Cancer Surgery Wait Times Symposium: Timely Access to Quality Care

February 29, 2008

SYMPOSIUM REPORT
Executive Summary

In February 2008, the Surgical Oncology Program (SOP) hosted the Cancer Surgery Wait Times Symposium, which brought nearly 120 people from across the province together to share regional initiatives, and to facilitate positive dialogue to further inform and add value to the Wait Times Strategy.

The agenda included presentations by leaders in Surgical Oncology, followed by an expert panel discussion and audience participation including the use of “point and click” technology which allowed for real-time display of survey results. The event was an excellent opportunity to share regional initiatives to foster a significant and lasting improvement in not only the access, but quality of cancer surgery in Ontario.

In this forum, a variety of benefits derived solely from the availability of wait times data were discussed. They include:

- The development of Surgical Oncology as an entity within the surgical realm
- Ontario becoming a world leader in health care information systems
- Using data to manage the entire system has enabled clinicians and managers to understand system-wide bottlenecks and pinpoint resource investments that will impact waits (need for additional pathologists, nursing staff, etc.)
- A culture shift towards performance management
- Provides a catalyst for quality improvement initiatives as funds facilitate implementation of accepted quality improvement guidelines and standards (eg. Multidisciplinary Cancer Conference Standards, Thoracic Surgery Standards, Prostate Surgery Guidelines)

There are opportunities to further evolve and improve the Wait Times Strategy and decrease patient wait times in Ontario. Some points included:

- Use of technology to minimize the administrative workload (eg. “Surgical Booking eForm”)
- Ongoing education to ensure it is being used properly. This will improve the data that are reported and build clinician confidence in its use. Identifying data quality issues and following up with direct interaction with the user to understand the problem and to provide direct corrective action. It was identified that usually any difficulties that have arisen have been corrected with minimal education.
- It is meaningful to clinicians and patients to collect data on the entire patient journey and that time points from first referral from primary care to the surgeon until completion of surgical treatment would provide the most meaningful description of the true wait for surgical care.
- Identify process improvements or efficiencies that optimize the use of human resources and share these practices between regions. For example, the role of nurse practitioners and family health teams in patient follow-up care when appropriate. This may provide additional time for surgeons to see new patients.

Moving forward, it is clear that there are a number of strategies that will continue and may be expanded upon. These include:

- Incremental surgery volume funding can lead to quality improvements and the CCO Surgical Oncology Program (SOP) should continue to emphasize the link between access and quality.
- The continued engagement of surgeons and administrators in both the planning and feedback of initiatives is imperative to the success of the access and quality improvement agenda.
- We need to continually evolve the processes with regards to innovative approaches to hospital collaboration and we also need to build sustainability across the system.
- The linkage of access to care and quality care needs to be emphasized and strengthened, regardless of the hospital providing the service. Though it may make sense for certain types of procedures, moving all cancer surgeries to larger centres is not the answer nor is it realistic.

Strong leadership and stakeholder engagement are key facets of the strategy. The Symposium was a successful contribution to the ongoing evolution of the Wait Times Strategy.
The Cancer Surgery Wait Times initiative has funded over 12,000 incremental cancer surgery operations over the last four years. Although most Cancer Surgery Agreement (CSA) hospitals have attained a 90% level of performance with regards to the number of cancer surgeries completed, a modest reduction in waiting times has occurred. It is clear that addressing fundamental system changes are necessary to produce a significant and a long lasting improvement in access to surgical care.

Moving into the next phase of the program, CCO’s Surgical Oncology Program felt it was an appropriate time to bring together people who have an important stake in the Wait Times Strategy to share their experience, data, and feedback in order to improve upon the current system and develop future strategies.

Participants of the symposium included but were not limited to surgeons, administrators, regional vice presidents, operating room staff, and wait times coordinators who discussed current opportunities and challenges with the Wait Times Information System (WTIS) and learned about system and process changes that have been implemented by regions, hospitals and programs across the province.

