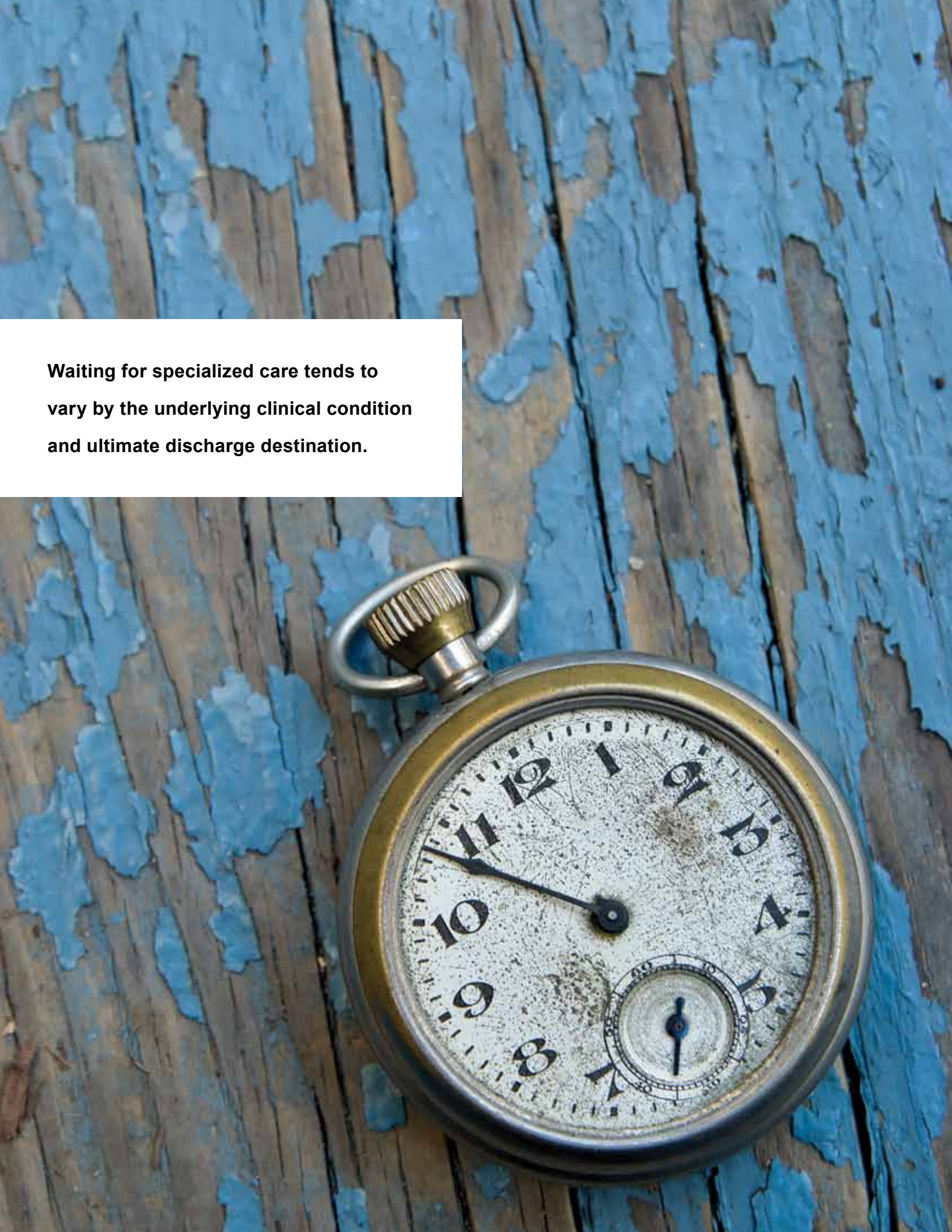
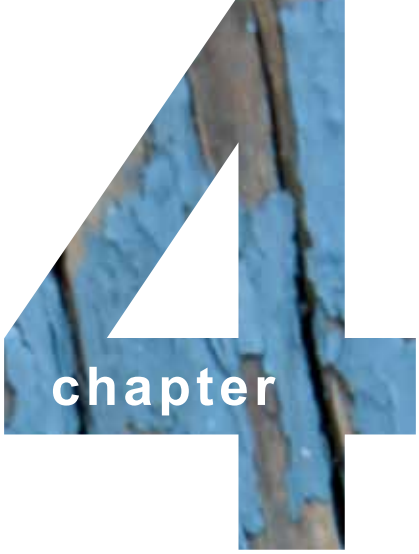


