient)	RVH	28 weeks	1 week	29 weeks
(outpatient)	MGH	7 weeks	1 week	8 weeks
(inpatient)	RVH, MGH	<1 day	<1 day	1 day
<u>WTA Standard</u>				6 weeks
ICD	RVH, MGH	28 weeks	1 week	29 weeks
Holter	RVH	28 weeks	1 day	28 weeks
	MGH	7 weeks	2 days	7 weeks
Stress ECG	RVH	28 weeks	1 week	29 weeks
	MGH	7 weeks	6 weeks	13 weeks
Cardiac echo	RVH	28 weeks	24 weeks	52 weeks
	MGH	7 weeks	12 weeks	19 weeks
Stress echo	RVH	28 weeks	10 weeks	38 weeks
	MGH	7 weeks	6 weeks	13 weeks

WTA standard not defined

Note : Data collected in February, 2006

*Consultation Time. RVH. Median (Upper Range) 8 Cardiologists, 28 (32)weeks.
MGH Consultations pooled 7 weeks*

Table 10

CARDIAC SURGERY

Emergency and Urgent Cases

Surgical consultation time for emergency and urgent cases, <1 day
WTA Standard. *Emergency <48 hours.* *Urgent <14days and 1'*

<u>Procedure</u>	<u>Site</u>	<u>Total Time</u>
Emergency CABG /Valve <u>WTA Standard</u>	RVH& MGH	<1 day <2 days
Urgent CABG/Valve <u>WTA Standard</u>	RVH& MGH	<1 day <14 days

Scheduled Cases

<u>Procedure</u>	<u>Site</u>	<u>Time to:</u>		
		<u>Consultation</u>	<u>Procedure</u>	<u>Total</u>
CABG / Valve <u>WTA Standard</u> <u>HM Standard</u>	RVH/MGH	3 weeks	4 weeks	7 weeks 6 weeks
			< 26 weeks	

Note: *Wait times are identical for RVH and MGH as the two sites are totally integrated. Surgeons cover both hospitals and manage a single waiting list*

Average (range) time for scheduled consultations (4 surgeons)=2.5(1-6)weeks

Data collected in March, 2006

DISCUSSION

This report differs from other reports on wait times in three respects. First, it presents examples of actual times waited by an individual undergoing a procedure, rather than the number of individuals alleged to be waiting for that procedure (a wait list). Second, although the report addresses the five principal wait times identified by the Ministers of Health, it also records the other significant components that add to these times, thus reflecting the total wait time experienced by patients. Finally, these data have been collected directly from the booking clerks or secretaries and are likely to be accurate. However, it must be noted that wait times are continually changing and that these data reflect only snapshots of the situation in the MUHC taken at different times during the first five months of 2006.

Perhaps the most striking result of this study is the success of the hospital, in collaboration with the Ministry and the *Agence*, in virtually eliminating excessive wait times in the areas of radiation oncology, and cataract surgery over the past year. In addition, the wait times for many MRI and nuclear medicine diagnostic procedures has been reduced to the levels recommended by the Wait Times Alliance. The wait times in the five areas designated by the Canadian Health Ministers is summarized below.

Wait times for emergency and urgent cases.

Benchmarks for emergency and urgent cases were satisfactorily met in all disciplines and for all the procedures investigated

Wait times for scheduled or elective cases.

Sight restoration.

The wait time for cataract surgery is now <7 days, and other elective surgical procedures are all below 2 months. However, to obtain access to this surgery requires consultation with an ophthalmologist, which takes up to 24 weeks.

Diagnostic Imaging.

CT. Apart from studies at the MNH, wait times for CT mostly exceed WTA benchmarks (< 30 days) by two to three fold (up to 110 days).

MRI At the time data were collected (January, February 2006) wait times for most scheduled procedures not requiring contrast administration were close to WTA benchmarks (< 4 weeks). There were major delays for MRI requiring contrast, such as 57 weeks for ortho-arthrography, and 53 weeks for abdominal studies. It should be noted that new MRI equipment at the RVH has since become operational and these wait times are falling.