The Surgical Oncology Program and Cancer Care Ontario would like to thank the many individuals and organizations that contributed to the Symposium. We would like to thank the speakers and panelists for their knowledge and expertise in the Wait Times Strategy. Their efforts contributed to a candid dialogue that shared common practices and ideas to foster the evolution of the Wait Times Strategy.

Overall, the Symposium provided further support for the mission of the Cancer Care Ontario Surgical Oncology Program which is to improve access to quality care for the patients of the Province of Ontario.

Sincerely,

Dr. Jonathan Irish
Provincial Head,
Surgical Oncology Program
Cancer Care Ontario

Dr Robin McLeod
Lead, Quality Improvement & Knowledge Transfer
Surgical Oncology Program
Cancer Care Ontario
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Dr. Terry Sullivan  
*Welcoming Remarks and Objectives*

Cancer surgery is an integral part of cancer services. In just a short period of time, there has been a tremendous improvement in cancer surgery waiting times yet some regions and disease sites have room for improvement. This forum provides participants an opportunity to reflect upon accomplishments and drive the bar higher in access to cancer surgery in the province of Ontario.

Dr. Sullivan highlighted the goals of the symposium, which were to: facilitate leadership engagement, share regional experiences, and discuss and reflect upon how we can improve data quality and process improvements learned over the short duration of the Wait Times strategy.

Dr. Alan Hudson  
*Overall Ontario Wait Time Strategy*

Dr. Hudson began his presentation by offering congratulatory remarks to the audience of regional leaders in cancer surgery. He reminded participants that only three to five years ago, surgical oncology did not exist as an entity in Ontario. Ontario is rapidly becoming a world leader in performance measurement and system management, and with the great leadership present at the symposium, participants will be improving the way for cancer surgery is delivered in Ontario. With the use of technology to measure results and set performance targets, a large-scale shift in the culture of health care has begun. Though it may be threatening to many health professionals, leadership on our part is defining what our professions (surgery, medicine, and nursing) will look like in the future.

Cancer Care Ontario (CCO) has led the provincial Wait Times Information Strategy (WTIS) under the strong leadership of Sarah Kramer. As a result, wait times data are both good and steadily improving. Priority-level data will be reported publicly in the near future. Currently the priority 4 target data looks sufficient; however, meeting the target levels for priority 2 and 3 surgeries may not be as good. Though this may cause controversy, it will encourage the system to further improve.

The provincial Wait Times Strategy has been very successful in all areas with the exception of the MRI wait times strategy which may need to be modified. WTIS is being implemented in many more surgical areas over the next few years, including general surgery.

There are other Ministry initiatives that influence cancer surgery and services, such as: Emergency Department wait times, Alternate Level of Care (ALC) access, primary care access and chronic disease management (CDM). Each initiative may pose its own challenge and like surgical oncology, these initiatives do not have baseline data. Data will be imperative, particularly in primary care to support system change and management.

Dr. Jonathan Irish  
*Where have we been? Where are we going?*

Dr. Irish provided participants with a brief history of the wait times initiative in Ontario by examining the changes that have occurred over the past four years. In 2002/2003, the wait times for cancer-related surgeries were lengthy and posed a significant issue to patient care. Since then, cancer surgery in Ontario has moved away from a compartmentalized system without targets on wait times and definitions of cancer surgery procedures, a system where there are accepted definitions of wait times, standardized benchmarks, knowledge of cancer surgery activity, wait lists, and a clear link to quality of surgery.

The recommendations on wait times were established to understand and develop consensus on these definitions and to ensure the targets were feasible. The process involved an expert panel of academic and community surgeons, and administrators, who reviewed the data from a systematic review of the literature then recommendations were vetted by an external review process.
The WTIS provides healthcare professionals with near real-time data on wait times; whereas, in previous years the data available for analyses were more than two years old. WTIS currently measures one component of the patient journey from ‘decision to treat’ to the ‘date of operation’, and this will be built upon in the future.

