Clinical Engagement for Performance Improvements

Jonathan Irish

It is important to understand the background behind the wait times process and the context in which implementation of the process occurred. In 2003–2004, the issue of access to care for cancer patients was significant. This was appreciated by "front-line" surgeons and supported by the fact that patients were increasingly complaining about wait times for cancer surgery, as well as for other surgical procedures, such as joint replacement and cataract surgery. Political pressure intensified when local media reported on patient frustration with lengthening surgical wait times and patients increasingly sought surgical treatment outside Ontario because they could not get timely care in the province. As the head of surgical oncology at the University Health Network and Mount Sinai Hospital, I determined that this was one of the most significant challenges we faced. However, when approached by media, administration and by Ministry officials for more details and analysis on these issues, I was unable to provide accurate data on how long patients were waiting for cancer surgery or to provide evidence-based standards on acceptable wait time targets.

It was at this point that three surgical groups in the province (University Health Network, Mount Sinai and Kingston General) started to collect wait time data manually. This data collection was not "real-time" and not related to performance targets. However, it provided a valuable initial environmental scan of how long patients were waiting for surgery. It also gave those surgical departments ammunition to advocate for more resources to provide surgical services. The data was also used to advise the Ministry of Health and Long-Term Care of concerns about increasing waits for services at a time when national and provincial attention was focused on addressing long-standing dissatisfaction about surgical wait times. Particular areas of concern included cancer surgery, joint (hip and knee) replacement, cataract surgery and cardiac care.

> **"Despite wait time** data reporting, there is still work to be done to improve wait list management at a regional, hospital and surgeon level. This is challenging, because on one hand it requires ensuring that operative resources at the regional or hospital level are matched to the demand for cancer surgery care, while on the other hand within a hospital unit it may require moving patients from one surgeon to another with a shorter waiting list."

A turnaround would require success in three main areas:

1. Establishing acceptable wait time targets guided by the best evidence and validated by expert opinion;

2. Creating a wait time information system that would allow near real-time reporting; and
3. Engaging the clinical community to ensure successful implementation of new processes and sustaining those processes.

Clinical Expert Panels (CEPs) were essential to developing acceptable targets for access to care. In the case of cancer, the length of time that a patient can wait safely for surgery is not known. Where evidence exists, it is based on retrospective data, and there will probably never be high-level evidence from a prospective trial to inform experts on acceptable wait times for cancer treatment. For that reason, it is unlikely we will ever have evidence-driven guidelines in this area. However, there is sufficient evidence to support general targets to determine a reasonable wait time. In other words, the process had to be guided by evidence but driven by common sense and validated by expert opinion, and the CEPs were able to do just that. In addition, wait time targets were compared to other jurisdictions' (e.g., the United Kingdom, Saskatchewan) to ensure that the targets were coherent with other "best practices."

Implementing the Wait Time Information System (WTIS) and ensuring that the new processes to capture and report on wait times could be sustained over time required engagement of the clinical community. "Top down" change rarely works, as it does not always engage the critical opinion leaders and definitely does not engage the "rank and file" community surgeon providing care to the cancer patient. Engaging clinicians early via the CEPs in the development of wait time guidelines and targets was important in establishing credibility for the process and in gaining buy-in from "communities of practice." Implementation was initially led by opinion leaders (such as major cancer hospitals and major cancer surgery leaders) and later the "herd effect" kicked in, as those who were not initially willing felt compelled to participate. The fact that the results of the process were transparent and wait times were publicly available also contributed to implementation. Some hospitals in the later stages of implementation systematically introduced wait time data entry as a regular part of the OR booking process. This "normalized" the wait time collection process and also helped improve participation.

The WTIS is now well-established and allowing near real-time tracking of wait times across most of the cancer surgery system. The access to care standards have been accepted, and most surgeons are aware of the recommended wait time targets for different priority levels of cancer patients. The process is now well into the phase of wait time management and performance improvement. Despite wait time data reporting, there is still work to be done to improve wait list management at a regional, hospital and surgeon level. This is challenging, because on one hand, it requires ensuring that operative resources at the regional or hospital level are matched to the demand for cancer surgery care, while on the other hand, within a hospital unit it may require moving patients from one surgeon to another with a shorter waiting list. This will necessitate increased engagement at the surgeon level by surgical leaders, administrators and system managers. Regardless, the steps made in this program are enormous, given that a few years ago we had no wait time data or targets to guide access to care activities for patients requiring cancer care. For this reason, I believe that the most important legacies of the entire initiative have been the establishment of a robust wait time data collection system combined with accepted standards of wait time definitions and accepted maximum target wait times.

> **"I believe that** the two most important legacies of the entire process have been the establishment of a robust wait time data collection system combined with accepted standards of wait time definitions and accepted maximum target wait times."

Surgery (e.g., biopsy, endoscopy) is the major entry point into the cancer system for most patients and is still the mainstay of cancer care for most malignancies. It is, therefore, essential that access to care be preserved and that access to care targets be adhered to. The availability of wait time information to all stakeholders (patients, surgeons, hospital and system administrators and government) will ensure that surgical services are maintained rather than eroded. As time goes on, I am even more convinced that this initiative is a major step forward in healthcare in the province. As budgets tighten, we will see the true test of the WTIS and the incremental volume funding process in supporting the mandate to improve access to surgical care for the patients of Ontario.

About the Author

Jonathan Irish is the Chief of the Department of Surgical Oncology at the University Health Network and Mount Sinai Hospital. He was the Lead for Access to Care and Strategic Funding within the Surgical Oncology Program at Cancer Care Ontario (CCO) and is now the Provincial Head for Surgical Oncology at CCO.