Ultrasound, Mammography, GI, Barium, Angiography. There are no benchmarks defined for these procedures. Wait times vary from 2-11 weeks. These procedures are essential steps in the “work up” of many patients and constitute a significant bottleneck in the healthcare process.

Nuclear Medicine. With the exception of MIBI studies nuclear medicine procedures are carried out within the benchmark limits set by the WTA (< 4 weeks).

Radiation Oncology

Wait times for this discipline are close to defined benchmarks (<4 weeks).

Cardiac care

Elective or scheduled procedures such as Coronary Angiography or Coronary Bypass Surgery are carried out well within the WTA benchmarks (<6 weeks). However, the time taken to achieve an appointment with a cardiologist (7-32 weeks), and the time taken for subsequent frequently required studies (Holter, Stress ECG, Cardiac ultrasound, Stress ultrasound), which range from 7-38 weeks, reflects a significant obstruction to access to health care.

Joint replacement

MSSS, WTA, and HM benchmarks for scheduled knee and hip surgery are approximately six months. In spite of increased throughput in the last two years at the MUHC, the wait times for these procedures (> 1-2 years) are unacceptable. They reflect a national problem that clearly cannot be solved within any one hospital alone.

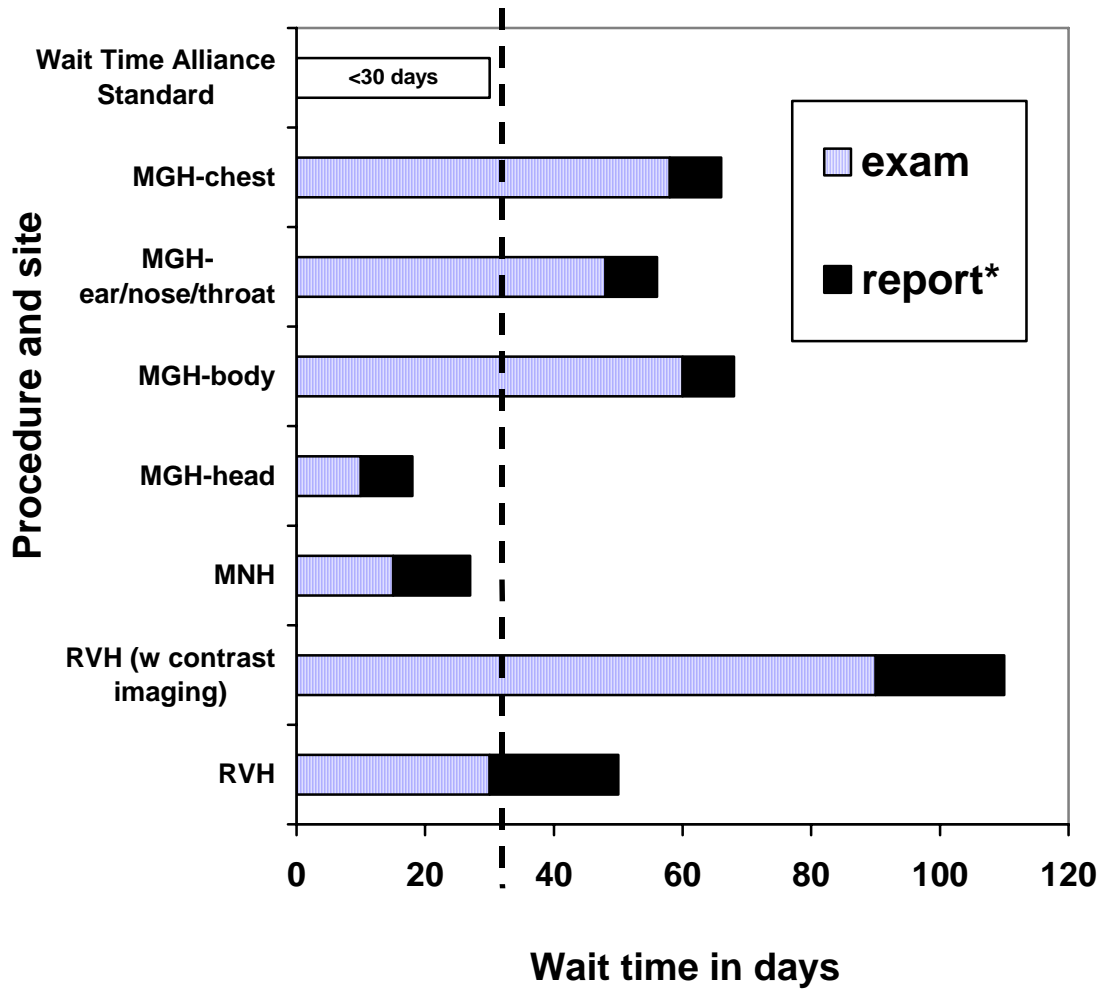
CONCLUSION

Although we have reported wait times in such a way that comparison can be made with commonly described benchmarks, our primary interest is to document accessibility, ie the actual delays experienced by patients. Thus, although as usually defined, procedural wait times for cardiac surgery, or cataract surgery may be satisfactorily short, the wait times experienced by the patients requiring these procedures are far from satisfactory. Numerous bottlenecks to patient flow have been identified. Their causes differ and are often extremely complicated. While these bottlenecks can clearly not be solved by the hospitals alone, these institutions can play their part by identifying the causes for each obstruction to patient flow, by defining the solutions that will be most effective, and by estimating their cost. These issues will be addressed in subsequent reports.