Upon examination of cancer surgery wait times data, results are better in both the median and 90th percentile targets. There is little variation between regions; however, seasonal variation is present especially during the summer, where waiting times can increase due to the closure of operating rooms. Some disease sites have seen a significant improvement in wait times.

The Access to Care agenda has been a catalyst for quality improvement, and a stronger relationship between both agendas should be encouraged.

Dr. Robin McLeod  
**Linking Quality to Access to Care**

The goal of Cancer Care Ontario’s Surgical Oncology Program (SOP) is to “continue to strengthen access to quality care”. The SOP:

a) Uses data, surveys, and evidence to identify a quality issue  
b) Develops standards or guidelines to address the issue by partnering with the Program in Evidence-Based Care (PEBC)  
c) Initiates knowledge transfer strategies, such as: encouraging development of communities of practice, audit & feedback, and opinion leaders  
d) Evaluates results by collecting indicator data (CSQI, mail outs, etc.)

Several quality improvement initiatives were highlighted, such as: multidisciplinary cancer conferences (MCCs) and breast sentinel node biopsy. With the breast sentinel node biopsy quality initiative, knowledge translation strategies, such as: education, toolkits, opinion leaders, and highlighting partnerships between community hospitals and regional centres, have been used. Furthermore, by guiding the regionalization of complex care, thoracic and pancreatic surgery standards have had a direct impact on patient welfare in Ontario.

All quality improvement initiatives occur locally and the participation of practicing surgeons in planning and managing change is essential. CCO provides the leadership, coordination, and support to the local surgeons to support these best practices.

**Discussion Highlights:**

- The leadership of surgeons has been pivotal in driving both access and quality improvement initiatives. For example, regional surgical oncology leaders have just ‘got on with’ implementing WTIS by using data. In addition, thoracic surgeons have been instrumental in moving the thoracic cancer surgery standards into practice.
- There was strong agreement that MCCs require input, drive, and participation from all disciplines, to succeed in implementation.
- The linkage between access to care funding and quality improvement initiatives is evolving.
- Patients should receive high quality care regardless of where they live. Regionalization of cancer surgery to large centres is not always the answer nor is it realistic for all surgeries.
- WTIS data has been a tool to:
  - Examine factors that affect surgical oncology, for example, wait times for diagnostic imaging
  - Near real-time data allow managers to understand issues present at the local hospital and consider region-wide solutions. For example, if the regional cancer centre is experiencing high wait times for breast cancer surgery, perhaps there is another hospital in the region more likely to accommodate the excess volume.
**Joanne Walker**  
*Overview of WTIS Progress and Access to Care Strategy*

The WTIS system has been the backbone of the Access to Care Strategy since its inception in April 2005. There are currently 1700 surgeons connected with 81 hospitals capturing and reporting wait times, and more than 255,000 surgical procedures are captured annually. Ontario differs from other provincial systems in that WTIS data are captured electronically, with data coming directly from surgeon’s offices and submission is coupled to incremental funding. The WTIS is connected to a Client Registry, which has capabilities that can link the same patient on multiple wait lists. The WTIS system has been modified to capture Wait One dates, where the time to see a surgeon will be known. This request has been eagerly anticipated, as it will be an important part in being able to monitor the entire patient experience.

In order to manage and monitor wait times, it is important to have an understanding of all types of surgeries. Although five surgical areas (cardiac, cancer, hip & knee replacement, cataract, and MRTI/CT scans) were the initial focus of the WTIS roll out, the Ministry has committed to fund the expansion of WTIS to all surgeries. This strategy will be completed in 2009.

**Lindsay Arscott**  
*Wait Time Information System (WTIS) Demonstration*

Lindsay Arscott provided a step-by-step demonstration of the WTIS, as used daily by physicians across Ontario. The WTIS captures wait times in real-time electronically from clinician offices, diagnostic imaging departments, and hospital information systems. It provides information at the clinician-level, service-level and hospital-level to allow informed decision-making and wait list management by clinicians. The system supports accountability and patient choice through public reporting and provides patient-level data for linkage to other data for approved research efforts.

