ASSOCIATION MÉDICALE CANADIENNE / CANADIAN MEDICAL ASSOCIATION

CMA POLICY

OPERATIONAL PRINCIPLES FOR THE MEASUREMENT AND MANAGEMENT OF WAIT LISTS

(Update 2011)

Preamble

This policy statement provides operational principles for the measurement and management of wait list systems that support timely access to necessary care for patients. This statement is based on the understanding that in order for wait list systems to be effective in improving timely access to medically necessary care for patients, physicians and other providers must be centrally involved and appropriately supported to assist in their development, measurement and management.

Since the late 1990s, Canadians have become increasingly concerned over lengthening wait times to access medically necessary care. As a result, a major focus of the 2004 Health Care Accord (10-Year Agreement to Strengthen Health Care) was to improve timely access to necessary medical care. Since then, provinces and territories have taken steps to measure, monitor and manage patient wait times. However, most efforts thus far to improve wait times have been focused on the wait between the specialist consultation and the scheduled date for treatment. Patients may also experience waits in accessing a family physician (many Canadians do not have a family physician) and waiting to see a specialist following a referral by a family physician.

Canadians deserve timely access to medically necessary care. Governments must ensure that patients are treated within established wait-time benchmarks for all major diagnostic, therapeutic, and surgical services. Physicians recognize that it is desirable to minimize waits and to properly prioritize and manage patients' wait for care by accurately capturing and utilizing wait-time data.

However, there remain serious concerns over the quality of wait-time data and who has the primary responsibility for capturing the data. Physicians and other providers are increasingly being requested to input wait-time data (e.g., length of wait for consultation or for start of treatment). Yet, in many instances, they are expected to do so without the necessary resources and supports.

Outlined below are **Operational Principles** for the Measurement and Management of Wait Lists developed originally through CMA's Access to Quality Health Care Project[1] with input from public opinion research as well as stakeholder groups, including CMA Core Committees, Provincial-Territorial Medical Associations and CMA Affiliates.

[1] Canadian Medical Association, *Access to Quality Health Care Project*, January 1998. Ottawa.

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Goals

1. To maintain or enhance patients' quality of life and health status through effective development, measurement and management of wait lists.

2. To ensure that the development, measurement and management of wait lists are based on the best available evidence of clinical appropriateness, clinical effectiveness, rational use of resources, clinical need and patient quality of life.

Principles

A. Stakeholder Involvement

1. Physicians in clinical practice must have a leadership role:
   - in identifying clinically relevant data elements through consensus;
   - in developing standard definitions and measures for prioritization for wait lists; and
   - in developing wait-time benchmarks.

2. Health care providers and other stakeholders should be involved in the development, measurement, maintenance, monitoring, management and evaluation of wait list systems, and should be appropriately compensated for their time and effort.

B. Database Development and Management Systems

1. Systems for developing and managing wait lists must require and provide reliable, current, useful and valid data and information.

2. Database development and wait list management requires involvement of multidisciplinary panels.

3. Systems for managing wait lists should:
   - provide accurate, reliable, timely, publicly accessible and real-time information in a cost-effective manner. Deadlines for inputting data should be reasonable and implemented without the use of threats or penalties;
   - collect and assess data on need, quality of life and health outcomes; be flexible and dynamic so that they can adapt over time with the development of new technologies and approaches to treatment; and
   - require policies and procedures on confidentiality, so that patients' and providers' privacy are protected.

C. Investment

1. Systems for managing wait lists require initial and sustained investment in dedicated human resources, sophisticated information systems and information technology infrastructure at all levels (e.g., medical offices, hospitals, health regions).

D. Accountability

1. The parties involved in managing wait lists must accept their responsibilities and obligations to each other and to the public.

2. Privacy and confidentiality of patient and provider information must be respected.

3. The systems, processes and results for managing wait lists should be widely communicated to obtain stakeholder involvement and support.

E. Evaluation

1. Systems for managing wait lists must:
   - be continually monitored and evaluated to identify opportunities for improvement; and
   - regularly undergo independent data audits and evaluations of process and outcome.

F. Governance

1. An independent, stakeholder-based, non-governmental organization with an advisory committee should be responsible for overseeing and administering systems for managing wait lists.