FIGURES

Figure 1

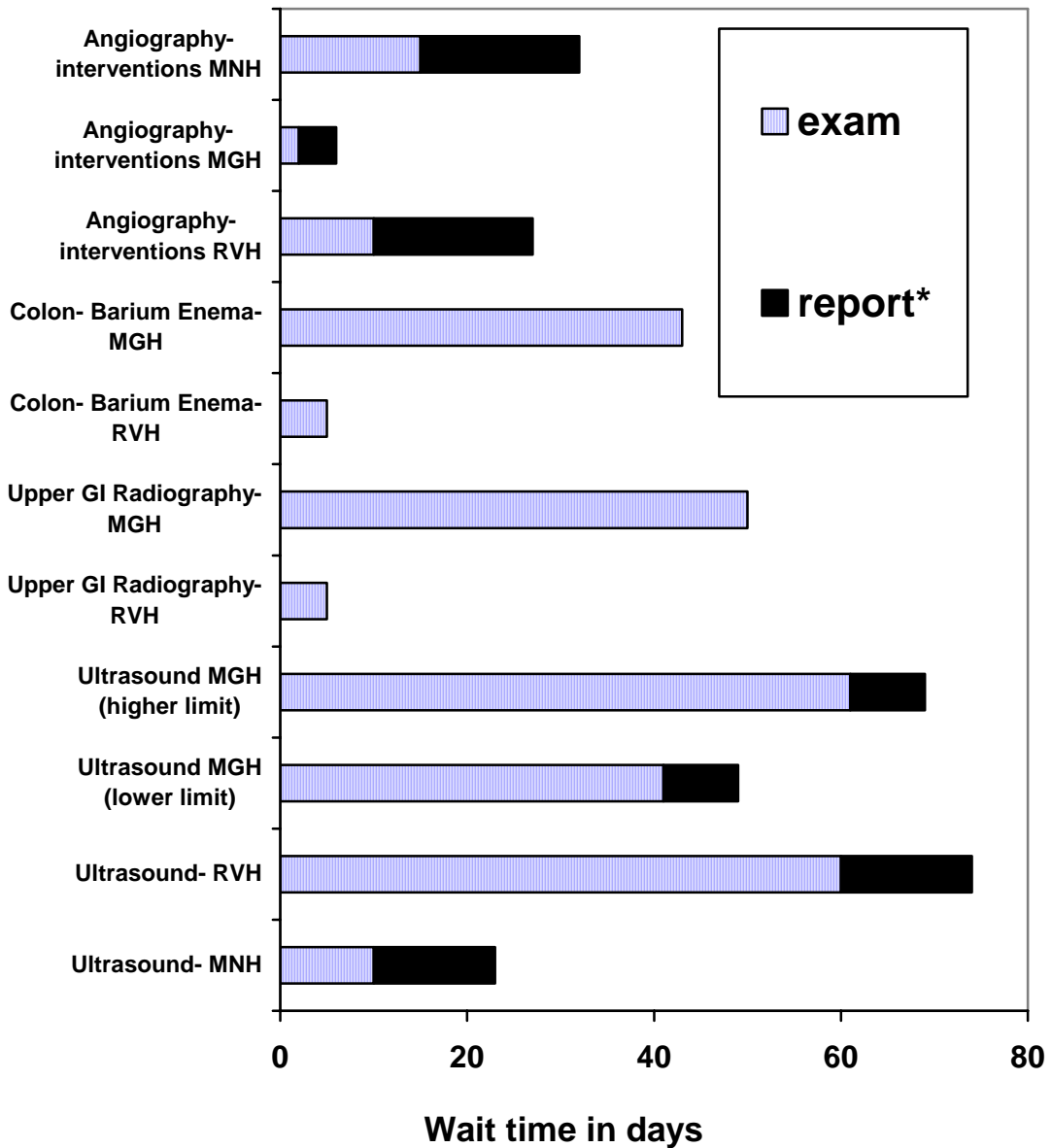
MUHC wait times for scheduled CT scans



* Jan-Feb 2006. Current report times are much lower

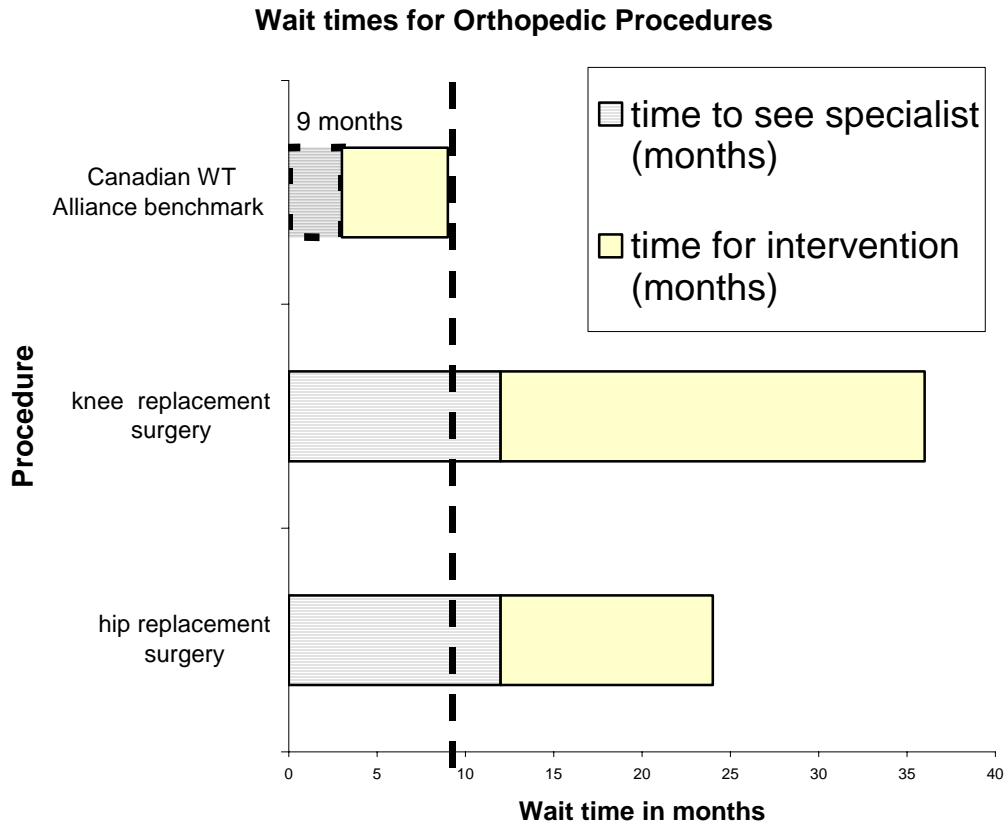
Figure 2

MUHC wait times for other scheduled diagnostic imaging procedures



*Jan-Feb 2006- current report times are generally much lower

Figure 3



NOTE: The times to see an orthopedic surgeon reflected above are misleading, since the majority of surgeons have closed their waiting lists and will not take on any further referrals other than emergency cases.

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Appendix I: Acknowledgements

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Appendix II: objectives for diagnostic imaging at the MUHC

Objectives targeted for diagnostic imaging at the MUHC:

RVH	MGH	MNH	MCH
Inpatient Requests:	Inpatient Requests:	Inpatient Requests:	Inpatient Requests:
CT without OM:1 day	CT without OM: 1 day	CT without OM: 1 day	CT with or without OM: 1 day
CT with OM: 1 day	CT with OM: 1 day	CT with OM: 1 day	
US: 1 day	US: 1 day	US:1 day	US: 1 day
Mammo: 1 day	MRI without OM: xx days	MRI without OM: 2 days	MRI without Sedation: 2 days
	MRI with OM: xx days	MRI with OM: 2 days	MRI with Sedation: 2 days
Angio: 2 days	Angio:2 days	Angio: 2 days	Angio: 2 days
UGI: 2 days	UGI: 2 days		UGI and Colon: 2 days
Colon (BE): 3 days	Colon (BE): 3 days		
Outpatient requests - Elective	Outpatient requests - Elective	Outpatient requests - Elective	Outpatient requests - Elective
CT without OM:28 days	CT without OM: 20 days	CT without OM: 15 days	CT with or without OM: 28 days
CT with OM: 28 days	CT with OM: 20 days	CT with OM: 15 days	
US: 70 days	US: 40 days	US: 10 days	US: 70 days
Mammo: 35 days*	MRI without OM: 90 days	MRI without OM:70days	MRI without Sedation: 120 days
* Patients booked to see a surgeon at the Breast Centre have their Mammography or Ultrasound the same day without an appointment. OP appointments are restricted to periods when there are not 2 surgeons in the Centre	MRI with OM: 90 days	MRI with OM: 84 days	MRI with Sedation: 120 days
Angio: 14 days	Angio: 10 days	Angio:14 days	
UGI: 14 days	UGI: 20 days		UGI and Colon: 14 days
Colon (BE): 14 days	Colon (BE): 60 days		
NB: All urgent Outpatient requests are addressed ASAP.	NB: All urgent Outpatient requests are addressed ASAP.	NB: All urgent Outpatient requests are addressed ASAP. There may be delays for cases under General Anesthesia depending on the availability of Anesthesia personnel	NB: All urgent Outpatient requests are addressed ASAP.

Appendix III: Maximum permissible delays. The Réseau Québécois de Cardiologie Tertiaire (RQCT), Access to Hemodynamic