Feedback on the tool is always appreciated to further develop and improve WTIS.

**Julian Martalog**  
*Provincial Wait Time Reporting and Data Quality Improvement*

WTIS allows users to run simple reports and request additional reports through the Wait Times Information Office (WTIO) Request for Information Process. The WTIO will proceed with implementation of an industry-standard Business Intelligence (BI) tool as the reporting layer, along with the WTIS reporting database. This initiative is planned to go live on April 14, 2008. This will be the first step towards a full wait time data warehouse. The BI Initiative will provide the MOHLTC, LHINs, hospitals, and the WTIO with the information required to allow informed decision-making and provide stakeholders with standardised, timely and reliable wait time information to help guide patient-referral decisions.

WTIS data are assessed rigorously for quality improvement, and is based on four dimensions - timeliness, validity, reliability, and usability. Along with the creation of tools to improve accuracy (i.e. case prioritization), there are areas for further education that have been identified.
Michael Sherar/Judy Burns

Cancer Care Ontario’s Role in Wait Times Reporting

Wait time information is critical and underpins the strategy to develop health system performance changes. It is a very simple approach that applies reasonable business practices to assist in running a high-performance health care system. The basis of the approach is the Ontario Cancer Plan, which leads to a set of annual priorities. The strategy closely links incremental funding for increased access to improved quality standards and guidelines. Priority targets are monitored and reported regularly, and in some cases disseminated publicly. Partnership with regional representatives including Regional Vice Presidents, Surgical Oncology Leads, partner hospitals and sometimes LHIN administration is imperative to the success of the cycle.

Through regular monitoring, in-year reallocations of funds are made to optimize the number of procedures completed. For example, if a hospital is not able to meet the incremental surgery volume targets, the funds may be transferred to another hospital that has both the demand and the capacity for more cases.

CCO measures, monitors, and reports surgical, radiation and systemic wait times. Performance monitoring and reporting are achieved through a structured quarterly process with input from Regional Cancer Programs and CCO. This process is aided by electronic access (via iPort™) to the most up-to-date regional performance on priority areas, as well as automatic blackberry updates when new data are available. The CCO website reports radiation and systemic wait times on a monthly basis and the Cancer System Quality Index (CSQI) reports annually. The performance improvement cycle continues to evolve, in particular strengthening the incentives for compliance on quality initiatives (schedule B) and pay for performance.

Discussion Highlights:

- Wait times reporting is based on the surgeon / individual level, yet waiting times reflect system-wide issues. Therefore reporting should be at the hospital level. This will be raised with WTIO.
- A small percentage of patients are on multiple lists. When this occurs, the user will receive a notification when submitting a case that the patient is already on another list.
- There is a need to look at the whole waiting period, and not just wait times for ‘decision to operate’ to ‘date of surgery’.
- With the increase in administrative work, it may be beneficial to provide hospitals with funds to complete the work.
- Some participants do not find reporting by the 90th percentile useful. Such long wait ‘outliers’ may be a data submission issue, and patients do not understand 90th percentile; therefore, median waits may be more meaningful. In response, it was recognized that public reporting is concerned with long waits, but this may not be an issue once the move to priority level reporting is completed.
- Surgeon participants were asked how often this statement was true “I personally set the priority classification of my patients.” The responses (please see table to the right) suggest that there is a good level of surgical input into the priority category. There is a concern that while the audience members may buy-in to this process, there may be a higher proportion of surgeons who are not in attendance that do not properly prioritize.

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<thead>
<tr>
<th>Always</th>
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<tr>
<td>Sometimes</td>
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<tr>
<td>Rarely</td>
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<tr>
<td>Never</td>
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Dr. Ken Gehman
Leveraging change in the Region (Northwest LHIN)

Northwestern Ontario, which accounts for 62% of Ontario’s landmass and is home to 13 regional affiliate hospitals, has always been viewed as under-serviced and under-resourced.