Waiting for specialized care tends to vary by the underlying clinical condition and ultimate discharge destination.



chapter 4

Waits for Specialized Care

To date, efforts to understand and measure waits in Canada have largely focused on acute care services. But the full health care continuum spans a much broader range of services. Many patients require care in specialized settings, such as rehabilitation, mental health care, home care, and residential care. This chapter explores what is known about waits for certain specialized care services, and highlights areas where information is still lacking.

Waits for Rehabilitation Services

Rehabilitation care includes a range of both hospital (inpatient and outpatient clinics) and community-based services (private clinics and home care) aimed at fostering independence among those who experience debilitating illness or injury.[1, 2] The shift in service delivery from hospitals to community-based providers in recent years was originally introduced to reduce pressure on hospitals. Indeed, today most rehabilitation takes place outside of the hospital setting.[3-5]

Hani's Story

In 2010–2011, 9% of the 50,000-plus knee replacement patients were subsequently admitted to inpatient rehabilitation. Due to his special circumstances (as noted in Chapter 3), Hani has been referred for inpatient care. He should not have to wait long; orthopedic patients wait approximately 1.5 days on average for admission to inpatient rehabilitation. Based on the median length of stay for orthopedic patients, Hani can expect to spend two weeks in the hospital receiving rehabilitation.

Wait times for rehabilitation in Canada are not well understood. Most published studies use wait list length as a proxy for wait times. Overall, the findings indicate that waiting for rehabilitation remains a challenge for Canadians.[6, 7]

Waits for Community-Based Rehabilitation Services

Timely access to community-based rehabilitation can reduce the number of emergency department visits, reduce the length of hospital stays and extend the time before residential care is needed.[8, 9] Waiting for access to rehabilitation can have several implications, including increased health care costs and increased prevalence of disability among those waiting, who may then require care in other settings.[6, 9] One Ontario study found that a typical patient waited 15 days for occupational therapy and 29 days for physical therapy.[3] Wait times for physical therapy in hospital outpatient departments were longer than for community care access centres, while waits for occupational therapy were similar in both settings.[3]

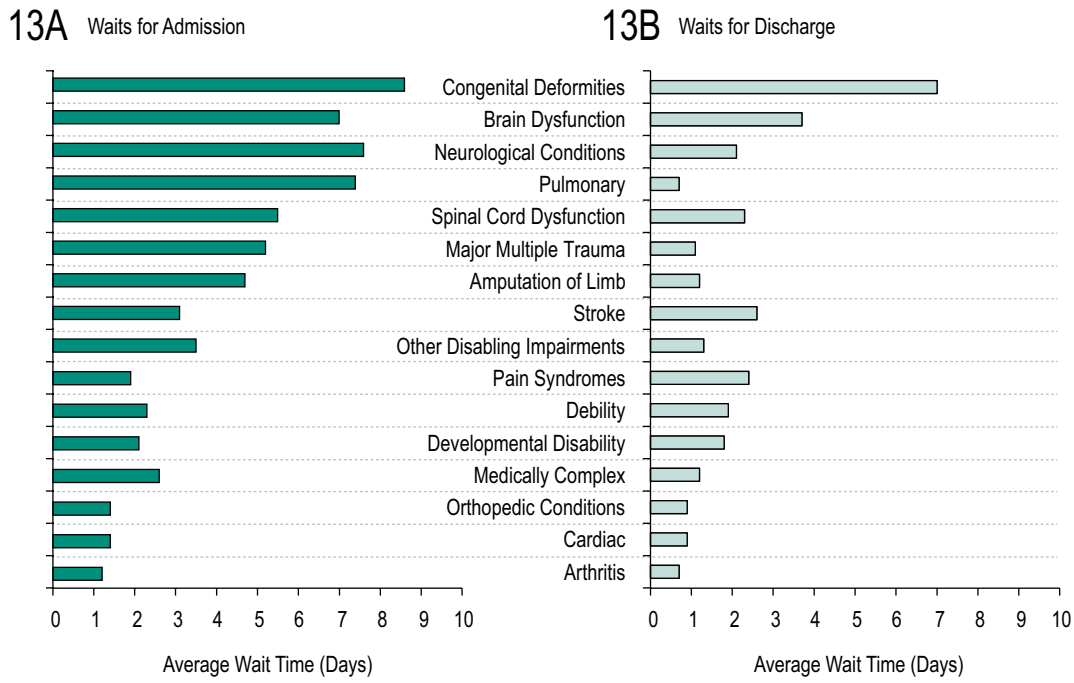
Several factors influence wait times for community-based rehabilitation, including hours of operation, the ability to pay for care, and geography. Access to publicly funded centres may be an issue, as most are not open on weekends or outside regular working hours.[9] Wait times have been shown to be shorter for privately funded practices, as well as for patients without chronic conditions.[6, 9] Wait times can be a bigger challenge in rural or remote settings than in urban areas because there are often few locations providing specialized rehabilitation care.[7]

