On posting wait times: an alternate view

Howard Ovens, MD, FCFP(EM)*; Andrew Affleck, MD†; Eric Letovsky, MD‡

We read with both interest and concern the article by Yip and colleagues[1] and the accompanying commentary by Grafstein[2] on reporting of emergency department (ED) wait times and improving patient experience in the ED. The issues they discuss are timely and will likely be the subject of much further discussion and debate. Given the confusing use of terminology in the Yip and colleagues' article, we feel that precision in taxonomy can only help with clarity in the debate around wait times, and placing the reporting of said wait times in a wider context may help us direct our advocacy as a discipline on the issue of ED crowding to where it will be most effective.

Ontario launched its program to reduce ED crowding on April 1, 2008. Ontario requires hospitals to report a broad set of performance metrics monthly, with a selected subset of performance indicators available on a public website.[3] The program provides the 74 larger hospitals in the province with incentive funding to improve their ED performance and a coaching program to help with strategies. Ontario used the same resources to implement and supervise the ED program as they had used to implement the five federally funded programs established to reduce waiting in selected clinical services (hip and knee replacements, cataract surgery, computed tomography/magnetic resonance imaging, radiation oncology, and coronary bypass grafting).

Although ED performance in Ontario is not reported publicly for several months until data quality has been confirmed, many hospitals use their ED Information Systems (EDIS) to capture all or most of their reportable metrics and follow their own performance closely. As Yip and colleagues report in their article, the London Health Sciences Centre (LHSC) chose to post its performance on its hospital website and update it daily with the previous day's performance.[1,4] Yip and colleagues sought to survey a group of patients at one of the hospitals' EDs to see if they were aware of this information and asked them if "given the chance" they would use this information in making a decision about coming to the ED or which ED to go to.

One of the problems in the Yip and colleagues survey and article is the use of the term "wait time."[1] The website they refer to published *length of stay* (LOS) information—the time from arrival at the ED to disposition from the ED to either home or an inpatient unit. Reporting total LOS is an important performance metric but is not the same as a "wait time." Most patients would interpret "wait times" as the time from arrival until they see a doctor (time from arrival to physician initial assessment or time to PIA). US hospitals that report "waiting" times generally also refer to this interval. Ontario collects time to PIA data ("wait times") but does not report it publicly at present. Furthermore, in the Yip and colleagues report, only 9% of respondents were aware of the LHSC website, so the large majority would not have had first-hand knowledge of the information available. The actual question in the survey, "If you were given a chance to see *the ED wait time statistics* before coming, would you base your decision on ED location on the data you saw on the website? [emphasis ours]" is misleading. Although 45% of respondents said "yes," few would have understood from the question that the

From the *Department of Family and Community Medicine, University of Toronto; Toronto Central Local Health Integration Network; and Schwartz/Reisman Emergency Centre, Mount Sinai Hospital, Toronto, ON; †Thunder Bay Regional Health Sciences Centre and North West Local Health Integration Network, Thunder Bay, ON; and ‡Department of Emergency Medicine, Credit Valley Hospital, Mississauga, ON; Department of Family and Community Medicine, University of Toronto, Toronto, ON; and Mississauga Halton Local Health Integration Network, Oakville, ON.

Correspondence to: Dr. Howard Ovens, Schwartz/Reisman Emergency Centre, Mount Sinai Hospital, Toronto; howard.ovens@utoronto.ca.

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data provided are LOS data that would at best be loosely associated with time to PIA.

It is equally puzzling that the authors felt patients should base their decisions on the previous day's performance report. They offer no data on how predictive the previous day's data were for the current day's performance. All EDs experience variations in performance related to time of day and day of the week. In predicting future experience with respect to waiting, an average of the previous day's 24-hour performance on LOS is likely to be of limited value

Grafstein does point out the difference between wait time and LOS and between reporting actual performance versus estimating current real-time waiting.[2] He further points out that the practice of reporting current waiting arose in the United States as a marketing tool by private hospitals promising rapid access rather than as a quality initiative. He points out some of the potential drawbacks of estimating wait times publicly only to dismiss them later.