**BEFORE WTIS:** There was no formal surgical oncology program, few tumour boards, and long wait times for surgical workups, including pathology and needle biopsy.

**AFTER WTIS:** With relatively little push back from the surgical community, WTIS was rapidly implemented. As a result, Thunder Bay Regional Health Centre leveraged the surgical oncology budget and was able to hire a clinical lead in surgical oncology, a surgical coordinator and a registered nurse; along with developing MCCs in all major disease sites and garnering support for a patient staging project. The data show that additional pathology resources are needed to decrease the wait times for diagnosis.

**RESULTS:** The Northeast LHIN is now a consistently high performer for wait times in cancer surgery.

**OVERALL:** WTIS in cancer surgery has permitted the region to push both quality and wait times agendas to improve patient care.

Dr. Michael Fung Kee Fung
Creating sustainable change - The Champlain Model

Champlain region demonstrated wide variations in clinical practice that resulted in disparity in outcomes, resource utilization, and access, which was mainly attributed to a system that promoted isolation of clinicians, multiple handoffs in the patient journey, and long wait times. In 2004, it was decided sustainable change was needed. The goals included: improved use of evidence-based cancer care practices, initiate communities of practice to engage in regional knowledge transfer, and to create a hub for high quality cancer processes.

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<tr>
<th>Enablers</th>
<th>Challenges</th>
<th>Lessons Learned</th>
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| • Provincial focus on cancer services quality improvement/ process re-design to decrease wait times  
• Defined Regional Cancer Surgery Model (Hub & Spoke)  
• Cancer Services Implementation Committee initiated (oversight)  
• Process re-engineering to decrease wait times | • Impact on non-cancer surgery services and wait times  
• Need to change management/administrative processes within the Ottawa Hospital to focus on issues of quality within cancer care  
• Patience for time required for improvement and measurable successes | • Engage both surgeons and interdisciplinary clinicians, and administrators  
• Leverage Burning Platform (eg. incremental surgical volumes)  
• Ensure relevance to practice  
• Clearly defined project team: roles & responsibilities  
• Build sustainability into the plan!  
  ▪ Seek funding opportunities & engage interested opinion leaders actively  
• Keep the momentum! |

**Overall**

Developed a platform to maintain sustainable improvement in cancer surgery care within the Champlain LHIN.

Dr. James Waddell
Toronto Central Hip and Knee Program

Recognizing the long wait times for hip and knee surgery, The Ministry of Health and Long Term Care provided funding for additional 1680 procedures between December 2004 to March 2005 and for another 6700 procedures from April 2005 to March 2006. The Hip and Knee Expert Panel recognized that in order to maximize the effect of these funds, it was important that services be delivered on a LHIN basis with: a common care pathway, assessment clinics, a single wait list, and transparent communication. The delivery of these services is based on 3 goals which included: improved pre-operative assessment, improved in-hospital efficiencies and improved rehabilitation services for patients after surgery.
The Toronto Central LHIN began a re-design of the patient care process, which has resulted in remarkable improvement. First, all patients are directed to a central intake centre which creates a single wait list; the patient is then referred to an assessment centre where the patient is considered for surgical consultation. If the patient is not considered a surgical candidate, his/her care does not end, but rather the patient is referred to an appropriate arthritis clinic. Otherwise, the surgical patient is able to choose his/her preferred surgeon or the surgeon with the shortest wait time.

**Results:** Using this model and additional resources, the Toronto Central LHIN increased the annual surgery capacity by 50% and decreased wait times from 115 weeks to 18 weeks.

**Challenges:** It is an expensive program; physicians are working longer which has an impact on teaching and research priorities, and there is a perception that the problem has been solved with the decrease in wait times.