Access to Hemodynamic – Priority Classification (CMQ ⁽¹⁾ – RQCT ⁽²⁾)					
Clinical Info.	Functional Class (RQCT)	Risk Level	Diagnosis	Priority	Delays
Coronary	IV-C2	N/A ⁽³⁾	Acute coronary syndrome with rhythmic or hemodynamically instability	1	Immediately
Coronary			Primary or rescue angioplasty for acute MI	1	Immediately
Valvular			Acute valvular syndrome with rhythmic or hemodynamically instability	1	Immediately
Vascular			Acute vascular syndrome	1	Immediately
Coronary	IV-C1	N/A	Acute coronary syndrome resistant to optimal medical treatment including intravenous treatment	2	< = 24 hours
Valvular			Acute valvular syndrome resistant to optimal medical treatment including intravenous treatment	2	< = 24 hours
Coronary	IV-B	N/A	Acute coronary syndrome improved with optimal medical treatment but persistent during minimal effort	3.1	< = 72 hours
Valvular			Acute valvular syndrome improved with optimal medical treatment but persistent during minimal effort without intravenous treatment	3.1	< = 72 hours
Coronary	IV-A	High risk	Acute coronary syndrome stabilized with oral medication, high risk	3.2	< = 1 week
Valvular		N/A	Severe symptomatic valvular syndrome stabilized	3.2	< = 1 week
Coronary		Low risk	Acute coronary syndrome stabilized with oral medication, low risk	4	< = 2 weeks
Coronary	III	High risk	High risk coronary syndrome	4	< = 2 weeks
Valvular		N/A	Stable valvular syndrome	4	< = 2 weeks
Coronary		Low risk	Low risk coronary syndrome	5.1	< = 1 month
Coronary	II	High risk	High risk coronary syndrome	5.1	< = 1 month
Valvular		N/A	Stable valvular syndrome	5.1	< = 1 month
Coronary		Low risk	Low risk coronary syndrome	5.2	< = 2 months
Coronary	I	High risk	High risk coronary syndrome	5.1	< = 1 month
Valvular		N/A	Stable valvular syndrome	5.1	< = 1 month
Coronary	N/A	Low risk	Low risk coronary syndrome	5.2	< = 2 months
Vascular		N/A	Stable vascular syndrome	5.2	< = 2 months

Note: The non-invasive test results performed are used to define the high risk and low risk variables. Thus, the notion of a user at high risk of cardiovascular complications determines, with other clinical informations, the user's priority level. A user will be at high risk with a positive non-invasive test result or with a left ventricular ejection fraction lower or equal to 40%.

Source: www.rqct.qc.ca

Appendix IV: Maximum permissible delays. The Réseau Québécois de Cardiologie Tertiaire (RQCT), Access to Cardiac Surgery

Access to Cardiac Surgery – Priority Classification (CMQ ⁽¹⁾ – RQCT ⁽²⁾)		
Diagnosis	Priority	Delays
Acute Coronary Syndrome: <ul style="list-style-type: none"> • Hemodynamically unstable • Malignant arrhythmias Acute Valvular Syndrome: <ul style="list-style-type: none"> • Hemodynamically unstable Acute Vascular Syndrome: <ul style="list-style-type: none"> • Aortic dissection • Hemodynamically unstable 	1 (very urgent)	< = 24 hours
Acute Coronary or Valvular Syndrome: <ul style="list-style-type: none"> • Resistant to medical treatment via intravenous • Severe left main disease 	2 (urgent)	< = 72 hours
Stabilized Acute Coronary Syndrome: <ul style="list-style-type: none"> • Precarious state • Under optimal medical control <i>Unless otherwise instructed, user under parenteral therapy</i> Non-Acute Coronary Syndrome: <ul style="list-style-type: none"> • Functional Classification IV Severe Valvular Syndrome: <ul style="list-style-type: none"> • Precarious state • Hemodynamically stable • Under optimal medical control • NYHA 4 <i>Hospitalized user who cannot be discharged without being operated</i> 	3 (semi-urgent)	< = 2 weeks
Non-Acute Coronary Syndrome: <ul style="list-style-type: none"> • Functional Classification III Stable Valvular Syndrome: <ul style="list-style-type: none"> • NYHA 3 <i>Non-hospitalized users</i> 	4 (semi-elective)	< = 6 weeks
Other Situations	5 (elective)	< = 3 months