Waits for Inpatient Rehabilitation Services

The average wait for admission to inpatient rehabilitation facilities is about three days. In 2010–2011, approximately 31% of patients in acute care settings who were discharged to inpatient rehabilitation had waited in the acute care setting for their rehabilitation to start. Data from CIHI's National Rehabilitation Reporting System (NRS) showed that in 2011–2012, more than 90% of rehabilitation patients were referred from acute care, while only 2% were referred from a private practice.

Despite the stability in overall waits, there is variation in wait times related to demographic and clinical factors. Factors such as a patient's clinical condition and age, the type of facility they are waiting for admission to, and where that facility is located all play a part in a patient's wait. Wait times for admission varied significantly by Rehabilitation Client Group in 2011–2012 (see Figure 13A), ranging from 1 day (Arthritis) to 9 days (Congenital Deformities). Reported wait times for admission to inpatient rehabilitation in 2011–2012 also varied by province, ranging from about 1 day in Alberta to 17 days in Nova Scotia.

Figure 13 (A and B): Average Number of Days Waiting for Admission and Discharge, by Rehabilitation Client Group, 2011–2012



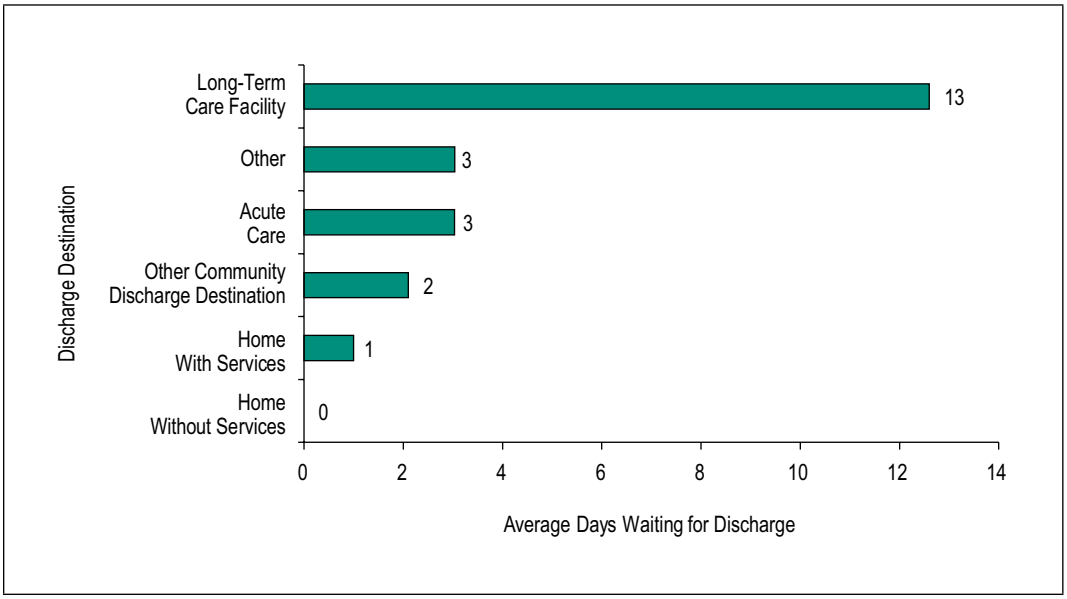
Notes
Includes clients discharged in 2011–2012 with complete discharge assessments.
Date Ready for Discharge was mandatory to record in the National Rehabilitation Reporting System only if a client's service goals had been met.
Please refer to *Inpatient Rehabilitation in Canada* at www.cihi.ca for specific details on the contents of each Rehabilitation Client Group.
Source
National Rehabilitation Reporting System, Canadian Institute for Health Information, 2011–2012.