### REGIONAL INITIATIVES: Use of Data

**Dr. Bryce Taylor & Cara Flemming**  
*An Academic Centre Perspective*

At University Health Network (UHN), the key to implementing the Access to Care Strategy has been the development of the Surgical eForm that allows a surgeon to book an operating room (OR) case, while simultaneously populating the WTIS information. A key motivating factor is that a surgery cannot be booked in the OR without submission of the eForm. This system is not unique to cancer surgery at UHN rather it is necessary for all types of surgery. This has been a benefit because as more surgical specialties are being introduced to WTIS across the province the transition and data collection has already been adopted at UHN. This is not a proprietary tool and is available to other hospitals. Proper use of the system has required intensive training and educational sessions with surgeons and administrators.

Challenges remain with the system:
- Are we managing our wait lists any better then we were before?
- Are non-funded surgeries being scheduled less frequently?
- With ever-increasing demands for data collection, can we keep up?
- Surgeons are paid fee-for-service; therefore, a culture change is required to refer patients to shorter lines
- Two-day submission of cases is difficult in the clinical setting

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<th>Entire Audience</th>
<th>Surgeons only</th>
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<td>44%</td>
<td>33%</td>
</tr>
<tr>
<td>5 business days</td>
<td>46%</td>
<td>60%</td>
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<tr>
<td>10 business days</td>
<td>10%</td>
<td>7%</td>
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**Dr. Craig McFadyen**  
*A Community Surgeon’s Perspective*

A Wait Times Steering Committee was convened to implement the initiative in the Waterloo Wellington LHIN.

1. Many surgeons’ offices did not have internet access or computers that supported internet access.
2. Educational sessions for both administrative staff and surgeons were provided.
3. Mandatory surgical case entry to book a surgery was instituted, similar to UHN eForm.
4. Data were monitored and regularly reported to each surgeon’s office, and outliers or ‘red flags’ were addressed with a personal phone call. A red flag could include a large proportion of Priority 2 cases or too many cases missing the priority wait time target.
   - Lesson: These issues were largely a result of data quality; including inappropriate prioritization and misunderstanding of the data entry process. To resolve the issue, further education was deployed.

**Results:** No significant changes in median wait times but the surgery case volumes have risen 50%

In a survey of the region, most community surgeons do not see the wait time initiative as a value added benefit to practice management, they rarely use the system to manage their wait times, and gaps in understanding and using WTIS still persist. At the surgeon level, there is the perception that there is a failure to link wait times with quality. Albeit not perfect, there are now data where they did not exist before. These data allow for useful and strategic resource based allocations and system management.
Dr. Jonathan Irish moderated the discussion, the panelists included:
- Dr. Michael Fung Kee Fung, Surgical Lead Champlain
- Dr. Ken Gehman, Surgical Lead, North West
- Mr. Garth Matheson, Regional Vice President North Simcoe Muskoka
- Dr. Craig McFadyen, Surgical Lead, Waterloo Wellington
- Dr. Robin McLeod, CCO Surgical Lead, Quality Improvement
- Dr. Ori Rotstein, Chair, General Surgery Expert Panel
- Dr. Bryce Taylor, Chief of Surgery, University Health Network
- Dr. James Waddell, Chair, Orthopedics Expert Panel

Experiences with Physician Buy-in
- Having an IT system that is mandatory to complete for an operation to be booked has been key to physician buy-in, especially now when it is used for all surgeries within the hospital.
- The demands for IT are immense.

Stronger link between Access and Quality Care
- Funding provided to improve access to care needs to be expanded outside the realm of OR resources and include other aspects of the patient pathway including access to diagnostics, access to multidisciplinary cancer conferences, and post-operative care.
- Data allow clinicians and administrators to speak the same language and make informed decisions on patient care.
- Strengthening the language in Schedule B, which is a part of the Cancer Surgery Agreements is not a huge driver. It is better to have a discussion without bringing a contract into the picture. Clinicians are not concerned with it, but rather building a culture of quality improvement.
- MCCs have created a collegial culture and built bridges between disciplines to work together, understand constraints and patient care issues. We believe this has also decreased patient wait times.

