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CANADIAN CONSENSUS ON MEDICALLY ACCEPTABLE WAIT-TIMES TARGETS: 24 RECOMMENDATIONS

A 2002-2003 Statistics Canada survey reported that the top health concern for 32% of Canadians was health care waiting lists and wait-times. Three years later, the majority of specialties, including gastroenterology, continue to lag behind in the pressing need for the benchmarking and standardized reporting systems required to begin to address this concern. The Canadian Association of Gastroenterology (CAG) has proactively begun to remedy this situation by implementing a representative multidisciplinary committee which has reached consensus on twenty-four fundamental recommendations for the advancement of gastroenterology care in Canada.

The Canadian Association of Gastroenterology released today the result of the *Gastroenterology Wait Times Program* (see other Fact Sheet) and 24 recommendations taken from *Canadian Consensus on Medically-Acceptable Wait Times for Digestive Health Care*. These 24 recommendations should be considered as targets. They have been developed by a multidisciplinary group of 25 voting participants representing national and regional gastroenterology associations, general surgery, internal medicine and family practice and are based on public input and extensive literature review.

Medically Acceptable Wait Times	Actual Wait Times
Patients referred with documented iron deficiency anemia should be seen, and if indicated, endoscoped within 2 months	2 out of 4 referred wait nearly three months; 1 out of 4 wait more than 5 months
Patients referred with one or more positive fecal occult blood tests should be seen and, if indicated, endoscoped within 2 months	2 out of 4 wait more than 2.5 months; 1 in 4 waits more than five months
Patients referred with poorly controlled reflux symptoms or other dyspepsia, but no alarm symptoms, should be seen, and if indicated, endoscoped within 2 months	2 out of 4 wait more than 5 months; 1 in 4 waits more than 9 months
Patients referred with dyspepsia and associated alarm symptoms (e.g. vomiting, weight loss, gastrointestinal blood loss) should be seen, and if indicated, endoscoped within 2 months	2 out of 4 wait 2.5 months; 1 in 4 waits 5 months
Patients referred with unexplained chronic diarrhea or chronic constipation should be seen, and if indicated, endoscoped within 2 months	2 out of 4 wait 5 months; 1 in 4 waits 11 months
Patients referred with clinical features highly suggestive of significant active inflammatory bowel disease should be seen, and if indicated, endoscoped within 2 weeks	2 out of 4 wait 4 months; 1 in 4 waits 7 months

ADDITIONAL RECOMMENDATIONS:

1. Patients referred with acute gastrointestinal bleeding should be seen, and if indicated, endoscoped within 24 hours.
2. Patients referred with bright red rectal bleeding should be seen, and if indicated, endoscoped within 2 months.

3. Patients referred because of a high likelihood of cancer based on imaging or physical exam should be seen, and if indicated, endoscoped within 2 weeks.
4. Patients with chronic gastroesophageal reflux disease referred for screening upper endoscopy should be seen, and if indicated, endoscoped within 6 months.
5. Patients referred for screening colonoscopy should be seen, and if indicated, endoscoped within 6 months.
6. Patients referred with clinical features of ascending cholangitis should be seen, and if indicated, have Endoscopic Retrograde Cholangiopancreatography (ERCP) performed within 24 hours.
7. Patients referred with acute severe pancreatitis should be seen within 24 hours, and if indicated, have ERCP performed within 72 hours.
8. Patients referred with severe decompensated liver disease should be seen within 24 hours.
9. Patients referred with acute severe hepatitis should be assessed within 24 hours.
10. Patients referred with painless, obstructive acute jaundice should be seen within 2 weeks.
11. Patients referred with chronic viral hepatitis should be seen within 2 months.
12. Patients referred because of persistent (more than 6 months) unexplained abnormal liver enzyme tests should be seen within 6 months.

13. Patients referred with esophageal food bolus or foreign body obstruction should be seen and endoscoped within 24 hours.
14. Patients referred with dysphagia and/or odynophagia which is severe or rapidly progressing should be seen, and if indicated, endoscoped within 2 weeks.
15. Patients referred with stable dysphagia which is not severe should be seen, and if indicated, endoscoped within 2 months.
16. Patients referred with new onset change in bowel habit should be seen, and if indicated, colonoscoped within 2 months.
17. Patients referred with chronic unexplained abdominal pain should be seen within 2 months.
18. Patients referred for confirmation of a diagnosis of Celiac disease (antibody testing positive) should be seen, and if indicated, endoscoped within 2 months.