Waiting to Leave Inpatient Rehabilitation

Some patients also experience waits when moving from rehabilitation to the next care setting. According to the NRS, on any given day about 8% of inpatient rehabilitation patients are waiting for discharge. These wait times have increased slightly over time, from about 1 day in 2006–2007 to just over 1.5 days in 2011–2012.

Patients requiring the most care after discharge (based on discharge destination and Rehabilitation Client Group) tended to wait the longest. Those who went home without any services waited less than 1 day, on average, while those transferring to residential care waited nearly 13 days (see Figure 14). Figure 13B shows the waits for discharge by Rehabilitation Client Group; patients with greater care needs (Brain Dysfunction, Stroke) tended to have the longest wait.

Figure 14: Average Number of Days Waiting for Discharge From Inpatient Rehabilitation Facilities, by Discharge Destination, 2011–2012



Notes
Includes clients discharged in 2011–2012 with complete discharge assessments; excludes those with unknown discharge destinations and those who died.
Date Ready for Discharge was mandatory to record in the National Rehabilitation Reporting System only if a client's service goals had been met.
"Other" includes discharge destinations such as boarding houses, assisted living facilities, shelters and public places.
Source
National Rehabilitation Reporting System, Canadian Institute for Health Information, 2011–2012.

Waits for Mental Health Services

It is estimated that about one in five Canadians, will experience mental illness in their lifetime.[10] The economic burden of mental illness on the Canadian health care system is significant and has been estimated at $51 billion among Canadians age 20 and older.[11]

Delays in treating mental illness can have several negative consequences, including deterioration in the patient's condition.[12] Yet long wait times for mental health services remains one of many challenges faced by individuals seeking help for their condition.[13] Lengthy wait times may also be a barrier to access, as the longer the time between initial contact and intake, the less likely the patient will persist in seeking treatment.[14]

Previous research has identified barriers to accessing mental health services at the system, community and individual levels. System-level factors may include

- Fragmentation in services;[13]
- Increased demand and shortage of health human resources;[15]
- A shortage of supportive housing;[16] and
- Difficulty in getting referrals to psychiatrists.[17]

Community-level barriers may include

- Geographic location;[14] and
- Societal perceptions of gender, socio-economic status and sexual orientation.[14]

Finally, individual-level barriers to seeking help and obtaining diagnosis/treatment may include

- Stigma;[10, 14]
- Tendency or preference to seek informal help;[14] and
- Previous experience with mental health care.[14]

In March 2006, the Canadian Psychiatric Association published a policy paper that included evidence-based benchmarks for patients with severe psychiatric illness.[18] Three general urgency levels were put forth: emergent, urgent and scheduled, as well as recommended benchmark wait times in accessing a family physician and access to a psychiatrist after being referred by a family physician.

Table 3: Recommended Wait Time Benchmarks in Accessing a Family Physician and Psychiatrist for Patients With Serious Psychiatric Illnesses, 2006

Recommended Wait Time Benchmarks			
Indication	Emergent	Urgent	Scheduled
Access to family practitioner			
Acute or urgent mental health concerns	As deemed appropriate after triage	Within 24 hours	Within 1 week
Access to psychiatrist after referral by family practitioner			
First episode psychosis	Within 24 hours	Within 1 week	Within 2 weeks
Mania	Within 24 hours	Within 1 week	Not generally applicable
Hypomania with previous diagnosis of mania	Not generally applicable	Within 2 weeks	Within 4 weeks
Post-partum mood disorder or psychosis	Within 24 hours	Within 1 week	Within 4 weeks
Major depression	Within 24 hours	Within 2 weeks	Within 4 weeks
Diagnostic and management consultation (includes consultation for child and geriatric conditions not otherwise stated above)	Within 24 hours	Within 2 weeks	Within 4 weeks

Source
Wait Time Benchmarks for Patients With Serious Psychiatric Illnesses, Canadian Psychiatric Association, March 2006.