Are there transferable lessons for the upcoming launch of WTIS throughout general surgery?
- More WTIS education for surgeons and administrators; following up with outliers in the data, which may be a source of misunderstanding the system, rather than a patient care issue.
- Luckily many general surgeons are already familiar with WTIS
- An issue will be the enormous volume of general surgery cases to manage in the system
- It has been the perception that every surgeon wants their administrative assistant to be paid for the data submission. In an informal poll of the audience the majority of surgeons do not pass additional funds onto their assistant for this work.

There is a trend towards seasonal variation of cancer surgery waiting times.
- Seasonal variation occurs typically during the summer vacation period and the December holiday season.
- Each centre had a slow down in activity during these periods, though there were exceptions, as surgeries were performed if required. The periods of decreased scheduling are not only caused by less available resources; but also, due to patients’ preferences not to be operated on during these times.

Process Improvements & Efficiencies
- MCCs have been a vehicle, to not only improving the quality of care, but also improving access.
- Specialized care when needed. Participants considered areas to streamline and improve processes of care including the function of nurse practitioners in the follow-up care of surgical patients. It is possible that nurse practitioners could take on a more significant role in patient follow-up care which would allow surgeons to see more new patients. In some locations, family practice is relied upon more heavily.
- Surgical eform – one system to book an OR and complete the WTIS information.
There has been a shift in the focus of the delivery of care across Ontario. We have moved away from a clinician-based focus towards a more multidisciplinary approach which takes into account hospitals and regional variations. The bottom line in all quality and access to care initiatives is being able to provide the best care for the patient, and that means performing the right surgery at the right time in the right hospital.

There is a perception that collecting Wait Times data is not a valuable use of resources nor does it have a significant impact on patient care. In this forum, a variety of benefits derived from the availability of wait times data were discussed, they include:

- The development of Surgical Oncology as an entity within the surgical realm
- Ontario becoming a world leader in health care information systems
- Using data to manage the entire system has enabled clinicians and managers to understand system-wide bottlenecks and pinpoint resource investments that will impact waits (additional pathologists, nursing staff, etc.)
- A culture shift towards performance management
- Provides a catalyst for quality improvement initiatives as funds are available to incorporate provincial initiatives (eg. MCCs)

The link of access to care and quality care needs to be emphasized and strengthened, regardless of the hospital providing the service. Though it may make sense for certain types of procedures, moving all cancer surgeries to larger centres is not the answer nor is it realistic.

There are opportunities to further evolve and improve the Wait Times Strategy and decrease patient wait times. Some points included

- Use of technology to minimize the administrative workload (eg. Surgical eForm)
- Ongoing education of the system to ensure it is being used properly. This will improve the data that is reported and build clinician confidence in its use. Dr. McFadyen described an effective method of identifying data quality issues (“bird dogging”), by personally calling the users to understand if there was a problem. In each particular instance, it was the result of a misunderstanding of the system and was corrected with minimal education.
- It is meaningful to clinicians and patients to collect data on the entire patient journey, namely how long from diagnosis to surgical consult a patient waited.
- Identify process improvements or efficiencies that optimize the use of human resources and share these practices between regions. For example, the role of nurse practitioners and family health teams in patient follow-up care when appropriate. This may provide additional time for surgeons to see new patients.

Moving forward, it is clear that there are a number of strategies that will continue and be expanded upon:

- Incremental surgery volume funding can lead to quality improvements and we will continue to emphasize the link between access and quality.
- The continued engagement of surgeons and administrators in both the planning and feedback of initiatives is imperative to the success of the access and quality improvement agenda.
- We need to continually evolve the processes with regards to innovative approaches to hospital collaboration and we also need to build sustainability across the system.

The Symposium was a successful beginning to the ongoing evolution of the Wait Times Strategy.
APPENDIX A: Pre-assessment Survey Summary

In preparation for the event participants were surveyed to gauge current use and understanding of the system. With a 41% response rate, the following responses were provided:

The Wait Times Reporting Initiative has had the following effects on my practice/hospital/region:

The Incremental Cancer Volume Funding Initiative has had the following effects on my practice/hospital/region:

I believe that the data used for the wait times reporting are of good quality, complete and useful.
How can the wait times data be improved?

