Stakeholder Engagement: Thoughts from a Clinician

Michael Marcaccio

I became involved in the WTIS project very early on when I was asked to consider becoming a member of the Wait Time Information Management Expert Panel. As I explored and came to understand the intent and dimensions of this project, I saw enormous potential for starting to develop solutions to chronic problems I had been encountering.

As Chief of a large Department of Surgery, I had long struggled with problems related to access to care, resource distribution and management. While these issues span the entire spectrum of surgical care, there was no doubt that at the time, the dominant focus was on what has now become known as "Wait 2," the wait from the time that the surgeon and patient decide that an operation will be part of the patient's care to the date that the operation takes place. In trying to manage these issues, I was often frustrated by the lack of any usable data. With few exceptions, the only data available was anecdotal and generated without any standardization. Thus, beyond ensuring that every member of staff had some operating room (OR) block time in order to survive in practice, we were mostly unable to identify resource requirements that would truly address access to care issues.

In my own personal surgical practice, I knew that I was making allocation decisions with respect to my assigned OR block time without any framework to guide me. I was also aware that a few of my colleagues took a simple first-come-first-served approach to assigning their block time to patients, while many others were making allocations based on their personal assess-ment of a patient's need. My experience led me to understand that there was wide variability in how prioritization decisions were made, raising questions of fairness of access for patients. When I knew that a patient I had seen would have a prohibitive wait, I had no knowledge of whether there was another option within the surgical care system that could offer my patient a more reasonable wait.

Another issue that I grappled with was effective communi-cation with our department members. I was surprised at the number of surgeons not using electronic communication, and this presented a real challenge in a department the size of ours. It also limited the ability to move forward with our hospital IT strategy. Therefore, I saw the WTIS as a potential stimulus to move the IT agenda forward, which I believe is an important evolutionary step in healthcare.

As department chief at an academic health sciences centre, I also had a unique experience with using a data-driven model. Our hospital was a member of the Cardiac Care Network, and I was very familiar with their data management system, the use of clinical data to drive system-level decisions, and the success of the process whereby good data demonstrating significant need led to major resource allocations. It was a long-standing point of contention within our department that there seemed to be a two-tier level of care, that is, the cardiac surgeons had continu-ously growing, specifically protected resources, while the rest of the department relied on expanding resources from global

funding allocations, for which there were a seemingly unlimited number of competing priorities. I had always pointed out to the department that the cardiac allocation system was based on the excellent data about patient need and access issues, and lamented that if only the rest of us had such a system we could more fairly compete in the resource allocation arena.

Thus, it was an easy decision for me to become involved in the WTIS project and, as I came to understand the methodology, to be a champion for its implementation and adoption. As I began these activities, I was not surprised at the level of initial resistance from clinicians. Having had reasonable experience with change-management initiatives, I was aware that any change would meet with some resistance, and this seemed somewhat more common in surgery than in other areas. Predictably, many of the barriers could be anticipated and good solutions found, as they were common to other change initiatives within surgery. These issues included impact on the administrative workload for surgeons and their staff, cost, general distrust of administrative and government initiatives and concern about loss of autonomy. It was clear that a key determinant of success would be the ability to manage these issues in a direct and tangible way. Another predictable occurrence was that as one problem was solved, new ones would be put on the table. Thus the change-management strategy had to be a continuously evolving process. However, there also had to be limits in place so that the project could actually move forward and not become paralyzed by the continuous generation of new barriers.

Several factors were key to the ultimate success of the WTIS project. Incorporating feedback while setting finite deadlines for implementation provided a good balance between consultation and action. A particularly important example would be the ultimate decision to extend the system to all surgical care. The initial phase of the project was targeted to five areas of high priority for the government. However, front-line surgeons made it very clear that they did not support a strategy that further propagated their perception of two-tier care within surgery, creating a "have and have not" environment. This feedback was incorporated into the strategy and became valuable leverage with surgeons when the time came to expand the system.

Another critical success factor was the ability to demonstrate that the availability of useful information about the wait for surgery led directly to improved access to care. From a healthcare system point of view, it was important that this improved access was driven through an array of methods and not simply from adding new fiscal resources, not the least of which was the improvement in wait times that came from implementation of the WTIS. This included the use of standardized definitions, the elimination of duplication where patients were waiting on multiple lists, and elimination of waiting periods that were not caused by the availability of resources, but rather by patient and practitioner preferences. There is no question that lever-

aging incremental funding to ensure adoption of the system was important, although this alone would not have led to success without some of the other elements.

I personally believe that another important part of this strategy was the decision of the Clinical Expert Panels to utilize priority assessment tools that require clinician judgment in the priority decision for each patient. This addresses one of the important issues of physician autonomy, as well as being key to a prioritization method that does not require massive data input and, therefore, an unacceptable workload.

Additionally, recognizing that some of the data capture process was purely administrative, and focusing educational efforts on surgeons' assistants – who are a key part of the process, proved an important step in adoption and in ensuring data integrity. Consideration of these issues is very important, as clinicians are rightfully concerned that the time they have for direct patient care is continuously declining.

As noted previously, surgeons require a range of communication and education strategies in order to make adoption successful. Thus, a comprehensive change-management strategy, offering an array of options, is critical to successful implementation as demonstrated in this project. While some resistance to the adoption and use of the system remains, perceptions are changing among clinicians. We have found that by presenting surgeons with some of the data the WTIS generates, they become more interested in the system because they see potential uses for the data. Since they do inherently want to provide better care for their patients, they will see value in the data when it is presented to them, and this in turn will enhance their support for the system.

Having accomplished a successful implementation, we need to ensure that the system continues to evolve and, as we move forward, that we continue to address surgeon concerns in a meaningful way. In particular, strategies that seek to minimize or reduce the administrative workload confronting clinicians will be important. Incorporating the WTIS into an electronic OR booking process is an example of where this can be achieved.

There is also the danger that the focus on new healthcare system wait time issues, such as the new Alternate Level of Care and Emergency Department projects, and political pressures might divert interest and resources from the surgery projects, negatively impacting clinician engagement and diminishing the commitment to moving forward. It will, therefore, be critical to demonstrate the ongoing value of the WTIS and the ability to capitalize on potential opportunities that the system offers for the future.

About the Author

Dr. Michael Marcaccio is a Professor of Surgery at McMaster University and recently concluded a 15-year term as Chief of Surgery at Hamilton Health Sciences. He is a member of the Wait Time Information System Expert Panel and Provincial Champion for the implementation of the WTIS.