Waits for Community-Based Mental Health Services

Most people with mental illness are treated in the community rather than in hospitals.[10] Yet there is no systematic collection of wait time information for community mental health services in Canada, and what does exist is somewhat disjointed. More specifically, there is wide variability in how wait times are calculated, which metrics are reported, what type of mental health service/support individuals are waiting for, and who is included in the wait time measure. The recently released Mental Health Strategy for Canada ("Changing Directions, Changing Lives") has recommended that standards be set for wait times for community mental health services, for people of all ages.[19]

Good information on waits for community mental health services is available for several provinces and regions:

- The Government of Nova Scotia's Wait Times website[20] includes public reporting of wait times for addiction services (for example, withdrawal management, structured treatment) for adolescents and adults. Median wait times for these services from January 1 to March 31, 2012, ranged from 0 to 6 days for withdrawal management, and 12 to 23 days for structured treatment.
- ConnexOntario, funded by the Ontario Ministry of Health and Long-Term Care, reports wait times for community mental health services.[21] Some of the median wait times for these ministry-funded services in 2011–2012 were 1 day (case management), 13 days (counselling and treatment) and 62 days (support within housing).
- Alberta Health Services has a series of provincial- and health region–level performance measure dashboards, which include information on the percentage of children younger than age 18 who received community mental health treatment (that is, a face-to-face scheduled assessment with a mental health therapist) within 30 days.[22] Third-quarter data for 2011–2012 showed that 83% of children were seen within 30 days.

Waits in Inpatient Mental Health Care

The capture of ALC data shows that many patients requiring inpatient mental health services experience waits for appropriate discharge at the end of their hospitalization. The ALC days are of concern because they contribute to the mismatching of patient need with appropriate level of care.[23] In 2009–2010, adult inpatients spent more than 2.2 million days being treated for mental illness in Canadian acute care hospitals; 23% of these days were spent in ALC. The most common discharge settings for mental health patients with at least one ALC day were continuing care (59%), home without services (16%) and home with services (14%). Those with personality disorders had the longest stays in ALC (median ALC length of stay at 25 days), followed by those treated for schizophrenic and psychotic disorders (24 days) and organic disorders, such as Alzheimer's disease and dementia (23 days).

In Ontario, more detailed data is collected for patients in designated mental health beds. Most of these patients have a diagnosis of mood disorder (for example, bipolar disorder and depression) or schizophrenia and other psychotic disorders, or have a substance-related disorder. In 2009–2010, ALC days represented approximately 4% of the total number of days among individuals in designated adult mental health beds in Ontario. Mental health stays for

all patients averaged 16 days, with half of them staying 9 days or less in hospital. However, for patients with ALC days reported, the average length of stay was approximately four times longer (66 days) than for those with no ALC days reported, and half of these patients stayed in hospital for 37 days or more. There is some evidence that patients with ALC days had more complex needs and challenges than those with no ALC days, such as higher scores on the Cognitive Performance Scale (13% versus 2% with severe or very severe cognitive impairment), the Self-Care Index (9% versus 4% having decreased ability to care for self) and Aggressive Behaviour Scale (7% versus 3% with severe aggression).

Waits for Residential Care and Home Care

As Canada's population ages, the demands for residential care and home care are likely to increase. Indeed, many people are waiting for such services today. Currently, more than 40% of ALC patients in acute care are waiting for residential care. One study has estimated that most (59%) of the ALC patients in inpatient rehabilitation are also waiting for residential care.[24] In Ontario, while waits for long-term care have stabilized over the past two years, the average applicant continues to wait almost four months (113 days) for placement.[25] In Nova Scotia, the average wait for a bed is approximately 154 days, with 68% of patients being placed within 6 months and 95% within a year.[26] Ontario data suggests that although 90% of home care patients receive their first visit within 7 to 9 days, there remains room for improvement.[25]

More information on the care needs of elderly Canadians waiting in hospital for placement in the community is available in CIHI's report *Seniors and Alternate Level of Care: Building on Our Knowledge*. Data from CIHI's Discharge Abstract Database, Home Care Reporting System and Continuing Care Reporting System was used to provide an in-depth look at transitions from acute care to the community for Canadians age 65 and older.