What specific topics would you like addressed at the wait time symposium?

How have the Access to Care Programs (CSA funding/WT Information System) Improved patient care in your centre?

- Additional resources and increased OR time.
- Provides data for pro-active decision making around resource allocation and program planning.
- Better understanding of patients in terms of timely access at various stages in their journey.
- Provide comparative data and benchmark targets.
- Very little impact/not known.
APPENDIX B: Audience Participation Questions

In my practice/hospital/region the Wait Times Reporting Initiative has affected CANCER SURGERY WAITING TIMES with a:

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<thead>
<tr>
<th></th>
<th>Entire Audience</th>
<th>Surgeons Only</th>
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<tbody>
<tr>
<td>1. Significant increase</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>2. Moderate increase</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>3. Low to No change</td>
<td>26%</td>
<td>44%</td>
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<tr>
<td>4. Moderate decrease</td>
<td>52%</td>
<td>52%</td>
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<tr>
<td>5. Significant decrease</td>
<td>7%</td>
<td>4%</td>
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In my practice/hospital/region the Wait Times Reporting Initiative has affected ADMINISTRATIVE WORKLOAD with a:

<table>
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<tr>
<th></th>
<th>Entire Audience</th>
<th>Surgeons Only</th>
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<tbody>
<tr>
<td>1. Significant increase</td>
<td>62%</td>
<td>39%</td>
</tr>
<tr>
<td>2. Moderate increase</td>
<td>29%</td>
<td>57%</td>
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<tr>
<td>3. Low to No change</td>
<td>7%</td>
<td>4%</td>
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<tr>
<td>4. Moderate decrease</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>5. Significant decrease</td>
<td>2%</td>
<td>0%</td>
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</table>
In my practice/hospital/region the Wait Times Reporting Initiative has affected RESOURCES (operating room time, human) with:

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<tr>
<td>1. Significant increase</td>
<td>9%</td>
<td>13</td>
</tr>
<tr>
<td>2. Moderate increase</td>
<td>42</td>
<td>35</td>
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<tr>
<td>3. Low to No change</td>
<td>44</td>
<td>48</td>
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<tr>
<td>4. Moderate decrease</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>5. Significant decrease</td>
<td>0</td>
<td>0</td>
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</table>

In my practice/hospital/region the Wait Times Reporting Initiative has affected PATIENT CARE with:

<table>
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<tr>
<td>1. Significant improvement</td>
<td>4%</td>
</tr>
<tr>
<td>2. Moderate improvement</td>
<td>53</td>
</tr>
<tr>
<td>3. Low to No change</td>
<td>54</td>
</tr>
<tr>
<td>4. Moderate failure</td>
<td>1</td>
</tr>
<tr>
<td>5. Significant failure</td>
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</table>
Overall Response rate = 65% (total no. of participants= 88)

1. Overall satisfaction with the Symposium event

2. Panel and audience discussion was valuable

3. What aspects of the event did you find most valuable?
   - Learning about the experiences of other regions
   - Real examples of regional issues and system change.
   - Understanding future directions of wait times reporting/data

4. How will you use this information in your facility region?
   Majority of respondents (87%) indicated that they would share the information learned at the symposium with RVPs, CEOs Surgical Committees etc.
   Specifically noted were:
   - Implementation of e-forms
   - Implementation of more comprehensive data quality sessions
   - Development of data monitoring tools

5. What aspects of the event do you think could be improved?
   - More focused discussion on wait times and links to quality
   - Hear feedback from hospital administrators
   - Provide a more interactive approach (i.e. small group sessions and interactive problem solving
   - Shorter presentations leaving more time for Question and Answer periods
   - Increase networking opportunities
## APPENDIX D: Attendance List

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Organization</th>
<th>Last Name</th>
<th>First Name</th>
<th>Organization</th>
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</thead>
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<tr>
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<tr>
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