Functional Classification (CMQ ⁽¹⁾ – RQCT ⁽²⁾)	
Class	Description
I	Asymptomatic or limitations occurring during strenuous, prolonged or unusual physical activities.
II	Slight limitations during regular activities. May occur while walking or climbing stairs.
III	Marked limitations during regular activities.
IV-A	Severe limitations or unstable state, now stabilized with oral medications.
IV-B	Severe limitation or unstable state. Limitation persists during light activities or at rest regardless optimal medical treatment.
IV-C1	Severe limitation or unstable state resistant to medical treatment and requiring intravenous treatment.
IV-C2	Severe limitation or unstable state requiring intravenous treatment and remaining hemodynamically or rhythmically unstable regardless of treatment. Also includes primary or rescue angioplasty for acute MI, aortic dissection and ruptured aneurysm.

Insufficiency Classification (NYHA) ⁽³⁾	
Class	Description
Class 1	Users with no limitation of activities; they suffer no symptoms from ordinary activities.
Class 2	Users with slight, mild limitation of activity; they are comfortable with rest or with mild exertion.
Class 3	Users with marked limitation of activity; they are comfortable only at rest.
Class 4	Users who should be at complete rest, confined to bed or chair; any physical activity brings on discomfort and symptoms occur at rest.

(1) CMQ: Collège des médecins du Québec
 (2) RQCT: Réseau québécois de cardiologie tertiaire
 (3) NYHA: New York Heart Association

Source: www.rqct.qc.ca

Appendix V: Maximum permissible delays. The Réseau Québécois de Cardiologie Tertiaire (RQCT), Access to Electrophysiology

Access to Electrophysiology – Priority Classification (CMQ ⁽¹⁾ – RQCT ⁽²⁾)					
User's Origin	Procedure		Clinical Cardiac – Information	Priority	Delays
User is hospitalized, in the emergency or transferred from another hospital			Hemodynamically Unstable	1	< 24 hours
			Temporary transvenous Pacemaker	1	< 24 hours
			User hospitalized for one of the diagnostics or other severe symptoms shown under section (Clinical Cardiac – Information)	2	< = 48 hours
User coming from home	Pacemaker/Defibrillator				
	• New implant	Without dependence		3	< = 2 weeks
	• Replacement electrode or pacemaker	With dependence		3	< = 2 weeks
	• Repositioning of electrode or pacemaker	With dependence		3	< = 2 weeks
	• Electrode extraction			3	< = 2 weeks
	• Replacement of electrode or pacemaker	Without dependence		4	< = 4 weeks
	• Repositioning of electrode or pacemaker	Without dependence		4	< = 4 weeks
	• Upgrade			4	< = 4 weeks
	• Removal			4	< = 4 weeks
	Ablation		Rapid atrial fibrillation	3	< = 2 weeks
	Ablation		Potentially malignant	3	< = 2 weeks
	Ablation		Arrhythmia	4	< = 4 weeks
	Ablation		Atrial flutter	4	< = 4 weeks
	Ablation		Wolf-Parkinson-White	4	< = 4 weeks
	Ablation	Redo	Syncope	4	< = 4 weeks
	Defibrillator test			3	< = 2 weeks
	Implantable monitor			4	< = 4 weeks
	Diagnostic study			4	< = 4 weeks
	Internal cardioversion			5	< = 3 months
	External cardioversion			5	< = 3 months
Ablation		(Without any other specifications)	5	< = 3 months	
Tilting table			5	< = 3 months	

Insufficiency Classification (NYHA) ⁽³⁾	
Class	Description
Class 1	Users with no limitation of activities; they suffer no symptoms from ordinary activities.
Class 2	Users with slight, mild limitation of activity; they are comfortable with rest or with mild exertion.
Class 3	Users with marked limitation of activity; they are comfortable only at rest.
Class 4	Users who should be at complete rest, confined to bed or chair; any physical activity brings on discomfort and symptoms occur at rest.

(1) CMQ: Collège des médecins du Québec
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Source: www.rqct.qc.ca