Key findings include the following:[27]

- More than half (54%) of seniors who waited in acute care were discharged to a residential care facility.
- Persons discharged from acute care to residential care account for more than 5 million ALC days in total. Some of these patients may be able to be cared for at home, with the right supports in place.
- Persons with symptoms of dementia, including challenging behaviours, were more likely than other seniors to have waited in acute care prior to residential care admission, suggesting that they were waiting for specialized services such as behavioural support.
- Clinical characteristics alone did not account as well for ALC days in those persons admitted to residential care. Persons with complex care needs without a strong support system were more likely than those with support to have waited in acute care before home care admission, suggesting that they were waiting for a caregiver to be available or for services to be put in place.

Strategies for Reducing Waits

Although knowledge of wait times in specialized care settings is in its infancy, there are a variety of strategies and pilot programs to learn from. Several examples are presented here:

Financial Incentives

- One of the new (2010–2011) funding incentives available to Nova Scotia family physicians participating in continuing care is the Long-Term Care Clinical Geriatric Assessment (CGA). This evidence-based clinical process allows for interdisciplinary input to best assess the health and care needs of nursing home residents. Physicians completing the CGA are eligible to bill for a CGA fee twice per fiscal year per resident. The information included in this assessment serves as the lead clinical document that travels with the resident when a transfer occurs (to the ED or to another facility) so that subsequent caregivers receive accurate clinical information about the resident. In addition to reducing the time taken to understand the patient's clinical state, this information will help enhance the quality of care received by the patient.[28]

Human Resource Policies

- One of the recommendations put forth in Changing Directions, Changing Lives, the mental health strategy for Canada, is to provide access to the right combination of services, treatments and supports, when and where people need them.[19] One suggested mechanism is to increase access to psychotherapies and clinical counselling by service providers who are qualified to deliver approaches based on best available evidence.[19]

Technology, Patient Flow

- Providence Healthcare in Toronto considerably reduced its number of ALC days through targeted efforts.[29] To improve patient flow (that is, rehabilitation patients waiting for long-term care), this rehabilitation facility used information services to collect, manage and report on ALC data on a weekly basis, giving a clear picture of the ALC process within the organization. Several new initiatives were implemented to improve patient flow, including discussing discharge planning soon after patients' admission, regularly communicating estimated discharge dates to patients and conducting "Rapid Rounds" to identify potential discharge challenges. Through these internal process changes, and coupled with building key relationships with upstream partner hospitals and downstream Community Care Access Centres, Providence Healthcare reduced the number of ALC patients on the wait list by approximately 35% between March 2010 and June 2011.[29]
- The former Chinook Health Region in Alberta had a clear vision for a regional health-care delivery model that was designed to closely match the needs of its specific catchment population. In 2003, the health region closed acute care beds and used the savings to strategically invest in supportive living facilities, which better suited the health care needs of its population. The result: improved management of acute care patient flow and a reduction in the percentage of ALC days, from 7% to less than 1% from 2006–2007 to 2010–2011.[30]

Conclusion

Waiting for specialized care tends to vary by the underlying clinical condition and ultimate discharge destination. Within rehabilitation, patients needing long-term care tend to wait the longest for discharge; these waits vary by clinical condition, with patients with greater care needs (such as brain dysfunction and stroke) experiencing the longest waits. Among mental health patients, those with personality disorders appear to wait the longest for discharge. The most common discharge setting for mental health patients collectively is continuing care.

At the time of the 2004 health accord, questions about how long patients waited for home care and other services (such as long-term care placements, inpatient mental health services and other types of care) could not be answered. Several years later, some progress has been made on this front, resulting in improved understanding of wait times in these care sectors. Information on waits for inpatient rehabilitation can be gleaned from administrative data, but gaining insight into community-based rehabilitation has not come as easily. Systematic data collection on waits for community-based mental health services is still lacking, although the recently released mental health strategy for Canada may serve to remedy the situation. Waits for home care and residential care are now better understood, through recent data expansion efforts in those areas. In the upcoming conclusion of this report, key areas for future focus are given consideration, to help inform those working to address these continuing wait time challenges.

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