A summary of the conclusions expressed or implied by Yip and colleagues and Grafstein could be summarized as follows:

- Overcrowding is the current situation in most urban EDs and will persist for the forseeable future.
- Estimates of waiting (or LOS) based on either real-time or historical information are accurate enough for patients to base decisions on them.
- Valid current wait time data might allow patients to adjust their behaviour (i.e., selection of an ED for care).
- The financial cost of providing this information is justified by the outcome but needs further study.
- The risk of harm from such public behavioural change is manageable.

The issues raised above have been discussed in Ontario as a matter of public policy by the Local Health Integration Network (LHIN) leads for emergency medicine. This group of 14 emergency physicians appointed by government acts as an advisor on policy issues related to emergency services in each of the 14 regional health authorities. Overall, we take exception to the above (summarized) viewpoints.

The experience in Ontario is that ED crowding can be alleviated and waiting reduced. Since the inception of the Ontario program, overall LOS in our EDs has declined by 15% (all data compare June 2012 performance to April 2008 performance). The median time to PIA is now about 1 hour; we have reduced the time to PIA by about 13% at the 90th percentile, and as a result of these improvements, left without being seen rates have declined by 30%. (Data in this paragraph were provided in a personal communication with Cathy Cattaruzza, Cancer Care Ontario, Access to Care, August 29, 2012). In general, the worst performing hospitals have had the biggest improvements. Although there is still considerable room for improvement, experience in Ontario and the United Kingdom suggests that a positive attitude and approach to addressing ED crowding are justified.

Estimating individual experience with respect to waiting is difficult even for experienced triage nurses. Algorithms to predict wait times contain assumptions (for instance, the Alberta Health Services website[5] applies to Canadian Triage and Acuity Scale [CTAS] 3, 4, or 5 patients, whereas St. Mary's Hospital[6] in Ontario has developed an algorithm for CTAS 4 and 5 patients only) that may be difficult for patients to understand. With no published data, it is not clear how well these algorithms perform. Given the dynamic nature of emergency arrivals and the complex factors that contribute to flow, it is inevitable that many patients will experience waiting beyond what is predicted.

Providing real-time estimates of waiting suggests that patients can and should use it to decide which ED to go to and when (as noted by Yip and colleagues, this approach would do nothing for patients in smaller communities that have only one ED[1]). We all know when our EDs are busiest. We could simply put a notice on our website saying, "For fastest service, come between 2 am and 10 am." Even better, any ED can—and should—analyze its data and bottlenecks and adjust staffing to meet the predictable variations in patient arrivals. This is one of the most basic strategies any business consultant would suggest to an ED and is stressed in the Ontario coaching program. If we are trying to give better service to our customers, should we not adapt to their needs rather than asking them to come when it is convenient for us?

The Ontario ED crowding program provides approximately $90 million of support annually to 74 hospitals. Spending hundreds of thousands of dollars on a wait time algorithm and website and/or an advertising campaign to get the public to use the information is not trivial. In a time of limited resources, we question the judgment of calling for expenditures on IT algorithms

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and advertising compared to direct spending in EDs to improve service and reduce waiting.

Grafstein is probably correct: few patients would come to harm because of a delay in seeking care caused by information gleaned from a wait time website.[2] However, he does not address explicitly how much risk is justified by the potential benefits of reporting estimated wait times. We do not think that any potential harm due to unnecessary delay in seeking care is justifiable to provide some information of questionable value to nonurgent patients.

Implicit in the provision of estimated wait times to the public is the idea that patients—specifically nonurgent patients—are responsible for ED crowding, that governments and hospitals are not to blame and cannot be expected to do much about it. This contradicts the Canadian Association of Emergency Physicians position on overcrowding,[7] validated by the experience in both the United Kingdom and now in Ontario, that crowding is not due to misuse of EDs by stable, nonurgent patients. We need to stop blaming patients, start looking closely at our practices, and hold decision makers accountable for addressing this critical system-wide issue.

We support accountability and transparency in ED performance. Reporting should be standardized nationally using common definitions and terms that the public can understand. We should publish our performance, using the timeliest data possible, and compare it to that of our peers and other jurisdictions. Report cards should be issued nationally. We need to educate the public on how to choose an ED for their circumstance while explaining the alternatives available in their community. We should also expect governments to be accountable; funding for ED crowding should demonstrate benefits in improved quality and experience while reducing wait times. We do not believe it is progress to use fashionable technology to estimate and report wait times and shift the responsibility for our inefficiency on an unsuspecting public.

Keywords: emergency department administration, emergency department overcrowding, wait times

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